Chapter 1

COMBAT AND OPERATIONAL BEHAVIORAL HEALTH: AN UPDATE TO AN OLD HISTORY

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INTRODUCTION

In the years since the attacks of September 11, 2001 (also known simply as "9/11"), the United States has been at war in both Iraq and Afghanistan, and has responded to myriad natural disasters and terrorist incidents. Although all wars produce stress casualties, during and after different wars these casualties have manifested in many ways, both with physical and psychological symptoms. With the notable exceptions of the data collected by the Walter Reed Institute of Research and the Mental Health Assessment Teams (to be described later in this volume), only a few articles have begun to appear in the literature about the behavioral health lessons learned during the conflicts in Afghanistan and Iraq. A plethora of practical information is not yet in the scientific literature. This volume seeks to consolidate, in real time, the information that is emerging, both to guide current policy and practice, and for the future.

Lessons learned include areas such as: (*a*) management of behavioral health issues on the battlefront; (*b*) care of the physical and psychological needs of the wounded; (*c*) reintegration of soldiers with their families; (*d*) return of soldiers with psychological symptoms to the battlefield; (*e*) deployment of troops into humanitarian and disaster situations, such as the 2004 tsunami and Hurricane Katrina in 2005; and (*f*) the special needs of children of service members, including the families of the wounded and deceased.

The disaster literature, which draws heavily on the combat literature, tends to focus on a single traumatic event. War is related to, but different from, disasters. It may start as unexpectedly as disasters do, but then persist for years. Unlike victims of disaster, service members are generally prepared for battle. They may or may not, however, be prepared for the sights, sounds, and smells of starving populations as seen in Somalia or mass graves, such as in Bosnia.

BEHAVIORAL HEALTH CHALLENGES FOR THE US MILITARY

The military has extensive mental health capabilities. Yet these capabilities sometimes fail to meet significant needs that emerge from recent deployments. These include service members home on leave brought to a civilian emergency room by a concerned family member; demobilized National Guard and reservists who may be remote from a military treatment facility or Veterans Affairs (VA) facility; and family members distraught over the frequent deployments of their soldier kin.

A recurrent issue is that of stigma and barriers to care. Numerous programs, which will be described in this volume, exist to encourage military personnel to seek help. But there are also considerable potential consequences of seeking mental healthcare. These include: leadership ignorance of psychological issues; the requirement to report to command if a soldier enrolls in the Alcohol and Substance Abuse Program; security clearances; and other potential impacts on the soldier's career. All of these issues are currently being addressed by the leadership.

Suicides are highly publicized, but they do not necessarily represent the status of the mental health of the force. US forces are all screened, employed, and have access to free healthcare—all factors that reduce the incidence of suicide. The Army continues to strive to reduce these rates further. However, the rate of suicide in the Army has continued to rise every year since 2004. The rate has just surpassed that in the civilian world, where age- and gender-adjusted rates are about 20/100,000/year. The US Army's suicide prevention training has been revised to reflect the motivations of soldiers who kill themselves. Suicide prevention, therefore, is a topic of enormous significance to the Army.

Over the next few years, based on historical data, many service members will leave the Army or other military services. Traditionally, about 10% of former soldiers who seek care do so through the VA. At the present time (late 2009), about 40% of former soldiers who seek care are using the VA. Most of the rest obtain it through standard civilian healthcare sources. Thus it is critically important that civilian providers know about the psychological issues facing soldiers and families.

The signature weapon of today' wars, both in Iraq and Afghanistan, is the blast. The clinicians' experience of caring for victims of these weapons is the result of years of technological, medical, and psychiatric advancements. But the history of military psychiatry is replete with attempts to answer many questions similar to the ones that the US military now faces. Military psychiatrists have only intermittently succeeded in capturing those historical lessons learned for contemporary application.

Many questions remain. How can the responses of military and civilian mental health systems be optimized? What has been learned about mental health risks facing today's soldiers and their families? How can practitioners engage returning soldiers, and what

are likely pitfalls they may encounter? These dilemmas apply to all services, but the Army and Marines have been most heavily involved in the ground conflict and therefore constitute the focus of the text.

HISTORY OF THE PSYCHIATRY VOLUMES OF THE TEXTBOOKS OF MILITARY MEDICINE

As the American military engaged in the armed conflicts of the 19th and 20th centuries, its mental health officers fought parallel battles treating service members' psychiatric wounds. Like battlefield commanders learning from past successes and failures, these pioneering clinicians developed potent strategies in the war against mental illness. For decades, however, despite numerous therapeutic advances, only a small number published their findings, leaving invaluable lessons vulnerable to the passage of time.

The disparate preservation and distribution of these "lessons learned" hindered future generations of mental health clinicians from acquiring crucial lessons on war psychiatry. For example, the World War II psychiatrist Frederick Hanson had to rediscover the principles of forward treatment of combat stress casualties in the midst of the North African campaign even though Thomas Salmon had established their effectiveness 25 years earlier during World War I.[1,2] Likewise, in the opening months of the Korean conflict, US Army physicians, unaware of the benefit of quickly treating combat stress cases close to their units, evacuated nearly one quarter of the fighting force as psychological casualties.[3] Fortunately, Colonel Albert Glass, well-versed in the practice of combat psychiatry in the course of his World War II tour under Hanson, sharply reduced combat stress casualties by implementing principles now known as "PIES," or proximity, immediacy, expectancy, and simplicity.

It was not until 20 years after the conclusion of World War II that the preeminent Army psychiatrists of the day, led by Colonel Glass, compiled the key behavioral health lessons of the campaign. The first volume of *Neuropsychiatry in World War II* appeared in print in 1966[4] and the second in 1973.[5] These two volumes became the foundation of modern combat psychiatry. Although valuable for their historical preservation of the failures and ultimate successes of psychiatry in World War II, the delay in publication prevented two decades of clinicians from applying their messages. In addition, the volumes could not account for the sizable cultural shifts of the 1960s, which would heavily influence the presentation of combat stress in the Vietnam War.

The Vietnam War and its social aftermath further demonstrated the effectiveness of forward treatment of combat stress and introduced new principles, such as the etiology and management of disorders of frustration and loneliness.[6,7] At the conclusion of the Vietnam era, these essential tenets, hard won through decades of painful experience, were preserved only as an oral tradition and in scattered literary sources.

Even before the end of the Vietnam War, several luminaries of the military psychiatric community realized that a comprehensively compiled, refined, and codified source of military psychiatric experience from this era was required to preserve the accumulated data and perpetuate its application in future conflicts. Lieutenant Colonel Kenneth Artiss took an interest in producing an inclusive textbook but left military service in 1964. Even before the beginning of the Vietnam War, Colonel Franklin Del Jones emerged as the lead editor of the daunting project.[8,9] Jones, one of the few career military psychiatrists who had completed a tour in Vietnam, also distinguished himself as a pragmatic clinician, expert pharmacotherapist, knowledgeable military historian, and master teacher.

Jones, a humble, soft-spoken Texan, had been mentored by Albert Glass, well-known throughout the military for his implementation of the forward treatment of combat stress casualties in Korea. Jones also shared Glass' steadfast commitment to preserve and develop the psychiatric lessons learned in past armed conflicts.[9] Throughout his Army career, Jones had held numerous prominent clinical, academic, and administrative positions such as Director of Psychiatric Education at Walter Reed Army Medical Center and the Consultant to the Surgeon General, US Army, but his greatest passion remained writing. As the leader of the textbook project, Jones invited authors from all armed services, multiple backgrounds, and various disciplines, but imbued the work with his own belief that practical experience takes precedence over speculation and theory. Jones retired from active military service in 1988 with the rank of colonel. He battled a severe autoimmune disorder, but nonetheless poured himself into the textbook project by personally authoring or coauthoring 18 of the 38 chapters, and researching and editing the remaining 20. During the first Gulf War (Operations Desert Shield and Desert Storm, 1990–1991), Jones provided bound copies of relevant draft chapters to the psychiatry consultants for the Army, Navy, and Air Force. These consultants, in turn, distributed these to psychiatrists throughout the theater of operations to enable them to use the lessons learned from previous wars in this rapidly evolving conflict. Through collaboration with the

Borden Institute, the endeavor blossomed into two volumes, one published in 1994 (*Military Psychiatry: Preparing in Peace for War*[2]) and the other in 1995 (*War Psychiatry*[10]) in the *Textbooks of Military Medicine* series. Jones died in 2005, remembered as an epic contributor in the annals of military psychiatry.

With the publication of *Military Psychiatry* and *War Psychiatry*, members of the military mental health community could for the first time quickly reference a central repository of military-specific psychiatric knowledge from Napoleonic times through the Persian Gulf War. Faculty at the Army's teaching hospitals integrated the texts into the curriculum for psychiatric residents and distributed them to psychologists, social workers, chaplains, and even to the US Army War College, which educates the Army's most promising combat arms leaders. Behavioral health clinicians based much of their intervention at the Pentagon on September 11, 2001, on the principles of forward treatment.[8,11] Perhaps most significantly, the generation of mental heath officers deployed as part of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) avoided mistakes made by their predecessors in the opening stages of previous wars. Instead, they rapidly adapted and implemented time-tested psychiatric treatment of US military fighters.

Lessons found within the volumes can guide contemporary mental health leaders as they set policies that improve on those of the past. The importance of an efficient transition of care for soldiers from active duty to the VA system is highlighted by the difficulties in the post-Vietnam era. The clinical presentation of posttraumatic stress disorder (PTSD) in OIF and OEF soldiers is presaged by Jones' description of the evolution of the syndrome from World War I through the Vietnam War. Post–World-War-II lessons depict the benefit of systematic emphasis on education and rehabilitation in recovery from PTSD. The textbooks present historical insights into many contemporary mental health issues.

Military Psychiatry and *War Psychiatry* spurred further useful debate about military and combat psychiatry. Since their publication in the mid-1990s, clinicians, researchers, and administrators have made countless advances integrating surveillance, education, treatment, and new neurobiological research, and adapting their practice to the post-9/11 world. These advances will be described further in this volume.

Today's military mission also differs greatly from that of Jones' era. Combat doctrine now emphasizes modular forces engaging in asymmetric wars involving multiple deployments, intense urban warfare, and without clearly defined front lines. An expanding body of research and clinical experience is illuminating the psychiatric impact of these new and demanding missions on service members and their families. Inspired by the Jones' texts, the military mental health community continues on a historically informed journey of debate and documentation.

SUMMARY

Although it has only been 15 years since the publication of Jones' two volumes on military psychiatry, a contemporary literary resource that encapsulates military behavioral health knowledge and experience has been overdue. Inspired by Doctors Glass, Jones, Artiss, and many others, this newest version of the behavioral health volumes of the *Textbooks of Military Medicine* provides clinicians with an indispensable weapon in the battle against the psychiatric illnesses that affect the men and women in uniform and their families.

There has been considerable discussion about the title of this book, which will be briefly summarized here. Early on, it was clear that "psychiatry" was too discipline specific. However, the question was what to replace it with. The Army has shifted from "mental health" to "behavioral health." The Department of Defense is beginning to use "psychological health." Some like the term "behavioral medicine"; other dislike the apparent emphasis on disease.

Parallel discussions ensued about whether to use the term "military" or "uniformed," as the Public Health Service plays a central role in responding to disasters. "Combat" describes the wars, but also leaves out the responses to natural disasters. Thus the title, "Combat and Operational Behavioral Health," was chosen to cast the widest net possible.

There are some caveats. Inevitably, this is not the whole story. In the 4 years it has taken to produce the book, there have been multiple new efforts. Rather than hold off publication to have time to judge their effectiveness, they are simply mentioned in the conclusion. Although there has been an effort to include as many sources and military services as possible, many practitioners are too busy during these times to write. In addition, new lessons are learned all the time. There are two first-person accounts, which are included as appendices, as they are more first-person accounts than scholarly chapters. However, their stories add to the depth of understanding of what it is like to be a practitioner in an immature and dangerous theater. There is also an account of media coverage of soldiers' behavioral health in Iraq during Operation

Iraqi Freedom 05-07, which is included as the third appendix. Finally it is hoped that this volume is a valuable addition to the literature, and a timely guide for practitioners and leaders.

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