Chapter 3

DISORDERS OF FRUSTRATION AND LONELINESS

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Edward J. Bowen *Bunker on Nuo Ba Dhn Mountain* 1969

Private Edward J. Bowen, a member of the U.S. Army Artist Program, depicts soldiers in their bunker in Vietnam. Low-intensity combat is characterized by significant lulls in the fighting, during which soldiers have time for a variety of activities, as shown in this painting. If not managed properly through constructive activity, such lulls can give rise to disorders of frustration and loneliness.

Art: Courtesy of US Center of Military History, Washington, DC.

INTRODUCTION

The future may produce many different types of war; however, because of the nuclear stalemate, modern wars involving industrialized nations are increasingly of the low-intensity, intermittent, but protracted type experienced by the French in Algeria and Indochina, by the United States in Vietnam, and by the Soviets in Afghanistan. Such conflicts range from low-frequency terrorist actions to full-scale but intermittent warfare. In mid-1986, 42 conflicts were occurring.[1] These ranged from World War II-type mid-intensity combat operations (Iraq-Iran) to low-intensity counter-terrorist/guerrilla operations. Conflicts of the latter type were occurring at that time in Afghanistan, Cambodia, Central America (Nicaragua and El Salvador), Chad, West Irian, Northern Ireland, India, Sri Lanka, Burma, and Angola. In 1992, the decline of Communism was accompanied by the emergence of factionalism or civil wars in Yugoslavia, Russia, Azerbaijan, Georgia, Moldavia, and Czechoslovakia. Also, Kurdish and Shiite minorities are at war in Iraq and Turkey and threaten other states. Virtually every large country and many small countries have the potential for such conflicts.

These conflicts are of low intensity in the sense that battles are interspersed with periods of inactivity and relative safety for the combatants. Overt combat is brief, and usually involves squads, platoons, companies, and rarely battalions, although at those levels casualties may be extremely high. There is often a civil-war quality. Guerrilla activity may be the predominant form of engagement, with small arms and booby traps accounting for most of the wounding and killing rather than artillery and other indirect fire weapons. Here, too, "low-intensity" does not necessarily mean low-casualty: one car bomb killed nearly 250 U.S. Marines in their barracks in Beirut.[2] Often the weaker military force will use terrorist activity to achieve political ends. Such conflicts and operations other than war are often ambiguous with no directly appreciable threat to the national interests of the more powerful country, which may be fighting a foreign, proxy war, or participating in a multinational peacekeeping or constabulary operation. As such they often do not enjoy full public support. The psychiatric casualties of operations other than war differ qualitatively and quantitatively from those of conventional wars involving prolonged or intense heavy (mechanized) combat. This chapter will describe these differences and propose methods of preventing and managing such casualties.

LOW-INTENSITY VS TRADITIONAL COMBAT STRESS CASUALTIES

The epidemiology of psychiatric casualties among troops in battle has been examined in numerous studies since World War I.[3–14] Such studies tended to emphasize the psychiatric casualties that resulted from battlefield stress even though casualties resulting from less dramatic causes had been recognized since World War I. These less dramatic casualties presented with problems of alcohol and drug abuse, disciplinary infractions, venereal diseases, and "self-inflicted" medical disorders (for example, malaria from failure to use prophylaxis). Not until the Vietnam conflict were these casualties recognized as potentially serious causes of ineffectiveness.

Although the casualties that occur during actual engagement with the enemy may present the traditional picture of battle fatigue (eg, anxiety, fatigue, and conversion and dissociative syndromes), the majority of neuropsychiatric cases in low-intensity combat present a picture similar to those that occur among rear-echelon troops in wartime and among garrison troops during peacetime (venereal diseases, alcohol and drug abuse, and disciplinary problems, often related to personality disorders). It is not surprising then that various authors have called such casualties "guerrilla neurosis,"[15] "garrison casualties,"[16] "disorders of loneliness,"[17] and "nostalgic casualties."[18,19] U.S. Army field manuals refer to them as "misconduct stress behaviors"[20–22] (Figure 3-1).

Jones[23] studied the features distinguishing psychiatric casualties among combat troops from those among combat-service-support troops not normally exposed to combat. ("Combat-service-support" in this context refers to soldiers whose primary mission is not to fight the enemy but to assist those

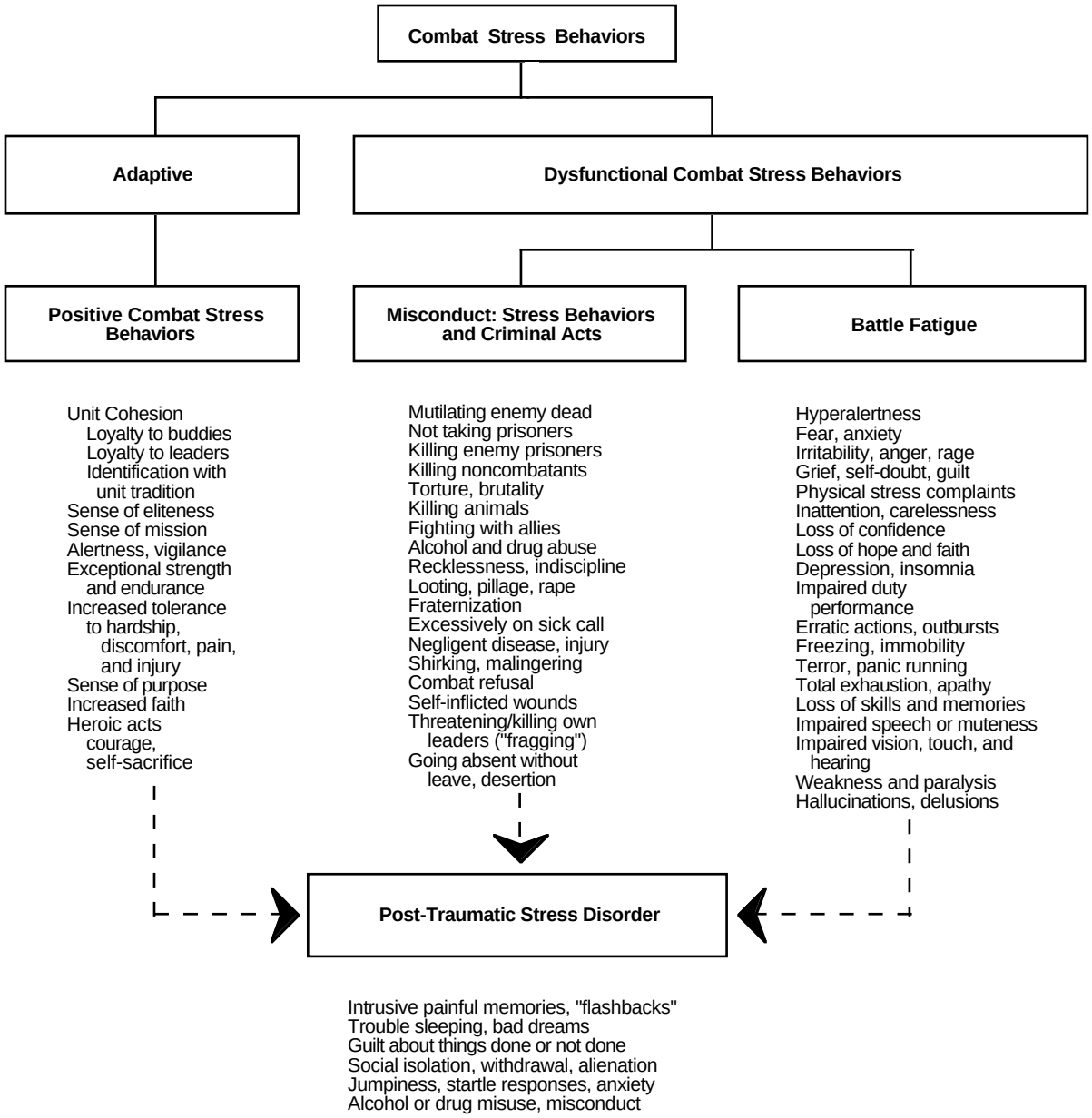

Fig. 3-1. Combat stress behaviors may be adaptive or dysfunctional. The most serious of these behaviors are those involving criminal acts. However, all stress behaviors can evolve into PTSD. Reprinted from US Department of the Army. *Leaders' Manual for Combat Stress Control.* Washington, DC: DA; September 1994. Field Manual 22-51: 2-12.

doing the fighting.) He concluded that such "garrison casualties" were found particularly among rear-echelon elements in Vietnam, a conflict in which each combat soldier was supported by about eight noncombat-arms troops. Such troops characteristically present with behavioral disorders related to separation from family and friends, boredom, and social and sometimes physical deprivation. Considering their source, Jones[17] had labeled these casualties as suffering from "disorders of loneliness"; however, since before the Napoleonic Wars, such disorders have been termed "nostalgia." Obviously, such disorders can and do occur in combat troops as well.

NOSTALGIA: REDISCOVERY OF A CONCEPT

Nostalgia was a medical concept recognized even before 1678, when the Swiss physician Hofer created this term to describe soldiers previously labeled as suffering from "Das Heimweh" or homesickness.[24] Earlier in the 17th century, soldiers in the Spanish Army of Flanders were stated to suffer from "mal de corazon" ("illness of the heart"), and Swiss mercenaries in France were said to suffer from "maladie du pays" ("homesickness"). Because the majority of such soldiers were mercenaries uprooted by financial exigencies from their farms in Switzerland, these soldiers were often described as suffering from "the Swiss disease." The critical variable was service, often involuntary, far from one's country, family, and friends. By the middle of the 18th century, nostalgia was a well-defined nosologic entity recognized as afflicting not just Swiss soldiers but potentially any soldier displaced from his milieu of origin, and generally was considered to be a mental disorder.

The symptomatology associated with nostalgia was consistently compatible with modern descriptions of depression, with complaints, for example, of "moroseness, insomnia, anorexia, and asthenia" in a report by Sauvages in 1768.[24] Even this early there were observations that nostalgia might be feigned as a method of avoiding duty. A French physician, De Meyserey, who published a treatise on military medicine in 1754, observed that war and its dangers always produced a fruitful crop of malingerers who must be discriminated from soldiers with "true nostalgia."

Baron Larrey, Napoleon's Chief Surgeon, prescribed a course of treatment which, while ostensibly biologically oriented, reveals a keen awareness of social factors and is surprisingly close to modern handling of combat psychiatric casualties, both preventively and curatively. He stated that it is necessary not to allow individuals who are predisposed to nostalgia more rest than is necessary, to vary their occupations, and after military exercises to subject them to regular hours, gymnastic recreation, and some mode of useful instruction. He also stated that they should have mutual instruction with troops of the line and that warlike music will contribute to preventing gloomy reflections which can lead to nostalgia. This would ensure physical bodily integrity, produce a conviction of health, give a sense of mastery of weapons, and integrate the unit. This regimen prevents evacuation home (the treatment approach of earlier physicians) and minimizes any secondary gain from illness.[24(p348)]

During the Civil War, Calhoun, reviewed in Deutsch,[25] ascribed a relationship between nostalgia and the recruiting methods of the Union Army that could have parallels with the "nostalgic casualties" of the Vietnam conflict. Calhoun described initially enthusiastic soldiers who had expected an early end to the conflict and who became disenchanted as the war dragged on. The statistics on desertion, draft dodging, and similar attempts to avoid duty were not much different during World War II, a more popular war, and the Vietnam conflict (in fact, these rates were generally lower during Vietnam than during World War II). This suggests that the disenchantment toward the end of the conflict in Vietnam may not have been as important a factor in generating nostalgic casualties as the loss of unit cohesion.

Nostalgic casualties occurred in soldiers separated from their home environment with attendant loss of social reinforcement. Rosen[24] has pointed out that one need not be a soldier for this to occur and that displaced persons and other groups often suffer from this "forgotten" psychological disorder. Situations such as the fighting of an unpopular war of indefinite duration are likely to increase these casualties, particularly in the absence of strong cohesive forces, which usually develop from shared hardship and danger. Hence, Calhoun cited battle action as a curative factor in nostalgia:

> Their thoughts were turned from home, and they felt they were men and soldiers, peers of the veterans with whom they associated; and from that day to this there has been but little or no sickness, and but one or two deaths...When men have passed through the baptism of fire together, they feel they have something in common. They have a common name, a common fame, and a common interest which diverts their thoughts away from home.[25(p376)]

Based on the recollections of Civil War veterans, Stephen Crane's *The Red Badge of Courage* eloquently described the development of cohesive bonds in response to the horrors of battle:

> There was a consciousness always of the presence of his comrades about him. He felt the subtle battle brotherhood, more potent even than the cause for which they were fighting. It was a mysterious fraternity born of the smoke and danger of death.[26(p31)]

Unit cohesion is group and self-preservative behavior that evolves from shared danger in an almost impersonal manner despite its very personal nature. This group cohesion evolves in almost any situation of shared hardship or danger. Belenky and Kaufman[27] found that vigorous training involving some danger produced cohesion in air assault trainees. In combat situations, cohesion needs little encouragement to flourish. Recognizing this, one company commander, when asked about cohesion in his unit in West Germany, commented, "I train my men to be skilled soldiers; I'll rely on the enemy to make them cohesive." Such a laissez-faire attitude ignores the possibility that noncohesive units may disintegrate in high-stress combat before cohesive bonds can develop.

Low-intensity combat, often characterized by long periods of idleness without the shared experience of cohesion-building danger, should produce more nostalgic casualties. This situation probably also accounts for the higher incidence of such casualties among support troops than among combat troops.[23]

During World War I, conditions of battle did not lend themselves to producing large numbers of nostalgic casualties; however, following the Armistice, the Third Army, which remained as an army of occupation, was in a garrison-type role. The casualties in this situation began to approximate those seen in low-intensity warfare. For example, from December 1918 to June 1919 at the hospitals at Coblenz and Trier, 1,022 psychiatric cases were evaluated.[28] In this garrison setting, the largest groups of casualties were those diagnosed as "defect" (presumably retarded) and "psychopathy" (36.8%). When these are added to alcoholism and drug states (6.8%), they account for nearly half of the psychiatric morbidity, and over half if epilepsy is excluded. There were many disciplinary problems in this occupation group. An attempt was made by commanders and medical officers to eliminate "misfits—defectives and psychopaths," which may have accounted for the identification of a relatively high number of mentally retarded and epilepsy patients; however, "Had not many been evacuated through other than hospital channels (replacement depots) the figures would be even higher."[28(p426)] (In a curious parallel with World War II, in the Vietnam conflict an attempt was made to utilize lower-functioning [though not retarded] men as soldiers in the U.S. Army, the so-called "McNamara's 100,000." Such soldiers performed more poorly as a group than normally selected soldiers but some were superior.)

At a time during World War I when the military population in France of U.S. soldiers averaged 200,000 persons, the incidence of hospitalized "psychopathic states" was 5 per 1,000, comparable with the overall rate for "character and behavior disorders" in overseas areas in World War II of about 4 per 1,000.[25] However, because diagnostic practices in World War I and World War II differed markedly, true comparability may not exist. The difference in types of casualties in garrison settings was observed by Salmon and Fenton, who commented that the cessation of hostilities did not reduce the need for psychiatric beds:

> A number of more recent cases showed simple depression…An intense longing for home was characteristic of this condition. It resembled a set of reactions to which the term "nostalgia" used to be applied and is common in all military expeditions when a period of intense activity is succeeded by an uneventful one.[28(p287)]

About one half of the U.S. psychiatric casualties of World War II were unrelated to combat and actually occurred during stateside service.[29] During World War II, "homesickness" was listed as a factor in the breakdown of 20% of psychiatric casualties among U.S. forces.[30] At that time, however, the relationship of these homesick casualties to combat situations was not explored.

The North Pacific Area (Alaska and the Aleutian Islands) during World War II was almost devoid of combat but was also a situation of extreme social deprivation. The ubiquitous state of "chronic depression" was not reflected in neuropsychiatric admissions because the overall neuropsychiatric admission rate was 10.5/1,000/y in the Alaskan Department, the lowest in any combat area. Of 325 neuropsychiatric admissions to the 186th Station Hospital at Umnak (Aleutians) from January 1942 through January 1945, 53% were for psychoneurosis, 14% for constitutional psychopathic state, 12% for dementia praecox, 1% for manic-depressive, 3% for mental deficiency, 1% for epilepsy, 3% for unclassified psychosis, and the remainder (13%) for miscellaneous, primarily situational reactions.[31(p723)] Despite a state of "chronic depression" that afflicted virtually everyone, hospital admission rates were

low.[31] Perhaps the fact that alcohol and drugs were scarce in the theater had a salutary effect on these statistics.

In the Korean conflict, three fairly distinct phases are reflected in the varying types of casualties reported. The mid- to high-intensity combat from June 1950 until November 1951 was reflected in traditional anxiety-fatigue casualties and in the highest rate of combat stress casualties of the war, 209/1,000/y in July 1950.[32] Most of the troops were divisional, with only a small number being less exposed to combat. This was followed by a period of static warfare with maintenance of defensive lines until July 1953 when an armistice was signed. The gradual but progressive buildup of rear-area support troops was associated with increasing numbers of characterological problems. Norbury[33] reported that during active combat periods anxiety and panic cases were seen, while during quiescent periods with less artillery fire the cases were predominantly characterological. Following the armistice, obviously, few acute combat stress casualties were seen. The major difference in overall casualties other than surgical before and after the armistice was a 50% increase in the rate of venereal disease among divisional troops.[32]

Commenting on the observation that psychiatric casualties continued to present in significant numbers following the June 1953 armistice of the Korean conflict, Marren gives a clear picture of the reasons:

> The terrors of battle are obvious in their potentialities for producing psychic trauma, but troops removed from the rigors and stresses of actual combat by the Korean armistice, and their replacements, continued to have psychiatric disabilities, sometimes approximating the rate sustained in combat, as in the psychoses. Other stresses relegated to the background or ignored in combat are reinforced in the postcombat period when time for meditation, rumination, and fantasy increases the cathexis caused by such stresses, thereby producing symptoms. Absence of gratifications, boredom, segregation from the opposite sex, monotony, apparently meaningless activity, lack of purpose, lessened chances for promotion, fears of renewal of combat, and concern about one's chances in and fitness for combat are psychologic stresses that tend to recrudesce and to receive inappropriate emphasis in an Army in a position of stalemate…Sympathy of the home folks with their men in battle often spares the soldier from the problems at home. The soldier in an occupation Army has no such immunity … Domestic problems at home are often reflected in behavior problems in soldiers, particularly those of immature personality or with character defects.[34(pp719–720)]

French experience in Indochina and Algeria[15] revealed characterological problems among French soldiers in these generally low-intensity campaigns. Because there is a several-hundred-year history of colonial wars and occupation forces for many European countries, it is surprising that reports of these casualties are sparse. It seems plausible that these were simply not considered medical, particularly psychiatric, problems but rather moral issues similar to earlier consideration of active combat stress breakdown as cowardice or lack of moral fiber. In the French Indochina War (1945–1954), such character disorders were reportedly responsible for a high number of evacuations, but no statistics are available. Crocq and colleagues[15] studied French psychiatric casualties of the French-Algerian War (1954–1962). They used statistics compiled by LeFebvre and colleagues for 1,280 cases of mental disorders at the military hospital at Constantine who were then evacuated to France between 1 July 1958 and 1 July 1962 (second half of the French-Algerian War). Diagnostically, 19.7% of the total cases were character disorders, and another 14.5% were organic psychoses, predominantly from alcoholism. Only 20% of all cases were related to a triggering event during combat. Functional psychoses accounted for 36.7% of cases with approximately one half of these being schizophrenia (224 of 464 cases). The remainder were mentally retarded (14.5%) and neurotic conditions (14.6%).[15] Because these are evacuation statistics, they only indicate in a general way relative prevalence because characterological problems usually are not handled by medical evacuation. It is unfortunate that actual behaviors cannot be examined to determine the comparability of problem behaviors among soldiers of this war and the Vietnam conflict; however, there is a strong suggestion of comparability in that only a small fraction of alcohol abusers will develop brain syndromes. The relatively high percentage of such cases among the French suggests that this type of substance abuse was widespread.

For the United States, Vietnam represented the epitome of a conflict in which nostalgic casualties occurred. During the early years of the war, the psychiatric casualty rate of about 12/1,000/y was lower even than that in noncombat overseas areas (Europe and Korea) at the same time.[9] The average psychiatric evacuation rate during the first year of the war was 1.8/1,000/y, lower than that from army posts in the United States.[9] The most intense fight-

ing occurred in 1968 to 1969, with one half of those killed in action killed during this period. In June 1968, 1,200 were killed, close to the peak number.[9] As the war dragged on and the U.S. presence took on many of the characteristics of an occupation force, characterological problems began to surface. Racial incidents began to occur, beginning in the rear areas. Psychiatric problems initially took primarily the form of alcohol and drug abuse but later, as the unpopularity of the war intensified, disciplinary problems approaching the magnitude of mutiny in some cases occurred.

President Nixon announced withdrawal plans on June 9, 1969. Fragging incidents (the murdering or injuring of a fellow soldier with a fragmentation grenade) increased from 0.3/1,000/y in 1969 to 1.7/1,000/y in 1971.[35] Psychiatric evacuations rose from 4.4/1,000/y (4% of all evacuations) to 129/1,000/y (60% of evacuations) in April 1972. Several authors have described these casualties and factors in their causation.[9,23,35–39]

These problems were further aggravated by the "Vietnamization" policy in which U.S. soldiers were increasingly relegated to garrison settings and roles in the later phases of the conflict. The subsequent drug abuse epidemic may have played a decisive role in the abrupt withdrawal of U.S. troops and the ultimate loss of the war. The "garrison neuropsychiatric casualties" in fact accounted for most of the consumption of mental health resources during the Vietnam conflict. When a policy of medically evacuating soldiers if they were found to have heroin breakdown products in their urine went into effect, heroin abuse became an "evacuation syndrome."

Marlowe[40] pointed out that Vietnam was aberrant compared with World War II and most of the Korean conflict:

> [T]he soldier's future was as much controlled by the calendar (DEROS) [date of expected return from overseas station] as by the outcome of combat with the enemy. The Viet Nam war was particularly variant in that the enemy lacked a significant capacity in weapons of indirect fire, thus providing a battlefield ecology that was substantively different both from the past and the anticipated future.[40(p1)]

This battlefield ecology, however, was not new to other nations. The French forces preceding the United States in Vietnam fought a similar war until the decisive defeat at Dien Bien Phù where they were beaten by indirect fire weapons artillery. The author contends that the casualties of such low-intensity, intermittent campaigns are similar to nostalgic casualties of the Civil War and of prior wars.

The 1982 Lebanon War is an excellent example of the problems of a war unpopular at home. While the 1973 Yom Kippur War has been used as an exemplar of modern, high-intensity combat and Vietnam as an exemplar of low-intensity combat, Lebanon had elements of both. There were approximately 2 weeks of intense combat in early and late June 1982 with the remainder of the war being more of a static situation with Israel as an occupying force. The result in terms of casualties is revealing, showing casualties similar to those during the intense battles of World War I, World War II, and the 1973 Yom Kippur War but also symptoms of estrangement and delayed stress casualties found in Vietnam (see Figure 3-1). Recent studies[41] revealed that about two thirds of the psychiatric casualties from the 1982 Lebanon War presented during the postcombat period as chronic and delayed posttraumatic stress disorder cases.

LONELINESS AND FRUSTRATION CASUALTIES: PRECIPITANTS

In making a diagnosis of combat stress casualty, the clinician must strive for balance and avoid a "recipe" approach. A major failing in the psychiatric management of casualties in the Vietnam conflict was in not recognizing early enough that psychiatric casualties were taking new forms: alcohol and drug abuse, and venereal disease and malaria from failure to take prophylactic measures. Armed with a stereotypical model of combat fatigue and a recipe for its treatment, psychiatrists were slow to recognize that escape from battle (evacuation syndrome) had taken a new form. Even when the recognition occurred, the ability to adapt "forward treatment" to these casualties was hampered by moralizing and punitive regulations[42] and by stereotyping casualties as drug addicts, alcoholics, cowards, and malingerers. Lost amid a welter of negative reports were occasional successful interventions, particularly at the division level. Such approaches included medical screening of prostitutes, making malarial prophylaxis a command responsibility, and alcohol and drug abuse rehabilitation programs at the division level.[43]

Psychiatric casualties occurring in actual combat are qualitatively different from those occurring in soldiers less exposed to combat. Billings reported

that 28% of all medical evacuees from the South Pacific Command during World War II were sent to the Zone of the Interior because of personality disorders during 1943.[44] Billings also described the stresses and personality symptoms of combat and combat-service-support troops. Writing of the men sent to the South Pacific during World War II and subsequently diagnosed as having personality disorders, Billings believed that certain characteristics of Americans helped produce this outcome. He recorded as follows:

> Men … were products of our sociology and ideology. Individualism; the belief in a freedom for all men to compete on an equal basis; the tendency for the American to need tangible evidences of success at frequent intervals; the inclination to be too dependent on others for distraction, recreation, and maintenance of interest; the assumption that American business philosophy is a matter of "not what you do but what you are caught doing," with the unconscious realization that the one who does not or cannot do the job gets the benefits and escapes unpleasantness whereas the one who accomplishes the task only faces more work or loses his life—all stood out as dynamic factors in breakdowns in morale, occurrence of resentment reactions, aggressive tendencies, and hurt feelings. These in turn placed certain personalities in considerable jeopardy of psychiatric disability when they were subjected to special circumstances.[44(pp479–480)]

Precipitants for Combat Troops

Billings describes such "special circumstances" as a variety of precipitants for combat troops.[44]

1. Facing impending danger, especially for a period of time without specific happenings to break the tension or circumstances permitting the venting of physical effort. For example, remaining alert for a prolonged period of time in a concealed position or foxhole, subjected to the full effects of loneliness and jungle sounds; being pinned down by artillery or heavy mortar fire; or being caught in the open by strafing from the air, especially when immobilized by impediments or terrain.
2. Subjection to heavy artillery fire.
3. Occurrences of a lull, following a period of danger, which allowed for cogitation and a fuller intellectual realization of what was and might be experienced.
4. Occurrence of transitory, psychobiological disorganization in a particularly susceptible personality when subjected to fear-inducing circumstances.
5. Prolonged patrol and reconnaissance work in enemy-controlled jungle.
6. Promotion, in the field, to positions of great responsibility.
7. Grief over loss of "buddies," or loss of a tactical position taking the form of self-condemnatory thinking.
8. Inadvertent evacuation to a position of safety with that [cogitation] noted in paragraph 3 resulting.
9. Loss of confidence in leaders.
10. Mass psychological reactions.
11. "Snow jobs" or tall tales told often by the veteran combat soldier to the new replacement at, or before, a critical time.
12. Unwarranted or unexplained evacuation or transfer of psychiatric and minor medical and surgical casualties ... resulting in loss of the individual's security in his bodily or personality integrity, loss of identification with his unit, diminished esprit de corps, decreased desire or feeling of need to continue fighting—all being replaced by a conscious or "subconscious" appreciation that it might be possible to return home and thereby honorably escape further danger.
13. Ill-considered or poorly-timed statements to troops by visiting high-ranking officers, which lead to misinterpretation of policy, or promote loss of confidence in the administration.
14. Repeated dress parades for visiting dignitaries when the combat team is staging for a forthcoming operation.

Precipitants for both Combat and "Service" Troops

Billings also describes the "special circumstances" that act as precipitants for both combat and "service" (support) troops.[44]

1. Hypochloremia, dehydration, fatigue, and subclinical or clinical illness decreasing the efficiency and smooth psychobiological functioning of the individual, thereby often setting the stage for insecurity, tension, and anxiety with personally alarming symptomatology.
2. Enemy propaganda.
3. Rumors stemming from isolation, ignorance of facts, and inactivity.

4. Postponement of the promotion of enlisted men and officers, and the filling of position vacancies with new men in grade or rank.
5. Ill-advised promotion of men and officers to responsibility beyond their ability.
6. Discrepancy between War Department and politically announced policy and plans for rotation and redeployment of overseas personnel.
7. Knowledge of the unfair discrepancy in remuneration to and appreciation for the individual in military service and the one in the merchant marine and industry.
8. Seeming ignorance of the average commander and the officer in personnel work either of War Department policy or of how to comply therewith in regard to proper assignment and readjustment of military personnel.
9. Poor leadership, especially of high-ranking officers, as evident in the officer looking after his personal comfort and safety before acquiring them for his command.
10. Apparent "empire building" of general officers.
11. Work or combat under adverse conditions prolonged to the breaking point of the "average" man.
12. Failure to expedite the elimination of ineffectuals from a unit.
13. Disturbing news from home, such as of a wife's infidelity, business reversals, deaths, illness, and encouragement to forego continuance of further military responsibility.

LONELINESS AND FRUSTRATION DISORDERS: PRESENTATIONS

Soldiers less exposed to combat and presenting with personality problems may be called loneliness and frustration casualties. Huffman[45] reported that only 48 of 610 soldiers (8%) seen in Vietnam from 1965 to 1966 suffered combat-related stress, while Jones[23] found combat-related stress in 18 of 47 soldiers (38%) seen in a similar hospital setting (September–December 1966). These 18 cases, however, were given character and behavior disorder diagnoses. As the 25th Division psychiatrist, Jones[17] saw approximately 500 patients from March through October 1966, of whom about one third were awaiting legal or administrative action. Of the remaining two thirds, almost all were diagnosed as having character and behavior disorders including situational fright reactions. The term "combat fatigue" was misleading to the novice psychiatrist with its mistaken implication of prolonged combat and cumulative fatigue. In retrospect, some of these cases would more appropriately have been so diagnosed; however, the treatment approach was the same: rest, reassurance, and return to his unit.

The term "loneliness and frustration casualty," like "combat stress reaction," and "battle fatigue," is an intentionally vague term describing a variety of dysfunctional behaviors, although unlike "battle fatigue" it is not readily understood by the average soldier or his sergeant and junior officer, and so should not be used when talking to them. Nostalgic casualties require interventions much like those for managing combat fatigue. U.S. Army doctrine[21,22] terms many of these casualties "misconduct combat stress reactions." The term suggests that disciplinary action may be indicated. This may be a profitable approach; however, command-sponsored substance abuse programs, programs to strengthen morale, and hygiene/prophylaxis programs may be more profitable. These dysfunctional behaviors often cluster in patterns forming syndromes. Such syndromes typically have many overlapping behaviors; however, it is useful to divide them into the categories of substance abuse, sexual problems, and indiscipline.

These cases (misconduct combat stress reactions) are ones which violate unit regulations or the Uniform Code of Military Justice or the Law of Land Warfare. The manuals state that such cases require disciplinary action. They cannot simply be treated as battle fatigue, with reassurance, rest, physical replenishment, and activities to restore confidence. Depending on the seriousness or criminality of the misconduct, disciplinary action ranges from simple verbal correction through assignment of unpleasant duties and denial of special privileges; written reprimand; nonjudicial punishment (Article 15); judicial punishment (court-martial); less than honorable discharge; confinement and, for extreme misconduct, the death penalty. For criminal cases, psychiatric expertise may be called upon to establish the validity of an insanity defense. In all cases, mental health personnel can advise regarding potential for recurrence or rehabilitation, and treat any associated mental disorders.

Substance Abuse

During the Civil War, the liberal use of opium caused widespread dependence called the "soldier's disease."[46] In low-intensity combat and garrison settings in which the risks of being intoxicated are not as great as in higher-intensity combat, substance abuse flourishes.

Froede and Stahl[47] evaluated the 174 cases of fatal narcotism retrieved from over 1.3 million surgical and autopsy cases sent to the Armed Forces Institute of Pathology from 1918 through the first 6 months of 1970. Although the data were incomplete, some interesting trends were observed that strengthen the observation that drug abuse is associated with low-intensity combat situations in geographical areas in which abuse substances are available (about two thirds of the deaths occurred in the Far East). In terms of combat intensity, the majority of cases in World War II, Korea, and Vietnam occurred in the closing years of the wars and in the postwar periods when fighting had diminished and large numbers of troops were serving in support roles. Their findings are supported by Baker's[48] estimate that there were 75 opiate deaths in Vietnam from August 1, 1970 through October 18, 1970, 11 confirmed by autopsy and 64 suspected.

Alcohol was the first substance of abuse in Vietnam. Huffman[45] reported that of his 610 patients seen early in the war, 113 (18.5%) suffered from severe problems associated with alcoholic intoxication but there were only five cases of unquestionable nonalcohol substance abuse. As the war progressed, marijuana came to be preferred because of the absence of a "hangover." Roffman and Sapol[49] reported that in an anonymous questionnaire given to soldiers departing Vietnam in 1967, 29% admitted using marijuana during their tour. Similarly, a survey of 5,000 enlisted men at Fort Sill, Oklahoma who had not served in Vietnam from January through April 1969[50] revealed that 29% admitted to using drugs sometime in their lives, 83% of the users identifying marijuana. In the early years of the Vietnam conflict marijuana users apparently were reflecting the experiences of their stateside cohorts, but this began to change. In a review of studies of drug abuse in Vietnam, Stanton[51] found that from 1967 to 1971 the proportion of enlisted men who used marijuana "heavily" (20 or more times) in Vietnam increased from 7% to 34%, while the proportion of "habitual" users (200 or more times) *entering* Vietnam remained at 7% to 8% for the years 1968 through 1970 and the proportion of habitual users *in* Vietnam stabilized at 17% to 18% between 1969 and 1971. Thus, about 9% to 10% of the lower grades of enlisted men first *became* habitual smokers (daily usage) in Vietnam.

Heroin abuse became significant in early 1970 when 90% to 96% pure heroin derived from the "golden triangle" of Thailand, Burma, and Laos became available countrywide. This pure heroin was so cheap that a significant "habit" could be maintained for $8 to $10 a day.[51] The preferred route was "snorting" through the nostrils or smoking. Of the small percentage who injected at all, this was only occasionally. At a peak in October 1971, almost one half of all lower ranking enlisted men (E-1 to E-4) were using heroin and half of these may have been addicted.[52] Like venereal disease rates, drug abuse rates tend to increase when there are lulls in combat or when exposure to combat is decreased.

Heroin reportedly displaced cannabis because it had no characteristic strong odor allowing detection, made time seem to go faster rather than slower as with marijuana, and was compact and easily transportable. However, McCoy[53] argues that heroin did not so much replace marijuana as augment its use and that the real reason for the heroin epidemic was enormous profits that South Vietnamese officials could make by selling it to Americans.

These findings must be considered in the light of a nationwide epidemic of drug abuse in American youths at that time. The biggest difference between drug abuse in Vietnam and in the United States was the ready availability of very pure, inexpensive heroin in Vietnam.[54]

Treatment of substance abusers has varied considerably over time. Early approaches were to consider such casualties problems of a moral nature and later of a character defect with punishment as the primary intervention. It was only when such losses of manpower became significant in the Vietnam conflict that a nonpunitive, therapeutic approach was undertaken. By 1971, more soldiers were being evacuated from Vietnam for drug use than for war wounds.[51] The U.S. Army had adopted a countrywide voluntary treatment program in Vietnam in October 1969 aimed primarily at marijuana abusers. This was patterned on an amnesty program developed in the Fourth Infantry Division in May 1969. Army regulations tended to be slow in changing to accommodate the therapeutic perspective, sometimes resulting in paradoxical punishment of recovered abusers.[42]

The main lessons from the U.S. experience in managing substance abuse in Vietnam are that treatment should be in-country to prevent an evacuation syndrome and that the factors that prevent breakdown in general—cohesion, effective leadership, and good morale—may protect soldiers from substance abuse. For example, the Australians serving in Vietnam did not have significant personnel losses from substance abuse.[55,56] Their forces were based on a regimental system with unit rather than individual rotations, and officers and troops had usually served together for long periods of time. This may have produced greater unit cohesion, a crucial difference from U.S. troops that protected Australian troops from developing nostalgic problems of substance abuse and indiscipline.

Sexual Problems

The most common nostalgic behavior coming to medical attention is sexual intercourse with prostitutes leading to venereal diseases. The following case, known to the author, reveals that officers were not immune.

Case Study 1: The "No-Sweat" Pill

When the author was taking sick call in the headquarters company dispensary, he was approached by Major INF, who stated that he was going to Saigon overnight and wanted a "no-sweat pill." The author was slow to realize that the major wanted penicillin to prevent getting gonorrhea or syphilis. When he did understand, he refused and gave him a lecture on the dangers of incompletely treated syphilis leading to tertiary lues of the brain and absence of protection from viral venereal diseases. Later the author learned that the major purchased antibiotics over the counter in Saigon and indulged himself apparently without complications.

Comment: The availability of antibiotics in Vietnam (and Korea) without prescription may have hastened the development of resistant strains of gonorrhea that have been reported since the Vietnam conflict.

Low-intensity combat operations frequently show an increased incidence of drug abuse and sexual disorders. The following case from the early phases of the Vietnam conflict reveals both.

Case Study 2: Seductive Marijuana

Sergeant First Class (SFC) MC was the noncommissioned officer in charge (NCOIC) of a technical support battalion assigned to an infantry division. He was given a forensic psychiatric evaluation in the course of a court-martial proceeding. SFC MC was a kindly, friendly man, well-liked by the officers and enlisted men with whom he worked. In the combat setting he was unable to satisfy his homosexual feelings by "cruising." Finally he hit upon a method that took advantage of the nostalgia and fears of the young soldiers. He offered them friendship, alcohol, and marijuana to alleviate their homesickness and fear, then performed fellatio when they were intoxicated. Most victims kept silent from embarrassment or fear of disciplinary action until a soldier who wanted to be separated administratively was seduced. He reported the incident.

Comment: Examples such as this have been used to vindicate the military policy of eliminating homosexuals from the service; however, a study of homosexual college students who served in World War II[57] revealed that the great majority served adequately and some with distinction.

Sexually-transmitted diseases (venereal diseases or VD) have been a major cause of lost soldier strength in wars of the 20th century. While modern medicine has markedly reduced the time lost and complications of venereal diseases, it has not reduced the infection rates as seen in Table 3-1.

Although the venereal disease rate of the American Expeditionary Forces (AEF) in World War I was a relatively low 34.3/1,000/y,[58] there were over 6.8 million lost man-days and 10,000 discharges.[59] Each

TABLE 3-1

VENEREAL DISEASE RATES BY WAR/1,000 TROOPS/YEAR

War	Years/Location	Rate
World War I	Expeditionary Force	34.3
	Continental USA	127.4
World War II	1941–1945	42.9
Post-World War II	1946–1950	82.3
Korea	1951–1955	184.0
Vietnam	1963–1970	261.9
	Peak Jan–Jun 1972	698.9
	Continental USA	31.7

Data sources: [World War I] Michie HC. The venereal diseases. In: Siler JF, ed. *Communicable and Other Diseases*. In: *The Medical Department of the United States Army in the World War*. Vol 9. Washington, DC: Medical Department, US Army, Office of The Surgeon General; 1928: 263–310. [World War II, post-World War II, Korea, Vietnam] Deller JJ, Smith DE, English DT, Southwick EG. Venereal diseases. In: Ognibene AJ, Barrett O Jr, eds. *General Medicine and Infectious Diseases*. In: Ognibene AJ, ed. *Internal Medicine in Vietnam.* Vol 2. Washington, DC: Medical Department, US Army, Office of The Surgeon General and Center of Military History; 1982: 233–255.

case resulted in over a month of lost duty time (from 1929–1939, lost days per case ranged from 38–50).[59] By the time of the Vietnam conflict, 9 of 10 cases were for gonorrhea (lymphogranuloma venereum, chancroid, and syphilis accounted for most of the rest), and lost duty time averaged only a few hours per case. Deller and colleagues[59] echo the observation of Jones[23] that rates were greatest in support troops with little combat exposure, and they add that such troops were most often near population centers. The peak incidence of nearly 700/1,000/y occurred in the period January to June 1972 when almost all U.S. troops were in support roles in accordance with the "Vietnamization plan" of using South Vietnamese forces in combat.

Prevention through education is a valid approach to venereal disease even though some soldiers will risk infection no matter what the threat. Prevention should not be directed at preventing sexual intercourse, which is an unrealistic goal, but toward the avoidance of high risk ("off limits") partners and the use of condoms, which should be made readily available. A study[60] that revealed that 50% of all prostitutes who have been randomly tested in the United States carry the HIV (human immunodeficiency virus) antibody suggests that this retrovirus, which is thought to cause the currently incurable and usually fatal acquired immunodeficiency syndrome (AIDS), may be a problem in future wars. In battlefield conditions, soldiers may have to donate blood to each other, and the presence of a soldier who is HIV positive could prove hazardous not only to the health but also to the morale of troops.

Although unlikely to have immediate effects on combat efficiency, the HIV virus poses severe problems in long-term prevention. Many of the world social tensions and ongoing wars are occurring in Africa, where the HIV infection is reaching epidemic proportions. Unlike in the United States, where the populations at risk are mainly homosexuals and intravenous drug abusers, the spread of HIV in Africa is primarily through heterosexual intercourse. In South America, another politically troubled area with insurgencies and narcotics production in several countries, AIDS is emerging as a difficult public health problem. Because urban areas in these third-world countries are being hit hardest by AIDS, there is concern that the professional and leadership classes of African, and to a lesser extent South American, countries could experience severe setbacks in goals of industrialization and democratic reforms. Internal unrest in Latin America frequently has led to U.S. deployment beginning before 1900.

Indiscipline

Indiscipline is a psychiatric issue in the sense that sociopsychological factors play a paramount role in its emergence. Furthermore, indiscipline and psychiatric breakdown merge almost imperceptibly as evacuation syndromes. For example, failure to take preventive hygiene measures in Korea allowed the development of frostbite in some cases. Similarly, failure to take the prophylactic chloroquine-primaquine pill in Vietnam allowed the infestation of malarial protozoans. In both cases, indiscipline rendered the soldiers unfit for duty.

Indiscipline may range from relatively minor acts of omission to commission of serious acts of disobedience (mutiny) and even murder (fragging). In an analysis and historical review, Rose[61] indicated that combat refusal has been a relatively frequent occurrence in most significant wars for which there is adequate data. The military has often colluded with the perpetrators in hiding the true nature of collective disobedience (mutiny) by using various euphemistic phrases ("unrest," …"incident," "affair," "collective protest," "insubordination," "strike," and "disaffection").[61(p562)] Rose indicates that there are compelling reasons for command to do this: "…mutiny is the antithesis of discipline,"[61(p562)] and a commander who "allows" a mutiny to occur jeopardizes his career and those of his "commanding officers up and down the line."[61(p563)]

Most indiscipline, of course, is more subtle than combat refusal and does not appear to be related to it. However, unavailability for combat is a frequent consequence of indiscipline. The main role of the psychiatrist is in prevention because the same conditions that give rise to neuropsychiatric casualties may produce indiscipline as another evacuation syndrome. This section will address primarily clinically observed situations involving indiscipline actions.

The following examples of indiscipline, provided by the author, were fairly typical of conditions in Vietnam.

Case Study 3: The Major's Bullets

During the early phases of the Vietnam conflict Major MSC was the executive officer in the headquarters of a support battalion of an infantry division. Prior to deployment to Vietnam he had earned a reputation as a strict disciplinarian, once having demoted a soldier for having a pocket unbuttoned. The battalion commander, an alcoholic, stayed sequestered in his "hooch" leaving the major to run the unit despite his lack of expertise in the highly

technical field in which most of his subordinates were far more skilled than he was. Feeling threatened by lack of proper technical background, the major became increasingly authoritarian, producing impaired morale in his unit. His authoritarian approach to leadership was not appreciated by the troops: he began finding bullets with his name written on them. This physical threat did not change his behavior. The appropriate intervention would have been to make higher command aware of the adverse effect on morale of Major MSC; however, he was well-regarded by command for taking over for the incompetent battalion commander and higher command turned a deaf ear. Eventually, Major MSC made a serious error leading to the death of a prisoner of war and he abandoned his authoritarian approach.

Comment: Early in the Vietnam conflict the majority of U.S. soldiers were volunteers who served together prior to deployment to Vietnam. Morale was generally high. In the later phases of the war an officer as unpopular as Major MSC would have been a likely fragging victim.

Linden[62] reported that there was a progressive rise in the number of courts-martial for insubordination and assaults (including murder) on officers and senior noncommissioned officers (NCOs) during the Vietnam conflict. He attributed these incidents to disaffection and poor morale because the war was increasingly seen as useless by the soldiers who were unwilling to risk their lives in a lost cause. The specificity of circumstances and the importance of leadership surrounding that form of indiscipline called combat refusal is seen in the following case.

Case Study 4: The Silver Star Medic

Specialist 4th Class (SP4) MC was the medical aidman ("medic") attached to an infantry company. In several battles he had performed with great valor, risking his life to treat wounded comrades, resulting in his being recommended for award of the Silver Star. He was referred for psychiatric evaluation when he refused to go out on a combat mission. The author found no evidence whatever of psychiatric impairment or personality disorder. The young soldier stated that he would not go into combat with a "green lieutenant" who had replaced the company commander, a captain, with whom the medic had deployed. The captain had been wounded and was currently performing light duties in the division headquarters. The medic stated that on the first engagement with the enemy the new lieutenant had foolishly risked his troops, resulting in several wounded soldiers. As much to protect his comrades as himself (because the unit could not go out without a medic), SP4 MC refused to go on a combat mission.

Comment: This young soldier was actually sent to the psychiatrist as a ploy on the part of command in hopes that a medical solution could be found for a leadership problem. When the psychiatrist refused to label the soldier psychiatrically ill, the medic was transferred to another company. The appropriate solution is a consultation with the lieutenant's commander in which assignment manipulations are recommended.

Indiscipline is not limited to subordinate ranks. Perhaps the most notorious example of collective indiscipline during the Vietnam conflict occurred in the My Lai atrocity, in which over 100 men, women, and children were killed in a village by U.S. forces.

Case Study 5: Lieutenant Calley

[Although the author was one of three U.S. Army psychiatrists who examined First Lieutenant William Calley and testified at his court-martial, the information given in this case comes from public records of the trial.—Au.] Calley testified that he had been ordered to go to My Lai and "kill the enemy"; however, the major who had allegedly given the order was killed before the trial began. Several factors are important in understanding this incident. First, prior to assignment in Vietnam, Calley was stationed in Hawaii where he was exposed to numerous "after-action" and "lessons learned" reports coming from Vietnam. Many of these emphasized the dangers from civilians who were secretly Viet Cong. Many reports included descriptions of Vietnamese women and children unexpectedly killing and wounding Americans with grenades and satchel bombs. While this intelligence justified heightened awareness and precaution to protect against such attack, it in no way justified the rape and murder of unarmed women and children, not even ones taken prisoner after committing such an attack, let alone ones rounded up in a village without resistance.

Secondly, Calley identified strongly with his men and was quite upset when his company incurred large numbers of casualties in the My Lai region (thought to be pro-Viet Cong) not long before the killings in My Lai. He was even more upset because he had been away when this occurred. This concern for his troops is to his credit, and qualifies his action as a misconduct stress behavior, rather than as simple criminal misconduct. It does not, however, excuse it or justify it.

Finally, Calley tended to see things in a black or white, all-or-none fashion. If the enemy included women and children and the enemy were supposed to be killed, so be it. Had the villagers (men, women, or children) been firing at the American troops, it would have been entirely correct to shoot and kill them, but only up until the point where they surrendered. If noncombatants had been killed in such a firefight, that would have been regrettable but justified. But Calley was convicted of having ordered and participated in the deliberate massacre of about two dozen unarmed Vietnamese men, women, and children. Evidence in the Peers Investigation Report suggested that over a hundred persons were in fact murdered.[63]

One of the soldiers at the My Lai atrocity, rather than participate in killing women, children, and old men, shot himself in the foot. Although self-inflicted wounds are usually intended to escape combat (in Vietnam this evasion was often thwarted by orthopedic surgeons who put some of these soldiers in "walking casts"), in this case an altruistic outcome was effected. When the author reviewed the testimony of all the U.S. Army participants at My Lai in preparation for his testimony at Calley's court-martial, he found most of the soldiers were deeply conflicted and some approved the self-inflicted wound solution to the conflict. Others, however, felt that this soldier was cowardly. His "indiscipline," via his self-inflicted wound, prevented worse indiscipline on his part.

Comment: Testimony[63] indicated that some of the U.S. soldiers committed unspeakable acts of sexual assault in committing the murders. The fact that presumably previously normal and moral human beings can commit such atrocities under the influence of uncontrolled combat stress makes clear why it is so important that leadership not let such misconduct begin. Calley's argument that he was just obeying the major's orders is irrelevant. The Uniform Code of Military Justice requires each soldier to refuse to obey a clearly illegal order such as the murder of unarmed prisoners or noncombatants. The command climate in Vietnam, and the training prior to the My Lai atrocity, may have failed to make that clear. No soldier appears to have overtly tried to get Calley to rescind his illegal order. Forms of indiscipline in which not only military but also international rules for handling prisoners and noncombatants are disregarded may be more common in low-intensity conflicts. Following the recapture (by U.S. and South Vietnamese forces) of Hue during the Viet Cong and North Vietnamese Tet Offensive, a mass grave was found containing the bodies of about one thousand men, women, and children presumably slaughtered by the North Vietnamese. Similarly, torture and killing of prisoners of war (POWs) occurred in the French-Algerian War, in the guerrilla warfare in Central America (El Salvador and Nicaragua) and South America (Argentina), and in 1992 reports of POWs in the former Yugoslavia.

"Indiscipline" by a high-ranking officer occurred in the 1982 Lebanon War when Colonel Eli Geva (commander of the Israeli tank force outside Beirut) refused to lead his troops into Beirut, which he expected to entail killing civilians. Geva urged that Beirut not be attacked and asked to be demoted to tank crew member if the city were attacked. Geva's courageous act resulted in rapid decisive action (Geva's prompt removal and isolation from other military personnel) coupled with the decision to launch a more discriminating attack that would minimize civilian casualties. This prevented other commanders from following suit.[64] Calley showed no concern for civilians; by contrast, Geva was criticized for showing too much concern.

Stress Disorders

To the heterogeneous syndromes found in low-intensity wars that have been labeled loneliness and frustration casualties ("nostalgic casualties") should be added acute stress disorders and chronic and delayed post-traumatic stress disorders (chronic and delayed PTSD). PTSD is usually and appropriately thought of in the context of acute overwhelming stress; however, the frequent morale problems of low-intensity, ambiguous wars may carry over into the postwar lives of the former combatants. The current discontents of these war veterans may find expression in the reappearance or new appearance of symptoms associated with combat: anxiety and fears, automatic hyperactivity, reliving of psychologically traumatic events, and a variety of other malaises. Such symptoms often follow service in wars of high intensity as well, particularly when the outcome was unsatisfactory or there is psychological or financial gain from such symptoms. This was seen, for example, in the large numbers of German veterans of World War I who developed chronic war neuroses (many of whom would now be labeled chronic post-traumatic stress disorder) compared with the small numbers of such cases following World War II.[65] In both cases Germany lost the war, but one difference was that after World War II veterans were not given pensions for neurotic (nonpsychotic or nonorganic) conditions due to the experience of German psychiatrists who knew of the World War I findings, and due to the general opprobrium earned by the military because of Nazi atrocities.

Post-traumatic stress disorders evolved from the Freudian concept of "traumatic neurosis" and technically are part of the combat stress disorders spectrum, of the acute, chronic, or delayed type. The chronic and delayed forms of PTSD have assumed considerable importance as sequelae of combat in Vietnam and in the 1982 Lebanon War. PTSD is explored at length in Chapter 16, Chronic Post-Traumatic Stress Disorder. Here it is important to recognize that PTSD symptoms can follow any serious psychological trauma, such as exposure to combat, accidents, torture, disasters, criminal assault, and exposure to atrocities or to the sequelae of such extraordinary events. POWs exposed to harsh treatment are particularly prone to develop PTSD. In their acute presentation, these symptoms, which include subsets of a large variety of affective, cognitive, perceptual, emotional, and behavioral responses delineated in Exhibit 3-1, are

EXHIBIT 3-1

APA DIAGNOSTIC CRITERIA FOR 308.3 ACUTE STRESS DISORDER

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relatively normal responses to gross psychological trauma. If persistent, however, they develop a life of their own and may be maintained by inadvertent reinforcement. Early intervention and later avoidance of positive reinforcement (which may be subtle) for such symptoms are critical preventive measures.

Current doctrine[22] emphasizes the importance of routine debriefing after any traumatic action to minimize subsequent post-traumatic stress. These debriefings may involve just the small unit itself, as leader-led after-action debriefings. These sessions review lessons learned while clarifying the facts of the event, by getting everyone to describe what they saw and did. Misperceptions and misunderstandings are corrected in the process, and feelings and reactions are shared openly. After an especially traumatic event, the small units should receive a formal critical event debriefing. These sessions should occur within several days of the event, and are led by trained debriefing teams. Critical event debriefings also get everyone to describe the facts of the event, and deliberately help everyone verbalize and process their thoughts, emotional reactions, and physical stress symptoms. The debriefing team must emphasize the normality of those reactions, and the value of talking them out now as wise preventive maintenance. Units should also con-

duct routine end-of-tour debriefings as part of prehomecoming activities. Chapter 11, Debriefing Following Combat, explores these issues in greater detail.

The only units in which psychiatric casualties of either the high-intensity combat stress or of the low-intensity combat stress type appear minimal are highly cohesive, usually elite units. Thus, the building of cohesive, well-led units is as important in this form of warfare as in higher-intensity combat. The dynamics of cohesive units are discussed at length by Manning.[66] The level of material support does not appear to be a factor in such units and, by giving an appearance that sacrifice is unnecessary, may even be detrimental. While some soldiers benefit from abundant material support and close communication with loved ones, many soldiers may paradoxically benefit from a more austere situation.

LOW-INTENSITY COMBAT STRESS CASUALTIES: PREVENTION AND TREATMENT

Although successful treatments for low-intensity combat stress casualties were developed as early as the Napoleonic Wars, circumstances can prevent the application of remedies. For example, during the Vietnam conflict the 1-year rotation policy, ostensibly for the purpose of preventing psychiatric casualties due to cumulative stress, the policy of rotating commanders out of combat units after 6 (and later only 3) months in order to give more officers combat experience, and the policy of individual replacement of losses rather than unit replacements, all interacted to impair unit cohesion, which might have prevented at least some of the nostalgic casualties. Most combat soldiers and marines left the combat zone by commercial air, without any combat comrades with whom to talk out (debrief) the memories of the tour. Their reception in the United States also usually discouraged further sharing and validation of their (and their dead comrades') experiences, accomplishments, and sacrifices.

Some aspects of treatment have been exemplified in the foregoing cases and in preceding chapters. It may be summarized as treatment of acute post-traumatic stress disorder following combat psychiatric principles, not reinforcing symptoms associated with chronic and delayed post-traumatic stress disorder, use of evocative therapies emphasizing correcting current maladaptive behaviors, and judicious use of pharmacotherapy in some cases.

A critical component of treating chronic post-traumatic stress disorder is determining associated conditions, especially drug and alcohol abuse, and treating them as well. The use of a relaxation technique such as one of those described by Benson[67] can be critical in managing anxiety symptoms without resorting to medications or may be adjunctive to their use.

SUMMARY AND CONCLUSION

This chapter has described the emergence of symptoms more often encountered in garrison settings—various character and behavior disorder problems—as the primary nosologic entities in low-intensity combat. The resurrection of the ancient entity "nostalgia" seems appropriate as a generic approach to conceptualize and treat these casualties. The postwar emergence of large numbers of veterans suffering from chronic and delayed post-traumatic stress disorder following the Vietnam conflict and the 1982 Lebanon War is explored in Chapter 16, Chronic Post-Traumatic Stress Disorder, in terms of the evolution of the post-traumatic stress disorder concept and approaches to prevention and treatment. Studies from World War II reveal that improperly treated cases of acute post-traumatic stress disorder (combat fatigue) account for most of the subsequent postwar disability from chronic post-traumatic stress disorder (formerly called war neurosis). Studies of American prisoners of war held by the Japanese and North Koreans reveal that harshly treated prisoners of war are at high risk for developing chronic post-traumatic stress disorder.

In the future, U.S. forces are far more likely to encounter low-intensity combat than high-intensity combat. The psychiatric casualties, which undoubtedly will be unique to the situation, are still likely to resemble in some fashion those of previous low-intensity wars. The human organism is amazingly adaptable, and responds to threats to its existence by calling forth the maximum adaptive strategies to escape from the perceived danger. When effective methods for returning combat fatigue cases to battle were developed, is it possible that newer symptom complexes to avoid danger occurred as an

adaptive function? Failure to take malarial prophylaxis, drug abuse, and misconduct defy the application of traditional combat psychiatric principles but may reflect the same psychodynamic processes seen in combat fatigue. Given this difficulty, treatment and preventive psychiatric procedures must be flexible to optimize the return of such casualties to normal functioning.

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