DAVID STEWART-SMITH

Humour is the best medicine: Sgt Michael Shepley (left) and Sgt Steve Wilson, of the Cheshires, share a joke while on duty with the 7th Armoured Division in Bosnia

How the army keeps its head

Comradeship helps war veterans to survive trauma, says **Ian Palmer**

When we are daily reminded of the unfolding tragedy of the Balkans and its impact on the local population and world community, the effect on our soldiers may seem to pale into insignificance. So it was right for Dr Wessely in Body and Mind, May 18, to ask the question "Will soldiers returning from Bosnia need psychiatric help?" Having been the army psychiatrist in the theatre, I feel well placed to answer, and to explain what the army psychiatric services are up to.

Men have fought each other since time immemorial and their reaction to the stress of combat is well known. In psychiatric terms, this is an acute stress reaction and is reversible with rest, sleep and feeding. It is now well accepted that treatment is quite straightforward — keeping the sufferers in the military environment with their comrades and as close to their unit as feasible. Since the Arab-Israeli wars this has come to be called battle shock and officers and soldiers are taught about it in much the same way as they are taught first aid. The aim of this training is to "normalise" the reaction to such stresses.

What is less clear is the term post-traumatic stress disorder (PTSD). Every year at Queen Elizabeth Military Hospital we see about a hundred new cases of mainly combat-related PTSD consequent upon service in the second world war, the Falklands, the Gulf and Northern Ireland.

We find that those exposed to traumatic situations experience symptoms of PTSD such as nightmares, intrusive thoughts, jitteriness or hypervigilance. These symptoms seem to be a natural reaction and usually settle down within a few months. What is unclear is who will go on to develop full-blown PTSD. As Dr Wessely states, it seems in part a mixture of pre-existing personality and psychological health, and the severity of the trauma. A number of soldiers will have come from abusive and broken homes which have left them with feelings of vulnerability and helplessness.

Soldiers in Bosnia have witnessed women, children and the elderly being shot. They have recovered bodies which have been tortured and defiled before being shot or burnt alive. They have witnessed the plight of refugees. Each time, under the United Nations mandate, they have been unable to intervene. Soldiers are not trained to be helpless, and for some of them the sensation has dredged up hidden memories.

Historically, soldiers have, over the years of involvement in such situations, dealt with them by humour (however black), talking to colleagues and drinking. It is pretty clear that those who have stable personalities and good psycho-social support can cope well and, indeed, may profit from the experience.

As with most psychiatric illness, those with difficulties in personality, inter-personal relationships and with poor social support, and who may have been brought up in a neglectful family, tend to run into most problems.

One of the problems in dealing with established PTSD is the individual's tendency to withdraw into himself. It is difficult to share the experience with those who were not there. Many become alienated and withdrawn and are less likely to seek help.

It is difficult to anticipate who will get PTSD, and it does not seem morally right simply to wait and see. So we offer debriefing to those involved in traumas. The aim of debriefing is to ensure a more healthy processing of the emotional information of the event by sharing the experience with others, especially those who were there. Ideally, this should be done by the unit or group itself, but members of the psychiatric services have the necessary skills, too. Such work can be harrowing and daunting for non medics and training can be given through a programme in Germany which attempts to disseminate skills in the army community.

There are also standing instructions for commanders on debriefing following incidents in Northern Ireland. And within the next six weeks a new training video on PTSD will be launched to supplement and extend existing educational material.

There is always a risk that psychiatrists may be seen to be "medicalising" traumatic experiences but it is our aim to normalise the experience and encourage the sharing of emotions.

There is, of course, plenty of informal debriefing among soldiers themselves. This is encouraged and the benefits of the army community are at their best in these situations: be it platoon, company or regiment. To this end it is now standard policy for there to be a wind-down period back in base before leave is taken.

Exit from today's duty or battlefield can be very rapid and can lead to a surreal experience; one minute a soldier is suffering the hardships of conflict, the next sitting in a pub with his family and friends.

Unlike psychiatry in the NHS, we have the advantage of being an occupational service and are integrated into the administrative and medical support of the army. We are thus involved with education and prevention as well as simply responding to the problems when they arise.

Almost to a man, our PTSD cases at Queen Elizabeth hospital have somehow missed out on debriefing. They all regretted this and we aim to prevent such oversights in future.

We have a broad understanding and agreement on how to diagnose and treat battle shock. Post traumatic stress disorder is, however, much more complicated.

We are guided by the old saying that prevention is better than cure and we hope that through education and debriefing we will if not prevent, then at least mitigate, aspects of PTDS which once established is a most invidious and difficult condition to treat.

● *Major Ian Palmer is the senior specialist in psychiatry at the Queen Elizabeth Military Hospital, Woolwich, London SE18.*