

A PERSONAL VIEW

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I joined the RAMC in 1975 and left in 2003. For about half this time I served with infantry units including Special Forces. From the outset I was most interested in physical trauma undertaking the ATLS for the first time in 1981 in USUHS, augmenting this later with two years in A&E and Anaesthetics. During my time as an RMO I developed a love of the Army and its soldiers; I was impressed with their stoicism and 'can-do' mentality and became an interested observer of their world, culminating in a switch from general practice to psychiatry in 1990, just as the First Gulf War started. The timing of my exit from my unit was difficult as the last time I was with them, during the Falklands Campaign, I lost over twenty of my patients.

During my time in military psychiatry I was extraordinarily lucky in being afforded the time, space and encouragement to develop my interest in the subject. The whole area of human interaction with combat and other toxic events continues to intrigue me and has led me well beyond the narrow confines of psychiatry. I know I share a morbid fascination in the growth of the 'subject' of traumatology, the 'trauma industry' and the culture of victimhood so frequently portrayed in the media; a place where it must be remembered that 'bad news is good news' and that newsworthiness equates to rarity. As time has passed, I have come to realise that, for those unfortunate individuals who suffer following exposure to toxic events, focus on the individual, their resilience and personal strengths and where they were in their life cycle when the event(s) happened, rather than a focus on the event per se, is the key to success in all, and particularly 'complex' cases.

Having been initially 'sold' on the idea of PTSD, I have come to realise how limiting a concept it is. PTSD never disappoints when it comes to controversy, so I am glad the Journal has devoted a special edition to the subject of psychological trauma and am deeply honoured to have been invited to write this introduction.

Military psychiatry may seem to hold little relevance to mainstream (civilian) psychiatry but it is my contention that the mental suffering of soldiers, sailors and airmen has led to a deeper understanding of individual resilience and how individuals (and groups) cope with extraordinarily stressful situations at the time and subsequently. There seem to be two current fallacious beliefs portrayed in the mass, and to a lesser extent medical, media. The first; that all those exposed to toxic events will be damaged by their exposure. The second; that PTSD is the hallmark, or only, psychiatric disorder following such exposure. In our media saturated world it is easy to forget that only a minority of soldiers, sailors and airmen breakdown either at the time or following exposure to disturbing events.

All will however be changed by their experiences, some more than others, some positively, some negatively. Whilst a number will find it difficult to readjust to society and civilian life after exposure to toxic events, others will find proximity to death leads them to an improved quality of life.

In terms of psychiatric labelling, 1916 and 1980 are landmark dates in psychiatry. Although their naissance was separated by over half a century, Shellshock (1916) and PTSD (1980) have much in common and are often incorrectly conflated. Shellshock is a powerfully descriptive word which continues to conjure images of acute psychological breakdown under extreme stress, embedded as it is in the Western cultural images of the carnage that was the Western Front. Initially appended to soldiers who broke down under exhaustion and the tremendous and continuing pressure of combat, within a short space of time it was being used to describe 'breakdown' in recruits training in UK before they had even left for France. Shellshock rapidly became a catchall for a wide variety of psychiatric disorders ranging from depression and anxiety to agitation, psychosis, hysteria and malingering. Despite this potential utility to the psychologically untrained, or inclined, doctors of the day, it swiftly became redundant in medical circles at least. In my opinion, shellshock was the first and most important step in developing our understanding of how external events can affect internal psychic mechanisms in 'sane' individuals who would, prior to World War I, have been sent to a lunatic asylum. It is a common error for shellshock and PTSD to be used synonymously.

Whilst shellshock describes what happens 'at the time', PTSD is one of a number of psychological sequelae following exposure to toxic events. 64 years after shellshock was first used, the American Psychiatric Association, under immense political pressure from the veterans lobby and anti-war psychiatrists, coined the term PTSD. Like its predecessor, PTSD is an important milestone in the endeavour to understand the long-term psychological and emotional consequences of combat and other toxic exposures. Like shellshock, PTSD has been embraced by society at large and has come to form part of the ontological and existential discourse relating to the human condition. PTSD is a most interesting 'diagnosis' which involves 'negotiation' between parties as diverse as biological psychiatrists, anthropologists, lawyers, students of religion, politicians, psychotherapists, psychologists, philosophers, sociologists, journalists and survivors. It is a condition encircled with controversy and a medical label with extensive social and societal consequences.

Almost alone amongst psychiatric disorders PTSD has an aetiology enshrined in its diagnostic criteria (Criteria A) - this is both its appeal and Achilles' heel. Predominantly through the action of tort lawyers, the list of 'traumatic' events which serve as eligible for Criteria A grows longer and longer. Such actions run the risk of debasing the diagnosis as was the case with shellshock; as succinctly put by Professor Simon Wesley "*inflation always leads to devaluation*".

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Focus on Criteria A (the toxic event), encouraged by tort law, has allowed mental health professionals to avoid contemplation of the thorny issue of 'predisposition' or vulnerability, in all its ramifications; whilst concurrently ignoring resilience. Once in service, predispositions are in large part mitigated by the process of acculturation to service reinforced by the horizontal and vertical support networks of the military which are further strengthened by external threat such as combat. Predisposition in service personnel is thus generally only an issue at the enlistment medical or if breakdown or behavioural problems occur during or after service.

It must be remembered that, in line with nearly all other psychiatric disorders, PTSD is multi-factorial in genesis. It is the product of the interaction between the individual (or group), the event, the environment afterwards and the culture to which the individual (or group) returns. A moment's contemplation will reveal that numerous (uncontrollable) variables are in action in each and every toxic or traumatic encounter. Focus on the event alone may thus be therapeutically unhelpful. I well remember overhearing one soldier tell another "*they're not interested in me, only my f*****g trauma*". Yet another soldier had seen numerous mental health professionals all of whom had focused on a traumatic event in Northern Ireland. Countless attempts to probe the incident were prevented by his amnesia for the event. It transpired that the problem was not the incident in Northern Ireland but his witnessing the murder of his alcoholic father years before; once this was dealt with the amnesia disappeared and the incident was no longer a problem. Today this case might be afforded the label of complex or refractory PTSD or possibly untreatable PTSD – with 12 sessions of CBT that is. It must be remembered that that there is about 80% co-morbidity in PTSD cases and CBT will not work for at least 30% of PTSD sufferers.

During my service I saw many cases of what has been called 'sub-syndromal PTSD' i.e. although having the vast majority of symptoms they did not fulfil 'caseness'. When confronted with such silliness, do not forget that PTSD, like nearly all psychiatric disorders, is a categorical construct, necessary for research but by its nature a hypothetical construct. Most cases seen in clinical practice are dimensional in nature with marked co-morbidity. I rapidly came to view the post traumatic

psychological reactions as just that, reactions – shared by many, transitory in nature and only developing into a problem for a few. As mentioned above, PTSD is only one of a number of possible, and more frequent, post traumatic mental health disorders. They include depression and anxiety, phobias, substance misuse, personality change and medically unexplained symptoms. But the commonest psychological reaction is coping without the development of a mental disorder.

PTSD, in common with nearly all psychiatric disorders has no 'gold-standard' diagnostic test and there remain numerous controversies surrounding it 27 years on. For example, although arousal is one of the fundamental triad of symptoms of PTSD only 60% of individuals who have a bona fide diagnosis show objective physiological reactivity (arousal). Moreover, when presented with triggers relating to their symptoms, individuals who believed they had been abducted by aliens showed the same level of arousal as individuals who had seen combat or been raped. The controversies in regard of PTSD are interestingly and extensively covered in *Posttraumatic Stress Disorder: Issues and Controversies*¹, I commend the book to all interested readers.

Criteria A remains a problem for me therapeutically when, or if, it encourages the notion that 'it is/was not my fault'. PTSD is frequently accompanied by concepts of justice, retribution and compensation - habitually encouraged by the media, lawyers and other interested parties, particularly where money is involved. Whilst justice has to be seen to be done, 'blame' can prevent resolution, rehabilitation and recovery. Acceptance of change, responsibility and forgiveness are potent positive indicators in recovery.

I would like to be around in 25 years to be asked to write an introduction to the next JRAMC symposium on this subject when our understanding of post traumatic stress reactions and disorders is likely to have advanced. However, for those of you in search of new ideas on the subject may I recommend you read outside psychiatry? Particularly in the areas of sociology, military history, anthropology and above all personal testament of man's involvement with war.

¹Rosen, G.M. (Ed.) (2004) *Posttraumatic Stress Disorder: Issues and Controversies*. Chichester, England: John Wiley & Sons