APPENDIX F
COMBAT STRESS CONTROL AND MENTAL HEALTH SERVICES IN LOW INTENSITY CONFLICT

F-1. Introduction

a. Low intensity conflicts may have brief periods of extreme violence or prolonged periods of siege. These conditions can produce classic "disaster shock" or battle fatigue. The operations may even involve NBC threats which add the psychological stressors of MOPP. However, the more usual stressors are those of frustration, resentment, loneliness, and boredom. These stressors come from being in unfamiliar lands far from home; among unfamiliar and perhaps hostile people; and with rules of engagement that limit even self-defense. There is also often ready access to drugs and alcohol. Enemy tactics attempt to magnify these stressors and to provoke misconduct stress reactions. These reactions can sap the Army's and the national will. The HN may have rudimentary concepts and resources for psychiatric care, mental health promotion, and social services delivery. These limitations could be the focus of enhancing the HN government stability, but only if cultural differences are fully taken into account.

b. Combat stress control and mental health personnel have provided commanders with effective service in many previous LICs. They have and will continue to provide mental health support to all categories of LIC. For example, mental health personnel—

- Provided support to soldiers in Vietnam.
- Were members of numerous peacekeeping task forces assigned to the Middle East.
- Organized stress management teams which provided assistance to soldiers, civilians, and family members exposed to terrorist actions, or natural or man-made disasters.

c. The following tables briefly describe a number of approaches, principles, and techniques used in the prevention and treatment of battle fatigue and stress reactions associated with LIC. Mental health personnel have the capability to assist commanders in implementing these strategies.

F-2. Low Intensity Conflict Issues and Mental Health Recommendations and Actions

Tables F-1 through F-4 provide mental health recommendations for the four operational categories of LIC.

Table F-1. Mental Health Recommendations for Low Intensity Conflict Issues—Support for Insurgency and Counterinsurgency

Support for Insurgency and Counterinsurgency Issues	Recommendations and Actions
—Cultural conflicts. —Language barriers. —Unfamiliar terrain. —Climate differences.	Develop effective sponsorship program.
	emphasis on understanding local culture, values, practices, and pressures affecting HN people.
—Reaction to hit-and-run tactics.	—Provide time for soldiers to debrief on their experience.
—Support troops live in comparative luxury to combat soldiers.	—Do not overbuild support base.
—Soldier and family unclear concerning Army's mission in the area.	—Using a variety of media, continue to explain unit mission.
—Continuing the fight with slow progress.	—Educate soldiers on realities of the mission.
—Dealing with extended periods of no activity.	—Provide relevant training during lulls.
—Inability to decisively engage the opposition.	—After completion of operations, conduct debriefings. Discuss what occurred, individual reactions, and feelings, strengths, and weaknesses of the operation. Link accomplishments with unit goals.
—Host nation support roles may be indirect, such as for training only and not combat.	—Leadership clearly communicates soldiers' roles, rules of engagement, and reason or rationale for rules to HN leadership and own forces.

Combatting Terrorism Issues	Recommendations and Actions
—Shock of the event. —Sudden violation of familiar, safe setting. —Loss of control. —Hostile feelings (repressed or expressed). —Feelings of dependence. —Observation of atrocities. —Feelings of impotence. —Regressive behaviors. —Relocation and isolation responses. —Positive identification with terrorists. —Sense of being a victim. —Negative feelings about own country.	—A multidisciplinary stress management team assists victims, family members, and staff involved in terrorist or hostage situations. A variety of individual and group techniques are used to help return persons to normal functioning and to reduce the impact of posttraumatic stress disorders.

Table F-3. Mental Health Recommendations for Low Intensity Conflict Issues—Peacekeeping Operations

Peacekeeping Issues	Recommendations and Actions
—Isolation. —Boredom. —Cultural alienation. —Repetitious or routine duties. —Overtime, sense of nonsignificant mission. —As mission continues over the years, increase in fixed facilities versus austerity for soldier on the front line. —Lack of understanding of cultural and political issues of other nations making up peacekeeping force.	—Develop and maintain unit cohesion initiatives. —Job rotation, job cross training. —Trips and recreation in host nation. —Job expansion, job rotation. —Continuous emphasis on importance of the mission. Be clear on US role. —Push mobile support packages forward or reduce glamor of fixed facilities in the rear. —Establish effective orientation and cultural exchange programs.

Table F-4. Mental Health Recommendations for Low Intensity Conflict Issues—Peacetime Contingency Operations

Peacetime Contingency Operations	Recommendations and Actions
—Sudden unit deployment.	—Develop program for soldiers and families to receive timely information.
—Unplanned catastrophe or incident (no textbook solution).	—Develop cohesive unit with strong individual and group problem-solving skills.
—Small unit activity has great political interest.	—Develop strategy to keep soldiers focused on mission.
—Cultural and language differences.	—Implement a sponsorship program for soldiers and families with HN input.
—Lack of freedom of movement.	—Develop support system to fight isolation.
—Post traumatic stress of helpers [illegible] or mission.	—Implement debriefing process [illegible] missions. Develop unit goals based on mission priorities.
—Feelings of isolation and frustration.	—Ensure social support system and activities to support cohesion.
—Lack of typical military base operations.	—Develop mobile system to support operations.
—Excessive security (develop bunker mentality).	—Ensure security is in balance with the threat.

F-3. Mental Health Activities in Support of Low Intensity Conflict Operations

a. Support for Insurgency and Counter-insurgency. Mental health support is designed to meet specific missions. As the level of combat intensity and the duration of the mission increase, combat stress related problems also increase. It is expected that battle fatigue rates will not normally exceed 1:10 per wounded in action. Organic mental health staff use the combat stress principles of proximity, immediacy, and expectancy in treating battle fatigued soldiers. However, the main problem will be misconduct combat stress reactions. These misconduct combat stress reactions can include substance abuse, commission of atrocities, and acts of undiscipline. Misconduct combat stress reactions may seriously interfere with the LIC mission unless prevented. It is expected that soldiers will suffer from adjustment reactions endemic psychiatric disorders, and drug and alcohol abuse.

b. Combatting Terrorism. Stress management teams are an integral part of the military's approach to helping personnel involved in a terrorist situation. The team's mission is to support the rapid return to duty and to preclude post-traumatic stress disorders in captives and those persons closely associated with a terrorist activity. This team is a multidisciplinary group and should be on call to rapidly deploy to a selected site. Experiences with the bombing of the Beirut United States Marine Corps force, Transworld Airlines hyjacking, the Achille Lauro release, andother incidences have demonstrated the requirement for stress management teams. The treatment principles and approaches parallel those used in the treatment of battle fatigue.

c. Peacekeeping Missions. Selected mental health staff should accompany US peacekeeping task forces. Historically, these task forces require reinforced organic logistics and HSS. Mental health staff have been used effectively to support a variety of peacekeeping missions. Mental health officers can assist commanders in completing predeployment unit effectiveness surveys, provide training and consultation related to stress management and unit cohesion, and complete mental health screenings and evaluations. During peacekeeping operations, the focus is on mental health assessment and consultation.

d. Peacetime Contingencies. Mental health support is designed to meet the unique needs of the situation. Mental health personnel have a history of providing assistance during NEO and a variety of disaster relief situations. Support is provided to assist soldiers and their families or in some cases the civilian population to minimize the effects of sudden separation or loss of loved ones. Mental health expertise is most useful in reducing support or emergency assistance personnel stress during times of continuous operations. Crisis intervention and short-term treatment approaches are used.

F-4. Basic Mental Health Approaches During Low Intensity Conflict Operations

a. Unit Assessments. These are provided during predeployment or reconstitution.

b. Command Consultations. Consultations are available at all echelons.

c. Training. General program education, life-coping skills, recognition of stressors, and stress symptoms are appropriate topics.

d. After Action Debriefing. Debriefings are conducted in support of combat or special operations, terrorist incidents, or other significant actions.

e. Treatment. Soldiers and families are treated for problems associated with LIC.

f. Evaluations. Mental health evaluations to screen soldiers with maladaptive behaviors are provided.

g. Alcohol and Drug Abuse Prevention and Control Program. Staff expertise and support for the implementation of this program is provided.

F-5. Mental Health Task Organization

Mental health professionals are organic to combat divisions. Commanders can task organize tables of distribution and allowances (TDAs) mental health staff to support LIC contingencies or activate psychiatric (OM) teams. In the mid 1990s, the Army will field combat stress control detachments and companies. These units are part of the Medical Force 2000 TOE organizations. Personnel will be organized and trained to provide mental health support across the spectrum of combat.