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Letter to the Editor

Combat psychiatry: Indian perspective

Dear Editor,

I read with extreme interest the Military Medicine Special Edition titled article 'Combat psychiatry: Indian perspective' by Bhat, published in *Med J Armed Forces India* 2017;73:404–406.¹

1. Role of military psychiatry to tackle 'Stress in the Indian Armed Forces' a subject which has been scarcely discussed and researched with very few large scale studies to date.^{2–7} The author needs to be complimented on bringing this important issue of military psychiatry to the fore by his paper on the subject.^{8–10}
2. The author has traced the evolution of military psychiatry. As can be seen from the article Psychiatrists were posted at divisional level which manned 'exhaustion centres' in the mid 20th century. Having served alongside the author in field formation, no such arrangements exist today. Authors may like to inform of any such arrangement if it exists.
3. While discussing the 'Combat psychiatry services' author clearly brings out the ground for 'felt need' for combat psychiatry but authors fail to bring out any elements of combat psychiatry existing as on date. Neither a vision for laying out a roadmap for such an initiative has been mentioned. Authors may like to educate the readers.
4. With due regards, may I submit to highlight the difference between 'military psychiatry' and 'combat psychiatry'. Combat psychiatry is a subset of military psychiatry which is relevant to operationally deployed soldiers in combat and combat stress related issues. Combat psychiatry would encompass elements of psychological screening, first aid, counseling, preventive and promotive aspects of mental health with some curative role. Combat psychiatry would have a major role for paramedics. It is submitted that both terms are not used interchangeably. Authors are requested to clarify the differences between the two.
5. Training on 'Combat psychiatry' to our specialists is presently limited to classroom teaching and as suggested

by the author that postgraduate certificate course would really be a welcome step.

6. There were 635 cases of suicide including attempted suicides and 67 cases of fratricidal killings in three services of the Armed Forces during the years 2003 to 2007 as per Standing Committee on Defense of Parliament in its Action Taken Report (ATR) of March 2010. Between 2007 and 2010, 533 soldiers committed suicide and there were 15 cases of fratricide.¹¹ These cases are just the tip of iceberg of the stress epidemic in the armed forces. Misconduct behaviors, deliberate self harm and non-fatal impact of combat stress is not even documented and data does not exist. Despite this the author in their previous paper on the subject had debated about the very existence of a stress epidemic in the Indian armed forces.⁸ If that be the case, then why are we talking about combat psychiatry and as per author all we need to do is already in place. Authors may like to comment and clarify if the point is being missed for being politically correct.
7. Another point that needs attention is the common mistake of attributing most stress related events to domestic factors without ever researching on it whether events occurring in peace or field may be linked to past or present deployment and combat stress. No such study has been done to refute the link.
8. In the armed forces there is no system to profile soldiers before enlistment, before deployment and after deployment which can be a way forward in mitigating the issue. Doing a critical event debriefing is not practised at all in our settings which can be crucial in reducing the impact on those who are witness to the event.

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Reply

Dear Editor,

It is highly gratifying to see the keen interest evinced by the reader on such an important but neglected part of our Combat Medical setup. The reader has totally echoed my sentiments on some of the issues of Combat Psychiatry. However, following clarifications are submitted on other issues.

1. Psychiatrists are posted at Psychiatry centers of Military hospitals located in field areas. There are no “exhaustion centers” at Divisional level presently. Author also is not aware of any roadmap or initiative in that direction.
2. Author agrees with reader about difference between “Military psychiatry” and “Combat psychiatry”, and wants to submit that the same has been clearly brought out in the article. It has been described as a branch that deals with the mental health issues of soldiers deployed in forward locations. It may be in war or war- like situations including Counter-insurgency or Counter-terrorism and Military psychiatry subsumes Combat Psychiatry.
3. Training in nuances of Combat psychiatry is being imparted to future military psychiatrists during their Advance Specialist Course at AFMC and other teaching hospitals. The view of reader that it is only a class room teaching seems far from reality. Theoretical part has to be in class rooms only and Combat Psychiatry is now officially part of the curriculum. They get great input from psychiatrists serving in combat zones, by interacting with them during Annual National Conference of Military Psychiatry (ANCEMP) being held regularly at AFMC & other teaching hospitals. Anyway, they gain practical experience subsequently while serving in forward locations.
4. By quoting figures of suicide and fratricides, and of a previous article of the author, reader seems to have missed the stream of logic in his argument. Author would like to remind that stress of various kinds including combat stress

in the life of a soldier was always there and in future also will be there. Based on input from environment including mental health professionals, various measures have already been put in place by the organization over the last two decades to mitigate the adverse consequences of these stressors. Informing the environment about the stress reduction measures implemented recently is in no way amounts to “political correctness”. Authors in that article had debated the issue of stress, measures implemented, suggested future direction and also recommended field psychiatric units in the operational commands. I honestly believe, with the experience gained by the reader in field formations as stated, it would have been prudent for him to suggest constructive measures rather than casting aspersions on the ethical stand of authors.

5. Statement by reader that most stress related events are being attributed to domestic factors without any study, also seems incorrect and requires revisit. Due to sensitive nature of issues involved in suicides and fratricides, and inherently secretive nature of armed forces, much of the research on the subject done by service psychiatrists do not get clearance for publication in the peer-reviewed journals. However, studies done by Defense Institute of Psychological Research (DIPR) and others that are available in the public domain have highlighted the importance of domestic factors as highly contributory to the stress related events among soldiers, especially suicides.
6. Authors agree with the reader that at present no psychological profiling of soldiers is done before enlisting. However point to be noted here is that the validity, reliability, job relatedness and fairness of psychometric tests for recruitment of soldiers has not yet been scientifically established. At the best, they may help to screen out some individuals who are highly vulnerable to break down. Some work in this direction has already been done by DIPR. Similarly, the efficacy of Critical Incident Stress Debriefing (CISD) in preventing post traumatic stress disorder has been doubted

by recent studies. Of all the factors, one important all time protective factors has been a good officer-men relationship in preventing untoward stress related events among soldiers.

7. Having served with the reader in field formation, author is acutely aware of genuine concerns raised and the need to mitigate adverse situations faced by soldiers in combat zone. It is heartening to note that, of late, importance of preventive and promotive psychiatric services is being more and more recognised by the commanders. I am sure, in the coming days, Combat Psychiatry will occupy its rightful place in Military Medicine.

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Letter to the Editor

It is crucial to have specific programs to stop smoking in the military

Dear Editor,

We read with great interest the original article titled, 'Tobacco use among serving army personnel: an epidemiological study' by Puthia et al published in *Med J Armed Forces India* 2017;73: 134–139.¹ The authors have elaborated on the smoking trend among serving Military Personnel (MP) of a large Military Station in India. The authors also suggested various preventive measures to reduce the prevalence of smoking even further.

At the end of the decade of the 90s and the beginning of the decade of 2000, in Spain, we carried out successive surveys of MP, finding prevalence of tobacco consumption that ranged from 53% to 36% (37.42% men and 34.94% women).² Subsequently, a decade later, we carried out a new survey of MP with the aim of once again determining the prevalence, in this case, in a deployment situation.³ We found again a prevalence of 39.8% of active smokers and 3.1% of ex-smokers.

Really, what are we doing wrong? In Spain, the consumption of tobacco in the civilian population has been decreasing throughout the last decades, however, it seems, that in the army consumption is maintained. We know³ that specific barriers arise against smoking cessation in the military, derived from the structure and culture of the army; cultural barriers including peer pressure; smoking norms; and a lack of discouragement from the "regimental family". Other factors in turn contribute to an increased opportunity to smoke in terms of time, place and cost. Due to the increase in tobacco use among MP, it is crucial to find messages that can prevent these people from increasing or taking up smoking. Some works³ offers us some cues: MP play a model role as non-smokers for children and adolescents. Physicians and teachers are considered social models for preventing smoking initiation in children and adolescents, though it would be advisable also to incorporate MP to this message. Another key point for reducing the prevalence of tobacco use is to present smoking

as an issue that negatively affects physical and psychosocial factors related to military readiness. It is also important to emphasize the idea that smokers are less productive than non-smokers, and even that a recent history of cigarette smoking is an important determinant of hospital admission risk even for healthy young MP.³

We believe that studies like this¹ are necessary because, as has been shown, there are no great differences between the different armies; we know that smoking in the military has a long tradition and remains a current public health challenge. The prevalence of daily smokers is high among MP. We think that it is necessary to have more active intervention and health promotion programmes as well as specific messages for prevention and smoking cessation in the military.

Conflicts of interest

The authors have none to declare.

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