

The victor as victim: stress syndromes of operational service

I: Acute stress syndromes

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All operational duties and realistic peacetime training exercises engender acute stress with its normal physiological manifestations. The prevention, recognition and initial management of severe acute stress reactions has always been a requisite management skill of military command and leadership.

Between 2% and 11% of United Nations peacekeepers in deployments beginning with UNIFIL (UN International Force in Lebanon, from March 1978) have been treated for post-traumatic stress disorder.¹ How to reduce this figure, by the skills of command and those of military medicine, remains a great challenge for the future.

The stress of combat or emergency deployment

An underlying doctrine of both best command practice and of military psychiatry is not to “medicalise” servicemen and women who manifest normal stress reactions encountered in combat or the crises of disaster response. A policy of “forward management” is best, using methods that have been summarised as providing sanctuary and applying the PIES principle.²

“Sanctuary” means a place of physical safety and quiet, but still within the military command system. Sanctuary may be a relative term in combat, when the demands of the operation or mission must override the immediate needs of an individual. Its real significance is that it is perceived as a zone of relative safety in the mind of the stressed victim.



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Synopsis

- ◆ Acute stress reactions are a normal physiological and psychological response to the highly abnormal environment of combat, emergency disaster relief and the flashpoint crises that occur during refugee or peacekeeping duties. They also occur in civilian scenarios of horrific trauma, criminal assault and personal violation.
- ◆ In some stressed individuals, the stressor reactions of fear, horror or revulsion exceed the normal adaptive responses of fight or flight.
- ◆ Maladaptive acute stress reactions may involve ego-defence mechanisms of depersonalisation and derealisation.
- ◆ Military and emergency medicine now recognise five traumatic stress disorders: acute stress disorder (overwhelming fear and revulsion), conversion reaction (hysteria, the development of physical symptoms such as blindness or paralysis in response to stress), the counter-disaster syndrome (excessive excitement and inappropriate overinvolvement), peacekeepers' acute stress syndrome (rage, delusion and frustration in response to atrocities) and the Stockholm syndrome (identification by the victim with the perpetrators of violence).
- ◆ Acute stress management should be immediate. In the military system, acute stress should be managed as far forward as possible, with the expectation that short-term cure will be effected and that individuals will return to normal duty.
- ◆ Psychological debriefing (critical incident stress debriefing) is currently best-practice for those exposed to normal stress reactions. Its role in the prevention of post-traumatic stress disorders remains under review.

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The “PIES” principle was first articulated in 1922, when the British War Office published its “Report of the War Office Committee of Enquiry into ‘Shell-Shock’”.³ PIES stands for:

- Proximity of care;
- Immediacy of diagnosis and management;
- Expectancy of return to normal duty in one's own unit; and
- Simplicity of initial care and return to duty — temporary sanctuary, rest and sleep, medical treatment for physical injuries, food and clean clothes, and an understanding listener.³

Traumatic stress syndromes

Syndrome

Acute stress disorder

A syndrome known since time immemorial. Intense fear, horror, helplessness, violation or pain produces this syndrome, with varying threshold points (“breaking points”) in different individuals.

Conversion reaction

Long recognised. Since Freudian theories (which were first expounded 1895) it has been accepted that everyone has a personal threshold which, if exceeded, will lead to involuntary ego-defence escape or protective mechanisms.

Counter-disaster syndrome

Long recognised by all emergency response groups, but specifically described in the 1990s.¹²

Peacekeepers’ acute stress syndrome

Recognised in many United Nations peacekeeping deployments, where combat soldiers, often facing grave personal risk, have been subjected to humiliation or confrontation with a duty of enforced passivity in the face of unresolvable moral and ethical dilemmas.¹

Stockholm syndrome

Well described in many kidnap and hostage scenarios. Encountered also in modified form in UN deployments where servicemen and women side with antagonists.

Diagnosis

Organic signs of fear, tachycardia, hyperventilation, diarrhoea, involuntary micturition, uncontrollable tremor. Panic disorder. Refusal to “go forward”. Physical symptoms of revulsion (eg, vomiting). Includes elements of derealisation and depersonalisation.⁸

Appearance of non-organic symptoms of hysterical paralysis, “unconsciousness”, hysterical blindness or other bodily symptoms.

Excessive excitement of involvement in the drama of combat, rescue or of disaster support operations. Generation of a “high”, sometimes bordering on hypomania. Inappropriate over-involvement. Sense of omnipotence.¹²

Rage, delusion and frustration.¹³⁻¹⁶ Feelings of impotence and helplessness when confronted with violence and atrocities but unable to respond.

Captive or victim adopts philosophies and mores of the perpetrators of kidnapping, hostage-taking or incarceration. May develop in prisoners without overt attempts to indoctrinate on part of captives or gaolers. Seen also in child sexual abuse victims; and in victims of intrafamilial physical abuse, especially women and children.

Prevention and management

Treatment is both a command and a medical function.⁸ Primarily relief, safety and rest. Important not to “medicalise” this natural response to severe acute stress. Primary prevention often impossible — “war is war”. The breakpoint threshold can be raised by cohesive training, high unit morale, strong leadership, good discipline, buddy support; cultural expectations of self-control in the face of sudden stress or danger; self confidence in skills-for-task.

Management consists of a confident diagnosis, evacuation and redeployment if tactical circumstances permit. Those forced to reconfront the precipitating stress or confrontational, horrific situation are at considerable risk of longterm morbidity.

Primarily a command function to insist on adequate rest and the provision of sanctuary; forced adherence to duty shifts, if sufficient manpower present.

Counselling, education and the firm philosophy of “forward psychiatry” and stress management. Prevention is essentially a command function.

Prevention helped by education and by predeployment code-of-conduct training. Longterm support and counselling needed, if subject remains voluntarily compliant.

Acute stress reactions are a normal psychological and physiological response to grossly abnormal situations.^{4,5} Most servicemen and women who experience such reactions will recover completely and return to duty without sequelae. In the civilian world, some 90% of rape victims do not suffer post-traumatic stress disorder.⁶

Each individual has his or her own personal threshold of acute stress reaction in the face of physical risk (sometimes moral risk), pain, horror, disgust or exhaustion. Such thresholds are raised by prior training for the task-in-hand, realistic training simulations of battle, early recognition of and response to acute stress signs, high unit morale and a milieu of individual respect and support.

If a serviceman or woman, having experienced such an acute stress reaction, is not able to return to duty within hours or days of sanctuary, rest and the opportunity for debriefing, then the potential for evolution to one or more of the acute stress disorders becomes obvious. Modern military medicine must recognise and treat such reactions to severe acute stress, yet not encourage a milieu in which such reactions are “expected” in the deployed force as a whole.

Traumatic stress syndromes

Acute stress disorder has been recognised as a formal psychiatric diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* only since 1994.⁷ It includes what used to be called “acute shell shock”.³

Acute stress disorder is a decompensated progression from the more normal acute stress reaction. People with acute stress disorder manifest derealisation and depersonalisation (eg, they may become withdrawn, appear mute, or deny personal or environmental reality).⁸ They are temporarily ineffective in their operational role and may be a risk or burden to others. Their treatment is both a command and a medical function.⁸ Management is based on an understanding that the disorder is a reaction to horror, helplessness, fear or violation that exceeds the individual’s ability to cope. As for acute stress reaction, the PIES principle applies — keeping the victim within the military system, within sanctuary but without unnecessary evacuation; and with the expectation of recovery and return to duty.

Critical incident stress debriefing is assumed to be valid in a wide range of settings but its effectiveness remains unproven and is currently under review.⁹⁻¹¹ The debriefing is conducted as a small group process by a trained person, usually an experienced officer or non-commissioned officer. Such counselling typically takes 2–3 hours. It provides a safe, secure and private forum for the ventilation of shock, grief, guilt or concern, and offers an opportunity to correct factual misunderstandings and establish a true perspective on the circumstances of the critical incident. The counsellor expressly acknowledges that shock, horror and denial are normal reactions to highly abnormal events. The primary aim is to reduce the intensity of stress reactions that might follow an incident, but it is not assumed that critical incident

stress debriefing will always prevent the development of post-traumatic stress disorder.

An outline of the diagnosis, prevention and management of acute stress disorder and other traumatic stress syndromes is shown in the Table. All are acute syndromes, presenting within days or weeks of the stressor, and all are potentially curable.

The next article of this two-part series discusses post-traumatic stress syndromes.

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