TRAUMATIC WAR NEUROSIS EGYPTIAN EXPERIENCE

BRIG MOSTAFA EL SUDANY EL RAYES, MD, MRCPsych

Director, Military Psychiatric Hospital, Cairo

Over the last 24 years the Egyptian Military Forces have been involved in 5 wars. Each war had its own characteristics. The Yemen War, an overseas battle, the theatre of which was completely different from our Egyptian desert, being mountainous and not leading to a modern or even classical combat. The 1956 war, the 1967 war, the war of attrition lasting from 1968 to 1970 and lastly the war of October 1973, all in a relatively short period have enriched our psychiatric experience in handling the problem of traumatic war neurosis.

The Egyptian military psychiatric team believes that "traumatic war neurosis" is a well defined nosological entity, a belief which is not yet shared by a group of Egyptian civilian psychiatrists. Traumatic war neurosis has its own precipitating factors, its own clinical picture, its own psychopathology as well as its own management. This paper is about traumatic war neurosis as an Egyptian experience, and is limited to two main items, namely, the various clinical pictures which we, as a military psychiatric team, have seen among Egyptian psychiatric casualties and secondly their management.

Clinical picture

We are accustomed to classifying the various clinical pictures into two main groups, the acute and the chronic.

Acute cases

The clinical picture does not differ much from what has been written in the literature. The patient is seen a few hours to a few days after evacuation from the combat area, depending on the nature of this area, how far it is from the battalion aid station and the facilities of evacuation to the rear. Most patients exhibited severe anxiety manifestations with hyperactivity of the sympathetic autonomic system, irritability and restlessness. Most of them were showing marked startle reaction to noise, some others were aggressive to the medical staff and also to their comrades. Hysterical conversion symptoms were seen among soldiers as deafness or blindness. A fairly limited number were coming in with clouded consciousness, perplexity and sometimes confusion. Fugue states were seen in the 1973 war only during the Devrsoire combat, while in the 1967 war only a few cases were found to suffer from such a condition in spite of the fact that a relatively large number of the Egyptian troops had retreated in an irregular way, walking on foot for days, their only aim being to reach the west bank of the Suez Canal. This retreat was under very severe and abnormal conditions. It seems that when the existence of the combatant is threatened, there is no place for dissociative processes, which, if they occurred, would minimize the chances of survival.

The acute clinical picture varied from mild, moderate to severe depending on the pre-morbid personality, the nature of combat and the traumatic situation itself, which to me is the most important of all. In the 1967 war, although the actual combat was of rather short duration, the incidence of severe cases was much more frequent than in the 1973 war which lasted a longer time. The retreat of the 1967 battle was across the desert of Sinai under almost continuous air raids, without any protective anti-aircraft weapons, and without any natural shelter. This very severe traumatising situation was almost continuous for several days. For most of the severe cases, a diving jet plane with its high speed and roaring sound, in the absence of effective anti-aircraft weapons, was the most traumatising situation. Severe startle reaction to the noise of aeroplanes was almost a universal finding in the acute cases suffering from traumatic neurosis in the 1967 war. On the contrary, startle reaction to noise was not a feature of the cases seen on the Yemen Front. There, Egyptian troops were not subjected to air-raids or heavy artillery shooting. Most of the casualties came from ambushes or a sabotage operation. Fugue states and aggressive behaviour were more common in traumatic cases in this war. In general, cases of traumatic war neurosis were mostly mild in the Yemen War, very few cases were found to be severe, and most of them were survivors from a sabotage operation during which they had witnessed the death and mutilation of their comrades. During clinical interviews and also in abreaction, it was found that the mechanism of identification and guilt were decisive factors underlying the traumatic reaction.

During the first 10 days of the battle of October 1973 it was observed that the number of psychiatric casualties was much less than had been expected. Also the percentage of the severe cases was minimal, most of the cases were showing mild traumatic reactions. After the 10th day it was seen that the number of severe cases was shooting up. This was concomitant with the crossing of the Israeli troops to the west bank of the Canal starting the Devrsiore Combat. There, the Israeli troops were attacking and were not in a defensive position as they were before. In this battle the struggle was not any more severe than it had been before, but it was concluded that the defensive posture which the Egyptian troops had taken up was very much more demoralizing than the previous attacking posture.

Panic states were not common in the 1967 war or in the 1973 war. Cases of panic were encountered on the Yemen Front, also coming from ambushes or after certain situations of sabotage. A few cases were seen in the Devrsiore area in the 1973 war.

Chronic cases

Cases of chronic traumatic war neurosis were found to have various clinical pictures which actually made the basis of the present conviction that traumatic war neurosis must be a separate nosological category.

The most common presentations, all associated with bouts of free-floating anxiety and sympathetic hyperactivity were: Insomnia: Recurrent catastrophic battle dreams: Startle reaction to noise, particularly to aeroplane roaring noise, or a noise similar to it: Aggressive behaviour with marked irritability: Neurasthenic symp-

toms: Psychosomatic complaints, the most important of which was impotence: Depressive reactions: Behaviour disorder: Various psychotic reactions.

Insomnia was found to be a universal symptom among cases of traumatic war neurosis. It was seen to be mostly at the beginning of sleep. A lot of cases still complain of insomnia some 13 years after the end of the war. Cases from the 1967 war were the most resistant to treatment, in contrast to cases seen in the Yemen who showed mild insomnia, usually responsive to treatment.

Recurrent catastrophic dreams of battle, although considered characteristic of traumatic neurosis, were, in many cases of chronic neurosis, absent. In some cases they were replaced by terrifying dreams not related at all to war.

Startle reaction to noise was almost always present in cases of the 1967 war and in the attrition war, and to a lesser extent in the 1973 battle before the Devrsaire combat. Startle reaction was found to be infectious, particularly in the ward. Some cases were found to pass into a state of panic following the roaring sound of a jet plane.

Aggression towards comrades as well as to members of the family was, and still is, met with in cases of chronic traumatic neurosis. Wives of those patients used to come to the clinic with, or sometimes without, their husbands to complain of the abnormal aggression of the husband towards her or her children. A considerable number of the families were considered to have broken homes, and many cases ended in divorce. In a number of cases impotence was concomitant with aggression and paved the way to a rapid and permanent divorce.

Impotence, as a monosymptomatic presentation in chronic traumatic neurosis was a matter of discussion and investigation amongst our team. It was found unaccompanied by manifest anxiety or depression or any other psychiatric symptoms. I would like to stress that impotence here is not of the type secondary to the use of medication or a part of an anxiety syndrome. It was also characterised by being resistant to treatment. In psychotherapy and under abreaction, it was found that impotence was a symbol of lost manhood due to severe overwhelming sense of defeat in the battle.

The depressive reactions were almost always accompanied by a sense of guilt due to loss of a comrade during the battle. In the 1967 war the depressive reaction was much more frequent than in 1973. Most probably this was related to the irregular retreat and sense of guilt accompanying this.

Psychotic reactions presenting as chronic traumatic reaction were not very common. They were seen more as acute cases. Except for one which is still under management from severe traumatic paranoid psychosis occurring in the 1973 war, almost all cases have shown marked improvement.

Deferred traumatic reactions were usually seen in cases of physically injured combatants who had been treated and improved. The moment they were informed that their injury had healed, they started to show a picture of traumatic neurosis. The physical injury was most probably damping down the severe existing anxiety

underlying the traumatic reaction. Another form of delayed traumatic neurosis worth mentioning — soldiers retreating across Sinai for days were found to make their way in a properly planned manner, heading for the Canal to be safe on the west bank. The moment they had arrived at their destination, a full blown picture of traumatic neurosis flared up. Saving life is definitely a goal which makes compensation an important and indispensable mechanism. When this goal is achieved, spontaneous decompensation takes place immediately.

Management

Our methods developed for the treatment of combat neurosis were guided by three principles of Artiss, namely: the principle of proximity, which means that the patient must be treated as near as possible to the place where he had his traumatic reaction; the principle of immediacy, which means that psychiatric intervention must occur as early as possible after the traumatic reaction; and the third principle, that of expectancy, which implies that the patient must expect to return to his unit after a short time of self-organisation. But these principles were not always possible to fulfil: the nature of the combat theatre and the type of the battle both affected management. In the 1967 war, psychiatric casualties did not have a proper chance of psychiatric intervention until after reaching the west bank of the Canal. The reverse was true for the 1973 war: psychiatric casualties could receive psychiatric management within a short time after evacuation from the combat area.

The methods of treatment were not much different from those described in the literature.

In the case of severe traumatic neurosis, sleep therapy was the treatment of choice. The results from the 1967 war were very encouraging. Cases which displayed severe aggression were given a chance to join group psychotherapy. Mild cases had symptomatic treatment. Some cases of conversion reactions and maybe those who were showing marked inhibition, were given a chance to abreact by the help of either short acting barbiturates or by stimulants such as IV amphetamines. Chronic cases were the most disappointing; cases with early psychiatric intervention produced better results.

Comparing the results of psychiatric treatment in various wars it was found that the psychiatric casualties of the 1967 war and those of the war of attrition did not respond much like the cases of the 1973 war and the Yemen War. The reason for this difference, we believe, was the type of the traumatic situation. What we mean by "traumatic situation" is the moment, during the combat, when the soldier gets an overwhelming feeling that nothing is nearer to him than actual death, without any way to avoid it.

From the various clinical interviews and abreactions, and from impressions obtained during psychotherapeutic settings, we came to the conclusion that the following findings favour the occurrence of the traumatic situation which in many cases leads to traumatic war neurosis:

(a) A sense of absolute helplessness. (b) To be in a position of defence. (c) Absence of good leadership. (d) The lack of a sense of belonging to a well-knit

group. (e) Absence of any deep conviction in the goal of the battle (f) Poor level of morale in general.

In the 1967 war most of the above mentioned features were present to a large extent in the majority of our patients. The reverse was found in the 1973 war. For that reason the number of psychiatric casualties was much less both in frequency and in severity. There is no doubt that proper and good training in an atmosphere similar to true combat minimises the occurrence of combat neurosis. This training must be supplemented by reducing, to a great extent, the factors favouring the traumatic situation.

Honorary Consultants

Dr Michael Norman Maisey, MD, FRCP, has been appointed Honorary Consultant, in Nuclear Medicine to the Army, with effect from 1 April 1982.

Dr William Green, MRCPsych, MRANZCP, DPM, has been appointed Honorary Consultant in Psychiatry to the Army in Hong Kong, with effect from 1 April 1982.