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P003 996	Battle Stress Casualties in the Israeli Defense Force during the War in Lebanon. Revision
P003 997	Tasks and Functions in Dealing with Combat Stress Reactions

COMBAT STRESS REACTIONS OCCURRING IN THE ISRAELI DEFENSE FORCE DURING THE LEBANON CONFLICT OF 1982

John A. Miller

TABLE OF CONTENTS

*This information was received too late to be incorporated into the body of this report. The enclosures in this appendix were supplied by LTC Gregory Lucas Belenky, M.D., Department of Medical Neurosciences, Division of Neuropsychiatry, Walter Reed Army Institute of Research, Washington, D.C. 20012.

INTRODUCTION

This report summarizes my attendance at The Third International Conference on Psychological Stress and Adjustment in Time of War and Peace hosted in Tel Aviv, Israel. During my attendance at this conference I obtained information concerning battle stress casualties suffered by the Israeli Defense Forces (IDF) during their recent conflict in Lebanon. The information contained in this report was obtained primarily from my attendance at panel presentations scheduled by the conference. Some unofficial supplemental information was obtained through private conversations with members of the Israeli Mental Health Department of the IDF, an IDF paratroop officer and a reserve IDF tank sergeant who was a member of a tank crew which saw action in the Lebanon conflict.

The IDF appears to have been very successful in returning large numbers of battle stress reaction casualties back to duty. The actual numbers of casualties of this type which occurred and the actual numbers which were returned to duty were not made publicly available. Unofficially, however, the total number of psychiatric casualties who received treatment was reported to approach 600. It was reported at the conference that between 70-95% of all combat reaction casualties were returned to some form of duty. The majority of the combat reaction casualties were treated at the forward aid stations of the Advanced Medical Battalion (AMB). This first echelon forward treatment facility was typically located 2-4 KM to the rear of the battle area. Second and third echelon treatment facilities were initially established in Northern and Central Israel respectively. These second and third echelon treatment facilities were established for those combat reaction cases which did not respond to forward treatment modalities. It would appear that the IDF has learned a great deal about treatment of combat stress reaction casualties since their initial experiences in the 1973 Yom Kippur War.

BACKGROUND

My attendance at The Third International Conference on Psychological Stress in Time of War and Peace took place in Tel Aviv, Israel from 2-6 January 1983. My primary interest in this conference concerned the obtaining of information from IDF mental health personnel that was directly related to their battle stress casualty program. I had hoped to use the information obtained from the conference to further develop a battle stress reaction consultation, prevention and treatment program for the 101st Airborne Division (Air Assault), Fort Campbell, Kentucky, with whom I am currently assigned as the Division Psychologist. A great deal of information was obtained during my attendance at the conference and a great deal more information should be forthcoming from the IDF contacts I established. Much of the information which is contained in this report is preliminary data of sorts and subject to future revisions as the IDF Mental Health Department makes more definitive data available.

GENERAL FINDINGS REGARDING COMBAT

It appears that the IDF strongly believes that in combat, men are sustained primarily by their comrades and secondarily by their equipment. Those units with lower morale, less intimate knowledge of their fellow soldiers and less training as a unit, tended to generate higher physical and combat reaction casualties. This occurrence was especially true for reserve units. Also, much as the US units in Vietnam discovered, individual replacements tended to diminish group morale, cohesion and effectiveness. During the 1973 Arab-Israeli War, for example, tank crews who were assembled as they arrived and sent forward, had a three times higher incidence of stress reactions than those crews who had been together for some time. The critical factors in this example were shown to be the elements of cohesiveness and trust. Tank crews who were assembled ad hoc did not have sufficient time to develop

group cohesion and trust prior to entering combat.

The IDF emphasizes the need for trust in commanders as a primary mode of developing and maintaining unit morale. The commanding officer plays a crucial role in leading his combat team. They have a three times higher incidence of death by enemy action than do other officers. Trust in one's commander and unit morale and cohesiveness appear to be the primary factors which support a willingness to fight and follow commanders even in the face of political and personal disagreement. The personal example of the commanding officer was identified by Israeli soldiers as the primary component of trust. The commander checking on the welfare of his soldiers was another trust developer. Perceived competence of the commanding officer was shown to be able to increase gains and decrease negative outcomes among unit members and thus the unit as a whole. The commander, himself, does not create cohesiveness, he fascilitates cohesiveness towards unit goals.

Unit morale and cohesion are not enought to sustain a soldier in battle. Adaptation to combat depends on personal as well as group factors. The Israeli data indicated that when a soldier entered combat with an unresolved personal problem (family, self-esteem, self-confidence, other premorbid factors) he was more likely to be a physical or psychiatric casualty almost regardless of the type of unit from which he came. Some data also suggest that when combat reactions occur late (months or years following combat) they appear to be the result of, or an underlying symptom of, a personal disturbance (premorbid personality) which cannot be directly attributed to the unit or the combat experience.

The Israeli experiences support the notion that combat effectiveness among soldiers requires good leadership, strong unit cohesion, self-confidence and a stable family and emotional situation. Even in the presence of these characteristics,

fear of combat becomes a natural reaction among soldiers. Although the fear of combat appears to increase with experience, effectiveness is not necessarily diminished. In fact, the Israeli experience suggests that readjustment to combat after a breakdown (severe battle stress fear reaction) is usually better than prior to the breakdown. A good record and presentation of fatigue symptoms at the time of the breakdown are the more positive signs for successful readjustment. When the soldier is returned to a unit for duty, unstipulated acceptance of the individual will secure the greatest probability of the soldier being a highly effective member of that unit. Since battle stress casualties may be a primary replacement and reinforcement resource, it would appear that unit acceptance of the returning soldier becomes a vital key to effective unit performance. The Israeli Mental Health Department assigns Battle Psychologists to each Division and Brigade Commander to provide education and consultation on matters such as those discussed above.

USE OF MENTAL HEALTH RESOURCES

The Israeli Defense Force has shown the vital need for the appropriate use of mental health resources. The experiences of the IDF in the 1973 war and most recently during the Lebanon conflict, lend strong credence to their reliance on their Mental Health Department to provide important combat support services. The Mental Health Department of the IDF has three main functions: (1) Provide treatment, (2) provide command consultation (prevention and education) and (3) research. This report will focus special interest on the roles of the mental health treatment teams and command consultation programs.

In the area of treatment, five-member mental health treatment teams are typically assigned to each combat division. These teams are usually made up of a psychiatrist, psychologist, and three other mental health officers (psychologists and or social workers). When deployed, these teams operate in the forward treatment

facilities of the Advanced Medical Battalion (AMB). The AMB, during the Lebanon conflict, was usually located 2-6 Km to the rear of the forward fighting. In many cases, the sound of battle was readily heard and experienced at these facilities. Other treatment teams, assembled ad hoc, were located in the rear treatment facilities in Northern and Central Israel. These treatment facilities were staffed by varying numbers and types of professional personnel on an as-needed basis. More will be said about these Israeli treatment facilities later in this report.

The command consultation program is conducted by the Battle Psychologists. One of the primary roles of the command consultation team is the conducting of unit morale surveys. These surveys are performed at many different times under combat and non-combat conditions (see INSERT I and II for sample Israeli Questionnaires). The surveys are conducted on a regular basis with most every unit. The surveys are also conducted in response to specific events such as a change of commanders, prior to entering combat, following certain combat missions and the like. The surveys are conducted at the Brigade and Division levels by military officers (Battle Psychologists) who function in a manner similar to our organizational effectiveness officers. The surveys are administered only with the agreement of the commanding officer. The results are not presented to higher headquarters without first being presented to the commanding officer. The results are also not presented to a higher commanding officer without first being presented to the subordinate commanding officer. The results are presented and followed by a discussion concerning the significance, possible ramifications and recommendations based on the data collected. Areas which are surveyed include: Unit morale, perceived cohesion, combat readiness (psychologically speaking), confidence for combat in the commander, equipment, training of comrades and the overall willingness of the unit to fight, etc.

I have been in the process of modifying the Israeli questionnaires for use with units of the 101st Airborne Division (Air Assault), Fort Campbell, Kentucky. (see

INSERT III). The commander of the 326th Medical Battalion, to whom I am assigned, has given me permission to begin surveying our Air Assault medical companies for initial feedback and analysis of usefulness. If successful with this unit, and with proper command emphasis, a division-wide ongoing program can be developed.

SYMPTOMS OF BATTLE STRESS REACTIONS

Ineffectiveness among soldiers of the 17th, 18th and 19th centuries was originally seen, by medical persons, to be a result of nostalgia, an "organic illness". Social and environmental factors were gradually recognized as part of the overall symptomatology. In World War I, for example, psychological explanations were used to describe combat breakdown and sophisticated treatment procedures were employed. In World War II the need to examine the role of unit cohesion and the influence of physical exhaustion was recognized. During the Korean War the use of rest from combat and the recognition of battle anxiety played important roles in influencing treatment procedures. The Vietnam War witnessed the rise of characterological problems among participants in low-intensity, politically unpopular conflicts In the 1973 Yom Kippur War (Arab-Israeli War) large numbers of casualties were produced from the high intensity nature of the conflict. The Israeli's officially admit to 10% of all casualties being psychiatric in nature. More recent figures suggest that psychiatric casualties may have been greater than 30%. Privately however mental health officers suggest that the incidence was probably slightly higher. The discrepancy appears to be the result of recognizing the role of inadequate diagnosis and insufficient record keeping. The preliminary figures from the Lebanon conflict suggest a combat reaction incidence rate of more than 20% of all casualties. Potentially, as many as 10-20% of all Israeli personnel engaged in the Lebanon conflict may have suffered some symptoms associated with battle stress reaction, though most did not require treatment.

Exposure to war itself appears to be the primary stressor in current conflicts. The high-intensity nature of current combat takes a tremendous toll on the psyche of even the most stable and hardy soldier. Some researchers believe that recent trends in combat reaction symptomatology may be due more to diagnostic labeling than to actual symptom differences (Refer to Table 3 for symptom prevalence by war). In the Lebanon conflict, for example, the primary and most prevalent symptoms of combat reaction included anxiety/irritability, depressive affect, sleep disturbances, fears and social estrangement (Refer to Table 1 for symptom list and Table 2 for frequency distribution). The above symptoms were also prevalent in the 1973 Yom Kippur War, however initial treatment was not as appropriately available as in the Lebanon conflict. Return to duty rates were therefore, proportionately lower in the 1973 war, probably as a result of the use of a different treatment paradigm than that which was used in the Lebanon conflict.

In both of the above Israeli conflicts, as well as the U.S. experiences in World War II and Korea, the initial combat reaction symptoms of anxiety, confusion and fatigue progressed into more severe depressive, dissociative, conversive or antisocial symptoms if initial treatment was delayed or ineffective. Battle stress symptoms appear even before combat, with the anticipation of combat action, and continue throughout the conflict. In Lebanon, combat stress symptoms continue to be seen among the Israeli occupation forces. Although they are being seen in very small numbers, they occur even in the absence of major combat actions. This data suggests the probability that stress symptoms are potentially a part of any military action.

INCIDENCE OF BATTLE STRESS CASUALTIES

As has been mentioned, the IDF suffered significant numbers of battle stress casualties. The Israeli Mental Health Officers at the conference were not allowed

to release actual casualty numbers. The reported percentages of battle stress casualties range from 10-40% of the total number of casualties. Not all battle reaction casualties were counted because not all of these casualties were evacuated for treatment. Many were reported to have been treated by their commanders, comrades, friends, etc. without evacuation from the unit. A paratroop officer and a tank gunner each told me about soldiers who began to break down in combat and were taken by the commander into his vehicle (tank, APC, jeep, etc.). These commanders appear to have unknowingly applied battlefield psychology procedures through a crisis management model. In many cases, the reassurance and role-modeling of the commander resulted in effective return of the soldier to his normal duties in 2-3 days.

Battle stress reactions also occurred among the physically wounded. There were no figures released concerning the number or percent of battle reaction cases which were also physically wounded. However, the best estimates of the mental health officers suggest that 10% of all combat reaction casualties also suffered some physical wounds. There were also no detailed records of which came first, the combat reaction or the wound. In general, the data from the Lebanon conflict and the 1973 War was not significantly different in respect to numbers and types of battle stress reaction casualties.

TREATMENT FACILITIES AND METHODS

Forward treatment of combat psychiatric casualties has been considered the preferred treatment since World War I. This treatment typically consists of short-term, intensive and brief psychotherapy as close to the place of breakdown as possible with the full expectation of returning the casualty to duty in 2-3 days. The major aim of forward treatment is the restoration of biological deprivations such as food, water, sleep and warmth. Forward treatment procedures rely on unit cohesion and leadership to help motivate the individual to rapidly return to his unit.

Wars since World War I have demonstrated the superiority of forward treatment facilities over rear treatment facilities in the return of psychiatric casualties as effective soldiers. The conflict in Lebanon supported the expectation that forward treatment was by far superior in returning battle reaction casualties to effective functioning as soldiers. These treatment facilities ultimately returned 90% of all combat reaction casualties they treated to forward units. Those forward treatment facilities which were able to keep the combat reaction soldier near and in contact with his unit had a greater than 90% return rate.

As previously mentioned, during the Lebanon conflict the first echelon of treatment was the Advanced Medical Battalion (AMB) located 2-6 Km to the rear of fighting. It was staffed primarily by younger professionals with more combat experience and expertise in the treatment of combat reaction casualties than the staff of the rear treatment facilities. The combat reaction casualties typically arrived by ground ambulance (APC) after being referred for treatment by the battalion aid station. These casualties were held at the AMB for up to 48 hours. They would then be returned to their units or if not sufficiently improved, evacuated rearward. Treatment at the AMB consisted of biological replenishment (food, water, rest) and intensive therapy conducted 2-3 times daily.

The main goal of treatment at this forward facility was to convey to the person that he had worth and could quickly recover and return to his unit with full effectiveness. Soldiers from the casualty's unit were encouraged to visit when possible. The purpose here was to help re-establish self-esteem and alleviate guilt and shame. The casualty was continually reminded that he was a soldier. He retained his personal weapon (when appropriate), was used to help other wounded and combat reaction soldiers and was generally made a productive member of the facility. He was not segregated or isolated from the other physical casualties and was thus not made to feel like an outcast. Combat reaction soldiers were labeled as casualties, not patients. The

latter label tended to inhibit positive treatment. In this facility, rest did not mean lying down. Reaction casualties received rest from combat while being kept productive. This proved to be another means of enhancing treatment results. The greatest problem for this facility was in the establishment of reassignment channels for soldiers to be returned to their original unit. It appeared that fewer combat reaction casualties suffered relapses or required re-evaluation when they were succes fully returned to, and accepted by, their original units.

Those soldiers initially treated at the AMB who failed to improve within 48-hour or who were evacuated directly to Israel, were treated at a second echelon facility. This facility was originally located on a military base in Northern Israel and met with only limited initial success. The staff was assembled ad hoc and, unlike the forward treatment teams, had not been extensively trained in the treatment of battle stress casualties. . The casualty return rate from this facility, during the early weeks of fighting, was reported to be less than 30%. Most of those casualties not returned to forward duty received discharges or psychiatric profiles. Later in the conflict, this facility was closed and the IDF established second echelon treatment in Southern Lebanon. These new second echelon facilities were located close to or even co-located with the AMB. Toward the end of the conflict, the second echelon treatment began returning close to 100% of the casualties they treated. The experier of the IDF with these facilities adds further support to the need for forward treatme of battle stress casualties by well-trained and well-organized mental health personne

The second echelon treatment facility had three main goals: (1) To return the battle stress reaction casualty to optimum function, (2) to retain the casualty with a military framework without the psychiatric discharge stigma and (3) to return the soldier to his original military unit if at all possible. The major principles of

the facility were as follows: (1) To co-locate with a military training center which had heavy military traffic in the area, (2) to maintain the military milieu at all times (to include possession of and training with one's individual weapon, (3) intensive group and individual therapy, (4) include daily military training, (5) arrange for commanders to give group talks, (6) limit treatment to a maximum of 14 days and (7) include daily physical training and recreation activities. These principles for the treatment of combat reaction casualties reflect the current doctrine as it was developed from the lessons learned by the Israelis during their 1973 War.

The third echelon of treatment was the Combat Fitness Retraining Unit (CFRU). It was established for the treatment of combat reactions who failed to return to normalcy after one or two previous therapeutic attempts. It was developed to help prevent psychiatric hospitalization of the more severe combat reaction casualties. The major goal of this treatment facility was the improvement of the casualty's functioning to that of the pre-war level, within their natural environment, within three weeks. Return to combat was the primary goal of the facility.

Most of the casualties treated at this facility displayed extreme stress reactions and all were said to have had significant civilian and miiitary adjustment reactions. The major presenting symptoms of the casualties were focused around depression and fears. Depression was attributed primarily to feeling helpless, attributing this helplessness to some self-defect, not having adaptive solutions, and a loss of reinforcers. The fears appeared to be caused by a conditioning of the emotional trauma to the military and the presence of strong irrational beliefs. Ninety percent of these more severe casualties were said to have premorbid personalities which included character disorders, schizoid, paranoid or other personality disturbances. The methods of treatment reflected the more serious nature of these casualties and varied somewhat depending upon the specific symptom pattern of the casualty. The

principles under which the facility functioned were the same for everyone:

1. Maintain the military milieu at all times.
2. Development of a comprehensive treatment strategy.
3. Use of short-term goal-directed crisis intervention treatment.
4. Additional psychopharmacologic and behavioral methods developed as needed and on a case by case basis.
5. Use of an interdisciplinary approach.
6. Therapeutic cooperation was maintained between the professional and non-professional personnel.
7. The therapist functions as the casualty's military commander.

The comprehensive treatment strategy listed above included the use of individual and group psychotherapy, individual and group athletics, physical fitness training and military regimentation. This facility placed major importance on developing group cohesiveness and promotion of individual identity. This goal was accomplished by maintaining a military regimen and using competitive athletics and physical training within the same physical and emotional setting. Staff personnel carried weapons from day 2 and encouraged the casualties to do the same. Military formations and inspections were regular daily occurrences. Participation in weapons demonstrations and firing range exercises were also encouraged from day 2. Military physical fitness training, military drills, skill development and skill rehabilitatic were a regular part of this rehabilitation program. Sports coaches who were experienced in working with combat reactions conducted rigorous athletic training focused on group cooperation and group effort.

As noted above, the major goal of this treatment facility was the effective return to combat of the stress casualty. The therapeutic principles of treatment were thus designed to include the above military and physical training in a general

treatment program. Individual psychotherapy was an integral part of the whole military and therapeutic program. Individual therapy focused on abreaction (expression of pent-up affect) of the traumatic experience(s) which contributed to, or produced, the breakdown. The individual was helped to work through and resolve the underlying problems and trauma. He was helped to attain personal insight into himself and thus strengthen his own self-identity resolving his guilt and shame and reasserting his strength and manhood. Each therapist was also the immediate commander of the casualty and took part in all of the physical and military activities. The therapist thus was able to encourage, motivate, order, analyze and direct the individual's daily activities in a positive influential manner. In general, this individual therapy approach appeared most successful when it focused specifically upon dealing with the post-traumatic crisis itself. The foci here were issues of shame and guilt, aggression, manhood vs weakness, dependency vs independence, coping vs flight, and self-esteem vs self-depreciation.

The comprehensive nature of the treatment program at the CFRU also included group therapy. The focus here was designed to parallel the combat reaction process. The main issues of the group were; dealing with the trauma of combat and the breakdown, the post-traumatic process, and concern with loss of group and personal identities. Since the group experience is a crucial element in a fighting unit, the failure of group involvement increases the chances for combat reaction. Recovery from combat reaction appears to be enhanced by improving group experiences and re-establishing group identity. Therefore, the total program of the CFRU emphasized the group experiences of belonging, trusting and sharing. Group therapy was an important part of this emphasis. One premise of combat psychiatry is that when a combat reaction casualty is evacuated from the close proximity and support of his comrades, the separation becomes a lonely experience which produces a severe blow to his self-esteem and identity. The group process of the CFRU functioned to develop a new

group identity for its members and thereby improve personal identity. For this group therapy program to be successful it required the resolution of three distinct stage sequences: (1) The abreaction of the trauma and preoccupation with the symptoms (2) forming group cohesion and crystallizing group and individual identities and (3) learning to cope with the future, separation, and return to military service or the civilian life. The success of the CFRU's group therapy program appears to support the premise that with severe psychiatric stress reactions, abreactive group work is the treatment of choice.

PREVENTION OF BATTLE STRESS REACTION CASUALTIES

As mentioned in the early part of this report, battle stress reaction casualties appear to be a normal consequence of war. It also appears that total prevention is unlikely and every combatant and support soldier, regardless of rank, can become a combat reaction casualty. Although combat reactions cannot be totally prevented, they can be minimized. Primary prevention techniques include the education of individual soldiers and commanders in the use of prevention methods, development of unit morale and cohesion based on mutual respect, confidence and personal identity, acceptance and use of mental health resources for treatment and training, and regular surveying of units to provide feedback to commanders on current unit effectiveness and suggestions for potential areas of change.

The Israeli Defense Force maintains an active, ongoing and extensive combat reaction prevention program. It assigns psychologists to the staff of each division to advise division commanders concerning the morale and other psychological factors important in maintaining combat effectiveness. Typically, one psychologist is assigned to the division commander's staff and one to each brigade commander's staff. These psychologists are typically referred to as Battle Psychologists and function as command consultants similar to our organizational effectiveness officers. They are not primary treatment personnel. Treatment is the function of a separate group

of five mental health officers who are assigned to each division to specifically provide treatment.

During the Lebanon conflict, the Battle Psychologists appear to have played an important role in helping to minimize combat reaction cases. It was reported that those brigade commanders who used their psychologists as consultants had lower incidences of psychiatric casualties, higher unit morale and better unit cohesion than those commanders who failed to appropriately use their psychologists. It should also be noted that the elite units, those units whose training emphasis is on unit morale, cohesion and pride, had few significant problems with psychiatric casualties. These units are typically small (company or smaller) and have highly specialized strategic missions. They are similar to our Special Forces, Pathfinders, Navy Seals, etc.

The IDF experiences from the 1973 War and the Lebanon conflict have shown the need and effectiveness of a well-developed and command supported battle stress prevention program. Command utilization of mental health resources was shown to be a critical element in the success of such a program, while the availability of psychological consultants within the brigades appears to be a necessary part of any preventive program. With minor TO&E changes, and command education, we in the U.S. Army are capable of providing even more comprehensive and effective command consultations than the Israelis. These changes could include the following:

1. Assignment of a mental health officer (psychologist or social worker) to each brigade. This officer would function much like the Israeli Battle Psychologist, as a command consultant, but could also provide direct clinical treatment.
2. Make combat training more realistic through the use of psychiatric casualty plays. Commanders should be made aware of what combat reaction casualties

are going to do to their manpower. These casualty plays should be supervised and evaluated by the mental health teams at brigade and division level and used during every FTX.

3. All mental health personnel should be cross-trained in emergency medical specialty skill areas. In high intensity combat, mental health specialists will probably need to treat the psychiatric and physically wounded under battlefield conditions and thus need the extra medical training.
4. Eliminate the psychiatric field chests from TO&E inventories and substitute portable aid bags. These bags should contain a minimum of psychological equipment (surveys, unit questionnaires, on an as needed basis) and a maximum of first aid equipment. The metal psychiatric chests are bulky and the current equipment contained within them will likely not be used during combat operations.
5. Mental health survey teams should be a regular command consulting element of every unit. These teams would survey the units during special events such as change of command, prior to field exercises, during field exercises, following field exercises, as the unit rotates in and out of combat, before, during and after deployment (such as MFO), etc. The areas to be surveyed would include morale, cohesion, confidence, combat psychological effectiveness, etc. Potential problem soldiers could also be identified and potentia severe problems minimized.

IDF FUTURE PLANS

Based on the experiences of the Lebanon conflict, the IDF has begun to make changes in their mental health format. Some of the proposed changes include the following:

1. Mental health personnel are to be placed far forward with medical treatment capabilities.

2. Simulated combat exercises will be made as real as possible and will integrate the mental health capabilites.
3. Commanders are to be indoctrinated into the use of psychologists to eliminate their mystique and bias.
4. Whenever the mental health facilities are positioned, they will be dependent on the medical element.
5. Medical personnel will be involved in the psychiatric treatment of casualties.
6. Commanders of combat units will be made a part of all decision processes; convince him that mental health treatment is a systems approach; keep the lines of communication between commander and treatment facility open and two-way.
7. Mental health is an extention of command. Mental health providers are to be leadership trained and experienced.
8. Train forward mental health providers in communication skills, military skills and professionalism.
9. Consider the mission of the mental health provider just as important as anyone else's.
10. Use of psychological teams to survey units after heavy fighting, heavy casualties, after being hit by friendly fire, etc., to clear up rumors and immediately treat developing symptoms to avoid evacuation rearward.

SUMMARY AND CONCLUSIONS

This report summarizes my attendance at The Third International Conference on Psychological Stress and Adjustment in Time of War and Peace, hosted in Tel Aviv, Israel. It presented major information available concerning psychiatric casualty occurrence and treatment obtained from the Israeli experiences during their recent Lebanon conflict.

The Israeli Defense Force admittedly suffered significant numbers of psychiactric casualties during their Lebanon conflict. Although some of the physically wounded also displayed psychiatric symptoms, the majority were unalloyed battle stress reactions. They occurred in large numbers primarily to units which did not appear to have high cohesion and morale, did not have significant training time together, were hit by friendly fire or were involved in very intensive sustained combat. Combat stress reactions are seen as a normal reaction to the stressors of war and are more likely to occur in the mid and high-intensity combat scenario. The IDF feels that it has been able to reduce the incidence of combat reactions through the use of Battle Psychologists and realistic combat training exercises which integrate mental health capabilities. During the Lebanon conflict, those Brigade commanders who utilized their Battle Psychologists as consultants, had a lower incidence rate of combat reaction casualties.

The IDF used a three echelon treatment program for their psychiatric casualties. The forward treatment facilities were able to return 90-95% of combat reaction casualties back to their units within 48 hours. The rear echelon facilities were less successful in returning the more severe reaction cases. Forwar treatment is concluded to be the treatment of choice, since the further to the rear the initial treatment, the less likely the potential for effective return of the casualty to a combat unit.

The IDF learned a number of lessons during the Lebanon conflict. They have plans to implement changes in their mental health program as a result of these lessons. They determined that mental health resources can be more effectively used in treatment of battle reaction casualties and unit training of preventive measures The development of good morale, leadership, training and family and community stability were seen to promote effective combat performance and reduce the incidenc

of battle stress casualties. The planned use of Battle Psychologists in an expanded role in these areas is a further development toward improved pre-war planning and training.

The recent Israeli experiences with combat reaction casualties would appear to suggest that the U.S. Armed Forces may need to reexamine the role and current use of their mental health personnel.

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