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Combat Stress in Chechnya: "The Equal Opportunity Disorder"

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Introduction

Russia's conflict with Chechnya, a republic in the southwestern part of the Russian Federation, lasted from Dec 94 to Aug 96. Like the war in Afghanistan in the 1980s, the Chechen conflict produced severe cases of combat stress and psychological trauma. Unlike the war in Afghanistan, where most of the fighting was conducted in valleys or in the mountains, the fighting in Chechnya was conducted in cities or at close range in the countryside. As one Russian officer noted about the latter conflict:

The majority of analysts have arrived at the opinion that the course and outcome of modern war in large part will depend on the psychological condition of servicemen, their ability to endure an ever-increasing (psychological) load, overcome fear in battle, and preserve their will to win.¹

These recent wars reinvigorated Russia's military medical service to look for new ways to prevent or limit psychological trauma in servicemen, and to find new methods to rehabilitate those affected. For the U.S. Armed Forces, which hasn't suffered combat stress casualties on such a scale since the war in Vietnam, the lessons learned by Russia's medical services offer a smorgasbord of options and treatments that should be examined closely for their relevance and potential applicability.

In addition, as was the U.S. experience in Vietnam, Russian society to some extent has become a victim of the fighting. The proper means to rehabilitate combat stress victims are currently under study, but most treatments are coming too late. Unable to acclimate to social conditions and feeling unappreciated for their sacrifices, some Chechen veterans are even turning to violent or organized crime to make a living, a consequence of the fighting that will plague Russian society for years to come.

Russian Forces in Chechnya: The Psychological Environment

One of the key lessons of the war in Chechnya for the study of military operations other than war (MOOTW) is that the psychological climate of small-scale operations may be more complicated and stressful than large scale operations such as Desert Storm. Correspondingly, there may be a much larger role for mental health professionals to play, at or near the front. War always invokes fear in man. But the psychological climate for Russian forces in Chechnya was exacerbated by specific conditions. For example, the Russian armed forces, over the preceding 3 years leading up to the conflict, had been poorly trained. Worse, the intervention into Chechnya was poorly planned and initiated under horrible weather conditions. The fighting pitted poorly trained Russian forces fighting primarily in cities where combat stress is significantly higher than in the countryside

against guerillas who knew the city layouts like the back of their hands. Many of the local noncombatants resented the Russians presence as well. The situation was ideal for producing combat stress related disorders.

Only 3 years earlier, many of the Chechen guerillas had been part of the Soviet armed forces. Therefore, most of them spoke Russian fluently and had an excellent knowledge of Russian tactics and military culture (staffing procedures, logistics, etc). Russian combatants realized that the guerillas could predict their every move, listen in on their communications, and easily deceive them. This impacted negatively on the psychological condition of the Russian leaders and conscripts. Acts of subversion and terrorism also kept Russian forces on their guard and in a high state of readiness and anxiety. These factors made Russian forces extremely tentative in their activities since Chechen forces appeared able to predict their every move. This, in turn, allowed rumors to "become facts" much more easily. While the Chechen force had a specific perspective and goal - the survival of its race - the Russian force was less certain in December of 1994 just why it was fighting.

This environment persuaded the Russian force to look at every male (old or young) and even females as potential enemies. Was it the old man (need to check his arms for powder burns), the young child (look under his coat for a grenade), or the nongovernmental organization worker (is he a Chechen posing as a Red Cross worker simply to get inside Russian defenses)? Or was it the good-looking female with an accent (a Lithuanian sniper), or the Russian officer (a Ukrainian mercenary working for the Chechens and dressed in a Russian officer's uniform)? Such continuous uncertainty allowed the Chechens to exert intense psychological pressure on the Russian force. The Chechens manipulated this fact to their benefit whenever possible. In addition, much of the fighting in Chechnya was hand to hand or at close range in "rebel" territory. Mutilations or torture were commonplace against Russian prisoners, further increasing stress and battle fatigue.

The Chechens also used several psychological operation campaigns that not only intimidated Russian servicemen but provoked certain anti-Russian responses from the population. One of these campaigns was run against the Russian Air Force. For example, the Chechens tried to **intimidate** pilots. They exploited the Russian Air Forces' inefficient bombing practices (due to poor weather and a lack of training, the air force often hit civilian targets) by issuing demands from the populace for reprisals and revenge (which could also be a potential problem if North Atlantic Treaty Organization (NATO) forces enter Kosovo under other than peacekeeping/peace enforcement reasons). One Moscow report noted that pilots who had ejected were executed by Dudayev's forces on the spot when captured. Reports also noted that in a Chechen raid on a hospital in the Russian town of Buddenovsk in the summer of 1995, hospitalized Russian pilots (none of whom had fought in Chechnya) were shot on the spot by the rebel group led by Shamil Basayev.

In another instance, Basayev, interviewed nearly 7 months into the war, indicated that he or his compatriots possessed bacteriological weapons, 5-liter bottles of red mercury, and Stingers, the latter passed on to him "by a fellow Chechen." Whether Basayev possessed these weapons or not has not been verified, but there was enough circumstantial evidence (pictures in a newspaper of them lying on a blanket, and a photo of two Stingers being held by a masked man) to make the claim worthy of concern to Russian pilots (Americans can clearly recall the psychological terror posed by the "potential use" of chemical weapons by Sadaam Hussein during the Gulf War). Stingers had inflicted severe psychological and physical damage to Russian pilots in Afghanistan (see discussion below), and now pilots were led to believe they had to confront them again. In addition, a string of Russian ground attack fighters (three, in all) blew up in mid-air when pulling a certain number of Gs, and the rumor circulated that these fighters had been sabotaged by Chechens. As a result for a long time there was great reluctance among pilots to perform certain air maneuvers.

Chechens also intimidated Russian pilots by warning that they knew which pilots were bombing them, their addresses, and the names of their family members, and warned the pilots that they could not protect themselves or their families all the time. Officers' families, whether ground troops or pilots, received threatening phone calls warning the family to tell the father not to fight or bomb Chechens, or face the consequences. Obviously, these actions were all designed to intimidate pilots to stop flying or shoot poorly. Interestingly, the NATO pilots currently flying missions in Kosovo, even those shot down have not been named.

Another type of psychological operation was **provocation**. A classic use of this technique involved the Chechen exploitation of Russian aircraft hovering or flying over villages. When this happened, Chechen rebels in the village would open fire on the plane if they had air defense assets, hoping not only to hit the plane but to draw return fire. Since return fire from the aircraft would usually miss the weapon system (a point target), no harm was done to the guerilla force but it was not uncommon for a house or road to be destroyed. This incurred the wrath of the local villagers, and the militants used this anger to recruit additional local fighters. Provocation became a recruiting technique and caused stress for the Russian soldier on the ground because everyone hated him even more. As a result, soldiers were constantly looking behind them.

Deception was also used heavily in Chechnya. The Chechens took control of some radio nets associated with the direction of artillery or air force firepower on several occasions, and directed Russian air strikes on friendly forces. According to one British analyst:

To further compound communication problems, it was found that virtually all radio frequencies and nets were being monitored by the Chechens ... because requests for close air support (CAS) missions included details of troop concentrations, weapons, and enemy positions, it was often the case that the targets would disappear before the mission was on task, or the Chechens would engage the Russian positions with artillery or mortar fire ... there were even reports of Chechens taking control of CAS missions and redirecting aircraft onto Russian positions. As the conflict wore on, many unit commanders were unwilling to indicate the position of friendly forces or even to accept CAS missions in their areas of operation.²

Persuasion, the old game of loud speakers and leaflets, was also used. Dudayev's special services carried out propaganda activities to urge home guards to engage in sabotage, and to persuade inhabitants that Russia's military actions, and the conflict in general, had a religious bias aimed against Muslims and Islam. If Allah was on their side, what did they have to fear? For the Russian soldier, this implied that people were driven by some religious fervor or extremism and increased the psychological pressure on them due to their exaggerated image of the enemy as driven religious fanatics.

Sergei Stepashin, a former Prime Minister of Russia, but the head of Russian counterintelligence at the time of the fighting, believed that a difficult task for Russian mass media in the future would be to change the psychological stereotype that Dudayev's ultra nationalist propaganda drummed into the consciousness of ordinary Chechens, particularly rural inhabitants. Russian activities, however, did just as much to reinforce this tendency. Chechen difficulties were highlighted against the backdrop of Russia's air power brutality. It was not until much later that word circulated about Chechen brutalities. As a result, morale among Russian pilots and servicemen plummeted as they fought a war no one, in their opinion, appreciated or understood. And with that depression came more combat stress injuries.

What is Combat Stress?

Combat stress is the result of internal and external stressors. It most often relates to stress that a soldier experiences while actually performing a combat or combat related mission. Combat stressors do not come from enemy actions alone. Many stressors are generated from the soldiers own unit leaders, and mission demands. In MOOTW environments, stress may result from rules of engagement that are different than in a traditional combat zone, the proximity of the combatants to one another, or the severity of the fighting, among other issues. If the stressors continue for an extended period, an individual's adaptive resources become overwhelmed.

One of the primary (and obvious) factors leading to combat stress is a soldier's fear of dying. This can be curbed somewhat by proper preparatory training, good unit morale, proper leadership, and high state of an Army's equipment quality and readiness. It is also dependent on the proximity of medical assets and personnel to properly diagnose and treat battle stress. The absence of these factors allows tension to increase without any precautionary pressure releases. Soldiers can simply be overwhelmed by feelings of helplessness and rage. As

casualties mount and if performance does not meet expectations, a unit will experience more combat stress casualties. In Chechnya, soldiers used in the initial assaults were poorly trained, lacked unit cohesion (some soldiers did not know the last name of others in the same tank), and confronted guerrillas fighting for the survival of their nation (while many Russian conscripts had no idea why they were fighting!).³

Combat produces two types of behavior, one positive or adaptive, the other dysfunctional. Both may cause a soldier to become a combat stress casualty either in the short-term (during or immediately after a battle) or long-term, after the fighting has stopped and the soldier is either out of the combat zone or even out of the armed forces. Some elements that help form adaptive behavior are unit cohesion, a sense of mission, vigilance, loyalty, and acts of heroism. However, overexposure to conditions can stress even a good soldier, and the individual may end up committing criminal or other acts of misconduct. Elements leading to dysfunctional behavior are criminal acts, which include mutilation of enemy soldiers, looting, alcohol abuse, riding sick call, desertion, and killing noncombatants; and battle fatigue, the latter characterized by hyper alertness, fear, impaired performance of duty, apathy, and other factors. All of these behaviors, either adaptive or dysfunctional, can lead to Post-Traumatic Stress Disorder (PTSD), which produces intrusive flashbacks, guilt, sleep disorders, social isolation, exaggerated startle responses, substance abuse, or various forms of misconduct. A formal definition of PTSD is:

The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. The full symptom picture must be present for more than 1 month and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.⁴

PTSD is an equal opportunity affliction, capable of affecting the newest private or the commanding general. Treated immediately and in close proximity to the front the expectancy is that soldiers experiencing PTSD could return to their units in 3 days. The severity of combat stress seems to depend on whether the soldier endured an intense combat period (resulting in a high incidence of significant psychiatric disorders); a moderate stress environment (somatic complaints or fatigue cases); or intermittent stress (behavioral disorders).

An Initial Evaluation of Stress-Related Injuries in Chechnya

The first visible indicator of the traumatic nature of the attack on the psyche of Russian servicemen as a result of combat activity in Chechnya was an article in *Military Medical Journal*, a mere 4 months after the start of serious fighting. In his article, "Psycho-Physiological Support of Combat Activities of Military Personnel," V.S. Novikov, professor and Major General in the medical service, gave a scathing account of the neurological disorders he was observing in Chechnya.⁵

To Novikov, psycho-physiological support includes an assessment and then prognosis of the combat readiness of troops based on their physiological condition; and includes psycho-physiological selection and psycho-physiological monitoring. Selection is based on screening troops and selecting those still capable of performing combat activities. Monitoring includes researching psycho-physiological conditions; discovering functional and pathological disorders; assessing a unit's combat readiness; correcting and rehabilitating combatants; and forecasting possible consequences of combat stress to combatants.⁶

Novikov screened 1,312 troops in his survey. He found that 28% were healthy and the other 72% had some type of psychological disorder symptoms, such as insomnia, lack of motivation, high anxiety, neuro-emotional stress,

tiredness, and hypochondriacal fixation (when a soldier is primarily concerned about cardiovascular functioning. Frequently, this is expressed as concerns about heart attacks, difficulty in breathing, and may be diagnosed as a panic attack). It was reported that 46% of the sample exhibited asthenic depression, a weak, apathetic or retarded motor state; and the other 26% exhibited psychotic reactions such as high anxiety or aggressiveness, a deterioration of moral values or interpersonal relations, excitement or depression (psychotic disorders are those with marked stressors diagnosed by DSM-IV typically when there is evidence of delusions, hallucinations, disorganized speech, grossly disorganized behavior, or catatonic behavior). About 40% of those screened demonstrated a lack of neuro-psychological stability that included depletion of cardiorespirator system reserves and a deterioration in psychological self-regulation and communications capability. The longer a soldier was stationed in the war zone, as expected, the more radical the change in his neuro-psychological condition. Novikov termed this condition Post-Traumatic Stress Syndrome (PTSD, that is, Novikov used the English abbreviation (!) in the Russian original). The percentage of troops with combat stress disorders was higher than in Afghanistan, he added, which implied that combat in cities produces more combat stress symptoms than some other types of conflict, and consequently, is a category of combat that should be closely monitored.⁷

The research also revealed that some 32% experienced extreme stress while preparing for combat. These soldiers were taught active and passive muscular relaxation, and others received psychological therapy or even pharmacological treatment (to treat insomnia or stress). As expected, the peak of psycho-physiological stress occurred during times of real danger, as first emotions, then exhaustion, and finally, personality disorders emerged. After their removal from combat troops asthenic (that is depressed, retarded motor skills, or loss of interest to the extent of self-preservation or actions in response to orders) symptoms decreased while their psychotic disorders increased. This offered a trend toward the formation of sociopathic/psychopathic inclinations, including increased impulsiveness and unreasonable focusing on minor problems.⁸ Individuals focused intently on self-interests and lacked the capacity to care about others in the physical, moral, or emotional sense, with a marked disregard for standard social values.

In conclusion, Novikov noted that the psycho-physiological support of combat activity should include a determination of the psychological characteristics of individuals, and a determination as to which group of combat activity (support troops or fighting troops) an individual should belong. It should also include assessments prior to, during, and after combat by a specialized psycho-physiological group. To correct psycho-physiological problems, collective suggestive influences and pharmacological treatments are the most effective. There should be five specialists at Army level - two psycho-physiologists, and one each psycho-pharmacologist, psychiatrist, and medical psychologist. This group can assess and provide help to 200-250 people per day, in Novikov's opinion. Finally, a recommendation was made to provide psycho-physiological support to units in support of combat activities. These specialists could be trained at the Military Medical Academy by establishing a special psycho-physiological department. This latter recommendation offers evidence of the seriousness of the psychological injuries that were sustained in Chechnya, and the medical staffs inability to cope with them at the time.⁹

Post-War PTSD and Care

The analysis indicates, and the *Military Medical Journal* substantiates, that the primary lessons learned by the medical service in Chechnya were to pay special attention to psycho-preventative measures to reduce combat stress, preclude or reduce psychological injuries, and thereby preserve or raise the combat capability of the force.¹⁰ The Military Medical Academy may be at the forefront of these efforts. Another area of concern, highlighted by the military press, was the rehabilitation of soldiers released from service and still suffering psychological trauma after their return to society.

An entire series of articles was devoted to the condition and fate of these young men who were attempting to return to civilian life. The articles indicated that the young Russian soldiers who fought in Chechnya, similar to

America's youth after Vietnam, suffered from PTSD and found it difficult to adapt. The measures adopted by the Russian military to treat PTSD are offered here for consideration.

Apparently, this problem did not receive much attention for a number of years, perhaps because the Soviet military did not fight a prolonged war after WWII until Afghanistan. For example, one article noted that not until the 1980s did the Soviet Union's medical personnel begin to look at the psychological consequences of combat stress. At first, the focus was on manic depression, epilepsy, mental debilitation, and schizophrenia. Later, other lesser reactions were examined. In general, Soviet psychologists believed that psychological afflictions appeared to be temporary due to their adaptive nature, that is, they appeared to be afflictions that responded to treatment. Soviet psychologists also believed in the power of "internal energy" to help heal a victim. But if too much "negative energy" slipped past a person's defensive barriers, the energy could manifest itself later in unmotivated aggression, sleep disruption, the use of alcohol or narcotics, or the degradation of a person's vital signs. Without timely attention, this could result in psychological derangement and require more than a psychologist to help the victim, the author noted.¹¹

The author also underscored the importance of having a victim of combat stress recall both what he remembers and, with a psychologist's help, what lies in his subconscious. If this process is repeated a sufficient number of times, then a person's internal energy will help neutralize the trauma and bring the body back to some state of equilibrium. To make the psychological help effective, six principles were recommended: the victim must realize he needs help and must work with and trust the psychologist completely to achieve some satisfactory result; assistance must be offered immediately, even during pauses in combat; the assistance must be offered near the field of battle; the structure of daily military activity of the individual and the composition of the unit must be preserved; information-educational work must be oriented toward the recognition of the high value of the missions completed; and the amount of time spent on psychological help to an individual must be limited. Some psychological ailments or afflictions can be handled in hours, but others must be sent on to evacuation points, and their care may take several days. If this does not work, then the patient is sent on to division medical points for up to 2 weeks.¹²

These afflictions affected both ground soldiers and pilots. Experience in Afghanistan demonstrated that within 5-12 hours after a combat mission, some pilots suffered several types of psychological disorientation. They could experience one or a combination of the following symptoms: a rise in body temperature, serious headaches, weakness and indisposition, shivering, back, neck and extremity pain, or dry mouths. Vision decreased temporarily in some and others went into a stupor. Psychological assistance helped alleviate these symptoms within 36-48 hours, and allowed afflicted pilots to return to their military duties in 3-5 days.¹³

For others, however, it was only when war ended that their psychological afflictions became known. From March 97 to March 98, which was 7 to 19 months after the end of fighting in Chechnya, estimates were that 10,000 Russian soldiers needed psychological help. Rehabilitation points, centers for psychological consultation, and rooms for psychological relief were established on three levels: in military units; in military sanitariums or rest homes; and in government and nongovernment regional rehabilitation establishments. These centers already helped return over 20,000 former soldiers to work.¹⁴

A second article of interest for the discussion of PTSD in Chechnya, "Life after Military Service," was devoted to the psychological adaptation of participants of wars to modern living conditions. Written by military psychologist Aleksander Kucher, the article noted that nearly 35,000 soldiers and their families (the latter often forgotten by many military specialists) had received psychological counseling since 1996. Many suffered from PTSD, characterized by increased aggressiveness and emotional instability. This affliction resulted from recollections of comrades who died, and manifested itself in nightmares and insomnia. Similar symptoms were even found in the parents of soldiers if the latter did not return from the war.¹⁵

Kucher also attacked some of the other works published in Russia about psychological problems caused by combat in Chechnya, noting that they were neither objective nor correct. He was particularly upset that some

authors labeled soldiers as murderers, rapists, marauders, sex perverts, and abnormal people who should not be hired until they became "normal." Kucher felt these authors divided people into two groups: those who enjoy taking risks and killing, having overcome their fears; and those who, when killing, find comfort in drugs, alcohol, and perverted sex. One such article he attacked asked "Is it possible to restore the humanity of such a person?"¹⁶

Kucher objected strongly to this classification, noting that such authors have completely ignored the group of soldiers who returned in near normal psychological shape. These latter soldiers fulfilled their duty to the Motherland while risking their lives, yet still maintained a degree of emotional stability. Some found after returning home that they had no money, no place to live, were forgotten by their friends and the government and simply asked "why"? Sometimes, the criminal world is successful in recruiting these unappreciated kids, Kucher added. This happens most often if they are given no attention, no respect, or no recognition by society. Kucher believes that a government law is needed not only to offer these people respect, but to rehabilitate them. He is most worried that an attitude is forming toward Chechen war veterans that is void of understanding and far from friendly.¹⁷

Some Russian Recommendations/Conclusions

There are many indicators that the Russian military is trying to cope with this problem. New methods beyond the old fashioned "100 grams of vodka" given in World War II to increase a soldier's bravery (or reduce his rational understanding of fear) are in various stages of progress. One new development is a medical "psychological first aid tent". Here, medical personnel experimented with the creation of a "club" that mixes a video salon and a classical music center. The purpose is to offer a musical and soft scene treatment to soothe the injured psyche of the soldiers. Psychologists recommended showing on video screens burning logs in a fireplace, a view of the ocean, or a mountain scene. In an adjoining tent they developed a mini-hall featuring the music of Vivaldi, Schubert, and Chopin. In a corner, personnel positioned a white screen on which they showed landscapes, flowers, and waterfalls - yet other methods of "psychological correction".¹⁸

Psychologist Viktor Razduev noted that in future wars Russia would expect, at a minimum, that 20% of the participants would return home with some type of post war psychological syndrome. A specialist from the Ministry of Internal Affairs (a Russian ministry responsible for civil order and quelling ethnic conflict in the country, and a direct participant in the Chechen conflict) noted that after 1 month, up to 60% of its soldiers serving in "hot spots" had a change in their psyche in one form or another. He recommended forming "collectives" of specialists (psychologists, psychiatrists, psycho-pharmacologists, etc) in mobile teams for future wars to treat those suffering such afflictions. He, and others, recognized that if you can get to a person in hours, or no later than 2-3 days after suffering psychological trauma, you could weaken or even prevent PTSD's onset. Another important finding was that even in peacetime or in pre-combat conditions, psychological help (training, conditioning, etc) should be rendered as well.¹⁹

In conclusion, Chechnya was clearly a war infested with a special psychological flavor for Russian combatants because of the special circumstances of the conflict (fighting their own citizens under the toughest of circumstances, that is, combat in cities using a poorly trained and informed force vulnerable to intimidation, persuasion, deception, and provocation). The emotional environment was high risk. The combat stress casualties sustained by the Russians were predictable, based on the experiences of armies fighting in World War II, Korea, Vietnam, Israel, the Falklands, and Somalia.

The fighting in Chechnya possessed many of elements that should give pause to any military planner: a civilian population that did not welcome foreigners, an unpopular and poorly supported war with an open-ended mission, a lack of predictability, and a mobile enemy force that seemed to know everything about your armed force. These circumstances reinforced the need to have a clear military agenda, proper training, effective command relationships, and the national will to pursue the fight when forces are deployed.

The rehabilitation of troops suffering psychological injuries after this conflict will take a sustained effort by the Russian medical service, especially since a recent lack of experience caused many mistakes to be made. Soldiers who were treated inadequately at the front are at increased risk to be chronic patients in the medical system. Attempts at using drugs or rest tents with classical music and peaceful scenes is only a partial answer for many soldiers. The basic principles of keeping the soldier near his unit, and keeping the unit in contact with the soldier with the expectation he will return to the unit is crucial during the early stages of treatment. Many of these principles were violated in the early fighting, when the duration and intensity of the conflict was unknown, and it will be more difficult to rehabilitate these soldiers.

Another crucial area for the Russian medical service today is the identification and treatment of those soldiers who are classified as PTSD patients. The PTSD does not always appear immediately after a conflict, taking as long as months, or even years to appear. This will certainly add additional stress to the lives of many veterans.

The experiences of the Russians in Afghanistan and Chechnya (and the U.S. experiences in Vietnam and Desert Storm) offer analysts an excellent chance to study the impact of modern warfare on the psyche of the soldier. A joint conference between the Russians and the U.S. would prove beneficial and interesting to discuss the effects of combat stress in varying environments, from desert and jungle to cities. Both nations have extensive experience and expertise in the way warfare is conducted, and casualties counted and treated. Studying the symptoms and treatments of soldiers involved in fighting on different types of terrain is an important peacetime function of the medical corps. The growth of the science and art of mental health evaluations for soldiers participating in MOOTW environments is a specialty worthy of closer study.

References

1. Igor Panarin. "Psychological Security of Servicemen." *Orienteer*. 1995; No. 8, p 48.
2. Marshall-Hasdell DJ. "Russian Airpower in Chechnya." Conflict Studies Research Center. England. March 1996, p 20. This is an excellent summary of air operations in Chechnya.
3. Noy S. "Combat Stress Reactions." In: R. Gal, D. Mangelsdorff, ed. *Military Psychology*. John Wiley and Sons; p 511.
4. Diagnostic and Statistical Manual of Mental Disorders, 4th ed (DSM-IV). P 424.
5. Norvikov VS. "Psycho-physiological Support of Combat Activities of Military Personnel". *Mil Med J*. 1996; No. 4, P 37-40. The discussion and information in this section was taken from this article. The interplay of psychological and physiological stresses a soldier encounters on a battlefield is termed differently in the U.S. than it is in Russia. The Russians use terms that are somewhat antiquated to a U.S. medical specialist, where the terms biopsychophysiological or psycho-immunological are more in vogue than psycho-physiological.
6. Ibid, p 37.
7. Ibid, p 37-38.
8. Ibid, p 38-39.
9. Ibid, p 39.
10. Chizh IM. "The First Priorities of Medical Service." *Mil Med J* 1997; No. 7, p 11.
11. Korchemnyi P. "It is not so simple to Withdraw from the Battlefield". *Indep Mil Rev*. 1997; No. 6, p 8.

12. Ibid.

13. Ibid.

14. Ibid.

15. Kucker A "Life after Military Service." *Indep Mil Rev.* 1997; No. 43, p 8.

16. Ibid.

17. Ibid.

18. Kurichenko, Ya. "Psychological First Aid: Experiment or Reality." *Mil Herald S Russia.* 1997; No. 35, p 5.

19. Razduev V. "Save Scorched Souls." *Orienteer.* 1996; No. 7; p 43-45.