Reviews & Mini Reviews

Psychiatry and Military Medicine

A. El Sheshaai

Introduction

In these uncertain times of unstable governments, terrorism, global mistrust and ineffective verbal negotiations, wars appear to be more prevaient. Therefore, it will become increasingly prudent to study, understand, and treat the conditions that may affect a soldier's ability to initiate and sustain combat, be it in the front lines, ambush situations, or the rear areas of operations *(Hicklin T.A. 2003).* Psychiatry and the behavioral health sciences are a central part of military medicine. Military Psychiatry has long emphasized the principles of prevention and early intervention in preparing for and treating those suffering from the psychological wounds of war *(Ritchie E.C. 2003 a).*

History of Military Psychiatry

Historically, military medicine has had one central theme and purpose to conserve fighting strength, with the aim of minimizing the manpower losses from these real and quasi-mental disorders. Prior to World War I, the concept of combat stress had not been defined. Stress casualties were restricted to soldiers experiencing psychotic disorders, characterized by a "break from reality" and often accompanied by hallucinations and delusions. *(Artiss KL. 1963)– (Jones F. 1995)* During World War I, the intensity of battle reached levels previously unknown due to advanced weaponry. Soldiers were confronted with intense battle situations, death, and destruction and, as a result, experienced severe levels of fear. Enemy shelling, gas attacks, and the smells of the battlefield lead to the term "shell shock." Soldiers experiencing shell shock were evacuated to the rear and diagnosed as suffering from war neurosis. Little effort was made to return them to the front lines *(Artiss KL. 1963) – (Jones F. 1995).*

In an effort to reduce the loss of manpower, the medical division experimented with treating the affected soldiers near the front lines and discovered that most of the soldiers could in fact be returned to duty. This was a remarkable discovery, from which a three-step system emerged, organized by Major Thomas Salmon, chief psychiatrist of the American Expeditionary Forces. Near the front, divisional psychiatric facilities treated soldiers for up to 5 days for shell shock and war neurosis. If the condition persisted, they were then sent back to neurological hospitals for several weeks. Long-term definitive care was given at a psychiatric base hospital farther from the battle area. This arrangement is still practiced by military mental health professionals *(Salmon TW 1929).* After World War I (WWI), military psychiatry became a legitimate, permanent part of the military community. However, not until World War II did the military psychological screening of troops during the induction process became the primary focus of the Army's mental health professionals. This delayed efforts to establish treatment for soldiers suffering from combat stress. Efforts to treat soldiers near the front lines seemed to have been forgotten. These soldiers were labeled as having psychoneurosis and were treated in the rear operational areas. Medical discharges were recommended for many, resulting in a serious loss of manpower on the battlefield *(Shepard B 2001).*

By the end of 1944, a resurgence of efforts to prevent and treat psychiatric casualties closer to the front lines occurred, recalling the lessons learned from WWI. Consultation services also emerged, whereby small teams of mental health personnel focused on providing preventive consultation and assisting units in stress prevention. Effective leadership and unit cohesion were emphasized, as well as adequate rest, food, and physical comfort in areas close to the front lines *(Shepard B 2001).*

During the Korean War, the concept of teamwork among psychiatrists, psychologists, social workers, and enlisted behavioral technicians was instituted, resulting in a decline in the frequency of psychiatric casualties. At the beginning of the Vietnam war, a division of 15,000 to 18,000 soldiers averaged 100 to 200 referrals per month. By 1971, up to 61% of all medical evacuations were for mental health reasons. The concept of "combat stress misbehaviors" was developed, with well-known issues of substance abuse, various forms of war atrocities, and desertion *(Richie EC 2002).* During 1991's Operation Desert Storm, combat stress control companies (CSC) were developed to augment the divisional mental health teams' efforts to understand, treat and prevent combat stress. Various stress management aspects were organized, including the measurement of a unit's level of cohesion