

# Chapter 19

## SUMMATION

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## INTRODUCTION

Foremost among the peacetime activities of the military is the preparation to fight in defense of the nation. In that regard, the authors of this book have addressed the garrison military in terms of morale and cohesion, which involve family issues and burn-out; liability to diseases; and mental illnesses that may manifest themselves as drug and alcohol abuse and homicides and suicides.

Clearly related to morale and cohesion are commanders acting ethically and in the best interests of their charges in accomplishing the mission. Readiness always requires appropriate training that may include the use of disasters and incidents of terrorism, rioting, and refugee management as material. The development of community mental health is an extension of the concept of readiness.

## APPLICABILITY OF PRINCIPLES TO NONCOMBAT SETTINGS

Although developed empirically in the different settings, the practice of military psychiatry in the combat setting and in the garrison setting has a number of similarities, particularly when one is

handling acute adjustment disorders. These practices include various elements of the proximity, immediacy, simplicity, expectancy, and centrality elements of combat psychiatry.

## DEVELOPMENT OF ARMY COMMUNITY PSYCHIATRIC SERVICES

Halloran and Farrell<sup>1</sup> and Cohen<sup>2</sup> established mental hygiene consultation programs at replacement and training centers within the first years of United States' entry into World War II. Initially, these programs furnished a kind of orientation and "pep talk" for soldiers being sent overseas. Later, as the success in decreasing psychiatric casualties through such strengthening of morale became recognized, they spread to other settings and, by the end of the war, were an integral part of the mental health program of the army.

The continued conscription of young men after World War II and after the Korean conflict resulted in large numbers of unhappy soldiers who would much prefer to follow other pursuits. The Mental Hygiene Consultation Service became the preferred method of managing them.

Bushard<sup>3</sup> chronicled the empirical development of army community psychiatric services (the Mental Hygiene Consultation Service) during the decade following World War II. Cold War tensions had resulted in the continued need for drafted soldiers, many of whom preferred to be civilians. The early psychiatric services were little other than struggling outpatient clinics that were totally overwhelmed by the problems presented to them of large numbers of disaffected troops. Applying the usual psychiatric treatment techniques growing out of psychoanalytic theory in this situation produced

results that were frequently discouraging. The usual conclusion was that, in view of the disparity between large referral load and psychotherapeutic talent available, little could be offered. Considering the large caseload and the brief period of the patient's stay on post, traditional psychotherapy was not feasible.

Eventually, a view of the soldier emerged in which he is seen as part of an interactional set with his environment. The dynamics involved relate not so much to oedipal traumas and disturbed biochemistry as to disturbed homeostasis in the soldier's social ecology. Adaptability was seen to relate to supports and circumstances that tend to prevent or strengthen the illness role. Depending on the balance achieved, one may see increased or decreased rates of ineffectiveness as measured by absent without leave (AWOL), venereal disease, sick call, and disciplinary action rates.

### Civilian Settings

Usually it will be rare that the civilian psychiatric casualty has been exposed to the kind of conflict experienced by a combat soldier. Examples of persons exposed to hazardous occupations include police, firefighters, pilots, and so forth, but these are rare and do not involve legal or psychological stigmas as with the soldier.

The better analogy is the marriage partner, teacher, therapist (as in “professional burnout” syndrome), parent, supervisor, or other person who has responsibilities to a group or another person and who becomes demoralized in discharging those responsibilities. (See Chapter 3, Burnout in Military Personnel.)

In the workplace, psychological burnout can occur in those in stressful occupations such as the police, teaching, mental health workers, and so forth. Burnout is the civilian equivalent of combat fatigue and can be treated in similar fashion. Burnout seldom occurs in a cohesive group whose members can give psychological support to its members. Thus, prevention consists of maintaining group cohesion and morale, while treatment consists of establishing or reestablishing such bonds, sometimes after a period of rest from the job.

Many patients who are responding to crisis situations emanating from psychological antecedents will be given labels such as *adjustment reaction*, *depression*, or *anxiety neurosis* depending on presenting symptoms and therapeutic school. The comparability with the combat stress casualty is in the acceptance of a medical label as the solution to one’s problems of living and one’s inability to cope with them. This is not limited to psychiatric patients; in fact, it may be more common in other conditions; chronic low back and tension headache syndromes are frequent ailments prone to result in one’s escape from the daily fray of work. Such organic conditions do not carry the psychiatric stigma, making them even more desirable as avenues of escape. Such persons are usually not malingering or consciously ineffective; rather, for them, the short-term rewards of the invalid or medical label outweigh the long-term rewards of mastery of the situation.

### Training of Personnel

Training of personnel involves several important dimensions: technical proficiency, personality characteristics, strength and endurance, group cohesiveness, and stress inoculation. There is considerable overlap in all of these areas; for example, technical proficiency, which may require strength and endurance, leads to the personality characteristic of self-confidence, which along with technical proficiency produces a sense of mastery and increases one’s value to the group, promoting group cohesion. All of these characteristics are positively associated with the ability to withstand combat stress.

Much of military training addresses all of these dimensions. Shared vigorous training not only increases strength and endurance and builds self-confidence but also increases group affiliation and cohesion.<sup>4</sup> Aware of the importance of cohesion, the military has kept personnel together in cohort units from basic training to deployment. In addition, efforts have been made to keep commanders with the same unit for longer periods to enhance not only horizontal (peers) but also vertical (hierarchical) cohesion (see Chapter 1).

### Substance Abuse Problems

Although sporadic drug abuse problems, primarily in overseas deployment, have existed since World War I<sup>5</sup>, they did not reach prominence until the Vietnam conflict.<sup>6,7</sup>

Treatment of substance abusers has varied considerably over time. Early approaches were to consider such casualties problems of a moral nature and later of a character defect with punishment as the primary intervention. It was only when such losses of manpower became significant in the Vietnam conflict that a nonpunitive, therapeutic approach was undertaken. By 1971, more soldiers were being evacuated from Vietnam for drug use than for war wounds.<sup>8</sup>

The main lessons from the U.S. experience in managing substance abuse in Vietnam are that treatment should be in country to prevent an evacuation syndrome and that the factors that prevent breakdown in general—cohesion, effective leadership, and good morale—may protect soldiers from substance abuse. For example, the Australians serving in Vietnam did not have significant personnel losses from substance abuse.<sup>9,10</sup> Australian forces were based on a regimental system with unit rather than individual rotations, and officers and troops had usually served together for long periods. This approach may have produced greater unit cohesion, a crucial difference from U.S. troops, and protected Australian troops from developing nostalgic problems of substance abuse and indiscipline.

### Sexual Problems

Infectious diseases have plagued armies since ancient times. Venereal diseases (VDs) have been a major cause of lost soldier strength in wars of the 20th century. While modern medicine has markedly reduced the time lost and complications of VDs, it has not reduced the infection rates. Al-

though malaria, hepatitis, and tuberculosis caused significant soldier attrition in Vietnam, the most common nostalgic disorder coming to medical attention was sexual intercourse with prostitutes leading to VD. Although unlikely to have immediate effects on combat efficiency, the human immunodeficiency virus (HIV) poses severe problems in long-term prevention.

Prevention through education is a valid approach to VD even though some soldiers will risk infection no matter what the threat. Prevention should not be directed at preventing sexual intercourse, which is an unrealistic goal, but toward the use of readily available condoms.

### **Indiscipline**

Indiscipline is a psychiatric issue because sociopsychological factors play a paramount role in its emergence. Furthermore, indiscipline and psychiatric breakdown merge almost imperceptibly as evacuation syndromes. For example, failure to take preventive hygiene measures in Korea allowed the development of frostbite in some cases. Similarly, failure to take the prophylactic chloroquine-primaquine pill in Vietnam allowed the infestation of malarial protozoans. In both cases, indiscipline rendered the soldiers unfit for duty.<sup>11,12</sup>

Indiscipline may range from relatively minor acts of omission to commission of serious acts of disobedience (mutiny) and even to murder (fragging). In an analysis and historical review, Rose<sup>13</sup> indicated that combat refusal has been a

relatively frequent occurrence in most significant wars for which there are adequate data. Most indiscipline, of course, is more subtle than combat refusal and does not appear to be related to it. However, unavailability for combat is a frequent consequence of indiscipline. The main role of the psychiatrist is in prevention because the same conditions that give rise to neuropsychiatric casualties may produce indiscipline as another evacuation syndrome.

### **Terrorism**

The U.S. Army maintains a special unit, Delta Force, at Fort Bragg, North Carolina, to combat terrorists. The need for such a unit with a unified command can be seen with the failure of a combined services attempt to rescue the 52 hostages in Iran.<sup>14</sup> Since Islamic terrorists have recently targeted the Central Intelligence Agency (CIA) and the World Trade Center in New York City, there will likely be an increased role in countering or responding to such threats.<sup>15,16</sup>

Since World War II (as, indeed, long before World War II), the Middle East has experienced essentially continual conflict. These conflicts have ranged from state-sponsored terrorism through low-intensity and guerrilla warfare to high-intensity and chemical warfare.<sup>17</sup> The significance of terrorist activities should not be minimized. In 1983, a single terrorist suicide attack killed 241 U.S. Marines on a peace-keeping mission in Beirut, producing nearly as many American deaths as the Spanish-American War.<sup>18,19</sup>

## **RESCUE OPERATIONS**

### **Grenada**

In October 1983, American forces invaded Grenada. Operation Urgent Fury was undertaken to ensure the safety of about 1,000 Americans, including 700 medical students, and to restore order as requested by Grenada's neighboring island countries. Most of the Americans killed in Grenada died from accidents although U.S. forces did meet stiff resistance from 600 well-armed and professionally trained Cuban soldiers.<sup>20</sup> Because elite forces (rangers, SEALs [SEa Air Land commandos in the U.S. Navy], and airborne units) made the assault, few psychiatric casualties were expected, and few occurred (3 so designated in 3,000 invading troops with 19 killed in action and 73 wounded in action).<sup>20</sup>

Dehydration and heat exhaustion casualties accounted for the majority of the preventable casualties. Fullerton<sup>21</sup> debriefed most of the commanders after combat had ended. He reported that one battalion suffered 29 heat casualties in a single day, but another battalion suffered only 2 heat casualties on the same day while both engaged in virtually identical tasks. The commander of the latter battalion had emphasized water discipline.

Some of the wounded soldiers suffered delayed post-traumatic stress disorders.<sup>21,22</sup> Mateczun and Holmes-Johnson<sup>18</sup> had an interesting opportunity to compare the psychological adjustment of Marines wounded in Grenada with those wounded in the Beirut massacre when casualties from both incidents arrived almost simultaneously at Bethesda

Naval Hospital. About 25 marines, more from Beirut than Grenada, were treated in a psychiatric consultation-liaison model with group therapy as the primary intervention. The group therapy was modeled after Marshall's<sup>23</sup> group debriefing technique; however, the Beirut casualties had less to recount because they were sleeping when the bomb exploded. Their memories centered on feelings of helplessness and fear of dying before rescuers could reach them. Survivor guilt was high among Beirut casualties but almost absent among Grenada casualties. Both groups had some symptoms of post-traumatic stress disorder (nightmares, intrusive thoughts, and anxiety), but Grenada casualties had high morale and a strong desire to return to the combat unit. In contrast, the Beirut casualties wanted to go home. These differences in symptoms are attributable to the different forms of combat. In Beirut, the marines had no clear enemies or mission, and some viewed themselves as vulnerable targets; however, American forces in Grenada had a clear mission with a known enemy and had numerical and logistical superiority.

### The Persian Gulf War

When Iraq invaded Kuwait and threatened the West's oil supply lifeline, the United States formed a coalition with other forces to rescue Kuwait and end the aggression. Operations Desert Shield and Storm were the largest deployment of U.S. forces since Vietnam.<sup>24</sup> The 540,000-member U.S. forces had 148 killed in action and 467 wounded.<sup>25</sup> Of these casualties, 35 were killed and 78 wounded in fratricidal ("friendly fire") incidents. Iraq's military is estimated to have lost between 30,000 and 100,000 killed and 100,000 to 300,000 wounded. There were an estimated 60,000 to 70,000 Iraqi prisoners of war by war's end.<sup>25</sup>

Neuropsychiatric casualties were relatively few. During the deployment phase (Operation Desert Shield), some soldiers anticipating deployment sought psychiatric care, usually for anxiety symptoms but sometimes for somatic symptoms. During the fighting phase (Operation Desert Storm), combat stress casualties were minimal.<sup>26</sup>

Nostalgic casualties were few because the host country (Saudi Arabia), in keeping with Muslim tradition, did not allow importation of alcoholic beverages or prostitution. Accidents reportedly were one-third the rate of other U.S. forces because of the absence of alcohol.<sup>27</sup> However, casualties secondary to substance abuse may have occurred when soldiers attempted to make homemade alcohol. Only a few drug-related incidents occurred including that of an air force pharmacist who used and distributed drugs illegally. After the liberation of Kuwait, U.S. forces assisted Kurdish and Shiite refugees displaced by the fighting.<sup>28</sup>

### Somalia

In 1992, President Bush ordered U.S. troops to assist in the distribution of food to starving Somalis. The Secretariat of the United Nations also wished to disarm local warlords and restore representative government, resulting in a state of undeclared war. There have been few reports of psychiatric casualties among American military personnel in Operation Restore Hope to Somalia despite sporadic combat casualties, including 18 American soldiers dead and 75 wounded in an ill-fated attempt to capture a local warlord in October 1993.<sup>29</sup> In part, this may be due to the humanitarian nature of the mission, the use of volunteer forces, and the very low rate of surgical casualties. Febo<sup>30</sup> reported that there was a very liberal evacuation policy so that over 700 soldiers had been evacuated with complaints such as headaches, backaches, and so forth. Some of these cases may have been masked psychiatric casualties.

## FUTURE ROLES OF THE MILITARY

While defense of the nation through readiness for combat is the *raison d'être* of a military, many other roles have been played in the past and will be played in the future. These roles have included peacekeeping (currently underway in the Sinai and Macedonia)<sup>31,32</sup> often with other United Nations forces, refugee management and relocation (as occurred in the influx of Cuban refugees and Haitians and Bosnians),<sup>33-35</sup> rescue operations (as occurred in

Grenada and Somalia), large-scale rioting (as occurred in Chicago, Washington, D.C., and Los Angeles),<sup>36-38</sup> assistance in disasters (as occurred with Hurricanes Hugo and Andrew and with the 1993 Mississippi River flooding),<sup>39-41</sup> and interdiction of drug trafficking (as occurred in South America and as a cooperative effort with the Justice and Treasury Departments<sup>42</sup>). Recently, military forces have taken a proactive stance,

interdicting commercial refugees from Haiti and China.

New roles for the military may include resocialization of offenders of the criminal justice system. Experimental programs based on basic train-

ing approaches and run by former military personnel are being tried by some jurisdictions. It is reasonable to expect that the military itself could assume such responsibilities if not engaged in other pressing activities.<sup>43</sup>

## SUMMARY AND CONCLUSION

As events in the past decade have demonstrated, there is an ongoing need for a strong U.S. military. The military missions have ranged from major military deployments and high-technology combat to small-scale police actions. The U.S. Army Medi-

cal Department must remain flexible in supporting these missions. The principles of military psychiatry, while the bedrock of treatment, will require adaptation to ameliorate the stress of combat on the soldier.

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