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Psychiatry in a War Situation: *In Situ* Therapeutic Approach to an Attack Case of Ber, Timbuktu in Mali

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Abstract

Objectives: At the beginning of 2012, northern Mali was occupied by several jihadist movements with the aim of creating a Khalifa that required the intervention of a UN peacekeeping mission after a war that slowed down their development. This mission is the deadliest in a complex attack and UN attack. This experience feedback in an international context of the resurgence of asymmetrical wars makes it possible to share in order to better anticipate and improve strategic approaches to assessments and therapeutic techniques. **Description:** After the presentation of the context with these particularities and the various adaptations, we made formulations of the missions such as lived and the details on the medico-psychological techniques used. The place of the brief physical examination should not be overlooked. The debriefings, even if they have proven themselves in the evaluation and prevention of psychotraumatic pathologies, must be adapted on a case-by-case basis in a certain programmed improvisation. Maintaining the site of the attack survivors without real military activities by reinforcing them with a new functional team was a decisive element in the mourning process according to their own statement. **Conclusion:** Forward psychiatry is a necessity in asymmetric warfare to maintain the operationality of the troops.

Keywords

Military Psychiatry, Blue Helmet, Attacks, Psychotrauma, UN Mission

1. Introduction

State of West Africa, The Republic of Mali is bordered by Mauritania to the west,

Algeria to the north and northeast, Niger to the east, Burkina Faso and Côte d'Ivoire to the south and southwest, Guinea to the southwest and Senegal to the west and southwest [1]. As a former French colony, it has retained borders inherited from this period. This country covers an area of 1,220,190 Km^2 with a density of 18 inhabitants per Km^2 and population estimates are at 21,473,764 on July 1, 2022 [2]. With 20 million residents, the Malian population is made up of different ethnic groups, the main ones being the Bambaras, the Bobos, the Bozos, the Dogons, the Khassonkés, the Malinkés, the Miniankas, the Peuls, the Sénoufos, the Soninkés (or Sarakolés), the Sonrhaïs, the Tuaregs, and the Toucouleurs (**Figure 1**). French is the official language, but the population mainly speaks the national languages, Bambara being the most used and serving, alongside French, as a vehicular language. There is a great disparity among the subtropical South region, semi-arid Center and the West, East and North desert, *i.e.* in terms of human distribution 90 inhabitants/Km^2 in the central Niger delta to less than 05 inhabitants/Km^2

(a)

(b)

Figure 1. Image of the site of the Ber attack August 2014. (a) Transport car damaged by the blast of the explosion; (b) Crater left by the explosion, a damaged car and desert environment.

in the northern Saharan region. The geographical immensity, the unequal sharing of resources and political-historical difficulties have constituted fertile ground for conflicts of religious ideologies of multiple rather complex influences in a favorable international context.

Mujao and Aqmi groups, carried out attacks on Malian military camps and towns located in the regions of Gao, Timbuktu and Kidal, calling into question the territorial unity of Mali whose army has been put in difficulty. The political unity of the country was thus more than ever threatened [3], especially with the proclamation on April 1, 2012 of the independence of Azawad by the Tuareg rebellion with several other groups in the northern regions with the imposition of Sharia. In a state of emergency, Mali having defense agreements with the former metropolis, France requested the agreement of the UN to trigger a military intervention (Operation Serval) to liberate the country [4]. This intervention was supported by the armed forces of the Economic Community of West African States (ECOWAS) called the International Support Mission in Mali (AFISMA) under African leadership. On July 1, 2013, the authority of AFISMA will be transferred to the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) created by resolution 2100 of April 25, 2013 [5].

From the beginning, MINUSMA's missions included helping the Malian transitional authorities to stabilize the country by giving priority attention to the main towns in the North and the communication axes. Indeed, the security context in northern Mali is extremely degraded, with incessant attacks by armed groups targeting MINUSMA personnel, Malian forces, and French forces deployed as parts of Operation Barkhane, as well as civilian populations. This is why a large part of the workforce was deployed in the western sector (Timbuktu, Goundam, Ber, Gossi), the northern sector (Kidal, Aguelok, Tessalit) and the eastern sector (Gao, Ansongo, Menaka) as shown in [6]. This trend has been the same since the beginning of the establishment of the mission. There were several troop-contributing countries of which Burkina Faso had a large workforce. The Burkina battalion was stationed in the western sector with the mission of securing Timbuktu airport. The troops of this country had a detachment made up of a company in the city of Goundam and a reinforced section in the city of Ber. It was this reinforced section that suffered a "kamikaze" attack in August 2014.

MINUSMA being in its infancy at this time, army psychiatrist, we were the head of the level 1 hospital of the formed police unit (FPU Togo level 1 Hospital) stationed in Sévare (West Mali sector) where there is also had the Togo level 2 Hospital (Togo-HN2) awaiting redeployment in Kidal (northern Mali sector). The Force Medical Officer (FMO) requests the Director of Togo-HN2 and the Commander of FPU Togo to put our skills as military psychiatrists in a mission with several objectives on the site of the attack and in a second time on the rear base of the Burkinabe battalion. This return of experience, done on purpose at a distance from the event for strategic reasons and in an international context of the resurgence of asymmetrical wars, makes it possible to share with the aim of

anticipating and improving the approaches to strategic evaluations and therapeutic techniques. This article highlights the mission *in situ* of the traumatic event.

2. Context and Attack

MUNISMA is the deadliest of the UN missions [7]. On the western sector, a battalion from Burkina Faso had a detachment in the town of Goundam made up of a company and an outpost in the town of Ber made up of a reinforced section. It was the 3rd reinforced section of the 4th company composed of 45 soldiers commanded by a junior officer. While they had just relieved the day before, August 16, 2014 around 11:25 am, when the men finished their first patrol and it was time for soup, a car was announced by the sentry. We see a sand-colored pick-up truck filled with bags apparently containing potatoes. Note that this type of car was often used by rebel leaders in the area to come and greet the detachment on their site. After slowing down, the fair-skinned driver with a blue turban around his neck and head smiled and waved as if he should go to the command tent. Suddenly he began to accelerate his pick-up without obeying the warnings of the sentry. The car avoided the situational barrier, passed the detachment commander's tent and drove straight at high speed towards the arms magazine which it hit. The explosion was heard over 60 km away. The impact crater is more than fifteen meters in diameter. The body of "Kamikaze" was not found except for part of his scalp. The bodies of two (02) senior NCOs were mutilated to shreds and eight (08) seriously injured were evacuated to Togo-HN2 in Sévaré then to Level 3 Hospital in Dakar (Senegal) including the unit commander. Two died of their injuries. There is a smell of blood and fresh meat on the first day and rotten meat the following days on the whole site with the presence of flies. It should be noted that the mission was in its infancy, the force's engagement mandates [8] were not as clear as over time, the rebels' modus operandi was not well known and the knowledge of the terrain by the contingents was relatively limited.

Whatever the level of training of the military or the level of warning of the professional or resident populations, the fact of experiencing an event of this type with brutality and violence in terms of sound, as well as the confrontation with a situation of vulnerability without being able to escape that this gives the survivors to be totally helpless in the face of inevitable death, this coupled with the presence of the bodies of brothers in arms or friends could only generate a situation difficult to register as such at the identical in the human psyche. The force and above all the instant of the trauma no longer leaves time to understand so that instead of the logical time proper to each person's subjectivity unfolding and until the moment of conclusion, there is a short-circuit by this encounter with reality [9]. This puts an emphasis on time, the delay in understanding reality. Trauma is described as a brief and sudden phenomenon. Without having had time to protect himself from the danger, the man is suddenly seized by the eruption of violence, he is then fascinated, flabbergasted [10]. The psyche is then invaded by an influx of violent and aggressive excitations that overwhelm its de-

fense capacity, thus fundamentally upsetting its functioning [10] [11]. The psychopathological consequences of psychological trauma are united under the name of psychotraumatic syndrome [12]. The literature also includes the term acute stress disorder or post-traumatic stress disorder (PTSD), or post-traumatic stress disorder (PTSD) [13] [14] [15] [16].

3. Mission Objectives

In MINUSMA, medical support is placed under the command of the Chief Medical Officer (CMO) with a component of military personnel under the FMO. The decision of a psychiatrist on the site of the attack was an opportunity linked to his occasional availability at the place of care for the Togo-HN2 field surgical unit, which is supposed to carry out the first interventions in this geographical sector of the UN mission. This is how the FMO had the psychiatrist on board for this mission, which he describes according to his observation of seeing several simultaneous components from which three axes emerged.

3.1. Site Security Mission

Just before the arrival of the medical helicopter, a reinforced section had immediately joined the site of the attack from the Timbuktu battalion. They surrounded the area of the attack, keeping local residents and curious observers as far away as possible. They looked for avenues of new dangers and organized the landing of the helicopter which could evacuate the wounded. It was mostly Burkinabe soldiers but also blue helmets of other nationalities.

3.2. Fact-Finding Mission

In addition to the provosts and some gendarmes from Mali, we found a few MINUSMA experts of various nationalities who looked for clues and elements allowing us to know the types of explosives and also the likely commendatories. They took the exhibits but were able to listen to some of the victims who could speak.

3.3. Health Mission

The health mission is essentially devoted to medical and surgical emergencies with the evacuation of serious and less serious injuries and then the collection of bodies. The medico-psychological component, not initially planned, was done in three parts. This is addressed to the survivors of the blue helmets of the victim section of the attack, then to the various stakeholders (caregivers, provosts, blue helmets for security), especially the collectors of the bodies of victims and also to the local populations who have requested. The collection of the bodies was done by the blue helmet nurses of the new reinforcement section, helped by some victims, who packed them in body bags in order to send them to the morgue of Nigeria-HN2 in Timbuktu. This collection of bodies was carried out without much psychological preparation. This situation was relatively badly experienced in the

functional team dynamic.

4. Procedure and Intervention Methods

4.1. Framework and General Provisions

The environment in which the attack took place has living conditions marked by rusticity and precariousness, both in terms of accommodation and food and individual and collective hygiene, all in a heat suffocating [17]. This is a short-term mission on the site, *i.e.* 3 to 7 days. The blue helmet's direct victims were not to be extracted immediately after the attack but should not be fully operational either. In therapy, several said that it was the perception of smells at the site that made them realize that the attack had really happened. This short period of presence on the site was therapeutic. This is the period of transition and adaptation before withdrawing to a rear base, otherwise, their stay of six (06) weeks was shortened to one (01) week or five (05) days after the psychotraumatic event.

The battalion (armored vehicle) which alone served as an infirmary and which had withstood the shock by making a leap of more than seven (07) meters had served as a medical assessment office. The soldiers of the section direct victim and some of the reinforcement group were received in collective debriefing under the improvised tents. Some doctors, investigators and other workers had individual debriefings. The psychiatrist permanently on the site observed each other in the ways of behaving, in the interactions and in the attitudes to improve his evaluation and his therapeutic approach. He remained a privileged and open interlocutor offering an approach other than that of the psychologically solid military environment which could force certain peacekeepers to withdraw into themselves, sometimes dramatically individually or collectively.

4.2. Procedure of the Intervention

Apart from the physically injured who were taken care of by the medical evacuation team (MEDEVAC) [7], all the blue helmets of the section were in good apparent health and the claimants systematically benefited from immediate care in three orientations: somatic, psychiatric and purely psychological.

Somatically, the assessments related to the complaints mainly consisted of taking hemodynamic parameters and glycaemia in the batillon (armoured vehicle). In the event of a hypertensive attack, cardiac arrhythmia, palpitations, dyspnoea, fever and/or impaired consciousness, the subject was reassessed a few minutes later in a calm manner in order to reassure him and by dedramatizing the context with an insistence on the antecedents and the medical course. The prescriptions essentially consisted of making prescriptions for antihypertensives, B-blockers, anxiolytics and hypnotics. On several occasions, malarial symptoms were reported, which justified the prescriptions of antimalarials.

On the psychiatric level, we had to deal with acute states [18] marked by states of anxiety, behavioral disorders (autonomous functioning, emotional detachment, soliloquy, agitation, auto and hetero aggressiveness, stupor, torpor), as well as pseudo-

delusional ideas, all of which required the administration of psychiatric treatment with a mainly sedative and preventive purpose.

From a purely psychological point of view, our approach favored taking charge of groups of people through collective debriefing and individual interviews. In the immediate future, our first concern was to provide them with clear information on the traumatic events and on their situation, thus allowing everyone to reclaim or give meaning to this story which was theirs and to realize and then go beyond the emergency situation they had just faced, which is a situation of war.

The technique of psychological debriefing has demonstrated its curative and preventive interest for subjects who had gone through a "serious event" during which these subjects were able to realize the vulnerability of all military techniques and strategies to the test of war, or the annihilation of a powerful explosive. Nevertheless, the effect of "cohesion" of people who felt the same pain suffered could limit the aggravation of their suffering and their isolation. These had a mode of operation and/or a history very close to each other, hence the need not to immediately disperse these peacekeepers who were direct victims of the attack.

4.3. Defusing Methods and Debriefings

In the first hours, our work was more an accompaniment of the medico-surgical emergency team, mainly made up of the air evacuation personnel and other caregivers present on site. Then quickly for post-immediate care, we had to proceed with simple techniques of the defusing type which consists of arranging a reception space containing security, favoring the first verbalizations in connection with the psychotraumatic experience. Afterward, we followed our debriefing technique, which was based on the model of immediate post-psychotherapeutic intervention (IPPI) proposed by the French teams [19] [20] as well as on the indications provided by our experienced clinicians [21]. This device, which has been the subject of numerous studies, is sometimes the subject of controversy in the scientific literature [22] [23] [24]. For this debriefing, after introducing themselves, the facilitators stated the reason for their presence, the instructions for confidentiality, respect for everyone's word, and free participation in the group. The actual debriefing could then begin. It followed a breakdown into three stages according to the statement of each, the circumstances of the event and the people involved. Nevertheless, three times were available during which everyone was first asked to specify the circumstances and the subjective context in which they were confronted with the event; it was then a question of everyone specifying the changes caused by this event, and finally of individually evoking the perception of the near future. It was important to specify that it was necessary to make case-by-case adjustments to this tool, on the initiative of the specialist in the face of the event or put in front of the traumatic facts according to the parameters of the context. Faced with situations with varied contingencies and the constraints intrinsic to each event, the challenge for the therapist is undoubtedly, without renouncing his fundamental principles [25], to offer care which, far from

the stereotyped application of a technique, is part of a form of prepared improvisation [26] as in the context of United Nations missions. For medical-military administrative decisions the salmon principles [27] developed during the First World War, still retain their relevance today: immediacy of care, proximity to the place of intervention, simplicity of means and care system, expectation. The symptomatology in a crisis situation does not in fact prejudge the future, and it is sometimes important to give yourself a few days before making, for example, a decision for medical repatriation.

5. Conclusion

This presence of a psychiatrist in an improvised manner with competence in the event of an attack in an environment geographically difficult to access in the context of asymmetric warfare proves the importance of a system of support and attentive listening essential to psychological health. This constitutes with the armed forces another approach rather than the usual discourse of force. The psychological damage caused by traumatic events has been known for a very long time. They are as old as violence, the violence of nature, violence of men [14] [28] [29] [30]. The frequency of attacks with asymmetrical wars sometimes in urban areas [31] should make us evolve in the psychiatric approach and avoid being limited to somatic care even in an emergency. Practical psychological debriefing with peacekeepers who were victims of an attack was part of the care strategies applied to people "likely" to be traumatized by an event [32]. Given the lessons on the importance of mental health care for military troops and given the relatively small number of professionals in the field of military psychiatry, it would be necessary before the deployment of contingents to transfer skills to generalist military doctors in the form of hardening in accelerated course with immersion or stimulation of exercises. It can also organize inter-university or joint diplomas in the sub-regions of the African continent in a certain pooling of experiences.

Founding

The human material or human data were performed in accordance with the Declaration of Helsinki. Contextually, there is no ethics committee and or reference number to be provided.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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