

CHAPTER 21

**MANAGEMENT OF PSYCHOLOGICAL/
BEHAVIORAL PROBLEMS****Section I. BATTLE FATIGUE (STRESS)****21-1. General**

During combat, soldiers can experience conditions of overwhelming stress, both physical and emotional. The conditions that can produce battle fatigue include physical exertion, the requirement for constant alertness, the trauma of seeing other soldiers wounded or killed, the fear of being killed or maimed, and the necessity of killing. Transient (temporary) debilitating psychological disorders may develop, even in previously stable personalities. Psychological reactions to combat are generally not so incapacitating as to demand removal from the combat environment. When a soldier can no longer function effectively in his job, the medical specialist or other soldiers may provide appropriate initial treatment or psychological first aid.

21-2. Types of Psychological Reactions

Although psychological reactions may manifest themselves in many ways, there are two types of reactions thought to be the most common in a combat situation:

a. Battle Fatigue. This stress reaction, which has fear as its biggest factor, is brought about primarily by extended exposure to a combat situation. It is frequently seen in units that have been committed to long-term continuous combat. Battle fatigue is also referred to as *combat stress reaction, shell shock, psychoneurosis, anxiety state, psychoneurosis mixed, conversion hysteria, combat fatigue, flying fatigue, operational fatigue, or traumatic war neurosis*. Although there are other psychological reactions such as transient battle reactions (discussed below), this chapter will deal primarily with battle fatigue, its symptoms, and its treatment.

b. Transient Battle Reactions. These reactions are also temporarily debilitating in nature but may be more drastic than battle fatigue. Fatigue is normally not a factor in transient reactions. Soldiers not previously engaged in combat may experience transient battle reactions; however, most individuals can adapt and learn to cope with abnormal amounts of stress.

21-3. Battle Fatigue and Its Severity

Battle fatigue is a psychological condition encompassing the physical and emotional stresses experienced in combat. These stresses are experienced by every individual in a combat situation. Physical fatigue and/or fear (emotional fatigue) can produce battle fatigue. Battle fatigue can be exhibited by minor reactions such as impairment of self-confidence, trembling or irritability, or more severe reactions such as panic running, hallucinations, or hysterical paralysis. Battle fatigue may occur in individuals who have been in continuous prolonged combat, individuals not previously in combat but who experience a short-term intense combat situation, or those soldiers who spend long periods of time waiting to go into combat. From 70 to 90 percent of battle fatigue patients can return to duty after rest and treatment. Those patients who do

not respond after 48 hours of treatment require evacuation for definitive psychiatric care. Battle fatigue can be broken down into three levels of severity:

- *Mild*—the soldier relates sensations of fear in battle with no evidence of anxiety. This level does not require removing a soldier from combat.
- *Moderate*—the soldier displays tears, gross trembling, or difficulty on concentrating.
- *Severe*—the soldier can no longer relate to his environment and can suffer from hysterical blindness and paralysis.

21-4. Emotional Reactions of Battle Fatigue

a. *Fear*—an emotional experience in response to real danger. Under combat conditions, this can include—

- Fear of death, pain, injury, or mutilation.
- Fear of incapacitation through over-reaction to a frightful experience.
- Exhibiting fear and losing prestige with peers in the combat group.

b. *Panic*—the pathological counterpart of normal fear, involving temporary major disorganization of thinking and loss of control.

c. *Anxiety*—an expectation of danger, involving feelings of apprehension, uncertainty, and insecurity.

d. *Noise Sensitivity*—becoming sensitive to noise. Can lead to *abnormal noise sensitivity* which is a nervous reaction to a noise that does *not* represent a threat.

e. *Sleeping Difficulty*—a normal reaction resulting from tension, the need to remain alert, lack of comfort, and presence of combat noises. Can lead to *abnormal sleeping difficulty*, when the nighttime environment becomes terrifying for no apparent reason.

f. *Apathetic Tendency*—a frequent response to the stress of battle which results in some decrease in drive, flow of speech, initiative, readiness to undertake new tasks or problems, range of interests, and feeling of well-being. These complaints may be of considerable magnitude and they constitute a true apathy or depression extending well beyond the period of battle stress.

g. *Irritability*—a normal characteristic of someone subjected to long, continuous battle.

h. *Resentment*—a normal response for the soldier who has lost close friends and has faced danger. Resentment is strong where there is shirking or discrimination against the combat soldier.

i. Postcombat Behavior—various temporary behavior patterns exhibited after combat. These include overwhelming physical fatigue combined with apathy and subnormal reactions to stimuli. Eventually, tension creates a “letdown” and, consequently, the soldier can react with alcohol, sexual or social behavioral excesses.

k. Depression—a low level of functioning which manifests itself through feelings of sadness, despair, hopelessness, dejection, discouragement, self-condemnation, and/or disorders in eating and sleeping. Depression may develop during a lull in combat or as postcombat behavior.

NOTE

By knowing these definitions, the concerned soldier or supervisor can determine the severity of battle fatigue. You should advise your supervisor or unit commander about the suspected status of the battle-fatigued soldier. The responsible level of command can then take definite action.

21-5. Lethality and Its Effect on Battle Fatigue

Lethality refers to the accuracy and killing power of modern weapons. The high intensity and greater deadliness of modern weapons and weapons systems will increase the level of individual psychological stress. The battlefield environment may now include possible use of nuclear, biological, and/or chemical weapons. These weapons increase the number of soldiers killed or wounded in combat; this in turn creates fear which is a major cause in the increased rate of battle fatigue cases.

21-6. Principles of Battle Fatigue Treatment

There are three principles of treatment for battle fatigue—proximity, immediacy, and expectancy. When treated according to these principles, an estimated 80 to 90 percent of battle fatigue soldiers develop no long-term disability. In addition, the chances of later psychiatric problems (delayed or hidden reactions) are reduced.

a. Proximity—treatment as far forward as practicable increases the potential for full recovery. It also reduces the suggestion of serious disability and usually avoids the necessity of evacuation that would upset the soldier’s morale and disrupt his sense of group identity.

b. Immediacy—initial treatment (psychological first aid) is to be applied as soon as possible to limit later effects.

c. Expectancy—refers to the ideas that you should communicate to the battle-fatigued soldier:

- Instill the expectation of a rapid recovery after a brief rest. You should also avoid giving the impression that the soldier has an incurable mental illness.

- Reassure the soldier of the fact that he is expected to return to duty. He will realize that his skills are needed and that he is a part of the combat team. In this way, he is also reassured that battle fatigue is only temporary.

NOTE

The soldier should wear his uniform and be treated in a "non-hospital" environment. This includes being housed in tents rather than in a hospital-type ward with involvement in light duty and exercise. This environment suggests to him that he is taking only a brief therapeutic rest and will soon be ready for duty. The soldier should be encouraged to believe that *fatigue, not stress*, is the greatest factor involved.

21-7. Symptoms of Battle Fatigue

a. Common Reactions to Combat.

(1) There is a wide range of reactions to fear and anxiety that affect all soldiers to some degree. Within this variety of reactions, you will need to recognize those that are manageable and found in combat. You should also be able to recognize those soldiers with more severe (disruptive) stress reactions.

(2) Not all stress reactions can be recognized immediately; however, your observations of changes or modifications in behavior among personnel in your unit can identify the early stages of stress reactions. In many instances, you may have to rely on information from supervisors or from the soldier's close associates.

b. Manageable Reactions.

(1) Muscular tension—increases with exhaustion.

- Headaches.
- Inability to relax.
- Cramps.

(2) Shaking and tremors.

- Mild shaking—may appear when undergoing shelling or bombing. Appears and disappears rapidly and is a normal reaction to dangerous conditions.

- Marked or violent shaking—sometimes incapacitating; may also persist after the cause has ceased.

(3) Perspiration—it is normal to experience either mild or heavy sweating or sensation of chills under combat stress.

(4) Digestive and urinary systems reactions.

- Nausea and vomiting which may occur during or immediately after a fire fight, shelling, or intensive battle conditions.

- Loss of appetite.

- Acute abdominal pain which may occur during shelling.

- Urinary frequency, particularly at night, or urinary incontinence during actual battle.

- Inability to control bowel functions may occur under catastrophic combat stress.

(5) Circulatory and respiratory systems reactions.

- Heart palpitations.

- Elevated blood pressure and increased pulse rate are common reactions.

- Rapid heartbeat, a sense of pressure in the chest, and chest pains may be felt.

- Hyperventilation—may be identified by rapid respirations, shortness of breath, dizziness, and a choking sensation.

- Sensations of faintness or giddiness—may occur with physical fatigue and extreme stress, together with generalized muscular weakness and lack of energy.

(6) Sleep disturbances.

- Difficulty in falling asleep.

- Inability to sleep when the tactical situation permits or in the absence of disruptions due to the combat situation.

- Physical environment may not permit restful sleep (excessive heat, cold, insects, or lack of food or water).

- Nightmares.

- Terror dreams, battle dreams, and nightmares of other kinds may cause sleeping difficulty.

- Sleep disturbances in the form of dreams are part of the coping process. This process of “working through” combat experiences is a means of increasing the tolerance level to combat.

- Restless sleep. When a person is asleep, the sleep may not be restful or refreshing. The individual wakes up as tired as when he went to sleep.

- Excessive sleep. This can be a sign of extreme depression or possible drug abuse.

(7) Death anxiety.

- Fear of death, pain, and/or injury causes anxiety reactions. After a soldier has been in combat and has seen his fellow soldiers killed or wounded, he loses whatever feeling of invulnerability he may have had.

- The death of a buddy can lead to a serious loss of emotional support along with feelings of guilt. The soldier may feel blessed that he was not killed and he may experience guilt about having such feelings.

(8) Body arousal. In response to a threat, the brain sends out chemicals that arouse various body systems, making the body ready to fight or take flight.

- Hyperalertness. The general focusing on certain external stimuli that may signal danger. A hyperalert soldier is ready to immediately respond to danger. His senses are alert to danger and possible threats, such as the noise of a mortar being fired which can send him running for cover long before the shell lands in the vicinity.

- Startle reactions. These reactions are a part of an increased sensitivity to minor external stimuli known as the on-guard reaction. These reactions include leaping, jumping, cringing, jerking, or other forms of involuntary self-protective motor responses to sudden noises. This type of reaction may occur not only to noises but also to sudden movement or sudden light. A sound as simple as the crumpling of cellophane may cause someone to jump and/or become angry. The unexpected movement of a person or animal may result in inadvertent weapon firing.

(9) Irritability—ranges from angry looks or sharp words to acts of violence.

- Snappishness, verbal flareups, and tears are common. Irritability is manifested externally by over-reaction to normal, everyday comments or incidents, flareups with profanity, and tears in response to even relatively minor frustrations.

- Explosions of aggressive behavior. Sporadic and unpredictable explosions of aggressive behavior (violence) may occur with little or no provocation. The stimulus may be a noise, an accidental bumping, or a normal conversation.

(10) Short attention span. Individuals under stress may have a short attention span and find it difficult to concentrate. A short attention span can cause a soldier to have difficulty following orders. The soldier may hear, but fail to comprehend, what others are saying. He may also have difficulty following directions, aiding others, or performing unfamiliar tasks.

(11) Depression (numbing of normal responsiveness). Soldiers may respond to stress with protective defensive reactions against painful perceptions. Emotional dulling (or numbing) is a result. These reactions are easily observed changes in the individual's usual personality:

- Low energy level. This can result in decreased effectiveness on the job, decreased ability to think clearly, excessive sleeping or difficulty in falling asleep, and chronic tiredness. Such qualities as pride, shame, grief, and gratitude may no longer be of importance to the soldier.

- Social withdrawal. A soldier may be less talkative than usual or show limited response to jokes. He may be unable to enjoy relaxation and companionship, even when the tactical situation permits. Tears and/or crying may be noted.

- Change in outward appearance. In a depressed mood, very little body movement and an almost blank, expressionless (mask-like) face may be noted.

(12) Substance abuse. Some soldiers may use substances such as alcohol or other drugs as a means of escaping stress. The use of these substances in a combat area can make soldiers less capable of functioning on the job. The soldiers may be less able to adapt to the tremendous demands placed upon them during combat.

c. *Disruptive Reactions.*

(1) Soldiers with more severe (disruptive) stress reactions are those who:

- Cannot function on the job.
- Compromise their own safety and the safety of others.
- Exhibit panic running (rushing about without any self-control).

- Have visual and/or hearing problems (perceived by the individual), and partial paralysis. These physical symptoms enable the individual to escape or avoid a stressful situation. The paralysis is usually confined to one arm or leg. A prickling sensation, tics, or rigidity of the larger joints may occur.

- Utter incoherent language. A soldier may babble like a child, be unable to speak logically, and have a bewildered appearance.

- Have loss of appetite which results in the loss of 5 pounds per week or more.

- Suffer from persistent and severe abdominal pain.
- Have continuing inability to control bowel function after stress stimulus (combat) has ended.

21-8. Initial Treatment Procedures for Battle Fatigue

a. *Treat the Battle Fatigue Casualty.*

(1) Provide initial treatment as time and tactical situation permit. The initial treatment for battle fatigue should be based on the factors of proximity, immediacy, and expectancy (PIE).

(2) Provide a place for the soldier to rest. At least 4 hours rest should be provided in a comparatively secure area.

(3) Provide food, when available.

(4) Provide an opportunity for the individual to ventilate (put his strong feelings into words). An individual with battle fatigue needs to express pent-up thoughts and feelings. Problems seem more tangible and manageable once they have been put into words. Working with a group of two or more persons can help reverse the stress reactions by using the soldier's natural coping skills (strength) in a group environment. The individual should be allowed to express emotions without interruption. Tears, anger, intense fear, and worries are commonly expressed. Arguments or opposing positions should be avoided and the soldier should be able to express feelings that are usually considered to be "unacceptable."

b. *Evacuate the Soldier or Return Him to Duty.*

(1) Evacuate the soldier. Recognize *disruptive* battle fatigue reactions and recommend immediate evacuation if the tactical situation permits. Soldiers who have undergone 48 hours of treatment without resolution of symptoms should be evacuated for definitive psychiatric care. It may be necessary to use physical restraint on soldiers with disruptive battle fatigue reactions.

(2) Return the soldier to duty if he is able to function on the job. A soldier's unit is stronger when he is functioning on the job. Without the soldier, a greater burden is placed on those who remain in the unit. Returning him to his original unit (and to his original job) is the best mental health assistance that can be provided and is the "treatment of choice." To return to normal duty after severe stress, most soldiers need to perform familiar useful work and receive group support. The soldier's unit can provide such an environment. Despite anxieties and traumatic experiences, every soldier is expected to perform combat duties. Experience in past wars is clear—failure to return to duty can lead to permanent disability.

Section II. ALCOHOL AND DRUG ABUSE

21-9. General

a. Alcohol and drug abuse is an increasingly serious problem in the military services. It affects combat readiness, job performance, and the health of military personnel and their families. It also costs millions of dollars in lost time and productivity; more specifically, it affects the individual.

b. The reasons for alcohol and drug abuse are as varied as the individuals who use them. People apparently abuse these substances to change the way they feel. They may want to feel better and happier or escape from pain, stress, or frustration. Some may want to remember or to forget; others may want to be accepted or just be sociable. Other people abuse alcohol and/or drugs to escape boredom or out of curiosity. Peer pressure can also be a very strong motivating factor in their abuse.

c. People often feel better about themselves when they use alcohol or drugs, but these effects do not last. Alcohol and drugs never solve problems—they merely postpone them. People who abuse alcohol and drugs to solve one problem run the risk of continued usage, which creates new problems and makes old problems worse.

d. In your work environment, there may be situations in which alcohol or drug abuse is suspected. In such situations, it will be necessary to use your knowledge of the appropriate signs and symptoms to determine suspicion of alcohol or drug abuse and to report your findings.

e. This section will assist you in identifying a suspected alcohol or drug abuser. To accomplish this, it is necessary to be aware of the terminology associated with, as well as the signs and symptoms of, alcohol or drug abuse. In addition, it will be necessary to know the proper procedures and referral methods that are necessary when handling a patient who is a suspected abuser.

21-10. Terms Specific to Alcohol and Drug Abuse

a. *Drug or Substance Abuse.* Drug or substance abuse is the pathological use of a chemical substance (licit or illicit) which results in impairment of a person's social or occupational functioning for a duration of at least several months.

b. *Drug Dependence.* Drug dependence is the use of a drug to such an extent that there is an increased tolerance for the drug or stopping the use of the drug would result in withdrawal symptoms.

(1) Psychological dependence exists when a drug's effect becomes necessary for an individual's continued mental well-being. Withdrawal of the drug results in compulsive drug-seeking behavior.

(2) Physical dependence exists only if withdrawal symptoms occur when the drug use stops or if tolerance to the drug has developed.

NOTE

Withdrawal symptoms are physical (such as vomiting, muscle tremors) and not psychological.

c. *Tolerance.* Tolerance is a physical condition that develops from the continued use of certain drugs and which requires larger amounts of these drugs to produce the same effects.

21-11. Classification of Drugs

Drugs are classified as central nervous system (CNS) depressants, narcotics, stimulants, or hallucinogens.

NOTE

Drugs are classified by their intended use and dosage level. For example, Valium can be classified as a muscle relaxant, an antianxiety agent, and a psychotherapeutic agent. Phencyclidine (PCP), for example, is pharmacologically classified as a basal anesthetic, but at abuse-level dosage, it acts as a hallucinogen.

a. *CNS Depressants.*

- (1) Alcohol (ETOH).
- (2) Barbiturates (sedative/hypnotics).
 - Pentobarbital (Nembutal) (Yellows).
 - Secobarbital (Seconal) (Reds).
 - Combination of Amobarbital and Secobarbital (Rainbows).
- (3) Nonbarbiturates (sedatives/hypnotics).
 - Dalmane.
 - Chloral hydrate.
 - Methaqualone (Quaalude).
 - Paraldehyde.
 - Valium.
 - Librium.

b. *Narcotics (Analgesics).*

- Opium.
- Morphine.
- Heroin.

- Demerol.
- Methadone.

c. *Stimulants.*

- (1) Amphetamines.
 - Dexedrine.
 - Benzedrine.
 - Methedrine.
- (2) Cocaine.
- (3) Caffeine.
- (4) Nicotine.

d. *Hallucinogens (Psychedelics).*

- Marijuana, hashish tetrahydrocannabinol (THC).
- LSD (lysergic acid diethylamide).
- Psilocybin.
- Mescaline.
- Dimethyltryptamine (DMT), diethyltryptamine (DET), 2, 5-dimethoxy-4-methylamphetamine (DOM or STP), 3, 4 methylenedioxy-amphetamine (MDA)
- Phencyclidine (PCP).

21-12. Signs and Symptoms of Use and Abuse of Depressants, Narcotics, Stimulants, and Hallucinogens

You need to recognize the signs and symptoms of depressants, narcotics, stimulants, and hallucinogens. Early recognition and referral of an abuser of these substances could play an important role in rehabilitating him and possibly saving his life.

a. *Depressants.*

(1) Intoxication.

(a) Mental.

- Memory losses (blackouts).
- Decreased emotional control (such as inappropriate crying or laughing).

- Impaired judgment.
- Inability to speak coherently.

(b) Physical.

- Decreased muscular control (staggering, loss of reaction time).
- Breathing difficulty (respiratory depression).
- Nausea and vomiting.

CAUTION

These combined effects can lead to the individual inhaling his own vomitus and suffocating.

(2) Alcohol abuse.

(a) Liver disorders.

- Alcoholic (Laennec's) cirrhosis—chronic diffuse liver disease which can lead to serious metabolic problems and death. May also be seen as fatty cirrhosis or fatty liver when the liver breakdown is associated with extensive fatty infiltration.

- Alcoholic hepatitis—an acute inflammation of the liver which results in excess plasma bilirubin. The excess bilirubin causes yellowish skin and eyes (jaundice) and may result in death.

(b) Stomach disorders.

- Gastritis—an acute inflammation of the stomach lining which causes pain, nausea, vomiting, and loss of appetite (anorexia).

- Gastric ulcers—an erosion of the stomach wall by digestive juices which causes pain and bleeding and may lead to perforation, infection, and death.

(c) Circulatory disorders.

- Anemia—a red blood cell shortage which results in weakness and fatigue that is typically caused by iron or vitamin deficiency.

- Heart disease—weakening of the heart muscles leading to congestive heart failure.

(d) Nervous system disorders.

- Brain cell deterioration which leads to impairment of memory, judgment, balance; severe organic brain syndrome may be observed.

● Psychotic disorders (alcohol hallucinosis, toxic psychosis) which may be characterized by disorientation, confusion, hallucinations, and/or incoherent speech.

b. Drugs.

(1) Barbiturates/abuse. There are no known specific physical disorders commonly associated with barbiturate abuse.

(2) Narcotics.

(a) Drug intoxication.

● Rush (warm flushing of the skin and sensations in the lower abdomen described by addicts as similar to sexual orgasm).

- Euphoria.
- Drowsiness.
- Decreased anxiety.
- Decreased appetite.
- Decreased sexual drive.
- Decreased blood pressure.
- Decreased respiration.
- Constipation.
- Tolerance develops.
- Psychological dependence may develop.
- Physical dependence may develop.

(b) Abuse.

NOTE

Most disorders and diseases associated with narcotic abuse (hepatitis, venous collapse, poisonings, malnutrition) are the indirect result of the drug abuse and are caused by poor diet or lack of hygiene.

(c) Withdrawal symptoms.

- Tearing, runny nose, sweating.
- Yawning.

- Nausea and vomiting.
- Diarrhea.
- Muscle aches and abdominal cramps.
- Anxiety and irritability.
- "Goose-flesh".

(d) These symptoms usually begin 3 to 8 hours after the last dose of the drug, peak at 36 to 72 hours, and diminish within 5 to 10 days.

c. *Stimulants.*

(1) Intoxication.

- Euphoria.
- Increased self-confidence.
- Alertness and energy.
- Irritability.
- Talkative.
- Insomnia.
- Loss of appetite.
- Rapid pulse.
- Dry mouth.
- Dilated pupils.
- Shakiness.

(2) Problems caused by abuse.

- Weight loss.
- Exhaustion.
- Mental deterioration.
 - Impaired judgment.
 - Increased suspiciousness.
 - Increased aggressiveness.

- Indirect effects (due to poor diet, lack of hygiene, and self-injection with contaminated products).

- Skin ulcers.

- Abscesses (pockets of infection in organs, blood vessels, joints, and the brain caused by contaminated drugs and needles).

- Overdose (usually clears up within 10 days after last dose).

- Violent behavior.

- Toxic psychosis (paranoid ideation, hallucinations).

- Tolerance develops.

- Psychological dependence may develop.

(3) Drug withdrawal has the following features:

- Depression—may be severe or suicidal.

- Exhaustion.

- Muscle cramps.

d. Hallucinogens.

(1) Intoxication.

(a) *Mental symptoms.*

- Altered thinking and feeling states.

- Distorted perceptions.

- Time and space.

- Visual, auditory, and tactile (touch) sensations.

- Hallucinations.

- Impaired judgment.

- Increased suggestibility.

(b) *Physical symptoms.*

- Increased pulse rate

- Dilated pupils.

- Lack of coordination in extremities.

(2) Abuse of hallucinogens can cause the following symptoms:

- “Bad trips”—usually temporary adverse drug reactions such as severe panic, withdrawal, delusions, and hallucinations.
- “Flashbacks”—a spontaneous hallucinogenic experience without any drug intake that may occur weeks or months after the last drug use.
- Toxic psychosis—may be caused by the drug or by it being mixed in contaminants.
 - Paranoid ideation.
 - Hallucinations.
- Psychological dependence may develop (rare).
- Tolerance develops rapidly but disappears with drug withdrawal.
- No well defined withdrawal syndrome.

21-13. Psychosocial Signs/Symptoms of Alcohol/Drug Abusers

The following are additional psychosocial signs and symptoms of alcohol/drug abusers:

- a. General personality changes.
- b. Mood/behavioral changes—
 - Irritability.
 - Nervousness.
 - Agitation.
 - Argumentative attitude.
- c. Changes in work habits—
 - Lowered quality/quantity of output.
 - Inconsistent work pace (likely to change frequently without apparent reason).
 - Errors in judgment.
 - Lack of interest in work.

d. Frequent or increased—

- Tardiness to work.
- Absence from work area.
- Marital problems.
- Financial difficulties.
- Avoidance of family and friends.
- Deterioration of appearance, dress, and personal hygiene.
- Physical changes such as marked weight loss, exhaustion, and a lack of coordination.
- Frequent changes on or off the job.
- Slurred speech.
- Frequent skin problems (ulcerations, abscesses).
- Dilated or constricted pupils.

21-14. Procedures for Reporting and Referring of a Suspected Alcohol/Drug Abuser to a Physician

a. In a medical treatment facility (for example, ward, clinic, dispensary), the medical specialist will inform the patient's physician of suspected alcohol/drug abuse.

b. At unit level (for example, company, battalion), the medical specialist will—

(1) Annotate on the DD Form 689 (Individual Sick Slip) that the suspected abuser exhibits behavior other than normal.

(2) Refer the suspected abuser to a physician at the nearest medical treatment facility. Inform the physician directly of the information and observations regarding the patient.

NOTE

In the medical chain of command, only the physician can notify the unit commander of the suspected alcohol/drug abuser.

Section III. THE SUICIDAL PATIENT

21-15. General

a. Suicide is a major problem in our country. It is the tenth leading cause of death in the United States and the third leading cause of death for adolescents and adults under thirty. Additionally, the suicide rate for this group is increasing.

b. Seventy-five percent of potential suicides visit a medical facility within 6 months prior to their death. Timely awareness of pre-suicidal signs and symptoms can lead to correct intervention and prevention. For each documented suicide, a comparable number of persons die as a result of actions which likely were intended to be self-destructive but could not be verified. For example, such actions could be "accidental" overdoses of medication or taking needless chances while driving.

c. In wartime, the suicide rate among soldiers tends to decrease. Aggressive drives are channeled toward the enemy. However, some deaths due to inappropriate behavior during combat may, in reality, be suicides.

d. A soldier who is a potential suicide may be identified by the medical specialist, after which he will be referred to trained medical personnel for appropriate action. For each of the individuals who committed suicide, it is estimated that an additional 10 individuals attempted suicide but survived. On the basis of numbers alone, it is likely that you may be involved directly with persons who are potentially suicidal.

21-16. Definitions and Terms

a. Behavior Signs. Actions or behaviors that a person takes, such as spending more money than usual or increasing alcohol consumption. These signs may also give some indication of the person's thinking.

b. Crisis. The point at which customary problem-solving or decision-making methods are no longer adequate. At this turning point, a person may choose suicide as a way to solve the problem.

c. Depression. Refers to feelings (moods) of sadness, despair, and discouragement, and as such may be a normal state. Depression which may be disruptive to the soldier is commonly manifested in decreased thinking processes or purposeful physical activity, guilt, self-condemnation, hopelessness, and disorders of eating and sleeping.

d. Intervention. Treatment by health care personnel when there is some question of the individual's ability to cope with his own resources and requires assistance. This action is also known as "crisis intervention" when the individual shows signs of reaching a crisis point.

e. Stress. Any situation or action that places physical or psychological demands upon a person. Exhaustion refers to prolonged and unrelieved strain and tension generated in a person by situations encountered in life.

f. Stressors. Specific situations that may trigger stress in a person (for example, taking a test, playing a game of football, receiving or not receiving a promotion, a permanent change of station).

g. Suicide. The act of intentionally killing oneself.

h. Suicidal Attempt. The act of self-damage inflicted with self-destructive intention, however vague and ambiguous. Sometimes this intention has to be inferred from the person's behavior.

i. Verbal Signs. Spoken words or acts or interpersonal communication, such as telephone calls or an ordinary conversation. These signs may reveal the thoughts of a person.

21-17. Suicide Factors

a. A person who decides to commit suicide has become overwhelmed by problems he cannot face and solve. He feels powerless to find a solution to his intolerable situation and may think that no one really cares about him. He may be suspicious of the people who try to help him and suicide may seem to be the only way out.

b. Basically, it is not the patient's problems that make his life seem intolerable; it is the way he feels about these problems. For example, blindness may be a reason for one person to attempt suicide but a motivating factor for another person to become a great composer. Many factors influence a patient's decision to try to end his own life; loneliness seems to be a primary reason. The patient who does not identify himself with some group (such as a family, church, or community) is more susceptible to suicidal tendencies. The psychiatric patient who is also physically ill may resort to suicide, particularly if he is in pain, his prognosis is poor, he feels that he is a burden to others, or he is severely disfigured. Loss of a loved one accompanied by feelings of guilt and depression or inability to transfer affections to someone else may be an influencing factor in suicide. Loss of prestige or decline in social position may also be contributing factors.

c. A patient's psychiatric condition may cause him to attempt suicide. The patient who is recovering from an attack of depression may feel unable to cope with the stress and strain of living. He may be discouraged to the point of trying to take his own life. The patient who recognizes the symptoms of an oncoming attack of depression may feel he cannot go through the painful experience again. A patient may have delusions or hallucinations which threaten him or command him to kill himself. A confused, disoriented patient suffering from an organic mental disorder or from substance abuse is also likely to commit suicide. This is especially true at night when he tends to be the most confused.

d. It is also possible for a patient to have an unconscious motive which drives him to attempt suicide. For example, the patient who cannot direct his aggression against a person whom he hates may turn these feelings of hatred and aggression against himself. When he kills himself, he is symbolically killing the hated person. A patient may kill himself for spite or revenge. He may feel that by destroying himself he can make certain persons grieve and repent for real or imagined wrongs that they have done to him. Or, he may feel that only death is severe enough punishment for his own imagined wrongs. Not every patient who attempts suicide plans for the outcome to be self-destruction. He may see a suicidal attempt as the only way to get people to understand exactly how badly he feels and to do something for him. He intends for someone to rescue him in time to prevent death.

21-18. Planned and Unplanned Suicides

One patient may plan suicide for weeks or months; another one may act on impulse. The patient who plans his suicide schemes to obtain and hide necessary articles. He carefully works out every step in the plan. He may have two or more plans in the event one fails. The patient who attempts suicide impulsively may act in response to bizarre ideas or voices he hears. He attempts suicide when an opportunity arises. Such an opportunity may be presented by careless personnel who are not alert to hazards or who inadequately observe and supervise patients' activities.

21-19. Physical and Psychosocial Symptoms and Warning Signs

a. Physical Symptoms.

(1) Many of the physical symptoms of suicidal intent are due to depression. However, stress caused by traumatic personal injury, severe illness, or pain may trigger this depression and these symptoms.

(2) An individual who uses drugs or alcohol may also exhibit some of these physical symptoms.

b. Procedures and Steps.

(1) Observe the individual for physical symptoms of suicidal intentions. Physical symptoms of suicidal intentions are—

(a) Change in eating habits.

- Extreme weight gain.
- Extreme weight loss.

(b) Change in sleeping habits (must be more than a casual cycle of change).

- Inability to sleep.
- Excessive sleep.

(c) Change in normal energy level.

- Low energy level (chronic tiredness).
- Overactivity (agitation).
- Restlessness.
- Physical exhaustion.
- Change in mental response.
- Difficulty in decision making.
- Confused thinking.
- Short attention span.

(d) Complaints about physical problems. The potentially suicidal individual may come to you with a physical complaint. You need to be alert to possible emotional problems which may be signaled by surface physical complaints, such as—

- Chest, stomach, back.
- Head, extremities.
- Constipation.
- Decreased sexual desire or performance.

(e) Personal injury/accidental dismemberment (carelessness around field equipment may cause accidental loss of limbs).

(2) Observe individual for psychosocial symptoms of suicidal intentions.

NOTE

Psychosocial symptoms are nonphysical symptoms that refer to human emotions and to any change in the life pattern of an individual. Many of these symptoms are caused by stress due to a recent situation.

(a) An individual who abuses drugs or alcohol may exhibit some of these psychosocial symptoms. Observe the individual for—

- Depressed moods (feels low, sad, gloomy).
- Expresses low self-esteem.
- Is fearful and/or trembling.

(b) Changes in appearance can be indicative of a person's mood and deteriorating self-image.

- Self-neglect.
 - Personal hygiene.
 - Lack of concern for appearance.
- Body movements.
 - Sluggish—moves in “slow motion.”
 - Posture stooped and bent.
- Facial expression—blank or sad.

- Changes in work habits.
 - Lowered quality/quantity of work.
 - Inconsistent work pace, likely to change frequently without apparent reason.
 - Lack of interest in his work.
- Changes in usual patterns of behavior.
- Loss of interest in recreation or hobbies.
- Loss of interest in people.
 - Avoidance of family and friends.
 - Decreased sexual drive.
- Marital and family problems.
 - Separation/divorce.
 - Difficulties with spouse.
 - Child-rearing problems.
 - Loss of self-control.
 - Social isolation.
- Financial problems.
 - Debts.
 - Living within a restrictive budget.
- Interpersonal problems.
 - Lovers' quarrels.
 - Difficulty in accepting authority.
 - Homesickness.
 - Loss of supportive community or family ties.
 - Difficulty with people at work.

(3) Observe individual for signs of suicidal intentions.

(a) Warning signs.

- Statements of hopelessness/helplessness (for example, "I can't take it any longer.").

- Statements of loss of meaning in life (defeat, failure) (for example, "I never seem to do things right." "I never asked to be born.").

- Statements of an end to a personal relationship (for example, "My girlfriend ran off with someone else.').

- Questions about death and/or suicide.

(b) Direct verbal signs indicate recognition of a need for immediate intervention.

- Statements that the soldier intends to commit suicide must be taken seriously especially when physical or psychosocial symptoms are also noted.

- Statements that the soldier has a specific plan to commit suicide. This may include the time, date, and means to be used. Such a person is a greater risk because he is more likely to follow through with his expressed plan.

(c) Behavioral signs are nonverbal communication that indicate a need for outside assistance (intervention). You should be alert for a pattern of behavioral warning signs that indicates possible suicidal intentions, such as—

- Preparations for death (making a will; making funeral arrangements).

- Drastic change in possessions/finances (giving expensive gifts; giving away prized possessions).

- Putting his affairs in order.

- Extreme risk-taking behavior.

- Driving a car or motorcycle at an excessive rate of speed.

- Refusal to follow medical advice or take life-essential prescribed medication.

- Refusal to use safety equipment or follow safety rules.

- Increased alcohol use.

- Withdrawal from social relationships.

- History of suicide attempt(s).

- A person who has already attempted suicide once is statistically more likely to attempt suicide again.

o Information about an attempt to commit suicide may come from medical records, friends, verbal interaction with the individual, or other sources.

o Physical signs (such as scars on the wrist) may be noted.

o Deliberate attempts to commit suicide by means of a gun; jumping from a high place; overdose of medication (most common); wrist slashing; or hanging.

(4) Intervene and take immediate action when the soldier shows sign of suicidal intentions.

(a) Communicate with the soldier.

● Tell him that you care and hope that solutions to his problems can be found.

● Convey a willingness to listen and try to understand him.

(b) Assessment of suicidal risk is not easily accomplished. If there is any suspicion of possible suicidal intentions, you should take the individual to specially trained personnel, such as a Behavioral Science Specialist (91G) or a Neuropsychiatric Specialist (91F).

(c) If an individual confronts you with an immediate means of suicide (such as medication, a knife, or a gun) intervention may be necessary—but *extreme caution* should be exercised so as not to endanger yourself or others.

(5) Notify supervisor of possible need for immediate intervention. **DO NOT LEAVE THE INDIVIDUAL ALONE.**

● If physical and psychosocial symptoms are observed and indirect verbal and behavioral warning signs are noted, immediately request evacuation, or contact the hospital for an emergency appointment.

● Accompany the individual to the referral agency or to the consulting professional for assessment, or turn the individual over to the evacuation personnel.

NOTE

An individual who is a potential suicide should be referred to medical personnel for appropriate action. The survival ratio for attempted suicides as opposed to aborted suicide attempts is 10:1.

Section IV. DEATH AND DYING/POSTMORTEM CARE

21-20. General

a. All of us must eventually die, since death follows living; it is a natural process. In our society, birth is a cause for celebration, but death normally is a dreaded and unspeakable issue.

b. Death reminds us of our human weaknesses in spite of all our modern advances. We may want to delay death, but we cannot escape it. Death is the last and loneliest experience for all of us. Therefore, it is difficult to help others face it.

c. As a medical specialist, you are frequently faced with the reality of another person's death; this is often painful and stressful. It is only natural for fears of death and personal concerns to intensify whenever you are in contact with someone who is dying. To effectively work with the dying patient, you must recognize and understand the individual's needs, feelings of tension, and discomfort.

21-21. Characteristic Elements and Health Care Action

Denial, anger, bargaining, depression, and acceptance are the five basic stages of dying. The patient may or may not follow these stages in a fixed pattern. He may go back and forth, or he may never get beyond a certain stage, such as denial.

a. Denial.

(1) *Patient reaction.* The patient may—

- Seek additional opinions from other physicians.
- Request that certain tests be repeated or flatly refuse the results and say that these results belong to another person.
- Express denial verbally (for example, "No, not me!" "It can't be true!" or "There must be some mistake!").

(2) *Health care provided by the medical specialist.*

- Listen—but do not contradict the patient.
- Reinforce prescribed medications/diet routine indicated by the physician.
- Respect the patient's wish to deny impending death.

b. Anger.

(1) *Patient reaction.* Patient may—

- Attack you or other members of the staff on a personal or professional level and may tend to be very critical of the care received (even that received from his family).

- Feel angry inwardly/outwardly, making you the object of his anger.

NOTE

You should be aware of the negative feelings of the patient and not take these angry feelings personally.

- Replace the denial stage with questions and feelings of rage, resentment, and envy. This is characterized by "Why me?" "Why is this happening to me?" "I didn't do anything to deserve this punishment."

(2) Health care provided by the medical specialist.

- Be patient and tolerant.
- Let the patient know that you accept and understand his feelings.
- Permit the patient to express his anger and any other feelings that he may have.

NOTE

Do not react with anger or avoidance. Just allow the patient to express his anger. Do not attempt to answer all of his questions.

c. *Bargaining.*

(1) *Patient reaction* (this stage may be short, irregular, and possibly not even apparent). Patient may—

- Attempt to postpone death.
- Replace the previous question of "Why me?" to "Yes, it is me, but....," or "Why now?"

NOTE

The medical specialist may hear the patient say that he would do anything if he could live a little longer ("I promise I will...").

(2) *Health care provided by the medical specialist.*

- Listen and be available to the patient for assistance.
- Know that when the patient bargains it is helpful to him.
- Do all you can to keep the patient comfortable.

NOTE

Remember that this stage may not always be perceptible since the patient may bargain privately.

d. *Depression.*

(1) *Patient reaction.* The patient may—

- Be anxious to put his affairs in order.
- Feel a sense of great loss.
- Have apparent feelings of sadness and guilt over not having provided for his family.

(2) *Health care provided by the medical specialist.* Allow the patient to mourn, cry, or talk about his losses.

e. *Acceptance.*

(1) *Patient reaction.* The patient—

- Has prepared to die.
- Is now at peace.
- Is tired.

(2) *Health care provided by the medical specialist.*

- Respect the patient's need for quiet and offer reassurance by being there when possible.

- Although you may feel sad or uncomfortable about the dying patient, you must learn to control your feelings so that they will not affect the patient.

- Do not whisper, as this may upset the patient if he can hear you talking but cannot understand what is being said.

NOTE

The last sense believed to leave the body is that of hearing. The patient often understands what is being said even though he may not be able to answer verbally.

21-22. Hospital Death

When a patient dies in a hospital, the physician is responsible for examining the body, declaring the patient legally dead, and notifying the next of kin. You, as the medical specialist, are expected to perform postmortem (after death) care. When providing this care, you must conduct yourself so as to preserve the dignity and respect of the body.

21-23. Procedures for Providing Postmortem Care in a Hospital Environment

a. Obtain Special Instructions. Ask your supervisor for any special instructions in caring for the deceased.

b. Perform Initial Postmortem Care.

(1) Place screens around the bed, draw the curtains around the bed, or close the door to provide privacy for the body.

(2) Close the patient's eyelids by applying light pressure downward with your fingertips.

(3) Adjust the bed to a flat position. Use one pillow under the head of the body to prevent discoloration of the face. (Facial discoloration results when blood is pooled in the head region.)

(4) Inspect the body for soiling. Wash soiled areas. You should wear gloves during cleaning. Change the hospital gown if it is soiled.

(5) Align the body in the natural anatomical position: supine (on the back) position, arms at the side, and palms turned toward the thighs. Poor alignment will result in deformities due to rigor mortis (profound stiffening of the limbs and body as a result of death).

(6) Replace the bed linens, if soiled, and straighten top bedding.

(7) Clean and replace dentures according to local SOP. Comb the hair. If necessary, close or support the patient's mouth by using rolled ABD pads to prevent the jaw from sagging. (Most local policies discourage the use of chin straps since discoloration of the face may occur.)

(8) Clean the deceased patient's area and remove all unnecessary equipment.

NOTE

If the family wishes to view the body, it is accomplished at this point. Be supportive and compassionate with the relatives and friends who visit the body.

(9) Perform a patient care handwash.

c. Perform Final Postmortem Care. Final postmortem care on the ward begins after the patient's family has viewed the body. After it has been viewed, prepare it for transfer to the morgue.

(1) Obtain the necessary equipment.

(a) Gather commercially or locally prepared death pack or equipment according to local SOP. Generally, a death pack includes:

- Mortuary sheet.
- Absorbent cotton or some type of underpads.

- Gauze or bandage rolls (ties).
- Safety pins.
- Instruction sheets for completing required forms.
- Required forms:
 - Death tags (3).
 - Hospital Report of Death.
 - Authorization for Autopsy.
 - Disposition of Body.
 - Local forms.
 - State death certificate information worksheet.
 - Form for organ donor designation.

(b) Gather additional equipment.

- Clean sheets.
- Diapers.
- Basin of warm water and soap.
- Clean gloves.
- Paper bag.
- Acetone/benzine (optional) per local SOP.
- Stretcher.
- Litter straps (2).
- Laundry hamper/bag.
- Comb.
- Washcloth, towel.

(2) Provide privacy. Continue to provide privacy for the body by placing screens around the bed, drawing the curtains around the bed, or closing the door.

(3) Put on clean gloves.

- (4) Remove clothing, bedding, and personal belongings.
 - Top bedding except for a drape sheet.
 - Pajamas/gown.
 - Soiled dressings (discard with contaminated waste).
 - Jewelry and personal items (get-well cards, eyeglasses, religious articles).

NOTE

Throughout final care, note and remove any remaining jewelry and personal articles. Notify your supervisor regarding any such items found. Never leave valuables unattended.

- (5) Tie off or clamp all drains and tubes.
 - Do not remove any drains or tubes from the body unless specifically directed by your supervisor.
 - If there is to be an autopsy, tubes are generally left in the body.
 - Prevent unnecessary exposure of the body.
- (6) Wash the body and remove adhesive markings from the skin (if applicable). Remove adhesive markings with solvent as prescribed in the local SOP.
- (7) Apply new dressings over wounds, using a minimum amount of tape and dressings.

NOTE

New dressings reduce the possibility of odor caused by microorganisms.

- (8) Pad the anal and urinary areas with adult diapers or by folding a drawsheet and pinning it in place. The perineal pad is placed to absorb feces and urine which are expelled as the sphincters relax; also, this pad is used to absorb drainage from the vagina.
- (9) Remove gloves if you are wearing them.
- (10) Secure ankles and wrists.
 - Pad ankles with an ABD pad and secure them with a gauze roller bandage or according to the local SOP.
 - Pad wrists with an ABD pad, cross the right wrist over the left wrist, and secure them with a roller gauze bandage or according to the local SOP.

- (11) Attach two body tags to the body.
- Obtain completed and signed death tags from your supervisor.
 - Tie a death (body) tag to the right great toe.
 - Tie a death (body) tag to the left wrist.

NOTE

Do not tie the tag so tight as to cause pressure. Pressure causes severe skin discoloration.

- (12) Wrap the body.
- With assistance, roll the body to the side of the bed.
 - Place one clean sheet diagonally under the body.

NOTE

Method of wrapping the body may differ between hospitals. In some hospitals the body is placed in a zippered bag; in others, a specially prepared shroud is used. Follow your local SOP.

- Roll the body back to the center of the sheet.
 - Fold the upper corner of the sheet loosely over the head and face. Fold the lower corner over the feet.
 - Fold the right and left corners of the sheet over the body.
 - Fasten the sheet corners with a safety pin.
- (13) Attach signed exterior body tag to the outside of the sheet.
- (14) Transfer the body to a cart or stretcher.
- With assistance, lift the wrapped body onto the cart/stretcher.
 - Secure the body to the cart/stretcher with straps at the chest and just above the knees. Avoid using pressure (this will cause discoloration of the skin).
 - Cover the wrapped body with a clean sheet.

- (15) Transport the body to the morgue.

- Obtain all records and forms which are to accompany the body to the morgue from your supervisor.

- Notify the morgue that the body is being transferred.

NOTE

A ward staff member must accompany the body when it is being transported to the morgue. Service elevators and seldom used corridors should be used for transporting. Avoid transferring the body in the view of visitors and patients; they may become depressed, develop anxious feelings, or become frightened.

- Assist the morgue attendant with the transfer of the body from the cart/stretchers to the morgue equipment.
- Give the morgue attendant all the available records.
- Return the stretcher to the ward and clean it according to the local SOP.

(16) Perform a patient care handwash.

d. Clean the Deceased Patient's Area. Give the patient's area a terminal cleaning. Follow the principles of medical asepsis and local SOP.

e. Report the Procedure. Report completion of postmortem care to your supervisor.

GLOSSARY

Section I. ACRONYMS AND ABBREVIATIONS

ABC's	airway, breathing, and circulation surveys
ABO	Blood typing system
ABG	arterial blood gases
AC	hydrocyanic acid (blood agent)
ACTH	adrenocorticotrophic hormone
ADH	antidiuretic hormone
ADAPCP	Alcohol and Drug Abuse Prevention and Control Program
AF	Air Force
AMEDD	Army Medical Department
AMOSIST	Automated Military Outpatient System
ANC	Army Nurse Corps
AR	Army Regulation
ARNG	Army National Guard
ATTN	attention
AWOL	absent without leave
BMR	Basal metabolic rate
B/P or BP	blood pressure
BSA	body surface area
Bx	biopsy
C	centigrade
Cau	Caucasian
CBC	complete blood count
cc	cubic centimeter
CDC	Center for Disease Control
CHF	congestive heart failure
CK	cyanogen choloride (blood agent)

cm	centimeter
cmm	cubic millimeter
CNS	central nervous system
CO ₂	carbon dioxide
COLD	chronic obstructive lung disease
CONUS	Continental United States
COPD	Chronic obstructive pulmonary disease
CPR	cardiopulmonary resuscitation
CRO	carded for record only
CSF	cerebrospinal fluid
CX	phosgene oxime (blister agent)
CT	connective tissue
D5NS	5 percent dextrose in normal saline
D5W	dextrose 5 percent in water
DA	Department of the Army
DET	diethyltryptamine
DIFF	differential count
DMT	dimethyltryptamine
DOA	death on arrival
DOD	Department of Defense
DOM or STP	2, 5-dimethoxy-4-methylamphetamine
ECG or EKG	electrocardiogram
EEG	electroencephalogram
est	estimate
ETOH	alcohol

F	Fahrenheit
FBS	fasting blood sugar
FCT	fibrous connective tissue
FDCA	Food, Drug, and Cosmetic Act
FM	field manual
FMC	Field Medical Card
FMP	family member prefix
Fr	French (denotes size of catheter or tube)
FTCA	Federal Torts Claims Act
g	grain
ga	gauge
GA	Tabin (nerve agent)
gal	gallon
GB	Sarin (nerve agent)
GB series	gallbladder series
GD	Soman (nerve agent)
GI	gastrointestinal
GI series	gastrointestinal series
Gm	gram
HCT	hematocrit
HD	mustard (blister agent)
Hgb	hemoglobin
HQDA	Headquarters, Department of the Army
hr	hour
HREC	health record

ICP	intracranial pressure
ID	identification
IM	intramuscular
in	inch
IPDS	Individual Patient Data System
ITP	inpatient treatment record
ITRCS	inpatient treatment record cover sheet
IUD	intrauterine device
IV	intravenous
IVP	intravenous pyelogram
JPA	job performance aid
K	potassium
Kg	kilogram
L	Lewisite (blister agent)
Lab.	laboratory
lbs.	pounds
lig.	ligament
LP	lumbar puncture
LSD	lysergic acid diethylamide
LUL	left upper lobe (of lung)
LUQ	left upper quadrant
Lymphs	lymphocytes
m	meter
MAST	military anti-shock trousers
M.D.	medical doctor

MDA	methylenedioxyamphetamine
MEDCEN	Medical Center
MEDDAC	Medical Department Activity
mg	milligram
MG/L	milligram per liter
MI	myocardial infarction
MILPO	Military Personnel Office
ml	milliliter
mm	millimeter
MM/Hg or mm hg	milliliters of mercury
MOS	military occupational speciality
mph	miles per hour
MPRS	military personnel records jacket
MTF	medical treatment facility
NATO	North Atlantic Treaty Organization
NATO STANAG	North Atlantic Treaty Organization Standardization Agreement
NAVL	nerves, arteries, veins, and lymphatics
NAVMED	Navy medical
NBC	nuclear, biological, or chemical
NCT	nerve condition time
NF	National Formulary
Neg	Negroid
NGR	National Guard Regulation
NH	nitrogen mustard (blister agent)
NO.	number
NS	normal saline

O ₂	oxygen
OB	obstetrical
O.D.	oculus dexter—right eye
OF	optional form
O.S.	oculus sinister—left eye
OT	old tuberculin
OTH	other
OTR	outpatient treatment record
O.U.	oculus uterque—both eyes
oz	ounce
Pap	Papanicolaou
PCP	phencyclidine
PDR	Physician's Desk Reference
PE	physical examination
PERLA	pupils equal and react to light
PHS	Public Health Service
PID	pelvic inflammatory disease
ppm	parts-per-million
PREOP	preoperative
psi	pounds per square inch
rad	radiation absorbed dose
RBC/rbc	red blood cell
RTC	return to clinic
RES	reticuloendothelial system
Rh	Rhesus factor
RLL	right lower lobe (of lung)

RLQ	right lower quadrant
RML	right middle lobe (of lung)
Rpt	report
RTD	return to duty
RUL	right upper lobe (of lung)
RUQ	right upper quadrant
SF	Standard Form
SG	Surgeon General
SIDPER	Standard Installation Division Personnel System
SL	sublingual, under the tongue
SOAP	subjective (signs and symptoms), objective (observations), assessment, and plan (a format for progress notes)
SOP	standing operating procedure
Sp Gr	specific gravity
SQ	subcutaneous
SSE	soap suds enema
SSI	special skill identifier
STAT/stat	Statim (immediately)
SSN	social security number
TB MED	technical bulletin, medical
THC	tetrahydrocannabinol
TKO/Tko	to keep open
TMC	troop medical clinic
TPR	temperature, pulse, and respiration
TOE	Table of Organization and Equipment

unk	unknown
USAR	United States Army Reserves
USC	United States Code
USP	United States Pharmacopeia
VD	venereal disease
VX	unnamed nerve agent
WBC/wbc	white blood cell
WIA	wounded in action
yrs	years

Section II. DEFINITIONS AND TERMS

Addiction	A marked psychological and physiological dependence on a substance such as alcohol or a drug, which has gone beyond voluntary control.
Anaphylaxes	An unusual or exaggerated allergic reaction to foreign proteins or other substances.
Aneurysm	A permanent blood-filled dilation of a blood vessel resulting from disease or injury of the blood vessel wall.
Antibody	A protein substance in the body that develops the body's immunity to a specific pathogen.
Battle casualty	Any casualty incurred in action. "In action" characterizes the casualty status as having been the direct result of hostile action; sustained in combat or relating thereto; or sustained going to or from a combat mission provided that the occurrence was directly related to hostile action. Included are persons

	killed or wounded mistakenly or accidentally by friendly fire directed at a hostile force or what is thought to be a hostile force.
Body resistance	The body's ability to oppose an infection, but does not imply immunity.
Brackish water	Highly mineralized, salty-tasting water that contains dissolved solids in excess of 500 parts per million.
Carded for record only (CRO)	A term which applies to those special cases for which a medical record is required to be prepared in the same manner as for an admission, although no admission has actually occurred.
Cartilage	A tough, white connective tissue that covers the joint surfaces of bone.
Chlorination	Disinfection of water by the addition of a chlorine compound such as calcium hypochlorite.
Chlorine demand	The amount of chlorine which reacts with and is consumed by organic material, bacteria, and other substances in water.
Chlorine dosage	The amount of chlorine added to a given quantity of water.
Chlorine residual	The amount of chlorine remaining after the demand has been satisfied. Dosage minus demand equals residual.
Clinic	A medical treatment facility intended for and staffed and equipped to provide emergency treatment and ambulatory services. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for those cases which cannot be cared for on an outpatient status, but which do not require hospitalization.
Contagion	Communication of a disease from one person to another by direct or indirect contact.

Contaminate	To soil, pollute, or taint; any contact with unsterile or radioactive materials or surfaces.
Contaminated water	Water that is unfit for human consumption even though it may be palatable. Contaminated water contains disease-producing organisms and/or excessive amount of mineral and organic matter, toxic chemicals, or radioactive materials.
Convalescent leave	Convalescent leave is an authorized leave status granted to active duty uniformed service members while under medical or dental care which is a part of the care and treatment prescribed for his recuperation (convalescence).
Cravat	Triangular bandage that is used for fashioning a sling or swathe.
Crepitation	Crackling; the sensation felt or heard over the fracture site when broken bone ends rub together.
Definitive medical treatment	That specialized care of the sick and wounded given by highly trained medical personnel, ordinarily the physician.
Delivery	The procedure of delivering a liveborn infant or stillbirth (and placenta) by manual, instrumental, or surgical means.
Diaphysis	The main, central shaft of a long bone.
Died of wounds received in action (DOW)	The term used to describe all battle casualties who die of wounds or other injuries received in action after having reached any medical treatment facility.
Disease	A condition in which physical and/or mental health is impaired as the result of some process other than that caused by accident, violence, or poisoning.
Disinfect	To reduce the numbers of micro-organisms, usually by germicides or boiling water.

Disinfection	Treatment with chemicals or by boiling to destroy disease-producing organisms.
Dislocation	Displacement of a bone from its joint.
Dispensary health clinic	See Clinic.
Ecchymosis	The purplish discoloration of skin caused by the passage of blood from ruptured blood vessels into subcutaneous tissue; bruise.
Emergency medical care	The early care given by trained medical personnel.
Epigastrium	The upper and middle regions of the abdomen with the sternal angle.
Epiphysis	The end portions of a long bone.
Ethanol	Ethyl alcohol; the type of alcohol present in alcoholic beverages.
Existed prior to service (EPTS)	A term added to a medical diagnosis to signify that there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.
Fomites	Any objects (books, clothing) that can harbor and transmit infectious organisms.
Forceps	An instrument used to grasp, pull, and extract objects; there are many types, varying according to their usage.
Fracture	A break in the continuity of bone.
Closed fracture	One in which the skin overlying the site is intact.
Comminuted fracture	One in which the bone is broken into more than two pieces.
Greenstick fracture	An incomplete fracture commonly found in children.
Impacted fracture	One in which the broken ends of the bone are jammed together.

Oblique fracture	One in which the fracture line crosses the bone at an oblique angle or in a slanting direction.
Open fracture	One in which there is an open wound over the fracture site.
Spiral fracture	One in which the fracture line twists around and through the bone.
Transverse fracture	One in which the fracture line is straight across at a right angle to the long axis of the bone.
Geriatric	A term that refers to the elderly.
Germicide	A chemical substance that destroys bacteria.
Habituation	A situation in which a patient produces a tolerance to a drug and becomes psychologically dependent on the drug.
Hallucinogen	An agent or drug that has the capacity to stimulate hallucinations.
Hexachlorophene	A bactericidal or bacteriostatic substance contained in certain soaps.
Hives	A vascular reaction of the skin marked by the transient appearance of smooth, slightly elevated patches (wheals) which are redder or paler than the surrounding skin and often attended by severe itching. Hives are usually caused by reactions to foods, drugs, or emotional stress.
Hospital	A health treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, preventive medicine services, and has the supporting facilities to perform its assigned mission and functions.
Hygiene	The individual employment of practices that will keep one healthy. These practices include proper diet and body cleanliness.

Hyperglycemia	An abnormally increased concentration of sugar in the blood.
Hyperthermia	An abnormally increased body temperature; hyperpyrexia.
Hypoglycemia	An abnormally diminished concentration of sugar in the blood.
Hypothermia	An abnormally reduced body temperature.
Infection	A condition in which the body is invaded by a pathogenic agent that under favorable conditions multiplies and produces injurious effects.
Immobilization	Prevention of the movement or use of an injured structure.
Inpatient	An inpatient is an individual, other than a transient patient, who is admitted (placed under treatment or observation) to a bed in an MTF which has authorized or designated beds for inpatient medical or dental care.
Inpatient treatment record (ITR)	The medical record used at an MTF for recording inpatient medical or dental care. It is begun on admission to the MTF and completed at the end of hospitalization. This record applies to all beneficiaries.
Inpatient Treatment Record Cover Sheet (ITRCS)	A medical and administrative summary of each continuous, uninterrupted period of inpatient treatment and is prepared for each case an ITR is needed. (For CRO cases, the ITRCS may be the entire ITR.) ITRCS are also essential documents for HREC and OTR. In addition, they serve as source documents for statistical information of major military and medical interest.
Insulin	A hormone secreted by the islets of Langerhans in the pancreas; essential for proper metabolism of blood sugar and maintenance of proper blood sugar levels.

Medullary canal	The hollow central portion of the bone; contains the bone marrow.
Methanol	Methyl alcohol; wood alcohol; poisonous if ingested, causing extreme metabolic acidosis and blindness.
Military personnel	Any person on active duty or active duty for training in the US Armed Forces, including cadets of the Armed Forces academies.
Narcotic	A drug used to depress the central nervous system, thereby relieving pain and producing sleep.
Nonbattle injury	An injury which is not the direct result of action by or against an organized enemy or other battle casualties which may be so classified by departmental regulation.
Outpatient	An individual receiving health service for an actual or potential disease or injury that does not require admission to a medical facility for inpatient care.
Outpatient treatment record (OTR)	A medical record documenting outpatient treatment of the nonactive-duty beneficiary.
Palatable water	Water that is pleasing to the taste but which may be unsafe (contaminated).
Parts per million (ppm)	A unit of measurement for expressing the number of units of a substance in one million units of water by weight.
Pathogen	Microorganism capable of producing disease.
Pathogenic	Capable of producing disease.
Periosteum	The outermost layer of bone.
Peritoneum	The membrane that lines the abdominal cavity.
Physical dependence	See addiction.
Polydipsia	A condition of excessive thirst.
Polyphagia	A condition of excessive hunger.

Polyuria	A condition of excessive urination.
Position of function	Maintenance of the normal position of a joint or limb.
Potable water	Water that is safe for human consumption. Potable water is free from disease-causing organisms and excessive amounts of mineral and organic matter, toxic chemicals, and radioactive materials. The water may not be pleasing to the taste.
Prime beneficiary	An individual who because of his status is eligible for medical care in accordance with AR 40-3.
Primary cause of admission	The immediate condition which necessitated the patient's admission to the MTF.
Psychological dependence	<i>See</i> addiction.
Purulent (suppurative)	Forming or containing pus.
Pus	A liquid product of inflammation made up of tissue debris, bacteria, leukocytes, and serum.
Quadrant	The term used to designate one of the four quarters of the abdomen.
Quarters patient	An active duty uniformed service member receiving medical or dental treatment for a disease or injury that is of such a nature that inpatient care is not required, but he cannot perform his duties. The quarters patient is treated on an outpatient basis, remains in his quarters between treatment, and normally returns to duty within a 72-hour period.
Reduction	Restoration of the ends of a fractured bone to their normal anatomical position.
Retroperitoneum	The area behind the peritoneum.

Sanitation	The effective use of measures that create and maintain healthful environmental conditions. Among these measures are the safeguarding of food and water and the control of disease-carrying insects and animals.
Self-aid, first-aid, and buddy aid	Emergency medical procedures carried out by anyone, whether trained or untrained in medicine.
Sling	A bandage that is suspended from the neck to support an injured arm or hand.
Splint	Any device used to immobilize a fracture or dislocation.
Spore	A reproductive cell produced by plants and some protozoans that has a thick wall enabling it to withstand unfavorable environments.
Sprain	Injury in which ligaments are partially torn.
Strain	Soft-tissue injuries or muscle spasms around a joint.
Swathe	A bandage used in conjunction with a sling that is wrapped around the body to secure the injured arm.
Tendon	A fibrous cord or band that connects a muscle to a bone.
Tolerance	A diminished susceptibility to the effects of a drug or toxic substance acquired after continued ingestion of it.
Toxin	A poisonous substance of plant or animal origin.
Traction	Method used to realign fractures and dislocations by application of a pulling force to the site.
Transient patient	A patient en route from one medical treatment facility to another medical treatment facility.

Transmission	Transfer from one individual to another, such as a disease or hereditary characteristic.
Urticaria	Hives.
Vasoconstriction	The narrowing of the diameter of a blood vessel.
Vasodilation	The widening of the diameter of a blood vessel.
Venomous poison	A poison derived from reptiles or insect bites.
Virulence	Relative power or strength of a pathogen to produce disease.
Water treatment	Removal of undesirable elements in water through coagulation, sedimentation, filtration, and/or disinfection.
Withdrawal	A symptom produced by abstinence from a drug to which one is addicted.