Garrison Neurosis: Malaysian Army Perspectives in Psychological Challenges in Low Intensity Warfare

Major (Dr) Mohd Farid Md Yusof [1] & Brigadier General (Dr) Mohd Badli Mahmud[2]

[1] Psychiatric Department, Tuanku Mizan Armed Forces Hospital, Kuala Lumpur.
[2] Psychiatric Department, 94 Armed Forces Hospital, Melaka

ABSTRACT

The psychological impact of low-intensity warfare is less studied as compared to high intensity war. In addition to the broad symptomatologies, misconduct stress behaviours are always the subjects of debate. This study aimed to determine the prevalence of combat stress reaction among soldiers attended 94 Armed Forces Hospital psychiatry clinic and its association between sociodemographic characteristic. The study was conducted via restrospective review of medical records of all soldiers who attended the clinic from January 2019 until June 2019. Total of 78 patients fulfilled the study criteria. The study showed more than half of the patient have combat stress reaction (57.7%). Majority of the patients were non- commissioned officers (85.9%), male (93.6%), Malay (87.2%) and married (59%). The mean age was 29.5 years old. Majority have secondary education with Sijil Pelajaran Malaysia (67.9%), and have been in service between 10 to 15 years (34.6%). The prevalence of combat stress reaction is 57.7%. Age and level of education were found to be associated with combat stress ($p < 0.05$). As conclusion, prevalence of combat stress among attendees to psychiatric clinic HAT Terendak is high. More proactive measures should be taken to prevent this in the future.

KEYWORDS: Armed Forces Hospital, Combat Stress Reaction, Low Intensity Warfare, Psychosomatic

INTRODUCTION

Modern warfare is evolving from high-intensity to low-intensity, intermittent but protracted. Low-intensity war means the battles are interspersed with periods of inactivity, relatively safe for the combatant, rarely involves the battalions, much more like civil wars. As the name implies, the tempo of operations is lesser, with fewer soldiers, a reduced range of tactical equipment and limited scope to operate in a military manner. The majority of casualties in low intensity conflicts tend to be resulting from small arms and improvised explosive devices.

High-intensity war, such as in World War I and World War II is particularly characterized by the involvement of major tactical military formation in continuous operation with entire spectrum of military weapons. War intensity is not parallel with casualties, such as in Beirut, where one truck inside the Marine headquarters building exploded, killed more than 200 U.S Marines[1].

Malaysia is not excluded from war, ranged from high-intensity war such as World War II to intermittent and guerilla-type of war, such as in the Communist Insurgency and the Lahad Datu Standoff. Malaysian Armed Forces (MAF) also participates in multiple peacekeeping missions, humanitarian assistance missions and peacetime military operations.

Many epidemiological studies among the combat troops highlighted the association between battlefield stress with disciplinary problems, venereal disease, alcohol abuse, illicit substance use, and gambling. Although these phenomenon have been manifested since World War I, it was only documented after the Vietnam conflict when they started to recognize that troop inefficiency may be a potential factor. According to Jones (1967), combat-service-support troops (soldiers whose primary mission to support those doing the fighting) experienced similar behavioral patterns related to separation from family, boredom and social isolation. This is known a as `disorder of loneliness,` `garrison neurosis,` or `nostalgia' [2]. This concept of the psychological reaction was known even before 1678, when Hofer, a Swiss physician coined the term called `*Das Heimweh,*` or homesickness, after observing his soldier's behavior during de ployment far from their home. The symptomatology of nostalgia was described as moroseness, insomnia, anorexia, and asthenia, which mimics the depressive symptoms. This illness was not only confined to the Swiss army, it was called the `*maladie due pays*` (homesickness) in the French army and `*mal de corazon*` (illness of the heart) in the Spanish army [3].

This psychological disorder or ` nostalgia` or `garrison neurosis` happens to soldiers who are deployed far from home as well as hose serving in camps or bases in their home country. Malaysian soldiers are no exception. The soldier presented with symptoms that do not fit into the usual psychiatric diagnosis. The common presentation are disciplinary issues, ooccupational challenges, relationship conflicts (e.g., officer, spouse, colleague, etc.), and social problems (e.g., substance use, gambling, etc.). It is a challenge for a military psychiatrist to obtain a history and form a diagnosis. Sometimes, the presentation might masquerade or actually prodrome of a more serious illness.

This paper aimed to determine the prevalence of combat stress reactions among soldiers attending 94 Armed Forces Hospital (AFH) psychiatry clinic and the association between age, level of education, gender, military rank, marital status, and duration of service.

METHODS

Study setting and population

This study was conducted at 94 AFH psychiatry clinic, Terendak Camp, Melaka. This clinic is responsible for providing mental health support for soldiers under 3 Division, includes the 10th Paratrooper Brigade, special forces or elite troops, mechanized, armor, and artillery regiments, and combat training centers. The soldiers were referred by a battalion medical officer/regiment medical officer or a commanding officer to the psychiatry clinic for assessment or expert opinion from a military psychiatrist. Some of them required hospital admission for behavioral observation and investigations.

Methodology

This is a retrospective study, involving all soldiers attended psychiatry clinic from January 2019 until June 2019. Total of 78 patient`s medical records were reviewed and analyzed. Several variables were determined, including age, rank service years, gender, marital status, gender, level of education, and race. Psychiatry diagnoses were categorized into 5 main groups, namely; combat stress reaction, mood disorder, psychotic disorder, anxiety disorder and traumatic brain injury. Those who presented with adjustment disorders, relationship conflict, occupational problems and substance abuse were included under the umbrella of combat stress reaction. Mood disorder includes depression and bipolar disorder; psychotic disorder includes schizophrenia, schizophreniform and brief psychotic disorders; anxiety disorder includes generalized anxiety disorder, panic disorder, agoraphobia and obsessive-compulsive disorder whereas traumatic brain injury includes any major and minor neurocognitive disorders secondary to traumatic brain injury.

Statistical analysis

The descriptive analysis of the data was done using SPSS Version 23. The Shapiro-Wilk test was used to test for the normality distribution of the sample. A p-level < 0.05 was considered statistically significant.

RESULT

Non -commissioned officers accounted for 67 (85.9%) of the total patienst (n=78). Most male (93.6%), Malay (87.2%) and married (59%). Corporal rank constituted most of the patient (35.9%) followed by private (25.6%).

Table 1: Socio-demographic Data of the Sample

Variable		Number	Percentage
Gender:	Male	73	93.6
	Female	5	6.4
Race:	Malay	68	87.2
	Chinese	0	0.0
	Indian	3	3.8
	Others (Iban, Dusun, Kadazan)	7	9.0
Age (years):	17-26	26	33.3
	27-36	43	55.1
	37-46	7	9.0
	47-56	2	2.6
Rank:	Officer	12	15.4
	Non-officer	66	84.6
Education level:	PMR	13	16.7
	SPM	8	67.9
	Diploma	53	5.1
	Degree	4	10.3
Marital status:	Single	28	35.9
	Married	46	59.0
	Divorced	4	5.1
Service duration (years):	≤5	12	15.4
	6 - 10	21	26.9
	11-15	27	34.6
	> 15	18	23.1

The mean age of the patients was 29.5 years old and most patients have secondary level of education with *Sijil Pelajaran Malaysia* (67.9%). Most of them have served between 10 to 15 years (34.6%). The detail is shown in Table 1.

In terms of type diagnosis, most were diagnosed with combat stress reaction (57.7%), followed by psychotic disorder (14.1 %). Most common manifestation of combat stress in this group were relationship problems, workplace problems and substance abuse. Age and level of education have significant associations with the combat stress category. Other groups, such as rank, race, marital status, and service years, a showed no association as shown in Table 2.

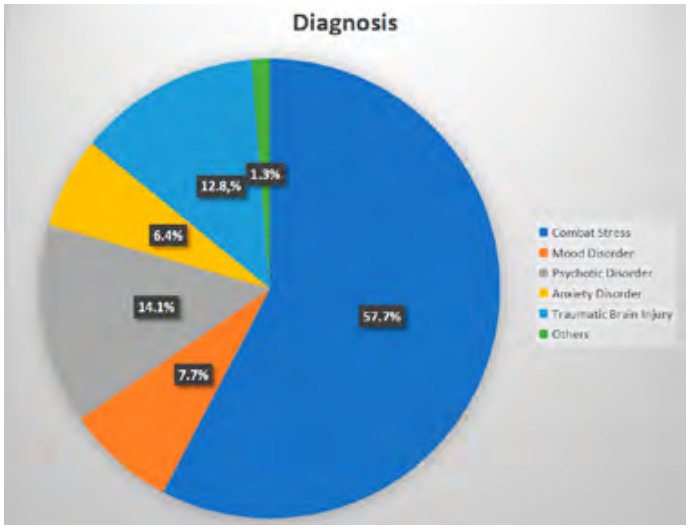

Figure 1: Percentage of Type of Diagnosis of the Sample

Table 2: Association between Age, Service Years, Level of Education, Race, Marital Status, and Gender with Combat Stress Reaction

Variable		**Chi-square**	***df***	**P value**
Rank:	Officer Non-officer	6.36	5	0.076
Education level:	PMR SPM Diploma Degree	14.334	15	0.035*
Service duration (years):	≤5 6 - 10 11-15 > 15	8.963	15	0.253
Age (years)	17-26 27-36 37-46 47-56	26.888	15	0.035*
Marital status:	Single Married Divorced	10.203	10	0.343
Race:	Malay Chinese Indian Others (Iban, Dusun, Kadazan)	5.561	10	0.683
Gender:	Male Female	5.56	10	0.683

* $p < 0.05$

DISCUSSION

More than half (57.7%) of personnel attended psychiatry clinic, 94 AFH were found to have combat stress reaction. Combat stress is referring to military occupational issues garrison, training, and deployed environments. Recognition of psychological presentation of combat stress in the soldier during peacetime or previously called `garrison neurosis,` are always challenging. The presentations were varied and can form multiple symptom constellations in which may change dramatically over time. If not properly managed, some garrison neurosis cases will progress into more serious illnesses, such as major depressive disorder, panic disorder, etc.

The military psychiatrist`s professional opinion are important to determine whether the individual soldier to be charged under disciplinary action or to mitigate the punishment and subsequently change the situation. Hence, the military psychiatrist must be clear about his role, the conception of punishment and discipline, and expectations [4].

General work stressors (administrative issues, delayed promotions, failure to eliminate the ineffective ones from the unit, poor leadership) in addition to specific military stressors (military training, deployment, military adaptation) are the main contributing factors to combat stress. Loneliness, frustration rumors originating from inactivity, enemy propaganda and clinical illness may also contribute to combat stress during deployment [5].

An example of rumor and enemy propaganda is during the 2013 Lahad Datu Standoff in 2013. Rumors circulating among the Malaysian soldiers were that enemies had special abilities such as immunity from bullets and the ability to disappear during an ambush. This propaganda indirectly leads to anxiety and shakes the confidence among the Malaysian soldiers, leading to incompetency. Physical conditions such as chronic illness (Type 2 Diabetes, Hypertension or Osteoarthritis, etc.) and pain, acute dehydration secondary to diarrhea may also interfere with personnel psychological and biological functioning thus may lead to further stress.

Some personality traits have been showed to be associated with combat stress. A review by Porter (1941), found that the soldier with psychopath personality traits is the one that creates disciplinary problems in the military environment or has a `neuropathic predisposition' for war neurosis [6]. However, no specific personality traits directly contribute to the reaction to the combat situation [7].

Apart from that, leadership is another contributing factor in a combat and non-combat situation. A case-control study by Solomon et al. (1986) showed that lack of social support from the officer and colleague was related to loneliness and combat stress reaction [5]. Poor social support can lead to poor administration, poor faith in the command, and poor unit cohesion, which are the factors contributing to psychiatric casualty [6].

The leader personality is also important. During the Boer War (1899–1902), higher rate of casualty, and the cost of the war mounted to £22,000,000, revealing the leadership's incompetence. The Boer War's incompetent leadership included underestimating the enemy, equating war with sport, a tendency to blame others, passivity, and indecisiveness in senior commanders. The general during the Boer War brought along his baggage, which included pianos, long-horned gramophones, a chest of drawers, and a well-equipped kitchen, which slowed troop movements. This poor logistic arrangement was valuable to the Boer [8].

While separation from family members when stationed far from home can lead to loneliness and social isolation, news from home may also influence the soldier's psychology - disturbing news such as financial problems, spouse infidelity, death or illness of the family member, and sometimes the encouragement to not continue the military service. Some of the soldiers may benefit from close communication with the family, but the others may benefit from the opposite. There always the competing demands and responsibilities on military commanders to look out for the welfare of individual service members and their families, while being tasked to complete their primary assignment and mission.

This study found a significant association between age and level of education with combat stress. This is comparable (except of age) to a local study by Badli (2009) which showed that combat stress cases were higher among young personnel (under 20 years old) who were poorly motivated, new in the service (within six months), and had little experience with lower education levels [9,10]. Similarly, other study found that soldiers with lower military rank, age over 26 years old and lower level of education were found to be more vulnerable to developing combat stress, especially in high intensity war [11].

The main limitation of this study is the study design itself. The data was taken from secondary data, and the sampling was not randomized. There were also inadequate information regarding the precipitants for combat stress. The result only reflects the population in that area and could not be generalized to the whole army`s population. A larger comparative study can be done with improvement in the study design and selection of the sample in the future.

Managing low-intensity combat stress casualty is more complex. It involves the basic selection of recruiting, unit cohesion and commander roles, administration role such as rotation of postings, activity during peace, training, etc. The casualties from combat stress were lower in the Vietnam War than World War I and the Korean War after a few administrative changes such as rotation period ie officers had 6-month rotations, and enlisted soldiers had 12-month rotations [12]. Instead of replacing individual soldiers in the unit, the entire unit changed during rotations. Unsanitary environments, poorly prepared food, sickness and boredom make subtle contributions to soldiers' stress [12, 13]. It is imperative to train a unit and individual soldier to develop individual resilience and build the unit's strength.

CONCLUSIONS

The broad, vague and inconsistent presentations of the behavioral and psychological symptoms are often encountered in the low intensity war or the garrison setting. The current approach toward misconduct behaviour, substance abuse, sexually transmitted disease, and failure to adhere to medical advice among the servicemen seems to be inconsistent with the traditional concept of management of combat stress. Are we missing the "misconduct stress behaviors"? Finally, the `garrison neurosis` often successfully managed at unit level. However, more severe cases may require more intensive and holistic approach to maximize the soldier's return to their normal function. Absolutely, more research, especially in military psychology, needs to be done to explore the best possible approach to this matter.

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Correspondence: Major (Dr) Mohd Farid Yusof. Psychiatrist. Tuanku Mizan Armed Forces Hospital, Kuala Lumpur. Telephone : +603-41454200/ +60196674017. Email: blackjeack27@yahoo.com