

KEY AREA #8

HEALTH, SAFETY, AND DRUG & ALCOHOL ABUSE

- 1. Commanders are responsible for the health and safety of their soldiers.* The use of illegal drugs has long been recognized as intolerable in a military setting. More recently, the Army has recognized that the abuse of alcohol also presents unacceptable health and safety risks—as well as being a personal tragedy for the soldiers and family members involved.
2. Health, safety, and substance abuse: these can be separate categories, but often are related. Commanders recognize that health and safety are both readiness and ethical issues; that soldiers who are ill or hurt will not be assets to the unit in time of war, and that there is little or no excuse for the existence of unsafe practices which may potentially kill or maim soldiers. This area provides information concerning drug and alcohol abuse, healthy lifestyles, and stress reduction. A parallel focus is for soldiers to identify safety concerns they encounter in their normal duties.
3. This area most particularly relates to Quality Individual Leadership, Family Concerns, and Ethical Development.

Historical example and case study:

COMBAT STRESS CONTROL: A FORCE MULTIPLIER

Stress can be as debilitating as any physical injury and can detract from a soldier's overall fitness, health, and performance. Combat related stress was first identified among Army troops during the Civil War. During that conflict, otherwise healthy soldiers were perceived as suffering from a syndrome known as "irritable heart," whose symptoms included shortness of breath, palpitations, fatigue, headache, and disturbed sleep. Another Civil War stress syndrome was a severe form of homesickness that medical practitioners of the day called "nostalgia." This condition was characteristically accompanied by extreme apathy, loss of appetite, diarrhea, and obsessive thoughts of home.

Many of the same symptoms observed among soldiers during the Civil War appeared again during World War I. Army doctors called a complex of symptoms that included headaches, dizziness, confusion, lack of concentration, forgetfulness, and nightmares as “soldier’s heart” or “effort syndrome.” The symptoms appeared to be exacerbated by exertion and exhaustion from lack of sleep in the trenches. The onset of the symptoms sometimes was associated with burial duties. In addition to this syndrome, Army physicians also identified an acute illness attributed to combat stress, which they called “shell shock” or “trench neurosis.” Typical manifestations of this stress reaction included breakdown in battle, dazed or detached behavior, exaggerated startle response, and severe anxiety. Army doctors at first evacuated soldiers with acute stress symptoms to England for observation and treatment. During the war the Army learned that soldiers showing signs of acute stress could be more rapidly rehabilitated if they were cared for near the front. Soldiers so treated were more likely to return to combat duty than those evacuated out of the theater.

The Army’s manner of dealing with wartime psychological stress during World War I became the model for the identification and treatment of such cases in later conflicts. Acute combat stress reactions, known during World War II and the Korean War as battle fatigue, combat exhaustion, or operational fatigue, had become better understood since World War I as having a psychological or psychoneurosis basis. During World War II and the Korean War, soldiers with acute combat stress, as shown during World War I, were more likely to return to duty if they were treated quickly and near their units and their condition addressed as a normal response to extreme stress rather than as an abnormal condition. The most prominent stress-related illness related to the Vietnam War was post-traumatic stress disorder, which more often refers to long-term consequences of extreme psychological stress rather than to an immediate acute combat stress reaction.

In the Persian Gulf War, the quick intervention of mental health specialists of the 528th Medical Detachment (Psychiatric) reduced the number of soldiers needing evacuation for psychiatric reasons by at least fifty percent. Many of the stress problems encountered by this unit were “situational adjustment disorders” that stemmed from family separation, isolation, and overwork rather than from battle fatigue. More recently, the Army’s brisk operating tempo has multiplied opportunities for the occurrence of stressful situations. Soldiers on peacekeeping, humanitarian, and disaster relief missions or experiencing the pressures of downsizing and modernizing have shown themselves to be as susceptible to stress as combatants. Combat stress control units in the active and reserve components of the Army have served with Army forces in Bosnia, Somalia, and Haiti.

Since World War I the Army has viewed the control of combat stress as a force multiplier, enabling the service to retain soldiers whose skills can be used productively or to prevent an individual's stress from overwhelming a unit. The management of stress, whether in a combat or garrison environment, is regarded today as an important element of readiness. Like drug or alcohol abuse, which may indicate stress, acute stress poses health and safety concerns. Left untreated, the corrosive effects of stress can destroy a soldier's life, endanger the lives of his colleagues, and ravage family ties.

This area is directly supported by the following suggested lesson plans contained in this publication:

The Drink
Cold & Hot Weather Injuries
HIV and "Safe Sex" Practices
Alcohol and Drug Abuse