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Editorial

Psychiatry and War

Learning lessons from the former Yugoslavia

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The repeated failure of political negotiations and worsening of fighting on the ground makes the prospect of peace in the Balkans ever more remote. Increasing numbers of soldiers and aid workers continue to witness warfare of the worst possible kind with little prospect of an end to the conflict. The potential for serious psychological sequelae is considerable. Minimising the impact and managing the psychological aftermath of repeated severe traumatic stress have become matters of concern to both the military and civilians alike.

More than 4000 British servicemen currently serve with United Nations (UN) forces in the former Republic of Yugoslavia. They are involved in convoy protection and the provision of humanitarian aid in Bosnia as well as refugee protection within UN 'protected' areas. The British force includes a 'medical battalion' of approximately 250. Psychiatric support is provided primarily by attached Army community psychiatric nurses (CPNs) and, latterly, from a visiting psychiatric trainee.

The role of CPNs and mental health professionals within the UN force includes the assessment of 'cases' and the psychological debriefing (PD) of soldiers following traumatising incidents. With proximity and immediacy of treatment, there is the expectancy of full recovery, and so PD is provided wherever possible within 72 hours of any potentially traumatising incident. CPNs also have an important educational function in teaching the principles of PD to soldiers and their commanders, as well as more general topics such as alcohol and drug abuse and first aid. An effort is made to deploy CPNs from the area to which many of the soldiers will return. This enables links to be established with particular units in an attempt to facilitate any further intervention that may be required once a unit has returned home. Finally, the CPN also plays a role in assessing the need for additional mental health services in 'theatre'.

Although the UN forces undertake a humanitarian role and are not engaged in active combat, the nature of the conflict subjects many soldiers to repeated distressing and potentially traumatising events. All soldiers receive briefings before their deployment to prepare them to cope with the emotional response to stress; however, many feel inadequately psychologically prepared for their experiences. Events which soldiers find particularly upsetting include witnessing atrocities and torture being committed (but being unable to intervene) and the retrieval and disposal of human remains–particularly those of civilians, and especially of women and children. These events occur against a background of poor living conditions in a hostile environment. The workload is considerable, with soldiers facing periods of intense activity, particularly at the beginning and end of each six-month tour of duty.

The CPNs have already helped provide valuable psychological support to many UN personnel from a variety of nations in the former Yugoslavia. The problems they experience in the course of their work highlight difficulties frequently encountered by those providing psychological support following civilian disasters, problems which must be taken into account in planning for the aftermath of disaster. After a potentially traumatising incident, the personnel involved often become geographically dispersed; unless PD takes place quickly, it is often impossible to reunite a group of people for PD or any other intervention. Access to units themselves can be extremely difficult, hindering rapid intervention. Smaller units detached from the main body of troops often undertake extremely stressful and arduous duties and can easily be overlooked. A lack of suitable transport may further impede access; mental health workers must be mobile, and have suitable transport to help them negotiate what can be extremely difficult terrain, in order to be effective. Other requirements for mental health workers include effective communication and sufficient military skills to enable them to work safely in an area of conflict without becoming a liability to their own side. Mental health professionals in many settings suffer from a lack of status and recognition, and often face antipathy and an understandable reluctance by military commanders to acknowledge psychological distress within their units. Any professional must have sufficient seniority in order

to overcome these difficulties and help achieve recognition and cooperation.

Some referrals come from non-English-speaking personnel, despite the desire of many national contingents to deal with their own medical problems and not to be seen to need assistance from other forces. Many UN personnel, such as attached police (UNCIVPOL), lack medical services of their own. The considerable communication difficulties which result (interviews often take place using translators) lead to problems in accurately assessing and offering effective help to these people.

Despite the valuable work of CPNs within the UN force, the primary role of mental health professionals is one of training, consultation, education, and explaining the importance of PD. Debriefing should ideally be a unit responsibility, undertaken by the unit within the unit. Outsiders, especially mental health workers, are often perceived as an unwelcome intrusion into what are frequently tightly knit units. 'Medicalising' the PD process is generally unhelpful. Outside professionals are frequently unavailable when required to facilitate immediate debriefing and their presence may undermine the group cohesion and camaraderie of a shared experience.

The experience of mental health professionals in the former Yugoslavia should be of more than passing interest to civilian colleagues. The conflict continues to provide a valuable opportunity to train professionals who would otherwise have difficulty obtaining practical experience of PD. The experience gained and lessons learned are readily applicable to civilian settings. The unpredictability, setting, and chaos of war and civilian disaster alike make research extremely difficult. In civilian life, attempts to prevent or minimise morbidity following traumatic events have resulted in calls for the routine provision of early psychological intervention for the victims of trauma, and the emergence of a 'disaster industry' led by a variety of professional groups, including lay counsellors, psychologists, social workers and psychiatrists, all of whom have sought to establish a role for themselves following traumatic incidents. Although this may be intuitively appealing and a response to perceived need, a controlled study investigating outcome after PD in a group of Gulf War veterans has cast doubt on the effectiveness of early psychological intervention (Deahl *et al*, 1994). Moreover, it has been observed that an inappropriate and ill-timed intervention may only serve to accentuate symptoms of stress (Lieberman, 1982).

The present conflict provides an opportunity to study the natural course of post-traumatic stress-related symptoms (which are themselves poorly understood), as well as to assess the efficacy of prophylactic measures, PD, and other interventions designed to reduce psychological morbidity. If PD or any other professional intervention is to be made widely available in civilian settings, considerable resources would be required. At present PD falls into that group of psychological interventions discussed by Fahy & Wesseley (1993) as urgently requiring proper evaluation. The tragedy of the former Yugoslavia offers the chance to remedy this state of affairs and teach important lessons which may be relevant far beyond the realms of military psychiatry.

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