Therapeutic Response to Combat Stress Reaction During Israel's Wars: Introduction

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Combat stress reaction (CSR), a psychological breakdown on the battlefield, is currently viewed in Israel as an inevitable consequence of war. It is seen as a transitory crisis that may affect any soldier as a result of the massive stress to which the soldier has been exposed. The IDF has adopted functional rather than clinical diagnostic criteria to assess CSR. These are based on Kormos' (1978) definition:

Acute combat reaction consists of behavior by a soldier under conditions of combat, invariably interpreted by those around him as signalling that the soldier, although expected to be a combatant, has ceased to function as such. (p. 8)

The treatment of choice for CSR is frontline treatment which is administered on the battlefield, as soon as possible after the outbreak of symptoms, based on the assumption that it is a transitory crisis. It is expected that the soldier will be able to return to duty after replenishing physiological deficits (food, liquid, and sleep) and exposure to therapeutic suggestions of expectation for a rapid recovery. Treatment is very brief and directive. Defining the CSR as a normal crisis prevents stigmatization and labelling and preserves the soldier's military identity. Social supports within the soldier's unit are also mobilized in order to prevent his taking on the sick role and to prevent chronicization in the form of posttraumatic stress disorder.

While the above definition of CSR is the official IDF Medical Corps and Mental Health Department policy, there are no doubt many individuals in the army who view a breakdown on the battlefield in a very different light: for example, as a wish to escape, to survive at the cost of others, to achieve secondary gains, etc.

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A team of military reserve psychiatrists headed by Dr. Amihay Levy and Dr. Eliezer Witztum initiated an historical research examining the military mental health professionals’ perceptions of combat stress reaction during Israel’s wars. The research used four independent sources: debriefing materials collected routinely in the Lebanon War and sporadically prior to that found in the records of the IDF Medical Corps; some one hundred interviews with therapists and military hospitals’ commanders; interviews with military historians who were considered independent informants; and professional literature on the Israeli wars. This historical research was reported on in detail in Hebrew in the journal *Sihot—Israel Journal of Psychotherapy* in a series of seven papers (Granek, Levy, Witztum, & Kotler, 1990; Levy, Witztum, Granek, & Kotler, 1989a, 1989b, 1990; Levy, Witztum, Solomon, & Kotler, 1991; Witztum, Levy, Granek, & Kotler, 1990; Witztum, Levy, Solomon, & Kotler, 1991), and some of its conclusions are briefly summarized here.

The inevitable existence of CSR during wartime was not recognized in all of Israel’s wars and, for this reason, CSR was not always diagnosed and treated appropriately when it appeared. Despite the many wars fought in one generation and despite the fact that CSR is recognized as an inevitable part of war, the IDF dealt only marginally with the problem. CSR was not perceived as one of the human costs of war that demand serious attention on the part of army authorities and it was largely denied as a problem by the IDF.

In the three wars that proceeded the 1973 Yom Kippur War (1948 War of Independence, 1956 Sinai Campaign, and 1967 Six Day War), combat-induced psychiatric casualties were viewed as rare and affecting only the morally, ideologically, and physically weaker elements of the population. CSR was perceived as cowardice and “gold bricking,” a shameful, less than legitimate weakness.

However, the military establishment had to deal with CSR when it appeared, as it unavoidably does in any war. On the one hand, the prevalent treatment modes followed Salmon’s (1919) principles, according to which treatment should be short and structured, emphasizing therapeutic suggestion, and giving importance and legitimacy to abreaction. On the other hand, their outlook was highly judgmental, describing the casualties as weaklings, unfit, fearful, psychopathic, hypochondriac, and eager to evade army service. The general Army command and the Medical Corps command assigned the treatment of combat stress the lowest priority, and considered it a necessary evil. They had no interest in perpetuating its structures, writing therapy guides, training therapists, providing guidelines for commanders or taking any steps that would confirm the dimensions of the problem. Moreover, there was no clear treatment approach. Thus, pro-