COMBAT AND OPERATIONAL BEHAVIORAL HEALTH
The Coat of Arms
1818
Medical Department of the Army

This book is dedicated to the many professionals committed to diagnosing and treating combat and operational stress casualties. These include our predecessors—Doctors Frank Jones, Kenneth Artiss, and Albert Glass—as well as the many who worked on this project, and those who will no doubt labor many years from now on the next volume in this series. All of these caregivers pursue this effort not just to conserve the nation’s fighting strength. They also believe, as do all military personnel, that we take care of our own—the service members who face the difficulties of combat and the families who support them.
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COMBAT AND OPERATIONAL BEHAVIORAL HEALTH

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Foreword

Military healthcare has the unique opportunity of truly addressing the full continuum of illness, injury, disease, and health. Just as military healthcare professionals have made significant contributions to the improvement of physical health and lessening of injury and disease over the history of the United States, we are now a leading proponent of changes in prevention, recognition, and treatment in multiple areas of behavioral health.

Essential to progress in this arena is developing awareness of behavioral health needs and educating our beneficiaries about the appropriateness of receiving care for what are often “invisible” diseases or injuries. The need for this education and developing a toolkit of successful skills, techniques, and strategies for resilience have never been more apparent than during what has become a persistent state of conflict. We are committed to leading the Nation in eliminating the stigma of behavioral health problems. Men and women within our militaries and across America must learn that it is just as acceptable and appropriate to seek behavioral healthcare as it is to seek treatment for a broken bone.

Since the publication of the two Textbooks of Military Medicine psychiatry volumes—Military Psychiatry: Preparing in Peace for War (1994) and War Psychiatry (1995)—we have made tremendous strides. This volume, Combat and Operational Behavioral Health, expands on these previous two volumes, covering the full breadth of the psychological and behavioral health continuum. Important contributions include preparation for deployment and resiliency training; the provision of services in theater; recovery after physical or emotional injury due to combat; reunion and reintegration; military children and families; operational psychiatry; and the daunting challenge to prevent suicide.

I see our effect on social attitudes toward behavioral and/or psychological health as potentially substantial. Our prospects are good for a better understanding of the neurochemistry and basic pathophysiology of many common stress-related problems, and our grasp and management of millennia-old problems of armed conflict are much improved. However, major challenges remain. One may think the diagnosis of posttraumatic stress disorder (PTSD), for example, would be straightforward. On the contrary, it varies widely among different stakeholders. The more complex issues of the etiology of PTSD and traumatic brain injury, and effective treatments for these conditions, as well as their interaction with age, gender, and other medical issues, are far more daunting.

This new textbook is an excellent resource for all healthcare professionals as they strive to provide the finest quality and most compassionate care of the men and women in uniform and their spouses, significant others, and children. Every person who is in contact with a military member struggling to cope with the emotional trauma of war, disease, or injury needs our support and best efforts.

The contributions of the exceptional civilian and military professionals in this outstanding text can raise the quality of behavioral healthcare across our land and help eliminate the stigma of requesting this care. Although we talk a lot about the reduction of stigma, to actually reduce it and improve Soldiers’ willingness to seek treatment is a Herculean task. Therefore, let us all participate in this essential step forward for the health and well-being of those who have often suffered in silence and alone.

Lieutenant General Eric B. Schoomaker, MD, PhD
The Surgeon General and
Commanding General, US Army Medical Command
Washington, DC
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Preface

This book was begun in 2005 when it became apparent that an update to the previous volumes on military psychiatry—Military Psychiatry: Preparing in Peace for War (1994) and War Psychiatry (1995)—was needed. In the almost 20 years since the chapters in those two volumes were drafted, enormous changes and advancements in classification, diagnosis, and treatment of combat stress have occurred. The pace of change has accelerated with the wars in Afghanistan and Iraq. These wars have become known by many names: Operations Enduring Freedom and Iraqi Freedom, the Long War, and continuous overseas contingency operations, among others.

In the early years of the operations in Afghanistan (2001) and Iraq (2003), changes in operational tempo and resulting extended deployments were extremely taxing for military families. What was problematic in these early years (tempo and deployment) because of the change from past experience has now become problematic because it is the norm. The murders and murder/suicides at Fort Bragg, North Carolina, in 2002 highlighted the perils of soldiers’ rapid return from Afghanistan battlefields to civilian life. The investigations at Fort Bragg and other installations revealed continuing problems with access to care, as well as reluctance of career-minded soldiers to seek treatment.

In response to these and other events, training and systems were put into place to prepare soldiers for “ redeployment” (return to garrison). One of the earlier approaches, “Battlemind,” was designed to help reintegrate service members and families. Battlemind recently evolved into the Comprehensive Soldier Fitness program, which is focused on enhancing resiliency. Despite these various new programs, many soldiers remain reluctant to seek behavioral healthcare for many reasons, perhaps the greatest of which is worry about its effects on their careers. Stigma is a persistent problem, despite numerous efforts to reduce its prevalence. Often it is the soldiers’ families who try to get these service members in for treatment. To improve access to care, the Army and other services have dramatically increased their number of mental health providers, up about 70% between 2007 and 2010.

To assist this growing population of service members, the military behavioral health community has added many new systems of evaluation and care. The Post-Deployment Health Assessment (PDHA), which screens soldiers on return from theater, was implemented after the Persian Gulf War (1990–1991). However, soldiers often did not admit to symptoms after deployment because they wanted to get home as soon as possible. Beginning in 2005, the PDHA was joined by the Post-Deployment Health Re-Assessment (PDHRA), administered at 3 to 6 months after return. It was designed to connect with service members after “the honeymoon” of returning home was over.

Family programs have been expanded to help with issues that arise during both deployment and redeployment. There are specialized programs at Walter Reed Army Medical Center and other facilities for families of the wounded that attempt to prepare children to see parents missing a limb or disfigured from a blast. Another difficult area has been support to families of the deceased. US military families have not faced these numbers of service-connected fatalities since the Vietnam War. In the past, spouses and children were required to leave base housing and service-centered support systems relatively soon after their loved one’s death. This policy has changed over time, with longer access to housing and healthcare afforded these families.

Traumatic brain injury (TBI) is another major concern and affects families as well as service members. The sources of these injuries are varied: blasts, gunshot wounds, accidents. TBI can present with many symptoms, some similar to posttraumatic stress disorder, including irritability, impulsiveness, and personality changes.

The rising suicide rate has been a major concern for all in the Army. The combination of unit and individual risk factors include high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. Consistent and high-profile attempts have been made to reduce suicide with numerous training programs for service members, focusing on buddy aid and gatekeepers. However, thus far these efforts have been only partially successful. The prolonged effects of exposure to violence and death are not easy to change.

New efforts to assist service members continue. The Defense Center of Excellence was stood up in November 2007, with a focus on best practices and reducing stigma. Other programs are the Comprehensive Behavioral Health Campaign Plan, the Department of Defense–Department of Veterans Affairs Integrated Mental Health Plan, and the National Intrepid Center of Excellence.

An ongoing concern is the long-term effects of the Long War, for the next 20, 30, or 50 years. After the Viet-
nam War, far too many veterans ended up on the streets—unemployed, homeless, and addicted. By examining the potential causes of combat stress and emotional trauma, the various approaches to diagnosis and treatment, the roles of providers (and their own resiliency), and the many programs available to help, this volume seeks to reduce the difficulties faced by veterans as they reenter civilian life. However, success in this area will require a concerted effort by all on the home front, including the Army, other branches of the military, the Department of Veterans Affairs, other federal agencies, and state and local agencies, as well as civilian and private organizations. It is hoped that the interventions described in this volume will contribute to that effort by informing and guiding military and civilian healthcare providers, the public, and both active duty service members and veterans of these most recent conflicts.

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