Combat Stress Disorder and the Military Physician An Approach to a Category of Post-Traumatic Stress Disorder

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SUMMARY: The paper addresses the clinical entity of Combat Stress Reaction as it occurs in its immediate, undifferentiated form as well as its well-defined form – PTSD. Some aspects, such as the adaptive function of the syndrome and its relationship to physical injury, which may be of particular interest to the general military physician are touched upon.

After several wars and continuous military tension, we in Israel have accumulated much experience with Post-Traumatic Stress Disorder (PTSD), especially the sub-group known as Combat Stress Reaction. Current psychiatric classification¹ includes Combat Stress Reaction (CSR) within a new diagnostic category: Post-Traumatic Stress Disorder. PTSD is a well-defined syndrome which expresses the psycho-pathological result of experiencing a traumatic event beyond the range of usual human experience. This experience may include natural disasters, serious accidents, concentration camps and war. Despite the apparent differences between the experiences mentioned there is a common denominator of trauma and/or great stress which leads to formation of a typical syndrome. This syndrome has several components:

- a) Recurrent re-experiencing of the trauma through mental images, dreams and nightmares concerning the traumatic event.
- b) A decrease in responsiveness and involvement with one's surroundings, with feelings of remoteness and alienation from people, loss of interest in activities and areas previously important to the person.
- c) Various symptoms of an autonomic or dysphoric or cognitive nature which did not exist prior to the trauma. These include such phenomena as nightmares and insomnia, panic reactions, irritability, concentration and memory difficulties. Avoidance of any activity that arouses recollection of the traumatic event may also occur. Frequently, there are painful guilt feelings about the affected person's behaviour during the war or because he survived. Depressive and anxiety symptoms of varying severity are common.

The PTSD syndrome described seems to represent a final common pathway for different traumatic events, and a rape victim, for example, might suffer from a

similar constellation of symptoms as would a traumatized combat veteran. The criteria as defined have recently been considerably strengthened as to their diagnostic value in the screening of war casualties in Israel and abroad^{2,3}. Signs of combat stress appear following either a single traumatic war experience or an accumulated series of events; the first symptoms may appear immediately or they may occur after a delay in time.

Immediate Combat Stress Reaction

The fully differentiated syndrome of PTSD described above develops after a certain time lapse, in the course of which the affected soldier has already been removed from the field of combat. Therefore, the PTSD syndrome is not of diagnostic use, per se, in the heat of battle when the early symptoms of immediate CSR appear⁴. It is in this period, before the picture has gelled into one of classic PTSD, that the importance of the diagnosis of immediate CSR must be emphasised. Without such a diagnosis, the application of specific, provenly effective front-line treatments, which speed the victim's recovery and return to military functioning cannot be performed.

The prevailing medical consensus is to view return to military functioning as a pre-condition to, and expression of, the victim's convalescence and recovery. The military physician recognizes the fact that the military system, in whose framework this treatment concept of early return to military function was fashioned, has a vested interest in attenuating such casualties and returning them to active duty. Since the incidence of CSR may range as high as 15-30% of total casualties⁵ the interest in reducing this loss as quickly and efficaciously as possible becomes understandable.

In order to improve early identification and diagnosis

of CSR victims, one must understand the special circumstances of the soldier in combat, and how CSR comes to be expressed in the context of the battlefield. Fear of death is the dominant feeling of the soldier on the battlefield. His central conflict is between, on the one hand, his impulse to flee and at any cost be safe from the danger which threatens his existence, and on the other his soldierly duty to remain, combined with an obligation and attachment to his comrades. The soldier's staying power and ability to function are directly affected by the intensity of this flight/fight conflict. To these basic elements may be added a wide variety of biological, psychological and social factors, which also influence the soldier's tolerance and hence his personal breakdown threshold⁶. In addition to the aforementioned general stressors, soldiers in therapy frequently cite highly specific factors of a more individualistic nature as contributing to their breakdown. Included in such detailed accounts are stressors such as massive sensory assault, witnessing gruesome wounds in others, isolation and, not infrequently, command incompetence. Recently, and in line with American experience in the Vietnam war⁷, our soldiers have had to deal with the exceptional stressogenic combination of bizarre suicidal terrorism in a climate of overall political uncertainty and lack of clear objectives.

At the opposite end of the therapeutic pole, the physician's ability to detect such CSR in evanescence is determined by what has been called the identification threshold⁸. The identification threshold is in turn a product of the physician's knowledge and awareness on the one hand, and the nature of the battle, together with factors such as morale, leadership, and unit cohesion, on the other. Thus, the identification threshold does not always correspond to the severity of the developing clinical picture and severe psychopathology may exist without being recognized.

The initial symptomatology of immediate CSR is characterized by free floating anxiety lacking a uniform clinical expression. Symptoms are varied and may involve a combination of psychological (effect, cognition, orientation, concentration, memory); physical (autonomic, motor and sensory); and behavioural elements (disturbance in communication, disruptive or aggressive behaviour, withdrawal and excessive submission).

The clinical syndromes which form and are described in the literature are many and varied. One may see a reaction in which the main component is physical exhaustion together with a lack of military functioning and anxiety of different levels of severity. Traumatic dissociative conditions with two extremes may also present; one of hyperkinesis and extreme unrest, and the other of withdrawal and dissociation to the point of stupor. Conversion symptomatology, phobic reactions, conditions characterized by severe behavioural disorders, depressive reactions and even acute psychotic conditions are also not infrequently seen^{9,10}.

Thus it will be appreciated that the Post Traumatic Stress Disorder as defined above is, as compared with the immediate syndrome, much more differentiated and distinctive than Immediate CSR. Also, Immediate CSR is, when first seen by the forward medical officer, newly occurred and relatively plastic and thus tends to lack readily predictable characteristics. In contrast to PTSD, Immediate CSR has a multiform appearance with accompanying symptoms from a wide psychiatric spectrum.

In this context it is interesting to note the powerful suggestive influence which the prevailing clinical description itself has on the symptomatic expression of CSR. Thus, in World War I the term used at the time was "shell shock", and the victims indeed appeared "shocked and confused". In the World War II period, when the term "battle fatigue" was the vogue, the common clinical presentation was "fatigue and inability to function". Hence the need for a "neutral" term such as "Combat Stress Reaction"¹¹.

Noy⁵ points to the change in constellation of symptoms at different organizational levels in a given war. Thus the expression for Combat Stress Reaction in fighting units was, "I cannot go on fighting", which leads to the evacuation label, "lack of ability to function militarily". In front-line general medical treatment stations this evolved to, "Multiple somatic complaints". In front-line psychiatric installations, on the other hand, the main complaints registered were, "Various expressions of anxiety". In rear-echelon installations, as a final contrast, "Depressive conditions" predominated. Hence the authors conclude that these symptoms being neither specific nor static possess certain psychodynamic significance. The symptoms serve to convey the message that the victim is unable to continue functioning as a fighter and thus requires to be removed from and kept out of the battlefield.

These findings contribute an additional dimension to the understanding of CSR. Not merely a reaction, CSR serves also an adaptive function. The result permits the soldier to be removed from the battlefield and the terror of death. This conception enables an expanded definition of acute CSR. In accordance with such a view, Immediate CSR would not be limited to psychological or behavioural syndromes exclusively, but would include certain somatic or somatoform illnesses. Indeed, Immediate CSR may, in addition to behavioural or somatic disorder, even encompass certain accidents (including self-inflicted harm), which present to the military physician. All of the above may be the outcome of prolonged exposure to combat stress on the one hand and a (basically unconscious) attempted resolution of the soldier's difficulty on the other. In this conflict resolution occurs by tipping the scale towards "illness" or injury and thus, exit from the war.

If the treatment agency in times of war uses a widened definition of CSR which incorporates all the requests for evacuation from the battlefield not due to direct injury

by enemy fire, it facilitates the integration of preventative and therapeutic efforts by all medical personnel in the field. It also encourages and promotes the front-line treatment approach which is so strongly indicated for the majority of cases mentioned above.

Physical Injury and CSR

In the various Post-Traumatic Syndromes, especially in those associated with severe accidents, the physical injury itself is frequently recognised as a major aetiological factor in the syndrome's development. The view which posits CSR as an adaptive reaction, removing the soldier from the battlefield, may prompt the somewhat premature, if logical, inference that the soldier who is physically injured has already received legitimation to leave the battlefield and will therefore not "need" CSR as an exit ticket. However clinical reality demonstrates that physical injury may very well co-exist with serious psychic damage although the latter is often masked initially.

Conventional Medical or Surgical units tend naturally to concentrate on physical disease or bodily injuries, splitting off and tending to neglect the psychological component. This artificial dichotomy is responsible in large measure for the absence of prompt psychiatric intervention. Since clinical experience on both sides of the Sinai¹² emphasizes the regular development in physically injured soldiers of serious post-traumatic syndromes, it is obvious that immediate appropriate psychiatric intervention at an early stage is vital. Such treatment is likely to prevent fixation and to keep serious disturbance from becoming chronic.

A good illustration of the complex interrelatedness of physical and psychological injury in CSR is provided by the Russian psychiatrist Juslin¹³. He describes Russian soldiers during the World War II period who, towards their recovery from serious physical injuries and imminent release from hospital, developed a psychiatric syndrome. This condition consisted of difficulty in forming relationships to the point of stuporous withdrawal with typical paranoid ideas of reference.

Juslin emphasises that among them were heroes decorated for their fighting before being wounded. He characterizes them generally as having had strong pre-morbid personalities with good coping capabilities. He notes with a trace of sadness that, ironically, "they are now being examined before trial for treason against the motherland. They will be exposed as cowards and traitors ostracized from society and sentenced to death". Juslin speculates that the renewed threat contained in recovery and anticipated return to combat following the injury, and its accompanying legitimation to be out of the battle is what brought the patients to breaking point and to develop the psycho-pathological syndromes which he described. They generally recovered from it after a few months treatment.

Conclusion and Summary

It may be expected that the modern all-round military

physician, just as he does not retreat from infectious or other illness or from competently assessing, treating, or onwardly referring the physically injured under his care, will not fail to apply his acumen and training to the various aspects of combat stress. He will recognize the difference between immediate and prolonged CSR and will be especially alert for the former, which will frequently declare itself under actual battle conditions. The physician will be aware that Immediate CSR has many presentations. These may include various psychiatric syndromes, individually or in combination, but may also appear as somatic or somatiform disorder. Many accidents and incidents of self-harm will, upon close investigation, also prove to be a product of combat stress. The physician will recognize that only by employing an expanded definition of CSR will he raise his chances of early diagnosis and early deployment of provenly effective front-line treatment approaches. Finally, the military physician will be aware that even a physically wounded battle-field evacuee may, contrary to traditional medical belief, subsequently develop PTSD. He will recognize the importance of prompt and energetic psychiatric intervention in these cases.

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BOOK REVIEWS

Principles of Medicine and Medical Nursing. 6th Ed. J C Houston and H H White. Hodder and Stoughton. 1985. Pp 1 + 235 £4.95. Illustrated.

This is a new edition of what was previously an excellent and popular textbook. The book gives a useful amount of information about the common diseases and unfortunately very little about specific nursing care. The nursing process and the problem solving approaches to nursing care which have been part of various schemes of nursing education since the late 1970's have not been discussed at all. No consideration appears to have been given to the concept, philosophy or implementation of modern nursing as it relates to the psychological and social needs of patients.

Despite the book's useful review of medical conditions I feel that I could not recommend it to my learners because of its very traditional style, which is rather outdated.

T MURNAGHAN

Surgery and Surgical Nursing. 4th Ed. S Taylor and M Birchall. Hodder and Stoughton. 1985. Pp 1 + 334. £8.50. Illustrated.

This book is intended to provide nurses with a broad knowledge of the pattern of disease and trauma and of surgical treatments, from which to develop and apply their nursing skills.

The authors' approach is a traditional one in which a wide range of common surgical disorders and their treatments is systematically described. In covering such a wide range within 334 pages however, the information given on any particular subject is necessarily brief and is not likely to provide the reader with anything more than a superficial knowledge.

For a book on surgical nursing written for nurses, the coverage given to nursing care of surgical patients is totally inadequate. For example, the nursing care of patients with intestinal obstruction is described in only seven lines. In spite of credit being given to the nursing process in the preface of the book, the authors fail to demonstrate how it might be implemented in the case of surgical patients.

It is difficult to recommend this book to either trained or student nurses. The same material is available in many other texts which are far more likely to provide the nurse with the necessary level of understanding of the care of surgical patients.

M D DEVLIN

Exotic New Disease – Review of the Emergent African Viral Haemorrhagic Fevers. Ethelwald E Vella. Directorate of Supply (Army) Technical Equipment Divisions, Forms & Publications Branch, 1985. Pp 1 + 263 £19.00 (UK), £23.00 Overseas Illustrated.

BOOK REVIEW

As the title indicates, this book is concerned with the quite recently described viral haemorrhagic diseases found in, and exported from Africa. The principle diseases covered are Lassa Fever, Marburg Virus Disease, and Ebola Fever, although shorter accounts of related diseases are also included.

The quality of the content is extremely high, and the inimitable style of the author shines through every page, greatly enhancing the book's readability. Where else in the literature of virology would quotations from Thucydides and Ecclesiastes mingle with medicine? The inclusion of extensive bibliographies makes this more than a well written review; it is indeed a starting point for anyone who wishes to research any aspect of the subject.

I have already mentioned that the style of writing makes the book extremely readable, and I particularly enjoyed the introductory narrative accounts of the early identification of the diseases. There is much in this book which will be of interest to pathologists, clinicians, and scientists and it should certainly be made available to all military hospitals, tropical diseases hospitals and practitioners who care for those who regularly undertake international travel or come from the African continent.

If I have a complaint about the book, it lies not in its content, but in its presentation. It is published in a plastic ring folder, the text being in loose-leaf form. I do note that page 1 contains an Amendment List Record, and presumably it is intended that in future years amendments will be incorporated into the text. In its present form, however, I do not believe that many volumes in use will last long into the future because the pages will tear on the rings of the binder and the book will become less easy to use. Such a well written and useful work deserves a better presentation.

Despite this criticism, the book must be endorsed as a major work from a distinguished author, and thoroughly recommended to all with an interest in tropical medicine.

R C MENZIES