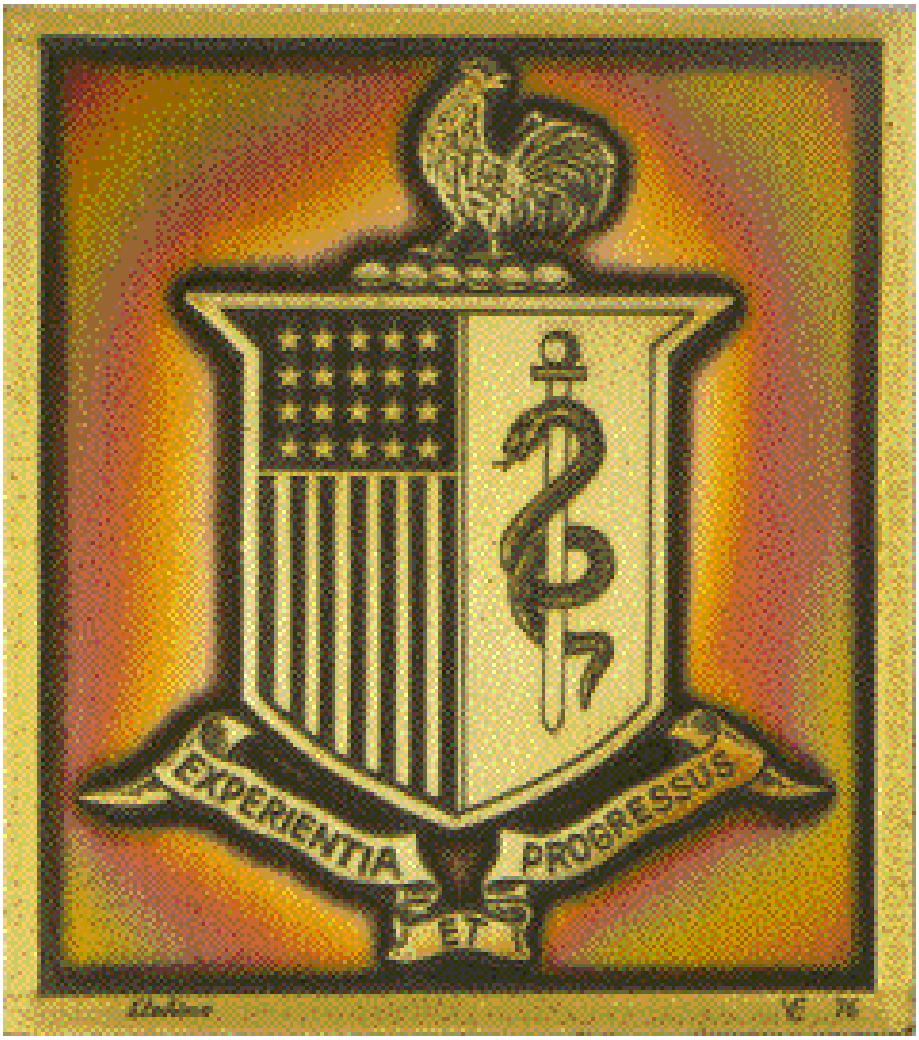
# WAR PSYCHIATRY




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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Soo Suk Kim *War* 1966

Soo Suk Kim, a 22-year-old art student, painted *War* in 1966 as a gift to his brother-in-law, Captain Franklin D. Jones, who was serving as a division psychiatrist in Vietnam. Soo Kim had experienced war first-hand as a 6-year-old refugee during the North Korean occupation of Seoul, hiding from a communist edict calling for the execution of his prominent family. The painting depicts his childhood recollection of the horrors and chaos of war.

# WAR PSYCHIATRY

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# Contents

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# Foreword

This volume of the *Textbook of Military Medicine* addresses the delivery of mental health services during wartime. The foreseeable future of the U.S. military includes the potential for involvement in a variety of conflicts, ranging from peace-keeping missions to massive deployments of personnel and materiel and possible nuclear, biological, and chemical threats as was seen in the Persian Gulf War. The medical role in wartime is critical to success of the mission. For the mental health disciplines, this role encompasses identification and elimination of unfit personnel, improvement of marginal personnel to standards of acceptability, prevention of psychiatric casualties, and their treatment when prevention fails. All of these efforts must be guided by past experience and sound principles of human behavior.

The identification and elimination of unfit personnel must be prudently managed. During World War II, medical personnel mistakenly believed that soldiers who had exhibited any prior symptoms of anxiety would be prone to breakdown. However, review of casualty breakdown in World War II revealed that breakdown was largely related to unit and battle conditions rather than predisposition.

Prevention of psychiatric casualties must address the factors known to be important in soldier efficiency and breakdown. These can be grouped into biological, interpersonal, and intrapsychic factors. Of these, interpersonal factors may be the most critical. Soldiers living and working together in conditions of shared danger and hardship will foster unit cohesion, which is known to reduce the risk of psychiatric breakdown. Thus, producing cohesive combat forces has become a mainstay of psychiatric prevention.

The soldier brings with him many, sometimes conflicting, intrapsychic beliefs and attitudes, including a strong sense of invulnerability. These contribute to his psychological defense against the rigors of the battlefield. It is the loss of such defenses that produces breakdown on an individual basis. The treatment of the combat psychiatric casualty near the front with replenishment of physiological deficits and expectation of return to one's unit shores up these failing defenses.

I strongly recommend that all commanders and medical officers read this book and heed its central theme: the stresses of combat are significant, but with appropriate and timely prophylaxis and treatment, the majority of these soldiers can be returned to their units as functional members of their group.

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

July 1995
Washington, D.C.

# Preface

The stresses of the military environment are diverse and significant—the potential for deployment and combat, long and arduous training missions, and separations from families. A companion volume, *Military Psychiatry: Preparing in Peace for War*, addresses these issues in a peacetime military. As stressful as garrison life can be, it pales when compared to the stresses of combat. These stresses are greatest during actual combat, but begin with notification of a deployment, and often continue after the fighting is over as the participants deal with the aftermath of the battlefield, which may include post-traumatic stress disorder, especially if they have been prisoners of war or experienced mutilating injuries. This volume discusses the evolution of the concept of combat stress reaction, the delivery of mental health care on the various battlefields our soldiers are likely to experience, and the psychological consequences of having endured the intensity and lethality of modern combat.

The concept of the stress casualty has changed considerably from times past when the symptoms of stress breakdown were thought to be evidence of cowardice and thus were punished rather than treated. As our understanding of the dynamics of the stress casualty and the battlefield environment have increased, we have discovered that the most important lesson learned from previous wars is the need for timely and appropriate handling of stress casualties. Psychiatric casualties should be seen as close to the battlefield as possible (proximity) and as quickly as possible (immediacy), and should be provided with rest and nutrition. They should be told that their symptoms are normal in combat and that they will recover (expectancy). These are the principles of proximity, immediacy, and expectancy, known by the PIE acronym. Psychiatric casualties treated under these principles are more likely to recover than those for whom treatment is delayed or occurs far from the battlefield. These principles can also be utilized in debriefing groups exposed to unusual stress whether in combat or in disasters (critical incident debriefing). This early intervention often prevents later development of chronic post-traumatic stress disorders.

While the principles of combat psychiatry are relatively universal, their application may vary in the different military services, depending on the mission. Thus, service-specific scenarios and issues are presented in separate chapters on combat psychiatry in the U.S. Army, the U.S. Air Force, and the U.S. Navy. An important area addressed in this volume is the need for uniform psychiatric procedures in joint operations, which will likely be more common in the future.

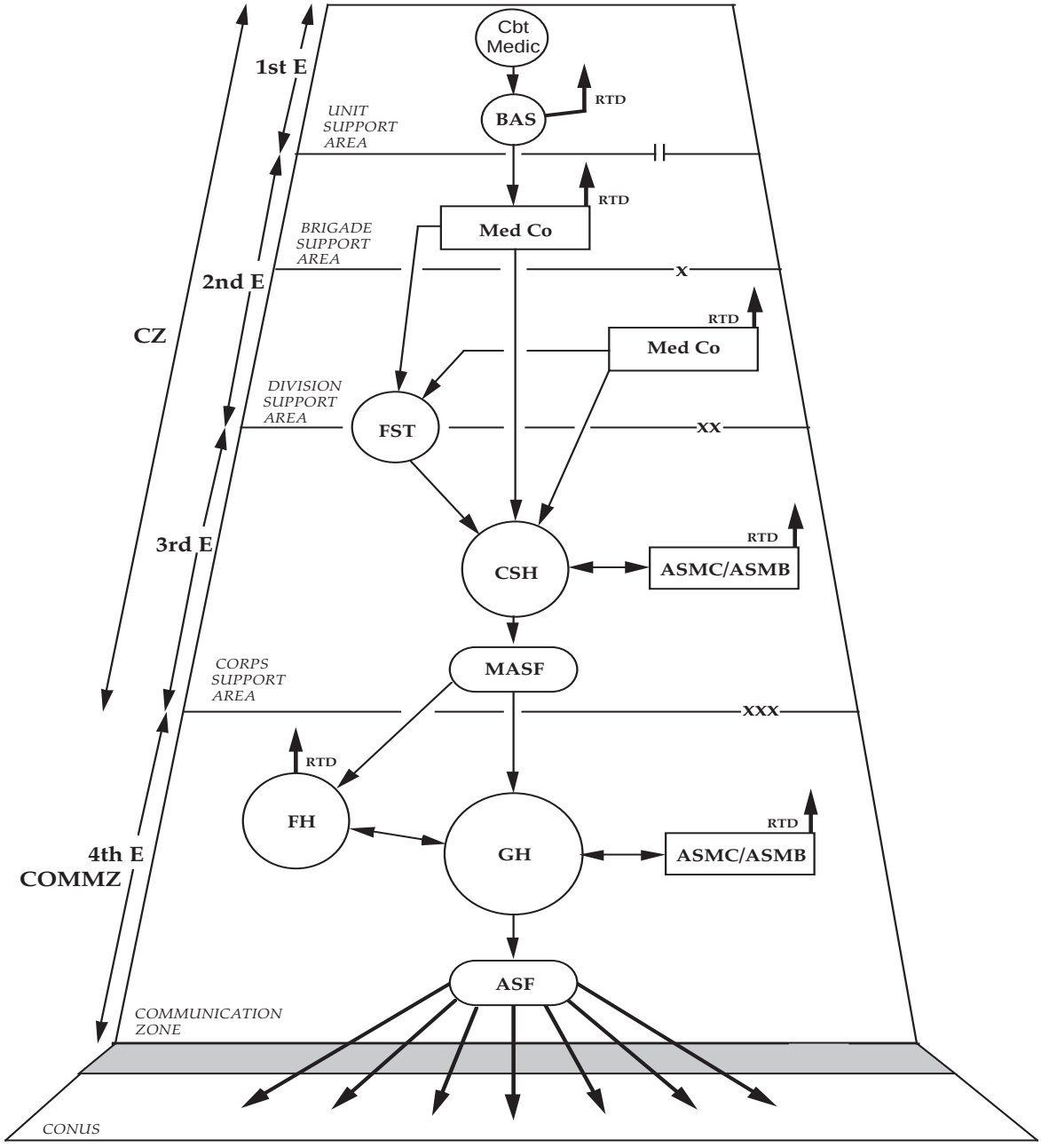
The prevention and treatment of combat stress reaction is not simply the domain of the mental health provider. Commanders must also play an active role by maintaining contact with soldiers when they are temporary casualties and welcoming them back to the unit after they have rested and recovered. This increases the likelihood of continued long-term functioning and enhances unit cohesion. It is also the honorable thing to do for those individuals who have temporarily been overcome by the horrors of battle, but are now ready to rejoin their unit to continue the fight.

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

July 1995
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

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|---|---|---|---|
| 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 |