

Human Behavior Course 2004

Military Psychiatry

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HUMAN BEHAVIOR COURSE 2004
MILITARY PSYCHIATRY - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. List the areas of expertise military psychiatrists must have to practice their specialty.
2. Describe the approach military psychiatrists use in the battlefield to prevent psychiatric casualties.
3. Describe aspects of psychological trauma and trauma treatment that are important to the military psychiatrist.
4. What are the key ethical dilemmas in combat and disaster psychiatry?
5. List factors associated with adverse psychosocial reactions to combat (i.e., combat stress reactions)
6. What group or individual level psychosocial factors predict resilience in combat?
7. Know the treatment of choice for combat stress reaction.
8. Know the role of medications for combat stress reaction.
9. Know the main names that have been used in the US for combat stress reactions since the Civil War.
10. List the important goals of the military psychiatrist during combat.
11. Describe technological trends that will likely impact on the practice of combat psychiatry in the 21st century?
12. What are the arguments for and against “psychological debriefing” (also known as “critical incident stress debriefing”) as an early intervention for people who have experienced severe psychological trauma? There is some evidence psychological debriefing may cause harm. In theory, how might that happen?
13. Know the psychiatric disorders commonly associated with military deployments
14. List key signs and symptoms that occur in an individual with a combat stress reaction?

Military Psychiatry – Terms & Concepts

- ★ primary prevention
- ★ secondary prevention
- ★ tertiary prevention
- ★ induction
- ★ retention
- ★ command consultation
- ★ contaminated environment
- ★ traumatic stress
- ★ combat stress
- ★ transition states
- ★ autonomic arousal
- ★ post-traumatic growth
- ★ trauma mediators
- ★ training
- ★ experience
- ★ leadership
- ★ torture
- ★ sexual assault
- ★ prisoner of war
- ★ respite
- ★ medicalization
- ★ forward treatment
- ★ frontline psychiatry
- ★ critical incident stress debriefing
- ★ combat stress reaction
- ★ battle fatigue
- ★ shell shock
- ★ neurasthenia
- ★ soldier's heart
- ★ irritable heart
- ★ buddy aid
- ★ stigmatization
- ★ "PIES"



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Military Psychiatry – Terms & Concepts

- ★ combat stress response
- ★ stigma
- ★ wounded
- ★ diazepam
- ★ amytal



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A Medical Officer & Military Psychiatrist

- **Absolute commitment**
- **Full commitment to both medical and military professional values**
- **Ethical & medical/legal sophistication**
- **Military, medical & psychiatric knowledge**
- **Physically & mentally fit**
- **Accepts exposure to extreme environments**

Military Psychiatrist

- **Advises on fitness for general and special duty**
- **Supports fitness for duty**
- **Restores fitness for duty**
- **Recommends return to or removal from duty**
- **Serves as practitioner, special staff and commands special units**

Military Psychiatrist

Knowledge of:

- **Military performance demands**
- **Administrative and forensic issues**
- **Epidemiology**
 - **Of military operations**
 - In war
 - In operations other than war (e.g. In peace keeping)
 - In garrison and training
 - **Of disasters**

Biopsychosocial Issues Military Psychiatry

The modification of doctrine, training, and practice to meet community, technological, and tactical requirements requires knowledge of

- **Bio-** (environmental stresses microbiology, fitness etc.)
 - **Psycho-** (education, beliefs, etc.)
 - **Social-** (cohesion, diversity, etc.)
- Parameters.

Psychiatric Issues in a Military Context

- Research & evaluation
- Consultation and referral
- Psychiatric prevention using public health model
 - Primary prevention (↓ incidence)
 - Secondary prevention (↓ prevalence)
 - Tertiary prevention (↓ disabilities)

Psychiatric Issues in a Military Context

- **Screening**
 - Induction standards,
 - During training and
 - Evaluate for duties
- **Rx – program:**
 - In-unit (command consultation),
 - Out-pt and
 - In-pt
 - » Retention and discharge

Psychiatric Issues in a Military Context

- **Psychiatric problems of mass casualties (burns, severely injured and problems of medical staff)**
- **Causes of behavioral dysfunction in austere, dangerous, contaminated environments**
- **Knowledge of socio-cultural influences**

Military Psychiatry Addresses

- **Endemic psychiatric disorders,**
- **Psychiatric disorders associated with deployment and combat,**
- **Mass casualties: triage & management,**
- **Practice with special populations (E.G. Intelligent personnel, Custodians of WMD, Pilots),**
- **Occupational operational psychiatry for all in armed forces.**

Stresses Of Deployment

- **Loss of social supports**
- **“Culture shock”**
- **Change in relationship**
- **with loved ones & family**
- **Economic problems**
- **Exposure to new stresses**
- **Exposure to new toxins & infections.**

Stresses Of Deployment

- **New microbial environment**
- **Opportunity for access to alcohol, illicit sex and drugs**
 - **Easier**
 - **New forms of alcoholic drinks & drugs**
- **Cultural challenges**

Diagnoses Associated With Deployment

- **Adjustment Disorders**
- **Various Character and Behavioral Disorders**
- **Malingering & Factitious Disorder**
- **Anxiety Disorders**
- **Affective & Mood Disorders**
- **Substance abuse and dependency**
- **Previously disguised disorders**
 - E.G. PTSD, & Panic Disorder

Deployment Problems: Treatments

- **Treat on site, usually do not evac, refer to psychiatrist as needed:**
- **Crisis management**
- **Reassurance & supportive psychotherapy**
- **Cognitive behavioral therapy**
- **Symptomatic management**
- **Do not excessively pathologize the patient's condition and**
- **Do understand the suffering of the patient!**

Deployment Problems: Treatments

- **Anxiolytic & antidepressants drugs (e.g. SSRIs) may be helpful for treatment of specific syndromes & symptom relief.**
- **Exceptions that may require evac**
 - **Psychotic or manic symptoms,**
 - **Severe depression**
 - **Complex dx issues**
 - **Suicidal or homicidal threat**
 - **Primary diplomatic or other special missions.**

Deployment: The high risk family

- **Few social supports**
 - **The young isolated spouse**
 - **No extended family support**
 - **Poor support from the unit**
- **Physically and psychiatrically ill spouse or child**
- **The failing marriage**
 - **Most report strengthened marriage**
 - **But failing marriages not helped**

Deployment Problems: the Return

- More problems on return than with departure
- Problem of shifting power dynamics in marital/significant other relationship
 - Children and role of returning spouse
 - New independence of spouse
 - Absence makes the heart grow fonder of someone else
- Unrealistic expectations

Effect on Marriage

40% +

29% 0

23% -

Effect on Positive Career Commitment

NCO and Officer

to Neutral

E1 to E5

to Negative

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TRAUMA: PSYCHIATRIC CONSEQUENCES

Extreme demands associated with

- Battles
- Terrorist actions
- Criminal actions
- Technological and natural disasters
- Result in consequences

The slide has a white background with a black border. The title "TRAUMA: PSYCHIATRIC CONSEQUENCES" is centered in a bold, black, sans-serif font. Below the title, the text "Extreme demands associated with" is followed by a bulleted list of five items: "Battles", "Terrorist actions", "Criminal actions", "Technological and natural disasters", and "Result in consequences".

COMBAT STRESSES: EXAMPLES

- **Extreme environmental exposure**
- **Chronic fear of mutilation and death**
- **Horror**
- **Failure, letting your buddies down**
- **Fear of displaying fear**

Mediators of the Consequences of Trauma

- **Physical injury & disease**
- **Psychologically overwhelmed**
- **Extreme psychophysiological arousal – sense of being physiologically overwhelmed**
- **Fail socio-cultural expectations**
- **Disruption of social supports**
- **Failure command and med care**

Transition States

Psychological states that occur when there is a catastrophic alteration of the environment.

(e.g. Extreme autonomic arousal & Dissociation)

Consequences of Trauma

- **Transient manifest changes in alerting and autonomic functions,**
- **Acute disorders,**
- **Chronic disorders & complaints of undefined causes,**
- **Growth**

Consequence of the Response to Trauma

Potential for reorganization of the perception of one's "self" & of one's sense of personal and social identity.

Trauma Mediators [Biopsychosocial]

- **Previous trauma**
(↑risk)
- **Successful training** (↓risk)
- **Experience managing response to disasters facilitates successful performance** (↓risk)

Note the paradox

Trauma Mediators [Biopsychosocial]

- **Leadership**
- **Unit/Community Factors
(Cohesion Versus Disorganization)**
- **Physical Conditioning**
- **Equipment that Works**
- **Good Preventative Medicine**

The Stresses of War & Battle

- **Destruction of social supports**
- **Destruction of expectations**
- **Physiological exhaustion, poor nutrition, infection**
- **Exposure to toxins, and injury and wounding**
- **Battle death, and injustice seem unending**

Combat Stresses: Examples

- **Death, mutilation & injury of colleagues,**
- **Chronic illness and nagging, untreated injury,**
- **Perform acts contrary to conventional moral sanctions,**
- **Separation from family and roots
(Communication with those at home important – mail, e-mail ,etc helps).**

Combat Stresses: Transcendental factors

**Threatened loss of
faith in:**

- **Leadership**
- **Nation**
- **Belief in the eternal verities**

Trauma Mediators [Biopsychosocial]

Biology-genetics

- **Illness**
- **Genetically mediated**
- **Endocrine-autonomic mechanisms**

Neuro-psychological

- **Learning and conditioning (learned helplessness?)**
- **Dissociation**

Increased Risk In Combat Deployed

- **Organic mental syndromes**
- **Mood and Anxiety Disorders**
 - **Major Depression**
 - **Bipolar Disease**
 - **Phobic Disorders**
 - **Generalized Anxiety Disorder**
 - **Panic Disorder**
- **Adjustment Disorder**
- **Dissociative Disorders**

Factors that Shape the Response to Trauma

- **Physical injury and disease,**
- **Psychophysiological change & Psychological change**
- **Act together - cohesion**
- **A potential reorganization of personal outlook**

Prevention

- **Screening,**
- **Buddy care,**
- **Manage social supports,**
- **Educate about disaster stress, &**
- **Educate health care providers concerning effective responses to victims prior to the casualty generating event.**

Prevention

- **Training**
- **Experience**
- **Leadership**
- **Manage meaning**
- **Manage exposure**
- **Manage fatigue**

Those most exposed to horror of trauma are at higher risk.

Intensity of horror related to nature of events, the number of exposures to very intense events, and influenced by expectation.

Respite helps!

Increased Risk in the Combat Deployed

- **Factitious disorder**
- **Adjustment disorder**
- **Malingering**
- **Acute Stress Disorder**
- **PTSD**
- **Post concussion syndrome (also occurs with PTSD)**
- **Complex substance abuse**

Higher Risk Groups

- **Combat personnel**
- **Rear area personnel (when attacked)**
- **Previously psychologically traumatized**
- **Perpetrator of torture or atrocity**

Higher Risk Groups

- **Untrained and inexperienced**
- **Refugees**
- **Very young and very old**
- **The wounded and injured**
- **Professional rescue teams**
- **Medical personnel**
- **Survivor of multiple losses of significant others**

Higher Risk Groups

- **Those perceiving self as failing others,**
- **Those tortured and sexually assaulted, male or female, &**
- **Torturers or murders.**

Recovery Environment

- **Provide respite**
 - Must be designed to be appropriate to the deployment, the mission, and the actions of the enemy
 - Safe, socially and personally supportive
- **Holding environment**
Do no harm - No 2° injury

Recovery Environment: Military Style

- "Critical incident debriefing" this technique has not been demonstrated to be efficacious. –
 - Many military trained to use CISD
- "Forward treatment"
May be buddy aid & medics aid in modern combat.
Avoid stigmatization

Recovery Environment

In combat the central concept of psychiatric care has been:

- **Provide respite [Cognitive behavioral support or psychpharm intervention ??]**
&
- **Expect recovery &**
- **Expect return to duty with 1 unit or in combat area.**

Maybe impossible on modern battle field.

Psychiatric Casualty Classification

- **According to the severity of the service person's loss of functional capacity &**
- **Non-diagnostic terms like "combat stress response" are used.**

Management Policy for Psych Casualties

- **Physical illness & injury is evaluated in the initial triage process &**
- **Reevaluated throughout the evac chain;**
- **DSM Dx is not permitted in the forward area;**
- **Initial treatment must be brief & simple.**

Incidence

- **Highest with high intensity battles lasting for prolonged periods**
- **Rates of occurrence vary between 1 in 20 physical casualties in elite units**
- **To 1 in 2 or 1 to 1 physical casualties in an intense land combat engagement**

Incidence

- **Lower on ships at sea and in surrounded units**
[Casualties may appear when ships reach port.]
- **Rear area soft target have highest rate of casualties when attacked**
- **Operational fatigue in air ops may relate to sortie rate.**

Management Policy for Psych Casualties

- **If impairment, is extreme or persistent evacuate to rear areas.**
- **A DSM-4 diagnosis will be developed after evacuation.**
- **Treatment is provided at all levels mostly by non-mental health personnel. Avoid stigma.**
- **Wounded are at higher psychiatric risk.**
- **Return to duty possible at all levels.**

FORENSIC ISSUES IN COMBAT

- **Those commit atrocities at increased psychiatric risk.**
- **Those who commit crimes may use psychiatric claims to avoid responsibility.**
- **Other issues include**
 - **Malingering and factitious disorders**
 - **Civil/tort (damage claims)**
 - **Disability determination.**

Medications for Acute Psychiatric Casualties

- **Sedation or extreme agitation - a diazepam**
- **To facilitate recall or treatment (amytal interview ?)**
- **Other “chemical” restraint in forward area to control agitation & psychotic symptoms?**

Presentations: Recovery Phase After The Battle

- **Startle or anxiety**
- **Withdrawal**
- **Dissociative sx or sy**
- **Insomnia**
- **Depression**
- **Substance abuse**
- **Somatic complaints**
- **"Hallucinations"**
(intrusive re-experiencing)

Risk: Interpersonal Violence

- **Risk of suicide and murder lower in the services but matters of great command concern. Make psychiatric referral non-stigmatizing.**
- **Inter-personal violence in family by family members against family members is serious. Make psychiatric referral non-stigmatizing.**
- **Supporting the prevention & management a major task for mil med & mil psychiatry.**
- **Make seeking psychiatric care non-stigmatizing.**