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Military mental health in the 21st century

THE SOLDIER'S ABILITY TO WITHSTAND FEAR is a critical determinant of the success of any military force. The complexities of human behaviour used to be lost in rhetoric about cowardice and bravery,[1] but the progress of science in the last 30 years has done much to overcome the prejudice that undermined the proper understanding of combat-related psychiatric morbidity.[2] The Israeli-Arab wars[3] and the legacies of Vietnam were key experiences in this reformulation of knowledge. The Gulf War,[4] with its peculiar threats of chemical and biological warfare, left in its wake novel patterns of physical and psychological morbidity demanding exploration.[5] In an attempt to understand these adverse health outcomes, there have been substantial research efforts that emphasise the need to consider multiple explanations. It remains the case, however, that one of the most enduring costs of war is post-traumatic psychiatric morbidity.

Lately, there has been a growing interest in the impact of peacekeeping on service personnel.[6,7] Unlike combat, where the soldier is well trained to act, peacekeeping requires soldiers to demonstrate restraint by example. Training for these roles as a conflict modulator and provider of humanitarian aid is more ambiguous and difficult. Another body of research has demonstrated that the unique stressors of each peacekeeping mission are critical in determining the prevalence of adverse mental health outcomes.

The central lesson about the psychiatric morbidity of war is deceptively simple, but has challenged health providers because it contradicts the prevailing prejudices.[2] Most service personnel who develop post-traumatic stress disorder have discharged their duty with stoicism and bravery. They did not break down in combat, succumb to fear or demonstrate disorganised behaviour. In the past, when these returned soldiers presented with their psychological suffering, it was attributed to pre-existing vulnerability and seen as a disorder which emerged in the absence of their combat exposure.[8,9] This erroneous conclusion failed to acknowledge the significant risks associated with increasingly intense levels of combat exposure and stigmatised the individual as not being made of the "right stuff". It is true, however, as shown by Solomon, that soldiers who develop acute combat stress reactions are a group at particularly increased risk of developing post-traumatic stress disorder.

In the UK, veterans of the Falklands campaign, Gulf War veterans and Northern Ireland veterans are suing the Ministry of Defence for failing to anticipate and offer treatment for their emergent post-traumatic psychiatric morbidity.[10] Regardless of the outcome of this litigation, defence forces can no longer ignore the predictable morbidity of combat. In essence, the British armed services failed to take the lessons of Vietnam and to provide active treatment in a way accessible to these veterans. It was presumed that the low numbers of acute stress disorders meant that there would be little long-term morbidity. The obligation now is to screen returning deployed personnel and to provide evidence-based treatment in active settings. Ideally, early preventive interventions would be offered, but the optimal form of such intervention is uncertain. Critical incident stress debriefing failed to live up to the promises and claims made by those who advocated it.[11] Despite this apparent lack of effect, the obligation remains to provide early psychological support in the

aftermath of combat or exposure to traumatic stress, so at least there is the beginning of a pathway to care.

The article by Haas in this edition of *ADF Health*[12] indicates the growing awareness of the need for mental health support among service personnel, even though they demonstrate continued ambivalence about accepting counselling. Haas also highlights the challenge to the ADF in deploying mental health personnel as part of a task force. In the US military, mental health personnel are a regular component of health support services, but this has not been the practice of the ADF. One of the benefits of deploying mental health personnel is to help document the exposures that are likely to contribute to future adverse consequences. It is critical to understand the nature of service personnel's anxieties and fears while they are in theatre, as these reactions mould their anticipation and perception of future health risks.[13] Post-deployment somatic syndromes have their origins in the failure to assist personnel to understand the nature of these reactions. As with any public health intervention, appropriate systems of care depend upon the accurate assessment of risk and careful definition of the potentially pathogenic exposures.

These issues should be considered against the background of what is known about the mental health of service personnel in peacetime. A recent study of US marines[14] who were deemed fit for deployment found that 19% had a diagnosable psychiatric disorder. Very few of these difficulties were known to the health services or commanding officers. These rates are very similar to those found in large epidemiological studies of the US and Australian communities. Soldiers recognise considerable disincentives to consulting a medical officer about their depression or alcohol problems, as it may have a negative impact on career progression and current employment. The failure to treat this actively symptomatic group is of considerable concern, as it is well established that these disorders are associated with significant cognitive disabilities, including slowed reaction times and inefficient target detection — handicaps that significantly undermine optimal performance.[15] Yet several of the new antidepressants can be safely given without any negative impact on performance and will normalise the abnormalities associated with depression and post-traumatic stress disorder.[16]

The challenge is obvious. We must overcome prejudice about mental illness that affects the efficiency of the Defence Force and encourage service personnel to seek appropriate mental health support when they need it.

The recently developed mental health policy for the ADF has been a major step forward in addressing garrison health care. A Directorate of Mental Health has been created in the Defence Health Service Branch to drive policy and implementation. However, there remain many unanswered questions about how to unravel the barriers to care created by prejudice, suspicion and a natural desire to minimise distress. As Haas points out, there is a need to better understand the reluctance and behaviour of consumers if early intervention and treatment are to be more than pipe dreams.

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