Psychiatric lessons learned in Kandahar

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Not since the Korean War have the Canadian Forces engaged in combat missions like those in Afghanistan. Combat, asymmetric warfare, violent insurgency and the constant threat of improvised explosive devices all contribute to the psychological stressors experienced by Canadian soldiers. Mental health teams deployed with the soldiers and provided assessment, treatment and education. Lessons learned included refuting the myth that all psychological disorders would be related to trauma; confirming that most patients do well after exposure to trauma; confirming that treating disorders in a war zone requires flexible and creative adaptation of civilian treatment guidelines; and confirming that in a combat mission mental health practice is not limited to the clinical setting.

Les Forces canadiennes n'avaient pas participé à une mission de combat comme celle de l'Afghanistan depuis la guerre de Corée. Combats, guerre asymétrique, soulèvements violents et menace constante d'engins explosifs improvisés sont autant de facteurs qui ont contribué au stress psychologique vécu par les soldats canadiens. Des équipes de santé mentale ont été déployées en même temps que les soldats pour fournir des évaluations, des traitements et de la formation. Les leçons tirées de l'expérience ont notamment permis de dissiper le mythe selon lequel tous les troubles psychologiques seraient reliés à des traumatismes, de confirmer que la plupart des patients se remettent bien d'une exposition à des traumatismes, de confirmer que le traitement des troubles de santé en zone de guerre exige d'adapter avec souplesse et créativité les lignes directrices civiles sur les traitements et de confirmer qu'en mission de combat, la pratique en santé mentale ne se limite pas au contexte clinique.

In 2006, the Canadian Forces (CF) moved to the volatile Kandahar region, assuming a combat role and lead-nation status for the Role 3 Multinational Medical Unit (R3MMU) located at Kandahar Airfield. Asymmetric warfare, improvised explosive devices (IEDs) and mass casualties became part of day-to-day reality. Trauma care was at the forefront, from the medical technicians saving lives in the field, to rapid evacuation to the R3MMU for acute surgical care, to eventual evacuation to rehabilitation centres in Canada.

It was anticipated that mental health issues and their treatment would be major issues, as the stress, psychological trauma and loss would be greater than that in any recent mission. In 2008, the RAND Corporation published a report raising awareness of the so-called invisible "signature wounds" of the current conflicts. The report predicted that posttraumatic stress disorder (PTSD) and mild traumatic brain injury would account for a very large number of psychologically and cognitively impaired veterans.¹ A robust multidisciplinary Canadian mental health team deployed to Kandahar and was augmented by US military personnel. Psychiatry, psychology, mental health nursing and social work were all available to deployed forces.

The end of the combat mission allows us time to reflect on lessons learned. First, a surprising fact to some was that, although the CF were operating in a war zone, at most only 50% of patients for the mental health team had psychological trauma. Second, the majority of deployed personnel do well, despite exposure to psychological stressors. Third, treatment regimens derived from evidence-based civilian guidelines do not always translate well to a deployed setting. Finally, one cannot understate the importance of providing ongoing care during deployment outside the hospital/office wherever the opportunity presents itself.

LESSON #1: IT'S NOT ALL PTSD

As a military psychiatrist, I have become accustomed to certain assumptions

made when I discuss mental health issues in the military with my nonmilitary professional colleagues. The most common assumption is that a military mental health practice is essentially a PTSD practice and that a psychiatric practice in a war zone would be a psychological trauma clinic. In reality, whereas members of the CF represent a screened and somewhat healthy subpopulation of the nation, they remain at risk for the same common mood and anxiety disorders experienced by the civilian population both at home in Canada and while deployed in Afghanistan.

Trauma-related conditions, such as combat stress, acute stress disorder (ASD) and PTSD accounted for about 50% of patients presenting to the mental health team in theatre at Kandahar Airfield. Given the high prevalence rates for mental illness in the general population (lifetime prevalence for mood and anxiety disorders approaching 20%),² the presence of these mental illnesses in the deployed CF population is understandable. Generally, 4 types of patients presented for assessment/treatment at the Kandahar Mental Health Clinic.

The first group consisted of CF members with pre-existing mental illness. The spectrum of illness in this group was broad, covering anxiety disorders, such as PTSD and obsessive-compulsive disorder; mood disorders, such as major depressive disorder; and substance-use disorders. Many patients in this category did not have conditions that had been previously diagnosed, and the illness only became apparent in theatre as it interfered with the soldiers' functioning. Others may have had a previous diagnosis and were considered to have been successfully treated before being deployed.

The second group consisted of soldiers for whom the illness first manifested during deployment. Disorders included the psychiatric illnesses discussed previously as well as illnesses, such as schizophrenia or severe bipolar disorder, that are typically not seen in active military members. The emergence of these illnesses may have been entirely coincidental to deployment and explained by epidemiologic risk or deployment factors, such as stress and sleep deprivation, which may have unmasked an otherwise dormant condition.

The third group comprised members with trauma-specific conditions. From a diagnostic perspective, these conditions included adjustment disorder, ASD and PTSD.³ A nonclinical term commonly used by soldiers to describe stress symptoms was combat stress reaction; the clinical terms that best describe this condition are adjustment disorder or ASD. These conditions posed the greatest challenge to the treatment team, as it was possible for them to present in large numbers of troops, often days after a significant event, such as an IED explosion with loss of life.

The final group comprised CF members for whom psychosocial issues, commonly family problems on the home front, dominated and interfered with their function-

ing. These issues are traditionally not in the realm of psychiatry; however, they can be a significant distraction for the individual and may jeopardize a mission. Management of these issues often involved creative approaches, such as clinicians conducting couples therapy simultaneously in Kandahar and at the home base.

LESSON #2: MOST DO WELL AFTER TRAUMATIC INCIDENTS

Studies that follow people exposed to psychological trauma demonstrate that PTSD will develop in a small but significant minority.⁴ Most soldiers exposed to trauma will not require any professional help to cope with traumatic incidents; usually, they cope well themselves or do so with the aid of their buddies and/or military leadership. Most soldiers who have difficulties will respond positively to brief interventions, such as rest, replenishment, brief use of hypnotics and rapid return to duty. Postdeployment screening identifies that about 6% of Canada's deployed soldiers report symptoms suggestive of depression and/or PTSD 6 months after such a combat tour.⁵ This group requires further assessment and possibly treatment. The important lesson here is a confirmation of what past wars have taught: despite training and selection, some soldiers who go to war will be overwhelmed by their experiences. These psychological casualties, while not predictable at the individual level, should be anticipated and planned for just as we would plan for physical injuries.

LESSON #3: TREATING IN THEATRE

Much like our surgical and medical counterparts, psychiatrists in theatre face the challenge of adapting civilian "best practices" to the war zone. Not all soldiers in whom psychiatric disorders develop require evacuation home — the decision is based on severity of symptoms. This is analogous to treating sprained ankles in a combat zone, whereas patients with open fractures are repatriated home. However, when one begins treatment in theatre it becomes evident that some adaptation of guidelines is required. For example, with trauma-related disorders, one of the main principles in treating psychological trauma is to ensure your patient is safe and reassure them that the trauma is part of the past — this simply is not possible in a combat setting. Similarly, one must be careful when considering the use of medications, particularly those that may sedate or impair concentration, as concentration and focus are necessary for staying alive in a combat environment.

LESSON #4: PSYCHIATRY'S ROLE OUTSIDE THE OFFICE

The practice of psychiatry during a combat mission is far from the typical. The psychiatrist and mental health team working in theatre quickly realize that much of their work

occurs outside of the clinical office. After arriving at Kandahar Airfield, one of the priorities of the mental health team members is to get to know the troops and to make themselves known. Conditions change so quickly in a war zone that it is imperative that members of the mental health team are easily available at all times. Much of the work occurs in informal settings, such as having coffee with a distressed member outside the hospital. There are also times when members of the mental health team travel to the forward operating bases to provide mental health education for individual soldiers and military leaders. These visits also provide the opportunity for the mental health staff simply to meet the soldiers stationed there. These opportunities that the deployed setting offers give soldiers the opportunity to see mental health professionals outside of the usual office or hospital setting and hopefully desensitize them to the idea of perhaps needing care at a future date.

CONCLUSION

Canada's combat role in Afghanistan challenged military health professionals like no mission in recent memory. Psych-

iatry was no different, and many lessons were learned. These include confirmation that not all psychiatric illness is trauma-related, and most will not become ill after severe trauma. Civilian treatment guidelines must be adapted for application in deployed settings, and psychiatric practice goes well beyond the comfort zone of the office.

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