

Principles of military psychiatry

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IN SEVERAL LARGE AND MEDIUM SIZED WARS psychiatric disorder has provided more casualties and discharges than any other cause. Inadequate or inappropriate management of these casualties can produce a catastrophe. As so often happens, lessons dearly bought are soon forgotten; this article is an attempt to keep the memory alive.

It is a reasonable assumption that the various tribes of *Homo sapiens* have been at war with each other for most of the time since they came down from the trees. Battle is a stressful activity. The earliest reference I could find to the consequences of that stress comes from Walter Alvarez, who quotes Sennacherib from almost 3000 years ago: "The vehemence of my battle line like a bull overwhelmed them ... to save their lives they trampled over the bodies of their soldiers ... with their urine they defiled their chariots and lost their excrements".¹

No doubt similar observations and experiences emerged in subsequent conflicts, but we have no information about the size of the problem of the psychological consequences of military conflict until the American Civil War. Even then the significance of the observations was not fully realised.

Early in that war, some 5200 cases of "nostalgia" were hospitalised; 58 died. The precise meaning of the diagnosis is not clear. It was probably something like depression. It was soon regarded as a reflection of a weak character and the diagnosis of "nostalgia" was firmly discouraged, with the result that between 1863 and 1865 not a single case was reported.

A further result was that there were 145 000 hospitalisations for constipation and 66 000 for headache, and there

Synopsis

- ◆ Psychiatric disorder may provide the greatest number of casualties in any prolonged war.
- ◆ Psychiatric disorders induced by war frequently have somatic manifestations (eg, headache, tremor).
- ◆ Prompt management will minimise psychiatric morbidity: treatment (rest, brief counselling, encouragement, expectation of recovery) at the scene, within the military unit, without evacuation.
- ◆ Psychiatric services must be as close to the action as possible. Psychiatrists must be seen to be part of the formation and not as civilians in uniform.

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were 58 000 cases of neuralgia.² One can move the problem around and provide it with new names: it is more difficult to make it go away.

Another example of the lack of appreciation of the significance and extent of psychiatric disorder in war time was provided by the diagnosis of "disordered action of the heart", also eponymously named DaCosta's syndrome, after the physician who described it in 1871. It was a diagnosis made by military surgeons in the Franco-Prussian War of 1870 and the Boer Wars of the 1890s. It remained an official diagnosis in World War One and some 60 000 British soldiers received it.³

Its status as a psychological disorder slowly became apparent and by the 1930s it had become "neurocirculatory asthenia".⁴ Some of those planning at the outbreak of the Second World War considered building hospitals for the anticipated epidemic of DaCosta's syndrome, but it did not arrive.

"Shell shock" provides a final example of the confusion of understanding. There were those who attributed psychological symptoms to the concussion of exploding shells but there were also those who attributed them to cowardice and malingering. It seems to have been a matter of luck as to where the sufferer found himself. If he had "shell shock" he was likely to be hospitalised; if he was regarded as a coward he was likely to be shot by a firing squad.

To look ahead briefly, in 1942 the morale of the forces in the Middle East was poor and there were many desertions. The Commander in Chief, General Sir Claude Auchinleck,



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decided against examining the reasons for the poor morale and instead made a strong recommendation for the reintroduction of the death penalty. When General Alexander took over and improved morale, the prevalence of desertion decreased significantly. There is good evidence to suggest that desertion is primarily a problem of selection and morale. Shooting the victims of senior-level ineptitude is not a good solution (see Ahrenfeldt, pages 271-273).⁵

Beginning to deal with the problem

Returning to the First World War, the problem of the psychiatric casualty rate was brought to notice when, in July 1916, during the First Battle of the Somme, several thousand soldiers were withdrawn from the battle zone with “nervous disorder” (Ahrenfeldt, page 5).⁵ It was August 1916 before the first “Consulting Psychologist” and “Consulting Neurologist” were appointed to the British Expeditionary Force. The distinction between these two areas of expertise was quite uncertain.

The United States forces showed more initiative. In 1917 a select committee advised the United States Surgeon General on “The Formidable Problem of War Neurosis”. The Surgeon General learned from the French military the importance of forward treatment. In France the American Expeditionary Force placed psychiatrists at triage points during combat, and the main psychiatric hospital (Base Hospital Number 117) was located immediately behind the forward lines. Of 3000 men admitted to the hospital, 50% returned to combat assignments and 41% to other duties.²

Another important advance in military manpower management was the introduction of the psychological testing of recruits in the United States in the First World War. Some recruits are intellectually dull and unlikely to become efficient members of the Services. The benefits of psychological selection were unequivocal and by 1936 the German Army had 87 full time specialist officers engaged in psychological selection (Ahrenfeldt, page 37).⁵

The British forces finally adopted the appropriate techniques in 1941, after much argument. The Australian forces got there even later — it was 1942 before the general testing of recruits began in the eastern States.⁶

How to deny the problem

Not only are lessons, painfully learned, quickly forgotten, but sometimes powerful voices are raised against learning anything at all. In 1942 Winston Churchill wrote to the Lord President in the following terms:

I am sure it would be sensible to restrict as much as possible the work of these gentlemen, who are capable of doing an immense amount of harm with what may very easily engen-

erate into charlatany. The tightest hand should be kept over them, and they should not be allowed to quarter themselves in large numbers upon the Fighting Services at the public expense. There are, no doubt, easily recognisable cases which may benefit from treatment of this kind, but it is very wrong to disturb large numbers of healthy, normal men and women by asking the kind of odd questions in which the psychiatrists specialise. There are quite enough hangers-on and camp followers already. (Ahrenfeldt, page 26)⁵

Perhaps the best refutation of this sort of nonsense is to be found in the experience of the United States during the invasion of North Africa in 1943. There were large numbers of psychiatric casualties, which were quickly evacuated to the rear areas and thence to the United States. Some infantrymen developed a shaking of the upper body which prevented them from holding a rifle and some flying personnel reported with paralysis of the fine movements of the hands which prevented them from flying.⁷ At that time, 957 of the 1300 psychiatrists in the United States Army were assigned to hospitals. Therefore, the casualties were evacuated to base areas: most were thought to be incapacitated and sent back to the United States. The loss of personnel from the North African theatre due to the evacuation of psychiatric casualties was such that at one point in 1943 a War Department message stated that “thorough investigation of returned shipments of patients reveals that 50% of the men being returned are better qualified than those being inducted”.⁸

Two psychiatrists were sent to the frontal evacuation hospitals in North Africa and thereafter 50% of the evacuated patients were returned to combat duty after four days of rest, food and encouragement. The Chief of Staff then issued a directive making health the responsibility of command and not solely that of the Medical Department. The result was clear. In September 1943 the discharge rate for neuropsychiatric disorder was 35.6 per 1000 man strength; by May 1944 it was reduced to 11 per 1000 men strength.⁹

Learning the lessons

Within 10 days of D-Day, 10%–20% of battle casualties were cases of “exhaustion”. By the end of the North West European Campaign there were 13 235 cases of “exhaustion”, 16% of all battle casualties (Ahrenfeldt, pages 175-176).⁵

The more forward and directly engaged the psychiatrist, the better the outcome of psychiatric management. The Australian Forces in Tobruk ran Z ward of the 4th Australian General Hospital in a concrete dug-out under a hill on top of which was an anti-aircraft battery — there were few evacuations (Ahrenfeldt, page 179).⁵

The important fact is that in the Second World War, in spite of careful screening at induction, the greatest number of discharges from the United Kingdom and United States

armies were for psychiatric disorder (30.5% of all medical discharges from the British Army were for psychiatric reasons; the United States figure was 35.7%) (Ahrenfeldt, page 279).⁵ Experiences in North Africa and elsewhere showed that if psychiatric services were inadequate or in the wrong place, a catastrophe would soon arise.

The prevalence of psychiatric casualties

The intensity of fighting can be estimated by the number of physical casualties, and it has been shown that there is a relationship between that figure and the psychiatric casualty rate. In the Mediterranean theatre in the Second World War the casualty statistics of the American 5th and 7th Armies showed that in general there is one psychiatric casualty for four wounded in action. If the ratio becomes disproportionate one looks for causes such as “unusually unfavourable environment, prolonged combat without rest, poor leadership, alteration in evacuation policy by the battalion surgeon or mass breakdown in unit morale from any cause”.¹⁰ Levav and his colleagues showed in an examination of the Yom Kippur War that the curve representing the psychiatric casualties lags behind that of the physical casualties by a couple of days but has much the same shape.¹¹

The more intense the fighting the greater the proportion of psychiatric casualties. In Normandy, 10%–20% of all battle casualties of the British 21st Army Group within 10 days of D-Day were psychiatric (Ahrenfeldt, page 175);⁵ in Italy and Sicily the figure was 11%.¹² The evidence suggests that if one keeps a unit engaged in heavy fighting long enough the casualty rate will approach 100%. The psychiatric casualty rate will accelerate towards the end. Swank’s study of better than average soldiers suggested that when about two-thirds of the members of the units have become casualties in one way or another, the remaining third will soon break down (Ahrenfeldt, page 186).⁵

Some principles of management

It is normal to be afraid and to have symptoms attributable to fear. Johnson reports several surveys in the Second World War which examined the experiences of infantry in combat for any length of time. About 50% experienced a pounding heart, 45% a sinking stomach, 30% cold sweat, 25% nausea, 25% shakiness and tremulousness, 25% stiff muscles, 20% general weakness, 20% vomiting, 10% involuntary bowel movements, and 6% involuntary urination.⁹ General S L A Marshall, surveying infantry fresh from combat in the Pacific Islands and in Normandy, found that even in highly motivated units, when hard pressed, no more than a quarter of all fighting soldiers had used their weapons against the

enemy.¹³ It is important not to mistake normal fear for neurosis or cowardice.

Everyone has a limit. Many of those who break down are experienced veterans, some of them decorated. A detailed United States Army report on the 5th Army in Italy in 1944 made the point that if infantry were kept in combat without relief they wore out and became incapacitated. There were several estimates of the time required to achieve this state — it ranged from 140 to 280 combat days. There was general agreement that after 90 days their efficiency began to fall off. If soldiers are relieved they last longer — thus the British Army believed that their infantry were good for 400 days of combat because they were rested for 4 days after 12 days or less of combat. American soldiers were kept in the line for up to 80 days without relief.¹⁴

If service personnel are kept going until they break down few can be returned to duty. If they are rested, but develop symptoms nevertheless, prompt early management will return them to duty.

Psychological assessment at intake cannot identify those more prone to break down in combat, although it can filter out the dull, the illiterate, and the severely disturbed — such as those with schizophrenia. Normal men and women can break down.

It is important to remember that there is such a thing as secondary gain. If one acquires symptoms which remove one from a difficult situation those symptoms can become a valued possession. The epidemic of tremor in North Africa showed that clearly. In Korea, in the winter of 1951, many troops presented with numb feet and symptoms suggestive of frost bite when there was no frost bite.⁷

If there is nowhere to go, as when units are rapidly retreating or surrounded, there is usually a low incidence of psychiatric disorder. For example, there were few psychiatric casualties in the early weeks of the Korean War, because the American forces were in rapid retreat and there was no benefit in having symptoms.²

Evacuation and hospitalisation should be avoided if possible, because the status of illness accorded to those managed in this way will be difficult to remove. Management must be on the spot and immediate. Since the inefficient management of psychiatric casualties can produce rapid disintegration of a military unit, it is important that the psychiatrists be where the action is and that they have a proper understanding of the role of a psychiatrist in war.

Psychiatric casualties should be managed in their uniforms, not in their pyjamas, and the expectation should be that after a rest and some help they will return to their unit.

Group morale is an important determinant of breakdown and recovery.

In Vietnam in 1967 I encountered the United States concept of the Social Work/Psychology Specialist Course. Psychiatrists there told me that those doing the course received a total of 720 hours intensive instruction in basic psychology and psychiatry in the military context. Graduates from the course served in infantry units. The syllabus covered a very wide area.

Soldiers showing signs of decompensating were managed by graduates from the program who wore the same uniform and were part of the same unit as the soldiers. Only if they were unsuccessful was the soldier sent to the divisional psychiatrist, who was right at hand. Only severe cases with psychoses were evacuated.

Conclusion

Psychiatric disorder is very likely to provide the greatest number of casualties in any prolonged war unless the correct principles of management are introduced from the beginning. For this to be done, those in very senior positions must ensure that there is uniformity of management.

The psychiatric services must be as close to the action as possible. Psychiatrists must be seen as part of the formation and not as civilians in uniform. They need to understand the military ethos and be part of it.

Unless it is quite impossible, management of casualties should be prompt, within the context of the service personnel's unit, relatively brief and with all understanding that the expected outcome is recovery and return to full duty.

These goals cannot always be achieved, but the more they are striven for the better the outcome is likely to be and the greater the chance of avoiding catastrophe.

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