MILITARY PSYCHIATRY
PREPARING IN PEACE FOR WAR

The Coat of Arms
1818
Medical Department of the Army

A 1976 etching by Vassil Ekimov of an
original color print that appeared in
The Military Surgeon, Vol XLI, No 2, 1917

The first line of medical defense in wartime is the combat medic. Although in ancient times medics carried the caduceus into battle to signify the neutral, humanitarian nature of their tasks, they have never been immune to the perils of war. They have made the highest sacrifices to save the lives of others, and their dedication to the wounded soldier is the foundation of military medical care.

Textbook of Military Medicine

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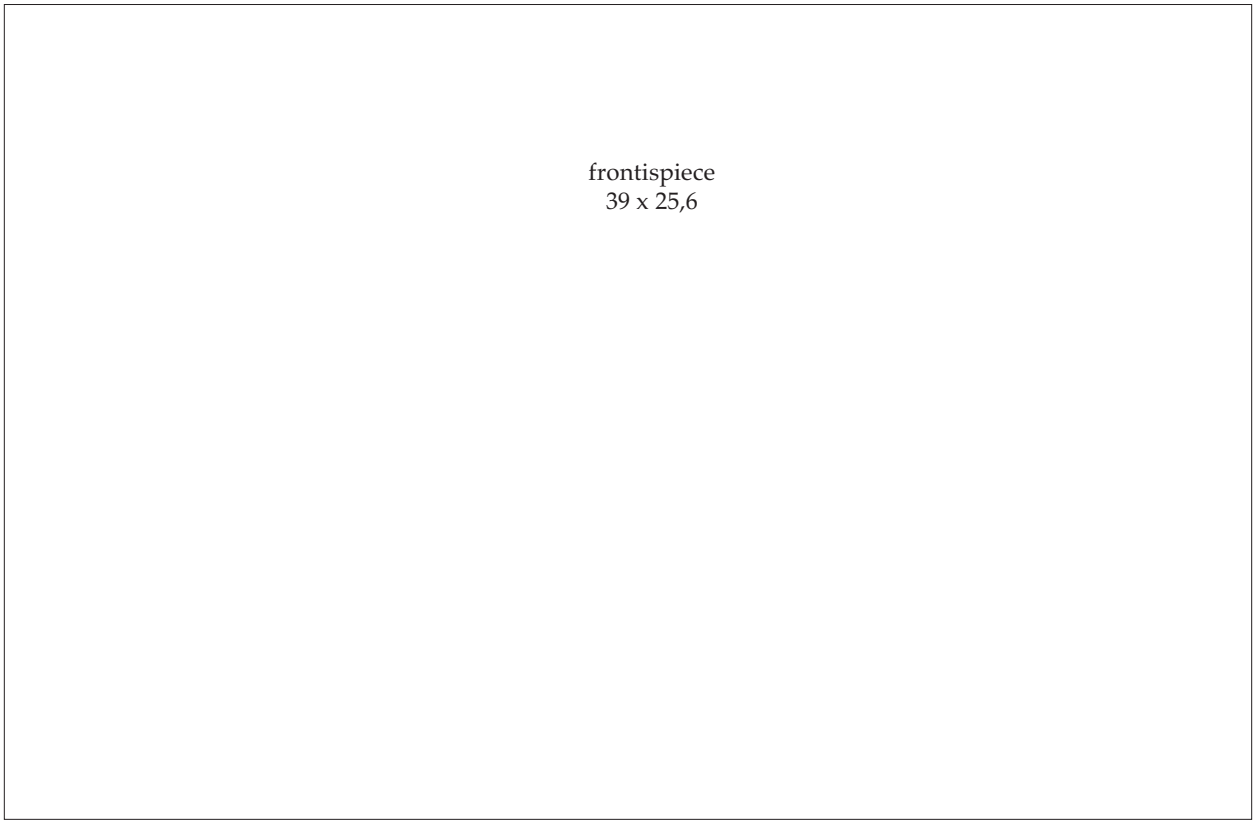

frontispiece
39 x 25,6

This 1944 painting by Jack McMillen was commissioned by the U.S. government for Walter Reed Army Medical Center as part of the Works Projects Administration (WPA) artists' program of World War II. It illustrates the historical function of the Forest Glen annex of the Walter Reed Army Medical Center as a holding and rehabilitation unit for medical patients, including psychiatric patients, during World War II. This is a role the Forest Glen annex also played in subsequent wars. Psychiatric patients were identified, and to an extent stigmatized, by wearing maroon hospital clothing. For many years this painting was on display at the Forest Glen annex in Silver Spring, Maryland.

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Contents

Foreword

This volume of the *Textbook of Military Medicine* addresses the multiple mental health services provided by the military during peacetime. Although military psychiatrists and other mental health professionals must view soldiers as they function within the larger organization and contribute to, or detract from, success of the combat mission, we must remember that soldiers and their families are also subject to mental and emotional stresses during peacetime. The U.S. Army's mental health services' peacetime roles include but are not limited to supporting soldiers and commanders as they participate in rescue missions with combat potential as occurred in Grenada and Somalia, peace-keeping roles as in the Sinai and Macedonia, combating terrorists and hostage takers, interdiction of traffickers in drugs and illegal aliens, providing assistance in handling large influxes of refugees, assisting civilian officials in the aftermath of large-scale civilian disturbances such as rioting and environmental disasters, and assistance following certain stressful human experiences such as accidents and deaths. What is not always recognized is that soldiers' families also require the services of military mental health professionals during these operations.

Disasters and other mass civilian disturbances, such as influxes of refugees, are opportunities not only for medical officers to sharpen our surgical and medical skills but also for commanders to use our military organizational and leadership skills, and our mental health professionals, to contain and ameliorate the mental and emotional sequelae of such disturbances. Disaster victims often exhibit symptoms similar to those of combat stress casualties (ie, disaster fatigue) and respond to the simple interventions and expectancy that are therapeutic for combat fatigue casualties. After disasters, some of these victims may develop chronic post-traumatic stress disorder. Early, appropriate treatment of acute post-traumatic stress disorder may be an important preventive measure for chronic post-traumatic stress disorder.

I strongly recommend that all commanders and medical officers heed the central theme of this book: the stresses of military life can be significant, and it is the responsibility of the commander to assure that appropriate, timely prophylaxis, psychiatric intervention, and other mental health services are delivered to the entire military family.

Lieutenant General Alcide M. LaNoue
The Surgeon General
U.S. Army

August 1994
Washington, D.C.

Preface

The stresses of the peacetime military environment range from the traditional (garrison life, training, deployment), to the contemporary (disaster relief, peace-keeping, hostage situations, civil disturbances). Soldier's families are also subjected to these stresses. Soldiers who are worried about the emotional stability of their family members can be distracted from performing their duties.

One of the cardinal lessons relearned during the Vietnam War is that unit cohesion and morale are essential to conserving fighting strength. The integrity of a fighting unit depends not only on the quality of its materiel, training, and public support but also on the emotional well-being of its individual members. Although soldiers are generally young and physically healthy, they are at risk—both for the fear and anxiety that accompany battle, and for the same psychiatric and emotional disorders that are seen in their civilian cohort.

A forthcoming volume, *War Psychiatry,* covers the psychiatric and emotional problems of soldiers in combat. This volume of the *Textbook of Military Medicine* deals with the full spectrum of mental health in the peacetime military community. However, the principles of military psychiatry that have proven successful in managing combat stress have been successfully adapted to noncombat settings. For example, mental health professionals and commanders use these principles—centrality, proximity, immediacy, simplicity, expectancy—to enable soldiers to use their own strengths to recognize that anxiety is a normal, not a pathological, phenomenon, and that recovery is not only possible but also expected. The soldier's treatment is enhanced by the mental health professional's intense familiarity with the soldier's unit. Avoiding hospitalization and keeping soldiers in geographic proximity to their own units enable the soldier to return to work rapidly, with follow-up at the working level rather than the clinic.

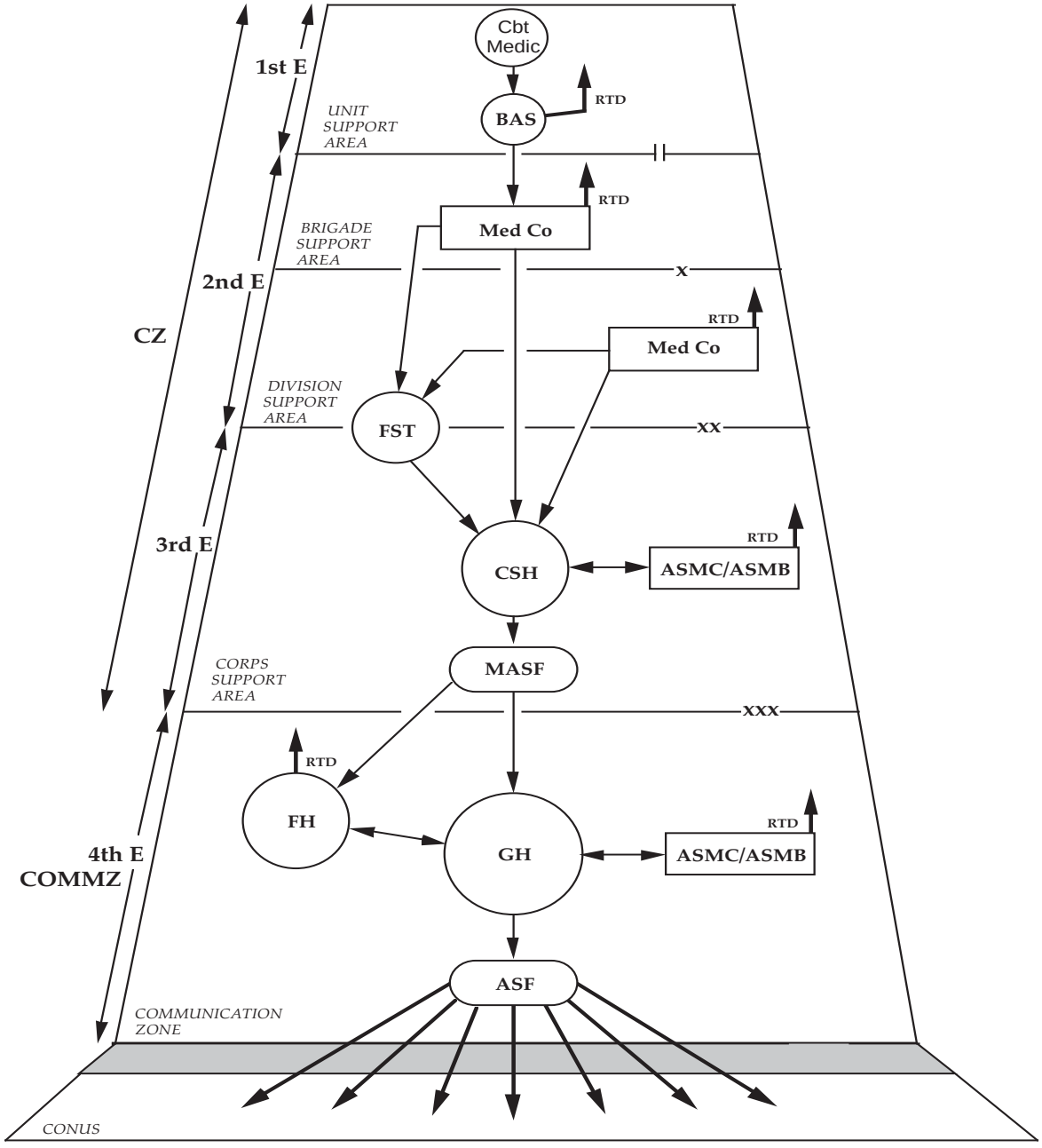
From malaria to sexually transmitted diseases, prophylaxis is a command responsibility. Medical officers and other mental health professionals must strive to educate and reeducate their commanders so they will understand that, in psychiatry as in other medical specialties, effective prophylaxis is vastly more cost- and time-effective than treatment.

Brigadier General Russ Zajtchuk
Medical Corps, U.S. Army

August 1994
Washington, D.C.

The current medical system to support the U.S. Army at war is a continuum from the forward line of troops through the continental United States; it serves as a primary source of trained replacements during the early stages of a major conflict. The system is designed to optimize the return to duty of the maximum number of trained combat soldiers at the lowest possible level. Far-forward stabilization helps to maintain the physiology of injured soldiers who are unlikely to return to duty and allows for their rapid evacuation from the battlefield without needless sacrifice of life or function.

Medical Force 2000 (MF2K)
PATIENT FLOW IN A THEATER OF OPERATIONS



ASF:	Aeromedical Staging Facility, USAF	E:	Echelon
ASMB:	Area Support Medical Battalion	FH:	Field Hospital
ASMC:	Area Support Medical Company	FST:	Forward Surgical Team
BAS:	Battalion Aid Station	GH:	General Hospital
Cbt Medic:	Combat Medic	MASF:	Mobile Aeromedical Staging Facility, USAF
CSH:	Combat Support Hospital		
COMMZ:	Communication Zone	Med Co:	Medical Company
CZ:	Combat Zone	RTD:	Return to Duty