

Chapter 11

EDUCATING MENTAL HEALTH WORKERS

RONALD J. KOSHES, M.D.,* JOHN M. PLEWES, M.D.,† BRIAN G. McCAUGHEY, D.O.,‡ AND JAMES STOKES, M.D.§

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*Medical Director, Adult Services Administration, Commission on Mental Health Services, Department of Human Services, District of Columbia, Washington 20032; Guest Scientist, Department of Military Psychiatry, Walter Reed Army Institute of Research, Washington, D.C.; Clinical Assistant Professor of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland; President, Society of American Military Psychiatrists

†Lieutenant Colonel, Medical Corps, U.S. Army; Chief, Department of Psychiatry, Fort Bragg, North Carolina, and Clinical Assistant Professor of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland 20889-4799

‡Captain (ret), Medical Corps, U.S. Navy; Naval Health Sciences Education and Training Command, and Assistant Professor of Military Medicine and Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland 20889-4799

§Colonel, Medical Corps, U.S. Army; Chief, Psychiatry and Neurology Branch, Behavioral Sciences Division, Academy of Health Sciences, Fort Sam Houston, Texas 78234-6133

INTRODUCTION

Mental health workers play a unique role in military organizations. They work with families, military units, individual soldiers, sailors, and airmen to promote cohesive working and family relationships, improve morale, and maximize unit effectiveness. They also provide direct services to individuals with psychiatric or emotional problems. Finally, mental health workers consult with leaders about effective strategies to support military units during war and peace. In these varied roles, military mental health workers focus especially on occupational health.

Military and civilian mental health professionals differ in many respects. For one, the arena of practice is different. Military mental health professionals must not only aggressively intervene with units and individuals during war but also provide a greater focus on families, assist in stress reduction within units, raise morale issues, and explore other preventive mental health concerns during peacetime. Civilian practice provides few models for military mental health workers. The calmness of garrison life may be interrupted at any time by a national emergency, requiring mobilization of individual units or entire armies that must face dangerous missions and uncertain futures. Mental health workers are often part of the mobilization and share the same risks and uncertainties of their client population. In addition, practitioners of various disciplines are required to work together within the military rank system. Mental health professionals, although experts in their field, often work under the jurisdiction of higher ranking officers in command of the fighting forces.

Stress is inevitable in combat and often decides success or failure. This recognition makes the military mental health provider unique from his civilian counterpart. Training, therefore, must reflect this difference in preparation for battle.¹ To improve training of psychiatrists to work with infantry commanders, Lee devised a course for psychiatry residents to participate in the activities of light combat infantry battalions at Fort Ord, California.² The first residents in the course (Leamon and Sutton) found that familiarity with the mission of the units helped them in providing effective psychiatric interventions.² The equally impressive finding was that all three battalion commanders involved in the project expressed "enthusiastic support" for the

program and requested that their units remain involved in the subsequent years. That program has not continued, but a conceptually similar program has been sustained at Schofield Barracks, Hawaii.

Although these special courses are novel and important, they are often carried forward by the enthusiasm and drive of their originators. The military unit consultation training must compete for time with other parts of the psychiatric curriculum that are required for accreditation of the residency program. The training may lapse unless other faculty members support it actively.

New army doctrine has been written that requires the intimate involvement of mental health personnel in the work of units. The Army Medical Department operational concept for combat stress control (CSC) and Field Manual 8-51³ specify that each maneuver brigade in a division needs a dedicated brigade CSC team consisting of one mental health officer and one behavioral science noncommissioned officer (NCO) from the division mental health section. Before combat, the brigade CSC team must be proficient in field and survival skills and knowledgeable about combat stress reactions and general mental health issues. The CSC personnel must know the equipment and mission of the supported units. They must interact with and teach all of the brigade's leaders, chaplains, and medical personnel to enhance combat performance and control stressors. The officer-NCO team from the division mental health section must be trusted as a cohesive part of the brigade and participate early in all operational planning.

If the mental health section officers and NCOs are to accomplish these requirements, they cannot remain in a clinic. They must go out and meet the unit leaders and soldiers in their work areas, motor pools, and barracks. They must sometimes take physical training with those units early in the morning. They must meet with the unit's spouses in the family support group meetings. They must live with the units overnight in field exercises. They must ride in the unit's vehicles and go with the soldiers as observers in their lines training and live fire drills. They must practice conducting unit survey interviews (structured small group discussions) to assess unit morale, horizontal and vertical bonding, trust and information flow, and the strengths and shortfalls of leadership. Based on these inter-

views, the CSC teams provide consultation to the unit leaders on how they can capitalize on their units' strengths and fix the shortfalls—being careful to safeguard the confidentiality of the sources.

Ultimately, the brigade CSC teams must deploy with their brigades' rotations to the National Training Center (NTC), Fort Irwin, California; the Joint Readiness Training Center (JRTC), Fort Polk, Louisiana; or the Combat Maneuver Training Center (CMTC), Hohenfels, Germany. These 2- to 3-week exercises have the realism, fast pace, and high stress provided by a highly trained and experienced opposing force (OPFOR) and the Multiple Integrated Laser Engagement System (MILES), which tells when each vehicle or soldier has been hit by enemy (or friendly) "fire." These exercises provide sufficient real-world fatigue and stress (including, sometimes, fatal training accidents) for the CSC teams to practice their real-world combat consultation and treatment missions under tactical conditions. Full involvement of the division mental health sections in these exercises must become standing operating procedure.

With this preparatory training accomplished, the mission of the mental health workers can be focused with specific emphasis on combat readiness. The following standards must be part of the working agenda for combat: provide far-forward triage and intervention to immediately return to duty over 50% of battle fatigue cases and prevent misconduct as a result of combat stress; supervise recovery of the battle fatigue cases with rest, nutrition, and expectancy of return to duty in their own units; supervise restoration or referral of battle fatigue casualties at the forward support medical company to assure 70 to 85% return to duty within 3 days; assure that recovered battle fatigue casualties are returned quickly to their units and keep relapse below 15%; assist units who have lost soldiers to battle fatigue in reconstitution to rapidly restore combat power; supervise or conduct unit after-action stress debriefings to prevent disabling post-traumatic stress disorder in effective soldiers; and serve as point of contact for other medical personnel assigned to the CSC teams from the echelon above division who will reinforce the brigades.

The army's new active and reserve component medical CSC detachments and companies, at the echelon above division, should also coordinate to send teams to reinforce the exercises at the NTC, JRTC, and CMTC (as well as to lesser field training exercises at the division and brigade posts). These units are discussed in the second part of this chap-

ter. The air force's four-person combat stress units from the 50-bed air transportable hospitals could also receive excellent training at the JRTC; they could work at the Fort Polk airfield, which serves as the entry point into the exercise. Navy mental health teams might also have the opportunity to work with marine or army units at the JRTC. All services' combat stress teams should be deployed in the major joint field exercises, such as Team Spirit in Korea and Ocean Venture in the Atlantic Command.

In peacetime and military operations other than war, as well as in war, the cohesion, trust, and involvement of mental health personnel with line units (both active and reserve) are important for controlling stress and maintaining readiness in the evolving post-Cold War force. This can only be accomplished by close working relations with those units and their unit families. The driving model must be one of proactive, primary and secondary prevention, conducted on the line unit's own ground, rather than the reactive patient-care model in a clinic or hospital.

One problem with achieving the required capability is that the military and civilian professional training programs do not provide sufficient hands-on experience with the military community and the prevention model. Therefore, most graduates do not overcome their initial hesitancy about trying it. No one likes to feel and appear ignorant or incompetent—especially not physicians or other mental health professionals. The graduates naturally feel more comfortable with, and gravitate to, the familiar direct patient care model in which they have trained. This occurs even when the graduates are assigned to division mental health or CSC unit slots where the community-oriented mission should be the highest priority. Their own natural tendency is reinforced by the pressure of full clinic appointment schedules and the natural desire of short-staffed garrison medical facilities to coopt the unit mental health personnel onto their clinic and oncall rosters. We must give the future practitioners sufficient baseline knowledge and confidence about CSC and preventive unit consultation during training so that they take the first steps toward learning to do by doing.

This chapter examines the unique role of military mental health providers and delineates the process of teaching them the principles of combat psychiatry. The essentials of combat psychiatry, the type of practitioners involved in treating combat victims, and suggested methodologies for teaching combat psychiatric principles are also presented.

ESSENTIALS OF COMBAT PSYCHIATRY

The practice of military mental health is grounded in the principles of community mental health that emphasize primary prevention, group dynamics, healthcare delivery system issues, and individual treatment.^{4,5} Most military mental health professionals are trained in nonmilitary settings where they primarily learn to diagnose and treat individuals. Most military mental health practitioners must augment their training to be effective in a military setting. In the early European mobilizations of World War II, it was evident that while the number of military psychiatrists (most of whom were on-the-job trainees with 90 days of education) was adequate, most did not have the background to prevent what we now call combat exhaustion.⁶ This is because the psychiatrists, most of whom had no prior psychiatric training and had been drafted from civilian practices, were not trained to deal with this problem. Because of this, dysfunctional soldiers were inappropriately evacuated from combat zones to the United States, which decreased unit morale, cohesion, and fighting strength and caused long-term morbidity among these psychiatric patients.^{6,7} Under the leadership of Roy Halloran, William Porter, and William Menninger, programs were established to train on-the-job psychiatrists to triage and treat military psychiatric casualties.⁸

The following sections describe the unique principles of combat psychiatry. Not merely a collection of techniques, the field of combat psychiatry involves the training of the mental health worker as a military professional whose knowledge-base and attitudes reside within the military organizational structure.

Situational Aspects

Anyone who has taken a course in either creative writing or public speaking knows the importance of understanding one's audience. If asked to give a banquet speech, the logical questions are, "Who will be in attendance and what is their level of interest in this subject matter?" Likewise, mental health professionals must know their military organization to be effective. "How large is the unit; what is its mission, location, composition, and recent deployments?" These are just some beginning questions to ask. More sophisticated ones include: What are the demographics of the group? Are most married? Single? Is this the first assignment for most of the members? Where do they come from? What has

been the particular history of the unit throughout its command and leadership? Insight into these particular features of the military organization can make the mental health worker more effective. The process of finding out this information can also promote effective liaison between caregiver and unit personnel.

During the time-consuming process of information gathering, the worker has an opportunity to get to know the people who make up the unit and to learn what their jobs are and the problems they face. A military police unit, for instance, may have frequent, short-term deployments that come unexpectedly and have high visibility within the community. This may predispose them to higher rates of alcoholism or other dysfunctional ways of dealing with stress. This instability will be stressful for their family members. A personnel agency may have a high degree of stress during mobilizations but be bored the rest of the time. This can promote job dissatisfaction and frequent work conflicts.

A failure of the mental health worker to understand the work environment of the personnel he is responsible for can result in distrust and anxiety on the part of the unit. Recommendations concerning management style or retention of personnel may be ignored. As a result, mental health workers may deal more with the frustrations and emergencies of a unit, leaving little time to deal with morale or unit effectiveness.

Mental health workers in the military must also deal with unique administrative issues. They must be familiar with key regulations⁹⁻¹¹ to be able to effectively provide militarily unique services, such as forensic evaluations, clearances for specialty schools, or how to initiate the removal of commanders from their positions because of alcohol or drug abuse or psychiatric illness.

Understanding the importance of what constitutes good military leadership is crucial to the work of the mental health worker. While many for-profit, civilian organizations emphasize individual and central responsibilities to increase productivity, a military organization needs cooperation among its members for it to function properly. Effective military leaders understand this principle. During peacetime as well as during conflict, effective communication among members of the unit is paramount. The training and relationship building that occurs during peacetime within the unit prepares that organization for rapid assumption of its mission dur-

ing armed conflict or mobilization. Mental health workers can help leaders to maximize cooperation among their personnel and consequently improve productivity.

An understanding of leadership also allows the head of a mental health team to deliver services more efficiently to the unit. For all military organizations, strict adherence to the chain of command, as well as obedience to leadership, is essential for the morale and effectiveness of that organization. Mental health workers cannot act as individual parties in the treatment of patients, but they must recognize the responsibilities and authority of the unit's commander and be able to work effectively with him. In this way, the mental health worker functions as a consultant.

Individual/Role Aspects

Mental health workers often function as liaisons to units and advisors to commanders, in addition to being individual caregivers. The mental health worker must be knowledgeable of the principles of primary prevention and community psychiatry, including the importance of stress reduction techniques, as well as the importance of family and other support structures available at the base or post. Often, a mental health worker can learn a great deal about the functioning of the unit by reading police reports, knowing the number of referrals for alcohol and drug treatment, and learning about disciplinary actions. At training sites, the pass rate of a particular unit may reflect not only the difficulty of the subject matter but the general morale of the group.

During combat, the liaison role is especially important and onsite presence of the mental health worker is essential. Contrary to most civilian mental health practices, military workers have an onsite mission, and they must be proactive; they should not wait for patients to come to them. These principles have been most clearly articulated in contemporary community psychiatry doctrine¹² that applies to working with chronic mental illness in the community, as well as the management of disaster victims that requires an onsite intervention approach. A mental health worker must give up his office for the onsite field environment.

Mental health workers can be troubled by their own anxieties and frustrations during combat. The leader of the mental health team is responsible for the morale of his workers and must emphasize the need for debriefing, rotations, rest time, and proper

medical and nutritional support during these periods. Mental health workers are at risk for burnout; they must monitor themselves for signs and symptoms of decreased effectiveness and personal stress.

Perhaps the most difficult of the mental health worker's roles is being a command adviser. Commanders may excessively depend on the advice that is given by mental health workers, placing unrealistic demands and expectations on them, and thereby abdicating their own responsibility as leaders. Another possibility is that mental health workers may be branded as causing the problem rather than contributing to the solution. In the case of military trainees, a rising number of suicide attempts was blamed on the presence of a mental health worker operating on the training post. Only after discussion with commanders were a variety of environmental stresses identified as the actual causes of the increased suicide attempts, namely a war mobilization, incapacity of several drill sergeants due to alcohol and drug problems, unrealistic expectations of soldiers during the war effort, and an increased training mission and increased standards for training.¹³

In much the same way that a unit's commander and executive staff may depend on a mental health worker, so too can command actions and decisions be delayed until the counsel of the worker is obtained. While in many instances information provided by the workers may directly impact command decisions, some military leaders may excuse their own inability to make decisions based on "expert advice" from mental health workers. Specific aspects of this point are well documented by Bion in his work with leaderless groups during the 1950s.¹⁴⁻²¹ He found that in a leaderless situation, group members can become dependent on each other, suspicious and distrustful, or apathetic. Bion's thesis was that in the work group, certain basic assumptions such as dependency, paranoia, and expectancy decrease the efficiency and effectiveness of the group.

Mental health workers may be the first to identify dysfunctional groups. There are several examples. In dependency groups, commanders will make decisions that can be made by the first sergeants or other operational personnel. A "fight or flight" group may have members that are so competitive that they are paranoid. A "pairing group," or one that is incompetent without a leader, will push off decisions until a commander returns from vacation or temporary duty, thereby paralyzing any work progress within that group. An essential element in

all these situations is that the group leader's anxiety will determine how effective the unit can be. The mental health worker may be chiefly responsible for relieving the leader's anxiety through whatever means are available.

Educational Principles

The principles of immediacy, proximity, and expectancy in managing combat stress casualties deserve another airing. Removing an individual from stress is the goal of modern psychiatric hospitalization. In contrast, during combat, rest and return of the individual to his military unit have been shown to decrease long-term psychiatric morbidity, improve morale, and promote unit cohesiveness and effectiveness.²²⁻²⁵

There are important differences in the kinds of casualties that occur during various types of combat. High-intensity conflict, in which there is either a rapidly mobile land force or a static battlefield, tends to produce combat exhaustion characterized by anxiety and confusion disorders. Low-intensity garrison warfare can produce "nostalgic" types of combat reactions that include alcohol and drug abuse, depression, and suicide. The mental health worker needs to be

aware of the variety of stress responses that result from the different types of combat.²⁶⁻²⁸

Command consultation is another essential principle of combat psychiatry. The process of getting to know a unit and providing effective consultation involves a slow, steady progression of meetings, often held weekly with key leaders in a military unit, to discuss the needs of those leaders. Just as medical consultants would behave improperly if they took over complete care of a consultee's patient, it would also be inappropriate if the mental health worker attempted to gain control of the unit. Mental health workers, although they possess unique professional abilities, must be replaceable at any time during the life of a unit. A unit cannot grow too dependent on the worker, nor can the worker see the unit as his command. Specific techniques to be used in command consultation include involving the chain of command in any presentation made to the organization, deferring to the authority of the command structure in any decision regarding personnel retention or separation, allowing commanders to initiate requests for consultation, being available as consultant on a regular or predictable basis, responding aggressively and appropriately to a commander's request for help, and providing feedback to commanders on referrals or treatment of an individual unit member as needed.

SPECIFIC AUDIENCES

The education of mental health personnel occurs in a variety of settings and utilizes many techniques. This section will describe the specific audiences for which training in combat psychiatry is necessary.

The most often neglected individual who needs to be properly educated to maintain the mental health of a unit is the individual soldier, sailor, or airman. Several pamphlets have been produced that emphasize the need for the "buddy system" in promoting unit morale and cohesiveness. Simply put, each soldier should look for dysfunction in his comrades. Isolation, decreasing attention paid to uniform cleanliness and personal hygiene, and insubordination may indicate that a problem exists. Unit members may often be the first ones a troubled soldier turns to, and education of all unit members about the importance of referring him to appropriate personnel within the command is essential.

Medics, those enlisted personnel who function mostly as licensed practical nurses, medical techni-

cians, and orderlies, are also part of the military mental health team. While these medics are not always practicing in the field of mental health, it is important that they understand the basics of psychiatric triage. Important concepts for them to learn are the difference between neurotic and psychotic behavior, the characteristics of psychiatric illness that can masquerade as physical illness, management of anxiety, management of suicide, management of combat stress reactions, and substance abuse disorders. For the most part, the medics who specialize in mental health will learn how to work with patients in their first assignment while under the supervision of a psychiatrist or social worker.

Psychologists and social work officers work closely with psychiatrists in the care of emotionally disturbed patients. Although these individuals may be credentialed to provide unsupervised care, the care of patients on medications and those who require hospitalization must be supervised by a physician. The psychologist and social worker should

have a working knowledge of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM), be able to conduct a comprehensive interview of a patient, make a provisional diagnosis, and develop a diagnostic or treatment plan. By the nature of their education and training, the psychologists and social workers will have an advanced academic degree in the field of mental health.

Medical students are often challenged by learning psychiatry. For a military medical student population, introducing the concepts of battlefield management of combat stress reactions is crucial. Participating in field exercises that realistically include battle fatigue cases and cases that mimic battle fatigue will prepare the practicing physician to make cogent and useful referrals to his psychiatric colleague. A model program for the education of medical students is described in the next section.

Nonpsychiatric physicians are the usual source of referrals for psychiatrists, and they may be the first physician practitioners to come in contact with

combat stress casualties. Educating these professionals must be an ongoing enterprise.

Psychiatric residents can learn about combat psychiatry by first learning how a military unit functions. Electives should focus on field placement of residents for a realistic experience in the practice of military mental health. In the next section, a model for the education of psychiatric residents is proposed. Residency is also an opportune time to teach the techniques of psychiatric debriefing, a process by which survivors of trauma or combat begin a reintegration into their communities and units.²⁹

Nursing staff have the most contact with patients when hospitalized, and during combat this contact is probably increased. Military nurses in all areas of specialty should be taught how to recognize and treat combat stress reactions. Part of any military nursing continuing education conference should include update, review, and latest techniques for managing these disorders.

METHODS OF TEACHING

The following section describes three programs designed to educate military personnel in the field of combat psychiatry. The first is primarily aimed at medical students, the second is for psychiatric residents, and the third is a field exercise that tests the overall medical and mental health capabilities of a medical unit. While these programs are far from ideal, we feel these are the best educational models tested to date.

Medical Students

A course for medical students concerning the practice of medicine during combat was designed by McCaughey at the Uniformed Services University of the Health Sciences. A basic concept about the course is that there is a stepwise approach to the training.^{30,31} Exhibit 11-1 is a comprehensive description of this course that gives students the ability to learn basic concepts, practice them, and make evaluation and management decisions under simulated wartime conditions.

Some institutions may not be able to adapt all aspects of this course because of their limited capabilities. For instance, it may not be possible to get all of the equipment that is necessary to conduct certain parts of this course in the field. But this should not prevent the faculty from doing the best that can

be done. Even with a very limited amount of equipment, a worthwhile field exercise can still be conducted.

The planning faculty includes a course director and several other faculty members who can act as advisers to help develop and revise the course as needed. They should be motivated to teach and be knowledgeable about battle fatigue or be willing to learn. Initially, they need to meet to establish the goals and objectives of the battle fatigue course and decide how it is going to be taught in their institutional setting. Later, they should meet periodically to look for ways to implement improvements.

The teaching faculty conducts the teaching. Training them properly is critical to the success of the course. This group will present the lecture and conduct the case discussions groups and testing in the classroom and the field. Like the planners, they should have an interest and ability to teach and should be knowledgeable about battle fatigue. This group may include members of the planning faculty. This course was originally designed to teach medical students, but if modified, it could be used to teach other groups.^{30,31}

If others are to be included, the next step is to identify the students and construct a course that will fit their background, needs, and interests. The course can be basic and still benefit a group with

EXHIBIT 11-1

PSYCHIATRY TRAINING COURSE

Phase One: Providing Information

Information should be provided in three forms: handout, lecture, and videotape presentation.

1. *Handout.* The handout should include information about battle fatigue and how the course will be conducted. Information about battle fatigue should include published articles from various perspectives, one of which is historical. It is important to convey to the students that battle fatigue is not just a recent problem but that it has been around as long as wars themselves. There should be case examples from the American Civil War, Russo-Japanese War, World Wars I and II, the Korean and Vietnam conflicts, and the Arab-Israeli wars. The various names that have been given to designate battle fatigue (nostalgia, shell shock, and so forth) and how it was managed for each of these wars should be included. Other topics should include how to deal with battle fatigue management and prevention today and the application of battle fatigue management principles in other settings, such as civilian disasters.

The handout should be distributed well in advance of the course so that the students have enough time to read the background material. Any additional instructions, such as the name and telephone number of a person to contact if there are questions, should also be included with the handout.

2. *Lecture.* The lecture should include the following topics: types of battlefield stressors and the reactions of service personnel to these stressors; description of battle fatigue and its extremely variable presentations; physical and psychological symptoms associated with battle fatigue; a sample case; theories about the cause of battle fatigue; battle fatigue epidemiology; importance of battle fatigue to the serviceman, combat unit, and medical facilities; a list of the groups of medical personnel that need to be informed about battle fatigue; management of battle fatigue; prevention; and uses of the battle fatigue management principles in the peacetime setting.
3. *Videotape presentation.* The videotape presentation is given immediately following the lecture. It should show various types of actual battle fatigue casualties. After each case is shown, the presenter should stop the tape and discuss the case

with the students. A suitable videotape, edited from a World War II documentary black and white film, is entitled *World War II U.S. Army Battle Fatigue Cases—Combat Exhaustion* (A1701-90-0059). It is available from the Army Medical Department Center and School for restricted use in training military and medical and mental health workers.

Phase Two: Practicing

The students use the information they have learned about battle fatigue in the following settings: pretest, case discussion groups, and the classroom testing.

1. *Pretest.* The pretest is taken after the lecture and graded by the students. It is then discussed in a classroom setting.
2. *Case discussion groups.* Five to seven students meet with a mental health professional for about 2 hours. Individual cases, found in the handout, are discussed. The focus is on the identification of battle fatigue, differentiation of battle fatigue from other problems, management, and returning to duty. Students, in pairs, also practice interviewing skills by having one student conduct the interview while the other one plays the role of a battle fatigue casualty. The rest of the group has the opportunity to observe the interview and participate in the critique.
3. *Classroom testing.* Just before going on to the field exercise, the students are tested in a classroom setting. This is a pass-fail test whose purpose is to see if the students have gained the basic skills and knowledge they need to effectively evaluate and manage battle fatigue cases. The students are tested in pairs. They alternate roles as an interviewing physician or a battle fatigue casualty while a faculty member evaluates the interaction. The faculty member also asks general questions about battle fatigue. If the students demonstrate that they have minimal competence, they can go to the next phase.

Phase Three: Testing

There are two parts for the testing: written test in the classroom and practical testing of simulated battle fatigue casualties in the field.

EXHIBIT 11-1 (continued)

PSYCHIATRY TRAINING COURSE

1. *Written test.* The test includes material from the lecture, reading material, videotapes, and the case discussion groups.
2. *Testing in field under simulated wartime conditions.* A field exercise is the last part of the training program. The students are evaluated on their ability to evaluate and manage simulated battle fatigue cases. If possible, this should be part of a larger field medical exercise that includes a variety of other surgical and medical problems to add to the realism.

Simulated battle fatigue casualties are trained before the field operation starts. They are introduced into the medical care system and, through triage, are sent to a combat stress center that is manned by

students who are supervised by faculty. The interview of the battle fatigue casualty is observed by a faculty member. After this, the faculty member meets with the student to discuss the case and ask general questions about battle fatigue. The student is evaluated on the following points: orienting the casualty to the interview, identifying the reason for referral, conducting past history and mental status examinations (adapted for the battle fatigue situation), formulating the problem (diagnosis and differential diagnosis), developing the intervention, ability to elicit information, and general knowledge about battle fatigue and leadership. Students should be evaluated individually and feedback given at the end of their rotation at the combat stress center.

mixed backgrounds, such as one that includes physicians, nurses, physician assistants, corpsmen, medical service personnel, and so forth. Alternatively, the course can be designed for specialized groups, such as just psychiatrists, just psychiatric residents, or any one of the other groups mentioned above.

All courses, no matter who the audience is, should use a phased approach, in which each phase prepares the students for the next phase. The first phase provides information through reading material (handout), lectures, and videotapes. In the next phase, the students practice the use of battle fatigue identification and management techniques using the information they have learned. The last phase is testing, which occurs in the classroom and in the field.

The students should be given the opportunity to provide feedback about the course. This feedback is best done at the end of the course. Forms with open-ended questions and or scales that indicate how well teaching objectives were met can be used. The feedback should be submitted anonymously. Changes to the course should be based on the faculty's observations and the student feedback.

Psychiatric Residents

The following is a model for a residency elective in community psychiatry. The goals of the elective are to attain the skills necessary to function as a military psychiatrist, especially during combat, and

TABLE 11-1

ELECTIVE IN COMMUNITY AND MILITARY PSYCHIATRY

Component	Comments
Course Directors	Insert names of individuals who will be responsible for the training; one a member of the medical center faculty, the other the onsite director.
Place	Provide the exact location of facility.
Duration	This will usually be 2 weeks to 2 months depending on extent of material covered.
Participants	Will be selected from appropriate level psychiatry residents.
Housing	Arranged by the onsite director.
Cost	Per diem costs and transportation expenses will be covered.
Rationale	While military psychiatrists function in a variety of settings (divisions, research, and hospitals), most graduating residents are assigned to community hospital/clinic settings. This training prepares them for their initial practice experience.

to develop strong collegial relationships with commanders and other unit personnel. Tables 11–1 and 11–2 are examples of a proposal that could be developed for this elective, along with a discussion of the aspects of the field setting.

Field Training Exercises

The U.S. Army usually conducts one large-scale medical field exercise each summer except when world events such as the Persian Gulf War or budget limitations have taken precedence. Since 1984, these field training exercises (FTXs) have rotated among several medical brigades (headquarters units). Each of these FTXs has involved between 3,000 and 9,000 medical troops. The medical brigade headquarters commands two or three medical group headquarters. Each medical group controls two to four hospitals (usually evacuation hospitals, combat support hospitals, and mobile

army surgical hospitals). The hospitals do not come at full strength and usually are staffed for 50 to 100 medical and surgical beds.^{32–38}

Each medical group headquarters also usually controls one or more medical clearing companies (with 50 to 100 of its 250 patient cots). The medical battalion, or an evacuation battalion headquarters, also controls several helicopter and ground ambulance companies and detachments.^{32–38}

Additional medical and surgical specialty detachments augment the hospitals. Preventive medicine, dental, and veterinary detachments are assigned to the medical brigade or the medical groups to provide area support. Simulated and actual medical supply and logistics for the many medical units are provided as they would be in a combat zone by medical supply units.

In all of these FTXs between 1984 and 1992, there has been at least one U.S. Army Reserve “OM team”

TABLE 11–2
ASPECTS OF THE FIELD SETTING

Component	Comments
Background	Describe the training site and its unique features.
Elective Experience	Residents working under the chief of psychiatry will experience all levels of patient care to include consultation-liaison, outpatient and inpatient evaluations and treatment, supervision of social workers, psychiatric technicians, and the psychologists. Emphasis will be placed on providing the resident with an opportunity to observe and participate in the operation of a full-scale, multiservice psychiatric practice, as well as interact with crucial hospital personnel supporting that practice. The resident will attend the usual departmental meetings, as well as hospital governance boards, and meet with officers in logistics, administration, resource management division, and clinical support. A major feature of this field elective will be command consultations and unit visits. This will be accomplished under the auspices of the community mental health service. If timely, the resident can participate in the post’s chief of staff briefings.
Patient Population	The profile of the patient population should be described here.
Supervision and Evaluation	All patient care supervision will be provided by the chief of the department of psychiatry. A meeting of all practitioners in the department will be scheduled at the end of the resident’s stay to gather performance data. The final rating of the resident will be done by the chief, department of psychiatry, and returned to the training director at the medical center in a timely fashion. Additionally, the resident will have the opportunity to rate the program as a part of his or her semi-annual evaluations conducted by the medical center staff.
Requirements	The training director at Medical Center X will review this proposal and contact the chief, department of psychiatry, regarding appropriateness for training and seek clarification if needed. The training director and chief, department of psychiatry, at Medical Center X must formally approve the elective and schedule the first resident participant(s).
Time Table	Give time that the program will be operational.
References	Provide pertinent references for the proposal.

(the designation for a psychiatric medical detachment) to fulfill the CSC mission. The OM teams served in the Persian Gulf War but have since converted to the new CSC companies or detachments. An OM team at full strength had 48 persons. It included five psychiatrists, six social workers, two psychiatric nurses, a clinical psychologist, enlisted psychiatric and behavioral sciences specialists, and administrative support personnel. In practice, most OM teams came to these FTXs with between 20 and 35 personnel with only one psychiatrist and no psychologist. They were augmented by volunteers from the other OM teams and by active duty, U.S. Army Reserve, and U.S. Air Force occupational therapists and by occupational therapist enlisted specialists. The occupational therapists were especially eager to demonstrate their field role in promoting return to duty of battle fatigue casualties. The OM teams also had some (but usually not enough) vehicles, tents, and equipment.³²⁻³⁸

One of the best features of these field exercises is the opportunity they provide for individuals or small teams from other organizations to reinforce or fill out the CSC unit that has been programmed into the FTX. The operational concept for CSC calls for the capability to concentrate CSC personnel and expertise rapidly at sites of acute need by having them temporarily reinforce the small CSC teams already near the site. The CSC personnel themselves need to be highly adaptable and able to integrate new team members quickly. Cross-attaching personnel among active duty or reserve CSC units in FTXs practices this critical skill. It has the added benefit of sharing ("cross-fertilizing") practical experience and initiating networking. The FTXs also provide an economical way for mental health interns, residents, and practicing clinicians who are slotted as PROFIS (Professional Filler System) fillers in CSC units to receive high-quality, emotionally positive, field experience.

In most of the FTXs, the OM teams operated according to evolving U.S. Army CSC doctrine. The OM team headquarters were assigned directly to the medical brigade headquarters. The detachment divided into smaller, dispersed teams. Depending on the numbers of each professional discipline and the vehicles available, the CSC unit tried to provide CSC support to one or all of the subordinate medical groups in the medical brigade.

Because these FTXs were played at the level of the medical brigade in support of a corps, the OM(CSC) detachment had as one mission the staffing of a reconditioning center. *Reconditioning* by definition^{3,39,40} is the 4 to 14 day treatment of battle

fatigue casualties who do not return to duty in the first 3 days of restoration treatment. Reconditioning cannot be simulated in real time in a 4 to 5 day FTX. However, the staff can do the admissions workup and then go through the daily schedule of structured activities in "quick time" or "time compression" in which 10 minutes equals 4 or 6 hours.^{3,39,40}

In the FTXs, as in evolving doctrine, the OM(CSC) reconditioning facilities collocated with an evacuation or combat support hospital. They were dependent on the hospital for food, water, fuel, medical records, and often tents and cots. This was as it would be in real combat. The CSC teams must establish duty-sharing arrangements with the host hospital without letting their personnel and equipment be absorbed into that hospital. Absorption would rightly happen to a hospital-augmentation detachment like a neurosurgery team, which becomes an integral part of the hospital, but must not happen to a mobile CSC team. The CSC team uses the hospital as a base of operation but must deploy its teams elsewhere, often on short notice. Even those treatment functions such as restoration and reconditioning must, by doctrine,³ maintain a separate "nonhospital" identity and atmosphere.

Experience has shown that the reconditioning center is best set up in the hospital staff quarters area, near the kitchen and mess hall, laundry, and motor pool. It should not be among the triage or ward tents, and it must maintain a nonpatient, soldiering milieu. The patient role players simulating battle fatigue can be assigned to assist the host hospital with real work details, as well as being fed, showered, rested, and involved in recreational, physical fitness, and group debriefing activities.

In these FTXs, other subteams of the OM detachment were normally deployed to one or more of the medical clearing companies under the medical battalion in the medical groups. These teams usually attached to the medical company for support and remained with it 24 hours a day to triage, evaluate, and provide restoration treatment for locally generated battle fatigue cases (both simulated and "real"). *Restoration*, by definition,^{3,39,40} is the 1- to 3-day initial treatment of battle fatigue soldiers and is best done at the medical treatment or clearing company closest to the soldier's own unit, not at a "hospital." Restoration requires a reasonably sized tent, preferably with cots, dedicated to the recovering battle fatigue casualties.

The CSC teams at the clearing companies also provided actual preventive consultation, education,

and case evaluations to the medical company and all other nearby units. In some FTXs, when there were too few CSC personnel to provide a continuous presence at the medical companies, the CSC team instead provided a regular schedule of circuit-riding. The team spent the night at the OM team headquarters or reconditioning center (base camp) and drove to visit one clearing company in the morning, then on to another each afternoon. The teams were prepared to spend the night at a clearing company as the workload or the tactical situation required. In this situation, the patient-holding sections and medical treatment teams of the clearing company were trained to manage and restore all but the problem cases. The problem cases were evaluated by the CSC team each day, and, if necessary, they were taken back to the reconditioning (and restoration) center by the team as it completed its daily rounds.

The medical FTXs also routinely included non-medical combat support and combat service support units, especially signal battalions and detachments to set up and operate the communications equipment. Some FTXs also had military police companies to provide rear area security and manage enemy prisoners of war. Engineer units may be available to assist with hospital site preparation and personnel replacement elements to coordinate the return to duty of simulated casualties.

At some of these FTXs the U.S. Air Force provides C141 and/or C130 aircraft to conduct simulated air evacuation from the combat zone (taking off with the simulated patients, flying around, and landing nearby so that the patients can be "recycled"). The air force also provides a mobile air staging facility with medical and nursing staff to hold and prepare the patients for the flight. In the future, it may be possible to involve a navy hospital ship in these exercises.⁴¹ Having a hospital ship offshore was considered for Wounded Warrior '92, part of which took place at Camp Pendleton and involved a marine medical battalion working under an army medical group headquarters. However, it was not feasible then because of expense.

A few of the FTXs in California and Mississippi have combined the medical brigade's exercises with the annual training of the states' national guard division or separate brigade. In some instances, the maneuver brigade or division medical companies and organic battalion assets were included in the medical evacuation play.^{33,34,36} On those occasions, the OM team has fulfilled its forward CSC mission by sending mobile teams

forward to reinforce the division and brigade medical companies.

The virtue of such large-scale medical exercises for training in CSC is that the exercises suggest the magnitude and complexity of the real combat mission. The FTXs illustrate the real-world problems of exercising command and control through multiple layers of headquarters, communicating with dispersed teams over other units' overworked and breakdown-prone field switchboards and radio nets,⁴¹ traveling and navigating to find unfamiliar units, and negotiating allocation or loan of scarce resources such as tents, food, water, and vehicle maintenance. All of these problems must be overcome in the combat theater.

The larger FTXs provide actual supported units and audiences for staff briefings, command consultation advice, and preventive educational presentations. They may provide extensive patient play that can include simulated stress and neuropsychiatric cases. Invariably, they also provide actual overstressed soldiers who need individual case evaluation and, when appropriate, onsite treatment. Exercises of this size also always provide one or more true neuropsychiatric cases, usually with a pre-existing disorder, who decompensate and must be evacuated to the supporting hospital system.

The shortfall of these FTXs is that, large as they are, they are still only a small-scale model of a real U.S. Army area of operations. The medical units are not surrounded by the many more nonmedical combat service support units with which they would be aggregated into base defense areas and base defense clusters. The distances between clusters during actual combat would be much greater than can be achieved at some of the posts hosting the FTXs. The rear battle threat may be simulated by OPFOR attacks, but there is little real danger or difficulty when going from unit to unit, which may create a false sense of security. Still, such FTXs are much better preparation for learning to live and function in the field as part of a huge system than are purely individual or small unit training exercises.

The major medical FTX typically has between 300 and 600 personnel assigned to play the simulated casualties. The FTXs generally try to achieve a mixture of simulated surgical wounds and injuries plus nonbattle diseases (including neuropsychiatric disorders), which conforms roughly to the expected incidence in mid- to high-intensity conflict. They may include battle fatigue casualties. Chemical casualties are usually included and nuclear casualties may be included.

Role players who simulate soldiers who have diseases or minor injuries can be briefed quickly at the FTX patient operations center (POC). Role players with simulated surgical wounds must receive extensive make-up (“mouflage”) from a trained mouflage team at the POC. Make-up artists do a remarkable job of mimicking serious and even grossly deforming wounds.

The realism of the mouflage is one of the factors (along with sleep loss, field sights, sounds and smells, and sometimes the sound of actual artillery firing in the distance) that has provoked distressing and even temporarily disabling post-traumatic stress syndrome symptoms in some medical personnel who have had previous combat experience in Vietnam or other conflicts. Such persons may request help themselves or be referred to the CSC teams to help them deal with their memories. Many more may simply “tough it out” and then perhaps decide to leave the army, national guard, or reserves rather than face another painful training exercise. This is one of the reasons why the CSC teams have active and visible outreach programs.

Most of the simulated patients are picked up at the patient mouflage center and taken directly to one of the medical treatment facilities by the helicopter or ground ambulances that are dispatched to transport them. A few patients may be taken by truck to remote field sites, where the ambulances must find them. The patient players in these FTXs may be made up and sent out once, twice, or even three times in a 12-hour shift. The number of times depends on how extensive their make-up is and the prognosis of the injury. Those who can be treated and released quickly, or who are “dead on arrival” or “die” soon after they reach the clearing company, can be returned to the POC by a shuttle service and be recycled quickly. For the role players, the experience can be tiring and uncomfortable. They are covered with make-up and prosthetic rubber or plastic, strapped to a litter, and then transported in the summer heat in a vibrating helicopter or bouncing ground ambulance to one or more medical facilities where they may wait for minutes to hours to be examined. It is a demanding job.

The patient players are often members of another medical unit within the medical brigade’s area (such as a general hospital) that has been tasked to provide “patients” as its part in the FTX. They usually serve as patients for the entire 4 to 5 days of continuous scenario operations. They are “guaranteed” time to eat and sleep, but that guarantee may be disrupted by transportation difficulties or the in-

hospitable field or barracks environment. In other FTXs, the patient players may be borrowed from the participating hospitals and other medical units on a day-by-day basis. When national guard divisions or brigades have been involved in the FTX, some line unit soldiers may be declared casualties and be evacuated through their organic medical platoons and companies to the corps facilities one time only. These soldiers will not have extensive mouflage make-up unless a mouflage team is deployed forward. In some FTXs, there may also be volunteer role players from other organizations, such as the state’s national guard cadet program. These details of where and how the role players are obtained have proved very relevant to the real-world stress control missions of the CSC teams.

A recurrent finding³²⁻³⁸ is that both the role players and the medical units become involved in the scenario portion of the FTX with enthusiasm. However, for the medical units the novelty of realistically mouflaged patients wears off after a while because the triage and surgical teams only pretend to start the intravenous infusions and insert the nasogastric and chest tubes and only get to explain what surgical procedure they would be doing. The triagers, operating room teams, and ward staffs themselves become progressively more sleep deprived, hot, dirty, and uncomfortable. They become increasingly short-tempered with and even negligent toward the role-playing patients. That increases the stress and undermines the motivation of the already uncomfortable patients.

Those role players who have been assigned to serve the full duration of the FTX (and even some of the volunteers) begin to grow weary of the exercise. Some may actually require the attention of mental health workers for the transient exercise fatigue they suffer. They begin to find ways to delay or evade being made up and sent out again. By the last night, a few may even become “combat refusers,” flatly declaring to the POC (or telephoning home tearfully to family) that they will resign from the army if forced to go out again as surgical patients. The result has been that the CSC teams have performed excellent service treating the battle fatigued surgical mouflage players.

Anecdotes from actual exercises help to underscore important points about these experiences. During MEDEX [medical exercise] ‘86 (Camp Shelby, Mississippi, 1986), the OM team elements at the clearing companies established ongoing “ventilation/gripe” sessions for the surgical and medical

role players. These sessions were reported by the role players as being very helpful to them. A memorable moment in the FTX occurred during a brief afternoon thundershower when lightning struck a pine tree that fell and barely missed the tent in which such a session was going on.

During the Dusty Bull FTX (Fort Hood, Texas, 1988),³⁵ the OM team is credited by the 807th Medical Brigade's chief of the patient operations (mouflage) center with "saving" the FTX.⁴² The mouflage role players became very disgruntled by the evening of the fourth day, and the corps surgeon and POC leader consulted the OM team. They immediately implemented the recommendations to call a temporary halt to give all role players food and sleep. Meanwhile, the OM team sent a contingent on night convoy to the POC and, early in the morning, initiated a concentrated schedule of debriefing sessions mixed with entertainment that had the role players ready to continue the FTX soon after sunrise.

Wounded Warrior '92 (Camp Roberts, California, 1992) provided an even more dramatic real-world demonstration of the value of a multidisciplinary, multipurpose stress control team. The 12-person CSC team was composed of a psychiatrist, psychiatric nurses, social workers, and enlisted behavioral and psychiatry specialists from three reserve OM teams. No simulated combat stress casualties were scheduled among the surgical and medical patient play because there was a shortage of patient role players. The "patients" were male and female members of a state cadet organization, aged 11 to 19 years. The cadets had been enlisted initially to play only a 1-day, joint military/civilian disaster medical assistance team earthquake scenario. They had agreed to continue through a 4-day continuous (12-hour shifts) battle casualty scenario. By the first day of the army exercise, it was clear that the cadets' cadre were not able to keep the adolescent cadets sufficiently occupied (on an old army post) while they were offshift. A social worker and two technicians from the CSC team, who had civilian expertise with adolescents, were pulled in from the field to advise and train the cadet cadre, to establish a program of recreational activities, and to maintain order in the barracks' dormitories.

One of the young female cadets became extremely agitated while she was being driven out to the field in an ambulance as a surgical wound case. She had asked to be allowed to use one of the portable latrines and had then perceived the behavior of the male medics as a sexual assault. The cadet reported

this perception by telephone to her mother, and the post provost marshal was notified. Fortunately for all, the female social worker was able to work therapeutically with the cadet that evening. Several years earlier, that cadet had been molested in a public restroom, which made her especially sensitive to the threat of sexual assault. The next day, when the formal hearing was held, the girl's testimony of what the ambulance medics had done and the testimony of the medics themselves were sufficient to convince everyone that only poor judgment, not wrongful intent, had been involved. The timely assistance of a trained mental health worker helped the cadet work through a psychological trauma—and also arguably saved the careers of more than just the ambulance medics if the accusations had reached the news media.

Thus, the psychiatric (stress control) detachments can be fully and profitably occupied in these FTXs by concentrating on their real-world preventive and treatment missions. Unlike the surgical teams (and like the dental, preventive medicine, and veterinary food inspection teams), they have plenty of real-world missions, provided they are proactive, mobile, and helpful. They must not remain in their tents waiting for "patients" to be sent to them. Indeed the people who would send such cases to them (or come on their own behalf) are more likely to misunderstand and mistrust the mental health teams if those teams are relying only on their professional reputations.

In fact, too much simulated stress casualty play may actually be counterproductive. It may keep the mental health teams so busy (doing what they already know fairly well how to do) that they put off undertaking the new challenges of going out, meeting, and forming trusting professional relationships with all of the units that they should be supporting. They need to become fully familiar with the missions and stressors of the supported units.

The major medicine FTXs (especially the earlier ones—Dusty Bull '84 and '88, Wounded Warrior '85, and MEDEX '86) did have extensive simulated stress casualty play. A mobile training team (MTT) from the Behavioral Sciences Division, Academy of Health Sciences, U.S. Army (San Antonio, Texas), was requested through command channels⁴¹ by the medical brigades to assist in training the OM teams and guiding their employment. The MTT also assured that a suitable number and variety of simulated battle fatigue and neuropsychiatric casualties were played.

The moulage source book⁴³ provides very few neuropsychiatric and combat stress roles (with sample field medical cards). The battle fatigue cases are mostly the dramatic (but actually rare) and problematic cases. The recommended treatment (contrary to current doctrine) is to prescribe diazepam (Valium) or chlorpromazine (Thorazine). The neuropsychiatric cases are also rather limited. For example, the alcoholic with impending delirium tremens has physical findings (such as a large and tender liver with ascites). That would be common, perhaps, in a big city hospital emergency room but would not be typical of the heavy drinking but otherwise successful army NCO or officer who might go into delirium tremens if he suddenly cuts back from his regular heavy daily drinking. The soldier-alcoholic's general health and physical fitness might appear good with only the more subtle signs of heavy alcohol use.⁴¹ The army's programs of physical fitness testing, weight control, the mandatory physical periodic examination, annual performance appraisals with interim counseling sessions, plus the Alcohol and Drug Abuse Prevention and Control Program are usually sufficient to detect the gross signs of chronic physical deterioration because of alcohol abuse.⁴¹

To provide a wider variety and more representative sample of battle fatigue and neuropsychiatric cases, the MTT has fielded and tested a set of role player instruction sheets. Examples are given in Figures 11-1, 11-2, and 11-3.

Each instruction sheet included the field medical card (DA Form 1380) entries and physical findings. It included general instructions to the role players plus a checklist of recent stress events they should incorporate into their story about themselves. It gives specific instructions on what to do, how to look, and what to say, plus further instruction on how to change or not change the scenario based on how they are treated.

The battle fatigue cases have been written in sets of 20 cases. Each case is unique, but in each set, there are three simple exhaustion/sleep deprivation cases, five with primarily anxiety symptoms, five with primarily depressive and/or survivor guilt symptoms, three variations on dissociative (memory loss) symptoms, and four variations on conversion symptoms. This breakout still somewhat favors the dramatic and problematic end of the battle fatigue spectrum at the expense of the more common exhausted, anxious, and depressed forms. However, that shift is appropriate for corps-level or division rear-level exercises, where most of the simpler cases

can be assumed to have been treated and released further forward.

The instructions deliberately omit the stereotypical "pseudopsychotic," "acting out," and potential violent types of battle fatigue cases. This omission was done for two reasons. First, they are actually rare, and it is important to counteract that stereotype lest it become a self-fulfilling prophecy as soldiers become overly suggestible with battle fatigue. Second, there will always be a few role players who will overact or use this opportunity of playing a stress casualty as a license to play "psycho," in spite of warnings not to.

In addition to the 60 variations on battle fatigue, instructions were written for neuropsychiatric cases, including a manic episode, paranoid schizophrenic-like psychoses, acute organic brain syndromes (atropine or anticholinergic type), alcohol withdrawal, and other substance abuse problems. Some of these cases require additional administrative or legal action. Some of these cases do provide for the players to become threatening and disruptive. This will give the medical or psychiatric triagers and treaters the opportunity to practice safe management and restraining techniques without erroneously targeting battle fatigue as the likely cause. The players of these roles must be strongly instructed not to continue their resistance to the point where they or others get hurt.

Interestingly, there was a case during MEDEX '86³⁴ when one of the nonviolent battle fatigue cases—a soldier with psychogenic deafness who was pretending to be unable to hear instructions or questions—was wrestled to the ground and his eye glasses broken by overzealous triage and security personnel who mistakenly identified him as either a "psycho" or an enemy infiltrator. All of the observer and controller personnel in the FTXs must be trained to intervene to prevent such unnecessary safety violations by the role-playing patient or the treaters.

Several "special combat stress cases" that involve misconduct and other legal issues have also been prepared as role player instruction sheets. Examples are the soldier who confesses that the guilt he is feeling comes from having participated in the commission of an atrocity or the "combat refuser" who describes a pacifistic religious conversion experience while under extreme stress. These cases provide training not only in clinical management but also in the administrative actions that should be initiated and followed through the system.

The role player instruction sheets are sufficiently detailed that a reasonably literate and motivated

soldier could take one out of his pocket, read it carefully, and know how to play a fairly detailed case using his imagination to fill in the necessary details. However, experience shows that it is best to invest more effort in the selection and training of battle fatigue and neuropsychiatric role players.

If there are psychiatric nurses as members of the moulage team, they may be recruited and trained to choose only those role players who are themselves mentally stable and able to act the part. Otherwise, members of the MTT must be detailed to do this.

SUMMARY AND CONCLUSION

Military mental health providers function differently from their civilian counterparts. During peacetime missions, they may deal with service members who are lonely and frustrated and have any number of family, occupational, or financial problems. During combat, the provider is likely to provide care to patients who are acutely anxious and exhausted. Therefore, not only does the scene of practice change for the military mental health provider, but the type of pathology is likely to be different depending on the setting.

Taken together, this situation means that the practice of military mental health is grounded in the principles of community mental health. The providers perform an occupational health role, focusing on preventing combat stress casualties and determining the fitness of the individual to function at his given job.

Training military mental health providers starts at the entry level. For specialists, technicians, social workers, and psychologists, training is available in the recognition and treatment of combat stress casualties. Most other providers, such as physicians, and specifically psychiatrists, often have not been trained in medical school to treat battle fatigue casualties. An innovative course for medical students has been described in this chapter. In addition, a model proposal to teach psychiatry residents how to interact with commanders and hospital personnel in the field is included. Last, the major medi-

cal FTXs have been described in detail. These FTXs are important in the preparation and training of all healthcare personnel in the proper management of battlefield stress casualties. For most mental health personnel, on-the-job training is the best possible way to learn about the practice of military mental health.

Recommendations for training must take into account military structure. Put simply, the management of combat stress cannot be taught in the medical center. Psychiatric residents and allied mental health professionals must have exposure to officers and enlisted service members in a variety of military settings.

With this in mind, the following four specific recommendations can be made: (1) Develop a short course and training packages in combat stress management that are mandatory for personnel assigned to troop mental health support slots. Include as many allied healthcare personnel as needed. To be sure, nurses, chaplains, and hospital commanders should be specifically asked to participate in this training. (2) Require inclusion of brigade combat stress teams in FTXs, especially at combat training centers. (3) Increase combat stress training in core career courses armywide to the level of application in practical exercises. (4) Train and program unit medical and mental health personnel to give sustainment training to unit leaders in the garrison and field.

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