

## The times

### Doctors at war: psychiatry in the Gulf

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When Britain committed an armoured division to the Gulf in the autumn of 1990, it was inevitable that psychiatrists and other mental health personnel would be required. Battleshock, or combat stress, is important to the Army – it not only accounts for significant numbers of casualties in any land war, but, unlike other casualties, represents a potentially avoidable loss of manpower and important source of reinforcement. Based largely on the experience of Arab-Israeli conflicts it is believed that, with appropriate management, up to 90% of battleshock cases can be returned to duty within seven days. Moreover, it is thought that early recognition and intervention may reduce the incidence of PTSD and other long-term psychiatric sequelae (Foy *et al* 1987; Solomon & Benbenishty, 1986). Fortunately, Battleshock claimed few victims in the Gulf, due mainly to the brevity of the land war and the high state of motivation and morale of the allied force. The effectiveness of the Army's policy of early recognition of battleshock cases with minimal medical intervention on the battlefield and rapid return to duty remains uncertain and untested (Dunning, 1990).

Although allied casualties overall were mercifully few, we were needed, and we were busy. The British Army established four hospitals in Saudi Arabia, providing 1,600 beds to deal with hundreds of battle casualties each day. In four months one of the four field hospitals alone treated more than 3,000 patients; the results of accidents and illness, as well as battle casualties. Although the majority of casualties were British, anyone brought into the hospital was treated equally and according to need ... other coalition forces as well as Iraqi prisoners of war.

The field hospital is rather like a civilian general hospital – up to 600 beds in tents albeit with simpler more basic equipment. The hospital's objective was not to provide definitive treatment; once large numbers of casualties were expected its function was simply to provide sufficient treatment to save life and stabilise casualties enough to withstand a ten hour evacuation flight to England. Such a policy is necessary in order to cope with large numbers of casualties coming into the hospital in a short space of time.



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The field hospital sees the worst of war and its staff are especially vulnerable to the effects of stress. Many do not work in hospitals in peacetime and have little or no experience in handling severe trauma cases. Working conditions were difficult and the environment hostile. Tents magnify the outside air temperature, very cold at night and unbearably hot by day. The desert sand, fine, like salt, gets everywhere. Although the tented hospital looks not unlike the familiar TV images of MASH, things have evolved considerably since the Korean war. The possibility of having to treat casualties in an environment contaminated with chemical or biological agents poses enormous difficulties. Thus, much of the hospital was built inside special inflatable rubberised bubbles, known as collective protection, or Colpro. These bubbles, inflated by filtered air under high pressure, enable patients to be treated free from the fear of contamination from the outside air. Unfortunately, there is a price to pay for this security. There are no windows in Colpro, no night or day, and the environment is claustrophobic and disorientating. The swaying of the internal lighting by even the gentlest outside breeze can cause motion sickness, and the temperature inside can soar, becoming extremely hot during the day. Unpleasant aromas from the operating theatres had a tendency to linger in the confined



*Devastation on the road to Kuwait City. (Burning oil fields in background).*

environment, unsettling the most experienced theatre sister. All the time staff work against the continual drone of air filtration units. Movement inside the cramped bubbles, and getting in and out of Colpro through an airlock to the outside world, can be a lengthy time-consuming business.

As one of four consultant Army psychiatrists in Saudi Arabia I saw more than 100 referrals in two hospitals. In the early stages acute stress and adjustment reactions predominated, often presenting with somatic symptoms. Many rapidly resolved requiring little more than rest and reassurance.

As the drama unfolded and missile attacks became more frequent, the symptom focus shifted – approximately 50 cases seen in two of the British hospitals presenting with symptoms of severe anxiety and panic. Some of these subsequently developed severe phobic anxiety to air-attack warnings or to wearing their respirators. The inability to wear a respirator because of hyperventilation and retching as a consequence of severe anxiety, or removing a respirator in panic in the middle of a missile attack, not only endangered lives but heightened everybody's anxiety and distress. Simple behavioural psychotherapy employing graded exposure, desensitisation, and modelling successfully alleviated symptoms in the majority and usually led to a rapid and complete recovery.

Despite our early victory, some soldiers underwent horrifying experiences and it is hoped that in time the effectiveness of early psychiatric intervention – “debriefing” – or small group brief psychotherapy, in which individuals have the opportunity to relive and recount their experience and ventilate their feelings, can be judged. There were a small number

of cases of more serious mental illness, the psychiatrist's job being to identify these and arrange their evacuation out of theatre as quickly as possible. As in civilian life, stress and mental illness in the Gulf was no respecter of age, rank, or experience.

We all turned our hand to a variety of jobs, often unfamiliar to those of us used to the NHS. Shifting over 2,000 tons of sand, by hand, to fill 160,000 sandbags was a truly moving experience!

None of us, regular, reservist, or TA had ever experienced anything like it before – self doubt and fears about our ability to do the job were just as worrying as the threat of terrorism or Scud missiles. Although living conditions were often far more comfortable than one might imagine, it was not an experience I would recommend or wish to repeat. It is hard to describe how stressful the uncertainty of the situation was; uncertainties about our own safety, whether or not we would cope, not knowing whether we would be moved to another unit at a moment's notice, what our friends, colleagues and the public back home thought of us, and most importantly, not knowing when we would return home. There was a tremendous sense of helplessness – of being out of control of events and one's own fate. There was little freedom of movement, no privacy, little personal space, the only escape from the situation was sleep, videos, or the “walkman” . . . it felt like being in prison with an indeterminate sentence! Reservists and TA faced additional problems: a sudden change of role identity – a new job in a strange environment, concerns about maintaining civilian living standards – fears of unpaid mortgages and debts, the inevitable scapegoating between regulars, reservists and TA.

Everybody's prayers were answered when the land battle ended so quickly – no one was “gung ho” or wanted war. Back in the NHS the experience now seems like a dream. There are many lessons to be learnt, political and military. Perhaps the most important lessons of the war are personal: forgotten in public, but known to everyone involved, especially those unaccustomed to active service and military life. Effects of the conflict on attitudes, and outlook on life may, I suspect, be considerable. For many, only time will tell if their experience will prove to be formative or not. Regardless, I doubt if anyone involved will ever be quite the same again.

## References

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## Referrals to an out-patient forensic psychology service

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Following the recommendations of the Butler Report (Home Office, 1975), there has been a slow growth in the number of Regional Secure Units (RSUs) (Snowden, 1985), which aim to assess and treat mentally disordered offenders in England and Wales in conditions of “medium security”. One particular recommendation of the Butler Report was that:

“The main emphasis in forensic psychiatric services ... should be on community care and out-patient work.” (paragraph 20.14)

I am unaware of any publications with descriptive data on the out-patient work as recommended by the Butler Report. This brief report therefore aims to give the reader an indication of the out-patient referrals to the clinical psychology department of the Regional Forensic Services in the North West of England over a three year period.

### *The study*

The North West Regional Health Authority covers a large geographical area of England with a population of approximately four million. Although it has had a forensic service for a considerable time, it is only in the last three years that a RSU has been established and functioning. This development of a 66 bed in-patient service has been paralleled by the development of an out-patient service for both former in-patients and for clients needing assessment/treatment, but who are not considered to require the

level of security provided by residence in the RSU. It is the clients referred to this out-patient service who will form the focus of attention in this article.

Referrals are taken from all sources, including voluntary agencies and self-referrals, and clients are generally seen in out-patient facilities near the RSU. In addition a number of clinic sessions are provided in probation offices in other parts of the region. Data on all referrals have been routinely gathered in the three years since the RSU was established.

Between 1986 and 1989 there were 270 new referrals to the forensic psychology out-patient service. None of the referrals were for compulsory treatment under probation orders. Males accounted for 89% of the referrals, and 52% of those referred were under 30 years of age.

From the perspective of the referrer, clients were referred for the following problems: aggression (23%); sex with children (22%); other sex offences (10%); gambling (11%); diagnostic advice (9%); and thefts (8%). The remaining clients were referred for a variety of reasons, including arson, homicide and management problems.

By far the highest percentage of referrals came from the probation service (46%), which is probably a reflection of the close working links which the forensic psychology service has with probation, links which are strengthened through the regular clinics held in probation offices and through formal training workshops. The remaining referrals were from solicitors/courts (16%); forensic psychiatrists (15%); social workers/NSPCC (9%); self (8%) and others (6%).