

# Chapter 12

## A MODEL COMBAT PSYCHIATRY TRAINING PROGRAM FOR DIVISION PERSONNEL

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### INTRODUCTION

### THE TRAINING PROGRAM

Division Medical Personnel Course

Division Commanders' Course

Material and Methods

Results

Discussion

### SUMMARY

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## INTRODUCTION

When the training program described in this chapter was conducted, the U.S. Army Third Infantry Division (3ID) was a primary bulwark against aggression in Europe. Since the breakup of the Warsaw Pact and the Soviet Union, 3ID (and other divisions like it in Korea and the continental United States) must continue to train for missions that range from peacekeeping and peace enforcement in ethnic conflicts, which involve appalling atrocities, to nuclear, biological, and chemical regional wars. Combat psychiatric and stress casualties will be a significant area of concern in any future conflict. A simple statement, yet how to address this concern remains elusive. The members of the 3ID mental health team consisting of the division psychiatrist, the division social worker, and the division psychologist conducted a program evaluation in an attempt to answer this concern. The research consisted of a critical evaluation of present capabilities, field problems to assess the degree of difficulty in treating and identifying casualties, and a thorough

review of the literature on combat psychiatry. In addition, line commanders' opinions were solicited, as were opinions and practices in other divisions in the U.S. Army relating to combat psychiatry.

This material was compiled and thoroughly reviewed by the 3ID mental health team and the 3ID surgeon. As a result of this research, a training program designed for the 3ID was deemed necessary. The training program was designed to help maintain the fighting strength of the division. Any program initiated, however, must be practical and must reach the largest possible division audience.

Embodied in the program was the belief that even when the best evaluation means were available, the line medics and physician assistants would still, in most cases, see the earliest cases of combat stress reaction (CSR). However, if the CSR casualties were successfully treated, it was imperative that the commanders also be willing to accept back the treated soldiers.

## THE TRAINING PROGRAM

The training program that developed was in two parts. The first part involved training the medical units, and the second part involved training the commanders. The issue of pragmatism was constantly kept in mind in the program development. The training program for the line medics, for example, had to be understandable, yet not be so simple as to gloss over important issues.

Because time for training is always limited, the program must be concise, and it must aim at developing important concepts. The program must also have a means of assessing impact. In other words, was the program as delivered effective in developing the key concepts? Finally, the program must have a means available for critical feedback that can incorporate and adjust to the participants' needs.

The training program that reflected the philosophy and goals deemed important took form slowly. Many adjustments were made from that inaugural training exercise, and the program as now described is the end result of many mistakes, changes, additions, and deletions.

### Division Medical Personnel Course

The program for the participants begins at 0900 hours. The instructors arrive about 1 hour earlier to prepare the classroom. The presentation by the 3ID mental health team utilizes slide projectors, overhead projectors, chalkboards, and various handouts during the class. The required materials are listed below:

- 35mm slide projector
- viewing screen
- chalkboard
- handouts
- pencils
- patient triage cards
- overhead projector/overlays
- moulage kit
- protective mask
- load-bearing equipment

The 3ID mental health team has three officers, and it was among these three officers that the morning didactic session was divided. The morning

started with the 3ID psychologist distributing a pretest evaluation to gauge the knowledge of the participants before instruction. The pretest evaluation covered some of the basics of CSR or “battle fatigue” treatment, identification, and history. A synopsis of the pretest is presented below:

1. Provide service member’s (SM) identifying data (name, Social Security number, unit).
2. List previous CSR training.
3. Describe factors contributing to CSR.
4. Describe a CSR.
5. Estimate the number of CSRs in brigade unit.
6. List effective ways to treat CSR.
7. What percentage of CSR can be effectively treated?
8. Would you trust a returned CSR?

After the pretest evaluation was completed, the first phase of instruction began. This 1-hour discussion centered on the historical significance of psychiatric casualties. The purpose of this discussion was to provide a longitudinal view of CSR and its implications in war. Specific examples of psychiatric casualties in soldiers and units are explored.

Because one of the guiding principles in the conduct of this training program was repetition, an effort was made to examine key concepts from several vantage points. In the historical overview section for example, the principles of treatment were examined from their historical inception, through application, to current use in modern armies (principally the U.S. and Israeli armies). The examination of treatment principles in such a manner helps reinforce their validity and impresses on the listener the notion that these principles are “tried and true.”

For example, during World War II, certain units experienced large numbers of CSR casualties.<sup>1-3</sup> The impact this had on operations can then be examined. This analysis can be developed over a considerable period of history, thereby lending credence to the concept that CSR casualties are important. Hopefully, at a point during the historical investigation, the listener will be prompted to ask himself what factors might make a unit or a soldier more vulnerable to become a CSR casualty. This question also can be approached from a historical viewpoint. Numerous lessons have been gleaned from a study of previous conflicts. Such factors as the combat intensity, wounded in action (WIA) and killed in action (KIA) rates, the type of unit, and characteris-

tics in the service member can all influence the rate of occurrence of CSR. This information is important because it allows for potential modification of factors that might increase the rate of occurrence of CSR. Again, history’s lesson is that the most cohesive units, those with the highest esprit de corps, will have the least problems.<sup>2,4</sup> Those factors that increase cohesion can then become part of the preventive psychiatric approach.

In summary, the first didactic hour focuses on the lessons of history with the explicit purpose of “legitimizing” the CSR problem through historical survey. This is one of the main teaching goals.

The second hour of didactic was presented by the division social worker and focused on the division’s assets, limitations, and a different method that could potentially be employed in combat to address the CSR problem. In addition, this session focused on projected casualty generation figures, defining the scope of CSR in a statistical manner.

The assets of the division available to treat, manage, or otherwise respond to psychiatric battle casualties were explained from the standpoint of the available personnel. The division mental health team consists of three officers and six to eight enlisted personnel, who in Europe are geographically isolated from each other. Each officer has two or three enlisted personnel, depending on the community population that the team serves, that is, to staff a mental health center. The geographical fragmentation of the division mental health team is stressed as a limiting factor in the ability of the mental health team to pool its resources and develop a cogent training program.

On mobilization, the officers would support the forward support medical companies in the brigade support areas, with the 3ID psychiatrist providing supervision of the main support medical company in the division rear. This immediately poses a problem because one clearing company is left without a mental health professional. Another serious limiting factor of the European 3ID mental health team is the peacetime mission that emphasizes community mental health activities as a priority over the combat readiness mission. Varying with the professional degree, the division mental health team is almost totally ensconced in the deliverance of routine mental health services to active duty personnel, dependents, children, and civilians. In this case, the division mental health team either totally replaces or augments the medical command’s or medical activity’s supply resources. The division mental health team is so totally overwhelmed by these

duties that primary consideration to a substantive preventive psychiatry program becomes difficult, thereby not allowing the division to benefit from the expertise of the division mental health team to aid in combat readiness. A shift in focus, allowing a higher priority of the training mission, is discussed as a remedy to this problem.

Estimates of projected CSR casualty figures are also discussed in a relatively detailed way. To make the statistics more relevant, the casualty figures are also estimated for division- and brigade-sized units. The point is made that these casualties represent recoverable manpower through the application of effective treatment. Evacuation procedures are also examined noting the correlation between high numbers of CSR casualties and the routine priority they are given in terms of evacuation. Numbers and types of evacuation vehicles are also discussed.

Various management approaches to handling the large numbers of CSR casualties are explored. One method is to have all CSR casualties evacuated for treatment to the medical companies' clearing stations. Here the officer and two or three enlisted personnel will handle all evacuations and area support. However, one medical company that will be acting as a central evacuation point will have no mental health officer, but rather only a behavioral science noncommissioned officer. (This shortfall should be corrected if the division is reinforced by teams from a corps-level combat stress control unit.)

The evacuation priority of "routine" given to psychiatric casualties also suggests, in the heavy casualty war scenario at least, that the projected WIA may limit the likelihood of large numbers of CSR casualties being evacuated, probably a desirable situation. The lowest echelon of identification of the CSR casualty may therefore also become the "treatment facility."

Further potential hindrances to CSR evacuation are explored. These might include chemical contamination of an evacuation route, the need for frequent moves by the "treatment facility," and vehicle maintenance problems.

By reviewing the evacuation issues, the automatic notion of many line personnel to evacuate "back" is short circuited. The conclusion generally drawn by the participants, then, is that many CSR patients will by necessity need to be treated at the lowest echelons of medical care, that is, the company medic and the battalion aide station (BAS). Again, the importance of the CSR problem is borne out, and again, the necessity for a training program becomes evident.

After presenting these two topics, the history and longitudinal scope of the CSR problem plus present capabilities and projected casualty figures, hopefully, the listener is by this time asking himself, "How can I recognize and treat psychiatric and CSR casualties?" The answer to this question then becomes the basis for the third and final didactic discussion. Pragmatism must be the key concept in presenting the medical aspects of psychiatry in the combat zone. Esoterics have little place here. The discussion must underline the importance of combat psychiatry and then offer guidelines for field management.

The division psychiatrist presents the topic on the medical aspects of combat psychiatry. In addition to the lecture, a medical briefing booklet was prepared and given to each participant. The booklet covered in more detail what the lecture provided. The medical briefing booklet becomes a permanent resource to which the medic can return to review treatment, diagnostic, and evacuation guidelines.

The booklet contains information on more specific areas than time allows in the morning session. The subjects include the psychiatric aspects of chemical warfare, substance abuse, a brief primer on the major psychiatric disorders, and CSR. The booklet is designed to be used in the class and later to be a resource. In fact, the primary purpose for preparing such a booklet is to give the participants a concentrated referral source. Differences in division locations and missions will mean that only general guidelines can be provided in a medical briefing booklet.

The table of contents for the 3ID's medical briefing booklet, which was titled "Psychiatry in the Combat Zone," also served as the outline for the morning medical discussion. Exhibit 12-1 details this outline.

The discussion of the medical aspects of combat psychiatry starts with a review of the approach of the former Soviet Union to combat stress. Topics center on the exploitation of surprise, use of propaganda, doctrine relating to "battlefield paralysis," and methods of protecting their soldiers from becoming combat psychiatric casualties.<sup>5</sup>

In summing up the potential threat, it is noted that adversaries may be prepared both to exploit the enemy human emotional factor and at the same time to defend themselves from becoming potential CSR casualties.

After presenting this brief overview philosophy, the lecture turns to the medical aspects of combat psychiatry. In trying to provide the most pragmatic

approach to the issues of diagnosis and treatment, we repeatedly emphasized the time-honored medical approach. The listener must be left with a clear idea as to the variety of diagnoses that may be seen on the battlefield, in other words a differential diagnosis, and a means whereby the possibilities can be separated. To achieve this objective, the listener must learn what conditions may present themselves on the battlefield and then, through the use of a history and physical, separate them. Utilizing this principle throughout, the medical briefing starts with discussion of the psychiatric aspects of chemical warfare. In discussing chemical warfare from the psychiatric standpoint, we place particular emphasis on behavioral symptoms.<sup>6,7</sup> For example, the nerve agents are examined from the standpoint of tactical use, behavioral and physical symptom production, and treatment with atropine. This is not a general discussion but specific to include dosages of medications used in first aid.

In addition to discussing the hazards of exposure to chemical agents, we review other psychiatric difficulties encountered in a chemical environment. "Gas hysteria," a problem in World War I where symptoms developed without exposure to chemicals, is posed as a problem that may recur.<sup>6,7</sup> The need to obtain an adequate history and a thorough physical examination are thereby reinforced.

An anxious soldier not truly exposed to a chemical agent but thinking he was may inject himself inappropriately with atropine. The symptoms of atropine overdose are examined in detail. To reinforce the importance of gaining a history and doing a physical, we present a case example of an organically induced atropine psychosis. Without obtaining a good history and physical, the medic gives this "crazy person" chlorpromazine and evacuates him, a very common response from the uninitiated medics. The errors of such treatment in both producing a severe hypotension and the subsequent loss of the soldier's fighting strength are pointed out, as is the quick and effective treatment. Furthermore, chlorpromazine has strong atropine-like effects and may produce atropine psychosis when given to one already having atropine in his system.<sup>8</sup>

The psychological effects of prolonged confinement in mission-oriented protective posture (MOPP) gear are next examined, including possible symptoms.<sup>9,10</sup> For example, the increased respiratory effort needed to operate the protective mask may be misinterpreted as chemical exposure. To help differentiate these various problems, the medics are given guidance in history and physical assessment. For example, in taking a history of possible chemical exposure, questions that might be asked include the following:

- Was the unit exposed to chemicals, and if so, by what means and at what time?
- Where was the service member in relation to the other unit members?
- Did the service member have his MOPP gear on, and if so, for how long?
- What is the service member verbalizing as his problem?

The section on the psychiatric aspects of chemical warfare concludes with a short case example and its effective treatment.

Another medical problem that may be seen in the combat zone is the soldier with a substance abuse disorder. This is a large area of concern in peacetime, as indicated by the extensive military drug

**EXHIBIT 12-1**

**PSYCHIATRY IN THE COMBAT ZONE  
MEDICAL BRIEFING BOOK OUTLINE**

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- Section I** A Brief Synopsis of Philosophy of the former Soviet Army
- Section II** The Psychiatric Aspects of Chemical Warfare
- Section III** Combat Stress Reaction
- Section IV** Substance Abuse
- Section V** Major Psychiatric Disorders
- Section VI** Appendix
- a. WHO Chart
  - b. Conditions with Prominent Anxiety
  - c. The Acute Radiation Syndrome
  - d. Decision trees for differential diagnoses found in the *Diagnostic and Statistical Manual* of the American Psychiatric Association
  - e. A Simplified Overview of Combat Psychiatry
  - f. A Simplified Overview of Treatment Modalities
  - g. A Relaxation Program

and alcohol abuse program.<sup>11</sup> A primary focus of discussion in the medical aspects of combat psychiatry is the clinical problem of acute drug usage and withdrawal and the differential diagnosis from chemical exposure, CSR, and other similar problems.

To aid the combat medic, we give a review of the symptoms of alcohol withdrawal.<sup>8</sup> The importance of gathering an alcohol history is emphasized because the symptoms of alcohol withdrawal may be similar to other disorders. Questions the medic might ask to help elicit the information are also provided as guidance.

In discussing treatment and evacuation guidelines, one needs to separate mild withdrawal from more serious conditions. Mild cases of alcohol withdrawal can be locally treated, reducing the need for evacuation and the subsequent loss of manpower. After describing the more serious withdrawal symptoms, we discuss their treatment. Other drugs of abuse presenting with withdrawal symptoms will also be seen. Some of the specific drugs and their effects can be discussed.

Phencyclidine (PCP) received separate consideration as a drug of abuse because of treatment difficulties.<sup>8</sup> A service member under the influence of PCP may be combative, negative, and hallucinating.<sup>12</sup> To the medic who does not have access to an adequate history, this service member will just look "crazy" and be "treated" with restraints and chlorpromazine. The pitfalls of this approach are examined to help reinforce the need for proper diagnosis and subsequent treatment and evacuation. The point should be emphasized that a drug and alcohol history, when routinely gathered, will spare evacuation, conserve manpower, and ultimately provide better battlefield medical care.

There will be, of course, a few major psychiatric disorders present in a wartime scenario. To bring this into perspective, a World Health Organization chart detailing the frequency of major psychiatric disorders is made relevant to a division-sized unit. Obviously, the entire field of psychiatry cannot be discussed. Instead, one method is again to rely on differential diagnosis and history. After having ruled out physical injury, chemical exposure, inappropriate atropine injection, and drug withdrawal, then consider a functional psychiatric disorder. For example, a service member presents with hallucinations and delusions and is incoherent, in short, "crazy." The medic should consider the differentials and obtain a history and physical examination including any history of previous psychiatric problems.

If no obvious diagnosis presents itself, a period of drug-free observation may be useful; however, if the condition is too severe, evacuation is appropriate. Particularly severe disorders such as suicidal behavior and psychosis are discussed in depth. The level of expertise of the audience must be gauged so that this material is presented in an understandable format. This is particularly true when discussing psychiatric terms such as psychosis, hallucinations, delusions, incoherence, and other terminology.

The final broad topic discussed in the medical aspects of combat psychiatry is CSR or "battle fatigue." CSR is discussed last because it should be assumed only after all other potentially dangerous, life-, limb-, or function-threatening diagnoses have been adequately ruled out.

The CSR is first defined as to what it is and what it is not. The point is made that a CSR is not "crazy" or even violent as a rule. It is useful to explain that a CSR is an exaggeration of the normal responses that might be seen in any very stressful situation. It is also useful to describe common normal responses to combat. The difference between a normal response to combat and a CSR can then be better understood. The CSR is presented, then, as an exaggeration of a normal response to combat. However, the CSR is no longer functional. In other words, the CSR's degree of psychophysiological response is severe enough to *temporarily* disable him in the performance of his duties as a soldier. The factors that might contribute to more stress in a combat scenario and increase the numbers of CSR patients are closely examined. The participants are instructed to preferably use the label "combat or battle fatigue" to convey the transient, benign nature of the disorder.

Such factors as combat intensity, WIA and KIA rates, the type of unit, the service member's previous battle experience, and the expectation regarding the anticipated outcome of the battle are studied from the standpoint of affecting the CSR rate. In addition, such factors as sleep deprivation, family concerns, and the individual's ability to handle stress in general are viewed as possibly tipping the balance in the direction of temporarily disabling symptoms.

After a definition of CSR has been given and factors influencing the CSR rate presented, there must be a very concrete description of how the CSR patient will present to the combat medic. A good way to present this information is with a chart that by statistics relates the symptoms seen in various previous conflicts. For example, in the 1982 Leba-

non War, 56% of the Israeli CSR patients presented with anxiety, 38% as depressed, and 34% with fearful mood.<sup>13,14</sup> The presentation and discussion of symptoms will be followed by treatment and evacuation guidelines. The well-known treatment principles of the CSR patient are explained using proximity, immediacy, expectancy, and simplicity (PIES). Centrality, which is more of a management issue, is only briefly touched on here.

The relative safety of the medical unit, when combined with rest, food, and an expectation of return to battle, is the simple treatment. In addition, other treatments that can, and should, be used include work assignments, catharsis (debriefing), and a brief relaxation program that can be easily administered and “prescribed.”

The important factor is to give the medic the tools to treat the CSR patient and thus short circuit the use of medicines or inappropriate evacuation. Finally, it is noted that the treatment is effective

(relying on and reinforcing earlier material presented), and recidivism will be very low. However, for a small percentage of patients, the 48-hour period of restoration will not be successful, and evacuation to a reconditioning center should be considered. The 3-day to 2-week stay in a reconditioning center will still result in the return of the majority of CSR casualties to duty.

The morning session then ends with a summary that, in pictorial form, reviews the differential diagnoses and treatments. The medical briefing booklet that had been handed out earlier contains an appendix. The appendix has flowcharts that help organize a medic’s differential diagnosis and treatment (Exhibit 12–2).

Of course, no flowchart is complete, and such a chart will never replace a careful evaluation, as is pointed out in the briefing. The afternoon field training exercise begins when volunteers are selected from the battalion aide stations to act as

**EXHIBIT 12–2**

**DECISION TREE FOR COMBAT STRESS CASUALTY**

- 
- |  |   |
|--|---|
| 1. Anxious, Irritable, Depressed, and Nonfunctional    |   |
| 2. Psychological factors affecting physical conditions | 2a. History of physical injury  |
| 3. Neurologic condition                                | 3a. History of head or spinal cord injury   |
| 4. Withdrawal symptoms                                 | 4a. History of drug and/or alcohol use  |
| 5. Chemical symptoms<br>Chemical hysteria              | 5a. Contact with chemical agent   |
| 6. Atropine overdose                                   | 6a. Anticholinergic symptom and/or use of Atropine  |
| 7. Radiation syndrome                                  | 7a. Exposure to nuclear environment   |
| 8. Biological contamination                            | 8a. Exposure to biological agent  |
| 9. Psychiatric disorder                                | 9a. Presence of major psychiatric symptoms (hallucinations, delusions, severe depression, suicidal) |
| 10. Combat stress reaction                             | 10a. Unable to temporarily function as a soldier secondary to combat stress                         |

A soldier with symptoms (step 1) must be questioned about potential alternate causes (steps 2 through 9). The examining medic must rule out the alternates with negative responses to steps 2a through 9a before labeling the casualty as having a combat stress reaction (step 10) or as being a combat stress casualty (step 10a).

casualties, while part of the mental health team plays the role of psychiatric casualties. The remainder of the mental health staff (three people) act as trainers/supervisors to give both feedback and to create various scenarios during the actual running of the exercise.

A central casualty pool contains the physical, psychiatric, and CSR casualties. Through the use of color-coded patient cards (Exhibit 12-3), the 15 to 20 different patients are sorted and distributed to each battalion aide station. This method allows a regulated flow of patient types.

The color-coded cards give the medic information as to the medical/psychiatric history. The use of moulage kits adds realism for physical casualties. The mental health staff "acts" the psychiatric symptoms, thus also ensuring more realism.

Over a 1-hour period, 15 to 20 casualties of all types are sent from the casualty generation pool/forward edge of the battle area to the company aidmen. The company aidmen are required to triage the casualties. Physical casualties needing bandages, splints, or stretchers are administered by the aidmen. Evacuation priorities are enforced; that is, psychiatric and CSR casualties are evacuated only after serious physical casualties. The aidmen are forced to confront and triage a wide variety of psychiatric and CSR casualties, thereby increasing their sensitivity to the magnitude of combat psychiatry.

### EXHIBIT 12-3

#### SAMPLE PATIENT CARD

VITAL SIGNS: BP= 116/74; P= 74; R= 14;  
Airway: clear  
Hemorrhage: none

HISTORY: Over a period of several hours, the service member gradually withdrew and would not talk or follow any orders. The SM has refused all attempts to engage him, even refusing food and water. With great difficulty, the company aidman was able to evacuate the SM to the BAS.

PHYSICAL: Repeated attempts to question the SM were met with silence and a vacant stare. There is no evidence of neurologic abnormalities after a careful screen. There are no signs of, or history to suggest, drug abuse. SM has no history of exposure to CBR weapons.

After appropriate interventions, the aidmen will evacuate their casualties to the battalion aide station. Here, the physician assistant and his staff must diagnose, treat, and evacuate where appropriate.

To add further realism and to aid the training for "common soldiers' tasks," various scenarios are enacted. The trainer/supervisor will call a "gas alert," thereby requiring the donning of protective masks to both aidmen and to their patients. Patients will occasionally be evacuated with a protective mask, demonstrating the importance of facial cues and verbal communication in diagnosis. Physician assistants may also be "eliminated," forcing the battalion aide stations to operate without their services. Various other scenarios can be enacted including the decisions that must be made when the battalion aide station gets the order to move out.

The battalion aide station is required to fill out patient cards describing diagnosis and treatment. These cards are used later for feedback.

After completion of the training exercise, the participants return to the classroom. At this point, feedback is given, both positive and negative, as to unit performance. All the trainers/supervisors have their viewpoints. This is followed by a discussion of specific patients that were portrayed during the exercise and what might be considered as diagnostic, therapeutic, and evacuation guidelines.

A general discussion period follows that ends with the posttest examination being given. The posttest is used to gauge the immediate effectiveness of the training program and also to reinforce key points. Finally, a critique sheet is distributed that allows the soldiers to comment on the training program and give feedback on possible improvements. This has been a valuable tool for making meaningful modifications. The day-long program ends with each successful participant receiving a certificate of training.

#### Division Commanders' Course

As important as the training is for medical personnel, the command personnel must also understand what combat psychiatry is and how proper diagnosis, treatment, and evacuation will affect their fighting force. Commanders can also be told of preventive measures that may help reduce their losses.

The commanders' course is best initiated by first securing command support at the highest level available. Obtaining this support will generally entail a briefing that details the importance and need for



commanders' attendance at such a course. This briefing is best directed at the division commanding general at a meeting arranged by the division surgeon. Another valuable addition is to obtain an introductory letter signed by the division commanding general emphasizing the need for the course and its attendance by commanders. This letter then becomes an integral part of the material that is disseminated before the commanders' briefings. Having now received command support, mental health personnel can begin the second phase of the training program.

Part 2 of the combat psychiatry training program is again divided into three parts, reflecting the desire to allow all three officers to utilize their expertise in training. The three parts of the briefing include an historical review of combat psychiatry, a medical review, and a section dealing with preventive measures.

The historical review is a 30 to 45 minute presentation designed primarily to demonstrate to commanders the importance of combat psychiatry. This is best done by exploring, through history, the impact that CSR casualties have had on tactical operations. This is also illustrated with actual case vignettes. It becomes necessary to touch on the issue of readiness. The theme developed is that an unprepared army is a vulnerable army. Examples supporting this notion, such as experiences in World War I, World War II, and Israel, are fully explained. During this initial briefing, a very powerful concept that can be discussed is the casualty generation figures. Here the commander actually sees what impact losses because of CSR will have on his unit. At this point, the need for a training program to help decrease these losses becomes more apparent. The Israeli Defence Force experience before and after the institution of such a training program is discussed last to demonstrate how effective such training can be in returning effective soldiers to the commander. At the end of the first presentation, the commanders should have a better appreciation of the tactical importance of the CSR casualty and of a preventive training program.

The middle presentation is an abbreviated medical overview, similar to that in part 1. Key concepts that should be developed include the social approach to the CSR, a brief overview of the scope of combat psychiatry, what the CSR casualty will look like, how the CSR casualty will be treated, and the effectiveness of this treatment. It is also important to describe the part 1 training program to the commanders so that they can appreciate both our con-

cern and our approach to the issue of "readiness." The medical section concentrates less on specifics of diagnosis, treatment, and evacuation but instead leans toward issues of effectiveness of treatment, present preparedness, and the commander's vital role in the entire process. The point is made that without the commander's involvement, the whole program is less effective than it could be.

The final presentation revolves around preventive measures that commanders need to understand and, as appropriate, apply. Those factors that influence the rate of CSR casualties can be discussed. For example, the WIA/KIA rate, the expectation regarding the outcome of the battle, the service member's previous combat experience, and the combat intensity are just a few of the factors that are covered in this presentation. Unit cohesion, because of its particular importance in decreasing the rate of CSR casualties, receives special attention. Factors that might tend to produce more group cohesion such as regular combat training, physical training, and effective leadership are offered to the commanders for their consideration. The ability of the leader to influence the cognitive appraisal of the service member is emphasized.<sup>15</sup> Although effective leadership is a well-known principle for promoting more unit cohesion and subsequently less CSR casualties, this presentation does not offer guidelines for effective leadership because commanders receive this information elsewhere. The need for enforced periods of sleep is also discussed.

In the commanders' briefing, the use of research instruments to gauge the level of knowledge tends to be more politically sensitive than with the medics. If such an instrument is to be used, this should be thoroughly explained both when initially seeking approval to start the training program and later with the commanders themselves. A critique sheet, however, tends to be a less-sensitive issue and normally would represent the conclusion of the commanders' briefing. The critique sheet is designed to allow for feedback on the presentation as well as to elicit commanders' ideas for improving the program. Modifications can then be made to provide for more sensitive training.

## **Material and Methods**

In collecting the data, a questionnaire was used. The questionnaire was distributed in the pretest mode to all participants. This information is considered the baseline because it reflects knowledge before training. The posttest was the same question-

naire. It was completed after the training. This information would represent short and intermediate memory retention of key training principles. Fifteen months after the medics had completed the combat psychiatry training program a retest gauged the degree of learning loss.

In the commanders' training program, the same questions distributed to the medics were again used. This allowed correlation of data. There was no posttest given because of time constraints.

The multiple choice questions dealt with basic principles of combat psychiatry. The questions were designed to elicit the respondents' knowledge in such areas as detection, description, treatment, and probabilities of occurrence. The questions were constructed to allow prejudices and misinformation to be revealed. This was done to test the proposition that such prejudices might exist. The choices to each question were designed to allow appropriate and inappropriate responses to be discerned and later tabulated.

The pretest and posttest responses were collected in 1983. There were 202 questionnaires obtained from the division medical personnel. The units tested included the major elements of the division. These units are separated geographically by as much as 100 miles.

Fifteen months after training, a reexamination of original respondents was conducted. This sample netted 16 questionnaires or 8% of the original group. Personnel losses accounted for the small size of this sample. Statistics are included for information and not for statistical inferences.

One hundred and seventy-eight commanders who received their training in 1985 contributed the most current data in this study. The combat arms were the main unit-type represented.

Responses to each question were tabulated and then converted to a percentile figure. The percentages of appropriate and inappropriate responses were compared in the pretest, posttest, retest, and commander's program. The pretest knowledge was the standard to which subsequent shifts after training were compared.

## **Results**

In responding to the question "What are important things that cause a CSR?" the medics' top percentile choices on the pretest included: drug and alcohol abuse, 74%; previous difficulties adjusting in life, 68%; the KIA and WIA rate, 50%; and battle intensity, 46%. After the medical training, the data

shifted to battle intensity, 82%; the KIA and WIA rate, 80%; experience in combat, 76%; drug and alcohol abuse, 74%; and lack of sleep, 60%. The 15-month retest data included lack of sleep, 88%; battle intensity, 82%; the KIA and WIA rate, 81%; experience in combat, 76%; and few friends in the unit, 44%. The commanders' selections included the KIA and WIA rate, 82%; lack of sleep, 71%; battle intensity, 66%; experience in combat, 60%; and poor unit morale, 49%.

Reviewing the percentages of inappropriate responses is also important because it can have a direct negative effect on decision making. For presumed etiologies of CSRs, the medics' pretest included weak personality, 42%; the way he was brought up, 14%; and previous difficulties adjusting in life, 68%. The commanders on this question chose a weak personality, 29%; the way he was brought up, 26%; and previous difficulties adjusting in life, 37%.

In describing "How a CSR would most likely act," the pretest medical responses included scared, 89%; jumpy, 78%; nervous, 71%; in a daze, 71%; and normal, 64%. The posttest responses were nervous, 81%; quiet, 74%; dazed, 72%; withdrawn, 71%; and scared, 61%. The 15-month retest responses were nervous, 88%; quiet, 75%; withdrawn, 75%; scared, 69% and dazed, 69%. The commanders answering to this question listed their responses as nervous, 68%; withdrawn, 54%; jumpy, 51%; dazed, 51%; and scared, 48%.

Inappropriate pretest responses included crazy, 18%; nuts, 20%; freaked out, 18%; haywire, 12%; wild, 19%; and screaming, 22%. These same data after training were crazy, 4%; nuts, 5%; freaked out, 11%; haywire, 2%; wild, 1%; and screaming, 6%. Inappropriate responses chosen by commanders were crazy, 16%; nuts, 11%; freaked out, 27%; haywire, 14%; and screaming, 24%.

In selecting the most appropriate treatments, the generally accepted principles were considered. These principles were letting the service member know he will return to duty; treating him close to the battlefield; assigning him duties; resting; returning to his unit; and talking gently. The latter is an attempt to elicit and subsequently incorporate an empathic approach.

The medics' pretest choices were restrain him, 69%; make him shape up, 44%; assign duties as he recovers, 43%; rest, 41%; and treat far away from the battlefield, 38%. The posttest choices were talk gently to the service member, 94%; treat close to the battlefield, 91%; rest, 89%; and expect his return,

81%. The medics' retest responses were talk gently to the service member, 94%; rest, 94%; treat close to the battlefield, 88%; expect his return, 81%; and assign duties as he recovers, 69%. The commanders' choices were send to a doctor, 60%; rest, 57%; talk gently, 43%; treat like a WIA, 43%; and send to hospital, 40%.

How soon could a successfully treated CSR return to duty? The pretest medical responses indicated that 47% felt 1 week was needed. An additional 22% felt 1 month of treatment was required. Forty-four percent of the commanders felt 1 month of treatment was necessary before a soldier could be returned to duty. Twenty-one percent selected 1 week of required treatment. The medics' posttest responses shifted to the more generally accepted time periods. Seventy-two percent selected 3 days. The medics' retests revealed that 46% selected 3 days, and 20% selected 1 day.

A reflection of the underlying philosophy regarding successful treatment is suggested by asking what percentage of CSRs could be returned to active duty. The medics' pretest indicated that 37% of the respondents felt that 60% of the CSRs could be returned. Thirty-six percent of the medics felt only 40% could be returned. The posttest results shifted as 74% of the respondents chose 80% as the likely return rate. In the retest, 70% of the medics felt that a return rate of 80% or better was possible. Fifty-two percent of the commanders chose return rates of 60% or less.

## **Discussion**

The division medical personnel will be the first echelon that most CSRs will contact. Proper triage is mandatory to preserve the fighting strength. The general level of knowledge demonstrated by the medics' pretest was consistent with their lack of training in this area. If such unchallenged knowledge is taken into combat, the speculative results would be an intolerable mismanagement of CSRs. Although the relative inability to determine the etiology of the CSR could be excused, the identification and treatment cannot be. It was in these areas that the baseline knowledge of the medics was most deficient. A CSR was viewed as a scared, jumpy, crazy person or, as selected by a majority, even normal. Such responses do little to determine a CSR with an aim towards treatment. Even more important were the treatment choices selected. The general view of treating a CSR was consistent with their view of the CSR being unmanageable. The cluster of

responses indicated that restraining the service member, making him shape up, and treating him away from the battlefield were considered most appropriate choices. Again, consistent with the perceived untreatability of a CSR, the medics felt that at least 1 week, and in a sizable minority 1 month, was needed for successful treatment.

The commanders were more likely to appreciate the factors that contributed to the CSR rate. There was, however, a wide range of responses to the appearance of the CSR. The predominant view, however, was still one of an agitated, jumpy, wild individual. The commanders' main treatment options were to evacuate the service members. The selected evacuation to mental health specialists or a hospital could suggest either a desire to eliminate from their ranks the CSR or the commander's philosophy of using his combat service support elements.

The commanders were even more pessimistic regarding successful treatment. Forty-four percent of commanders indicated that a 1-month treatment program would be needed before a CSR could return to duty.

The medics' posttest was designed to measure the shift, from baseline, of acquired knowledge. In every tested area, the posttest medics demonstrated that the responses concerning etiology, diagnosis, and treatment were more appropriate. This knowledge taken into combat could favorably alter an otherwise unrestricted flow of CSRs out of combat units. As a result of this training program, emotional first aid would more likely be rendered in or near a service member's unit.

Fifteen months after training, the medics could still identify appropriate precipitating factors, length of treatment needed, and, most important, proper treatment interventions. A loss of knowledge was noted only in certain diagnostic areas. A minority of retested respondents returned to a view of the CSR as a crazy, wild individual.

The training program had a positive effect on the identification and treatment of the CSR. This was maintained in the 15-month retest. By implication, such training will lead to better battlefield care. The training program should be followed up by sustainment training, including the presence of division mental health personnel (and supporting combat stress control unit teams) in field training exercises. This is especially important at the high stress exercises conducted at the National Training Center, Joint Readiness Training Center, and Combat Maneuver Training Center.

## SUMMARY

The uncorrected myths and biases surrounding the CSR are not consistent with either good medical care or good leadership. As this study demonstrates, such myths and biases are prevalent. This study also concludes that effective training can have a definite impact. A well-briefed cadre of medics and commanders can only add to the readiness posture of the military.

All medical personnel in the military should attend a concentrated combat psychiatry training program. Commanders should attend a shorter, yet intensive, program. The issues in each program will be tailored to reflect the differing needs of the two groups. The goal of both training programs, however, should be the same—the preservation of manpower.

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