

Combat stress

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What is combat stress

- Combat stress is a polymorphic condition.
- Symptoms change in nature and severity over time (lability).
- A difficult reaction for even trained psychiatrists to identify and diagnose.

(Helmus & Glenn, 2004)

Early combat stress

- Combat stress reaction (CSR) was not a recognised term in the 20th century during the U.S Civil War.
- Soldiers instead suffered from what was believed to be nostalgia or soldiers' heart - named by a Swiss doctor in 1678. (Campise et al., 2006).
- Nostalgia was characterized by feelings of homesickness, extreme aggression, problems of authority, social isolation and constricted emotion.
- Soldiers heart was a cardiac condition which involved an increased heart rate and fatigue, but no physical medical problems were visible.

(Helmus & Glenn, 2004)

Principles

- 3 principles of frontline treatment – proximity, immediacy and expectancy.
- Soldiers displaying symptoms should be treated near the combat zone as soon as possible after the symptoms begin, the soldiers are expected to be able to return to combat in a quick period of time after.
- During this period of rest – limited psychiatric intervention is carried out to allow soldiers to process their recent traumatic experiences.
- This frontline treatment was considered simple intervention.

(Solomon & Benbenishty, 1986)

World War 1

- WW1 was a potent trigger for functional disorders with neurological or psychiatric symptoms.
- Dissociative disorders only occurred in servicemen who had been exposed to combat.
- Most common mental disorders within the grounds of war was Schreckpsychosen
- Symptoms of this type of combat stress was believed to be acute and short-lived.
- Schreckpsychosen condition found in Berlin case records – small group of soldiers who relived their traumatic combat experiences in dream-like dissociative states (nightmares).

(Linden et al., 2012).

World War 2

- U.S military attempted to reduce psychiatric casualties by preventing psychologically vulnerable individuals from joining.
- Potential recruits were rejected for educational difficulties, anxiety disorders or neurotic personalities.
- Lack of food, sleeplessness, and unrelenting attack resulted in a high number of psychiatric casualties, and rates of psychoneurosis were nearly equal to those wounded in combat.

(Helmus & Glenn, 2004)

Neurologist – WW2

- Frederick R. Hanson, and colleague Dr. Louis L. Tureen conducted two demonstrations that enabled the teachings of forward psychiatry.
- April 1943 – Hanson petitioned General Omar N. Bradley to use a diagnostic term which was less suggestive of illness than the term psychoneurosis.
- Resulting in new cases of breakdown to be labelled exhaustion, implying psychiatric breakdowns were the result of natural fatigue and simple rest was sufficient to return to duty.
- Symptoms of stress reaction worked against this belief as it generally caused restlessness, irritability, insomnia, depression and anxiety.

(Helmus & Glenn, 2004)

TOE

- Introduction of forward psychiatry envisioned by Thomas Salmon, the War Department authorized the addition of a psychiatrist to the U.S divisions Table of Organisation and Equipment (TOE).

The division psychiatrists acted as the first treatment provider, using neuropsychiatric centres which acted as the second echelon in each corps area.
(Helmus & Glenn, 2004).

Post WW2 - Korea

- Exhaustion casualties were high with 250 per thousand per year due to the absence of forward psychiatric treatment centres, leaving many to be evacuated to the United States.
- Psychiatric Colonel Albert Glass was sent to Korea as a consultant to establish forward psychiatry.
- A 3-echelon system of care was established, the division psychiatrist was the first echelon, theatre-level hospitals being the second and Japan and U.S hospitals being the third.
- The division psychiatrist worked alongside a psychologist, social worker and enlisted personnel to be able to educate division surgeons and line officers in preventative psychiatry.

(Helmus & Glenn, 2004)

Medical Detachment

- Dr. Glass created mobile mental health units called Medical Detachment.
- A group of psychiatrists were known as Team KO, they helped reinforce division psychiatrists during heavy periods of the war.
- Resulting in the reduction of psychiatric casualties suffering with combat fatigue.

(Helmus & Glenn, 2004)

Vietnam – Battle fatigue

- Rates of battle fatigue did not largely change during different peak periods of combat and casualties.
- Numbers of fatigue were less than during WW1 and WW2.
- A 12-month rotation policy for enlisted servicemen was established, with a 6-month command tour for officers.
- Soldiers and marines were less regularly subjected to indirect fire and enemy engagements – were only brief in duration when they did occur.

(Helmus & Glenn, 2004)

Vietnam - treatment

- Wounded soldiers were able to rely on helicopters to remove them safely and swiftly for treatment.
- Regular rotation to base camps reduced the exposure to the risks of front-line combat, further reducing the risk of combat stress reaction.
- Multi-echelon system of psychiatric care.
- Substance abuse became the most common type of misconduct disorder.

(Helmus & Glenn, 2004).

1983 onwards

- Dr. James Stokes in 1985 claimed Combat Stress Control (CSC) was recognised by the Army as an autonomous Medical Department functional area.
- CSC became a distinct Battlefield Operating System.
- Operation Desert Shield.
- Three OM Teams and a 43-person CSC unit were deployed.
- One of the teams set up a holding treatment centre adjacent to the combat support hospital, helping to reduce the increasing psychiatric evacuation rate.

(Helmus & Glenn, 2004).

Gulf War

- CSC units and other mental health assets participated in numerous operational deployments.
- Treated cases of acute stress reactions and provided outpatient treatment for soldiers with pre-existing mental health problems, command consultations, unit surveys, and stress management classes.

(Helmus & Glenn, 2004).

Diagnosing

- British and American armies in 1918 (during WW1) saw the harmful effects of labelling disorders on prognosis, they adopted the term Not yet diagnosed, nervous.
- Operational exhaustion was used to describe when dangerous duty produced psychiatric breakdowns, especially in aviators even when there was no combat involved.
- After WW2, Bartemeier did not correspond combat stress to any recognised or established psychiatric syndrome.
- Bartemeier identified three general types of CSR based on severity and pervasiveness of the reaction - incipient, partial and complete disorganisation.
- Grinker, Cavenar and Nash proposed 5 kinds of combat stress response - passive-dependant, hostile-aggressive, depressive, psychosomatic, and psychotic.

(Solomon et al., 1989).

Reference list

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Slide 2 - Notes

- Has many symptoms within a single casualty, can be different in two separate soldiers.
- Changing of symptoms throughout time, a change in the environment, distance from area of combat, amount and effectiveness of treatment.
- Symptoms change in nature and severity over time
- Combat stress reaction is difficult for even trained psychiatrists to identify and diagnose.

Slide 3 - Notes

- Soldiers believed to be suffering from nostalgia suffered with feelings of homesickness, extreme aggression, problems of authority, social isolation, constricted emotions.
- Soldiers' heart was a cardiac condition which involved an increased heart rate, fatigue, but there was no physical medical problems visible.

Slide 4 - Notes

- Soldiers displaying symptoms should be treated near the combat zone as soon as possible after the symptoms begin, the soldiers are expected to be able to return to combat in a quick period of time after.
- Treatment prioritises satisfying the basic physiological needs by allowing the soldiers to have sleep, food, and drink in relative safety.
- During the soldiers' period of rest there is limited psychiatric assistance given towards the to allow them time to grieve their traumatic experiences.
- The frontline treatment was considered a simple intervention which was believed to be effective in reducing the loss of strength and the possibility of a long-term psychiatric leave.

Slide 5 - Notes

- WW1 was a potent trigger for functional disorders with neurological or psychiatric symptoms.
- Dissociative disorders involving sensation and movement such as seizures or paralyses occurred in servicemen even without exposure to combat.
- Most common mental disorders within the grounds of war was Schreckpsychosen - Which was developed by Kleist which was considered a stress reaction.
- Symptoms of this type of combat stress was believed to be acute and short-lived.
- Schreckpsychosen condition found in Berlin case records - small group of soldiers who relived their traumatic combat experiences in dream-like dissociative states (nightmares).
- Symptoms of the dissociative state included aggressive outbursts, increased motor activity, restaging of battle scenes (shooting imaginary gun), unresponsiveness to external stimuli and amnesia about the episode once the episode is over.

Slide 6 - Notes

- 1,600,000 recruits were denied military service due to psychological or educational difficulties.
- Lack of food, sleeplessness, and attacks resulted in a high number of psychiatric casualties, the rates of psychoneurosis present were nearly equal to those who'd been wounded in combat.

Slide 7 - Notes

- The first demonstration reportedly allowed 30% of patients to return to combat within 30 hours of their arrival.
- The second returned 70% of the soldiers back to combat, with most of the remainder being able to return to base section duty.

Slide 12 - Notes

- First echelon of care was treatment in a battalion aid station, the next echelon was division hospitals, where soldiers with persistent symptoms were airlifted to. The third echelon was two neuropsychiatric specialty teams which could hold and treat patients for up to 3- days before out of theatre evacuations were considered.
- Illicit drug use rates in Vietnam increased from 50% of U.S servicemen in 1968 to 70% in 1973.

Slide 13 - Notes

- Battlefield Operating System - resulting in a large increase of positions within the Table of Organisation and Equipment surrounding care of CSC.
- Operation Desert Shield - The U.S Army deployed mental health teams in order to assist with psychological casualties.
- Focus was to deal with the overdraft of soldiers struggling with combat stress reaction.

Slide 15 - Notes

- Bartemeier – Did not believe combat stress to either be a state of exhaustion, ordinary neurosis, anxiety or fear.