Looking back and ahead: some perspectives of military psychiatry

MSVK Raju
Professor of Psychiatry and Head, Department of Psychiatry, Peoples College of Medical Sciences and Research Centre, Bhopal, Madhya Pradesh, India

ABSTRACT

Military psychiatry is a branch of psychiatry that is concerned with the mental health of soldiers and their families in war and peace time. It emerged as a special field of importance after World War I. With changing combat scenarios, peace keeping operations and terrorism modern soldier is obliged to confront and endure wide ranging demands for adjustment; with battle fronts becoming diffuse and coming closer to home unarmed civilians are sucked into war-like situations. Military psychiatrists as well as their civilian counterparts need to be aware of the essentials of the mental health consequences of military operations of various kinds and related situations.

Key words: military psychiatry; combat stress casualties; prisoners of war; terrorism; peace keeping operations

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Military psychiatry

Military psychiatry is a branch of psychiatry which is concerned with the treatment of mental disorders in soldiers and the dependent members of their families. [1] It is also concerned with the prevention of mental disorders, promotion of morale and mental health of soldiers. Military doctors are called morale builders. [2] Like all medical corps persons the primary role of the psychiatrists is conserving the fighting strength of the armed forces. [3] Considering the current complexities of war and war-like activities the above description of military psychiatry vastly enlarges the area of operations of a military psychiatrist. For the sake of brevity I have chosen to skirt the general psychiatric disorders in the military setting and to focus on the combat stress
behaviours only with brief digressions at places to facilitate proper appreciation of the topic. For the sake of brevity also I will confine myself to the issues related to land forces only. My aim is to sensitise you, ladies and gentlemen, to some of the broad issues of military psychiatry rather than dwell at length on many matters of military medicine and psychiatry.

In order to make you appreciate fully the role of military psychiatrists in the present day armed forces and the relevance of my talk here today I would like to outline at first the evolution of war and warfare over the eons.

**Evolution of war and warfare**

War has been an enduring aspect of human existence. \(^4\) As per an estimate, 14,500 wars have been fought between 3500 BC and late 20th century costing 3.5 billion lives. \(^5\) The Mahabharata war, as per astronomical and other calculations, was fought somewhere in 3000BC with an estimated loss of 33, 06,240 lives. \(^6\) Apparent at least such large scale killing was within the grasp or imagination of the human mind even in such ancient times!

A soldier of yore would pick up his armour and arms at dawn to fight; and fight he would as long he saw the streaming standard of his king. At sunset he would shed his armour and arms, stretch out for a welcome respite in full view of his enemy. War was like a game then and often fought over small stretches of land. In the World War I (1914-1919) technology entered the battle field in a big way in the form of the machine gun, battle tank, mustard gas and fledgling air force. Thousands died to increase the war making capacity of the adversary. \(^8\) The Vietnam War (1965-1971) brought the concept of ‘Total War’. In addition to the conventional war at battlefront strategic targets like factories, communication and transport hubs deep in the enemy territory were subjected to heavy aerial bombardment to destroy the war making capacity of the adversary. \(^8\)

Ultimately, the war ended with the dropping of two atom bombs. Thousands of unarmed citizens were vapourised on a sunny morning. War was no more confined to the borders. The Vietnam War (1965-1971) brought the concept of “low intensity conflict”. Short periods of high intensity operations dotted long periods of lull. Insurgents all over the globe found this type of war is quite suitable to their designs of overthrowing legitimate governments and this sub-conventional war has become the trade mark of this century so far. Finally now, the global war of terrorism. Unarmed and unsuspecting common people are deliberately targeted without any qualms to create fear. Every individual is a potential target; no place is immune. The gentleman or the lady standing next to you in the market place may be the one with a definite design to kill you and many! Battlefront is at every door-front now.

You would have guessed the point that I am driving at: all of us here today are potential military psychiatrists. As we undoubtedly are, we might as well familiarise ourselves with aspects of military stress, combat stress, combat stress behaviours and the many relevant allied but by no means unimportant aspects of current scenarios of war and its aftermath.

**Military stress and combat stress**

The raw young individual of a fiercely democratic country like ours becomes a soldier after military training and a seasoned soldier after facing active operations. As a new recruit he finds his milieu of choice is totally different with regimented daily life, strict discipline, strenuous physical exertions, chain of command, and lack of privacy, frustrations and home front worries. A trained soldier in the field is obliged to endure uncertainty, extreme climatic conditions, isolation and ever present home front worries. \(^7\)

Stressors in combat situation i.e. when soldiers are engaged in actual battle are due to deliberate enemy action aimed at killing, wounding or demoralising our forces. \(^9\) War need to be experienced to appreciate the stress of combat. The extremes of physical stress and privations; cognitive stressors like uncertainty, unpredictability, sensory overload and deprivation, difficult choices, and rumours and what not; emotional stressors like fear, anger, anxiety, guilt, rage, conflicts, boredom; all place enormous demand for adjustment and a seasoned soldier after facing active operations. A raw young recruit becomes a soldier after military training and a seasoned soldier after facing active operations. The raw young individual of a fiercely democratic country like ours becomes a soldier after military training and a seasoned soldier after facing active operations.

<table>
<thead>
<tr>
<th>Item</th>
<th>Life event</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Wife having illicit relations</td>
<td>82</td>
</tr>
<tr>
<td>2</td>
<td>court martial</td>
<td>80</td>
</tr>
<tr>
<td>4</td>
<td>Divorce from wife</td>
<td>76</td>
</tr>
<tr>
<td>7</td>
<td>Fighting in war</td>
<td>68</td>
</tr>
<tr>
<td>10</td>
<td>Marriage</td>
<td>67</td>
</tr>
<tr>
<td>16</td>
<td>Fighting terrorists</td>
<td>60</td>
</tr>
<tr>
<td>23</td>
<td>Casual leave sanctioned</td>
<td>44</td>
</tr>
<tr>
<td>30</td>
<td>Physical training</td>
<td>2</td>
</tr>
</tbody>
</table>

* All the items of the scale are not shown here

Despite the wide variety and overwhelming stressors soldiers stay mentally healthy because of their ability to adjust. This ability comes by living, training, and fighting together. Morale is a good indicator of the
mental health of a soldier. Morale is the capacity to stay on the allotted job with determination and zest.\textsuperscript{[7]} Morale is the wanting to want to do what one has to do.\textsuperscript{[13]} Physical fitness, confidence in leaders, confidence in training, conviction of the cause of war and above all cohesion of the group are some of the important factors that contribute to morale. Morale depends on group characteristics more than on individual personalities.\textsuperscript{[7, 13, 14]}

**Military psychiatrist**

The responsibilities of a military psychiatrist are quite different from those of his civilian counterpart. In addition to his professional duties he may be called upon to take charge of surgical or medical wards, duties of a staff surgeon, casualty medical officer, hospital superintendent, or even the secretary of the officer mess, which is a regimental institution in the army, and so on. In addition he will be required to perform certain military duties of the garrison on demand. All this, though initially quite taxing, gives a person enormous opportunities to learn and to become a well rounded military medical officer and psychiatrist. The duties of a military psychiatrist appear to be same in other countries too.\textsuperscript{[15]}

**Combat stress behaviours**

Combat stress behaviours cover the full range of behaviours, both positive and negative, that are seen in combat situations. Unit cohesion, espirit-de-corps, tolerance to hardships, heroic acts and self sacrifice are some of the positive spin offs of combat while combat fatigue, misconducts and PTSD could be the adverse outcomes to some.\textsuperscript{[8, 10]} Until the Vietnam War combat fatigue only was considered as ‘combat stress reactions’. Misconducts were treated as cases of discipline.

**Symptoms of combat fatigue**

Mild symptoms of combat fatigue manifest in the form of anxiety symptoms like tension, Startles, cold sweat, dry mouth, breathlessness, diarrhoea, frequent urination, fatigue and ‘thousand yard stares’. Frequent dreams, grief, guilt, irritability, anger and anxiety are common emotional symptoms. Mild combat fatigue symptoms are associated with over- or under activity become moderate combat fatigue. Agitation, ducking at the slightest sound, paralysis, sensory loss, total immobility, trembling, panic running and withdrawal are the usual behaviours that indicate moderate combat fatigue. A soldier may also talk rapidly, argue, and become sleepless, emotionally labile, amnesic and apathetic. Severe combat fatigue manifests in the form psychotic symptoms and gross abnormalities in behaviour.\textsuperscript{[8]}

**Psychiatric casualties in conventional war**

The Mahabharata warrior Arjun is perhaps the first well described psychiatric casualty,\textsuperscript{[16]} and by extension, Krishna the first military psychiatrist because he treated the casualty right in the battle field as the modern medical corps man does. Combat stress casualties (CSC) were also described in Bible and in the epic Gilgamesh. Herodotus described a soldier becoming blind without a blow of sword in the famous battle of Marathon. Frightening battle dreams were described by Hippocrates. In the Napoleonic wars (1800-1815) Soldiers collapsing into protracted stupor as the artillery shells brushed past them, were reported which led to the description of “vent du boulet” syndrome where subjects were frightened by the wind of the passing cannon ball.\textsuperscript{[8]} In the American civil war cases of “nostalgia” characterised by homesickness were reported in young soldiers. Bowlby described “functional nervous symptoms” occurring due to battle field excitement in the soldiers during Boer War.\textsuperscript{[18]} Mahatma Gandhi worked in the ambulance corps during this war.\textsuperscript{[5]} The term “war neurosis” for CSC was coined by the German physician Honigman for the CSC sustained in the Russian-Japanese war (1904-1905). During this war, for the first time in history, CSC was treated near battlefront by the Russian psychiatrist Avtocratov at Harbin in Manchuria marking the birth of ‘forward psychiatric treatment’ (FPT).\textsuperscript{[8]}

World War I (WWI) fought during 1914-1919 saw ‘a large number of unscathed soldiers and officers presenting with mental disturbances’. Symptoms consisted of sudden muteness, deafness, general tremor, inability to stand or walk, loss of consciousness and convulsions and were attributed to fright of exploding shells and mines and seeing maimed and dead comrades.\textsuperscript{[8]} In the initial stages they were evacuated to the distant general hospitals from where they never came back to fight. Lt Col Charles Myers, psychologist to the British expeditionary force coined the term ‘shell shock’ to describe the psychological symptoms occurring in battle field.\textsuperscript{[19]} He and Andre Leri of the French second army managed CSC cases close to the front line as a result of which 60-90% cases could be returned back to front line after short treatment. Unfortunately, some shell shock cases were also shot dead as punishment for desertion.\textsuperscript{[8]} After reviewing their experiences Major Thomas Salmon of the US army codified that CSC should be treated as close to the battle field as possible (proximity), as soon as possible (immediacy) with explicit statements of expected recovery (expectancy) and with simple reassurance, replenishment , rest for short time (simplicity) which formed the PIES principles of treating cases of Shell Shock.\textsuperscript{[20]} Mitchel and Smith reported 3938 cases of British CSC of which 77 to 99% could be returned to
duty with forward psychiatric treatment. \[21\] One million Indian soldiers fought under the British flag in WWI out of which 74,187 were killed in action (KIA) and 69,214 were wounded in action (WIA).\[22\] No figures for psychiatric casualties in respect of Indians are available. In the initial stages morale was low because they lacked proper clothes and shoes and the European commanders were not able to understand the language and customs of Indian soldier as a result of which there were large scale desertions. \[23\] Mahatma Gandhi and Kasturba actively participated in caring for the wounded Indian soldiers in England. The Indian people there even gave Mahatma Gandhi the rank of an honorary colonel. \[2\]

In the Second World War (WWII) lessons learnt in WWI were forgotten and psychiatrists were unwelcome in the theatre of war. \[7\] At one point, discharges due to CSC exceeded the rate of recruitment. \[24\] CSC versus WIA ratios varied from 1:1 to 1:5. \[10\] Psychiatric casualties constituted 5 to 30% of all sick and wounded evacuated from battle areas. \[25\] Only 5% of the psychiatric casualties evacuated to the base hospitals hundreds of miles away returned to duty until Frederick Hanson revived forward psychiatric treatment (FPT) in 1943 in North Africa. Instead of war neurosis or shell shock he used the term “exhaustion” for cases of CSC. This term liberated the symptoms from the yoke of a medical label and also effectively embedded the suggestion that recovery was expected. With FPT 50 to 70% of CSC could be returned to duty. \[8\]

Jones and Wessely, \[25\] in a comprehensive review posit that battle casualties bear a definite relation to the intensity of battle as well as the experience and preparedness of the troops exemplified by the casualty figures of the first Canadian division (Table 2). The sixth battalion suffered less CSC in the beginning because of better training while battalion 7 and 8 suffered more casualties in the second battle unlike others because of poor preparation and change of command. Two million Indian soldiers fought once again under the British flag. 87,032 were KIA and if we estimate twice as many would have been WIA. \[26\] A conservative estimate of 50,000 Indian CSC can be made from the total Indian casualties. Kirpal Singh reported of a ‘large number’ of severe cases of combat fatigue from Arakans in Burma and Comilla (now in Bangladesh). Pithily he observed, “One interesting fact about the psychotic reactions in the Indian troops is worth mentioning i.e. the condition is liable to change from day to day and what looks like a typical schizophrenia reaction may be recovered in a few days time”. \[27\] In Nov 1944 psychiatrists were posted for the first time in India at IV, XV and XXXIII corps and their divisions of the Allied Land Forces of South East Asia (ALFSEA). \[9\] That was the beginning and end of forward psychiatry in India. We are yet to see psychiatrists at our field formations.

India fought 4 wars with its western neighbour and one with its northern neighbour. Apparently psychiatric casualties were well managed at forward areas as it generally happens anywhere. \[10\] Singh studied 77 psychiatric battle casualties of 1965 Indo- Pakistan conflict. 87.7% of the cases belonged to the age group 17-29; 94.4% were from persons below officer rank (PBOR) and 68.9% had less than 5 years of service. After an average 8 days of treatment 87% recovered and returned to duty. \[29\] Dubey et al studied battle casualties of 1971 Indo-Pakistan war with limb injuries. They found 30% had high levels of anxiety. \[30\]

Due to better organised psychiatric services CSC were low in Korean War. \[10\] War exhaustion came to be labelled as ‘combat fatigue or battle fatigue’ during the Korean War. However during the latter half of Korean war “disorders of loneliness” in the form of alcoholism, venereal diseases, drug abuse and antisocial acting out started emerging due to lack of cohesion and boredom. \[17\] During Vietnam War, psychiatric casualties were less than 5%; \[10\] but psychiatric evacuations increased toward the later part while WIA decreased. \[31\] (Table 3). This increase was due mainly to large number of substance use cases. Incidents of misconduct like ‘fragging’ also became common. \[17\] Initially, Vietnam war was considered a psychiatric success but veterans increasingly complained of delayed psychological symptoms. \[33\] Ultimately this “post Vietnam syndrome” was given a nosological status in the DSM III as post traumatic stress disorder (PTSD). PTSD rates in civilian population range from 1% to 14% (APA 2000). 5% of US soldiers were found to have PTSD even before deployment. \[34\] Perhaps PTSD occurred in previous wars too. The term ‘reactivated PTSD’ is used in the case of WWII and Korean War veterans who were productive until 60 or 70 years of age but suffer due to return of PTSD symptoms. \[10\]

| Table 2 Battle casualties in a Canadian division | [25] |
| --- | --- | --- |
| Regiment | First battle | Second battle |
| 1 | 17.4% | 16.9% |
| 2 | 28.4 | 23.4 |
| 3 | 25.6 | 25.7 |
| 4 | 23.2 | 21.4 |
| 5 | 22.6 | 17.1 |
| 6 | 16.9 | 14.6 |
| 7 | 21.8 | 31.4 |
| 8 | 19.2 | 30.0 |
| 9 | 30.5 | 23.4 |
During the Yom Kippur war the Israeli army suffered 30 CSC for every 100 wounded (3:10) as they were caught unprepared by the Egyptians. During Operation Desert Storm only a few cases of CSC reported as the highly victorious ground operations lasted just 100 hours with relatively few casualties i.e. 148 KIA and 467 WIA. However, veterans of this war reported increased frequency of headache, fatigue, joint pains, rashes, sexual difficulties, and shortness of breath and concentration difficulties. These symptoms came to be dubbed as the Gulf War Syndrome (GWS). Though some initial support was there, the symptoms were found to be occurring also in those who were not deployed in the gulf and even in those who were deployed elsewhere. The consensus was that there was no unique Gulf War Syndrome. In the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) in Afghanistan PTSD rates ranging from 11 to 16% have been reported by various mental health advisory teams of USA.

**Psychiatric aspects of low intensity conflict (LIC) operations**

India is involved in LIC operations mainly in the form insurgency in various parts of the country since independence due to perceived inequalities by the people of those areas. This sort of activity is abetted and instigated by interested parties across the border. The army’s mandate in such cases is to keep the situation under reasonable control to enable the political processes to take place to resolve the issue. As these operations are conducted within our own territory battle lines cannot be drawn, there is no clear perception of friend or foe, full force cannot be used and the rewarding experience of victory is not possible as there is no enemy in the real sense. All these factors can be extremely stressful for soldiers who are trained for conventional war.

Due to certain incidents of misconduct in those areas I was given the responsibility to conduct stress management workshops in the operational areas along with senior scientists from the Defence Institute of Psychological Research (DIPR). This exercise, happened to be first of its kind in free India, gave my team an opportunity to study some aspects of combat stress first hand. About 20% reported leave related issues, separation, lack of time for family and lack of rest as stressful factors and surprisingly in non-operational areas also almost the same factors were cited as stressful. Increased movement was cited as stressful in non-operational areas (Table 4). Length of tenure had no effect on the symptoms.

**Table 4 Perceived stressors**

<table>
<thead>
<tr>
<th>Line of control</th>
<th>Peace</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leave related</td>
<td>20.5%</td>
</tr>
<tr>
<td>2. Separation from family</td>
<td>26.9%</td>
</tr>
<tr>
<td>3. Unable to solve family problems</td>
<td>17.9%</td>
</tr>
<tr>
<td>4. Prolonged deployment</td>
<td>18.75%</td>
</tr>
<tr>
<td>5. Less time to rest</td>
<td>15.0%</td>
</tr>
<tr>
<td>6. Uncertainty</td>
<td>12.5%</td>
</tr>
<tr>
<td>7. Combat</td>
<td>9.4%</td>
</tr>
<tr>
<td>8. Loss of life</td>
<td>11.25%</td>
</tr>
</tbody>
</table>

It was also found that small things like the lack of a vernacular newspaper could be a significant irritant (Raju and Singh). This finding underscores the need of continuous monitoring mechanisms to assess the mental health of troops. Chaudhury et al., administered various tests to assess the stress in LIC areas and compared the findings with those in non-operational areas. They found significantly high depression, anxiety and alcohol abuse in LIC areas; the mean scores were however below the cut off scores. Saldanha et al., studied PTSD in 601 polytrauma cases and found 75.7% cases had symptoms of PTSD and 24.3% had syndromal PTSD. At six months, 17.1% continued to have PTSD which came down to 4.95% at one year follow-up. The figures of the study are high when compared with Vietnam War, OIF and OEF and underscore the importance of monitoring mechanisms to assess long term course and factors associated with outcome of PTSD in Indian armed forces personnel.

**Psychiatric causalities in nuclear chemical and biological war**

Although, the Hague convention prohibits the use of weapons of mass destruction (WMD), threat of their use exists. Access of these ‘assets’ to terrorists or rogue states adds another dimension to the angst of our times. Chemical agents are categorised into blood agents (hydrogen cyanide), nerve agents (sarin, soman, tabun, VX) blistering agents (mustard gas, lewisite) and inhalation agents (phosgene, chloropicrin). They were used in WWI, Iran-Iraq war and by terrorists in Japan in 1995. Nerve agents are organo-phosphorus compounds and may cause ‘cholinergic syndrome’. Low dose exposure can impair night operations because of miosis. Chronic exposure to these agents is associated with anxiety and depression. Inappropriate use of antidote may cause ‘central anticholinergic syndrome’.
and may manifest as delirium. ‘Gas hysteria’ occurs in those who are not exposed and mimic the symptoms of chemical casualty. When the symptoms are prolonged the condition is called ‘gas neuroses’. Biological agents like anthrax, coccidioidomycosis, ebola virus and toxoplasmosis have been used. Neurotropic agents may cause primary psychiatric symptoms. Nuclear weapons cause casualties due to flash, blast, heat and radiation. Radiation sickness occurs in three stages. Initial phase is characterised by nausea, vomiting, headache and dizziness; in latent phase there will be no symptoms while in the final phase the initial symptoms will reoccur accompanied by alopecia, skin haemorrhages and diarrhoea. Final phase ends by recovery or death. Organic mental disorder was not common. Neurasthenia like symptoms was observed in some cases of Hiroshima survivors. The NBC suits impair communication and restrict field of vision and may cause paranoia. Needless to say, the WMD produce disaster like situations with special characteristics which depend upon the nature of agent used. The effects of chemical and biological agents or a radiation device could be insidious and one stands the risk of not seeing an enemy hand behind the occurrence of symptoms.

**Terrorism**

We are in the age of terrorism. More than 1000 terrorist organisations are active now in more than 100 countries. It is a species of political violence where violence or threat of violence is used against non-combatants to gain political, ideological or a religious goals through fear and intimidation. The social psychological experiments of Solomon Asch on conformity, Stanley Milgram on obedience and Philip Zimbardo on the effect of assigned role on behaviour perhaps indicate that anyone can become a terrorist! Victoroff, in a review of the theories of the mental makeup of terrorists feels that terrorists are heterogeneous characters emerging out of the interaction of individual, social and environmental factors. The demographic characteristics of terrorists also changed much over the years. Now even middle aged married men and women also found in their ranks. Victoroff identifies high affective valence on the cause, having a personal stake in the cause, low cognitive flexibility and capacity suppress moral constraints as the possible four factors which may define a terrorist.

Mael and Selzer in a Rorschach ink blot test study of the Nazi leaders found that 15 out of 16 had psychopathic characteristics. Saldanha et al, studied the personality of 31 militants by using Cassel's Somatic Ink Blot test. Age of the militants ranged from 18 to 68 years, 94% had education up to standard 10, 84% belonged to large families, 61% were bachelors, 61% were found to be hard core as per criteria, 61% showed hostility and aggression. They stated corruption and oppression as motivating factors. The hard core type were found to be sociopaths, medium core were emotionally unstable while the soft core group were immature and suggestible. They were more bonded to their group than their family members. The findings of the study are in agreement with Mael and Selzer, and Victoroff, in some respects.

It is important to understand the terrorist frame of mind as psychiatrists may be called upon to advise in a hostage situation or a disaster like situation of a terrorist strike. A hostage taker may be ‘willing to die’ but may not be ‘wanting to die’. If he is away from his group for some days he may be willing to negotiate. After the 11 September 2001 attack on Pentagon, novel therapeutic structures like Special Medical Augmentation Response Team-Stress management (SMART-SM), and interventional methods called Therapeutic Debriefing, and Therapy by Walking around (TBWA), emerged. Post, suggests five strategies to control terrorism: inhibiting potential terrorists to join terrorist groups by economic progress, education support and by establishing grievance redressal mechanisms; by producing dissensions within the group and reducing the stature of their leader; by facilitating exit from the group by offering amnesty, finances, new life and even plastic surgery; by reducing public support through activating silent voices; and by reducing the susceptibility of public to fear through vigorous public education.

**Peace keeping operations (PKO)**

It is said that peace keeping is not a soldier’s job but only a soldier can do it! India is one of the largest contributors for UN peace keeping missions. It has so far participated in 43 missions with a contribution of 1, 60,000 troops. 154 soldiers made the supreme sacrifice. The nature of stressors in Peace Keeping Operations (PKO) differs from mission to mission. Isolation, lack of communication, inherent ambiguity of the operation, frustration, danger, and boredom is some of the common stressors. Length of mission, amount of chaos, acceptance of local people and attacks from local forces determine the difference between one mission and the other. Peace Keepers Stress Syndrome was first described in Norwegian PKO. The symptoms consist of rage, frustration, feelings of impotence and helplessness when confronted with violence and atrocities which the peace keepers are unable to respond because of rules of engagement. Because of the facilities for rapid return by air, a peace keeper may hardly get any time to put their deployment experience in perspective and effect closure. In such a situation he may develop cognitive emotional and behavioural symptoms (Shigemura). There are just
a few studies, [51, 52] addressing the prevalence of psychiatric disorders in PKO. PTSD has been reported in 8% and 15% of peace keepers. However, in an Australian study Sareen et al. [53] found that PKO were not associated with any increased prevalence of mental disorder. Psychiatric morbidity in Indian peace keepers is unknown but figures are likely to be available as psychiatrists are accompanying our peace keeping missions these days.

**Prisoners of war (PW)**

The Geneva conventions do not permit ill treatment of PW. However, PW continue to be ill treated, incarcerated and deprived. The popular outcry against ill treatment of PWs at Guantanamo Bay by US forces is an example. [54] Psychiatric disability after repatriation may be related to degree of ill treatment. [55] Hunter, [56] described three stages of adjustment to capture; shock is experienced for first 24 hours after which survival instincts take over. Person calms down and after 48 hours a shift in values may occur and a person may develop positive feeling toward the captor.

**Prisoner of war syndrome** occurs to every PW at some time. It is characterised by marked withdrawal, apathy, refusal of food and lay curled up as if waiting for death. After release they displayed little enthusiasm at being free, little interest to go home and no hostility toward their captors. After returning home they may display out bursts of indiscriminate hostility. [57]

**KZ syndrome** occurs after long term stay in concentration camps and manifested in the form of severe weight loss, fatigability, dysphoria, impairment of memory, emotional instability, insomnia, loss of initiative, headache, vertigo, neuropathy, cognitive impairment of various degrees and cortical atrophy. [58]

**Brain washing:** After the Korean War some American GIs voluntarily chose to remain in Korea which was attributed to ‘brain washing’. It refers to a process in which a group or an individual use unethical manipulative methods to persuade others to conform to the wishes of the manipulator often to the detriment to the person being manipulated. [59] Beiderman, [60] described the eight methods used in coercive persuasion: isolation; monopolisation of perception; induced debilitation; threats of death; occasional favours; degradation and enforcing trivial demands.

**Stockholm syndrome:** In a hostage situation, hostages may express sympathy, empathy and positive feelings toward the captors. This term was coined by the psychiatrist Nils Bejerot in 1973. [61] After repatriation, residual symptoms like survival guilt and susceptibility to physical and mental problems may persist. [62] Singh et al. [63] studied a random sample of 40 surgically disabled Indian PW out of 121 in April 1963 after the Chinese war. 50% expressed depressive thoughts. There was no apathy, anxiety, resentment against unit, service or the government. 50% of the sample expressed depressive thoughts mainly related to the loss of their limbs. Morbid anxiety, apathy, guilt or paranoid ideas were conspicuous by their absence. 40% expressed hostility towards Chinese. Evidently, the Prisoner of War Syndrome did not occur in Indian soldiers. No direct questions were asked about indoctrination but apparently none mentioned any ill treatment at the hands of their captors. Prior survival training, mentally occupying oneself, communicate with others through tap code, and commitment to some cause are some of the factors that may see one through a PW experience. [62]

**The road travelled**

The armed forces of India do not just guard the borders; they are involved in nation building from the time of independence; in the process take on many responsibilities and therefore subject to varied stressors. Though the technology of warfare has changed the human element has remained the same. A level headed soldier is a minimum essential requirement in making war or in maintaining peace. Mental health, in military parlance, is a force multiplier. [64] There is a welcome awareness of this in the hierarchy of the forces. Many initiatives have been taken over the past decade which bore fair fruit. The formation of military psychiatry speciality section in our society in 1997 is a significant landmark. Non-uniformed psychiatrists are actively participating in the scientific deliberations at CMEs and conferences organised by military psychiatrists. Within the service, over the last dozen years or so we have been able to disseminate information about various aspects of military stress and identification of early symptoms of combat stress to a substantial number of officers and men. A large number of officers are trained in simple techniques of relaxation who in turn train their subordinates in their respective units. A booklet on combat stress authored by me and colleagues from the defence Institute of psychological research (DIPR) is widely circulated to military units. [65] A large number of junior commissioned officers have been trained as counsellors who go to various units. Non-Medical commissioned officers are undergoing training in military psychology regularly at DIPR. The principles of combat psychiatry are being taught to all non-specialist medical officers. Religious teachers in military units are also being trained in combat stress management. The incidence of misconducts and suicides has come down. Psychiatrists are being sent abroad along with troops on peace keeping missions. Overall there is a refreshing change in perceptions at all levels as far as mental health is concerned.
Looking ahead

Combating combat stress is not an activity confined to operational areas only. Actually it impinges on the entire cycle of deployment and there are whole lot of things to do. In order to fully realise the potential of the mental health services a careful look at the infrastructural and organisational aspects is needed. We need to build our field psychiatry research in all areas so that we may be in a position to share actionable information with the commanders for the good of the troops and the country. The armed forces are likely to remain involved in sub-conventional operations for some time and as these are by nature protracted in nature, placing mental health resources at the formation level is a requirement that merits serious consideration. Paths can always be made where none existed. I do foresee some of you attending short courses on military psychiatry at the Armed Forces Medical College, Pune, India in the not too distant future. Ladies and gentlemen I owe my deep sense of gratitude to you all for giving me a patient hearing. I am grateful to the organisers of this conference for giving me such a grand opportunity to say a few things about military psychiatry.

Jai Hind

Author information: The author has previously worked as Professor of psychiatry and Head, department of psychiatry, Armed Forces Medical College (AFMC), Pune, Maharashtra, India; and Senior advisor and consultant, Base hospital, Delhi Cantt, India and Commandant, Military Hospital, Kirkee, Pune, Maharashtra, India

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