Evolving Medical Strategies for Low Intensity Conflicts - A Necessity

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Abstract

Military medicine is the development within the art and science which is designed to carry out a specialized, essential and a highly significant mission under the adverse conditions of war. Low Intensity Conflict (LIC) is a mode of warfare which has come to stay and the Indian Military has to confront it as such. It is a campaign of nerves, less military and more psychological, with soldiers inevitably fighting with hands behind their back. The dichotomy the soldier faces, results in high levels of frustration leading to various stress disorders. The key in casualty survival lies in correct and timely psychological first-aid for which every section and platoon commander should be trained. Post Trauma Stress Disorder caused as a result of traumatic experience can deplete unit's efficiency and therefore needs monitoring for early detection and treatment. Evolving medical strategies for Low Intensity Conflict Operations (LICO), therefore assumes significance.

MJAFI 2003; 59 : 96-99

Key Words: Low Intensity Conflict; Post Traumatic Stress Disorder; Stress

Introduction

Military medicine is distinctive, in that, contrary to the usual medical practice, the care of the individual must necessarily become secondary to the military effort. No matter how good a medical officer may be in one field or another, he must always conduct himself within the purposes and limitations of the mission of the particular medical echelon in which he finds himself at the moment. In military medicine, almost invariably, lessons have had to be rediscovered, re-learned by additional hard experience and expanded and adapted by succeeding medical generations as new emergencies have arisen.

The basic concept of medico-military care is that it is provided by 'echelons of medical care', which is at variance with the accustomed physician-patient relationship of civilian practice. The principle of military medicine remains as it has always been, the salvage of the greatest possible number of lives for the support of the military mission [1]. This objective can be accomplished only by preliminary appreciation, pre-planned adjustments of resources, triage and the evacuation and hospitalization should be in conformity with the special military strategy and tactics designed to out-manoeuvre and defeat an enemy.

LIC has a history of over five decades in India but sadly there is no 'bible' for Indian LICO warriors. The tactics and doctrines have evolved informally based on the experiences in Nagaland, Mizoram, Manipur and later in Punjab and now in Kashmir and Assam.

The September 11 attack on the World Trade Centre,

New York and the Pentagon in Washington DC, USA, has shown the ugly face of terrorism to the whole world, when it took less than two dozen determined individuals, armed with nothing more sophisticated than knives, to cripple the very centre of United States military and economic power. Although, it has all resulted in a full-fledged war against the harbourers of terrorism, nevertheless, the idea of bringing an end to terrorism seems far fetched.

Material and Methods

History bears testimony to the dangerous effects of psychological stress. The war in Vietnam saw 33.5% casualties due to Post Trauma Stress Disorder (PTSD). Out of these, over 110,000 are reported to have committed suicide. The omnipotent threat of death from an unknown quarter, the low rate of success, the attrition suffered by comrades through sniper attacks, stand off attacks and improvised explosive device (IED) blasts, all combined to raise stress to dangerous levels, even leading a soldier to go berserk. The Indian Army has over the years also witnessed such 'Chronicles of Stress' [2] —

On June 15, 1997 a Havaladar at Shopian, 50 Km from Srinagar shot dead a Colonel, a Captain and two Subedars of his own unit.

On May 11, at Baramulla, a jawan shot dead one JCO and injured three.

In April at Doda, a jawan killed a Junior Commissioned Officer(JCO) and an officer.

In January at Kupwara, a jawan killed an officer.

On December 25, 1996 a jawan killed an officer, a JCO and four jawans.

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A large part of our Army is committed in Jammu & Kashmir and North East in LICO, under tremendous psychological pressure. If we do not take cognisance of these very significant incidents and take appropriate remedial measures, these types of distressing occurrences of a jawan's hand, supposed to be raised only to salute his officer raised to kill his superiors would not be uncommon.

The stressful events and conditions which are experienced most often is given in Table 1 [3]. The variety of symptoms which are experienced by the troops are given in Table 2 [3].

Table 1

Stressful events and conditions experienced most often

Stressful events	Weightage %
No information	85
Separation from family	75
Monotony and boredom	70
Uncertain results	70
Indifferent habitat conditions	65
Fear of becoming a casualty	60

Table 2

Common symptoms amongst the troops

Indicator	Likely hood (%)
Tiredness	100
Nervousness and tension	95
Sleep disturbance	95
Hyper-arousal	90
Anger and irritability	88
General loss of interest in tasks assigned	70
Disobedience or hesitation to act on order	65
Feeling of being victimised	62
Loss of appetite	62
Pessimism and sense of helplessness	55
Disorientation whenever faced with a changed situation	45
Sluggish response to orders or situation	42
Urge for alcohol	35

Discussion

LIC is an armed conflict for political purposes short of combat between regularly organised forces. That definition surely includes a terrorist act but excludes, for example, hostage-taking by a bank robber. It includes a counter-insurgency campaign in which a regular armed force is pitted against guerrillas or irregulars. It describes the activities of insurgents engaged in an armed attempt to overthrow a government. The definition also encompasses the efforts of a "peace-keeping force". It is not mid-intensity conflict, which is armed combat between regularly organized military forces. A high intensity conflict is armed combat involving the use of mass-destruction weapons. This type of conflict may include

incidents or campaigns of low-or-mid-intensity conflict [4].

Terrorists enjoy no legal protection. They normally conceal weapons, mingle with the civilian population for personal protection, and may take hostages to achieve their aims. Defying international conventions they are usually treated as common criminals. Terrorist method often involves armed and illegal, coercive propaganda. The most typical terrorist goal is to achieve widespread recognition for a cause through outrageous actions that compel international attention.

"The conventional army loses if it does not win.

The guerilla wins if he does not lose".

— Henry Kissinger

Current Doctrine and Tactics of the Indian Army has evolved informally from 50 years of hands on experience. In early 1950's the planners borrowed extensively from the Malaya model of counter-insurgency used with great success by the British. The basic model has undergone very little modification and is in vogue even today in the North East and Jammu and Kashmir. A unique feature of Indian Army's doctrine has been restraint imposed at all levels in the employment of the full range of fire power available to the fourth largest Army of the world. This restraint has not come cheap as is clearly reflected in the rising casualty rate of infantry units committed in counter-insurgency operations in valley and North-East [5].

Combat Stress is caused because LIC is a campaign of nerves, less military and more psychological, with soldiers inevitably fighting with "hands behind the back" constraints. The mental strain of having to fight one's own people is infinitely greater than fighting the enemy. Environmental stressors which adversely affect a soldier's operating efficiency in LIC are poor living conditions, adverse weather conditions and extended tenures beyond 18 months accentuating the loneliness, monotony and uncertainty of a soldier's life. He finds uncertainty in almost everything - the very purpose of life, of living, of dying or being maimed, the lack of information, the next contact with militant, of what tomorrow holds for him, the duration of their deployment in a given situation, his role, his success etc [3].

Consequently the conflicts that go in his mind are :

- (a) Dilemma in being able to resolve the contradictions between general war and LIC, particularly the concepts of 'enemy', 'objective' and 'minimum force'. Moreover, there are no clear cut victories like in wars. This is not a war against an enemy, therefore casualties are difficult to accept. As casualties occur over a protracted period, their

impact is greater.

- (b) The special, morale and ideological values that a soldier is brought up in, are often at cross-purpose with those of an unconventional battlefield (never a level playing ground). Whereas, in general war the nation looks upon the soldier as a saviour, out here he is at the receiving end of public hostility. Unable to understand these conflicting reactions, the soldier is desensitized.
- (c) Hostile vernacular press keeps badgering away at the security forces, projecting them as perpetrators of oppression. One paper described the soldiers of an Assam Rifle battalion as cannibals.
- (d) Continuous operations affect rest, sleep and body clocks, leading to mental and physical exhaustion. Monotony, the lure of the number-game and low manning strength of units leads to over use and fast burn-out.
- (e) The threshold level of absorbing own casualties varies from unit to unit, depending upon the background of the troops. Paradoxically, the pressure on troops is always to suffer less casualties and achieve more. The dichotomy the soldier faces is straight - "we want results but we do not want casualties".
- (f) The high frustration levels because of :
 Ambiguity regarding success i.e. are we moving forward or standing still? Lack of kills and recoveries for a long time.
 Apprehension regarding over-reaction that could result in a human rights violation.

Further, the improvement of general educational standards, technological advancement especially in communication and media, social changes, breakdown of joint family systems, materialism, scant regard for law and order, more and more people from urban areas joining the Army, changed moralities and value systems etc., all have a bearing on the requirements and aspirations of today's soldiers. A man, even if he is a soldier, is a social animal and he cannot remain immune to the changes occurring around him in socio-economic environment where his family lives and where he ultimately has to go on retirement.

The Stress Disorders which are generally encountered are related to anxiety [6].

- (a) Panic disorder - The cardinal feature of panic disorder is the sudden unexpected and often overwhelming feeling of terror and apprehension accompanied by somatic symptoms in multiple organ systems such as dyspnoea, palpitations and faintness. The symptoms and signs of panic

disorder are similar to those occurring during intense physical exertion or in a life-threatening situation.

- (b) Agoraphobia : An irrational fear of being alone or in situations from which escape might be difficult.
- (c) Generalised anxiety disorder : Unlike patients with panic disorder whose symptoms come on suddenly, patients with generalized anxiety disorder experience persistent diffuse anxiety without the specific symptoms that characterize phobic disorders, panic disorders or obsessive - compulsive disorders. All the symptoms and signs of anxiety vary from individual to individual, common signs are motor tension, autonomic hyper-activity, apprehensive expectation and vigilance.
- (d) Post trauma stress disorder (PTSD) : Patients with PTSD have experienced a severe catastrophic event that is outside the range of normal human experience and would be distressing to anyone. The patient persistently re-experiences the event by having recurrent dreams or nightmares, or suddenly feels as if the event were recurring. PTSD is classified as either acute or chronic (or delayed). In the former, onset of symptoms begins within six months of the trauma, or the duration of symptoms persists less than six months. In the latter, symptoms persist more than six months (chronic) or start more than six months after the trauma (delayed) [6].

PTSD is as old as the history of warfare. Nearly one fourth of those wounded are affected by PTSD. PTSD received wide publicity after Vietnam, the Falklands and the Gulf war (1990-91). Trauma affects all soldiers, some more and others less. If unattended, it can lead to long term psychological problems even after leaving service. The statistical evidence is staggering as in Table 3 [3].

Table 3

Percentage of psychological casualties and PTSD in various threats

Threat	Psychological casualties %	PTSD %
World war II (Far east)	82	28.00
World war II (NW Europe)	60	11.00
Korea	73	47.00
Vietnam	NK* (110 committed suicide)	33.5
Northern Ireland	50 soldiers per unit per tour of duty which lasted 6 months	140 per year
Falkland	NK	22.00
Kashmir (Include BSF)	15	7.00

*NK - Not known

The low PTSD rate experienced by the security forces

in Kashmir is a testimony to high quality leadership, sound training and the inherent resilience of the jawan. However, this should not deter psychiatric advice, monitoring and care for improvement of stress casualties must be considered as recoverable manpower and therefore a command responsibility. For early detection and treatment, the principles of proximity, immediacy and expectancy demand that casualties are treated close to their units. The farther a casualty travels, the lesser likelihood there is of his early return to the unit. The key in casualty survival lies in correct and timely first aid. Likewise, for psychological survival, the clue lies in emotional first aid for which every section and platoon commander must be trained. The implication is that treatment for nearly 70% stress casualties can simply be rest and sleep. However, if the symptoms are ignored for too long a period, the casualty will need specialist psychiatric care.

For a professional army like ours, it would be prudent enough to plan for emotional support team to identify the stress disorders and provide the first aid at the earliest. A training capsule under an experienced psychiatrist could be run for the medical officers before being posted to the units operating in such risk areas. The nursing assistant and the combatant commanders at the section, platoon, company and battalion levels can be trained by the medical officer by running cadres at the battalion level. At the brigade level for those operating in the valley and other insurgent areas, ideally an emotional support team manned by a team of psychiatrist, psychologist and trained psychiatric nursing assistant could be placed or else a mobile emotional support team may visit such formations once in a quarter and stay for a sufficient duration so as to train, identify and treat. These teams can provide immense psychological support to the battalions who

suffered casualties in an operation by visiting them immediately after. It may be a good idea to print and distribute to all soldiers the indicators on laminated cards with emotional first aid procedures. The next step is to take on PTSD head on; to detect it in the early stages and institute professional treatment.

LICO is not a passing phase in human history. It is a mode of warfare which has come to stay and the Indian military establishment has to confront it as such. The belief that a soldier who is trained and equipped for conventional warfare in the plains of Punjab or on the icy mountain tops of the Himalayas will be equally suited for LICO must be shed. With our adversaries constantly raising the stakes in the ongoing LICO being waged on our borders, and the proxy war, we must accord the importance that LICO merits. Any Army that neglects to prepare for LICO, does so at its own peril and at the risk of the nation's integrity. Therefore, evolving medical strategies for LIC is a necessity.

References

1. General considerations of forward surgery. In : Sheffer RJ, Brown BR, Gold D, editors. Emergency war surgery - NATO hand book. US Government office, 1958;1-7.
2. Mallick PK. Man Mangement in LICO. Combat Journal. Mar 2000;105-14.
3. Ray A. Kashmir Diary - Psychology of Militancy; Manas Publications New Delhi; 1997;187-205.
4. Military Operations in Low Intensity Conflicts; US Army Field Manual 100-20, Department of Army, Washington; 1990;E10-12.
5. Sah A. Evolving Strategy and Tactics to win Low Intensity Conflicts/Proxy wars. Combat Journal. Mar 2000;94-104.
6. Judd LL, Briton KT, Braft DL. Mental disorders, In: Isselbacher KJ, Braunwild E, Wilson JD, Martin BJ, Francis SA, Kasper DL, editors. Harrison's Principles of Internal Medicine, 13th ed, McGraw-Hill, 1994;2409-14.

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Three men were having lunch, one was CIA, one was Israeli Mossad, and the other was British M-5. There was a slight buzzing sound and the Brit opened his mouth, unscrewed a tooth, put it to his ear and listened. He then held the tooth to his mouth and said "I'm eating now and I'll get back to you." Next, the CIA man's tie-clip began to beep and he followed the same basic scenario. All of a sudden the man from the Mossad let out some rip roaring gas. "Excuse me", he said, "I'm getting a fax".

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