

## The demand for psychiatric services as a result of the Gulf war

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Despite the brevity of the Gulf war, there is still the strong possibility that it will leave long-term problems for psychiatric services within the NHS. The low incidence of acute psychiatric problems in the Falklands conflict does not obviate long-term problems. Surgeon-Commander O'Connell of the Royal Navy, reported informally in the newspapers (*Guardian*, 7 May 1990) that up to 30% of the 28,000 Falklands veterans are still suffering from post-traumatic stress disorder (PTSD). Hughes (1990), medical officer with 2nd Paratroop Regiment at Goose Green, described his realisation that he had PTSD, his subsequent treatment by the NHS and transfer to a military hospital. The Royal Navy still has a counselling service, set up in 1987, but it is clear that military services cannot deal with all the current problems, let alone those to come. The advice of the Ministry of Defence is that the initial onus to recognise a problem lies with the family and that sufferers should seek treatment through their GP.

Provision for short-term and long-term services needs to be made for all groups of victims. Describing disaster, Dudasik (1980) describes four categories of victims and Taylor & Fraser (1981) six. The wide range of victims which may report to the NHS is important, not just front line military, but all military groups, including the medical and nursing personnel, civilians in the area, including news personnel, relatives and friends of such groups and vulnerable people in the wider community affected by the war coverage.

### *Prevalence of psychiatric casualties*

There is a tendency in the literature to refer to the number of psychiatric casualties as a total, without clear indication of diagnosis. Rahe (1988) points out that military writing tends not to differentiate between acute and chronic disorders. Short-term problems such as combat-related stress (CRS) or battle shock are indicated as psychiatric casualties, elsewhere it is intimated that this is a natural reaction to extreme conditions and should not be labelled 'psychiatric'. Both short-term and long-term problems, primarily post traumatic stress disorder (PTSD), must be considered.

Overall, on evidence from World War I, World War II in both Europe and the Pacific, Korea, Vietnam, the Arab–Israeli war, the war in the Lebanon and the Falklands war an incidence of psychiatric casualties of about 20–30% could be expected. The National Vietnam Veterans' Readjustment Study (Blank, 1982) is the largest epidemiological study of PTSD and estimated, in the early '80s, that there were 829,000 veterans still with PTSD out of four million service personnel, and that there were approximately 75,000 new cases every year.

In a review of the literature on chemical and biological warfare (CBW), Fullerton & Ursano (1990) concluded that the CBW combat environment adds 5–20% to psychiatric casualty rates. These figures relate to the unique characteristics of the CBW environment and do not include casualties as a result of CBW contamination. Behavioural and psychological effects of contamination can last for up to a year and make determining fitness to return to duty difficult. In World War I it was reported that as many as two individuals described symptoms similar to contamination, even though they had not been exposed, to every one who is exposed. Romo & Schneider (1982) discussed the possibilities of casualties in future wars, especially where chemical or nuclear warfare is likely, and suggest that psychiatric casualties will be higher than in previous wars.

Becoming prisoners of war presents unique stresses to the individuals detained and also to their families. Such individuals who have long-term readjustment problems, including PTSD, require therapy geared to their unique problems.

### *Civilian casualties*

Families of service personnel are those at most risk. For families living on military bases anticipatory stress can usually be managed with support from the military and self support groups. The greatest problem with families will be likely to occur on the service person's return, either as a casualty, because of the service person's PTSD or because of more generalised readjustment problems. In many cases therapy will have to be offered to the family rather than an individual.

Rates of casualties among the wider community are likely to be similar to those for a peacetime disaster. Civilian populations under attack do not show significantly increased rates of mental disturbance (Romo & Schneider, 1982).

### Immediate management

Management of CRS has changed little since World War I. Front-line 'psychological first-aid', namely physical replenishment (sleep, food, water), emotional ventilation, and a clear expectation of return to unit and duty, lasting six to 72 hours, and carried out as close to the battle scene as practical minimises longer term psychiatric problems and maximises return to duty. Reports of return to duty using this approach range from 50–85 (Romo & Schneider, 1982; Ursano *et al.*, 1989). Research from Israel indicated that return to duty was more likely from soldiers treated at the front line than behind lines, and that they were also less likely to suffer PTSD (Solomon & Benbenishty, 1986).

Small (1984) described a practical training exercise used with the 1st Armoured Division Mental Hygiene Consultation Service of the US Army for management of psychiatric casualties. Current mental health services in the field are unlikely to be able to deal with all those requiring assistance.

### Service provision

The NHS's role will be determined, at least in part, by the adequacy and availability of front-line CRS treatment. Lack of support by commanders can decrease both this provision and its efficacy.

A comprehensive overview of management following disasters was given by Raphael (1986). Comparatively short in-patient treatment is less the issue (although services have to be found) than the long-term demand from personnel suffering PTSD. The United States evidence points to the importance of recognising PTSD as early as possible and to begin treatment immediately. The Veterans Administration did not recognise PTSD as a combat-related disorder until 1980 for men and 1983 for women when it was accepted in non-combat veterans.

Including services for families is essential for many veterans and provision needs to be made for possibly long-term family support. Learning from work with disaster, the use of victim support groups seems important. Victims of disasters may be in a position to support returning veterans. Support for victims is often long-term and can prove a strain for therapists. It has been suggested that the caseload of PTSD victims for each therapist or counsellor should be restricted (Rosser, 1989).

That casualties will continue to present for some time to come after repatriation is certain, and the war as a predisposing factor will need to be considered in ex-service personnel for years to come. The Vietnam evidence points to the high numbers of PTSD veterans who had additional, concomitant diagnoses. The most prevalent were alcoholism and drug dependency but included personality disorders, organic mental states and depression. Goderez (1987) describes 'survivor syndrome', PTSD with additional features, where 'reality adaptations in the traumatic situation' persist in civilian life.

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## The psychiatrist and war

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The year 1991 will be emblazoned on our minds as the year of the Middle East War. Saddam Hussein gave more than a clue to his own psychopathology when he named this conflict “The Mother of All Wars”. All nations which actively participate in battle will lose troops and civilians. Physical damage, terror and distress are the immediate accompaniments of battle. Starvation, sub-standard living conditions and infectious disease often follow. Modern weapons and terrorism are capable of inflicting major damage on populations which are far away from the centre of the war.

From the point of view of a psychiatrist who is merely a bystander initially, the major emotional toll of the war is seen months or even years later.

### *Mental health and war*

The psychological repercussions are prominent and various, ranging from the post-traumatic stress disorders of combatants or passive civilians to a variety of bereavement reactions. Spouses lose partners; children lose fathers; mothers lose sons; troops see

comrades being killed. Anticipatory anxiety over potential military attacks takes its own toll.

Curran *et al* (1990) found that 50% of survivors of a bomb attack in Enniskillen developed a post-traumatic stress disorder at six months, while all the victims had high scores on the GHQ.

Garb *et al* (1987) described the bereavement reactions of the soldier in battle. Appropriate grief is not facilitated in the battle or military situation, which may lead to delayed, inappropriate, chronic or excessive grieving, with consequences for subsequent psychological and social functioning. The incidence of psychiatric casualties corresponds directly with the number of men killed or wounded in action.

Wilfred Bion (1986) gave a personal account of his own experiences of chaos and slaughter as the captain of a tank crew in the First World War. Guilt over the death of comrades, anger over the futility of war and the stupidity of authorities left scars which persisted for a life time. It is possible that his subsequent understanding of the basic assumptive groups was strongly influenced by ‘commanding’ his men in the claustrophobic confines of a tank.