DIVISION-BASED PSYCHIATRY IN INTENSIVE WAR SITUATIONS

Suggestions For Improvement

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SUMMARY: This paper attempts to demonstrate that division-based psychiatry, as practised today in the US Army, is only effective in wars of light or medium intensity, and is entirely ineffective in an intensive war. It goes further to suggest some ways for improvement.

Definitions

The term "division-based psychiatry" as used here includes the consulting function of the division psychiatrist, the psychiatric work performed by the battalion physician or any other professional at the battalion level, and the work of the psychiatric team in the medical battalion of the division. The equivalent in the British Army would be Regimental Medical Officer, Regimental Medical Assistant or Padre and Field Ambulance.

The target population for division-based psychiatry is soldiers who "break down" in combat and develop a psychiatric reaction which incapacitates them as combat troops, and in addition necessitates medical treatment.

Essentially this "break down" is thought of as the end phase of a conflict between a sense of duty and a wish to survive. The soldier ceases to be able to cope with the anxiety of potential annihilation. This psychiatric reaction (labelled elsewhere as combat fatigue, war neurosis, shell shock, etc) is labelled here "combat reaction." It is said that every soldier is faced with the conflict of survival versus duty (Kardiner and Spiegel 1947, Grinker and Spiegel 1945, Menninger 1948). This conflict may become unbearable if either the main stressor, the threat of annihilation, becomes too extreme, as in the case of near death, or when the soldier's strength has been corroded by secondary stressors.

The primary stress, the threat of annihilation, is a subjective entity, which cannot be measured. The dominant overt stressors, the intensity of battle (Mullins and Glass 1973, Marlowe 1979), and the number of physical casualties suffered (Beebe and Apple, Levav *et al* 1979) can be measured. These are often used as independent variables.

The secondary stressors may be divided into physical and psychosocial. The physical secondary stressors consist of biological deprivations of water, sleep and food, coupled with extreme exertion. The main social and psychological secondary stressors are failures of unit cohesion, leadership and morale. The re-establishment of cohesion and leadership may be assisted by the preventive work of the divisional psychiatrist.

Historical Roots

Division-based psychiatry was established by Salmon (1919) in World War I

and re-established in almost every subsequent war as the most effective mode of treatment for psychiatric casualties in combat.

Treatment of psychiatric casualties in World War II was initially organized in the rear. It was however soon learned that few soldiers could be returned to battle once evacuated to the rear. It was also learned that the soldiers who had been evacuated often developed chronic reactions lasting for long periods in their lives thereafter (Brill and Bebe 1952, Archibald and Tuddenham 1965). The total loss of manpower due to psychiatric attrition was extremely high. It was then that division-based psychiatry was reintroduced, and the lessons of World War I re-learned.

The Israeli experience in the Yom Kippur War provided further support for the division psychiatry concept. It was further learned that the psychiatric conditions of many soldiers actually worsened the farther rearward they were evacuated.

The Treatment Goals

Division-based psychiatry is designed to treat soldiers afflicted by combat reaction near the front line and to return them to duty promptly. There are two main reasons for this aim: a) It has been repeatedly demonstrated that only very few soldiers return to active duty once evacuated to the rear. b) It has also been shown that soldiers with combat reaction who are treated at the rear are at higher risk of becoming chronic cases of post traumatic reaction than are patients who are treated forward and then returned to duty promptly. The establishment of treatment units and treatment agents as close as possible to the battle front aims at preserving the unit's strength by preventing undue attrition from combat reactions as well as at producing professionally sound treatment for the psychiatric casualties (Bey 1971, Bourne 1969, Glass 1961, 1957, 1969, Mullins and Glass 1972, Grinker and Spiegel 1945, Hanson, Jones 1979, 1967, Kardiner and Spiegel 1947, Levav *et al* 1979, Marlowe 1979).

Theoretical Rationale

The theoretical rationale for division psychiatry treatment methods is based on a synthesis of Salmon's philosophy of respite near the front line (as formulated primarily by Glass) with the knowledge of the process of combat reaction formulated by men like Freud (1921), Kardiner (1947), and Grinker (1945). The synthesis is a three-stage natural history of combat reaction. The stages are the **immediate**, **acute** and **chronic**. Ideally, the immediate stage should be treated by respite near the front line (Salmon) while the acute stage should be treated by abreaction in the rear (Noy 1978). Combat reaction near the front is in its immediate stage characterized by a fluid state of free floating anxiety. Quick restoration to health in the immediate stage prevents the formation of crystallized defence mechanisms which are difficult to remedy later. In contrast, evacuation to the rear takes time, and by then the patient may no longer be in the immediate stage and therefore less amenable to treatment. But even more important the evacuation to the rear harms the patient by: (1) weakening the strength derived

from the preserving forces of the unit's cohesion, and (2) by creating guilt over leaving one's comrades, and finally (3) by opening up avenues for unconsciously using the psychiatric condition for secondary gains. (eg, "the sicker I get, the farther away from the front line I will be evacuated.") The weakened soldier is not able to resist the temptation and consequently his symptoms get worse the farther back he is sent. Glass (1980) has made an interesting and pertinent observation that the passage from the immediate to the acute stage may be a function of the evacuation itself rather than a function of time alone.

Description of the Role of Division Based Psychiatry

The psychiatric task is performed at various levels in the combat zone. The psychiatrist as the divisional consultant, assisted by his team, works towards enhancing unit morale, cohesion, leadership and organisation as well as promoting some knowledge of treatment principles in the commanders and the battalion physicians and medics. As a result of the improved cohesion and organization there is a minimal attrition due to psychiatric casualties. Nevertheless when casualties do occur some of them are treated at the battalion level and whatever cases cannot be treated at the battalion level are referred to the medical battalion of the division. There a professional team provides them with rest, food and opportunity for emotional ventilation for no more than a few days, and then returns them to duty.

Treatment in the medical battalion consists essentially of the correction of deprivations without sacrificing the support the soldier receives from his unit, and of course thus prevents further disruption in unit cohesion by lowering the number of casualties being taken away from the unit. Physical deprivations are corrected by providing liquids, rest, and food in a relatively secure place. Social and psychological damage is corrected by supplying information, enforcing military activity in a group situation, and permitting emotional ventilation, all under a strict set of expectancy for returning to the unit. The treatment operates under the assumption that as long as immediate ties with the unit are preserved, opportunity for respite, correction of deprivations, and some emotional ventilation in a secure area are sufficient for restoring the soldier's strength to go on coping with the stress of war. The chief therapeutic agent is the cohesive force within the unit strengthened by the expectancy held in the soldier's unit and in the medical battalion. This expectancy is seeded and cultivated by the consulting psychiatrist.

Evaluation

Reviewing the literature of World War II, primarily Glass's detailed account of the history of combat psychiatry in the war (Mullins and Glass 1973), one may observe a recurring pattern in the effectiveness of division-based psychiatric treatment. It was effective only in long but moderate or light battles, and ineffective in severe battles. In an intensive battle, the number of hard casualties increases, and with them rises the number of all indirect combat casualties, including psychiatric (ie, diseases, accidents, AWOLs, etc). As a result the therapeutic system is swamped with too many patients. Furthermore, in an intensive battle the consulting psychiatrist can only harvest whatever preventive work he has pre-

viously sown, but he cannot do very much active consultation with the fully engaged command and medical staff. Similarly the battalion physician is too engaged in high priority life saving treatment and also does not have a quiet, relatively safe place to work with the psychiatric casualties. Therefore he must send all of his psychiatric casualties to the medical battalion. As a result of the impossibility of treatment in the line battalions, as well as of the intensity of the battle itself (ie, the high number of psychiatric and other casualties), the division medical battalion becomes swamped with too many cases requiring treatment. This flux of patients itself obstructs effective treatment. Consequently it is necessary to evacuate from the division the majority of the patients who could otherwise receive adequate treatment in the medical battalion. The consequence is that division psychiatry is ineffective when it is most needed: in intensive battle situations. Psychiatric casualties in hard-hit units may amount to 50% of unit strength and more within a short time, if the battle is severe enough. It seems then that division level psychiatric treatment has a crucial role in intensive battles in retaining unit strength and preventing permanent disability in the individual soldiers. But this important role is not yet adequately fulfilled.

Some examples may illustrate the ineffectiveness of and the need for adequate treatment. In the US Army in the North African campaign 30% of the casualties were psychiatric, of which only 3% were returned to duty. This was the first major battle waged by the American army in World War II. All the soldiers were new to battle¹, it was an intensive battle², and the psychiatric services were inexperienced.

Mullins and Glass (1973) and Marlowe (1979) point out that later battles showed the same pattern. Divisional psychiatrists kept complaining that every time the division was involved in a major battle they were swamped by too many casualties and had to evacuate them to the rear with the consequent minimal return to active duty. This was true of the Sicily, Anzio, Gustav Line, and the Normandy Invasion campaigns. In all of these battles casualties reached a high total, and the proportion of psychiatric to wounded in action (WIA) was between 10% and 54%. The percentage returned was usually 40% or much less, while the return in non intensive battles was 70% and above. In Anzio, of the many casualties treated by various teams, only 10% were returned to duty. However, after the stabilization of the front, about 50% were returned. The 88th Division in the Volterra battle had 1750 WIA and 564 psychiatric casualties (32% of the WIA). Of the latter, only 38% were returned to duty. This was the first intensive battle fought by that division. Later on, in the Gothic Line this division suffered 3600 WIA and 817 psychiatric casualties (22% of the WIA). 44% of the psychiatric casualties were returned to duty. One may see that with the experience gained by both soldiers and mental health teams, the percentage of psychiatric casualties goes down, while the percentage of those returned increases. Nevertheless, even in this second battle, the rates are far from the best standards set in less intensive battles. In terms of divisional strength, this division lost 11.7% of its strength in WIA, and 14.8% of its combat strength (assuming that 15,000 is a division size, 10,000 is the size of the combat force within the division, and 90% of the casualties fall within the combat force).

In contrast, 3.8% of the divisional strength or 5.1% of the combat force was lost as combat reactions within these 23 days. Beebe and Apple (1957) computed that on the average, 3-10% of the remaining men became psychiatric casualties in each aggregate of 10 combat days in World War II. The 6th Marine Div in Okinawa sustained 2662 WIA and 1287 (48.4%) psychiatric casualties in 10 days of intensive battle. None of the casualties was treated at the battle front and consequently only a few were returned to duty. (These examples were taken from Mullins and Glass 1973, or Marlowe 1979). Beebe and Apple (1957) reported regiments which suffered 1,600 casualties per 1,000 strength per year in some very intensive battles. Such casualties, if sustained for a long enough time and neither treated nor returned to duty may determine the result of a war.

It should be emphasized that the only thing that all these battles had in common was their intensity. Some units were new to battle and some were veterans. Some teams were experienced and some inexperienced. Intensity remained the common element. In an intensive battle like the ones reported above, the divisional medical battalion of the 88th was expected to treat 62 patients daily in the first four days of the Gustav Line campaign. (After the intensity subsided, the figure dropped to 18 daily). The psychiatric teams of the 6th Marines in Okinawa were expected to treat an average of 129 men daily in 10 days. Obviously, these unusual but not unique figures are beyond the capacity of the teams at the divisional level today. The recommended length of stay for a patient is two days in the divisional medical battalion. The figures quoted above should then be doubled in order to appreciate the load of the psychiatric teams.

Reasons for Ineffectiveness

The reasons for this observed ineffectiveness are related to the following factors: 1) the type of battle, 2) the soldiers' war experience, 3) the cohesion within the units, 4) the level of training of the mental health teams. In the following discussion, each of these variables is treated separately.

War Types and Battle Casualties

Stouffer (1949) has defined various types of battles and their consequence in non-combat casualties. The battle types with their specific conditions are the following:

1. Assault on a fortified position. Unless special tactics are used heavy physical casualties are to be expected. This type of war calls for highly organized force with especially high morale (Stouffer, 1949). In such a war the rate of psychiatric casualties is expected to be high, primarily the more severe clinical presentations (Glass, 1973). Glass's data supports Stouffer's expectations especially for psychiatric casualties.

2. Assault on defended beaches or water barriers (like Omaha beachhead). Hazards of incoordination, unexpected events, lack of support from heavy weapons and equipment, expected heavy physical losses (Stouffer, 1949). In parallel, the rate of psychiatric casualties is expected to be high and of a severe nature (Mullins and Glass, 1973).

3. Defending a position against heavy enemy attack (eg. Anzio beach). Round the clock strain for both combat and support troops. No hope for respite, extreme corrosion, pressing the limits of human endurance. Heavy casualties including psychiatric casualties are to be expected (Glass, 1973, Stouffer, 1949).

All of the previous three categories may be labelled intensive battle types where heavy physical and psychiatric casualties are to be expected. They are contrasted with the following types which may be considered less severe.

4. Advancing army: Organized but fluid front; close range fighting with light weapons, little opportunity for artillery; rapid movement forward, sense of achievement contributes to high morale. Expected small number of physical casualties and little or no psychiatric casualties. (Glass, 1973, Stouffer, 1949).

5. Infiltration warfare. Troops intermingled with enemy, front hardly exists. Defence is organized in perimeters. Little fighting and small number of physical casualties (Stouffer, 1949). Despite the incessant danger even in the rear, and the insidious strain on morale, the division-based psychiatry seemed to cope successfully with this situation. (See Mullins and Glass, 1973, reports on the Pacific campaign, and Bourne 1969, and Jones, 1967, reports of the first stage of the Vietnam campaign). This is primarily because of the small number of psychiatric casualties and the opportunity to treat soldiers within their units or in the medical battalion.

6. Retreat following an enemy breakthrough (eg, the Ardennes bulge campaign). While in the actual battle uncertainty and confusion are maximal when human resources are hardest pressed, when withdrawing there is little risk of casualties of any kind (Stouffer, 1949). Psychiatric casualties are nil or few in withdrawal (Glass, 1980 in report of Korean withdrawal).

7. Holding action. (eg, long periods towards the end of the Italian campaign): Small arms fire on patrols, some artillery exchanges, stable front. Only a small number of physical casualties.

Only when living conditions are very poor does one expect psychiatric casualties, primarily of the "fatigue" type. Even then treatment is expected to be very effective (Mullins and Glass 1973, Stouffer 1949).

The intensive periods of any war are usually the parts where casualties physical and psychiatric as well as other non-battle casualties, are most numerous and tax heavily the strength of the fighting units.

But at the same time the intensive battles are also the decisive segments of any war. Each side attempts to hit the other as hard as possible and make it lose as much as possible of its original strength. The decisive element is not only the relative strength each side possesses but also its ability to maintain its strength with minimal attrition. The result of the battle may be decided by the amount of attrition each side suffers. Successful psychiatric treatment is supposed to minimize losses by halting the stream of evacuees to the rear, and by returning most of the psychiatric cases and the other non-combat casualties to active duty. Thus successful psychiatric treatment in the division is critical at this period even more so than in other periods, but it is in this very period that psychiatric treatment is least effective.

War Experience and Psychiatric Casualties

Mullins and Glass (1973), Swank (1949), Swank and Marchand (1946), all make the point that soldiers new to battle are more apt to develop battle reaction both quantitatively and qualitatively. On the basis of the experience in World War II they observed that fresh soldiers had a greater number of combat reactions than did a hardened group of soldiers. Also markedly different was the clinical picture of the psychiatric reaction of the fresh soldier. He tended to show dramatic anxiety with conversion and amnesia more often than would be expected later on. The reason for this observed difference in the first battle is not entirely clear. One possible interpretation is that the weak are being sieved out. Another explanation is that in the fresh unit cohesion has not crystallized, and its protection against the psychiatric breakdown is not felt yet. Still another source may be the lack of combat experience itself, an old stager has acquired ways and means in which to protect himself against real danger, such as differentiating the sound of friendly artillery from the enemy's, learning to estimate the distance of the danger, etc. Obviously, the ability to protect oneself against real dangers creates some feeling of security which the new soldier misses. Instead, he is vulnerable to his own feelings of lack of control (Swank 1949, Swank and Marchand 1946, Mullins and Glass 1973). The vulnerability of the fresh soldier may be attributed to one or more of these factors, but regardless of the precise interpretation they all lead to the conclusion that the fresh soldier is more anxious than the old timer and has fewer means to cope with this anxiety. Research indeed shows that replacements suffer a higher percentage of casualties of all kinds (Beebe and Apple 1951).

Cohesion and Battle Casualties

In a discussion of combat reaction, Marlow (1979) employs an excellent review of the literature which shows unequivocally the relationships between cohesion on the one hand and psychiatric as well as non-battle casualties and even light battle injuries on the other. This observation was made repeatedly by many of the known authorities in the field: Kardiner and Spiegel, (1941) Grinker and Spiegel, (1947) Weinstein; Bartmeier, Kubie, Menninger *et al*, (1946), Marshal, Glass, Whitehorn, and others (in Mullins and Glass 1973).

Group cohesion is formed while the soldiers undergo intensive experiences together which require the formation of personal bonds for the sake of personal security. Cohesion may be created while training together but it is never as good as cohesion formed in battle. Obviously, such hardened-in-battle cohesion has not been formed before the first battle of any war, and is not expected to assist in reducing the anxiety of the soldiers or minimize the amount of psychiatric casualties in the first battle.

Thus in a first battle one may expect a high rate of battle casualties in the forms of psychiatric and other non-combat casualties which may tax the unit's strength if not treated properly. Again, this stands in contrast with the inability of the medical battalion to be of real help in such a situation. ("Non Combat Casualties" refers to casualties resulting not from a direct physical

hit of a projectile in combat. It includes diseases, disciplinary problems, AWOL, frost bite, trenchfoot, broken glasses, etc).

The Inexperience of the Mental Health Teams

Ideally mental health professionals in the army have received adequate training according to their designated profession. However, it has been shown repeatedly that specific training for the treatment of combat reaction is necessary in addition to the general professional training (Mullins and Glass 1973, and personal experience in Israel). The consensual rules of civilian psychiatry are different from those of military psychiatry. Developmental psychiatry predicts outcome in a different way (more conservative) than is adequate for severe stress reactions. The clinical picture in war is more severe. Paradoxically prognosis is much better. Consequently the novice mental health worker is likely to fumble and make mistakes in the beginning mostly in the direction of predicting poor outcome and evacuating soldiers to the rear, instead of treating them in the front and returning them to their units. Such a worker may also be frightened by the intensity and pain expressed by many of the soldiers he encounters, thus becoming ineffective as a therapist. The experiences of World War II and the Korean campaign demonstrated the initial ineffectiveness of the mental health teams. Their training was best in battle, but the price paid was the many cases not treated adequately in the beginnings of these wars (Mullins and Glass 1973). The situation in the Yom Kippur War in Israel corroborates the findings in the American army. Probably even the best pre-war training will never be as good as the actual experience in battle. In civilian psychiatry students are able to gain practical experience. But it is not possible to gain real practical experience in combat psychiatry when there is no war. Thus the starting point of any treatment team is merely theoretical. The North African campaign was characterized by totally inexperienced psychiatric teams who reformulated the theory while on duty. In contrast, in the Normandy invasion, the psychiatric teams had previous orientation, but no first hand experience with treating combat reaction (Mullins and Glass, 1973).

Projection for a Future Combat in Europe

In any future combat between the American army and one of the major powers (eg, the Warsaw Pact in Europe), one may expect a war of high intensity, probably of Stouffer's type 3: "holding a position against heavy enemy attack." If the Syrian and Egyptian attack on Israel in the Yom Kippur war may be taken as an example of the Soviet doctrine for a future war, the intensity and duration of the attack will both be unprecedented in American military history. At the same time most of the American units will be for a while without the benefit of previous war experience. Furthermore the units would probably not have the time to crystallize and form true, hardened-in-battle cohesion before having to meet the most extreme tests. In the case of a surprise attack, a long time will pass before fresh replacements arrive. In such a situation the ability of the attacked units to stand the initial blow and hold on until additional troops are able to join them is regarded as critical. Again, the Israeli defence in the

Yom Kippur war may serve as a model for such a projected attack in Europe. Had the troops being attacked collapsed before the additional troops arrived the result of the war would have been different.

As developed above, the factors causing a high percentage of combat reactions in battle are the intensity of the battle, the experience of the soldiers, and the amount of cohesion in the units. Each of these factors alone may affect the number of casualties. In a future war in Europe unfavourable loadings on all of the factors would be likely to be the case. Obviously, a battle combining all three factors can be expected to produce a tremendous amount of psychiatric casualties, as well as other "non injury" casualties. The inexperienced psychiatric teams would be asked to stop the heavy movement of evacuees and return them to duty, but, considering the circumstances, this expectation would be unrealistic. The psychiatric teams will be unable to stop the gush of casualties, and the majority of the casualties will arrive at the rear with a lesser chance to return to duty and poorer prognosis generally. If indeed the ability to hold on without undue amount of corrosion is important, and the psychiatric teams have an important role in minimising attrition by treating the casualties and preventing them from becoming permanent casualties, then this role will not be well played in the scenario described.

Corrective Measures

While an absolute remedy may not be possible, some steps may be taken to correct the sombre projection described here. These corrective measures could be in the areas of both prevention and treatment. In prevention, measures can be taken to enhance cohesion, morale, and the level of training of the troops. Furthermore the psychiatrist in his role as a consultant may contribute to the mental health of the unit. On the treatment side improvements in the organization of the treatment, and enhancement of the training, of the psychiatric teams should be considered.

Prevention

Successful prevention is probably the single most effective means of reducing non-combat casualties. Prevention at the divisional level is by the facilitation of group spirit and cohesion, good leadership and trust in the commander before a battle, and maintaining or reconstructing it after a battle. A unit which does not follow security operations (wearing helmets, digging trenches, etc.) or whose weapons are not constantly in optimal condition, a unit which does not provide adequate information to the soldiers, such a unit is more liable to have a high percentage of combat psychiatric casualties. These signs are the early precursors of low group morale and lack of trust. Through his role as a consultant to the divisional commander the psychiatrist should intervene to prevent such early signs before they turn into pathological signs of overt disciplinary problems and high incidence of diseases and psychiatric casualties.

While the unit is in combat prevention should focus on epidemiological studies in order to stop soldiers from using any unforeseen channel of evacuation

as an unconscious or conscious escape from stress. Instead such soldiers would be given treatment similar to that of combat reactions.

After a battle one should expect major disruptions in unit cohesion and organization, mainly because of the casualties suffered, but also because of the exertion and fatigue. By going into the units and talking to the various levels (from the highest command down to company level, and up again), the psychiatric team may facilitate discussions in the unit about the combat. Such discussions enable spontaneous abreaction as well as resumption of flow of information, and consequent trust.

Training the Psychiatric Teams

As with all emergency medicine, training should be as realistic as possible. Obviously real combat casualties are not available in peace time. Three ways to alleviate this situation are offered without claiming to be an exhaustive list.

Probably the best substitutes for real combat psychiatric casualties are some patients resembling them who may be seen in stress clinics in general hospitals (victims of disaster or violence, floods, earthquakes, hurricanes, accidents, rape, etc). While there are distinct differences between civilian stress reaction and post traumatic neurosis on the one hand and combat reactions on the other, the similarities are the best approximation possible in peace time, and the experience of treating the victims may be valuable. With good supervision directed to point out the differences between these patients and combat casualties, the trainee may get a fair understanding of the syndrome.

Another means for getting the training closer to real combat psychiatry is the utilization of simulants as patients in simulated therapy exercises. These simulants, preferably also mental health professionals, would receive a specific script including prescribed overt simulated patient's behaviour as well as ways of responding to the specific approaches by the therapists-in-training. This whole experience would be supervised by a senior worker who has had actual experience in treating psychiatric casualties in combat. Since both the "patient" and the "therapist" are professionals who are expected to treat combat psychiatric casualties, both should benefit equally from such an experience. It is best to perform such exercises routinely in the medical battalion manoeuvres and at other opportunities.

Finally, the lack of familiarity with real patients may be alleviated by extensive usage of professional films which convey the real appearance of patients in battle. Such films must be constructed by professional actors supervised by mental health professionals experienced in combat psychiatry. These movies may mitigate the element of alienation and surprise when real patients are seen for the first time, but cannot be considered as the only means for training the teams.

It is believed that mental health professionals who have received intensive training composed of these three elements are as prepared as one can be in peace time.

Organization of the Treatment

The number of people assigned to the psychiatric teams at the medical

battalions is not sufficient to stop and treat the influx of men who may come to treatment in an intensive war. But these teams may be quite effective in less intensive battles when the flux of patients is not so large. Therefore, to increase permanently the size of the team itself is wasteful and thins too severely the available manpower. Instead, mobile professionals seem to answer the needs better. Back-up units may be formed to be commanded by a central higher command. These units may be assigned to areas of severe battle to merge with an existing unit or to work independently, splitting the area of coverage with the existing unit. Such back-up units may be withdrawn and reassigned according to the changing conditions of the war. Another possible manpower source can be lent from the rear echelon psychiatric units. The personnel in the evacuation and base hospitals are not heavily engaged in the initial phases of a war. For better utilization of their professional expertise they could be deployed to the division to support the teams there in the initial phases of a war. They would be needed more in the front than in the rear at that stage. By the time the initial phase is over their need is going to be felt in the rear. But by then the nominal team of the medical battalion will have acquired the skills necessary for independent efficient functioning, and at the same time the big flux of patients to the medical battalion can be expected to have subsided, and the rear team can safely return to its original role.

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