

Correspondence

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Contents ■ War and psychological health ■ Post-traumatic stress after non-traumatic events ■ Patient-rated unmet needs and quality of life improvement ■ Abstinence-oriented treatment for opiate addiction ■ Diagnostic stability and status of acute and transient psychotic disorders ■ White matter in liars ■ Financial support and conflict of interest

War and psychological health

The study by Hacker Hughes *et al* (2005) is interesting but I wish to raise a few points. The end of pre-deployment mental health briefing was not the best time for assessment because the soldiers were aware that they would soon be going to war and hence their stress levels must have been high. One month after the return from the war, they must have felt relieved and their stress levels must have been reduced. Since the stress levels were high at the time of initial assessment, lack of increased morbidity at the final evaluation might not mean much. It would have been more appropriate to compare stress levels at the final evaluation with those measured during peacetime.

Although the soldiers were told that the commanders would be informed about only the pooled results, they were told that military mental health practitioners would contact them confidentially if results revealed cause for concern. This means that the answers were not anonymous and hence the soldiers may have hidden their psychopathology for fear of being considered weak and the consequences of being under treatment of the military mental health practitioner. These soldiers were in the war theatre for only 4 months and it has not been mentioned how much experience of combat they had but it is known that Basra was the scene of fewer hostilities than other areas. More combat experience may be associated with a higher prevalence of post-traumatic stress disorder (Hoge *et al*, 2004).

The figures do not add up. It is mentioned that 421 soldiers out of the original sample of 899 completed the questionnaires. Later it is mentioned that 35% ($n=254$) completed both sets of questionnaires. The number 254 is 35% of neither the original sample ($n=899$) nor the sample that completed the questionnaires at follow-up ($n=421$). The follow-up rate is

very low and hence the advantage of the study being longitudinal is minimised. It is also not mentioned how many soldiers did not volunteer for the study before and after deployment although it is mentioned that participation was voluntary.

The conclusion of the study that 'participation in war fighting may sometimes not necessarily be as deleterious to psychological well-being as has previously been thought' is premature. The small sample size compared with studies with positive findings, the high drop-out rate and lack of baseline data do not allow us to draw any conclusions from this study.

Hacker Hughes, J., Cameron, F., Eldridge, R., et al (2005) Going to war does not have to hurt: preliminary findings from the British deployment to Iraq. *British Journal of Psychiatry*, **186**, 536–537.

Hoge, C. W., Castro, C. A., Messer, S. C., et al (2004) Combat duty in Iraq and Afghanistan, mental health problems and barriers to care. *New England Journal of Medicine*, **351**, 13–22.

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Authors' reply: In response to Dr Jhingan's letter we should first point out that the rates of morbidity obtained pre-deployment were entirely compatible with those from other studies (Rona *et al*, 2004). Furthermore, it is illogical to argue that rates of pre-deployment stress must have been high in this group because of anticipatory anxiety. Not only is there no evidence for this assertion in this population but the converse probably applies. Troops in this elite formation would have probably been looking forward to the deployment, confident in the strong belief that they were going to win (Hacker Hughes *et al*, 2006).

The argument that post-deployment stress levels would be low because of relief to be home does not allow for the influence of any adverse events in theatre. In fact, 1 month after return is the earliest time to assess for possible post-traumatic stress using the screening questionnaire (Brewin *et al*, 2002).

For a brigade such as 16 Air Assault Brigade, there is no such thing as true 'peacetime'. This brigade has, to the best of our knowledge, been deployed more often than any other in the British Army since its formation and is constantly training for, or recovering from, deployments when not on operations.

With regard to responses not being anonymised, in fact the converse applies. Soldiers may use the questionnaires as a confidential means of signalling to command, via the mental health chain, that there is a problem. In addition, there are also data from the USA to suggest that when asked questions it is only information on banned activities (such as drug use) that is significantly affected by anonymity, rather than simple distress (Adler & Thomas, 2005).

With regard to the figures, they add up perfectly. There was a population of 899 with 733 initial responses (giving a response rate of 82%); 421 completed the follow-up questionnaires and, in total, 254 of the initial 733 (35%) completed both sets.

On this basis, it is totally reasonable to have stated that, for highly trained professional soldiers involved in brief, focused operations with positive outcomes, participation in active war fighting may not be necessarily bad for mental health, at least in the short term.

Declaration of interest

J.G.H.H., F.C., R.E., M.D. and N.G. are or were employed by Defence Medical Services. S.W. is honorary Civilian Adviser in Psychiatry (unpaid) to the British Army Medical Services.

Adler, A. & Thomas, J. L. (2005) Measuring up: comparing self reports with unit records for assessing soldier performance. *Military Psychology*, **17**, 3–24.

Brewin, C. R., Rose, S., Andrews, B., et al (2002) Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, **181**, 158–162.

Hacker Hughes, J. G. H., Campion, B., Cameron, F., et al (2006) Psychological morbidity in soldiers following an emergency operational deployment. *Military Psychology*, in press.