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Brief Therapy in a Battleshock Recovery Unit: Three Case Studies

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SUMMARY: Combat stress reactions may present in many forms. This study presents three cases from the Gulf War which illustrate the diversity of presentation and demonstrate the ways in which the principles of the management of Combat Stress Reactions — Proximity, Immediacy and Expectancy — can be combined with specific individual therapies.

Introduction

Combat stress reactions may present in a variety of ways; the common factor is that they are a response to the stresses of being in a combat zone and may represent, for the sufferer, a means of exit from it. Noy(1) discusses the "choice", whether conscious or unconscious, of the type of exit which the soldier may make. The channels available include the psychiatric, medical and disciplinary routes. He suggests that the type of presentation may vary according to the intensity and accumulation of stressors and, furthermore, suggests that the availability of particular channels of escape from the combat zone may encourage or discourage particular types of presentation. He illustrates this with the case of an individual physician, whose lack of awareness of the principles of combat psychiatry led to an increase in sick parade attendances and the number of self inflicted wounds, when he was dealing with a heavily stressed battalion.

Whatever the form of presentation, front line treatment has been emphasised as an important factor in recovery. The principles of this were originally articulated by Salmon(2) and have been reiterated by others (3,4). The main features of front line treatment are Proximity, Immediacy and Expectancy. Treatment should be carried out as close as possible to the combat zone as soon as possible after the onset of difficulties and with the expectation that treatment will result in a return to duty.

Carrying out treatment in the combat zone is thought to dramatically limit manpower losses(5) and has therefore gained wide acceptance within military organisations. While carrying out treatment in a forward setting has obvious advantages from a military perspective there is also evidence that following the principles of Proximity, Immediacy and Expectancy reduces the levels of Post Traumatic Stress Disorder (PTSD). Solomon and Benbenishty(6) demonstrated that not only were all three treatment principles associated with a higher return to duty, but were also related to lower rates of PTSD. The authors further suggested that the principles used as a framework for the treatment of Combat Stress Reactions may also be of benefit in the treatment of other acute stress related problems.

Within the British Army, it has been policy for some years that forward psychiatric treatment is carried out by Field Psychiatric Teams (FPTs) working within a Battleshock Recovery Unit (BRU). The Gulf War was the first time that these principles had been put into practice with the deployment of FPTs in advance of the conflict. It is worth noting that during the Falklands War there were no land based psychiatrists deployed and consequently no test of the concept of forward treatment.

While the principles which form the framework of treatment have been well articulated there has been little discussion as to how these principles can be integrated with particular models of treatment. The assumption appears to be that treatment is simply carried out within this framework rather than the two being integrated. These case studies of soldiers serving in the Gulf War in 1991 illustrate how the principles of front line management can be integrated with therapeutic models drawn from Cognitive-analytic Therapy and Cognitive Behaviour Therapy.

Case Reports

Case 1

Soldier A, in his early twenties with 2 years service, was from a local unit. He had been found in his tent with a loaded sub machine gun crying. He had been in this location, where he had no friends, for only three days. Previously he had been in the base area 350 kms away. On assessment he appeared extremely anxious and said he had been worrying about the threat of chemical weapon missiles; as a consequence he had been self medicating with caffeine tablets in order to stay awake in case of an attack. He had not slept for three nights and not been eating. He had considered injuring himself as a way out, but was not suicidal.

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Management: He was informed that he would be returning to his local unit and not back to the base area, on completion of his assessment and treatment. It was explained that his anxiety symptoms had been aggravated by the caffeine tablets, that these should be handed over and that he would have the opportunity to re-adjust in the BRU. He was occupied with appropriate tasks and treated as a soldier. He was able to sleep that night but the following morning was insistent that he should return to the base area.

During the day he had three sessions with a team member. In the first session an attempt was made to get him to look at the cognitive distortions which were associated with his insistence on returning to the base and the alternatives to these. He was very resistant. The second session involved training in relaxation techniques and was more successful. The third session involved a combination of relaxation training and cognitive work and again was more successful. The therapist contacted the soldier's officer and a job was arranged within his unit in a small team, where it was thought he would fit in well. Following a good night's sleep he had a final session of relaxation and cognitive work and returned to his unit. He settled happily and was able to face the prospect of being deployed further forward with equanimity.

Case 2

Soldier B, in his thirties with 15 years military service, came from a Field Hospital where he had been admitted with continuous severe headache. Analgesics had not been helpful; a full physical examination was normal but he appeared tense and tearful and was therefore referred to the BRU for an assessment.

Assessment and Management: On arrival he was anxious, tearful and irritable. He readily associated his headache with his emotional state, which he attributed to boredom. He was angry that he was to be held in the BRU: as he saw it, the only solution was for him to return home to his wife. When contacted his unit stated that he was an efficient, willing soldier, valued by his Commanding Officer. During the team discussion that followed B's initial assessment, surprise was expressed that a senior soldier, with a successful military career, could imagine that he would be allowed home at such a critical time. The following day Soldier B received three individual sessions with a team member trained in Cognitive-analytic therapy (7).

The first session was exploratory: B described the onset of his symptoms, the associated factors and the reasons behind his assertion that he had to go home. The second session concentrated on relaxation training in which he was able to abolish his headache. He found this helpful but it left him feeling sad. In the third session he was presented with a reformulation of his problem which enabled him to get in touch with what he valued about being a soldier. Following this session he made arrangements for his unit to collect him the next morning.

He had no further problems and reported, three months later, that he was very grateful for the intervention he had received at the BRU.

Case 3

Soldier C, in his early twenties with 2 years service, was evacuated from a forward unit during the land battle advance. He had been reprimanded for being slovenly and inattentive while on guard duty and appeared to react by pointing his weapon at the reprimanding guard commander. He was disarmed and sent to the medical officer because of his appearance and behaviour. The medical officer thought he could be suffering from a Combat Stress Reaction and he was inappropriately evacuated along the medical evacuation chain to a Field Hospital, from where he was transferred to the BRU.

Assessment and management: He had been frightened and not slept well for 3 nights and then self medicated with 2 temazepam capsules that he had 'acquired'; two hours later he had unexpectedly been required for guard duty. He had a history of previous violence and confirmed that he had pointed his weapon at the guard commander, for which he showed no remorse. He showed no commitment to his unit, wishing to leave at the first opportunity. He had been upset by the recent death of a relative but had been unable to talk about this.

His presenting behaviour was formulated as resulting from a combination of fear, sleep loss and possibly temazepam induced inhibition in a vulnerable personality who had been recently bereaved. He was kept in the BRU for food, sleep and further assessment and interviewed again the following day. He accepted that he was responsible for his behaviour but attempts to explore the relationship between this anxiety, the bereavement and his behaviour were not productive. His commanding officer was contacted and was reluctant to accept him back because of his recent and past behaviour. It was explained by the Officer Commanding the FPT that a return to the UK as a psychiatric casualty was inappropriate and that the correct solution would be to employ Soldier C in an area where he could be closely supervised and that any behaviour problems should be dealt with in the normal disciplinary manner. C was then taken forward to a location to await collection by his unit. While he was waiting to be collected his behaviour caused alarm in those around him and his admission to the Field Hospital was arranged. Despite the attempts by a psychiatrist to find an administrative solution to the problem this proved impossible and a decision to evacuate him as a psychiatric casualty was made. Once this decision had been made Soldier C was reported to be very helpful and content!

Discussion

The three case studies demonstrate the diversity of presentation of Combat Stress Reactions (CSRs). Much of the literature focuses on the more dramatic 'psychiatric' presentation although, as already men-

tioned, Noy (1) has indicated that medical and disciplinary presentations are important. Certainly the possibility of occult CSRs being dealt with as 'medical' problems was discussed by Abraham (8) in an addendum to a paper by Price (9) which examined the apparently low rate of CSR casualties during the Falklands Operation. With the contraints imposed by operational requirements, the identification of those CSRs that present with somatic symptoms is likely to be difficult. The established organisation of the Army Medical Services can provide an overview so that overuse of the medical evacuation chain for occult CSRs should be recognized.

Perhaps most importantly the case studies indicate the importance of the principle of Expectancy of a return to duty as the most important of the principles of managing CSRs. In the first case the principles of Proximity, Immediacy and Expectancy were all applied. Soldier A was seen rapidly, he maintained his soldier role and contact was maintained with his unit to ensure he would be received back into an appropriate job. In the second case Soldier B spent several days as a patient in a Field Hospital before transfer to the BRU, where he was made immediately aware of the expectancy that he would return to his unit. Given his presentation with severe, incapacitating headaches it was fortunate that he did not find himself travelling further down the medical evacuation chain. The willingness of the field hospital physician to seek an assessment from the FPT prevented this man from being lost to his unit and interrupted the vicious cycle of continuing somatization, loss of self esteem and long term morbidity.

Soldier C illustrates the problem of dealing adequately with individuals who have pre-existing personality difficulties and in whiom the presenting problems are conduct or disciplinary. The use of a psychiatric evacuation may well present an easy option for a busy commanding officer of a forward unit. However, even if the removal from the combat zone is achieved administratively, it may soon become apparent that conduct and disciplinary problems are the most certain method of being removed from the combat zone. As Noy has demonstrated this may have the effect of increasing the incidence of this presentation of CSR. Certainly individuals with conduct disorders are likely to be the most difficult to re-integrate into their units. Although Soldier C had features of a pre-existing personality disorder he had remained in the Army for 2 years: provided that an appropriate level of supervision could have been provided he should have remained in the combat zone. In retrospect the FPT, anticipating problems in returning Soldier C to this unit, could have attempted to find him employment in a rear area, where appropriate disciplinary measures were, perhaps, more easily available that to his own unit who were advancing in the Land Battle. As in other areas of clinical practice, the level of behavioural disturbance rather than the psychiatric diagnosis may determine the management of an individual case.

Conclusion

These case studies illustrate the possibilities of using an intensive therapeutic crisis intervention in the management of Combat Stress Reactions. Following the initial assessment interview on Day 1, the treatment sessions were held on Day 2. The experience of the therapists in Cognitive-analytic Therapy and Cognitive Behavioural Therapy offered both a method of formulating the problems which they and the soldiers could use beneficially within the principles of Proximity, Immediacy and Expectancy. One recurring problem for command in a combat zone is the problem of conduct disturbance: medical evacuation as a psychiatric casualty should only be used for sound clinical reasons and not as an alternative to administrative or disciplinary action.

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