Combat Psychiatry: Lessons from the War in Southwest Asia

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The war in Southwest Asia (SWA) was the Army's first opportunity since Vietnam to provide mental health services to a large deployed combat force. Despite the low number of combat stress casualties, information from corps and division levels suggests deficiencies in the Army's ability to provide wartime mental health support. Based on observations, interviews and written data, and from direct experience as a mental health officer, before, during and after ground combat in SWA, the author presents a number of mental health lessons learned.

This article examines aspects of combat psychiatric support during the United States Army's deployment in Southwest Asia (SWA). The focus is corps and division level mental health support.

Overall, corps and division mental health personnel and units were not adequately prepared to perform their combat mission. As individuals and as units, they were not ready for a "come as you are" war. Fortunately, there was time available in the SWA Theater for mental health personnel and units to get organized, equipped and oriented for combat. In some cases, there was even time for mental health personnel to develop working relationships with the units they were assigend to support in combat. The Army was fortunate that these "last minute" preparations were not severely tested.

The extremely successful 100-hour ground assault, with rapid advances on all fronts and very few physical casualties, had the expected result of almost no American combat stress casualties. If Saddam Hussein had been able to deliver on his chemical and biological warfare threats, and the Army had experienced significant numbers of physical casualties in a series of drawn-out battles across Iraq, corresponding numbers of battle fatigue casualties would have occurred.[1] One combat stress casualty for every three physical casualties would have been the norm, with higher ratios in mass casualty situations.[2] The total number of combat stress casualties could have easily overwhelmed the division and corps-level mental health resources in SWA.

Even a very successful war produces "pockets of trauma." There are small numbers of soldiers who experience firsthand the horrors of combat. These soldiers may witness the violent deaths of enemy soldiers and the severe injury and/or death of members of their own unit. They may encounter the terror of friendly fire, or they may be involved in providing comfort to the innocent victims of war; those women, children and elderly civilian refugees who seek food, water and medical help from front-line soldiers. Like all victims of trauma, many of these exposed soldiers will experience some of the normal symptoms of extreme stress, intrusive thoughts, difficulty sleeping, etc.[3,4] These soldiers need an opportunity to talk about their experiences with fellow soldiers, unit leaders and sometimes with professional helpers like chaplains and mental health personnel.[5] Despite efforts by senior mental health personnel to encourage these types of debriefings, they occurred in only a few locations. Prior to the start of the ground war, there was no systematic theater plan for conducting critical incident stress debriefings. When a plan was finally developed, it was too late to implement it. In addition, many of the mental health personnel in the theater did not have training and/or experience with this type of clinical intervention.

The author's assessments of corps and division mental health units are based on data collected in SWA during both Desert Shield (as a member of a HQDA stress assessment team) and Desert Storm (as a social scientist studying mental health operations and later as a mental health clinician in a forward deployed combat unit) Information also came from reviews of unit afteraction reports as well as extensive interviews with mental health and other medical and non-medical personnel who served in SWA.

While critical of the overall mental health effort, the author does not intend a personal criticism of any individual. There were notable individual achievements by mental health personnel and, in general, people did the best they could. Unfortunately, despite a repeated history of failing to prepare for combat stress casualties, the Army was not adequately prepared for what might have happened in SWA.[6,7]

Observations and Lessons Learned

The Corps Psychiatry Consultant: While not authorized by doctrine or current manning documents, one of the two corps deployed to SWA with a psychiatrist assigned to the Corps Surgeon's staff. The decision to deploy a psychiatrist in this role was based on two factors. First, it appeared that this large, heavy force would see the brunt of any massed ground combat, and the corps surgeon was concerned about the potential for heavy battle fatigue casualties. Second, as late as the end of December this corps believed it would have two reserve psychiatric medical detachments (OM teams), each with 50-plus persons assigned to it. The corps surgeon felt that a psychiatry staff officer would provide needed corps-level technical

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supervision and guidance for these units as well as facilitate their rapid integration into corps combat support plans.

A number of things changed once this corps arrived in SWA. The corps medical staff was absorbed into a reserve medical group that became the senior medical organization in command and control of corps medical units. In addition, only one OM team arrived in the corps. In the midst of this confusion, it was difficult to establish a role and define responsibilities for a psychiatry staff officer on the headquarters staff of the medical group. There was also some confusion and overlap between the role of the psychiatry staff officer and the commander of the psychiatric medical detachment (OM team) assigned to and colocated at the medical group headquarters. Despite all of this, the corps psychiatry staff officer was an asset. Two important lessons learned include:

— The value of a senior psychiatry staff officer at corps level as a communication link between (and among) the theater consultant and personnel in corps mental health units (in this case the OM team, the psychiatrists at the corps' five evacuation hospitals and the three division mental health teams operating in the corps). The OM team commander has too many other responsibilities to effectively carry out this important function.

— The importance of having an experienced, senior psychiatry officer in a position and place where he can influence command policy and practice, including the placement (or movement) of mental health personnel to meet rapidly changing operational requirements. A corps psychiatrist can perform this critical role.

Corps-Level Psychiatric Medical Detachments (OM Teams): The primary mental health unit supporting a corps is a psychiatric medical detachment —better known by its Army nomenclature as an OM team. The OM team concept is considered obsolete and is scheduled to be replaced by a new organization, the Combat Stress Control Company, which is better designed and equipped for modern combat.[2] Unfortunately, the fielding of these new units has been a very lengthy process, and they were not available for deployment to SWA.

The Army deployed three OM teams (one from the active Army and two from the Reserves) to support the SWA Theater; one to each corps and a third, initially deployed at Theater-level, but subsequently broken up with elements attached to the two existing corps OM teams. Each OM team consisted of approximately 50 individuals, including psychiatrists, social workers, psychologists, psychiatric nurses, enlisted behavioral science specialists and inpatient psychiatric specialists, as well as a few soldiers with administrative and logistical skills and corresponding vehicles and equipment needed to support the OM team's activities. OM teams are designed to operate a small holding section (approximately 25 cots) and to provide consultation and treatment sections in support of division mental health teams.

Each of the three OM teams deployed to SWA has its own story. This paper highlights a few of the more important lessons learned from the deployment and operation of these teams.

Whether from the active or reserve component, OM teams need to be staffed, equipped and trained so that they can perform their designated combat functions. (Obviously, the same will be true of the new combat stress control companies.) At a minimum, they should have a sufficient core of well trained key personnel so that they can be quickly filled and rapidly mobilized for combat. None of the OM teams deployed to SWA met this standard. Some of their deficiencies included:

— The active duty team commander, a PROFIS (professional officer filler system) medical officer was not allowed to deploy and a new commander was not designated until ten days after the team members began arriving at the mobilization station.

— The active duty team members, all PROFIS, had never trained together. Most team members were not trained as mental health professionals or soldiers for this type of mission.

— None of the OM teams had sufficient personnel to support combat stress restoration, an important function in any prolonged deployment and/or ongoing conflict.[2] At the last minute, the active duty team substituted mental health personnel for an occupational therapist and an occupational therapy technician. The other teams did not make this change and they deployed with limited restoration capability.

— Some OM team members lacked training and/or skill in rapid diagnostic assessment and brief treatment. These are critical skills required to support the OM team's preferred operational method of dispersing in support of division mental health teams and assisting in forward treatment of acute stress. This deficiency limited team effectiveness and sometimes resulted in other unit professionals having to "reevaluate and intervene" with patients already seen by these officers.[8]

— Each OM team had equipment deficiencies (including vehicles) that could not be resolved in the short CONUS mobilization period. Once in the SWA Theater, inadequate administrative and logistical capabilities made it difficult to correct these deficiencies, and trying to rely on other corps units for this support was often unsatisfactory.[8]

— Unit readiness reports for one reserve OM team did not reflect the team's actual personnel, equipment or training status. These reports were grossly inflated. The commander at the time of mobilization was not professionally qualified for his position—he was not a mental health officer—and was replaced before the unit deployed. The subsequent commander came from another region of the US,

had no prior contact with the unit, had to attend an officer basic orientation class before deploying and did not join the team until after it arrived in SWA. At mobilization, 21 team members were nondeployable and last minute replacements had to be found. When the team deployed to SWA, it was still short three of its required psychiatrists and one psychologist.

Despite a high readiness status, at least one of the reserve OM teams had an entire component of professional and enlisted members who had never trained together. Like the active duty team, the reserve teams also had professional members who lacked rapid assessment and brief treatment skills and almost everyone —officer and enlisted—on the reserve OM team lacked adequate soldier (field) skills. The lack of soldier skills became an important factor. As the ground war approached, not having these skills was a psychological barrier which delayed the dispersion of some of the reserve OM team treatment sections from their relatively safe and comfortable location (co-located with an evacuation hospital) to forward positions supporting the division mental health teams. This was also the primary reason why some of the same sections prematurely returned to a "safe and comfortable" hospital setting as soon as a cease-fire was declared, thus severely limiting their availability for post-combat critical incident stress debriefings in support of the divison mental health teams.

— Both corps OM team commanders recognized the need to provide mental health support to major corps units like the Armored Cavalry Regiments (ACRs). ACRs and separate brigades do not have organic mental health resources. These units received numerous attachments before the start of the ground war (active and reserve component combat, combat support and service support soldiers) so that the ACRs (and some of the other separate combat brigades) were the size of peacetime divisions. Unfortunately, only one of these units received its own mental health team before the start of the ground war.

— The OM team assigned to the Theater (a reserve unit) had many of the same problems as the two corps teams. For this reason, as well as the theater consultant's desire to place as many mental health assets as far forward as possible, sections from this team were broken off and sent forward before the ground war to augment the two corps OM teams. Even though this filled out the two corps teams, it was difficult to integrate last minute additions into existing OM team treatment sections.

Corps Evacuation Hospitals: There was an active duty or reserve psychiatrist at each corps evacuation hospital. Supported by a nurse and a few enlisted soldiers, these individuals were expected to operate 20 to 25 bed in-patient units. Some of these evacuation hospital mental health personnel had inpatient psychiatry training and experience, others did not. These resources were never tested. It appears that most of the evacuation hospital psychiatry units would have been adequate for a brief period and with limited casualties. With only one psychiatrist, any prolonged, intense conflict would have generated enough casualties to quickly exhaust their capabilities. There were no plans for augmenting these facilities.

The one area that seldom received attention at the evacuation hospitals during the pre-combat period was "liaison psychiatry" — the mental health diagnostic and treatment support provided to non-psychiatric patients. These cases range from individuals with serious injuries which will require major lifestyle changes to patients with minor physical conditions complicated by personal and/or family stress. A preliminary review of data from non-psychiatric patients evacuated from SWA to 7th Medical Command hospitals in Europe suggests that as many as 30% of these individuals were evacuated with minor physical conditions complicated by personal and or family stress.[14] Many of these soldiers would have benefited from mental health intervention in SWA. In a number of cases, such intervention might have prevented their premature evacuation.

There are other apparent lessons to be learned at the evacuation hospital level. They include:

— The need to establish a doctrinal relationship and direct liaison between the corps OM teams and the evacuation hospitals in order to ensure hospital augmentation as required.

— The need to establish communication links between division mental health teams and the supporting evacuation hospital psychiatric unit. Clearly, communication will be very limited during any actual conflict, but before and after periods of combat, this communication is necessary to ensure that recovered soldiers are returned to their units as rapidly as possible. For the most part, this type of communication did not exist in SWA. Arranging to return a soldier from an evacuation hospital to his unit was always difficult. Providing timely treatment information for the unit leader and division mental health officers was usually impossible.

Division Mental Health Teams: Division mental health teams are composed of three mental health officers —a psychiatrist, social worker, and clinical psychologist—and four to six behavioral science specialist. Their primary peacetime tasks include unit-level command consultation concerning a range of military related mental health issues and unit-level training for the prevention and treatment of battle fatigue. With a few exceptions, most division mental health officers spend the majority of their time at the local installation hospital or military community mental health clinic providing traditional out-patient clinical services to individual soldiers and their family members. Combat related mental health issues often receive a

low priority, and very few division mental health teams ever deploy to major training exercises or go on peacetime contingency missions.

Most division mental health professionals are company grade officers, lieutenants and captains, with limited military experience and training. Their lack of rank, skill and experience make it difficult for them to establish credible command consultation programs. Army divisions require and deserve better staffing. At least one of the officers on each division mental health team needs to be a senior mental health professional and an experienced soldier.

Seven division mental health teams were deployed to SWA: four in XVIII Corps and three in VII Corps. As mentioned earlier, the separate brigades and Armored Cavalry Regiments (ACRs) did not deploy with mental health personnel.

Like OM teams, each division mental health team had its own unique experience. This article highlights some of the SWA lessons learned.

— Division mental health teams need to be staffed, equipped and trained so that they are capable of performing their wartime (or peacetime contingency) mission. Most of the teams deployed to SWA were not prepared.

— A number of teams were not adequately staffed when their division's deployment was announced. Critical positions were filled just before the deployment with no opportunity to train or operate as a team before departure for SWA. The HQDA and MEDCOM mental health consultants were not always provided an opportunity to select (or even recommend) the best persons for these vacant positions. Mental health personnel were selected by rigid cross-leveling rules to fill vacancies. Some of these individuals, personally and/or professionally, were not qualified for the roles they were assigned, and a few of these individuals became obvious liabilities to their teams.[9]

— Some division mental health teams did not have tactical vehicles until just before the start of the ground offensive, and one team never obtained adequate transportation at all. Without adequate transportation, it was impossible to provide battle fatigue training, mental health consultation or treatment and follow-up services for divisional units spread over a large desert area. Even when they had access to vehicles, division mental health personnel often lacked field training and were comfortable simply "waiting" for patients to be brought to them.[9]

— Two division mental health teams were models of effective operations. In each case, success was rooted in their home station preparations. These teams had a history of going to the field, and the thrust of their garrison mental activities was focused on creating a system of care applicable in combat. For example, at home station these teams had close working relationships with division chaplain unit ministry teams. In each case, at least one mental health officer on the team had established division-wide credibility. The officer had been able to instill the importance of mental health issues, including battle fatigue training, in the minds of senior members of the division, typically battalion and brigade commanders, as well as key members of the division commander's headquarters staff. Teams without this preparation fell short in their efforts to build and operate credible command consultation programs in the desert.

— In conflicts that proceed as successfully as Desert Storm or "Just Cause" in Panama, there are very few battle fatigue casualties.[7] In these situations, divison mental health teams are valuable in dealing with a variety of situational stress issues before, during and after the deployment. These issues range from the stress associated with "home front" problems, to the soldier who exhibits phobic, debilitating behavior when required to wear a protective mask during a prolonged training exercise, or the soldier who is overwhelmed when exposed to combat fatalities.

While there may be very little for the division mental health team to do during battle, it is the period immediately after combat when the team can perform one of its most important functions, namely, supporting critical incident stress debriefings for those units and individual soldiers exposed to combat trauma.[5]

— Only a few division mental health teams actually sought out these trauma victims and provided small-unit critical incident stress debriefings. Without pre-existing unit relationships and some credibility with unit leaders, it is very difficult to gain access to the unit chain of command and, through them, these soldiers. In addition, very few mental health officers and almost no enlisted behavioral science specialists have the specific training required to conduct post-combat debriefings.

— For some divisons, the "follow-on" phase of the war in SWA involved moving back into Iraq and providing support and care to civilian refugees. This was a very stressful experience. This period provided another opportunity for division mental health teams to offer consultation and support, especially to medical personnel who often experienced the physical and emotional brunt of providing this humanitarian service. As one physician described his own reaction, "I was prepared to treat combat casualties (soldiers) and to see death. I was not prepared to see women and children die." While a few division mental health teams were active during this phase, none had trained for this unexpected and difficult post-combat role.

— A final role for the division mental health team (in cooperation with division chaplains) was preparation of soldiers for movement home and the associated family or "reunion" stress. Some teams were active in this role but few had actually prepared for this task as part of their home station readiness training.

Preventing Evacuation Syndrome

One of the most important roles for any mental health officer in the combat theater is to curb the tendency of line and medical leaders to evacuate casualties out of the theater of operations as quickly as possible. Military leaders want their soldiers to receive immediate care. They want to get the soldier out of harm's way and to the best treatment possible—and most often in their minds this means a hospital. The mental health officer's task is to demonstrate that providing the best care often requires keeping the soldier in the unit and on the job.[11] The mental health officer's goal is to use a brief treatment approach focused on "here and now issues." The expected outcome from the start is immediate return to duty. Other issues and concerns have to be put aside until later.[12] Over and over again, there were corps and divison mental health officers in SWA who demonstrated the success of focused, brief interventions and a "return to duty" approach.

Medical officers pushed evacuation, especially prior to the start of the ground war, because of the need to keep beds empty for combat casualties. The evacuation procedures were complicated by the fact that evacuation from SWA was a one-way ticket home.[13] Once you left the SWA Theater, a "return to duty" status did not mean getting you back to your buddies. You were out of the war and away from your unit. There were a number of mental health patients (as well as other medical patients) evacuated to Europe from SWA with conditions that, upon review, did not appear to warrant evacuation from the combat theater, and were not conditions that would normally preclude a soldier's return to duty even in a combat theater.[14] An individual unnecessarily evacuated from the combat zone may be at risk for subsequent adjustment problems, including difficulty "fitting in" with peers once their unit completes its combat mission without them.

CONCLUSION

Corps and division mental health teams (and the evacuation hospitals) did not have to cope with large numbers of battle fatigue casualties in SWA. If significant casualties had occurred, these teams would have found it very difficult to carry out their mission. They were not adequately staffed, equipped or trained in peacetime to perform their wartime role. The world is a dangerous place and the Army must be prepared today for tomorrow's conflict.[15] As highlighted here, lessons learned in SWA provide a reference point from which to prepare for this inevitability.

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