PSYCHIATRY

PSYCHIATRIC INTERVIEW, DIAGNOSIS, AND REPORT OUTLINE

INTRODUCTION

Psychiatric conditions represent a significant portion of the medical department's workload. There is sometimes a difficult to distinguish the line between "goldbricking" behavior and psychiatric disorder. Personality disorders comprise a good portion of psychiatric entities, and tend to drive the busy operational physician to distraction. Most medical officers and corpsmen have little experience with psychiatry during training, but future experience will demonstrate clearly the extent of the problem.   "Combat stress" is another consideration in maintenance of an effective force. Each individual has his or her own stress level tolerance, but each will be affected by one or more "major life events", such as a recent marriage, divorce, family death, birth, financial crisis or other. The persons most likely in a position to provide a perspective of the extent of these problems are the senior enlisted members of the command. They are the first to discover that BU-3 Jones is having marital difficulty, and should be encouraged to report all such events to you so that you may get a good "feel" for the mental health of your unit, and put you in a position to deal pro-actively with problems. This section reviews the basic principles of the psychiatric interview, the mental status examination, current psychiatric diagnostic classification, and the expected format of a formal report of a psychiatric consultation.

THE PSYCHIATRIC INTERVIEW

Overview
Good interview skills facilitate the grasp of essential issues in all fields of medicine, leading to a reasonable diagnosis and treatment plan in each particular case. The general goal of the psychiatric interview is to help the patient tell the interviewer what is wrong in order to comprehend the patient's problem. Psychiatric interview skills may be acquired and improved by various forms of supervised practice and discussion. The essential factor is practice.

Historical aspects of medical vs. the psychiatric interview.
Historically, the medical approach has been a stereotyped fact finding formula; whereas, the psychiatric approach has classically been the less structured flexible and "open ended".   The medical approach has been the focus on the what, when and where, whereas, psychiatry has tended to focus on how and why. It has also been described as focusing on a narrow detailed history of the present symptoms. The psychiatric approach has utilized a broader focus on general patterns of adaptation. The past history in the medical approach has been of less importance;

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whereas, the psychiatric approach the past history may be the only diagnostic information.   In the medical approach, the complete history is desirable whereas, historically in the psychiatric approach incomplete histories were often acceptable. In the medical approach, the contexts of the presenting symptoms of disorder were often irrelevant whereas, in the psychiatric approach the context is always of prime importance.

The approach
The approach that will be taught in this section is becoming standard in psychiatric training programs. This is the "structured" psychiatric interview. In this approach, the patient will be allowed to tell his story, discuss his symptoms in his own words and style for about ten to fifteen minutes. The interviewer can redirect or clarify as necessary but essentially this is the patient's time to present his facts and feelings without interruption. This gives the interviewer a chance to see how the patient forms his thoughts, produces his sentences, demonstrates the content of his thought and, utilizes his educational and social skills. After that period of time, then the interviewer can resort to securing factual information in a directed fashion using specific questions. The structured interview should consist of the following elements:

1. The patient identification - this information can usually be obtained from the patient's chart and consists of age, rank, occupational specialty, marital status, unit assigned, length of time in service, etc.

2. Chief complaint and present illness - this is the patient's story in his own words with elaboration of pertinent elements and in context.

3. Past history - much the same as would be obtained a medical interview with emphasis on psychosocial context.

4. Formal mental status examination may not be necessary on all patients, but when indicated should be performed.

5. Working diagnosis - this should be obtained prior to the patient being dismissed or if no diagnosis is available during the first interview, the patient should be rescheduled.

 Practical factors of the Psychiatric Interview
Time Factors

The average interview time is about 45-50 minutes, although psychotic or medically ill patients will require a briefer interview. You should advise the patient of the anticipated length of interview so that the patient's management of time can be monitored. Early arriving patients may be expressing anxiety. Late arriving patients may have a plausible excuse but may also be expressing resistance or anger.
If the doctor's management of time is one of carelessness, an impression of disinterest may be conveyed. On the other hand, seeing the patient early may convey the impression of special status

to the patient.

Spatial Arrangements for Psychiatric Interview

The setting should be private and away from interruptions.
Seating should be comfortable with an unobstructed space between the interviewer and the patient.

     c. The patient's selection of a chair nearer or farther from the interviewer may reveal oppositional or dependency tendencies of the patient.

     d. Safety is a concern at times - don't block a patient's exit!

  3. <u>Note taking during the psychiatric interview</u>

     a. Note taking by an experienced interviewer is discouraged.

     b. Patients' concerns about note taking should be respected. This is especially important when dealing with paranoid patients.

     c. Note taking may help the examiner's memory - for specific important details.

E. Definition of Terms

  1. <u>Transference</u> is the unconscious <u>expression</u> in a person's current life, the patterns of behavior and emotional reactions that originated with significant figures in childhood. Transference may be positive or negative.

  2. <u>Countertransference</u> is the interviewer's response to the patient, as if he were an important figure from his own past. Countertransference may be positive or negative.

  3. <u>Therapeutic alliance</u> is the positive relationship between the healthy aspects of the interviewer and the patient. This facilitates compliance and recovery hope.

  4. <u>Resistance</u> during the psychiatric interview is a <u>patient's</u> attitude or behavior that <u>compromises proper diagnosis.</u>

  5. <u>Active listening</u> refers to the interviewer's interventions or noninterventions, which facilitates the interviewer's understanding of the patient. Affect-laden words are especially significant.

  6. <u>Empathy</u> (versus sympathy) is the ability to comprehend what it is like to be the patient. During the interview, patients will offer many clues, both in what they tell you

(the content of the interview) and in how they tell it (the process of the interview).

F. Resistances - Some resistances with suggested examiner responses are:

1. Silence

   "You seem to be at a loss for words."

   "What are you thinking?"

   "Perhaps there is something difficult for you to discuss."

2. Generalization

   "Could you give me a specific example on how this relates to you?"

3. Display of Affect

   Can you tell me what thoughts are occurring?"

   Can you tell me what issue that we are discussing caused you to cry?"

4. Intellectualization

   "That's a very interesting opinion. How do you think that relates to your circumstance?"

5. Focus on preferred topic

   "That's a very interesting topic that you are discussing, but if we continue to talk too much about that, we will have little time left to discuss your problems."

6. Chronic lateness to appointments

   "Is there something that you wish to discuss that has not come up in our discussions?" "Has something upset you about your treatment?"

7. Talking excessively

   "I can hardly say anything without interrupting you."

8. Asking the interviewer a direct personal question

> If you do not choose to answer - Can you share with me how details of my personal life would relate to your problem?"

> If you do answer - "What have you learned from what I have told you about your problem?"

G. The structured interview

With this background, let's look at the specifics of the structured interview. Using the structured interview, it is occasionally helpful to have a brief outline of the subject areas to be covered on an index card or small piece of paper for reference. An often overlooked advantage of the structured interview is that the information gathered is in the same sequence as it appears on the psychiatric write-up, thus with practice, the psychiatric write-up is accomplished in a very short period of time.

1. Patient Identification - important information helpful to know prior to seeing the patient

    a. Age
    b. Race/Ethnic Background
    c. Marital Status
    d. Rate or Rank
    e. Present Command/Job Status
    f. Years in Service
    g. Charges Pending?

2. Chief Complaint and Present Illness

    a. Why referral to Psychiatry (Why Now)
    b. What is your opinion of what's Happening
    c. Has this ever occurred before?
    d. Patient's perception of stressors (job - personal financial-marital)

3. Past History

    a. Family

       1) Parents' Status

       2) Number of Siblings and Ranking

3) Family history of mental disorder, substance abuse or suicide

b. Personal

1) History of mental illness - hospitalizations - suicide gesture

2) Significant childhood problems/events

3) Adolescence - problems - heterosexual development - behavior

c. School

1) Grades - friends - interests - level achieved suspensions

d. Social

1) Civil arrests

2) Drug/alcohol use

3) Marriages, divorces, children

e. Military

1) Years, branches of service, marks, awards, disciplinary action

4. Formal Mental Status Examination

a. Appearance, mannerisms and reaction to the examiner

b. Orientation, (time, person, place, situation) and level of alertness

c. Mood - how patient describes his present state of emotion

d. Affect - how the interviewer describes the patient's emotional state

e. Neuro-vegetative symptoms of depression

f. Suicidal, homicidal ideation

g. Speech pattern and thought process (form and content)

h. Perceptual abnormalities, hallucinations and dissociation.

i. Intelligence and general cognition

j. Memory- remote, recent, immediate recall (digit span)

k. Abstract reasoning and concept formation

l. Insight and judgement

5. Terminating the interview

a. General Category of Diagnosis

1) Adjustment/situational

2) Characterologic/
personality disorder

3) Affective disorder

4) Psychotic illness

5)   Substance abuse - organic disorder

6) No diagnosis

7) Unknown - more information is necessary

b. Is this subject a danger to himself or others?

c. Is he fit and suitable for general duty? Is he responsible for his actions?

d. Is he PQ and AA?

H. The Formal Mental Status Examination.

The MSE is a systematic way of assessing a patient's emotional and mental functioning. This includes how he looks, acts, talks, feels and thinks. These five basic areas are usual subdivided more formally into: 1) appearance, 2) speech, 3) behavior, 4) thought, 5) perception, 6) mood, affect and, 7) intellectual functioning.

Just as each medical history and physical examination will differ, depending on the circumstances and clues from the patient about areas of pathology, the same is true for the

MSE. The following discussion of the MSE is, therefore, not intended as a checklist to be fully completed for each patient, but as a guide to gathering information about the mental status, with the amount of detail gathered in any particular area left to the discretion of the examiner.

1. Appearance - may include notation of dress, grooming, general self-care, posture, facial expression(s), distinctive physical features (scars, tattoos, marked obesity or emaciation, etc.).

2. Behavior - level of activity, degree of cooperation, general attitude and attitude towards the examiner, eye contact, gestures, mannerisms, motor behavior. If the patient is on psychiatric medications, look for dystonias or dyskinesias (tremor, grimacing, motor restlessness such as pacing, foot tapping, hand-wringing, writhing or jerky movements of the tongue and mouth, trunk and extremities, upward turning of the eyes).

3. Speech - focus on the way the patient talks rather than what he says. Note word choice and usage in the context of his educational level, rate of speech, tone, peculiarities in the way things are said (e.g., perseveration, echolalia) or not said (e.g., mutism, stuttering).

4. Thought process, generally divided into content and form.

a. Content - any strange, magical, bizarre or destructive thoughts. Delusions (fixed, false beliefs unresponsive to clear evidence that they are false). Ideas of reference? (people, events or objects which have particular and unusual significance for the patient; e.g., "I'm getting special messages from the TV - Walter Cronkite meant that for me!", "People are talking about me", "That song was written for me", etc.). Is thought content notable for grandiosity or Paranoia? Ambivalence just indecision, but intense and opposite feelings and thoughts about something or someone). Obsessions? Phobias? Strange somatic preoccupations? Suicidal or homicidal thoughts? Nihilism? (E.g. "the world is dead", "I'm nothing", etc.). Be aware of areas the patient refuses to discuss or seems to avoid.

b. Form - can the patient think clearly, and make sense? Do his thoughts follow each other in logical and organized sequence, or is he tangential, circumstantial (eventually returns to the point but in round about way), overinclusive or loose? (Associations that are unrelated, disconnected, leaving the examiner feeling as if he has missed something).

5. Perceptions - His sensory awareness and interpretation of inner and outer environment. Abnormalities may include illusions (misinterpretation of real external stimuli), hallucinations (false sensory perceptions in absence of external stimuli - can be any sensory modality). Dissociation (Derealization plus Depersonalization) Repeated deja vu?

6. Suicidal or homicidal ideation - Ask in a concrete fashion if the patient wishes to die - explore plans, the same for homicidal ideation. Remember the duty to warn.

7. Mood and Affect

   a. Mood - is subjective - what the patient tells you - how does he claim to feel? - elated, euphoric, euthymic (normal range), dysphoric, depressed lie along the range of moods. Descriptions of mood can also include subjective feelings like angry, expansive, anxious, fearful, etc.

   b. Affect - what the patient is feeling at the moment and its observable manifestations, such as facial expressions, demeanor, tone of voice, hand and body movements. Is the observed affect consistent with the stated mood? Is it appropriate to the subjects and being discussed? Is there a full range of affect (able to laugh and cry appropriately, and show flexible affective responses) or is it constricted, blunted (more limited range and intensity) or flat (most limited - hardly any observable emotion). Alternately, is it labile? - repeated, abrupt shifts of emotion, or inappropriate - discordant with the content of thoughts, e.g., giggling while describing killing someone.

8. Orientation - Person, place, time and circumstances.

9. Intellectual Functions - include registration, attention, concentration, memory, calculation, language, abstraction, insight, and judgment.

   a. Registration - Name five unrelated objects and ask the patient to repeat them.

   b. Concentration - serial 7's, "world" spelled backwards, digit span forwards and backwards.

   c. Calculation - simple additions, subtractions and multiplication.

   d. Language - following two and three-stage commands, naming of simple objects, part- objects and colors reading, writing (have patient write any simple sentence) and repetition.

   e. Copying - reproduce geometric figures.

   f. Proverbs - especially useful for detecting thought disorder. Look for concrete, bizarre or nonsensical interpretations of proverbs.

10. Recall - remember after five minutes the five objects given for registration. If free recall is unsuccessful, provide retrieval cues.

11. <u>Insight</u> - accurate assessment and understanding of his current situation.

12. <u>Judgment</u> - ability to compare and assess alternatives, makes and execute reasonable decisions, behave appropriately.

A general impression about most of these areas can be gained from listening to the patient relate his history. Where there is a question about intellectual capacity, or suspicion of alcohol or drug abuse, confusional state, delirium or dementia, intellectual functions should be specifically checked.

III. PSYCHIATRIC DIAGNOSTIC CLASSIFICATION

A. Overview

1. An increasing awareness of the importance of diagnosis for clinical practice, teaching, research, and various administrative purposes has encouraged the evolution of psychiatric diagnostic classification. As in other fields, the psychiatric diagnostic classification has been periodically revised. The medical officer should be familiar with the current diagnostic classification (DSM-III-R).

B. The Evolution of the Current Psychiatric Diagnostic Classification

1. <u>DSM-I</u> the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders appeared in 1952. The use of the term "reaction" throughout the classification reflected the influence of Adolph Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors.

2. <u>DSM-II</u>, the second edition, went into effect in 1968. The classification was based on the mental disorders section of the 8th revision of the International Classification of Diseases (ICD-9). The DSM-II classification did not use the term "reaction" and used diagnostic terms that by and large did not imply a particular theoretical framework for understanding the nonorganic mental disorders.

3. <u>DSM-III</u> was first published in 1980. Field trials demonstrated that clinicians could agree on the identification of mental disorders on the basis of their clinical manifestations without agreeing on how the disturbances come about. Multi-axial evaluation and diagnostic criteria are new to the DSM-III.

4. <u>DSM-III-R</u> was released in June of 1987 and is currently the publication of reference. Diagnostic categories remain essentially the same. The major revision occurred in criteria for diagnoses. There were two theoretical personality disorders added for reference and

for further study, these being the self-defeating and sadistic personality disorder.

C. Multi-axial evaluation

1. Axis I comprises the entire classification of mental disorders plus conditions not attributable to a mental disorder that are a focus of attention or treatment (V codes).

2. Axis II (the personality disorders and the specific developmental disorders) can be used to indicate specific personality traits when no personality disorder exists. Code numbers are not used when personality traits are noted, since a code number indicates a personality disorder.

3. The first three axes constitute the official diagnostic assessment:

a. Axis I

- clinical syndromes

- conditions not attributable to a mental disorder that is the focus of attention or treatment or "V" codes

- additional codes (i.e. no diagnosis or deferred).

b. Axis II

- personality disorders (personality traits)

- specific developmental disorders

- additional codes (i.e. no diagnosis or deferred)

c. Axis III

- physical disorders and conditions - may use ICD-9 coding if necessary

4. Axes IV and V are useful in patient evaluations and especially helpful in research settings.

a. Axis IV - Severity of psychosocial stressors (O-6)

b. Axis V - Highest level of adaptive functioning past year - global assessment of functioning (O-90)

D. Decision trees for Differential Diagnosis (Found in Appendix of DSM-III-R)

1. Psychotic features

2. Irrational anxiety and avoidance behavior

3. Mood disturbance (depressed, irritable, or expansive)

4. Antisocial, aggressive, defiant, or oppositional behavior

5. Physical complaints or preoccupation with physical illness or pain

6. Academic or learning difficulties

7. Organic brain syndrome

E. Review As a quick review, the following major categories of DSM-III-R is listed. You should have knowledge of their existence to facilitate utilization of DSM-III-R.

1. Disorders usually first evident in childhood

    a. Mental retardation

    b. Pervasive developmental disorder

    c. Specific developmental disorder

    d. Attention-deficit hyperactivity disorder

    e. Conduct disorder

    f. Anxiety disorder or childhood adolescence

    g. Eating disorder

    h. Gender identity disorders

    i. Stereotyped movement disorders

    j. Elimination disorders

2. Organic Mental Syndromes and Disorders

a. Organic mental syndromes, deliriums, dementias, amnestic syndrome; organic delusional hallucinosis, mood, anxiety, or personality syndrome; intoxication/withdrawal.

b. Dementia arising in the senium and presenium, (Alzheimers Disease, Multi-infarct Dementia and others).

c. Substance induced alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogen, inhalant, nicotine, opioid, PCP

3. Substance abuse disorders (dependence and abuse)

4. Schizophrenic Disorders

5. Delusional (Paranoid) Disorders

6. Psychotic Disorders not classified elsewhere

7. Mood (affective) Disorders

8. Anxiety Disorders

9. Somatoform Disorders

10. Dissociative Disorders

11. Sexual disorders

12. Sleep disorders

13. Factitious disorders

14. Disorders of impulse control not elsewhere classified

15. Adjustment disorders

16. Psychological factors affecting physical condition

17. Personality Disorder

a. <u>Dependent</u> - submissive - needy

b. <u>Histrionic</u> - gregarious - dramatic - attention seeking

c. <u>Narcissistic</u> - egotistic - entitled - lacks empathy

d. <u>Antisocial</u> - aggressive - disregard for other's - inconsistent performance

e. <u>Compulsive</u> - conforming - constricted - indecisive - perfectionistic

f. <u>Passive</u> - aggressive - negative, oppositional resistant to demands of others

g. <u>Schizoid</u> - asocial - things over people

h. <u>Avoidant</u> - withdrawn - shy - fearful hypersensitive

i. <u>Borderline</u> - unstable - affectively labile - destructive

j. <u>Paranoid</u> - suspicious - constricted affect - exaggerates

k. <u>Schizotypal</u> - eccentric - withdrawn - magical thinking

l. Personality Disorder NOS (Mixed or atypical)

m. Theoretical or proposed classifications

18. <u>V Codes</u> for conditions not attributable to a mental disorder that are a focus of attention or treatment

a. Malingering

b. Borderline intellectual functioning

c. Adult antisocial behavior

d. Childhood or adolescent antisocial behavior

e. Academic problem

f. Occupational problem

e. Uncomplicated bereavement

h. Non-compliance with medical treatment

i. Phase of life/life circumstance problem

    j. Marital problem

    k. Parent - child problem

    l. Other specified family circumstances

    m. Other interpersonal problem

  19. Additional Codes

    a. Unspecified mental disorder (non-psychotic)

    b. No diagnoses on Axis I or II

    c. Diagnosis deferred on Axis I or II

IV. THE PSYCHIATRIC REPORT

1. The written report of a psychiatric evaluation has evolved into a standard format that has proven to be useful for not only disposition but also almost any administrative medical report. Although individual creativity is encouraged, familiarity with the standard format is expected.

    a. To be of use to the reader, the report should be internally consistent and sufficient to justify the conclusions and recommendations.

    b. Specific issues should be addressed and specific questions should be answered.

2. By following this outline - which is basically the same sequence as the interview, the task of writing the report should be much easier.

V. PSYCHIATRIC CONSULTATION REPORT

1. Identifying information

2. Patient profile - where he lives - works - how he plays - major life stressors - administrative problems

3. Context (**signs/symptoms/situation**) (Why was the patient referred to Psychiatry?)

4. Background history (should include)

a. Familial/environmental - childhood - adolescence - mention presence/absence of emotional illness - substance abuse

b. Development/physical - past medical/ psychiatric - physical trauma/substance abuse - emotional abuse

c. Scholastic - grades - activities - peer relationships

d. Psychosexual - relationships

e. Occupational (including military) - legal problems, especially arrests

5. Mental status

a. Appearance/behavior

b. Speech

c. Defenses/if prominent

d. Affect/mood

e. Suicidal/homicidal ideation

f. Form/content of thought (hallucinations/delusions)

g. Sensorium (orientation/memory)

h. Intellect - (cognition/abstraction)

i. Insight

j. Judgment

k. Psychological testing

6. Summary

   a. Personality Pattern if noted - adaptive or maladaptive - prominent defense mechanisms

   b. Context of his behavior or chief complaint/ present illness

   c. Signs/Symptoms and how they relate to the diagnosis

7. Diagnosis (DSM-III-R) Multiaxial form

   Axis I
   Axis II
   Axis III

8. Disposition

   a. Recommendations

- Administrative
- Medical
- Suicide risk statement

   b. Follow-up plans

- Fit, suitable and responsible statement?
- Details regarding follow-up

SPECIFIC FEATURES OF THE PSYCHIATRIC REPORT

The psychiatric write up can be viewed as an amplification of the traditional medical history and physical examination. The following paragraphs, one through eight, give a structured outline of the sequence that could be followed.

1. Paragraph 1 - Identifying Information
      a. Age
      b. Marital status
      c. Rate/rank
      d. Service
      e. Continuous or broken service years
      f. Referral source
      g. Diagnosis and reason for referral

2. Paragraph 2 - Patient Profile

    a. Unit assignment
    b. Responsibilities
    c. Performance
    d. Where he lives and with whom
    e. Stressors
    f. Patient's perception of his referral
    g. Administrative or legal difficulties

3. Paragraph 3 - Present Illness

    a. Details of onset of present symptoms as presented by patient

    b. Why now

    c. Patient's perspective on his behavior

    d. Include information secured from other sources

4. Paragraph 4 - Past History

    a. Family

        1) Parents' marital status, geographic and socio-economic data

        2) Siblings' and parents' rank in sibship

        3) Family history of mental illness, suicide or psychiatric hospitalization

    b. Personal

        1) Early childhood events

        2) Adolescence: behavior problems, hetero/ homosexual development and experience, friends and social adjustment, interests and hobbies

        3) Substance abuse

    c. Social

        1) Disciplinary problems

2) Education level achieved

3) Marital relationship history

4) Plans/goals

5) Work history, dismissals

6) Military adjustment

5. Paragraph 5 - Mental Status and Psychological Testing

Mental status examination is referred to in previous parts of this outline. A "normal" mental status examination might be written as follows:

a. The patient was dressed in appropriate military attire; he was well groomed, pleasant and cooperative. He sat comfortably in the examining chair exhibiting no unusual signs of anxiety. His speech was logical, coherent and normal in rate and rhythm. His thought pattern focused on his difficulty in getting along with his superiors. He described his mood as "upset" but had an appropriate wide range of affect. The patient exhibited no psychotic tendencies. The patient denied suicidal ideation. The patient denied homicidal ideation. He was alert, oriented to person, place, time and Circumstances. His intelligence was clinically judged as average. The patients memory, including past, recent, and immediate recall were adequate. The patient's cognition and abstraction were determined to be adequate. The patient's insight and judgment were adequate. The MMPI was read as valid and not suggestive of overt psychopathology.

b. It may be helpful to memorize this outline as a guide to writing mental status exams.

1) General Appearance
2) Speech and coherence of thought

3) Mood/affect

4) Perception - psychotic symptoms

5) Suicidal/homicidal thoughts

6) Orientation

7) Memory

8) Intelligence level

9) Cognition/abstraction

10) Insight and judgment

11) Psychological Testing

6. Paragraph 6 - Summary/
Formulation

    a. Brief correlation of symptoms/stressors/personality traits

    b. How they combine to produce a working diagnosis or no diagnosis

7. Paragraph 7 - Multiaxial Diagnosis

    a. Axis I: Clinical syndromes or V Codes

    b. Axis II: Personality traits/disorders specific developmental disorders

    c. Axis III: Physical conditions/disorders

    d. Axis IV: Severity of psychological stressors (0-6)

    e. Axis V: Global assessment of functioning = current plus past year (0-90).

8. Paragraph 8 - Recommendations

Military psychiatric interviews usually include two parts, that of administrative recommendations and then of therapeutic recommendations.

Medical recommendations would include any therapy indicated; any need to return for further evaluation. If assistance is needed by some other facility or specialty this should be noted.

    a. Administrative statements

       1) Fit and suitable for general duty. Responsible for his actions

       2) Is not considered a significant suicidal or homicidal risk

3) Recommend administrative management IAW - Instruction number with month/ year of issue

b. Medical/psychiatric

1) Personal therapy to include medications if indicated

2) Marital/family therapy

3) Environmental manipulation

4) Referral to other appropriate source

PSYCHIATRIC EMERGENCIES

I. INTRODUCTION

Emergency psychiatry is a demanding area. The medical officer must be alert to physical illness that may produce acute psychiatric symptoms, the psychiatric accompaniments of many physical illnesses, and psychological reactions in the patient, significant others, and medical personnel. A restricted approach to evaluating patients with behavioral disorders, where psychiatric assessment is intense but medical assessment cursory, will produce a substantial rate of misdiagnosis. The frequency of misdiagnosis, therapeutic misadventure, and unacceptable outcomes may be decreased by the appropriate application of well-described general principles for managing any medical emergency. Medical history taking and physical/laboratory examinations should be even more thorough in mentally impaired patients, since they may not be able to state their complaints accurately or coherently. First priority is given to identifying potentially lethal but reversible physical disorders, which cause or coexist with mental impairment. Multiple diagnoses are frequent. Functional assessment follows diagnosis, and a major consideration is assessment of risk to self or to others. The questions to be answered are as follows:

1. Why is this patient here now?
2. What can be done for him now?
3. What should be done for him in the future?

II. PSYCHIATRIC EMERGENCIES

A. Definition

1. The potential for a psychiatric emergency exists when a change in a person (caused by intrapsychic, interpersonal, or biologic alterations) can no longer be tolerated by that person or by significant others in the environment.

2. The potential becomes acute when either the person or the significant others seek immediate assistance. (Urgency is one element of a psychiatric emergency all authors agree upon.)

B. Reasons for psychiatric hospital admissions

1. Danger to oneself.

2. Danger to others.

3. Gravely disabled by confusion or other mental process that does not allow an individual to adequately take care of his basic life functions.

4. In the military, admissions to the psychiatric facility are sometimes made as a result of operational necessity. A typical scenario would occur if a unit were about to deploy, someone was noted to be in need of psychiatric evaluation or treatment. A brief hospital admission can allow the unit to deploy without having the potential burden of a medical evacuation later. The unit can also file an unforeseen loss report if that person will be under treatment or evaluation for more than thirty days.

C. General principles of management of psychiatric emergencies

1. The setting for emergency psychiatric evaluations should have safety foremost in mind, at the same time making efforts to maintain the patient's dignity and relative privacy. The evaluator should have a firm, empathetic and honest approach while being very specific, concrete, and acknowledging the patient's concerns, and condition. The physician should be able to acknowledge his reaction to the patient.

2. Emergency evaluation should include history from reliable sources, a thorough physical examination (including vital signs and mental status), and indicated laboratory studies.

3. Specific history that should be elicited would include:

    a. History of mental illness or similar behavior
    b. Physical illness
    c. Drug and medication
    d. Life stressors (interpersonal, job or legal)
    e. Detailed information on the onset of the presenting symptom

4. Medical emergencies (organic etiologies) must not be overlooked. For example, psychosis is only a description of symptoms, not a diagnosis. Organic and potentially life-threatening illness must be ruled out.

5. Incapacitating confusion and dangerousness to self or others must not be overlooked. For example, there is no treatment for a completed suicide, which may have been preventable.

6. Psychosocial stressors are commonplace and not in any way incompatible with organic etiologies.

7. The frequency of misdiagnosis can be decreased by the following measures:

   a. Including physical illness in every differential diagnosis of behavioral symptoms. Include a disrobed exam to search for occult trauma.

   b. Performing a complete, rather than abbreviated, diagnostic medical assessment at the time of presentation.

   c. Avoiding dangerous assumptions, such as that absence of cognitive impairment means absence of organic brain dysfunction, that psychosocial stressors explain the symptoms, the recurrent symptoms reflect a recurrent cause, that a descriptive label (depression) may be equated with a causal explanation, and that consultations are always thorough and correct.

   d. Graded utilization of laboratory examinations is a good practice with routine screening of most patients. Toxicologic screens, blood alcohol level and chemistry panels are most often indicated.

D. Medical Illness and Other Organic Causes of Psychiatric Symptoms

1. The setting, circumstances, rapidity of onset, and the patient characteristics (age, general health, previous medical and psychiatric history) have considerable bearing on likely etiologies of psychotic thinking or behavior. For example, in a patient with a previously diagnosed significant medical illness, psychosis is often due to the illness or to its treatment. Other clues to organicity:

- if the patient is over forty, with no previous psychiatric history,

- if there is significant impairment of orientation, memory or visual or tactile hallucinations,

- if the vital signs (especially temperature) are abnormal, or there are signs of autonomic dysfunction,

- if onset of psychosis is sudden.

- the index of suspicion should be high for an organic etiology.

- The following is a list of potentially life-threatening organic conditions which can include psychotic features:

    a. Meningitis, Encephalopathies (look for fever, tachycardia, leukocytosis, meningeal signs, headache).

    b. Hypoglycemia (history of diabetes, weakness, sympathetic hyperactivity - check blood glucose).

    c. Hypertensive Encephalopathy (history of high blood pressure, high blood pressure on examination).

    d. Intracranial Hemorrhage (history of headaches, meningeal or focal signs).

    e. Diminished Cerebral Oxygen (signs of cardiac or pulmonary insufficiency, severe anemia).

    f. Poisonings (access or exposure to tricyclics, organophosphates, opiates, barbiturates or signs of their effects?).

    g. Wernicke-Korsakoff's (history of ETOH dependence or nutritional deprivation? Presence of disorientation, confusion, impaired memory, confabulation, apathy or lethargy, frightening hallucinations, peripheral neuropathy, ataxia, ophthalmoplegia?).

    h. Delirium Tremens (recent ETOH abstinence, irritability, tremulousness, hyperactivity, insomnia, fever, seizures, visual hallucinations).

2. The following conditions can also include psychotic features. They are grouped by general disease type:

    a. Neoplastic: Primary tumors, metastatic tumors (breast, lung), carcinomatosis, pheochromocytoma.

    b. Vascular: Intracranial hemorrhage, aneurysms, subdurals.

    c. "Functional Psychoses": Schizophrenia, Bipolar Affective Disorder, Reactive Psychosis, Atypical Psychosis, Paranoid Disorder, Borderline Personality Disorder ("mini- psychosis").

d. Toxic: Alcohol (Korsakoff's, withdrawal, hallucinosis), barbiturates hallucinosis), barbiturates (toxicity or withdrawal), opiates (same), amphetamines and cocaine, hallucinogens (LSD, PCP, mescaline, DMT, STP, etc), anticholinergics, organophosphates, heavy metals, carbon monoxide, carbon disulfide, other industrial agents, Wilson's.

e. Toxic Effects of Medications; Disulfiram (Antabuse), Lithium, antipsychotics, anti-depressants, Levodopa, anticonvulsants, antituberculous drugs (INH cycloserine), anti- inflammatories (corticosteroids indomethacin, phenylbutazone), anti-hypertensives (reserpine, Me-dopa), cardiac drugs (digitalis, procainamide, propranolol), cimetidine, bromide), idiosyncratic reactions to other drugs.

f. Metabolic/Endocrine/Nutritional: Fluid and electrolyte imbalance (including calcium/ magnesium, phosphates, glucose), heatstroke, exposure, porphyria, adult PKU; organ dysfunction - thyroid, parathyroid, pituitary insufficiency, respiratory, cardiac, or liver

E. Psychotic Emergencies Present in Various Combinations of Bizarre Behavior

As a general rule, acute psychoses are more disorganized, frightening, panicky, than they are assaultive. A psychotic person with paranoid ideation who feels trapped may become directly assaultive, however, the usual mode of behavior is to escape and find a place of safety.

F. Control Methods

Common sense and clinical experience suggest that conservative methods for behavioral control be used before drastic methods are employed.

1. The initial goal is to prevent harm to everyone concerned.

2. Awareness of negative countertransference toward mentally ill or intoxicated patients in emergency settings may prevent inadequate medical evaluation, punitive physical restraint, or inappropriate denial of treatment.

3. Documentation of behavioral observations, verbatim quotations of the patient's speech, methods of treatment, response to treatment, and laboratory examinations are often of critical importance.

G. Evaluation of Emergency Medical Problems

1. An abbreviated mental and physical examination can quickly determine the possibility of a medical condition requiring immediate care, such as drug-related problems, infection, metabolic problems, and neurological problems.

2. The most common causes of disruptive behavior in a Navy ER are not medical emergencies.

    a. The most common organic cause is alcohol or drug intoxication.

    b. The most common psychiatric causes are personality disorders.

    c. Acute schizophrenia and mania are dramatic but not common in a military setting.

    d. The physical examination and laboratory study results will be normal in pure psychiatric conditions.

H. Levels of Restraint

When an assaultive or disruptive behavior is becoming a threat to the safety of the individual or others, then a physical restraint or "take down" may be in order. Levels of restraint include - verbal restraint i.e. simply expressing your concern to the patient and asking him to exert control over his behavior. If that is unsuccessful, then physical or chemical restraint in some combination may be necessary.

1. All dangerous objects should be removed from the setting for medical and psychiatric evaluation.

2. A calm show of force is preferable to a threatening ultimatum.

3. A firm show of force, backed by team support, often calms the patient, who realizes the team leader has confidentially taken control.

4. The most commonly used method of restraint is the five-point restraint technique. When using this technique, a pre-trained team should be available.

5. Planning the takedown, one man is assigned to eachextremity and the fifth to the head. A leader or coordinator should be the person to control the head if his assistance is needed in the takedown. One caveat to keep in mind is that once the decision to perform a takedown is made, it should proceed without any hesitancy from any team member - otherwise injuries may occur.

6. If the patient remains disruptive, the leader instructs each team member to approach the patient and to grasp a specified limb at a major joint to avoid fractures.

7. Once the person is effectively restrained, the temptation is to medicate immediately, but tranquilization should be deferred until a thorough medical evaluation has been completed.

8. Remain aware of the location of your own body parts while restraining a patient.

9. Many patients will calm down once they are no longer overstimulated and frightened by strangers distracting noises, and sudden moves.

10. When a takedown is performed, it is extremely important to document the conditions that necessitated the takedown, the people involved, and the exact procedure utilized. Orders should be written for specific time period in restraints and to use only leather restraints. Once the patient has verbalized his ability to control his behavior with or without medication, he may be allowed to come out of the restraints and demonstrate that ability. If in doubt about a patient's continued assaultive behavior, one restraint at a time could be loosened to gain the confidence of both the patient and the staff.

I. Medication

1. The primary indication for immediately medicating a disruptive individual is that further assessment cannot proceed without tranquilization. (The decision to use medication to treat the underlying condition can be made later.)

2. In conditions other than toxic drug reactions and withdrawal, the drug of choice for immediate tranquilization is haloperidol (contraindicated in pregnant or lactating women).

3. Patient participation is encouraged by first offering the oral concentrate. If the patient refuses, the medication is given intramuscularly.

4. In emergency psychiatry, the term rapid tranquilization is often used. It can be confusing. By some terminology, rapid tranquilization means a large dose of neuroleptic to immediately sedate the patient. Another usage of that term implies frequent small doses of neuroleptic. As a general rule, one would prefer frequent small doses in order to titrate the patient to a level of behavioral control and still allow the patient to be alert for continued interviewing information gathering.

   a. One method of rapid tranquilization would be to use Haldol, 2 mg i.m. or p.o. every thirty minutes until the patient is calm. An alternate method would be to use 5 mg of Haldol i.m. or p.o. every one hour until the patient is calm. Maximum of 60 mg/24 hours as a general rule.

   b. Thorazine in a dose of 100 mg orally or 50 mg intramuscularly every hour until calm is acceptable. A maximum of 800 mg in 24 hours should be respected.

J. Confounding Personal Problems

Personality disorders frequently present to the emergency room exhibiting various forms of behavior.   Many times the behavior is complicated by acute alcohol intoxication or other substance abuse. There may be associated adverse life circumstances such as problems with wife or girlfriend. Frequently, a personality disorder will know specifically what environmental manipulations are necessary to bring relief to this situation.   Many times a history of similar behavior can be elicited from the patient or significant others.

K. Chemical Induced Emergencies

1. LSD does not as a general rule present as assaultive or disruptive behavior. The patients are usually panicky or frightened and treatment of choice is reassurance in a quiet dimly light safe place. If necessary to control agitation, low dose Haldol could be used. It is of utmost importance not to send a person back to duty while still actively intoxicated with LSD.

2. PCP classically presents in a very disorganized manner with bizarre behavior, "super strong agitation" and unprovoked violence. A PCP patient can easily overwhelm several personnel at once, and if this indeed is the case, attempts at restraint should be withheld until adequate personnel are available. Some studies have been published out of UCLA utilizing Thorazine, Xanax, or Ativan, and Inderal in appropriate dosages for the intoxicated PCP patient.

3. Amphetamines are a common chemical intoxicant seen in the military service. It is not unusual for an amphetamine intoxication to present with paranoid delusions, agitation, exaggerated bottle signs and tactile hallucinations or formication. These people should always be admitted for medical observation and if necessary, Haldol can be used to control their agitation.

L. Homicidal Behavior

Homicidal behavior is occasionally seen in the military emergency room. Most often this occurs in a person with significant characterologic traits and usually revolves around an interpersonal relationship. The prediction of homicidal or assaultive behavior is imprecise to say the least. The things that one looks for is:

Is this patient making a direct threat? If so, under most state laws, not only must the potential victim be notified, but also the local police, and in the case of the military, his Commanding Officer. If the patient has a history of violence, this certainly increases his tendency to repeat that behavior and if there is any paranoid thinking or psychotic thinking, psychiatric treatment is indicated. In the absence of psychiatric disorders, the

judgment between legal management and psychiatric management can present very interesting problems.

SUICIDE: RISK ASSESSMENT & INTERVENTION

I. OVERVIEW

A. Suicide is generally viewed as preventable. Retrospective analyses of suicides ask the question, "How could this have been prevented?" All suicides cannot be prevented, no foolproof formulas for the prediction of suicide risk exist, and individual case management ultimately rests upon clinical skills and judgment. The study of suicide has yielded valuable guidelines for emergency assessment, and these guidelines, along with a heightened sensitivity to one's own reactions, can make the care of a suicidal patient safer and more efficient. Suicide prevention is taken very seriously by the United States Navy, and the medical officer must be aware of the specific actions required (NAVMEDCOMINST 6520.1A) for the safe disposition of active duty personnel presenting to Naval medical facilities with suspected suicidal ideation or behavior. It is imperative that the identification and management of the potentially suicidal patient be cautiously and conservatively conducted in accordance with current directives. During the initial evaluation of someone presenting to the emergency room who is at risk for suicide, no attempt should be made initially to differentiate between suicidal ideation, suicidal gesture, or suicidal attempt. Even an experienced psychiatrist who has a self-destructive patient in long term therapy often has difficulty in separating one entity from another. Especially difficult is trying to separate manipulative attempts from lethal attempts. In many cases, manipulative attempts can be quite lethal by "accident". Conversely, a "lethal" attempt at suicide may be made in a very inadequate way. However, the patient still wishes to die.

II. EPIDEMIOLOGY

Suicide continues to be a major health problem in the United States. In the military, it is the third leading cause of death comprising 10% of all active duty deaths. The military rate of suicide is about 10 to 12 per 100,000 annually or in Fiscal Year 1986, 248 deaths. In the civilian population, there are annually about 12 deaths per 100,000 people. Much concern is given to the adolescent population, ages 15 - 19, in which there are approximately 2,000 suicide deaths per year. Of equal concern, is the adult population over 65 with 10% suicide deaths per year. Firearms continue to be the lethal method of choice, both in the civilian and military communities. Of interest in both military and civilian studies is the fact that on the average one third of all suicide victims are intoxicated at the time of death.

III. SUICIDE MYTHS

A. Suicidal people are fully intent on self-destruction and have the right to die.

B. Once decided upon, suicide is inevitable.

C. People who talk about killing themselves are not the ones who actually do it.

D. Improvement following a suicidal crisis means that the period of risk is over.

E. Discussing suicidal thoughts and plans with the patient will fix ideas of suicide more firmly in his or her mind.

IV. RISK FACTORS

A. Risk factors most consistently identified in recent studies

1. Age - males 45 + years, females 55 to 65.

2. Sex - men three times more lethal than females. Females make three times more attempts.

3. Race - caucasians have the highest overall rate. Black males between 20 and 35 are at risk.

4. Marital status - single, widowed, divorced, separated people in that order are at greater risk than married people.

5. Living situation - lower socio-economic status is at risk.

6. Employment status - sudden loss of job or change in status is a risk.

7. Physical health - loss of functional capability is a risk.

8. Mental health - major depressive episodes have a 15% suicide rate - schizophrenia also is at increased risk.

9. Alcohol abuse or addiction - 30% of all suicides are alcohol related.

10. Previous suicide attempts - 2/3 of all completions have made a previous attempt.

11. Interpersonal loss - loss of significant other combined with other risk factors should be thoroughly evaluated.

12. Life stresses - multiple life stressors with poor support can lead to suicide.

13. Interpersonal conflicts - usually associated with "primitive" character pathology - especially borderline on histrionics.

B. The suicide risk factor paradox

1. Studies of suicide risk are necessarily conducted among whatever population is available (VA hospital inpatients, suicide prevention center callers).

2. That which is true of one group cannot always be extended to others.

3. What may hold true of a very general population may not always hold within a special group.

4. Several recent studies suggest that old age, career failure, sleep disturbances, and other traditional indicators of suicidal risk are often absent in completed suicides.

5. Immediate clinical observations are of greater importance than any scale or checklist in the assessment of suicide risk.

V. ASSESSING THE SUICIDAL PATIENT

A. When to assess

1. Verbal clues (statements about killing oneself are always to be taken seriously until proven otherwise). It is of interest that about two thirds of completed victims will have communicated their intentions to another person within a six-week period prior to their death. 53 - 75% of all suicide victims have seen a physician four weeks prior to their death. Subtle statements from patients with risk factors such as "I don't think I can take it much longer" should be investigated thoroughly.

2. Behavioral clues can be revealing in patients to be at known risk for suicide. A noticed deviation from previous habits such as planning for the immediate future should be investigated. The sudden writing of a will or changes in insurance policies should also be cause for concern. Persons with severe depression manifest in unexplained and sudden elation and perceived recovery should be viewed with suspicion as on occasion the patient has made a decision to suicide and are relieved at having made the decision.

B. How to assess

1. A nonjudgmental, objective concern on the part of the clinician may do much to alleviate burdens of humiliation, thus enabling the patient to be more open about feelings and plans.

2. When the patient has made a suicide attempt, it is essential that the interview be conducted after medical evaluation and stabilization.

3. Avoid premature reassurance - acknowledge your concern for the patient.

C. What to assess

1. Suicidal intentions

2. Suicide attempts (if any have been made)

3. General psychiatric condition

4. Potential resources for correcting the situation.

D. Suicidal intent/ideation evaluation

1. How is your life going?

2. How are you feeling in general?

3. How bad does it get?

4. Do you sometimes feel like giving up?

5. Do you ever think you would be better off dead?

6. Have you thought of ending your life?

7. Do you ever feel close to harming yourself?

8. How would you do it?

9. Where would you get the means to do it?

10. At what time and in what place would you do it?

11. How close have you come to killing yourself?

12. Do you feel that you will kill yourself in the near future?

13. What has kept you from killing yourself until now?

14. Does anyone else know of these feelings?

E. Suicidal plans

1. Lethality of the method.

2. Availability of the method.

3. Likelihood of rescue.

4. Beware of patients who act self-destructively and, simultaneously, deny suicidal intent. Assess these patients by their actions.

F. Attempted suicide

1. No one who has made a suicide attempt should be sent home from a treatment facility without a psychiatric evaluation and in most cases in- hospital evaluation.

2. What physical harm was done in the suicide attempt?

3. What was the likelihood of rescue from the suicide attempt?

G. General psychiatric evaluation

1. Social circumstances - available support system.

2. Occupation - job stressors.

3. Psychiatric history - Axis I or II Diagnoses.

4. Drug and alcohol history - history of impulsive use.

5. Medical history - change in physical health - medications.

6. Mental status examination (focus on the presence or absence of depression, psychosis, alcohol or substance use, and suicidal/homicidal ideation/ behavior).

H. Availability of resources for support and management

1. Hospital facilities with "safe" ward.

2. Outpatient treatment facilities.

3. Family and friends.

4. The member's command.

5. Other - Chaplain - Family Services - social worker.

VI. TREATMENT AND DISPOSITION

A. After careful assessment of the situation, one must choose the best available disposition, based on clinical judgment about continued risk and available resources. The disposition of the military patient should keep in mind the provisions of NAVMEDCOMINST 6520.1A of 6 March 1986. Essentially, this instruction states that all persons identified as having suicidal ideation should be directed to the nearest medical department. The patient should be evaluated by a psychiatrist or psychologist if available; if not, then an appropriate credentialed physician. If the patient is judged to be a suicidal risk, he must be admitted to the nearest medical facility. If the patient is not at risk for suicide, he may be returned to his command with a written documentation in his health record outlining the evaluation decision and follow up care to be provided. The command should be notified at that time of the disposition of the patient to ensure adequate follow-up. The patient should always be discharged in the company of a responsible individual. In a patient who has no Axis I diagnosis and is not known to be manipulative, the Brig may be a safe alternative to hospitalization - if he has charges to warrant incarceration.

B. Options for Management

1. High-risk patients should be hospitalized. If any question of the patient's impulse control or suicidal intent remains after evaluation, one should err on the side of being conservative and admit the patient for evaluation. High-risk criteria would include those patients

   a. with no social or family support system

   b. those who have verbalized a lethal and planned method for suicide

   c. those who have multiple risk factors that might include major depression, psychosis or intoxication.

2. Low risk patients who might be sent home would include those who:

   a. Have a reliable significant other to provide support once they leave the hospital.

   b. A patient who has a history of good impulse control and no previous history of

suicide gestures.

c. A patient who agrees to participate in his management and therapy and agrees to follow-up.

d. A patient who is willing to make a verbal agreement that if he has suicidal ideation, he will notify a responsible person. Considerable debate surrounds both verbal and written suicide protection "contracts" and from a legal standpoint are probably worthless. However, it has been proven in practice that the presence of an authoritative figure, with reassurance that he can be contacted at any time, can provide a very viable safety factor with a potentially suicidal individual.

C. When a patient is hospitalized for suicidal behavior, upon discharge, management should be the same as previously described. It is of the utmost importance to equally share the responsibility of follow-up among the initial evaluating physician, the physicians specifically designated for follow-up, and if the subject member belongs to a unit, the cognizant medical officer. Unfortunately, all too often, patients evaluated for suicidal behavior are lost for follow-up due to the complexities of our system and the lack of individual initiative to "get involved".

VII. SUICIDE RISK FACTOR MNEMONICS

A. MA'S SALAD

M Mental status - primary affective disorder; schizophrenia

A Attempt - previous suicide attempt. Those who have been on the "brink" and attempted suicide before are more likely to do so again. "Suicide is like diving off a high board; the first time is the worst." (Alvarez)

S Support System - enough others of significance

S Sex - for females the highest risk is between 25-50; for males the risk is greatest over 45. Males complete suicide three times more than women.

A Age - hospitalize older patients

L Loss - loss within 6 months.

A Alcoholism

D Drug Abuse

B. "SAD PERSON'S" Risk Scale - One point is scored for each factor. Total score thus ranges from 0 (very little risk) to 10 (very high risk).

S   Sex
A   Age
D   Depression
P   Previous attempt
E   Ethanol abuse
R   Rational thinking loss
S   Social Supports lacking
O   Organized Plan
N   No spouse
S   Sickness

NAVY SPRINT AND CRITICAL INCIDENT STRESS DEBRIEFING

I. NAVY SPRINT

A. History

1. NOV 1975 USS BELKNAP & USS JOHN F. KENNEDY

2. JAN 1977 USS GUAM & USS TRENTON, formation of the Special Psychiatric Rapid Intervention Team at NH, Portsmouth, VA

3. OCT 1978 First SPRINT deployment USCG Cuyahoga

4. FEB 1983 SPRINT incorporated into MMART System

5. OCT 1983 On standby for Grenada Invasion. Deployed to the MED following Marine Corps Barracks bombings in Beirut, Lebanon

6. SPRINT or partial teams have been deployed to requesting commands following suicides, aircraft mishaps and incidents aboard the USS VINCENNES, USS LAWRENCE, USS BONEFISH, USS STARK, USS IOWA, and the USS LEXINGTON.

B. Staffing

2 psychiatrists
1 clinical psychologist
1 psychiatric nurse

1 chaplain
1 social worker (if available)
4 psychiatric corpsmen

SPRINT I NH SAN DIEGO CA
619-532-8551

SPRINT II NH PORTSMOUTH VA
804-398-5281

C. Goals

1. Assist NORMAL people having NORMAL reactions to ABNORMAL situations by

2. Applying special skills and knowledge

3. Identifying and assisting local resources and

4. Consulting with local resources to facilitate normal grief reaction and arrange for proper follow-up care as needed.

5. Also prevent further harm, stop rumors and reinforce group identity in order to facilitate return to a pre-crisis level of functioning.

6. Prevent or decrease long term impairment such as Medical Board, early discharge, psychiatric hospitalization, decreased work performance, marital discord, violence, child abuse, drug/alcohol abuse, PTSD and suicide.

II. CRITICAL INCIDENT STRESS DEBRIEFING

A. Definitions

1. Critical Stress- Stress that overwhelms an individuals ability to cope and causes severe longlasting symptoms.

2. Critical incident- A sudden and intense blow to the psyche which has sufficient emotional power to overwhelm a person's usually effective coping mechanisms.

3. CISD- a structured group meeting led by Mental Health Professional, which emphasizes ventilation of emotions and other reactions to a critical incident in order to reduce the impact of the critical incident and accelerate the normal recovery process.

B. Critical stress symptoms

1. Physical - exhaustion, collapse, dizziness, pain, nausea, diarrhea, sweating, chills, tremors and insomnia.

2. Cognitive - decreased alertness, difficulty making decisions, confusion, disorientation, slowed thinking, anomia, amnesia, or intrusive recollections, nightmares.

3. Emotional- panic, anxiety, fear, apathy, guilt, depression, anger, helplessness, anhedonia, wish to die.

4. Behavioral- Violence, crying, hyperactivity, withdrawal, silence, suspiciousness, increased or decreased eating, increased alcohol intake, avoidance.

C. **Sample critical incidents**

1. LOD death

2. Serious LOD injury

3. Suicide/Homicide

4. Mass casualty
5. Disaster with high media interest/involvement

D. **CISD**

1. Symptoms don't improve, get worse or reappear

2. Symptoms appear in a number of people

3. Affected people show persistent behavioral change

4. Personnel request help

5. Distress continues after three weeks

E. **CISD Team Assumptions**

1. People are potentially capable of managing with proper support

2. People are normal until proven otherwise

3. Focus on current problems, here and now

4. Be very cautious about advice

5. Reinforce positive activities, remind victims of skills and strengths

6. Never be pushy, leave when rejected - be prepared to return when needed.

7. Dispel myths/misconceptions regarding medications, telling people how to feel, and determination of blame as command's agent

F. Crisis stages

1. Pre-crises: equilibrium.

2. Impact: "Nothing like this has ever happened to me before".

3. Crisis: Confusion/
disorganization, trial and error reorganization.

4. Resolution: regain control over emotions and work toward a solution.

5. Post-crisis: integrates experience into growth or regression. Some experience a chronic oscillation between defensive numbness and intensive re-experiencing of the trauma.

G. Types of Critical Incident Interventions

1. On-scene support

2. Defusing

3. Demobilization (Decompression/de-escalation)

4. Formal debriefing (CISD)

H. CISD Format

1. Introductory remarks
2. Fact phase
3. Thought phase

4. Reaction phase
5. Symptom phase
6. Teaching phase
7. Reentry phase

I. Special considerations for CISD

1. Ideal time--24 hours after the incident until memorial

- for LOD deaths may be the same day

- rarely used after 12 weeks

- potentially harmful after 16 weeks

2. Strict confidentiality must be observed.

3. Group dynamics never allow one person to take 100 percent of the blame or 100 percent of the credit.

4. Never mix personnel and dependents.

5. No notes, recordings or media.

6. If group is larger than 30individuals, split into target groups-remembering support providers.

7. Keep debriefing distinct from investigation.

8. Debrief without interruptions.

ADMINISTRATIVE PSYCHIATRY

I. Introduction

If psychiatry is viewed as behavioral medicine, then it follows that psychiatry will often be involved in the disposition of behavioral problems in the service. The medical officer must be aware of the importance of current directives in administrative, and medical dispositions. The prudent medical officer may use readily available sources of reliable information in order to suggest appropriate dispositions in accordance with current directives.

II. Overview of the Directives System

A. Rules and regulations encompass so many aspects of military life that every active duty member is affected by them every time he is evaluated or treated.

B. Often, administrative issues are at least as complex as the clinical issues.

C. A competent medical officer must be proficient in administrative as well as clinical skills.

D. To master the administrative aspects of clinical practice, one must be aware of the content and relevance of specific current directives.

E. No single source offers this information, and the sheer quantity of regulations makes the task impossible for the average clinician.

    1. A 1983 survey found that the consolidated subject index alone listed 6,294 instructions issued by 25 subdivisions of the Navy.

    2. A survey of the change transmittal sheets issued by the Navy Publication and Printing Service for the year ending 1 October 1982 showed that there were 514 new instructions, 122 new notices, and 112 changes to existing instructions.

    3. The task becomes even more complex when the need to identify Marine Corps, Coast Guard, Army, and Air Force regulations is taken into account.

F. The Directives System, with its frequent changes, can be compared to a motion picture film, with a particular list representing just one frame.

G. In summary, the task is to know which directives are currently applicable to a specific disposition.

H. An Administrative Index for Mental Health Professionals, a 1983 project to provide Navy mental health professionals with a current, cross-indexed listing of all references for Navy, Marine Corps, and Coast Guard regulations pertaining to mental health, is used as a teaching aid at this point to demonstrate the volume of directives pertaining to mental health.

III. General Principles of Administrative Psychiatry

A. Psychiatric dispositions should be made in accordance with current selection, retention, and separation criteria.

B. For general duty, general requirements must be met.

C. For special duty such as aviation or diving, both general and special requirements must be met.

D. When behavior violates regulations, psychiatry may become involved in the disposition.

   1. Psychiatric consultation may be requested for diagnosis, treatment, and disposition of a compensable mental disorder.

   2. Psychiatric consultation may be requested to determine the absence of a compensable mental disorder before a member is processed for administrative separation.

   3. Psychiatric consultation may be requested to facilitate various legal processes.

E. Generally, there are three common reasons for selecting dispositions.

   1. Medical - A person has a medical condition which renders him unfit to continue to perform duties effectively or safely.

   2. Administrative - A person has a pattern of behavior or other unusual circumstance that is a burden to the Navy.

   3. Special Duty - To clarify a physical status for special assignments, such as diving, or to continue in a special designation.

IV. Administrative Disposition

A. Performance and conduct are key factors influencing administrative separation decisions.

B. Individuals must be counseled and provided with an opportunity to correct deficiencies prior to initiating administrative separations in the areas where performance and/or conduct form the basis for separation, as documented in the member's record. NAVMILPERSCOMINST 1910.1C currently governs administrative discharges.

   1. It requires the commands to expend every effort, via counseling, education, and discipline, to salvage an individual whose performance may be defective.

   2. Administrative dispositions should be invoked when a command has exhausted resources mentioned above, or when the individual becomes a burden and drain on the command resources equal to the burden of administrative processing.

   3. Commands are instructed to use rapid compliance with the processing of administrative separations only after all legal charges have been resolved.

   4. If an individual has served six years, he or she has a right to an Administrative Field Board, at which he or she may be represented by counsel in his/her own defense as a part

of the separation process.

5. Some formal reasons for administrative separation are listed.

a. Expiration of service obligation
b. Selected changes in service obligation
c. Convenience of the government
d. Defective enlistments 3620280
e. Fraudulent enlistment 3630100
f. Entry - level performance or conduct - MILPERSMAN 3630200
g. Unsatisfactory performance - MILPERSMAN 3630300
h. Homosexuality - MILPERSMAN 3630400
i. Drug abuse rehabilitation failure - MILPERSMAN 3630500
j. Alcohol abuse rehabilitation failure - MILPERSMAN 3630550
k. Misconduct - MILPERSMAN 3630600
l. Separation in lieu of trial by courts martial
m. Security
n. Unsatisfactory participation in Ready Reserve
o. Separation in the best interest of the service

D. Convenience of the Government specifically includes:

1. Personality Disorder
2. Parenthood
3. Obesity

E. Confusion often arises over the reasons for discharge versus the type of discharge. There are only five types of discharge.

1. Honorable discharge

2. General discharge

3. Discharge under conditions other than honorable

4. Bad conduct discharge (must be at the direction of a courts martial)

5. Dishonorable discharge (must also be at the direction of a courts martial)

V. Aviation, Diving or other Special Duty Disposition

A. An individual unfit for military service is also not physically qualified for aviation or diving, but one may be not physically qualified for aviation/diving and yet physically qualified

for general military service.

B. Therefore, to qualify for aviation or diving duty, one must be fit for full duty.

C. The function of the Medical Board is to return the patient to full or limited duty, if warranted. If the Medical Board (or consultant) decides that the patient is fit for full duty, they should so state. The question of special duty must be separately addressed by those who have received special training. In the case of aeronautically designated personnel, MANMED 15-67 places the responsibility for flight status determination on the shoulders of the Flight Surgeon. If the patient is placed on limited duty, even the patient's Flight Surgeon cannot return the patient to flight status.

D. Local Board of Flight Surgeons

E. Special Board of Flight Surgeons

VI. Medical Disposition - MANMED, Chapter 18 - 7/32

A. Nine reasons for Medical Boards

1. Physical defect which precludes military service.
2. Military service will aggravate an existing physical problem.

3. Long hospitalization or intense medical supervision is required.

4. Condition is temporarily incompatible with unrestricted duty but full recovery is anticipated.

5. Ultimate recovery is uncertain, and a period of evaluation is desirable.

6. Condition requires geographic or other limitations of assignment.

7. Mental competency is in question.

8. Patient refuses indicated treatment.

9. A condition likely to recur needs to be formally documented.

B. Three Medical Board dispositions are possible.

1. Fit for full duty.
2. Fit for limited duty.
3. Referral to the Physical Evaluation Board (PEB)

C. The Central Physical Evaluation Board

1. EPTE vs. DNEPTE
2. Line of duty vs. misconduct
3. Disabling compensable disorder
4. Disability rating

D. The Temporary Duty Retired List - TDRLs usually re-evaluated by the specialty clinic.

E. Appeals - Everyone who receives a medical board should be encouraged to rebuttal all levels if they have a legitimate case.

VII. SECNAVINST 1900.9D is reviewed to illustrate the application of a current directive.

VIII. Sources of Information Reliable sources of information for application of current directives

A. Administrative Officer
B. Legal Officer
C. Fellow Medical Officers
D. Other

COMBAT PSYCHIATRY

I. HISTORY

A. Man at War

1. Only 268 of 3,421 years of written history have been without war.

2. The nature of warfare has changed over time.

   a. Short skirmishes

   b. Protracted sieges

   c. World War I - introduction of tanks, gases, trench warfare and airplanes

   d. World War II - massive bombings, bacteriological warfare - nuclear war

   e. Korea - NBC warfare threat

    f. Vietnam - air superiority - small unit engagement - guerilla tactics

    g. Yom Kippur war - brief - intense

B. Combat psychology of the past

A basic goal of military medicine including combat psychiatry is to conserve as many men as possible for combat operations. The specific area of combat psychiatry has undergone several stages of development and some unfortunate instances of "reinventing the wheel" until it is at its present state of development.

1. Pre-World War II

    a. Civil War - at this time the concept of "nostalgia" was felt to be a reflection of either mild insanity caused by a longing to be home or in other instances "a moral problem" (weak character.) Then, the approach was to treat close to the front lines. The casualties were given unstressful work as close to their unit as possible. Those who were not salvageable or became unmanageable were discharged from the service.

    b. Russo-Japanese War - this conflict showed a significant contribution to the concept of combat stress. The Russians continued to treat their casualties as they treated their soldiers in this war, as close to the front line as possible. They sequestered these stress casualties in specially designated centers along the Tran-Siberian Highway maintaining rather exclusive channels of evacuation for them if necessary. In this conflict, Red Cross personnel and lay-personnel were pressed into service because of the lack of trained medical personnel to deal with the large number of casualties. This action demonstrated that supportive care in most cases was sufficient.

    c. World War I - The prevailing opinion of all armies concerned were that combat stress casualties were either "shell shock" secondary to chronic concussion and resulting brain damage or "emotional shock". Emotional shock was a pejorative term in that these were often labeled "cowards and moral degenerates".

    d. An interesting approach by the French and Germans treated the emotional shock cases near the front and threatened the victims with execution or electro-shock treatment - without anesthesia. The results were a surprising rate of return to service of these casualties. The "shell shock cases" were treated in rear echelon hospitals with a very low rate of return to the front lines. As a corollary, the British treated both types of cases in rear hospitals, and had a very poor return to the front line.

    e. By the end of 1916, the Allied Armies began to adopt a form of echelon system for

combat stress cases. The entity was now considered to be distinctly psychiatric and was now termed "war neurosis". Principles of treatment, included rest, encouragement, persuasion, and positive suggestions from their peers to return to the front lines. The Echelon system consisted of:

1) The division level where treatment would be provided three to five days.

2) The second echelon level at a major hospital as close to the front lines as possible. The treatment here might last as long as three to four weeks.

3) The final step prior to evacuation back to the United States was the specialized psychiatric hospital in the rear non- combat area.

2. Unfortunately after World War I, many lessons of military psychiatry were disregarded or forgotten. War neurosis again took on an aura of weak willed neurotic people who broke under stress. There was however a noted emphasis on screening people entering the service more thoroughly for the existence of or predilection to emotional illness.

a. World War II itself saw about 500,000 discharges from the military service for psychiatric reasons. Several important events pertinent to combat stress occurred during World War II. The psychiatric consultation became more common and the condition called "combat neuroses" was now called "combat fatigue" or "exhaustion". It is of interest to note that only in 1944 did the three system of management of combat stress casualties become reinstituted. The principles of proximity, immediacy and expectancy were again taken as the basic approach and proved to be quite successful.

b. The Korean War saw a more expeditious application of the previously learned principles for World War II and as a result the combat casualty rate for psychiatric reasons was significantly reduced.

c. Vietnam as a Armed Conflict presented unique problems in recognition and management. Coupled with the frequency of small unit contacts, individual guerilla attacks, the constant problem of unexpected individual attacks along with a lack of enthusiasm and motivation among a significant portion of the Armed Forces, it is no wonder that combat stress became often a very ill-defined entity. When suspected or identified, the principles of proximity, immediacy, and expectancy prevailed with the echelon system again being instituted. Those cases not responding to this treatment were medevaced back to CONUS.

II. CASUALTY FIGURES

A. Psychiatric casualties by hospital admission rates. The ratio of psychiatric to physically lowered varies from 6 to 50% depending upon circumstances.

1. Civil War - 27-29/1000
2. World War II - 101/100,000
3. Korea - 32/1000
4. Vietnam - 12/1000
5. Yom Kippur War - 600/1000 (?)

B. Return to duty after psychiatric diagnosis

1. Early World War II - 10%
2. Late World War II - 70%
3. Korea - 85-90%
4. Vietnam - Many variables make estimates difficult - poor morale, drugs, politics and malingering

III. PSYCHIATRIC PRESENTATION OF COMBAT STRESS

A. All persons, when confronted with a situation that is out of the ordinary, tend to react in their own unique fashion. Normal emotional responses become exaggerated in the combat situation. Among the emotions, e.g., love, hate, anger, and fear, fear is perhaps the one most critical to an adaptation to combat. One hopes to endure the combat situation without a discreditable display of fear; the fear of being unable to do this compounds the stress of the combat scene. A more experienced combat soldier may have more fear in combat but he may manage it better. The less experienced soldier may have less fear but may display it more helplessly or unacceptably.

B. Normal Stress Reactions

1. Psychological Manifestations

a. Generally, during the brief, relatively transient periods of combat, such reactions are rare in the combat situation per se; however, they are extremely common in the immediate post-combat period.

C. Combat Fatigue Reaction

1. Will not participate (an erosion in attitude)

2. Helplessness and despair verbalized (may reflect several problems; e.g., guilt, memory impairment, and confusional thinking.)

3. Hypervigilance coupled with expressions or behaviors of sustained alarm

4. Persistence of rapid speech, furtive or anxious behavior.

5. Severe reactions

   a. A matter of intensity and refractoriness to gentle restraint or persuasion by fellow unit members

   b. Garbled, unintelligible speech

   c. Gross deficits in thinking and understanding perceptions

IV. PRINCIPLES OF TREATMENT

The principles of treatment continue to be the basic "PIE" which stands for proximity, immediacy and expectancy. Two other mnemonics, "Biceps" and "Impress" are also useful in remembering the principles of combat stress casualty care.

A. BICEPS

B   B for brevity which indicates that the treatment should be as brief as possible.

I   I for immediacy which indicates that the combat stress should be identified early and intervention should occur in a timely manner as opposed to waiting for a complete clinical picture to appear.

C   C for centrality. The combat fatigue victim should be treated in one location separate from the main hospital and medical surgical cases. This decreases the self-identification as a sick person, helps maintain the military image and helps with the consistency of disposition.

E   E for expectancy. It must be clear to each individual through verbal and nonverbal message from professional staff, peers, and command that he will be returning to combat duty as quickly as possible. The explanation should be understood that this is not considered a moral or character issue in that the stress is real and legitimate and can be managed.

P   P for proximity meaning that the care should be provided as close as possible to individual's unit of assignment and to the area of activity.

S   S stands for simplicity meaning that goal of treatment is to restore the person to combat and not to provide in-depth psychodynamic therapy. Rest, reassurance, group support, a chance at verbal ventilation are indicated. Medications should be used very

sparingly and then only for sleep if necessary for one or two nights.

B. IMPRESS gives the same information from a different mnemonic.

I   I stands for immediacy.

M M equals maintained military milieu.

P P equals proximity. R equals rest and replenishment.

E E equals expectancy and return to duty.

S S equals simplicity, short and simple.

S S equals supervision to each level, both by military personnel and medical personnel. The involvement of medical personnel is mandatory to continually screen for organic or physical reasons that might contribute to the patient's presenting symptoms.

V. WHO SHOULD BE EVACUATED AND CONSIDERED A PERMANENT LOSS TO THE COMBAT UNIT.

A. Those obviously psychotic that do not resolve their symptoms within just a few hours.

B. Unresolved conversion disorders.

C. Repeated panic reactions - disorganized behavior that would constitute a danger to himself or to others.

D. Those in a leadership position whose improper judgment or unacceptable behavior would not only impact on the safety of the unit but impart unacceptable examples for other unit members.

VI. SUMMARY

Combat is usually "bad for your health". No matter in what capacity you serve, the level of stress can reach a point of temporarily overwhelming your psychological defenses. Untreated or mistreated, psychiatric casualties reduce combat effectiveness and expose the patient to the likely chronic sequelae of disability and/or invalidism. Psychiatric reactions to combat can be further divided into acute reactions and chronic reactions according to differences in signs/symptoms, precipitants, treatment and preventive strategies.

A. Acute reactions

1. Signs and Symptoms: Physiological hyperarousal panic, freezing, agitation and cognitive impairment.

2. Precipitants: environment, fatigue, intensity, surprise, interpersonal: cohesion, leadership personal: age, inexperience

3. Treatment: Control arousal ASAP, BICEPS/IMPRESS 95% RTD within 24-48 hours

4. Prevention: Physical fitness, increase coping strategies, realistic training, anxiety inoculation, esprit de corps

B. Chronic reactions

1. Signs and Symptoms: Physiological hypoarousal, withdrawal, dysphoria, slowness, substance abuse, "2000 yard" stare

2. Precipitants: environment; fast duration immobility Interpersonal; Pre-existing stress, limited communication Personal; AXIS I/AXIS II Illness, Helplessness/ Hopelessness

3. Treatment: Early group support, may require "special" treatment or medication. 40-70% RTD in 2 weeks

4. Prevention: Increase communication (debrief after stress), physical fitness, faith/humor, teach self pacing ("one day at a time"), and deploy no problem patients.

WAR PSYCHIATRY: COMBAT STRESS-RELATED DISORDERS

By Colonel David R. Jones, USAF, MC

The highly stressful combat environment inevitably produces psychological changes. Fear of death is present. One's friends may be wounded or killed, frequently right before one's eyes. There is nowhere to hide, especially with today's weapons. Sleep is of poor quality. Eating is irregular in quantity, quality, and timing. Physical exertion is required, and may be interspersed with unpredictable periods of anxiety-filled waiting. In some situations, one is helpless, and can only wait passively until the artillery or the bombs cease. There seems to be no end to it, and no way out of it.

Such stresses have inevitable effects on individuals. The reactions to them are fairly predictable for a group of individuals, and fall into recognizable patterns. Statistics may vary depending on a

number of circumstances; length and intensity of combat, offensive or defensive situation, and unit morale are important epidemiologic factors. Further, these stress-related reactions occur in a U-shaped temporal distribution: the incidence is large for the first few days of combat, then drops off as experience and adaptation occur. With time, however, fatigue and accumulated stress factors combine to raise the rate again. Thus, the bad news is that combat stress-related disorders may be a major source of loss of military personnel. However, the good news is that the condition is imminently treatable, if recognized early and treated correctly. Moreover, preventive measures may be quite effective in keeping a unit's losses low.

Those interested in the history of military medicine find this condition fascinating. It was essentially unreported and presumably unrecognized as a diagnostic entity until the American Civil War, when the word "nostalgia" was coined to describe it. The Russians recognized it during the Russo-Japanese War of 1904. It was labeled "shell shock" in World War I, and was thought at first to be organic in origin, due to the concussion of artillery explosions. The heroic victims were evacuated to their homeland hospitals, and recovery rates were low. Prior to the U.S. entry into the war, Dr. Thomas Salmon of New York studied this condition and outlined the features of successful therapy as he saw it; rapid treatment, close to the front lines, with early return to combat units. Using these principles recovery rates were 70-80%.

As frequently happens, these principles were forgotten during the peaceful interval between the wars, and psychiatric losses were high during the early days of World War II until proper treatment methods were reinstituted. For the first time, this condition, now called "combat fatigue" or "combat exhaustion," was studied epidemiologically, and its incidence rate tied to the rate of traumatic injuries and to the number of days under fire. The Korean War followed World War II closely enough that treatment lessons were not forgotten; proper therapeutic dispositions, coupled with rotation policies and fixed tours in combat served to lower the rate further. These factors also served to lower the incidence rate of psychiatric casualty evacuations in Vietnam. In the latter stages of the war in Vietnam, however, psychiatric casualty rates rose due to new factors involving drug abuse and poor morale.

Current USAF concern about this subject is different from the past, when we did not see it as a problem. We in the Medical Service must include the possibility of a war - particularly in the European Theater - in which we do not have total air superiority. Our bases may come under direct attack by air forces and by ground forces. We may become directly involved with our own casualties, and quite possibly with those of the Army. In the worst case, we may also have dependents present in the area as an additional source of concern, although the characteristics of their reaction might differ from those of active duty personnel.

Under the current psychiatric nomenclature, this reaction to the stress of combat is called an "acute post-traumatic stress disorder," which may be compared to the reactions of certain populations to national catastrophes or disaster situations. Such disorders occur in response to stresses that would evoke significant symptoms of stress in almost anyone. The predominant emotion is fear, and the predominant physical factor is bodily exhaustion. Fear may be manifested

as a hyperalertness and an exaggerated startle response. There may be gross tremors. Memory may be impaired to the point of amnesia, and the individual may be unable to concentrate. Sleep disturbance is common: there may be insomnia, or there may be terrible nightmares. The individual may be emotionally upset with crying and with great anxiety, or there may be emotional dulling, numbing, and withdrawal approaching catatonia. If there is recall of a specific precipitating event, it may be accompanied by strong feelings of guilt and shame over perceived shortcomings, or simply for having survived where others have died. Physical signs and symptoms may involve one or more of the major systems of the body: respiratory (hyperventilation), gastrointestinal (anorexia, nausea, vomiting, cramps, diarrhea), urinary (frequency), musculoskeletal (tension, tremors, postural changes), and a variety of altered sensations and increased reactions to stimuli representing central and autonomic nervous system dysfunction. There may be dissociative phenomena - "hysterical" paralysis, blindness, or muteness. And always, there is physical exhaustion.

These varied patterns of behavior and physical symptoms may vary from mild to extreme. Seen in a peacetime context, they would quite likely lead to psychiatric hospitalization. But this is not peacetime, and these reactions are the intense end of a spectrum of normal reactions to this abnormal situation. The individual has been under an extreme stress, and is reacting to it in a very human way.

Six elements are used to help the individual recover: Brevity, Immediacy, Centrality, Expectancy, Proximity, and Simplicity. (BICEPS is a helpful mnemonic).

Brevity. Treatment should be brief, lasting no more than three days at the second echelon level. If more extensive treatment proves necessary, ship the patient to the rear.

Immediacy. Identify the need for care early, rather than waiting for a complete clinical picture. Provide care right now; do not wait for a consultant to arrive, or for evacuation to another facility.

Centrality. Treat combat fatigue victims in one location, separate from the hospital. This decreases their self-identification as a sick person, and maintains their military image. Central treatment also helps consistency of disposition, since one person will be making the decisions about the return to duty.

Expectancy. It must be clear to the individual, through verbal and non-verbal messages from professional staff, technicians, friends, and chain of command, that he or she will be returning to duty in a few days. There is no illness here, no lack of character or moral fiber. This is a transient stress reaction, a combat exhaustion, a normal reaction, and one from which recovery is assured. Generally speaking, we avoid speaking of "illness," "syndrome," "patient," "treatment," or "hospitalization." This individual has been temporarily overwhelmed by circumstances and stresses that would affect anyone. Help strengthen the military self-image by requiring the wear of the uniform during the day, and by some symbolic duties such as calisthenics, drill, or area

clean-up.

Proximity. Provide the care as close as possible to the individual's unit of assignment. This maintains bonding with the unit, and allows friends to visit and give support.

Simplicity. The goal of treatment is to restore the person to combat, not to do any deep psychodynamic work. Determine what defenses have been used in the past, and bolster them. Rest, ventilation, explanation, reassurance, group support, suggestion and exhortation will help in restoring the ability to deal with the stress of combat. Use no medications except short-acting sedatives for sleep, and then only when necessary. (Medications help reinforce the sick role.)

So, as far as we can, we provide:

- rest, including sedation for a night or two if necessary.

- nourishing and appetizing food.

- professional support, under the model of crisis intervention. This is aimed at bolstering the individual's defenses, to show him or her that others feel the same way but can work in spite of the feelings. Unit integrity is emphasized, and acceptance, reassurance, explanation, and appeals to pride and to duty are used. In extreme instances, a mental health professional may use abreaction techniques to enable the individual to deal with a specific precipitating stress in a more adaptive way.

- confident expectation that this is a brief, temporary condition that will pass quickly and without residual impairment in two or three days.

- care given to a non-hospital environment, where individuals wear uniforms, not pajamas. A military identity is maintained.

A few statistics: The ratio of combat fatigue victims to wounded may vary from 1:12 to 1:1, depending on the unit morale and the combat situation. If mental health technicians can be assigned to work at unit level, or if medical surveillance can be used to intervene early through attention to some of the stressors that can be controlled (rotation, rest, food, sleep), incidence may be lowered. Army estimates are that about 80% of individuals seen for combat fatigue are mildly affected (not adequate for combat, but can function in noncombat jobs); 15% are moderate (cannot function in any duty capacity); and 5% are severe (cannot function as persons; i.e., need total care). When care is provided within the principles of BICEPS, we may expect a return of about 85% to combat or combat support duties. Of this number, about 7% will experience a recurrence of the reaction.

What are the alternatives? If we treat these people as patients, admitting them to the hospital, with the prospect of evacuation if they don't get better, they won't. In the 1973 Yom Kippur

War, the Israelis evacuated such people to civilian hospitals. Essentially none were returned to their units, and chronic disability has been the general result.

Some physicians may feel that it violates their ethical duty to a patient to establish a therapeutic goal of returning him to the dangers of combat. I offer three points in rebuttal:

1. <u>Somebody</u> will go in as a replacement. A decision not to return one individual is a decision to send someone else instead.

2. The replacement, not being psychologically bonded to the unit, will not have the support of friends, and will be more at risk than the others.

3. The patient who is thus "helped" is being branded a psychiatric patient; the result of this may be a lifelong chronic psychiatric disability.

We turn now to preventive techniques. The U.S. Army expects mental health professionals to serve as advisors to the commanders in much the same way that flight surgeons serve as advisors at squadron and wing level. The military mental health advisor functions in areas of morale and the impact of command policies on the psychological effectiveness of military personnel. He or she can educate the staff and unit command structure as to preventive techniques and the early recognition of stress disorders, as well as the inevitable occurrence of normal reactions under combat conditions that would be considered pathologic in peacetime.

Combat support troops may be exposed to combat only occasionally, in contrast to the day-after-day exposure of combat troops. Such Air Force personnel may therefore find themselves under a different kind of stress, with different behavioral manifestations. Here, loneliness and boredom may take their toll. Personal care may decline - infrequent bathing, lack of attention to food and water sanitation, failure to take antimalarial medications or to keep immunizations current, and neglect of proper maintenance of protective gear. Depending on the circumstances, skin problems, sunburn, frostbite, trench foot, fungus infections, gastroenteritis, and other "minor" medical conditions may cause an increasing amount of lost duty time. Alcohol-related disorders increase, as may drug abuse. Venereal disease rates may also rise; statisticians during the last three conflicts have noted that VD rates decline or remain low in periods of actual combat, and rise when the combat ceases; these rates are also higher in combat support personnel than in combat personnel. Homosexuality has also been noted more in support than in combat troops, and the incidence of psychosis has been higher behind the lines than on them.

This data is derived from U.S. Army experiences in World War II, Korea and Vietnam. Most of the Air Force experience during these conflicts was in the combat support role, with the bulk of the troops supporting the relatively few fliers who experienced the dangers of combat. This situation may not apply to future combat situations because some Air Force bases may be the scenes of ground or air attacks. Others may be free of such imminent dangers. In this latter situation, Air Force physicians will find themselves dealing with the less striking disorders of

bored, tired, lonely troops, disorders that have much to do with individual morale and group esprit de corps.

The essence of a successful combat unit is high morale, a sense of comradeship, and strong leadership. When these are present, psychiatric casualties tend to be low. When these are absent, psychiatric casualties are high. In a very real sense, the opposite of the psychiatry casualty is the hero. Thus, the psychological factors which we aim to foster are those which make an efficient, tightly-bonded, high-morale unit; when these are absent, we will see the psychiatric casualties go up. The maintenance of esprit de corps is far from the ordinary duty of most mental health professionals, and merits some discussion.

Unit bonding and esprit de corps must be carefully fostered in advance. We should not wait until a unit enters combat to pay attention to it. This sense of being in a strong, competent, capable unit, with enlightened leadership that has firm support from above and laterally must be strengthened by the supervisors and commanders before combat begins. In the Air Force, we will have a particular problem, because most of our troops are in the support role. There is a particular sense of helplessness which comes from being under attack, especially on a chronic or recurrent basis, with no means of fighting back. The infantry may have weapons which can be fired at will, but a maintenance supervisor or a supply sergeant or a motor pool driver is not able to do this. They simply have to "sit there and take it." Some of the charisma may have to come from the fliers themselves, since they represent "the tip of the arrow." They generally have to be transmitted throughout the wing and the base support systems. The identification may be fostered by the use of such devices as special insignia, personal contact with the fliers, sense of being a member of the "best wing in the world," a wing slogan, parties, sports events, projects, and other such devices well known to a good leader. In a combat situation, Air Force officers may have to switch from their traditional peacetime managerial model of leadership to a more charismatic model.

We know that closely-bonded loyalty and sense of personal support extends only to groups of about 35 people or so. Integrity of this size group is important in the base setting. As I mentioned earlier, the bond must be established before combat. A system of individual rotation in and out of the combat situation, such as in Vietnam and Korea play havoc with this sort of bonding. This is especially true in a non-draft environment; volunteers may tend to come from backgrounds of poor family stability and bonding. It may be that bonding can only be established by individuals who have the social skills required to bond, skills learned in childhood. The Yom Kippur War emphasized the increased rate of breakdown among non-combat units under fire, especially if they had poor morale, poor leadership, and low skill level. A poor family background also contributed to the breakdown rates; those who were dealing with strong emotions, once they broke down, had a worse recovery rate than those who had a history of being better at dealing with their emotions.

I realize that much of this will be beyond your capability to change before the fact, but there are several things that can be done in the peacetime environment or when there is an increased risk of

war. The mental health professional must get out of the hospital setting and become known to the wing-command structure. This may be done through working with the flight surgeon, or through direct intervention of the Hospital Commander to introduce the mental health professional into the roles of the Staff Officer. Some individual study of group dynamics might be useful, and it certainly would be well to have a sense of the sort of leadership that has been successful in wartime. The book "War on the Mind," by Peter Watson, has some information on this subject. The mental health professional must demonstrate credibility not only in the professional field, but also in the field of the military mission. Credibility established beforehand will be extremely useful in the chaotic situation of combat. Be alert for the indications of absenteeism, sloppy work, and general degradation of mission effectiveness. Indicators of poor morale, such as Article 15 rates, AWOL rates, indicators of drug and alcohol abuse, venereal disease rates, physical non-effectiveness rates, and rates of psychological casualties, all may serve to identify units which are poorly bonded, or have poor morale, or have poor leadership. A credible mental health profession may be able to help the wing commander by identifying some of the factors within such a unit and helping him to correct them. Some authors recommend a competition between units as to which has the lowest rate of psychiatric casualties evacuated out.

Individual factors may act to minimize the effects of combat stress on personnel. Planning preparation, maintenance of unit esprit and morale, knowledgeable commanders, and a well informed and prepared medical staff will all play a great part in minimizing the numbers of personnel lost from duty because of combat stress reactions. In general, avoid medications; they tend to reinforce the "sick" role. If any medications are used at all, they should be short-acting benzodiazepines. Even oxazepam, which generally clears the body in about eight hours, may leave some hangover. The object is to restore the soldier to alertness, not to induce torpor.

Leadership may play a major role in diminishing psychiatric casualties. Leaders must understand, and let their people know, that it is normal to feel fear under these circumstances, and not to be more anxious if they feel a pounding heart, tense muscle, visceral distress, dry mouth, trembling, sweating, or disturbed bowel or bladder function. This understanding that these symptoms are not unique, but are common to almost everyone, will keep an individual from feeling that he or she is the only one so affected.

At the same time, wise leaders let their troops know that, although feeling fear is normal, they are expected to control their reactions to the fear and to do their jobs. There is no disgrace in <u>feeling</u> fear; there is disgrace in giving way to it. If possible, assign shaky new troops with more seasoned, older "battle friends" to help them through the first stresses. Avoid bragging about how rough it is to new troops; emphasize instead the strength and cohesion of the unit through hard times. Individuals draw strength from the perception of belonging to strong units, ably commanded by leaders regarded as tough but fair, those who look out for their people.

Further, leaders need to understand from their medical advisors that the syndrome of battle fatigue does exist, that it does not imply cowardice or lack of moral fiber, and that it can be taken care of by early recognition and proper treatment, thus avoiding a major source of loss of

experienced personnel.

It may be useful to examine several different manifestations of battle fatigue because there are some differences in the way they are handled.

1. The shock of initial engagement may lead to transient battle reactions. These are clearly not due to fatigue, since they may occur in the first few hours of combat. Of the first 1500 casualties in one area of the Yom Kipper War, 900 were psychiatric. This was a function of the shock of the initial engagement, especially when surprise occurred and the troops were not used to combat. The main symptoms encountered were those of anxiety.

2. Later, fatigue becomes a factor, and this leads to true "battle fatigue." There is a period of adjustment of about a week, after which the psychiatric casualty rates fall. As people become accustomed to combat, and realize that there are things that can be done to defend themselves, the psychiatric casualty rates tend to level off. After a month or more, fatigue sets in in earnest and the symptoms tend to be more psychophysiologic. There has been some work done in the British Army demonstrating the importance of sleep, especially in the first week or so. It was said that the military's attitude toward sleep seems to be that of monks toward sex: <u>if you are really competent, you can get along without it</u>. This may be especially dangerous in the Air Force environment, since the first skills to deteriorate under prolonged sleeplessness are cognitive skills, with motor skills deteriorating later. Thus, leaders who allow their troops to sleep while they sit up all night making plans and preparing the reaction may be contributing to the downfall of their units. Research has shown that, over the long haul, four hours of uninterrupted sleep per night is sufficient to maintain the competency of the unit. Any less and performance deteriorates. The mental health professional must impress on the leadership the importance of allowing adequate sleep, at least four hours a night. It is said that the Russians emphasize this also, and feel that the hours between about 2:00 and 5:00 a.m. are the most important. When one sleeps on this four-hour cycle, the amount of Stage IV and REM sleep are soon returned to approximately the normal amount of an 8-hour sleep; Stage I, II, and III drop out entirely and apparently are not nearly as necessary.

3. After prolonged combat, we fine the "old sergeant syndrome." This may occur in non-commissioned officers and "middle management," who have been good leaders but who have lost too many troops, and have few friends left from the "old outfit." The symptoms tend to be more those of chronic depression than those of fatigue or anxiety. The prognosis for return to battle duties is very poor, in that when they return to combat, the symptoms recur fairly quickly. However, they can be returned to non-combat positions and apparently do very well at this. Thus, they are able to maintain their self-esteem as productive members of the military force, even though they can no longer do active combat. This will probably not be much of a factor in the Air Force because of our mission.

4. Delayed combat reactions have occurred, particularly in those who were physically wounded in the Yom Kippur War. In this condition, the patients manifested no psychiatric symptoms during triage and the emergency medical treatment phase, but had the onset of psychiatric symptoms as they got close to their homeland. For the Egyptians, such symptoms occurred when they returned over the Suez Canal into Egypt. For the Israelis, it occurred when they got to civilian hospitals in Tel Aviv. At this point, they psychiatric symptoms might become more severe than the physical symptoms, and would prevent the person from returning to duty.

I have discussed a great deal of the history of the condition we know as battle fatigue, and the principles which go into its treatment. One thing is certain; each successive war has been different, and no set of rules would serve for all conditions. I hope that by discussing the various historical conditions, the diagnostic categories, and the principles of treatment, I have given you enough information so that, if and when you are confronted with the need for caring for active battle psychiatric casualties, you will be able to maintain the strength of the force and prevent further psychiatric wastage.

In circumstances where there are few or no mental health professionals available, other medical and paramedical personnel will have to fill the gap. If you are involved in a combat situation, you will need to understand these factors so as to deal with them effectively from the first day. Knowledge of what to expect will help you master your own feelings, and to provide the best possible service to the units you serve.

* (For a further discussion of combat stress, consult Virtual Naval Hospital at www.vnh.com)

POST TRAUMATIC STRESS

I. INTRODUCTION

The concept of post-traumatic stress disorder, even though a relatively new one in the field of clinical psychiatry, continues to gain importance. In opposition to the emotional and financial impact it has on the military service and service members, there is interest in instituting programs that will in the future reduce the incidence of post-traumatic stress disorder.

II. DSM-III-R CRITERIA DSM-III-R criteria for PTSD consist of the following:

A. An experience or event that is outside the range of human experience and that would be marked as distressful to almost anyone.

B. The traumatic event is re-experienced in at least one of the following ways.

1. Recurrent and intrusive distressing recollections of thee event.

2. Recurrent distressing dreams of the event.

3. Sudden feelings or actions behaving as if the traumatic event were reoccurring.

4. Intense psychological distress at exposure to events that resembled the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma as indicated by at least three of the following.

1. Efforts to avoid thoughts or feelings associated with the trauma.

2. Efforts to avoid activities that arouse recollections of the trauma.

3. Psychogenic amnesia for the event.

4. Markedly diminished interest in significant activities.

5. Feelings of detachment or estrangement from others.

6. Restricted affect.

7. Sense of a "shortened" future.

D. Increased arousal as indicated by at least two of the following:

1. Insomnia

2. Irritability or temper outbursts

3. Difficulty in concentrating

4. Hyper-vigilance

5. Exaggerated startle response

6. Physiologic hyper-activity upon exposure to events that symbolize the trauma

E. Duration of the symptoms for at least one month.

III. SETTINGS IN WHICH PTSD MAY OCCUR.

In general, any event that one would experience emotional trauma above and beyond that usually encountered in human experience. These include:

A. Combat

B. Maritime Disasters - Collisions at sea

C. Man-made disasters such as fires, explosions, train wrecks, or automobile wrecks or airline crashes.

D. Personal Assault such as rape or attempted murder.

E. Natural Disasters such as tornadoes or earthquakes.

F. The sudden unexpected violent death of a loved one.

G. The presence of physical or emotional abuse that occurs when one is raised in a disturbed family or family impacted by alcohol or substance abuse.

IV. THE POST TRAUMATIC STRESS SYNDROME

A. Historical aspects - the formal designation of post traumatic syndrome has been in existence only since DSM-III originating in 1980.   Historical aspects include the 19th Century view that symptoms after a stressful life event were thought to be due to a hereditary weakness of the nervous system. The 20th Century saw the additional thought that malingering might play a factor and that personality traits might also enter into the development of stress reactions. Other approaches have included looking at PTSD as forms of adjustment reactions, prolonged grief or examples of neurotic conflict.

B. Pathology of traumatic events - It is now generally accepted that emotional trauma in the proper magnitude or individual setting can precipitate symptoms of PTSD in almost anyone.

C. Delay in presentation - present studies indicate that symptoms can arise as quickly as six months after the traumatic event. Two recent studies indicate that some surviving World War II veterans indeed suffer symptoms suggestive of PTSD that had been heretofore unrecognized or unrevealed. Many patients, as a general rule, continue to suppress or individually cope with post traumatic syndrome with the fear that revelation of this symptomatology will lead to a diagnosis of being "crazy". Patients who present with a puzzling refractory mental disorder characterized by a polymorphous rage, appearance of depression, substance abuse, anxiety and somatization should raise the suspicion of a masked PTSD.

D. Predisposition - there is some evidence that a person's basic ego strengths and general risk factors for mental illness may predispose one to suffering more profound symptoms of post traumatic stress syndrome. However, one has to be cautious not to attribute symptoms

occurring in a person diagnosed with a character disorder as just being "characterologic".

E. Forensic aspects - at the present time, PTSD is entering into the forensic arena having been used on occasion as insanity defense or as factors in plea bargaining. At the present time, it is still a controversial issue with the usual rules of competency being applied.

V. VIETNAM AS A SPECIAL CASE FOR PTSD

A. VA studies have outlined the magnitude of the problem with VA health care centers initially being inundated with persons seeking care. Of interest is the observation that many people initially requesting help from the VA had never served in the military and a significant number of those remaining did not see combat. The DSM enters the question of malingering secondary gain and attempts at compensation.   The secondary gain as noted can be a significant issue with varying personality styles being involved. Some studies show a prevalence of 20% among Vietnam Combat Vets, 3% to 4% among non-combat vets and civilian attack victims and 1% in the total population.

B. Premorbid personality of combatants is of interest, especially from the research standpoint when one looks at various types of personnel in the military who may be at risk for PTSD symptoms. This is especially noticeable when one studies ground combat troops with a relatively high rate of PTSD and the Prisoner of War group who have a very relatively low incidence. As the severity of the trauma increased, prior psychiatric history becomes less significant.

C. A clinician's knowledge of the Vietnam War is essential if one is to act as a therapist for combat related PTSD. In some legitimate group therapy sessions, actual participation in combat is almost a prerequisite. A therapist's skill in group settings and general knowledge of the experience can often overcome group antagonism.

VI. SYMPTOMS

Symptoms that bring a person into treatment are often varied but usually consist of some degree of aberrant or bizarre behavior - with alcohol or substance abuse frequently being present. Occasionally, patients will come to the physician complaining of affective disorders or overt anxiety. Relationship problems in the marriage or in sustaining a prolonged relationship are often present and not infrequently one finds a pattern of recurring unsatisfactory relationships.

VII. DIAGNOSIS AND TREATMENT

The diagnosis is appropriate if they meet the criteria as described in DSM-III-R. Treatment

consists of some combination of the following modalities.

A. Individual therapy

B. Group therapy

C. Other appropriate therapies such as couples therapy or marital therapy

D. Medications as indicated. Anxiolytics are indicated only for short term therapy due to the addictive potential. Monoamine oxidase inhibitors have been found to be useful in certain cases of PTSD where there is an affective component or nightmares occur with such a frequency and intensity that they are incapacitating.

VIII. SUMMARY

We all can show PTSD if the stressors are severe and prolonged enough. PTSD is perhaps a natural adaptation to overwhelming life events.

IX. CONCLUSIONS

A. Many of those militantly crying out and "demonstrating" PTSD symptoms were found to not qualify for the diagnosis.

B. There are quite a few who saw ground action who had PTSD symptoms, yet they avoided the medical and compensation systems.

C. Rapport is difficult to develop and maintain with PTSD patients.

D. Helping the real PTSD patient can be intrinsically rewarding.

THE MILITARY FAMILY

I. INTRODUCTION

A. The impact of the military family on military operations has been documented throughout history. In over 3,000 years of recorded history, only 268 have been without active warfare. Almost every generation of human civilization has encountered and had to cope with the impact of warfare and military deployment. Descriptions in Greek literature are not significantly different from descriptive scenes surrounding today's military families. The reasons for war and the reasons that individuals and families remain in the military service are vicariously interesting from the psychodynamic standpoint. A brief overview will be presented during the lecture.

B. Pertinent current figures (1987) indicate that there are about 563,000 total active duty personnel. About 53% of all enlisted are married and about 74% of all officers are married. Approximately 8,200 families have both parents as active duty members and each day in the Navy 84,000 geographically single parent families exist due to Navy deployments.

C. Our modern society puts unique stressors on each and every family. The military family not only faces the stressors associated with coping with daily life, but has added unique stressors of its own. These include;

1. Frequent Geographical Moves - it is estimated that at least one third of the Navy population moves each year to a new duty station. This can be particularly stressful on children in the adolescent years and the pre-school years. In one sample study, one half of all military children move each year as compared to a civilian population in which only one fifth of the civilian population changed geographical areas. Financial burden of changing duty stations is often significant with the average out-of-pocket costs of PCS for an officer being $2,000.

2. Military Deployment - frequent separations and reunions often keep a household in continued flux giving a sense of instability and insecurity to all family members.

3. "The Navy is First" is a dictum that is often very hard for wives in particular to adjust to. The active duty member often has to adjust his loyalty to his profession against the needs of his family.

4. Family Growth is sometimes structured to conform to the rigid and regimented military system. This particularly has impact on educational planning, spouse jobs, adding new members to the family and visits to relatives.

5. Risk of injury or death to the active duty member even during routine stateside training often generates fears and fantasies in not only the children but in the spouse also.

6. Feelings of detachment from the mainstream of society continue to occur. This can present as harsh reality in those communities that are not accepting of the military or its philosophy. Some families have a tendency to become totally involved in the military as a mechanism of security and do indeed become isolated from the daily American culture.

7. The effect of rank structure can be felt throughout a family. Social, family, and individual activities are often attended on a scale commensurate with the service member's pay grade or rank. At times this has been known to impact in school, places of employment for dependents and other social activities.

8. Lack of personal control over duty stations, leave, orders, training and deployment

often leave the entire family feeling helpless.

9. <u>Early retirement</u> and a second career heretofore not often recognized as a significant stressor is now found to have more and more meaning as a traumatic event in an active duty service member's life. This may be even more meaningful if adolescent dependents are required to again move to set up with the family in the new geographical location away from the lifestyle they are familiar with.

D. <u>Deployment</u> - The concept of deployment warrants special interest. Technically, it is defined as a forward movement of a military organization closer to the field of battle. Several studies have demonstrated the impact of family separation during deployment upon not only the active duty service member but his dependents. Studies done in San Diego have demonstrated that wives of deployed Naval service members all experience some subjective feelings of depression beginning two weeks prior to deployment. 50% of these women had symptoms of a magnitude that would be compatible with an adjustment disorder with depression and a few were approaching that of major depression. Of interest also was an observation of health records in which sick call visits in children increased dramatically just prior to the sponsor leaving. The visits then resolved to a normal visitation rate and subsequently increased dramatically just prior to the sponsor returning.

E. For a long time, it has been recognized that individuals and families undergo emotional changes during the deployment cycle. It is felt that these changes apply not only to the active duty member himself but to the remaining family members at home. Often the active duty member is overlooked because the frenzied activity of deployment not only occupies his time but helps mask the symptoms. In a recent article, the emotional cycle of deployment was outlined in a more formal fashion (see Proceedings, February, 1987).

1. The pre-deployment phases are noted as follows:

a. <u>Stage I</u> which occurs one to six weeks prior to actual deployment is manifested by all family members. Family members are anticipating a loss and initially rush to complete home projects and prepare for the service member's absence. There is often noted an increase in bickering, arguing and some initial attempts to withdraw from the emotional pain of separation.

b. <u>Stage II</u> occurs about one week prior to actual departure and is marked by increased detachment and withdrawal. A noted combination of tension and anger sometimes are prominent in the wife, and sexual difficulties may begin to arise. This phase of the pre- deployment emotional cycle can be especially devastating if the deployment is delayed.

2. The deployment phases are noted as follows:

a. <u>Stage III</u> begins immediately and lasts for about the first six weeks. Especially for wives at this time is noted an emotional disorganization in which they may experience a gamut of feelings from relief, guilt, panic, anger, and depression. At this time the actual clinical diagnosis of adjustment disorder and/or major depression can be made.

b. <u>Stage IV</u> occurs about the mid-point deployment and is very often incomplete. It is a period of recovery and stabilization. In a healthy well-supported wife, with good personality organization, it is an opportunity to cultivate new friends, develop a variable lifestyle, to make decisions on her own, and to become independent. Many women find that this actually is very satisfying, gratifying, and utilize the opportunity to grow to the fullest.

c. <u>Stage V</u> during deployment occurs just about six weeks prior to the ending and return home. It is often called the anticipation of homecoming. It again is marked, as was the pre-deployment stage, by panic, anger, feelings of a loss of dependence by wives, feelings of anxiety that "will my husband approve of what I've done."

3. The post deployment phases are noted as follows:

a. <u>Stage VI</u> occurs six weeks after return. It is a time of renegotiation of the marriage contract. It is at this time that the marriage must be reviewed, roles may need to be redefined, and the deployed member has to reacquaint himself with his wife, children, and entire family.

b. <u>Stage VII</u> occurs six to twelve weeks after his return and is often called a period of reintegration and stabilization. At this point in time, the family has identified its new lifestyle, roles have been redefined and people are interacting in an acceptable fashion and the family again returns to a routine.

F. There are several tips and techniques that can be utilized by deploying members to reduce the stress of deployment. The medical officer would do well to familiarize himself with an article, "When Daddy Comes Home", published by the Times Magazine, September 29, 1976. Tips on dealing with stress for personal use or counseling others are outlined.

1. The family must discuss as a unit their feelings about the upcoming separation. Anger, sadness, and fear should be clearly outlined. All family members who are able to talk, sit, or be held should attend. A tendency is often seen to exclude other than adults or teenagers. This can be extremely threatening and frightening to children as young as one year old.

2. It is essential that the mother keep the same rules for discipline and maintaining the household for the children while Dad is gone as they were when he was at home.

3. It is very important for the deployed father to send separate letters to each child, preferably on a weekly basis. Younger children often find it very helpful to have a calendar in an appropriate place to mark off the days until Dad returns. Sometimes it is very useful for Dad to deliver messages to Mom via the children's letters.

4. On returning from deployment, the father must remember that his role has been filled by the remaining family members for some period of time. He has to be willing to discuss feelings on return of insecurity, anger, resentment that may result from restructuring or renegotiation of roles.

5. Private time with the wife is essential. There should be a period of time free from the children for the husband and wife to become reacquainted. Each child should also separately be given at least one half day of individual time and attention.

6. For the first week, it is extremely important to exclude all other extended family members, friends, avoid unnecessary travel, and social commitments.

7. The immediate return from deployment tends to become bogged down with engagements, events and obligations that leave little or no time for family interaction. This may impair the struggle to achieve comfortable roles and not allow time to renegotiate the family structure.

8. It is extremely important for all family members, in a formal family conference to be able to their feelings and their desires and needs for the upcoming period of time that the family will be together.

G. Even more important than general needs of the family are the needs of the individual military wife. In our male dominated society, it is amazing at how frequently some wives are unable to do such minor household chores as sharpening a knife, changing a light bulb, checking the oil or changing a tire on the car. An alert and vigilant medical officer will be aware of the opportunities to discuss deployment preparation not only with individuals but with groups of individuals including wives clubs and all hands meetings. The following tips and techniques not only can be used to personal advantage but also will be part of one's individual armamentarium for advice to deploying init mates. It is of interest to note that often the wife feeling most estranged, most abandoned during deployment is the medical wife. She may be new to the military, younger than other unit wives, and often very reluctant to get involved in military life.

1. Wives clubs and unit wives associations are very important. Officer and enlisted wives are encouraged to attend, become a part, and participate. This is usually the medium by which group support is most effective and is usually strongly supported in their activities by the Commanding Officer.

2. All wives should be aware of whom the Ombudsperson is for that particular unit. By Secretary of the Navy Instruction, each unit is entitled to have a Commanding Officer appointed Ombudsperson who has direct access to the Commanding Officer to bring to his attention particular problems of wives and dependents.

3. Families with specific medical problems should have direct access to a preferred physician prearranged. It is wise for all who are about to deploy to make contact with the local dispensary or utilize TRICARE and contact a local physician. It would be wise to make one visit, introduce the family and have that physician available in case illness were to occur during his absence.

4. A will - even when not actively engaged in warfare, deaths do occur in the military. A will ensures that the wife will be able to transition into a life in the event of her husband's death with minimal legal complications.

5. An allotment to the bank for the paycheck saves the wife concern about whether the check will arrive in the mail and guarantees a steady flow of income.

6. Power of Attorney is mandatory. In the event of disaster, perhaps even as minor as having repairs on the car, without a power of attorney the spouse may be unable to make decisions on joint property or money.

7. AAA protection for the car may seem trivial, but if the family decides to travel, it is a significant insurance to keep from getting stranded and having unnecessary difficulties. Also AAA will assist in any advice on repairs and reliable mechanics if major car trouble were to occur while the husband is gone.

8. Service contracts on appliances remove concern from the wife, what to do if major appliance malfunctions occur.

9. A safe neighborhood is mandatory. If a service member is to deploy, personal safety is one of the major concerns of the spouse. On-base housing has definite advantages, especially at those bases where housing is considered appropriate and adequate. If on-base housing is not a preferred option, then certainly the most secure and reasonable neighborhood that one can afford is in order.

II. SUMMARY

The military family has tremendous impact on modern military operations. Military deployment has and will continue to be a major aspect of Navy life. Military deployment is one of the major stressors on the Navy family but there are many things that can be done to ease the burden. By understanding some of the concepts of the emotional cycle and possessing practical advice for deployment, the medical officer can ensure himself greater

security for his family and will also be able to offer advice and direction to those unit members who may not have the energy, wherewithal or knowledge to adequately plan ahead. Presentation of pre-deployment briefings from the standpoint of the medical department and psychosocial aspects of deployment is encouraged at every opportunity.

SUBSTANCE ABUSE

I. The Manual of the Medical Department, Article 15-54(1)(i) Change 104, states that alcohol dependence, drug dependence or drug abuse are disqualifying for service. Alcohol abuse within one year of entry is disqualifying.

II. The changing social structure and lifestyle patterns of our population between the ages of 18 and 25 make an evaluation of substance abuse, at the best difficult and frequently judgmental. The following data is presented to provide a guideline in the resolution of the apparent conflict between strictly applied criteria vice a reasonable compromise that considers society norms and psychosocial aspects of substance abuse behavior.

III. For purposes of this discussion cocaine will be used as a prototype of the addictive narcotic drugs followed by alcohol as the most common abused drug.

IV. SUBSTANCE ABUSE IN GENERAL.

A. Alcohol, 95% of the population between 18 and 25 have used alcohol on more than one occasion.

B. Marijuana, 64% of the population between 18 and 25 have used the drug on more than one occasion.

C. Cocaine, 28% of the population between 18 and 25 have used the drug on more than one occasion.

D. Hallucinogens, 25% of the population between 18 and 25 have used the drug on more than one occasion.

V. COCAINE (These data are from 1987 surveys)

A. Most common usage between age 20 and 40.

B. 15% of all high school seniors have tried cocaine at least once.

C. In this country, over 21 million people have socially used cocaine.

D. One million of these users will become addicted.

E. 60% of cocaine addicted people will also abuse alcohol.

F. The addiction rate in cocaine averages about 10%.

G. The most common period of relapse is between one and six months after abstinence. (This pertains to any substance abuse behavior.)

VI. ALCOHOL

A. The most common use is between the ages of 18 and 25. In this age group, at least 25 to 50% of the males will have one alcohol related incident. (For purpose of discussion, there will be no differentiation between alcohol abuse and alcohol dependence.)

B. There are 95 million users of alcohol on a regular basis in this country. (There are estimated to be 10 million alcoholics, i.e. alcohol is having a significant impact on their life functioning.)

C. Only 3% of alcoholics are ever totally dysfunctional. The remainder hold jobs, attend church, and participate satisfactorily in life events on a cyclical basis.

D. It takes 3-5 years to develop true alcohol physical dependency. That phenomenon manifests itself on the average in primary alcoholics between the age of 35 and 45.

E. 33% of all suicides are connected with alcohol.

F. 20% of all emergency room visits are connected with alcohol.

G. 33% of American families have some degree of alcohol related dysfunction.

H. Alcohol treatment program successes run between 30 and 75% with the Navy having 5-year success rates > 50%. (Younger age groups have less success on initial treatment.)

I. Attendance at AA after alcohol treatment gives an individual a 50% greater chance of maintaining sobriety for that year.

J. Controlled drinking still remains a controversy, however, increasing evidence is negating previous studies of successful controlled drinking.

VII. MAJOR RISK FACTORS IN SUBSTANCE ABUSE

A. A positive history of substance abuse in either parents or grandparents; most significant in males is a history of an alcoholic father.

B. An Axis I psychiatric disorder.

C. Presence of an Axis II personality disorder. The anti-social triad consisting of alcohol abuse and illegal substance abuse and anti-social behavior) has an especially grave prognosis.

VIII. FOLLOW-UP Most studies attempting to follow up substance abusers are short term in nature. Less than six months follow up is invalid because of the cyclic nature of substance abuse. A study of two years is considered adequate. Common aftercare monitoring criteria:

1. abstinence
2. work performance
3. personal recommendations from peers and supervisors
4. maintenance of a stable personal life
5. absence of disciplinary problems
6. maintenance of good medical health

IX. PREDICTORS Some predictors of good future functional capability consist of:

A. Lack of a family history of substance abuse or mental disorder

B. Lack of involvement of civil authorities.

C. Lack of psychiatric treatment for Axis I or Axis II diagnoses

D. An establishment of life goals that instill in the individual a need to accomplish and succeed

E. Substance free for at least one year

XIII. OPNAVINST 5350.4A of October 1990 contains the organizational structure and tasking of the Navy Substance Abuse Program. Procedural details include the referral process and medical officer responsibilities in legal situations.