REFERENCES:


AMEDD ARTEP 8-25, Division Medical Battalion, Chap 3, Section VI.


Objectives.

1. Terminal Learning Objectives.
   a. As a leader, recognize and take appropriate action in order to manage combat stress and prevent and treat battle fatigue, using the concepts presented in class.
   b. Brief command and teach subordinates about appropriate action which may be taken to manage combat stress and prevent and treat battle fatigue, using the concepts presented in class.

2. Enabling Learning Objectives.
   a. Given a list, select the five elements to the definition of "battle fatigue," as presented in class.
   b. Given lists or case descriptions of symptoms, select those of mild battle fatigue ("normal combat stress reactions", but which may be early
warning signs of more disabling battle fatigue), as presented in class.

c. Given lists or case descriptions of symptoms and of seven major subtypes of moderate to severe battle fatigue or "battle fatigue equivalents," match the symptoms to the subtypes, as presented in class.

d. Given lists or case descriptions of symptoms, select those which are physical/mental disorders that may be confused with battle fatigue, as presented in class.

e. List the principles of treatment of battle fatigue summarized in the memory aids "Easy as P.I.E." and "IMPRESS," as presented in class.

f. Given statements, select those which describe the mental health personnel and their functions in AMEDD units in the combat zone, as presented in class.

g. Given lists of factors or situations which influence combat stress, select those which increase or decrease battle fatigue casualties, as presented in class.

h. From lists, select measures that leaders, groups, and individuals can take to moderate stress and prevent battle fatigue or "burnout," as presented in class.

i. Given lists or case descriptions of symptoms, select those which represent Post-Traumatic Stress Disorder (acute, chronic, delayed), as presented in class.

A. Historical Perspective--Incidence Rates of Combat Stress Casualties.

1. Panic and death are ancient, but "battle fatigue" is modern, due to impersonal, mass lethality, and resulting dispersion.
2. Napoleonic Wars and U.S. Civil War ("nostalgia").


4. World War II ("Psychoneurosis" changed to "combat exhaustion", "battle fatigue").

5. Korean Conflict (1:4 ratio, similar to WWII).

6. Vietnam Conflict (1:10 ratio of "combat exhaustion" due to preventive factors, but many other problems instead).

7. 1973 Mideast War ("combat exhaustion" vs. "battle shock" or "transient battle reaction" in first hours, without physical fatigue).

8. 1982 Lebanon Invasion (proved again the value of treating in the Combat Zone).

9. U.S. doctrine is to use "battle fatigue" for all psychiatric casualties at front; sort out later, if don't improve.

   a. The "fatigue" in "battle fatigue" is an analogy of emotional with physical fatigue; in both,

   \[
   \text{Exhaustion} = f \text{ Intensity} \times \text{Duration} \times \text{Individual's Preparedness}
   \]

   b. In "worst case" high tech defensive scenario, ratio of battle fatigue to WIA may exceed 1:1.

B. Definition of "Battle Fatigue."

1. A deliberately nondescript name.

2. For a wide variety of behavioral, mental, and physical symptoms.

3. Possible in any normal soldier.
4. Due to multiple stresses of combat.

5. Temporarily overwhelming and redirecting psychological defenses.

C. Types of Stress in Combat.

1. Physical/psychological strain (lowers the "overload" tolerance, but does not produce battle fatigue unless fear and/or internal conflict are added).

2. Fear or anxiety of pain, mutilation, death.

3. Fear of failure, disgrace.

4. Grief, rage (at loss of friends, hatred of enemy, incompetent leaders...).

5. Ethical limits (killing, having to fire at noncombatants, leaving "expectant" patients to die...); may feel guilt at own rage, acts.

6. Internal conflict (survival vs. mission vs. loyalty vs. ideals).

7. Also much boredom, restriction, loss of privacy, etc.

8. Home front worries or disappointments.

D. Phases of General Adaptation to Stress (acute and chronic may be superimposed).

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<thead>
<tr>
<th>PHYSIOLOGY</th>
<th>PERFORMANCE</th>
<th>TIME COURSE</th>
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<tbody>
<tr>
<td>1. Alarm, arousal, (adrenaline, etc. due to unfamiliar threat)</td>
<td>&quot;fight or flight&quot;; good only if instinctive or well-drilled</td>
<td>(Acute) (Chronic)</td>
</tr>
<tr>
<td>2. Mobilization, resistance, adaptation (stress hormones)</td>
<td>Maximal effectiveness of &quot;mechanisms</td>
<td>Seconds to Days</td>
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|            |                      |  |  |  |
suppressed) fense," control fear if not anxiety, let down

3. "Exhaustion" due to deterioration, Hours Months
   loss of hope and failure, give up to to
   chronic hyper-
   response

E. Mild Battle Fatigue (normal combat stress reactions--still able to function, but can be warning signs).

1. Thousand-yard stare (normal and common after heavy combat, improves with 1-2 days rest).

2. Tension, startle response, fine tremor (become selective in veterans but increase again with sleep loss, cumulative combat).

3. Physical complaints, symptoms (normal and very common):

   a. Musculoskeletal (head/back/limb ache; pain, limitation from old injury).

   b. Cardiovascular (rapid pulse, palpitation, short of breath, hyperventilate).

   c. Gastrointestinal, genitourinary (pain, nausea, vomiting; urinary freq, diarrhea, "dumping reaction").

4. Irritability, tension-releasers (against rear echelon; alcohol, fights, VD), (Warning sign when becomes silent, withdrawn, or "vicious" in own group).

5. Inertia, indecision, tiredness (can lead to mistakes, increased stress).
6. Insomnia, terror dreams (terrifying, relive bad experiences, afraid to sleep, therefore tends to get worse).

F. Clinical Pictures of Moderate to Severe Battle Fatigue (unable to function, burden to unit).

1. Depression (motor retardation, crying, survivor guilt).

2. Anxiety reactions (gross tremor, extreme startle).

3. Memory loss (amnesias, complete or partial, "fugue" flight).

4. Loss of functions ("conversion reactions" which impair job).
   a. Sensory (eyes, ears, touch...).
   b. Motor (paralyses, abnormal tics).
   c. Speech (stuttering, mute, can't understand).
   d. May mimic NBC, laser, or other "hidden injury."

5. Disorganization (outburst, panic, freeze, stupor, hallucinations of battle).

G. Battle Fatigue Equivalents.

1. "Self-inflicted" wounds or illness.
   a. Negligent--trenchfoot, frostbite, malaria.
   b. Deliberate--gunshot.

2. Excessive pain and/or disability, failure to recover from minor injury/illness in MTF.

H. Differential Diagnostic Problems (may be mistaken for battle fatigue).

1. Environmental illnesses.
a. Heat--early heat stroke can cause confusion, agitation; must restrain, cool.

b. Cold--hypothermic "zombie" takes off clothes, looks and feels warm; must provide external heat or will die.

2. Blunt trauma injury.

a. Concussion--stunned, amnesic, sensory-motor symptoms; check scalp, eyes, ears, nose, vital signs. Transitory ischemic attack symptoms due to air emboli from blast overpressure in lungs?

b. Ruptured spleen--in shock, fetal position, "guarding" due to peritonitis.

3. Substance abuse.

a. Alcohol, barbiturates, and tranquilizers (intoxication and withdrawal).

b. Amphetamines (chronic overuse gives paranoia; cessation gives "crash;" may be serious depression).

c. Narcotics, etc.

d. Hallucinogenic drugs (LSD, PCP; give sensory. cross-referencing).

4. Anticholinergic delirium.

a. Atropine, BZ (visual, tactile, olfactory hallucinations, disorientation; check pupils, skin, salivation).

b. Do not treat with antipsychotic drugs (Thorazine).

5. Anticholinesterases.

a. Low dose nerve gas poisoning likely.
b. Chronic persistent depressive syndrome even after antidote.

6. Endemic psychiatric and personality disorders.
   
a. Schizophrenias.

b. Major affective disorders.

c. Personality disorders, conduct disorders (malingering).

I. Principles of Treatment.

1. "P.I.E." (easy as pie)--proximity, immediacy, expectancy.

2. "IMPRESS".
   
a. I = immediate (treatment begins with the first words said to the soldier!).

   b. M = maintain military atmosphere (rank, courtesies, field gear, relevant tasks).

J. Mental Health Resources in the Combat Zone.

1. Brigades' Medical Company (91G).
   

   b. Roles--perform triage, outpatient counselling and consultation; can hold for treatment (perhaps 48 hours) only if augmented.

2. Division Mental Health Section (at division medical support company).
   
a. Division Psychiatrist (SSI 60W).

   b. Division Psychologist (SSI 68S).
c. Division Social Worker (SSI 68R).

d. Behavioral Science Specialist (MOS 91G) X 1, 2, or 3.

e. Roles—consultation and prevention first priority; treat up to 96 hours if can RTD.

3. Evacuation Hospital (neuropsychiatric section) in corps.

a. Psychiatrist (SSI 60W).

b. Psychiatric Nurse (SSI 66C).

c. Psychiatric Specialist X 2 (MOS 91F).

d. Roles—medical/surgical consultation; receive severe psych and detox cases and slow-responding battle fatigue; treat (up to evac policy limit) or evac to general hospital in COMMZ or to CONUS.

4. OM Team (psychiatric service detachments).

a. Three mobile consultation teams of 60W, 2 X 68R, 6 X 91G.

b. Treatment team of 60W, 2 X 66C, 10 X 91F, 1 X 91G.

c. HQ section of 60W, 68S, 91F NCOIC.

d. Current status; realistic limitations (too few, too late) could reinforce EVAC, MED TRTMNT CO or DMHS; must have infrastructure to plug into.

K. Factors Which Influence Battle Fatigue.

1. First combat experience, level of training (realism helps).

2. Intensity ("noise" vs. KIA + WIA).
3. Fatigue (muscular, sleep loss major contributors, but not necessary or sufficient. Justifies physical fitness program).

4. Tactical situation.
   a. Uncertainty, surprise (major factors).
   b. Static continuous battle (moving in attack or retreat protects, but may break down when finally stop).
   c. Passive posture, defenselessness (indirect fire, hit by friendly fire worse).

5. Environment.
   a. Climate--cold-wet, hot-wet wear down; extreme cold "petrifies" the inexperienced.
   b. Terrain--jungle, desert, mountain, if unfamiliar.

6. Epidemiology (endemic fungal diseases, dysentery, malaria).

7. Nutrition and hydration: Food contributes more via morale, trust in leaders than via chemistry. Water is absolutely necessary.

8. Group factors ("cohesion"): If among friends, trusted and needed, are resistant to battle fatigue (but may not fight).

9. Unit factors ("Esprit de corps," type of unit); need identification with undying tradition to tell how to behave.

10. Leadership deficiencies: Incompetent, uncaring, incommunicative, or not credible, indecisive; loss or change of leader.

11. Personal predisposition.
a. "Home Front" worries often the precipitating stress ("Dear John" or picture of baby).

b. Personality--individual resistance differs greatly, but personality type has never proven to predict true battle fatigue, though it may influence recovery.

12. Surviving, being "short" ("Old Sergeant Syndrome," either anxious or obsessive--do well if given responsible rear echelon jobs).

L. What Leaders Can Do to Manage Stress in the Unit.

1. Be competent, plan for contingencies, maintain control.

2. Keep information flowing, control rumors, be confident but realistic.

NOTE: The leader must communicate to the subordinates all the pertinent information. When soldiers are placed in conditions of high stress and ambiguity, they will rely upon information provided by the chain of command to help them understand the situation. If this information is not available, they will GUESS. If the guess is wrong, their ability to perform their mission will go down. Thus the good leader must differentiate between appropriate and necessary information and unnecessary information.

3. Look out for the welfare of the troops (safety, water, food, shelter, duties, pay...).

4. Ensure as much rest/sleep as possible (3-4 hours per 24 minimum for long haul).

5. Strengthen unit cohesion, identification, purpose.

NOTE: The instructor should stress that training and work details should strengthen the group and respect group integrity.

6. Maintain unit readiness, tough realistic training.
7. Initiate a stress coping program, promote cooperation.

8. Task management.
   a. Task allocation—spread the load equitably.
   b. Task matching—fit the soldier to the task.
   c. Task paralleling—error minimization by double check.
   d. Task sharing—mutual support.
   e. Cross training—spread of competence.

9. Show interest in each individual.

10. Integrate new personnel quickly into the unit.

NOTE: A recent study by the Israeli Defense Force found that one of the few variables that helped identify a potential battle fatigue casualty in advance was that the individual was new to the unit and not well integrated into the unit.

M. What the Group (Buddy) Can Do to Alleviate Stress.

1. Recognize symptoms in each other.

2. Peer feedback (accentuate the positive).

3. Reassurance (of group solidarity, normality).

4. Ventilation (constructive).

5. Mobilize group support for those showing strain, home front worries.

6. Crisis management.
   a. Observe and calm the soldier.
b. Protect the soldier from danger (restrain if necessary).

c. Take charge.

d. Collect relevant information.

e. Take appropriate action.

N. What the Individual Can Do to Alleviate Combat Stress.

1. Rest/sleep, etc., as often as possible.

2. Learn relaxation techniques (progressive muscular, meditation...).

3. Ventilation, share feelings constructively.

4. Develop readiness/preparation plans.

5. Take appropriate action.

O. Post-Traumatic Stress Disorder (PTSD)--seen after all wars, as well as disasters, crimes, etc.

NOTE: Much publicized in Vietnam vets; may be more common due to nature of guerrilla war? DEROS? Racial and drug problems? Homecoming?

1. Acute (within first six months after trauma, overlaps CSR and "battle fatigue" symptoms).

2. Chronic (continuing beyond six months after trauma).

3. Delayed (onset after six months and may be years).

4. Symptoms much like CSR and battle fatigue.
a. "Normal" = alerting or startle reactions, bad dreams, memories.

b. Is "PTSD" only if more severe--
   
   (1) Intrusive thoughts, flashbacks.
   (2) Depression, insomnia, anxiety.
   (3) Alienation, social dysfunction.
   (4) Alcohol or drug use, acting out.

NOTE: Should not legally excuse violence and crimes. Individual still responsible for self-control.

5. Treatment.
   
   a. Individual, group, and family psychotherapy.
   b. Behavior therapies for target symptoms (dreams, flashbacks).
   c. Medication--antidepressants, beta-blockers?

6. Prevention (group debriefings? ventilation?).

P. Questions from Students.

III. SUMMARY (10 min).

A. Review of Main Points.

1. Historical perspective incidence rates of combat stress casualties.

2. Definition of "battle fatigue."

3. Types of stress in combat.

4. Phases of general adaptation to stress.
5. Mild battle fatigue.

6. Clinical pictures of moderate to severe battle fatigue.

7. Battle fatigue equivalents.


10. Mental health resources in the combat zone.

11. Factors which influence battle fatigue.

12. What leaders can do to manage stress in the unit.

13. What the group (buddy) can do to alleviate stress.

14. What the individual can do to alleviate combat stress.

15. Post-traumatic Stress Disorder (PTSD).

B. Closing Statement: In combat, battle fatigue is inevitable, but battle fatigue casualties are not. History shows that highly trained and cohesive units have had fewer than one such casualty for every ten wounded in action, even in very heavy fighting. This is significantly less than the usual one per four or five. By knowing what factors in the tactical and overall situation increase battle fatigue, leaders, buddies, and the individual soldier can take action to share the burden, resolve the internal conflict of motives, and reduce the stress. By tough, realistic training which builds confidence, and by caring for each other in combat, we can overcome the stressors of the AirLand Battlefield.