II. Topics Specific to the Psychiatric Treatment of Military Personnel

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The medical, surgical, and psychiatric casualties of Operation Iraqi Freedom will receive care from a broad group of clinicians working in diverse clinical settings. Although most service members will initially be treated in military treatment facilities (MTFs), many may find themselves returning to the Continental United States (CONUS) with conditions that are treated in MTFs, VA Hospitals, civilian treatment centers, or all of these as they move through their recovery. As a result, some clinicians involved in treating casualties returning from Iraq may not have an understanding of the experiences of the military patient, the military system in which he or she serves, the military medical services available, or the potential impact of medical decisions on the service member's future military career. It is essential that all health care professionals—civilian or military—who care for casualties from Operation Iraqi Freedom have at least rudimentary and relevant military knowledge.

In this chapter, we provide an overview of several military-specific topics. First, a brief history of the evolution and change in the size and components of the military force is discussed, highlighting the challenges of a highly deployed force that relies on National Guard and Reserve members. Next, the various types and stages of military conflict are described, with a focus on the specific stressors that each of these stages might engender. This is followed by an explanation of the military medical services delivery system, including the different echelons of care of the military evacuation system. The subsequent section provides a review of psychiatric disorders that often present during military conflicts. Available psychiatric services are outlined next. Finally, a section on military decision-making processes focuses on important administrative and medical procedures that are used to facilitate the evaluation, treatment and management of military patients with medical and psychiatric conditions.

A Brief Description of The History and Current Structure of US Military Forces

The size and configuration of the US military force have changed continuously throughout history, reflecting the defense needs of the country. Early in US history, the concept of a standing army was less popular due to concerns about incurred costs and the fears of the impact of military power on the political process. The Second Continental Congress created the first regular active US fighting force on June 14, 1775 and named it the Continental Army. Its purpose was to supplement local militia in fighting the British during the American Revolution. Upon the conclusion of that war the Continental Army was disbanded. Militia forces returned to their homes as well, available for call up only during times when national or state security required.

By early in the 19th century the need for a Regular Army was clear as militia forces could not be routinely relied upon for rapid and professional response to national crises. Since that time, the end strength of the Army has varied, typically rising during periods of war and decreasing during peacetime. The size of the combined US Armed Forces reached an all time high of 8.3 million during World War II. Through the Vietnam War, military members were conscripted in order to achieve necessary force strength. In 1973 at the end of the Vietnam War, the all male draft that was initiated as a Selective Service Act of 1948 was terminated. Since that time the military has been comprised of an all-volunteer force. During the period of Operation Desert Storm, the US

Army totaled approximately 750,000 service members. This number decreased to its current number of just fewer than 500,000 personnel by the mid 1990s, its smallest size since the beginning of World War II.

Today the military has become a more diverse and complex population than ever in its history. Ethnic minorities make up significant portions of the Armed Forces, ranging from 24% in the Air Force to 40% in the Army (Source: Defense Department's Defense Link). Since the American Revolution, about 2,000,000 women have served in the military. Today, about 16% of the active US Armed Forces are women. In addition, over 50% of service members are married and about 11% of the marriages are to other service members. Although educational levels vary somewhat between branches of service, over 95% of the military has either a high school diploma or has passed the General Educational Development high school equivalency test. All four military branches have active, as well as reserve components. Additionally, the Air Force and the Army also have National Guard components. These components are discussed below. As outlined in the Constitution, the US Congress sets the end-strength for all services. These current totals are provided in Tables 1 and 2.

Table 1. Armed Service Strength as of December 31, 2003

	Army	Navy	Marine Corps	Air Force	**Total**
Total Officer	79,954	55,044	18,714	73,157	**226,869**
Total Enlisted	406,074	320,457	158,316	299,224	**1,184,071**
Cadets-Midshipmen	4,146	4,241	0	4,021	**12,408**
Total	**490,174**	**379,742**	**177,030**	**376,402**	**1,423,348**

Source: www.defenselink.mil

Table 2. Armed Forces: Active and Reserve by Service

	Army	Navy	Marine Corps	Air Force	Coast Guard	**Total**
Active	499,000	371,000	377,000	177,000	37,000	**1,461,000**
Reserve	577,000	182,000	153,000	40,000	7,800	**959,800**
Total	**1,070,000**	**553,000**	**465,000**	**217,000**	**44,800**	**2,355,800**

Source: www.defenselink.mil

National Guard and Reserve Components. The National Guard was formed from the earlier state militias. Congress officially designated the National Guard in 1916, establishing procedures for training and equipping these units to active duty military standards. In so doing, the Congress made these state defense National Guard units available in times of national crisis or war. In times other than Congressional or Presidential call-up, the National Guard falls under the Governor of the State to which it is assigned with the Adjutant General acting as the Commander. Neither active nor reserve component service members may serve within the National Guard. National Guard duties are under the auspices of the USC Title 32, working in state level jobs.

The Army Reserve contains four elements – the Selected Reserve, the Individual Ready Reserve (IRR), the Standby Reserve, and the Retired Reserve (See Figure 1). The Selected Reserve and the

IRR are referred to as the Ready Reserve. In total, there are more than one million Army Reserve soldiers. Of these, 211,577 belong to the Selected Reserve, 120,721 to the IRR, 725 to the Standby Reserve and 727,239 to the Retired Reserve (See Figure 1).

Figure 1. Total Army Reserve Force

<table>
<tr><td colspan="5">Total US Army Reserve
1,060,262
Enlisted: 796,744
Officers: 263,518</td></tr>
<tr><td colspan="4">Ready Reserve
332,298
Enlisted: 271,633
Officers: 39,794</td><td rowspan="3">Standby Reserve
725

Enlisted: 261
Officers: 464

Individual Ready Reserve</td><td rowspan="3">Retired Reserve
727,239

Enlisted: 524,850
Officers: 202,389</td></tr>
<tr><td colspan="3">Selected Reserve
211,577
Enlisted: 171,783
Officers: 39,794</td><td rowspan="2">IRR
120,721

Enlisted: 99,850
Officers: 20,871

Individual Ready Reserve</td></tr>
<tr><td>TPU
192,355
Enlisted: 160,704
Officers: 31,651

Troop Program Unit</td><td>AGR
13,391
Enlisted: 10,058
Officers: 3,883

Active Guard Reserve</td><td>IMA
5,291
Enlisted: 1,021
Officers: 4,270

Individual Mobilization Augmentee</td></tr>
</table>

Source: 31 Jan 04 RCCPDS Strength Summary Report, www4.army.mil/USAR/organization/force.php

Within the Selected Reserve, Active Guard Reserve (AGR) soldiers serve full-time on active duty in units and organizations that are either within the Army Reserve or that directly support it. AGR duties are under the auspices of the USC Title 10, working in federal level jobs. Also within the Selected Reserve, the Individual Mobilization Augmentees (IMAs) are assigned to high-level headquarters where they would serve if mobilized. Most IMA positions generally require two weeks of annual training.

IRR soldiers are primarily prior-service members with two or more years of Active Duty who may be called upon to replace service members in Active and Reserve units. IRR are neither assigned to a unit nor part of the IMA. The Retired Reserves are former Army National Guard, Reserve, and Active soldiers who remain part of the Army Reserve, but in a retired status.

As of February 18, 2004, 184,132 National Guardsmen and Reservists on active duty support the Global War on Terror and other missions in 120 countries. The Army National Guard and Reserve activation total 155,838, Naval Reserve 2,238, Air National Guard and Air Force Reserve, 19,820, Marine Corps Reserve, 5,614 and the Coast Guard Reserve, 1,162. The Army inclusive of the active, Guard, and Reserve as of February 6, 2004 has 368,000 service members overseas with approximately 215,000 of these on unaccompanied (no spouse or family) tours.

Global War on Terrorism (GWOT) and Operation Iraqi Freedom

Military members are currently deployed to the following places: Iraq and Kuwait, 120,000; United States for Operations Noble Eagle/Enduring Freedom, 20,000; Afghanistan, Pakistan, and Uzbekistan, 11,000; Ft. Polk, LA in preparation for duty in Iraq, 4,200; Kosovo and Macedonia, 2,000; Horn of Africa, 1,800; Bosnia, Croatia and Hungary, 1,500; Fort Leonard Wood, MO, retraining for temporary MP duty.

Operation Iraqi Freedom has representation from all military components. One hundred seventy-five thousand (175,000) men and women from all five of the active US Armed Forces (as well as the Coast Guard) and the seven armed forces reserves (Army Reserve, Army National Guard, Navy Reserve, Air Force Reserve, Air National Guard, Marine Corps Reserve, and Coast Guard Reserve) initially crossed into Iraq. In November 2003, The Vice Chief of Staff of the Army, General John M. Keane, identified a total force of 192,800 involved in Operation Iraqi Freedom: 133,000 Army, 550 Air Force, 1,550 Navy, 8,600 Marine, 12,400 Coalition, 2,400 Army Special Operations, and 34,000 Army Forces in Kuwait. He described the Army's rotation plan for the Iraqi theater with a 2nd cycle of 12-month rotation for the Operation Iraqi Freedom-2. It is unclear, at this time, what level of military staffing will be required for the future mission in Iraq.

As of February 27, 2004, official US casualties in Operation Iraqi Freedom total 501 deaths, 378 hostile and 169 non-hostile deaths. In this same period 2709 service members have been wounded in action and 417 have received wounds from non-hostile causes (Source: www.defenselink.mil).

With the recent decreasing size of the US Armed Forces and increased numbers of assigned missions (both war and operations other than war), the tempo of operations (OPTEMPO) for active and reserve members has increased in frequency and intensity. It is expected that more military members will deploy to unaccompanied overseas assignments repeatedly during their careers. As such, many of those deployed to Iraq in the current conflict may have been previously deployed and will likely deploy again. For active duty members who deploy with the units with whom they train and who leave families behind within established military communities (bases and posts), the impact of deployment may be less than for Guard and Reserve members. For those service members in the latter groups, deployment may result in loss of civilian employment, financial penalty, or separation from family who may be left far from any military base or resources. These military members may also be assigned or inserted into units in which they know no personnel, leading to added stress and preoccupation.

Types of Conflict and Associated Stresses

During missions such as Operation Iraqi Freedom there are multiple stages and types of conflict. Throughout an operation, these stages can overlap depending on the location and mission of assigned forces. Each form of conflict may contribute to different forms or expressions of stress. It is therefore valuable to determine precisely the nature and duration of exposures for returning troops.

Pre-deployment phase. During pre-deployment phase military members face uncertainty and worry. Deployment orders change routinely, sometimes with multiple revisions of deadlines and locations. Service members worry about the safety of themselves as well as their family members. They struggle to ensure that finances, healthcare, childcare, and pets all will be managed in their

absence. In the current climate, deploying service members may have additional concerns about terrorist activities in the United States during the period of deployment. Pre-deployment can be extremely stressful on single parents, reserve forces, and military members who have not previously deployed. It is often difficult during this phase to determine the difference between reasonable anxiety and an excessive reaction or the development or recurrence of psychiatric illness.

Deployment phase. The deployment phase carries many additional pressures. The stress of traditional, high-intensity warfare leads to fear and uncertainty. Operational plans change constantly; knowledge of enemy capabilities is unclear; equipment breaks down; and logistical supply lines are uncertain. Combatants face the threat of their own death or injury and also witness the death, wounding, and disfigurement of their companions, enemy forces, and civilians. During this heightened physiologic state, the high level of emotion, and the intensity of sensory exposure may lead to heightened levels of arousal, attempts to avoid emotion, and intrusive recollections of events. The novelty of the situation may also contribute to symptoms of dissociation. The severity and duration of symptoms will vary among individuals. This phase of combat is highly conducive to acute stress disorder and posttraumatic stress disorder in military members.

Types of conflict. *Low intensity combat* is typical during peacemaking and peacekeeping missions. Fear of death or injury is less imminent, but chronically present. Some troops may intermittently encounter the exposures found in high intensity combat. The majority will experience chronic strain of deployment: family separation, heat, cold, harsh living conditions, extremely long duty hours with little respite, minimal communication with the outside world, and boredom. These strains can result in the development of adjustment disorders, mood disorders, anxiety disorders, and exacerbations of personality disorders. Some members with predisposing factors may develop psychotic disorders. Depending on the availability of substances of abuse, abuse or dependence disorders may develop, recur, or worsen (Jones, 1995a).

Terrorist activities and guerilla warfare tactics, such as car bombings, remotely detonated explosives, and mortar attacks lead to chronic strain and anxiety. Psychologically this can contribute to service members questioning their purpose, as well as negative attributions about the importance and need for the sacrifices encountered. Coupled with other exposures, exposure during this phase may exacerbate illness or delay recovery. Many of the veterans from prior wars have focused on their discontent associated with sacrifice and loss in a mission viewed as unpopular and unsuccessful.

In a highly armed nation such as Iraq, US troops cannot be certain whether an innocent appearing civilian may be carrying a firearm, an explosive, or a remote detonation device. Rules of engagement are altered regularly by command in response to political and tactical requirements. When an individual or a vehicle challenges a roadblock or security checkpoint, a delay in the use of force may result in friendly forces injuries. A premature response may result in the unnecessary death of civilians. Such conditions create chronic strain, particularly when split second decisions may undergo retrospective analyses to determine their appropriateness (Jones, 1995b).

Friendly fire events are among the most tragic. In the current military environment of high technology communication, command, and control, there is a much lower risk of such occurrences. When they take place it is usually when there are failures of communication between allied forces. To date, no major events have occurred during this campaign, but have occurred

during Operation Enduring Freedom, the war in Afghanistan. Similar to terrorist and guerilla acts, friendly fire incidents (either by those responsible for or those who experienced the act) also lead to negative attributions about purpose of mission and specifically about the failure of leadership in preventing such outcomes. Friendly fire incidents can be more difficult for service members to cognitively reconstruct, leading to less opportunity for integration and potential greater traumatic impact.

Clinical assessment must not assume that the experiences of all service members coming out of Iraq are identical. As illustrated above, exposure to military conflict can be of a variety of types and intensities. A careful assessment should ensure that there is a complete understanding of all pre-deployment and deployment happenings. As a military patient may be reluctant to share details of his or her experiences early on with an unfamiliar provider, a thoughtful and detailed accounting of experiences will likely require the time to develop a trusting therapeutic relationship. As is clear from the information presented above, a service member's emotional response to wartime exposures is determined by the specific experiences, but equally important is the context in which these experiences are encountered and the meanings they hold.

Military Medical Evacuation and Service Delivery

It is important to understand the echelons of medical care and evacuation when treating the combat veteran to understand the early interventions available and the limitations of far-forward treatments. Medical care is provided through the continuum of up to five echelons of care. Combat Stress Control doctrine promotes the "PIES" principle in the management of battle fatigue casualties: *Proximity* of treatment close to the front; *Immediacy* of treatment; *Expectancy* of Return to Duty (RTD); and *Simplicity* of intervention. Those who do not respond to early interventions are evacuated to the next echelon based on the capabilities and evacuation policy established by the Command Surgeon.

Echelons of care. *Echelon I* care is the treatment provided by the medical assets organic to the combat unit. Veterans who experience combat trauma will likely be attended by members of their own battalion. A veteran who has sustained a physical "Battle Injury" will receive first aid by his or her buddy and the unit medic. Initial care will focus on maintaining an airway, controlling bleeding, and preventing shock with intravenous fluids and field dressing. The veteran will be transported by air or ground ambulance to the Battalion Aid Station to be stabilized for further evacuation.

Echelon II care is provided at the brigade and division level. Emergency medical treatment, including resuscitation, is continued and the patient is stabilized for further transport. This level includes the farthest forward Combat Stress Control (CSC) elements available to address combat stress issues. Resources in the Division Support Area include the Division Mental Health Section (DMHS), consisting of a Psychiatrist, Psychologist, Social Worker and enlisted Behavioral Science Specialists; and a CSC Detachment with additional providers, nurses, and enlisted staff. The DMHS role is to provide command-consultation, preventive services, treatment and screening while the CSC augments treatment and screening and provides and holding capacity for respite and reconstitution. Brief supportive therapy and pharmacologic intervention are doctrinally available at this level. In practice, these treatments are variably present depending upon geographic, personnel, and logistical limitations.

Echelon III care is provided at the forward deployed Combat Support Hospitals (CSH) located in the Corps Support Area. These hospitals are staffed and equipped to provide resuscitation, initial wound surgery, and post-operative treatment. Inpatient and outpatient psychiatric care is available in the CSH, but the extent of available medical and psychiatric staffing may vary depending upon the organization of each CSH. As this is the first echelon of care where a fully staffed pharmacy exists, antipsychotic, anxiolytic and antidepressant medications are usually obtainable. Patients are treated at this level to the extent they can be managed within the guidelines of the theater aero medical evacuation policy. Recent policy in Iraq has been that patients who are not expected to respond to treatment and return to duty within seven days are to be evacuated out of theater. Psychiatrists at the CSHs in Iraq and Kuwait report that more than 90 percent of service members are treated and returned to duty.

Echelon IV consists of hospitals staffed and equipped for general and specialized medical and surgical care as well as reconditioning and rehabilitation for return to duty (RTD). These facilities are generally located outside the combat zone. Iraq veterans are evacuated to Landstuhl Regional Medical Center in Germany or US Naval Hospital, Rota Spain. Service members evacuated to this echelon are rarely returned to duty.

Echelon V is the definitive medical care provided in continental US Military and Veterans Affairs Medical Centers. Experience shows that the RTD rate for troops evacuated to the CONUS with disorders ranging from adjustment disorders, depression, anxiety, acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) is extremely low. Aggressive treatment of symptoms seeks to induce remission with the goal of retaining the military member in the military through stabilization at the unit's rear detachment, a demobilization station, or the medical center. Military patients whose symptoms cannot be resolved must be considered for referral to a Medical Evaluation Board (discussed later in this chapter).

Medical evacuation. At each echelon, the veteran is evaluated for ability to RTD. The mobility of units on the modern battlefield and the need for service members to be able to sustain the extraordinary demands of high OPTEMPO diminish the likelihood of returning someone to his or her unit. Commanders require military members to perform at full capacity; as such they are frequently reticent to re-integrate a combat stress casualty to the unit. This preference often is balanced by a commander's need to maintain sufficient manpower for combat readiness. As insomnia is the most common initial complaint of a military member referred to mental health providers, commanders will often allow a time-limited medication trial to determine if the individual will rapidly respond and be available for missions. Contemporary battlefield realities, however, create an environment in which the validity and feasibility of the PIES concept must be seriously rethought.

Reports from psychiatrists deployed to Iraq suggest that when a psychiatrically distressed service member is able to stay with his or her unit and is afforded modified duty for a limited time PIES remains effective. With each level of evacuation, the military patient becomes more removed from the unit. Experience demonstrates that once evacuated from the CSH a soldier is unlikely to be returned to combat. Combat stress casualties often begin to experience relief of some acute symptoms when removed from the combat trauma. This relief is a potent re-enforcer, serving to make the soldier apprehensive about his or her ability to tolerate re-exposure. This confluence of factors creates powerful forces in the direction of evacuation and diminishes the likelihood of returning the military member to combat duty.

Military patients processed through the evacuation system will have various modalities of treatment, ranging from supportive measures to fairly intensive treatment. It will vary in accordance with the patient, the diagnosis, disposition, and the availability of treatment at the various locations. By the time the patient has arrived in CONUS he or she will have had several screens and some level of specialized care throughout the evacuation and disposition process.

Psychiatric Disorders Seen during Wartime

The destructive force of war creates an atmosphere of chaos and compels service members to face the terror of unexpected injury, loss, and death. The combat environment (austere living conditions, heavy physical demands, sleep deprivation, periods of intense violence followed by unpredictable periods of relative inactivity, separation from loved ones, etc.) is itself a psychological stressor that may precipitate a wide range of emotional distress and/or psychiatric disorders. Psychological injury may occur as a consequence of physical injury, disruption of the environment, fear, rage, or helplessness produced by combat, or a combination of these factors.

The psychiatric differential diagnosis for military patients at war is quite broad. The clinical picture will vary over the course of a war depending on individual characteristics (e.g., personality traits, coping skills, prior illness) available social supports, and the amount of time that has passed between clinical presentation and the precipitating event(s). Thus, it is useful to consider the range of emotional responses in the context of the multi-phasic traumatic stress response (Table 3):

- an *immediate phase* characterized by strong emotions, disbelief, numbness, fear, and confusion accompanied symptoms of autonomic arousal and anxiety;
- a *delayed phase* characterized by persistence of autonomic arousal, intrusive recollections, somatic symptoms, and combinations of anger, mourning, apathy, and social withdrawal, then finally;
- a *chronic phase* including continued intrusive symptoms and arousal for some, disappointment or resentment or sadness for others, and for the majority a re-focus on new challenges and the rebuilding of lives (Benedek et al., 2001; Ursano et al., 1994).

Within this three-phase framework of traumatic response, symptoms noted in the *immediate phase* of combat generally reflect either predictable "normal" individual response to extreme stressors (e.g., psychic distress *not* meeting threshold criteria for DSM-IV-TR psychiatric disorders; "battle fatigue" or "combat stress" in military parlance), exacerbations of pre-existing conditions, or the neuropsychiatric effects insults. These insults might include exposure to trauma, the central nervous system (CNS) effects (e.g., delirium) of chemical, biological (Franz et al., 1997; DiGiovanni, 1999), or other naturally occurring infectious agents, head or internal injury from missiles, blast effects, or other projectiles. ASD or adjustment disorders may manifest themselves in the immediacy of combat and, as with other forms of trauma or disaster, exacerbations of substance abuse, depression, or pre-existing PTSD (Schlenger et al., 2002; Shuster et al., 2001; Vlahov et al., 2002) may also occur. As personality disorders are, by definition, pervasive patterns of maladaptive response to stress, the stress of war can certainly precipitate exacerbations of previously sub-clinical personality disorders or maladaptive traits.

In the *delayed phase* following intense operational stressors, PTSD, Substance Abuse, and Somatization Disorder (or Multiple Unexplained Physical Symptoms) may be observed, and persistent anger, irritability or sadness may signal Major Depressive Disorder or other mood

disorders. Symptoms of bereavement or traumatic grief may also occur as service members reflect on the loss of brothers-in-arms. Troops provide significant support to one another during war, so such losses may have as much emotional impact as the loss of a close relative and may be accompanied by feelings of guilt—particularly if the lost service member was a "battle buddy." While a "fight or flight" instinct may pre-empt self-injurious behavior during the height of battle, anxiety symptoms, social withdrawal, and depressed mood may occur during the *delayed phase* and increase the risk for self-injury or suicide during this phase. To the extent that the military member received psychological support from comrades before and during battle, medical evacuation (due to physical injury or neuropsychiatric symptoms) may disrupt the support of the service member compounding the risk of self-injury.

During the *chronic phase* some service members will experience persistent PTSD symptoms or the more subtle secondary effect of exposure to chemical or biological agents (or their antidotes). These secondary effects include depression, personality changes, or cognitive dysfunction (DiGiovanni, 1999). Dysthymic disorder, mixed sub-syndromal depression/anxiety or sub-clinical PTSD may evolve and substance use disorders may become more firmly entrenched. For some military patients with PTSD, the pervasive distrust, the irritability, and the sense of foreshortened future may have more debilitating effects on social and occupational function than intrusive symptoms. Indeed the avoidance of reminders of the trauma (a symptom of PTSD) may result in affected individuals declining exposure-based therapy, or any treatment whatsoever, thus compounding not only the impact of war-related pathology but any pre-existent illness as well.

Table 3. Psychiatric Disorders and War over the course of the Multi-Phasic Traumatic Stress Response

Phase	Description	Diagnostic Considerations
Immediate	During or immediately after traumatic event(s): Strong emotions, disbelief, numbness, fear, confusion, anxiety, autonomic arousal	Battle Fatigue, Delirium (from toxic exposures, head injury), Acute Stress Disorder, Adjustment Disorders, Brief Psychotic Disorder, exacerbation of Substance Abuse, Personality disorders or traits, or premorbid mood, anxiety, or thought disorders
Delayed	Approximately one week after trauma or in the aftermath of combat: Intrusive thoughts, autonomic arousal (startle, insomnia, nightmares, irritability), somatic symptoms, grief/mourning, apathy, social withdrawal	PTSD, Substance Abuse, Somatoform disorders, Depression, other mood and anxiety disorder, Bereavement
Chronic	Months to years after: Disappointment or resentment, sadness, persistent intrusive symptoms, re-focus on new life events	PTSD, Chronic effects of toxic exposure, Dysthymic Disorder, other mood disorders, Substance Abuse Disorders, Emotional Recovery – perspective

In summary, no single psychiatric diagnosis characterizes the service member's response to war. For many, the training, comradery, unity of purpose, individual coping skills, and mutual support provided by comrades may protect against the development of severe psychiatric disorders as a consequence of war. However, even individuals that do not develop symptoms meeting criteria for *DSM-IV* disorders may react with transient changes in mood, affect, cognition, or combinations of these and somatic symptoms typically termed "battle fatigue." They may require psychological support at one point or intermittently during a campaign as result of their individual response to

particular events or their operational environment. For others, ASD or the neuropsychiatric sequelae of head trauma or exposure to toxic agents may occur. Major depressive disorder and other affective disorders, bereavement, substance abuse disorders, and somatoform disorders may also occur over time (see Table 3). Although PTSD may not be the most common emotional response to war, symptoms such as dissociation and avoidance of reminders of trauma (which may be adaptive; or may occur as associated features of other war-related illnesses) may impede treatment efforts of PTSD or other syndromes. Given the wide range of potential disorders or symptoms of distress that may evolve over time, the difficulty in distinguishing acute adaptive responses from psychopathology, and our inability to predict who may be most severely affected over time initial interventions should be aimed at insuring safety to self and others and developing mechanisms to monitor symptoms over time and encourage access to care.

Psychiatric Care in the Military Treatment System

After first being air evacuated (AE) from the theater of war to Landstuhl Regional Medical Center in Germany, Operation Iraqi Freedom patients may be sent to one of four stateside medical center regions. These include Walter Reed Army Medical Center (WRAMC), Washington DC, Dwight D. Eisenhower Army Medical Center, Fort Gordon, GA, Madigan Army Medical Center Fort Lewis, WA, and Brooke Army Medical Center, Fort Sam Houston Texas. With some exceptions, this process is the same for Army, Navy, and Air Force personnel being air-evacuated from the war zone.

Patients who are AE but only require routine outpatient care are sent to the medical center closest to the site from which they were initially mobilized. On arrival at the medical center, patients are triaged to ensure that outpatient care is, in fact, appropriate. They are then processed through the region's Deployment Health Clinical Center (DHCC) for further medical screening, and referred for treatment near their mobilization sites. While at the demobilization site, they continue to receive treatment and are evaluated for appropriate disposition. Veterans who require more intensive services are assigned to the medical center's Medical Holding Company and treated there. Veterans that do not meet medical fitness standards are referred to a Medical Evaluation Board (MEB). Those that are determined unsuitable either because of pre-existing condition or personality disorder are administratively separated. Those that are fit for duty with minor limitations are retained at the demobilization site for the remainder of their current term of service (reserve component) or released to their home duty station (active component). A veteran requiring routine outpatient care usually remains at each echelon level hospital for 7-10 days until reaching his or her final destination. Due to time constraints, treatment is generally focused on acute symptom relief and supportive therapy. Case management serves to identify appropriate resources to provide definitive treatments, when required.

Treatment availability varies from one site to the next. If a treatment modality is required and it is not offered at the final destination consideration is given to the potential benefit of keeping a patient at the medical center for a longer period. More often than not, the military patient wishes to return home and does not want to delay the process any more than is necessary. In these cases, psychoeducation focuses on the early identification of symptoms and the importance of self-referral for rapid mental health intervention. (Typical service member and family responses are discussed in *Chapter 12*.)

Any military patients requiring a MEB or who may require intensive outpatient care or inpatient care are air-evacuated to a medical center. While programs vary with respect to available services, the process at WRAMC serves as an example of treatment practices at the medical center level. WRAMC offers several levels of mental health treatment. Upon arrival the on-call psychiatrist screens all air-evacuated patients for acute symptoms that might necessitate hospitalization. Any patient air-evacuated as an inpatient is admitted to the hospital and is continued in inpatient care until clinical safety is determined. During the course of the inpatient admission a comprehensive assessment is performed and treatment initiated.

Army personnel requiring a medical evaluation board remain at Walter Reed and are assigned to the Medical Holding Company. Air Force and Navy personnel undergoing a MEB may be followed in the WRAMC Continuity Service within the partial hospitalization program until stabilized and ready for further disposition. Navy personnel undergoing a MEB are usually assigned to a medical holding unit near their home of record. Air Force personnel undergoing a medical evaluation board typically are returned to their unit. Inpatients with more severe illnesses and who are refractory to treatment may be discharged directly from the service to a VA inpatient ward near their home.

Outpatient follow-up is variable at all locations. Most if not all locations will have some form of treatment available. The WRAMC mental health services are presented as a model of the process most mental health patients may experience in one form or another.

The WRAMC Continuity Service offers several levels of care to include intensive outpatient services (defined as patients who require more than once weekly therapy) and partial hospitalization (defined as daily treatment of at least 3 hours each day). Partial hospitalization serves as a step-down unit for inpatients transitioning to outpatient care or a step-up unit for outpatients who need more care than can be given in a routine outpatient setting. Treatment modalities include group, individual, medication management, family and couples therapies as well as command consultations. Services are geared towards the needs of the patient. Daily war zone stress related groups and individual therapies are available. Continuity Service also provides ongoing mental health treatment and case management for patients assigned to the Medical Holding Company to ensure effective psychiatric monitoring through the MEB process.

All Army mental health outpatients, whether they arrive as outpatients or are subsequently discharged from the inpatient service, are case managed by the Continuity Service until they leave WRAMC. This ensures continuity of care and provides a resource that the patient can use during the time spent at WRAMC. Those identified as primary mental health patients are monitored by the Continuity Service even if they are getting treatment on a different clinical service at WRAMC.

The Behavioral Health Service is an outpatient treatment resource for “routine” ambulatory care, acute assessments, and liaison with military patients’ units in the region. Treatments offered include individual and group therapies and medication management. Patient referrals come from the air-evacuation system, local units, and other medical specialties. The patient completes a comprehensive work-up and an appropriate treatment plan is generated. Like the Inpatient and Continuity Service this can include return to duty, administrative separations or referral to a MEB.

Psychiatry Consultation and Liaison Service (PCLS) screens all hospitalized Wounded In Action (WIA) service members and most Non-Battle Injury (NBI). Disease Non-Battle Injury (DNBI) patients are also regularly evaluated by PCLS when requested through routine consultation. A

mental health screening is performed on every patient admitted from the war zone and consists of a diagnostic interview, and psycho-education about Combat Stress, ASD and PTSD. Service members needing further psychiatric care are referred for treatment with PCLS, Continuity Services, or Behavioral Health as needed.

Patients requiring administrative separation or a medical evaluation board may be delayed in separation from the service for several months. The types of treatments available throughout the DoD vary depending upon location and available resources. The patients may receive therapy from any of the modalities discussed above and may be involved in various treatment modalities while awaiting their final separation.

Military Medical and Administrative Decision Making

Military Mental Health Officers are charged with the responsibility to evaluate service members at several points in the deployment process to ensure that these service members are psychiatrically fit to fulfill mission requirements. As the Medical Corps mission is to "Conserve the Fighting Strength" of the deploying forces, clinicians must carefully weigh medical decisions that keep service members from deploying. The impact of deploying military members with psychiatric conditions to combat also needs to be weighed. Psychiatrically vulnerable individuals who are deployed to a theater of operations create serious distractions for their commanders and their units. An individual who becomes unfit during a deployment will require special attention and resources. If evacuation is required, a replacement will not be forthcoming. Therefore, one must use common sense to screen out individuals who are ill or are likely become ill. As anxiety is a normal response prior to deployment, normal fear and apprehension should not be pathologized. Clinicians must always maintain a keen eye for potential malingerers, as well.

Soldier Readiness Processing (SRP) & pre-deployment screening. The DoD has developed extensive screening as part of the Pre-Deployment Health Assessment performed for all service members regardless of service or active/reserve status. All soldiers should receive SRP screening annually by their command to identify the presence of conditions that may make them unfit for deployment. This screening typically includes review of any medical "profiles" or limitations to duty determined by physicians, or due to dental status, HIV status, or other administrative reasons. Unfortunately, this screening is often not completed appropriately for National Guard and Reserve soldiers. Without routine SRP screening, soldiers with unfitting conditions are not recognized until they are called to Active Duty for deployment, creating serious concerns for unit readiness.

All soldiers, whether active, guard, or reserve, when notified for deployment, are processed through one of several mobilization (MOB) sites. An SRP screening is performed with the addition of a DOD-mandated Pre-Deployment Health Assessment (DD Form 2795) to gather baseline health information and screen for potentially unfitting conditions. This assessment screens for general medical and psychiatric conditions and is a source for comparison if the soldier develops any health concerns related to the deployment. With this in mind, soldiers may have a tendency to under-report any symptomatology or evidence of pre-existing conditions for various reasons to include a desire to deploy without limitations, fear of being charged with fraudulent enlistment for concealing a prior psychiatric treatment, concern about future disability claims, or other fears about the stigma associated with psychiatric conditions. When under-reporting exists, vulnerable soldiers are deployed with an increased risk of developing combat stress-related symptoms to include ASD and PTSD. Additionally, even when the soldier discloses a psychiatric history during

pre-deployment screening, commanders may determine that the soldier will deploy because of unit readiness requirements, despite the recommendations of the medical staff.

All screening forms are reviewed and soldiers are referred for more specific examinations when indicated. Soldiers with preexisting psychiatric conditions (e.g., psychotic, mood, or anxiety disorders), current symptoms of illness, substance use disorders, or personality disorders are evaluated to determine if these problems are unfitting or may predispose to combat stress-related illness. If an unfitting condition exists, the soldier is immediately demobilized and a recommendation is made for administrative separation for the condition that existed prior to service.

Pre-deployment screening for psychopathology has certain drawbacks. There are no accepted screening standards to inform how to exclude vulnerable individuals. Additionally, the risk factors for combat stress reactions, apart from a history of prior trauma, are unclear. When the threshold is set to eliminate vulnerable soldiers, one might ask who will pass muster to deploy. If screening is too permissive, high rates of combat stress symptoms can be expected. Pre-deployment level of social and occupational functioning, regardless of diagnosis, is an important indicator of functional capacity on the battlefield. Nevertheless, the function of the pre-deployment screening serves to identify most soldiers who are evidencing present or past psychopathology that could likely interfere with their functioning. Anecdotally, military psychiatrists serving in Iraq note that a soldier's level of pre-deployment social and occupational functioning often is the best predictor of outcome, regardless of diagnosis.

Mental health support during deployment – self- vs. command-referral. Once deployed, soldiers may access mental health services to continue previous treatment or to initiate treatment for new symptoms. Service members may self-refer at any time. They may present directly to Division Mental Health, or Psychiatric Services at the supporting Combat Stress Control Detachment or Combat Support Hospital. Military members often struggle with ambivalence about accessing mental health services. Additionally, in a war zone where Commanders must have constant updated accountability for their troops, and where travel is often limited to military convoys, it is difficult for military patients to access mental health services unnoticed. Despite frequent command-level briefings about combat stress and suicide prevention, the stigma of mental illness prevails. Service members also are concerned about the perceived limitations to their career if they access mental health. Frequently, they fear loss of opportunity for promotion, loss of security clearance, or elimination from the service. This ambivalence can lead to unnecessary suffering.

Equally problematic are service members who actively seek mental health care as a means of avoiding duty. Suspicions require close consultation with commanders to ensure proper diagnosis and disposition. Although successful return to duty may be the most adaptive disposition for such individuals, it must also be recognized that many are at increased risk of harm to self or others if acting out behaviors escalate. If the tactical environment does not allow the commander to commit the necessary resources to ensure short-term safety, evacuation from the combat zone with a recommendation for administrative discharge may be necessary.

When military commanders identify a military member who is at-risk or symptomatic, they may "Command-Direct" the individual for a mental health evaluation in accordance with DOD Directive 6490.1. These evaluations lack confidentiality as the results are uniformly released to the commander. As with self-referrals, the mental health officer may recommend treatment of the condition with retention in the military, limitations to duty, or evacuation from the combat zone.

The service member may also receive a recommendation for an administrative discharge, or referral to a Medical Evaluation Board. The disposition is determined by the nature and severity of symptoms, as well as the treatment resources available in theater. Combat psychiatrists work with commanders to encourage return to duty and provide treatment while remaining at duty. Currently deployed psychiatrists report good success in treating ASD, PTSD, and depressive disorders with SSRIs and short-term benzodiazepines. Only those military patients with psychotic symptoms, bipolar disorders and suicide risk are evacuated to a higher echelon of care.

Demobilization—post-deployment screening. When service members return from deployment, regardless of whether due to normal troop rotation, medical evacuation, or for administrative reasons, they receive a comprehensive screening evaluation for presence of medical and psychiatric illness. This DOD-mandated Post-Deployment Health Assessment (DD Form 2796) is performed either at the demobilization (DEMOB) site, or if a patient has been medically evacuated, at the Military Medical Center. This screening includes questions about depression, PTSD, and substance abuse. Individuals who screen positive are referred within 72 hours for a definitive mental health evaluation.

Service members with identified disorders are offered treatment and are evaluated for appropriate disposition. In the absence of non-psychiatric conditions, aggressive treatment continues with the goal of retaining the individual and returning him or her to full duty. Service members are given an adequate trial of treatment before a decision is made to refer to the disability system through a MEB unless other conditions mandate referral to MEB.

Medical Evaluation Board. If a service member requires evacuation from the combat zone for combat stress symptoms, the psychiatrist must decide whether the symptoms are due to a psychiatric condition, situational problem, or personality disorder. The psychiatrist must also determine the prognosis and likelihood of response to treatment. Generally, in the absence of a personality disorder or other confounding variables, aggressive treatment of combat stress reactions is indicated. If the symptoms cannot be stabilized within a reasonable amount of time, then referral to a MEB is indicated for disability retirement.

In deciding whether and when to initiate a MEB, the treating psychiatrist must consider the military patient's length of service, previous history, current symptoms, prognosis, as well as the time remaining on active duty for activated reservists. Junior ranking military members in their first enlistment with no prior deployment experience are likely to be referred to MEB. More seasoned military members are more likely to be monitored for up to one year with some duty limitations in an effort to retain them. Reservists who are nearing the end of their term of activation are likely to be allowed to be released from active duty (REFRAD) and referred for continued care and monitoring.

A service member may require referral to a MEB by virtue of his or her other medical conditions. When this is the case, a psychiatric addendum is performed to establish a service-connected condition, and to identify if the condition meets or does not meet medical retention standards.

One has to remain cognizant of the individual who may be attempting to manipulate the disability system in his or her favor by exaggerating symptoms, or seeking disability for conditions that are not medically unfitting. The psychiatrist must be mindful of all motivating factors and the potential for the influence of a disability seeking culture.

Administrative discharges. When the emotional condition is obscured or confounded by the presence of a personality disorder, primary substance abuse problem, or other situational issues, an administrative separation is indicated instead of a referral to MEB. Conditions such as unstable family situations, chronic suicide threats, substance abuse disorders, acting-out behaviors and malingering are best managed with an expeditious administrative discharge to minimize the negative effects these behaviors may have on the unit or rear-detachment. The Commander may punish service members who malinger with Uniformed Code of Military Justice (UCMJ) actions prior to discharge.

While the service member is pending separation from the service, treatment and monitoring by mental health is often beneficial.

Limits of medical authority. It is important to be aware of the limitations physicians have when treating the military patient. The military physician's role is to treat the patient, determine if the patient is medically fit to fight, and make recommendations to the patient's commander about appropriate disposition. The only area where the physician has full authority is when a condition is life threatening, requires hospitalization, or does not meet retention standards and referral to MEB is indicated. In all other situations, the physician is a consultant to the system and can make recommendations only. Recommendations may include: Return to Duty (RTD) without any limitations, RTD with some limitations or changes in environment, or administrative recommendations about rehabilitative or compassionate transfers, or discharge from the service.

Commanders have ultimate authority and bear ultimate responsibility for acting on recommendations. They may decide to attempt to rehabilitate a service member in his or her command despite recommendations for administrative discharge. A commander who chooses to ignore medical recommendations must review this decision with his or her higher commander. If the restrictions placed on a military member cannot be accommodated either by the nature of the mission or the individual's military occupational specialty (MOS), the commander may request a "Fitness for Duty Board" from the supporting hospital. If the service member is found fit with some limitations that constrain his or her duty performance, the commander may request evaluation by a MOS Medical Retention Board (MMRB). The MMRB can return the soldier to duty, change the soldier's MOS, or refer the soldier to the disability system.

Ethics of military psychiatry. Military mental health officers must struggle with the ethical issues and duties to the individual and the military. They should always be the "honest broker" in caring for military patients and making tough decisions about treatment, referral to the disability system, administrative discharges, and limitations to duty. They must balance the mission requirements with the best interest of the patient and attempt to make the recommendation that will afford the service member the best outcome and opportunity for retention. Additionally, military mental health providers have got to recognize when the demands of service cannot afford the luxury of a prolonged rehabilitative period. They are also obligated to serve the interests of the service by remaining alert to secondary gain and malingering.

Military clinicians must understand that combat is one of life's most significant traumatic events. They have to allow some vulnerable individuals to deploy and must recognize that some will become symptomatic. Ultimately, military mental health providers are required to remain empathic to the military patient as well as the needs of the service by providing compassionate treatment for combat veterans and referring service members who cannot be rehabilitated quickly to the disability system.

Conclusions

Clinicians involved in the treatment of casualties returning from Operation Iraqi Freedom require an understanding of the military system in which these service members work and receive their medical care. Unlike prior conflicts, casualties from this war will likely receive treatment services in a variety of settings by providers from non-military professional backgrounds.

Diversity within the military populations suggests that evacuated military patients are likely to come from different areas of the country and vary in terms of ethnic and cultural heritage. There is an increasing number of women as well. Patients' military experience may vary considerably depending upon the military component (e.g. active, reserve or National Guard) to which these service members are assigned. They may have been exposed to a variety of different combat stressors, depending upon their site of duty, the nature of conflict to which they have been exposed, and the roles in which they have served. The literature is clear that certain psychiatric conditions, including acute stress disorders and PTSD, are not uncommon responses to individuals exposed to combat. Clinicians must be aware of other psychiatric and organic disorders that might also contribute to their presentation, however.

The military system is designed to minimize psychiatric disorders on the battlefield through predeployment screening and by providing mental health services in the combat setting. When evacuation is required, service members may be treated within several echelons of care that are established. Additionally, military regulation guides the appropriate evaluation of psychiatrically ill military patients. Service members with behavioral or emotional disorders may require discharge from service through the Medical Evaluation Board (MEB) process or through command determined administrative separation.

All of these factors can contribute to the clinical condition of an evacuated soldier, airman, or sailor. An appreciation of these complex issues will serve the clinician well in evaluating and treating service members psychiatrically evacuated from theater.

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