

Coping with Stressors in Peacekeeping Force Deployments: The Role of Medical Leadership

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1. SUMMARY

This paper combines the author's 28-year experience as a U.S. Air Force flight surgeon and psychiatrist with a review of recent military psychiatric literature about stress-related deployment issues. The result is some "lessons learned" for medical support to NATO peacekeeping missions. Such lessons include: Be prepared to give care from the announcement of mobilization until the dispersal of the troops after homecoming, and even after that. Plan to be self-sufficient for 24 hours after arrival at a deployment site. Use a well-equipped ambulance as a portable dispensary. Learn to use the local communications systems as soon as you arrive. Civilian, political, medical and line authorities will all issue directives, and a clear chain of command is essential. Flexible leadership in a novel and chaotic situation is a crucial talent in the medical commander. Health care professionals are particularly stressed by lack of power and priority in a deployed situation. Changes in technology and troop demographics should temper one's dependence on past lessons. Mental health problems during active operations tend to be "stress reactions" or "acute adjustment disorders." As operations wind down, more "personality disorder" situations will occur. The immediate effects of stressful missions may be reduced by applying principles of treatment involving immediate, brief interventions on the spot, rapidly returning the individual to duty. Recent literature suggests using rapid crisis interventions after traumatic events to diminish later post-traumatic stress disorders. After-actions troop debriefings also have therapeutic value. Specific aircrew issues are addressed, too, including use of sedative and stimulant medications.

2. INTRODUCTION

During 28 years of active duty in the U.S. Air Force from 1957 to 1984, I experienced one year of real war in Vietnam, several three-month NATO deployments with fighter squadrons, many brief deployment exercises, two extended exercises, and a few contingencies (deployed to Puerto Rico during the Dominican Republic crisis, was alerted for deployment from Spain to Jordan when the PLO was expelled, and was in training during the first U.S. deployment to Beirut and during the Cuban missile crisis). I served as Director of Base Medical Services for five years (including the year in Vietnam), and was on active mobility orders for two years as an Air Transportable Dispensary Commander and four years as an Air Transportable Hospital Commander. Thus, seven years (25%) of my career was composed of combat, or readiness for combat, during the Cold War.

The general nature of military experience among the NATO forces has changed since the Cold War ended, and peacekeeping missions are now commonplace. In recent

years, the diffuse stressors encountered during peacekeeping operations have been increasingly acknowledged, although they are less dramatic and distinct than those encountered on the battlefield. During Stability and Support Operations (SASO), deployed troops' distress may be heightened by the lack of public gratitude and recognition for their unglamorous and oft-ignored service. Stressors during such missions include abstract or unclear goals, possible or actual terrorism, witnessing atrocities, exposure to dead bodies, fear for own safety in ambiguous situations, risk of capture, inability to defend self or others, and frustrating or frightening situations not covered by rules of engagement. (1-3)

Medical leadership requires several different sets of skills: medical, military and political. One of my first commanders, Brig. Gen. James Humphreys, stated in a staff meeting in 1960 that if your staff did not respect you as a physician, then you could never be an effective medical commander. He went on to point out that command abilities were not the same as medical abilities, and had to be learned separately. I would summarize his comments thus: "The military will assume you are a good physician until you prove that you are not; they will not assume you are a good officer until you prove that you are." My subsequent experience proved him right, and others have made the same observation. (4, pp. 132-133)

Medical leadership during peacekeeping duties requires all of the abilities needed for military operations in war: leadership, flexibility, foresight, imagination, a talent for improvising, and knowledge of communications, transportation, logistics, and medical strategy, tactics and intelligence. Such duties may also involve a keen political sense of how to deal with people who may or may not depend upon you for medical care, and who may or may not see you as a friend.

This presentation on medical leadership will concern two groups of people:

- Medical personnel under your own command
- All troops for whose care you are responsible

3. MEDICAL PERSONNEL UNDER YOUR OWN COMMAND

Deployment begins with preparation, including selecting and training people to deploy. Contingencies can occur with no warning—at least, none at the working level, and so medical troops who are on call for quick response must be disciplined to take their readiness seriously. This can involve continuous work regarding day-to-day location and actual health status of members. Affairs must be kept in order, physical fitness to deploy accurately assessed, immunizations kept up to date, uniforms and equipment kept ready, and location of key

personnel constantly known. (5) In my opinion, the recruitment, selection, training and retention of such personnel may be one of the most challenging facets of future military duty.

Specific deployment stressors begin for an individual with the first suspicion that he or she may be deployed. Medical leaders should be prepared to deal with such stressors from the moment of announcement of mobilization until the dispersal of the troops after homecoming, and even after that. Specific stressors include:

- Initial shock, fear of the unknown
- Disruption of occupation, possible financial burden
- Separation from and concern for families. (6-8) This is more acute in newly married or new-parent families, or in single parent or two-parent deployments, with concern for child care, or where there is family illness or another such significant family burden. Family stressors are major contributors to deployment stress-related symptoms, and I emphasize that *providing appropriate support to families left behind during the deployment will be a crucial positive contributor to unit morale*. Develop family support systems before deployment is imminent, so that troops will know their families have local resources available. This topic deserves a presentation all its own.
- Uncertainty as to length of deployment. "When will we be coming home?" is a recurring and important question, and its answer may be hard to find.
- Deviation from plans. This contributes to uncertainties and a feeling of lost control. Do all that is possible to deploy on time. "Hurry up and wait" is a well-known military circumstance, and troops should be mentally prepared for unforeseen delays.
- Waiting, boredom. If there is a known waiting period before the deployment, provide well-designed and evaluated training and exercises to encourage bonding, familiarity and confidence. Cross-training some basic skills may increase redundancy of their availability.
- Jet lag, fatigue, especially during the initial phase. Management of fatigue may depend as much on attention to individual symptoms of fatigue as to sticking to some kind of schedule. Never miss a chance for the troops to get some sleep, even if just brief naps during slack periods. Four hours of uninterrupted sleep per 24 is the minimum required; 6-8 hours is ideal. Give priority to providing the troops a time and place to rest or sleep. Appendix A below discusses the use of sedative or stimulant medications in deploying aircrew. Monitor the emerging literature on use of medications in this regard. (e.g., 9-12)
- Poor mail service, lack of personal communication and information. (This works both ways. Good communications means bad news comes faster.)
- Lack of privacy
- Physical discomfort
- Unpleasant climate
- Unpleasant food
- Lack of supplies and equipment

Pack, or at least inspect, your own gear before deploying. Don't depend on someone who is not deploying to do this. Include some provision for individuals' preferred items to be

packed and shipped at the last minute (e.g., special surgical instruments). If unit equipment is shipped separately from the deploying troops, arrange for a few troops to escort it for security.

In addition to emphasizing unit pride, work hard on team bonding within the unit, both for long-time members and newly assigned troops. After initial notification, or even deployment, you may receive further "outside" troops assigned to your unit who arrive one at a time. Such "outside" assignees are especially stressed: they may have no friends in the unit, and are not bonded to the unit. Avoid making these new arrivals cope alone the first day when they arrive: provide personal welcomes, escorts, sponsors, orientation in-briefings, a buddy system, drills and exercises to speed their integration into the unit and their work teams. (13, p. 10) Watch for misassigned personnel: the only thing worse than being deployed may be to be deployed with no job to do.

Plan to be self-sufficient for at least one day after arrival at a deployment site. Bring your own 24-hour supply of drinking water and food. Make yourself as comfortable as possible. If you are to set up in a "tent city," select the site carefully. Consider geography, weather conditions, prevailing winds, local disease vectors, access by land and air, and security. Bring work gloves for everyone, to avoid blisters and splinters (particularly disabling to surgical teams). If possible, arrange for your own communications net, generator, and tents.

Pay attention to basic amenities: sleep, water, food and comfort. Provide the best quarters, work/rest schedules, latrines, showers, and messing facilities possible. Field sanitation must be strict concerning mess gear, water supply and latrines. Enforce latrine discipline from the first moment you arrive—don't let troops urinate anywhere they please as they get off the trucks, or the whole area will smell of it. Hot showers are a morale boost. Problems with these basic amenities will be more readily detected and corrected if the officers share them. Stay in touch with your troops—don't send the officers or non-commissioned officers away to sleep in distant (and more comfortable) locations.

During such uncertain times, many people draw strength from their religious faith. Actively support chaplain programs and religious observances.

Resupply may be uncertain at first. Experience has shown that messages back to the home unit may provide a good alternate source for quick resupply via opportune airlift until things settle down. Consider having both re-usable and disposable items in your inventory; e.g., sponges, needles, syringes, etc. If resupply is poor, sterilization and re-use of such items may be necessary.

Learn how to use the local communications systems as soon as you arrive. People are accustomed to instant communication with anyone they want, and lack of that convenience may be stressful to the organization and to individuals. The proliferation of portable phones may change the situation, and the availability of worldwide communication to almost every individual may pose its own problems in ways that none of us foresee. The presence of media coverage with world-wide

dissemination is also possible, and some deployed troops have been in the position of seeing themselves on the news almost as soon as events occur. (7)

Most health care professionals are accustomed to being regarded as valuable resources, and treated with respect. Being deployed may reduce them to "just another unit," and a medical group may find this lack of power and priority to be a true stressor. Formal stress inoculation training may also help: focus on mission, mastery of relaxation and breathing techniques, positive self-talk, and talking with buddies. (1; 13, pp. 11.4-11.6; 14; 15, p. 221)

Professionally useful activities may be carried out during slack periods (health and first aid education, facility improvement through self-help), as well as local tours, local history and language courses, non-contact sports, entertainment shows, etc. (16) Look for chances for local civic action missions (for example, working with a local orphanage may be quite rewarding), but be certain of security. If conditions permit, consider pass, leave, or rest and recreation (R and R) programs.

4. ALL THE TROOPS FOR WHOSE CARE YOU ARE RESPONSIBLE

The arrival of a medical unit anywhere will automatically generate patients before the engines are turned off. Be prepared to give round-the-clock care the instant you arrive, even before unpacking. Use a previously prepared and well-equipped ambulance as an interim dispensary and first-aid station: place a well-qualified medical care provider and a few good technicians in the ambulance, slightly away from the set-up site. If possible, bring portable radios that communicate with your ambulances. These may serve as an immediately available internal communications system. Be prepared for alcoholic withdrawal episodes in just-arriving troops.

Civilian, political, medical and line authorities will all want to tell you what to do as soon as you arrive, and a clear chain of command and sense of mission is essential. The medical commander may need to become acquainted with the local situation while the deputy commander supervises setting up operations. Coordination between the two is essential.

Flexible leadership in a novel and chaotic situation is a crucial talent in the medical commander as well as in the supporting headquarters. Have a good plan, and be prepared to deviate from it if necessary. As in football, you need both a good playbook and a good broken-field runner. Keep plans and training updated as the situation progresses. Consider contingencies. The leader on the scene knows more about the actual situation, and needs to be confident of support from medical and line headquarters (HQ) to the rear. Be careful of "us vs them" situations with distant HQ. Personal contact with medical and line HQ is critical, and staff assistance visits can be helpful if they don't degenerate into over-detailed inspections. People have a well-documented tendency to blame everything on someone who is not a member of their own group, and local commanders may be tempted to blame local problems on absent authorities in discussions with their troops. This can backfire when the local leadership is not aware of the problems HQ is facing, and makes intemperate

public statements about perceived lack of support. Provide a good information flow—make the chain of command the most reliable information source in order to keep demoralizing rumors at a minimum.

On deployments lasting longer than six months, establish leave, pass and rotation policies that are clear and fair. Consult with local line commanders on an adequate rest and leave program and other factors affecting morale of the troops.

Don't make promises based on circumstances outside your personal control, and especially don't make promises you can't keep about when troops will go home. *If at all possible, do not extend the tour involuntarily.* If tours are extended by higher headquarters, try to "grandfather" those troops already there, so that the new policy applies only to new arrivals.

The military learns from its past, but changes in technology and troop demographics should also influence present plans. Technological changes are accelerating, and today's medical leadership must deal with factors unknown only a few years ago. Older medical leaders may resist full use of such innovations as telemedicine, telepsychiatry, computers, and cellular telephones. Today's leaders need a keen sense of balance between tried and proven older methods and the benefits of new technology, the same sense of balance needed by line officers who are faced with similar challenges. This challenge is not new; senior physicians throughout history have had to deal with their juniors, fresh from academic training, who seem unable to work without the latest medical advances.

Many mental health problems during active operations tend to be of the "stress disorder" nature. (See Appendix B below.) As operations wind down, more "adjustment disorder" or "personality disorder" situations will occur. (17) Medical leaders must have a firm grasp on the options open to them for dealing with such problems, particularly in crisis situations involving potentially hostile local populations, or troops from another nation.

Stress-related misbehavior may occur, especially if the troops feel frustrated by the situation that brought them there. Commanders must be alert for signs that the troops view the local inhabitants as inferior or contemptible. Lead by example. Do not use or tolerate the use of derogatory nicknames, or racial or ethnic slurs. Correct such language, and comparable behavior, as soon as it occurs.

If the unit is involved in a traumatic event that shakes morale or confidence, consider use of mental health professionals to conduct a formal Crisis Stress Debriefing. This is somewhat similar to an After-Actions Debriefing (13, pp. 13-17) This process is increasingly used in natural or man-made disasters, and seems to be effective in alleviating immediate stress responses, although its effectiveness in diminishing post-traumatic stress disorders has not yet been conclusively demonstrated. (1; 4, Chaps. 9 & 11; 18) In my opinion, as a part of their own pre-deployment training, medical commanders should become familiar with the theory and practice of debriefing techniques. By their very nature, events

that make debriefings necessary make it difficult to learn about this technique on the spot.

If the deployed medical unit is supporting aircrew, some specific factors need to be addressed. Examples are given in Appendix C below.

During draw-down at the end of the deployment, maintain as many medical services as possible for as long as you can. As people start to leave, the basic rule is usually: "First in, first out." Manage exceptions with exceptional care. When a specific medical specialty service is to be closed down, be clear how its type of patients will now be covered. For example, when your last ophthalmologist goes home, exactly how will eye injuries be managed? Be sure that those outside consultants upon whom you now depend know that they are on call for you. If possible, go through one trial of the new procedure before you lose your own capability.

At the end, arrange for some sort of formal closure, farewell party, or ceremony (recognition, awards, retiring the colors) before the draw-down begins, or at least before the unit returns to its home. The value of such closure is well known, but delaying it until after the return may mean that it will be disrupted by circumstances beyond your control. (4, Chap 4.)

A considerable body of literature attests to manifestations of stress after return from deployments, both in military members and in their families. (e.g., 2, 15). Although beyond the scope of this presentation, such circumstances should be considered in after-action planning and follow-up, especially in those individuals who leave the service after return, thus being deprived of unit support.

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7. APPENDIX A. Using sedatives and stimulants in aircrew in deployment situations.

The use of sedatives and stimulants in aircrew for operational reasons is and will continue to be controversial. The following remarks are the author's opinion, based on his experience, and do not represent any current official policy. Whatever the policy is now, it will undoubtedly change in the future, and so it is well to have some prior knowledge of how such medications may be used, and perhaps to institute the ground-testing procedures that keep the option open.

Sedatives may be used to help the flier get to sleep at an unusual hour, so that he or she may be rested when the flight begins. For example, if the time for takeoff is 0400, then the flier may have to sleep from 1900 to 0130. A sedative medication may be taken at 1830 to help with this schedule. In some circumstances, preparation for a high-risk mission may involve long hours of work, and the emotional tension may be so high that aircrew cannot get to sleep before the flight, even at an accustomed hour. Here, too, sedatives may be considered for use. (19; 20, pp.185-187)

Stimulants may be used in flight when the flier has been awake for many hours, and is expected to be fatigued at the end of a long flight. Generally, the idea is to take the stimulant about two hours before penetration, descent and landing, so that the flier will be wide awake and alert during this most critical phase of flight. An example would be a 15-hour transoceanic deployment of single-seat fighters with multiple mid-air refuelings. The landing might occur at sundown, after the flier had been awake for 18 hours, strapped into the seat, with only fair nutrition and hydration.

Using such medications exposes fliers to a risk beyond that of ordinary flight. Clearly, then, *such medications should not be used unless the estimated risk of not using them exceeds the risk of using them.* Assessment of such risk factors involves a joint line-medical judgment. As with any situation in aviation, one should make every effort not to take risks that one does not understand.

In order to understand the risks, the flight surgeon must be familiar with the flying unit, the nature of the proposed mission, and the proposed medications. Knowing the medications involves studying their pharmacokinetics and pharmacodynamics, their primary and possible side effects, idiosyncratic or allergic reactions, and other medical aspects. *Never use a medication in flight that the aviator has not previously taken on the ground.* Obtaining information for use of stimulants or sedatives in connection with a flight should involve ground-testing the flier in advance of their use in actual flight.

To ground-test, arrange for a two-day period when the aviator will not be flying. Usually, a weekend will serve. For example, on a Friday afternoon, confer with the aviator about the test. Emphasize that no other medications, and no alcohol or caffeine are to be taken during the test period. Inquire after any previous experience with the medications to be tested, and any adverse effects. Explain the nature of the medications to be tested, and the ground-testing procedure. On Friday night, the aviator will take the sedative medication one hour prior to retiring. Upon awakening the next morning, the aviator will assess the quality of sleep, and note any subjective symptoms upon an "effects" form provided by the flight surgeon. The flier should specifically note whether he or she feels any effects upon arising that might affect flying abilities.

If all seems well, the aviator will then take the stimulant medication, and will note its effects, especially the onset and duration of stimulation. Any "let-down" symptoms should specifically be noted. A second dose of stimulant may be taken four hours later, if this fits the operational profile, and any effects noted. For instance, 5 mg of dextroamphetamine may be taken at 0800 Saturday morning, and 5 mg more at 1200. Assuming all goes well, 1600 marks the end of the test. The flier should specifically assess whether the sedative affected sharpness for flight, and whether the stimulants might have had any adverse effects on perceived ability to fly. Monday, the flier will return to the flight surgeon and go over the experience. Together, the flight surgeon and the flier will decide whether the flier may be able to use these medications in actual flying conditions. The decision will be marked on the "effects" questionnaire that the flier filled out, and signed

by the flier and the flight surgeon. The form is then put into the flier's permanent medical records. Once this process is completed for the squadron fliers, the squadron commander is notified.

If a future operational situation arises in which flying without medications seems more hazardous than flying with the medications, then the commander and the flight surgeon will decide if medications will be offered to those fliers who have been previously cleared to use them. If the medications are offered, *each flier will decide for himself or herself whether or not to use them on this mission.* This should be emphasized: the commander and the flight surgeon decide that the medications may be offered to the cleared fliers, but each flier makes a personal decision whether or not to take the medications.

The flight surgeon should brief the squadron before the mission in question about the use of the medications, and should debrief and record afterward the use or non-use of medications, and any comments about their efficacy or ill effects. *All medications carried on the flight but not used must be taken back from the fliers, to avoid unsupervised future use.*

Squadron policy should be explicit that whether a flier has been cleared or not cleared to use the medications will have no bearing on being chosen for a mission, or on being cleared for full duty.

The procedure noted above was in common use in the Tactical Air Command during the Cold War for trans-Atlantic squadron deployments. Generally, less than half of the fliers would opt to take the medications (secobarbital 100 mg and dextroamphetamine 5 mg, in those days). The author recalls no ill effects or adverse incidents being reported by anyone during this era. For an account of a more recent unexpected secret mission requiring such action, see Senechal (19).

8. APPENDIX B. Stress Reactions

Early Acute Stress Reactions may occur even before departure, in the mobilization area, or the waiting room of the departure airfield. These reactions may be manifest as tearfulness, hyperventilation, palpitations, fine tremors or generalized trembling, sweating, agitation, gastrointestinal distress, or a childlike (regressive) refusal to cooperate. Treat with rapid intervention (on the spot, if possible), explanation, reassurance and return to duty. Act as a commander, not as a medical person. Your role may be that of an understanding but firm parent with high standards for yourself and those under your command. Remind them of previously learned relaxation techniques. Find easy tasks for agitated troops to do, to keep their minds off their troubles. "I know you're up-tight—we all are—but we're counting on you to do your duty along with everyone else. We'll all look after each other—you'll be okay. How about helping the sergeant refill those water coolers." You must set the example of calmness. Appeal to their sense of duty. Keep your troops focused on the mission; get them talking about how to do it successfully. Joke about the situation. Keep everyone informed. When problems arise, make timely and productive decisions. If symptoms occur, minimize their secondary gain (the benefits of being

symptomatic, such as being inappropriately relieved from duties).

Later Chronic Stress Reactions may occur in response to cumulative stresses that finally overcome physical and psychological resistance. Although everyone in the unit may show signs of the strain, a few individuals may become clearly ineffective because of them. Initial symptoms requiring unit support for any individual may include:

- Irritability
- Social withdrawal
- Loss of sense of humor
- Change of habits—beware of alcohol abuse
- Personality change
- Poor performance
- Tremors, jumpiness
- Continuing sleep disturbance

If mild or early, these symptoms may respond to something as simple as a day off, three good meals and a chance to rest. If such unit "first aid" measures do not restore the individual, the next level of medical response should involve brief, immediate, central, expectant, proximate, simple ("BICEPS") factors, similar to those used in combat situations [see below].

Stress reactions may progress to a spectrum of disorders of varying severity, ranging from extreme agitation to severe regression. Striking symptoms may result—marked agitation, aggression (even including weapons), panic behavior, hallucinations, nightmares, involuntary flinching, cowering, gross whole-body tremors, incontinence of bowels or bladder, withdrawal, apathy, loss of use of a limb or a sense (e.g., "hysterical blindness"), amnesia, or loss of speech. Treatment includes remaining calm yourself, "talking him/her down," using relaxation techniques (muscle relaxation, calm abdominal breathing, visualizing a calming scene), talking out the problem, involving the victim's buddies, reassurance that stress does this at times—and that a good troop can remain a good troop in spite of fear. If you are concerned about the trooper's reliability, unload his/her weapon (take it away only as a last resort—this is a serious symbolic act of lack of trust). Have a friend stay with the trooper in a safe place. Physically restrain the trooper only if it is necessary for the safety of that trooper, or other troops, or possibly for safe transportation to a medical facility. Be sure the trooper is not physically ill—one of the shaking troops that Gen. Patton slapped actually had undiagnosed malaria. Be aware, also, that true mental illnesses may occur in military members anywhere. The methods of treatment used for acute or chronic stress disorders will not be effective for true mental illnesses that may occur in deployed troops. Such mentally ill troops should be treated by mental health specialists.

When the symptoms go beyond unit levels and necessitate medical intervention, the unit physician may follow the BICEPS principles (18; 20 pp. 202-203):

- Brevity—keep the intervention to three days or less.
- Immediacy—treat as soon as the symptoms are recognized. Use medications sparingly, and only for acute management.

- **Centrality**—keep the victims together for mutual support and a consistent treatment plan. This should be given locally in a Rest Camp setting, not a hospital.
- **Expectancy**—reaffirms that you expect them to get well (firmly defined as returning to duty!).
- **Proximity**—treat near the unit to maintain bonding. This means that commanders and comrades should be able to—and must—visit their comrades to counter any sense of shame and separation. The trooper may be ashamed of perceived “weakness,” and such visits imply continued acceptance by comrades, and their desire to have him or her back in the unit.
- **Simplicity**—keep the treatment focused on getting the trooper back to duty. This is not the time or the place for deep-seated analysis of the trooper’s personality makeup. Use medications only for a brief period, since troops should not be taking tranquilizers while on duty in a dangerous situation.

9. APPENDIX C. Specific comments regarding deployed aircrew

On deployment, whether in combat or not, the flight surgeon must be to the fliers as the Maintenance Officer is to the aircraft. The flight surgeon’s message: “My duty is to help you to fly, not to rescue you.” The flight surgeon must do some observer flying while deployed in order to establish and maintain credibility with the fliers, as well as to maintain personal familiarity with the stressors of the various flying missions.

Trust the wisdom of experienced line officers about what the squadron can and cannot do, and remain aware of the opinion of the squadron members themselves about when fellow fliers have “paid their dues.” As is true with non-flying units, knowing what the organization expects may help the flight surgeon decide when to be tough and when to be sympathetic whenever symptoms of fear become evident.

Flight surgeons help provide:

- Good medical care
- Healthy coping skills to deal with stress
- Reinforcement of trust in the fliers’ own skill and training
- Best possible living conditions (flight surgeon should be billeted with assigned squadron)
- High motivation
- Group cohesion and a desire to succeed
- Trust in comrades (“You’re not the only one who’s tense. If they can do it, so can you.”)
- Trust in equipment
- Accurate information (May serve as an informal link in the chain of command.)

Note that quality of sleep is essential. Pay attention to the sleeping conditions and facilities for the aircrew, especially those with night missions. This is not coddling, but a wise investment in a crucial asset. You may not be able to use crew rest regulations in some situations. Depend upon close observation of the fliers, and if groundings for fatigue are likely, make such decisions in conference with the operations officer and the aircrew involved. (21) Remember that you are in a zero-balance system: if you ground one flier, another will be assigned the flight. The replacement flier may be almost as fatigued as the one you grounded.

“Rest” may involve several factors: the interval between missions, the duration of the missions, having one or two days (“weekends”) off at predictable intervals, and the length of the combat tour, however it is defined.

1. Interval between missions and duration of missions:

- **Short:** Israeli pilots flew up to 10 missions per day during the 1967 Sinai Peninsula War; some missions were as short as 20 minutes.
- **Long:** USAF B-52 crews flew 19-hr missions (26 hr crew day) over North Vietnam in Dec 72, and flew similar missions during the Persian Gulf War.
- **Longest:** British Vulcan crews flew 26-hr missions (40-hr crew day) from the Ascension Island base to the Falklands Islands during the 1982 South Atlantic War.

2. Rest includes attention to scheduled days off or “weekends” off, as well as longer rest periods such as “R&R” if the combat tour goes beyond about six months. If possible, the unit commander should relieve combat aircrew of all additional administrative duties, so that time off from flying is not eaten up by having to catch up on their paperwork.

3. Rest is also implicit in the concept of “flying tours.” The type of combat tour creates different kinds of reactions:

- If the tour is based on number of missions flown (e.g., a “100 mission tour”), aviators want to get them finished, and may not want to take breaks even if they need them.
- If the tour is based on a specified length of time (e.g., one year in the combat zone, regardless of number of missions flown), aviators are more willing to take time off.

Whatever the rule, try not to lengthen tours once established.