

CHAPTER 1

CONTROL OF COMBAT STRESS

1-1. Stress Control

a. *Control of Stress.* In one's own soldiers and in the soldiers of the enemy, control of stress is often the decisive difference between victory and defeat across the operational continuum. Battles and wars are won more by controlling the will to fight than by killing all of the enemy. Soldiers that are properly focused by training, unit cohesion, and leadership are most likely to have the strength, endurance, and alertness to perform their combat mission. In these soldiers, combat stress is controlled and positive combat stress reactions, such as loyalty, selflessness, and acts of bravery, are more likely to occur. However, uncontrolled combat stress causes erratic or harmful behavior, impairs mission performance, and results in disaster and defeat.

b. *Responsibility For Stress Control.* Control of stress is the commander's responsibility (see FM 22-51) at all echelons. The commander is aided in this responsibility by the noncommissioned officer (NCO) chain of support; the chaplaincy; unit medical personnel; general, principal, and special staff, and by specialized Army CSC units and mental health personnel.

c. *Control or Management.* The word *control* is used with combat stress (rather than the word *management*) to emphasize the active steps which leaders, supporting medical personnel, and individual soldiers must take to keep stress within an acceptable range. This does not mean that control and management are mutually exclusive terms. Management is by definition the exercise of control. Within common usage, however, and especially within Army usage, management has the connotation of being a somewhat detached, number-driven, higher echelon process rather than a direct, inspirational, and leadership-oriented process. Control of stress does not imply elimination of stress.

Stress is one of the body's processes for dealing with uncertain changes and danger. Elimination of stress is both impossible and undesirable in the Army's peacetime or combat mission.

1-2. Combat Stress Threat

a. *Stressors in Combat.* Many stressors in a combat situation are due to deliberate enemy actions aimed at killing, wounding, or demoralizing our soldiers and our allies. Other stressors are due to the natural environment. Some of these stressors can be avoided or counteracted by wise command actions. Still other stressors are due to our own calculated or miscalculated choice, accepted in order to exert greater stress on the enemy. Sound leadership works to keep these within tolerable limits and prepares the troops mentally and physically to endure them. Some of the most potent stressors can be due to personal or organizational problems in the unit or on the home front. These, too, must be identified and, when possible, corrected or controlled. See FMs 8-10, 8-10-8, and 22-51 for additional information on the overall threat, medical threat, and combat stress threat.

b. *Stress Casualties.* The combat stress threat includes all those stressors (risk factors) which can cause soldiers to become stress casualties. Stress casualties include—

- Battle fatigue (BF) cases which are held for treatment at medical treatment facilities (MTFs) for more than a day.
- Misconduct stress behaviors cases that have committed breaches of discipline which require disciplinary confinement.
- Post-traumatic stress disorder (PTSD) cases which disable the soldier for months or years after the battle.

The combat stress threat also includes some wounded in action (WIA) or disease and nonbattle injury (DNBI) casualties whose—

- Disabilities are a direct consequence of carelessness or inefficiency due to stress.
- Recovery and return to duty (RTD) is complicated by unresolved stress issues.

In a broader sense, the combat stress threat also includes the missed opportunities and increased casualties (killed, wounded, and/or taken prisoner) that come from impaired decision making or faulty execution of mission due to excessive stress.

c. Mental Stressors and Physical Stressors. A rough distinction can be made between those stressors which are “mental” and those which are “physical.”

(1) A mental stressor would be one in which information is sent to the brain, with only indirect physical impact on the body. This information may place demands on and evoke reactions from either the perceptual and cognitive system, or the emotional systems in the brain, or from both.

(2) A physical stressor is one which has a direct, potentially harmful effect on the body. These stressors may be external environmental conditions or the internal physical/physiologic demands required by or placed upon the human body.

(3) Table 1-1, *Combat Stressors*, gives examples for the two types of mental stressors (cognitive and emotional) and the two types for physical stressors (environmental and physiological).

(4) The physical stressors evoke specific “stress reflexes,” such as shivering and vasoconstriction (for cold), sweating and vasodilation (for heat), or tension of the eardrum (for noise), and so forth. A soldier’s stress reflexes can counteract the damaging impact of the stressors up to a point but may be overwhelmed.

(5) The distinction between mental and physical stressors is rarely obvious.

(a) Mental stressors can also produce some of the same stress reflexes nonspecifically (such as vasoconstriction, sweating, adrenaline release). These stress reflexes can markedly increase or decrease an individual’s vulnerability to specific physical stressors. Mental stressors presumably cause changes in the electrochemical (neurotransmitter) systems in the brain.

(b) Physical stressors can result in mental stress because they cause discomfort, impair performance, and provide information which poses a threat.

(c) Physical stressors can interfere directly with brain functioning and therefore with perceptual and cognitive mental abilities, thus increasing the stresses.

(d) Light, noise, discomfort, and anxiety-provoking information may interfere with sleep, which is essential to maintain brain efficiency and mental performance.

(6) Because of this intermeshing of “physical” and “mental” stressors and stress responses, no great effort needs to be invested in distinguishing them until the physical stressors reach the degree where they require specific (and perhaps emergency) protective measures and/or treatment. Prior to that point, medical and mental health personnel should assume that both physical and mental stressors are usually present

Table 1-1. Examples of Combat Stressors

PHYSICAL STRESSORS	MENTAL STRESSORS
<p style="text-align: center;">ENVIRONMENTAL</p> <p>HEAT, COLD, WETNESS VIBRATION, NOISE, BLAST HYPOXIA (INSUFFICIENT OXYGEN) FUMES, POISON, CHEMICALS DIRECTED-ENERGY WEAPONS/DEVICES IONIZING RADIATION INFECTIOUS AGENTS PHYSICAL WORK BRIGHT LIGHTS, DARKNESS, HAZE, AND OBSCURATIONS DIFFICULT OR ARDUOUS TERRAIN</p> <p style="text-align: center;">PHYSIOLOGICAL</p> <p>SLEEP DEBT DEHYDRATION MALNUTRITION, POOR HYGIENE MUSCULAR AND AEROBIC FATIGUE IMPAIRED IMMUNE SYSTEM OVERUSE OR UNDERUSE OF MUSCLES ORGAN SYSTEMS ILLNESS OR INJURY</p>	<p style="text-align: center;">COGNITIVE</p> <p>INFORMATION: TOO MUCH, TOO LITTLE SENSORY OVERLOAD VERSUS DEPRIVATION AMBIGUITY, UNCERTAINTY, ISOLATION TIME PRESSURE VERSUS WAITING UNPREDICTABILITY RULES OF ENGAGEMENT, DIFFICULT JUDGMENT ORGANIZATIONAL DYNAMICS HARD CHOICE VERSUS NO CHOICE RECOGNITION OF IMPAIRED FUNCTIONING</p> <p style="text-align: center;">EMOTIONAL</p> <p>FEAR- AND ANXIETY-PRODUCING THREATS (OF DEATH, INJURY, FAILURE, LOSS) GRIEF-PRODUCING LOSSES (BEREAVEMENT) RESENTMENT, ANGER- AND RAGE-PRODUCING FRUSTRATION, THREAT, LOSS, AND GUILT BOREDOM-PRODUCING INACTIVITY CONFLICTING MOTIVES (WORRIES ABOUT HOME, DIVIDED LOYALTIES) SPIRITUAL CONFRONTATION OR TEMPTATION CAUSING LOSS OF FAITH INTERPERSONAL FEELINGS</p>

and interacting. They should treat both types of stressors simultaneously as standard procedure.

d. Positive Stress. Positive stress is that degree of stress which is necessary to sustain and improve tolerance to stress without overstraining and disrupting the human system. Some level of stress is helpful and even necessary to health. Insufficient stress leads to physical and/or mental weakness. A moderate response to stress actually improves performance. Soldiers who have been trained to manage their responses to a stressful situation by maintaining neither too low nor too high a level of activation perform tasks better. Progressively greater exposure to a

physical stressor, sufficient to produce more than “routine” stress reflexes, is often required to achieve greater tolerance or acclimatization to that stressor. Well-known examples are cardiovascular and muscle fitness and heat and cold acclimatization. Stressors which overstrain the human system can clearly retard acclimatization and even permanently impair it. For instance, in the “physical stress” example given, excessive physical work can cause temporary or permanent damage to muscles, bones, and heart, while extreme heat and cold can cause heatstroke or frostbite with permanently reduced tolerance to heat or cold. The same may be true of emotional or mental

stress, although the mechanism is less clear. Up to a point, mental stress (even uncomfortable or painful mental stress) may increase tolerance to future stress without any current impairment. A higher level may cause temporary overtrain but may heal as strong or stronger than ever with rest and restorative processing. More severe overstrain, however, may severely weaken tolerance to future stress. There is reason to believe that immediate treatment can greatly reduce the potential for chronic disability, even for impairing emotional overstrain.

1-3. Stress Behaviors in Combat

a. *Combat Stress Behaviors.* Combat stress behavior is the generic term which covers the full range of behaviors in combat, from highly positive to totally negative. Table 1-2 provides a listing of positive stress responses and behaviors, plus two types of dysfunctional combat stress behaviors—those which are misconduct stress behaviors and those which are labeled BF.

b. *Positive Combat Stress Behaviors.* Positive combat stress behaviors include heightened alertness, strength, endurance, and tolerance to discomfort. Both the fight or flight stress response and the stage of resistance can produce positive combat stress behaviors when properly in tune. Examples of positive combat stress behaviors include—

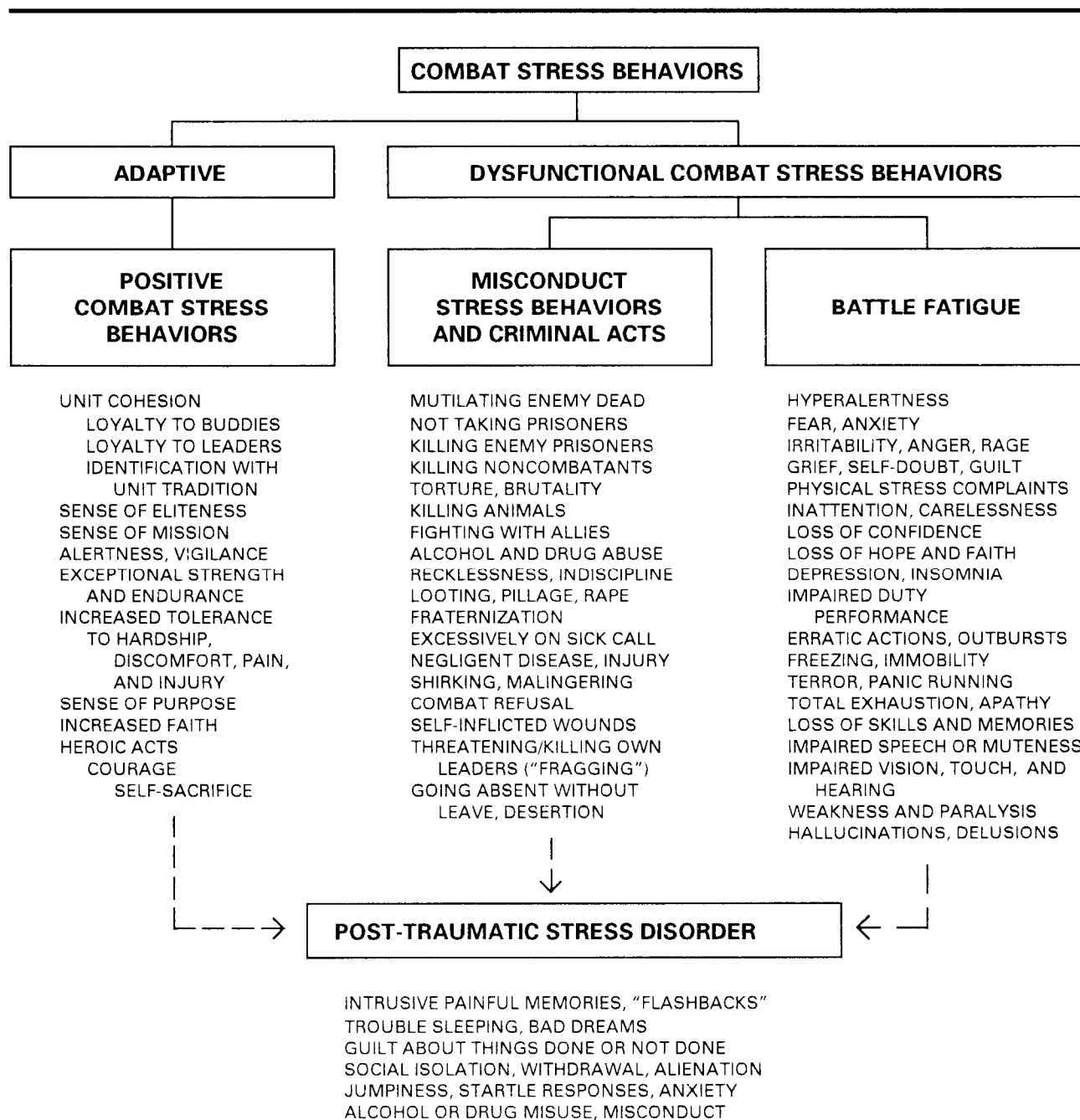
- The strong personal trust, loyalty, and cohesiveness (called horizontal bonding) which develops among peers in a small military unit.
- The personal trust, loyalty, and cohesiveness (called vertical bonding) that develops between leaders and subordinates.
- The sense of pride and shared identity which soldiers develop with the unit's

history and mission (this sense is called unit esprit de corps or simply esprit).

The above positive combat stress behaviors combine to form unit cohesion—the binding force that keeps soldiers together and performing the mission in spite of danger and death. The ultimate positive combat stress behaviors are acts of extreme courage and almost unbelievable strength. They may even involve deliberate self-sacrifice. Positive combat stress behaviors can be brought forth by sound military training, wise personnel policies, and good leadership. The results are behaviors which are often rewarded with praise and individual and/or unit recognition. For additional information on positive combat stress behaviors, see FM 22-51.

c. *Misconduct Stress Behaviors.* Examples of misconduct stress behaviors are listed in the center column of Table 1-2. These range from minor breaches of unit orders or regulations to serious violations of the Uniform Code of Military Justice (UCMJ) and the Law of Land Warfare. As misconduct stress behaviors, they are most likely to occur in poorly trained, undisciplined soldiers. However, misconduct can also be committed by good and even heroic soldiers under extreme combat stress. In fact, misconduct stress behaviors can become the second edge of the double-edged sword of highly cohesive and proud units. Such units may come to consider themselves entitled to special privileges and as a result, relieve tension unlawfully when they stand-down from their combat mission. They may lapse into illegal revenge when a unit member is lost in combat. Such misconduct stress behaviors can be prevented by stress control measures, but once serious misconduct has occurred, soldiers must be punished to prevent further erosion of discipline. Combat stress, even with heroic combat performance, cannot justify criminal misconduct. Combat stress may, however, constitute extenuating circumstances for minor (noncriminal) infractions in determining

Table 1-2. Combat Stress Behaviors



nonjudicial punishment under Article 15, UCMJ. Combat stress may also constitute an extenuating circumstance in the sentencing proceedings of a court-martial. See FM 22-51 for additional information on misconduct stress behaviors.

d. Battle Fatigue. Battle fatigue is also called combat stress reaction or combat fatigue. Fatigue by definition is the distress and impaired performance that comes from doing something (anything) too hard and/or too long. The term *battle fatigue* is applied to any combat stress reaction which is treated. All BF is treated (as all types of fatigue) with the four Rs—

- Reassurance of normality.
- Rest (respite from the work).
- Replenish physiologic status.
- Restore confidence with activities.

ties.

See Table 1-2 for examples of BF. The BF behaviors which are listed near the top may accompany excellent combat performance, and are often found to some degree in all soldiers. These are normal, common signs of BF. Those behaviors that follow are listed in descending order to indicate progressively more serious warning signs. Warning signs deserve immediate attention by the leader, medic, or buddy to prevent potential harm to the soldier, others, or the mission. If the soldier responds quickly to helping actions, warning signs do not necessarily mean he must be relieved of duty or evacuated. However, he may require further evaluation at an MTF to rule out other physical or mental illness. If the symptoms of BF persist and make the soldier unable to perform duties reliably, then MTFs, such as clearing stations and specialized CSC teams, can provide restorative treatment. At this point, the soldier is a BF casualty. For those cases, prompt treatment

close to the soldier's unit provides the best potential for returning the soldier to duty. Recovered BF casualties who are accepted back in their units are at no more risk of recurrence than their fellow soldiers.

e. Overlapping of Combat Stress Behaviors. The distinction between positive combat stress behaviors, misconduct stress behaviors, and BF is not always clear. Indeed, the three categories of combat stress behaviors may overlap. Soldiers with BF may show misconduct stress behaviors and Vice versa. Soldiers who exemplify the positive combat stress behaviors may suffer symptoms of BF and may even be BF casualties before or after their performance of duty. Excellent combat soldiers may commit misconduct stress behaviors in reaction to the stressors of combat before, after, or during their otherwise exemplary performance. However, combat stress, even with good combat behaviors, does not excuse criminal acts.

f. Post-Traumatic Stress Disorders. Symptoms of post-traumatic stress are persistent or recurring stress responses after exposure to extremely distressing events. As with BF, post-traumatic stress symptoms can be normal/common signs or warning signs. These signs and symptoms do not necessarily make the soldier a casualty nor does the condition warrant the label of a disorder. This becomes PTSD only when it interferes with occupational or personal life goals. These signs and symptoms sometime occur months or years after the event and may include—

- Painful memories.
- Actions taken to escape painful memories such as—
 - Substance abuse.
 - Avoidance of reminders of the traumatic event.

- Social estrangement.
- Withdrawal.

Post-traumatic stress disorder often follows inadequately treated BF. It often follows misconduct stress behaviors in those who committed misconduct under stress, as well as in the victims, reluctant participants, caregivers, and observers. Post-traumatic stress disorder can occur in soldiers who showed no maladaptive stress behaviors at the time of the trauma. Post-traumatic stress disorders can occur or recur years after the event, usually at times of excessive stress. In addition to their primary mission during war, leaders, chaplains, and medical and CSC personnel have the additional responsibility of preventing or minimizing subsequent PTSD. The most important preventive measure for PTSD is routine after-action debriefing in small groups. If properly debriefed, soldiers will often not develop clinical PTSD or misconduct stress behaviors. Experiences of excessive stress can be accepted and diverted into positive growth. For additional information on PTSD, its prevention, and treatment, see FM 22-51.

1-4. Stressors and Stress in Army Operations

a. *The Changing Focus.* The emerging concept for Army operations in the post-cold war era has reoriented the nation's military capability away from a primary focus on potential large scale war against Soviet forces in Europe. The focus has shifted towards a more ambiguous threat from current or future regional powers around the world.

(1) High technology weapons are available from a number of sources throughout the world. The dissolution of the Soviet empire may disperse quantities of high technology weapons (and weapons design expertise) to

ambitious countries who are hostile toward the US or toward nations important to the US. Consequently, the danger of regional armor-heavy battles at the high-intensity end of the continuum of conflict, and even of regional nuclear, biological, and chemical (NBC) war, may paradoxically increase over the next decades.

(2) Alternatively, hostile states (or ethnic/religious factions encouraged by them) may attempt to overthrow friendly nations or attack the US interest by conducting terrorist or insurgency operations. These attacks may require counteractions by US combat forces. In operations other than war (OOTW), contingency operations may be needed to protect US lives, property, and international standards of humane conduct in third world countries which are otherwise of little concern to the US. These operations will likely be conducted on short notice, under conditions of high operational security. They will also be subject to intense and near-instantaneous media coverage.

b. *High-Technology Joint and Coalition Operations.* Most combat and contingency operations will be joint operations. Many will involve working in coalition with countries whose customs and culture are quite different from our own. The US will make maximal use of our technological superiority in intelligence-gathering and weapons systems to mobilize overwhelming forces at the decisive point for quick and certain victory. However, those systems can only be as effective as the stress tolerance of the human commanders and soldier/operators make them. The combining of highly lethal weapons systems from different branches, services, and allies creates an intrinsic risk of friendly fire casualties. This risk, too, must be calculated and the stress consequences controlled.

c. *Brigade Task Force Operations.* The Army operations concept makes the brigade the critical unit for CSC prevention and immediate

intervention, more so than in previous wars. Divisional and separate brigades and armored cavalry regiments (ACRs) will be combined into task forces for rapid-deployment contingency operations. Within campaigns, brigade task forces will be rapidly organized for specific, brief, violent battles. During battles, the task forces can cover great distances quickly, concentrate for decisive action, and perhaps reconstitute at different tactical support areas than the ones from where they started. Between battles, brigades may remain widely dispersed. A brigade which is armed with modern weapons systems has more firepower and covers a larger area of responsibility than a World War I (WWI) or WWII division. At the small unit level, the importance of individual soldiers to the unit's combat power is also greatly increased for weapons operators and leaders. It is equally true for critical combat support (CS) and combat service support (CSS) specialists. Rear battle, in the form of long-range artillery fire, enemy airborne/air assault units, guerrilla activity, air interdiction, and terrorist or missile attacks, may strike far behind the battle area. Army mental health/CSC organization and doctrine were first designed to support WWI and WWII divisions. Our new mental health/CSC doctrine and units must adapt to these changing conditions by assuring integral CSC support at brigade level while improving coverage throughout the supported area.

d. Military Operations Other Than War. In addition to war, there will be many other Army missions which are prolonged. The National Command Authority may commit US Army units to military OOTW including—

- Conflict.
- Nation assistance.
- Security assistance.
- Humanitarian assistance and disaster relief.

- tions.
 - Support to counter drug operations.
 - Peacekeeping operations.
 - Arms control.
 - Combatting terrorism.
 - Show of force.
 - Attacks and raids.
- operations.
 - Noncombatant evacuation operations.
 - Peace enforcement.
 - Support for insurgences and counterinsurgencies.
 - Support to domestic civil authorities.

The rules of engagement for each of the above operations are unique to that situation. Requirements to maintain neutrality provide a show of force only, engage in constructive humanitarian, or other such actions may require that only defensive actions be taken once attacked. In conflict, however, the opponents may deliberately seek to provoke our forces into committing misconduct stress behaviors. By committing criminal acts, the role of the US Forces would be degraded in the eyes of local, US, and world populations. In light of this, the CSC role in the prevention of misconduct stress behaviors is extremely important. For definitive information pertaining to OOTW, see FM 100-5.

e. Neuropsychiatric Disorders. The focus of CSC is on the prevention and treatment of stress-induced disability in otherwise normal soldiers. Mental health/CSC personnel, by virtue of their professional training and experience, are

also best qualified to diagnose, treat, and recommend RTD or disposition for the endemic neuropsychiatric (NP) disorders. These NP disorders include the schizophrenic-type psychotic disorders, mood disorders, anxiety disorders, organic mental disorders, personality disorders, and substance abuse disorders. These NP disorders are significant impediments to combat readiness and also to peacetime training. Sound prevention and screening programs as identified in Army Regulation (AR) 40-216, as well as early recognition and treatment, assist the command in maintaining the fighting strength.

1-5. Army Combat Stress Control

a. Focus of Army Combat Stress Control. The focus of Army CSC is toward—

- Promotion of positive mission-oriented motivation.
- Prevention of stress-related casualties.
- Treatment and early RTD of soldiers suffering from BF.
- Prevention of harmful combat stress reactions such as misconduct stress behaviors and PTSD.

b. Implementation. The CSC program is implemented by mental health/CSC personnel organic to the divisions, the medical companies of separate brigades, and the area support medical battalions (ASMBS) in the corps and communications zone (COMMZ) (see Chapters 2 and 3). These mental health/CSC personnel are augmented by the CSC company or detachment. Combat stress control companies and detachments are assigned to the corps and in the COMMZ (see Chapters 2 and 3). Primary goals of mental health/CSC personnel when implementing this program are to—

- Monitor stressors and stress in units.
- Advise command on measures to reduce or control stress and stressors before they cause dysfunction.
- Reduce combat stress-related casualties by training leaders, medical personnel, chaplains, and soldiers on stress-coping techniques.
- Promote positive combat stress behavior and progressively increase stress tolerance to meet the extreme stress of combat.
- Recognize and treat BF and other stress reactions as early and as far forward as possible.
- Accomplish the earliest RTD of most soldiers who become stress-related casualties.
- Facilitate the correct disposition of soldiers whose BF, misconduct stress behaviors, and NP disorders do not allow RTD.
- Reduce PTSD, chiefly by training and assisting after-action debriefings and by leading critical event debriefings.

1-6. Historical Experience

The AMEDD identified "CSC" as a separate functional mission area in 1984, but CSC is not new. Historical experience in the Civil War, WWI, WWII, Korea, Vietnam, the Arab-Israeli, and other wars has demonstrated the basic principles of combat psychiatry and combat mental health. The goal is to preserve the fighting strength by minimizing losses due to BF and NP disorders.

a. *World War I.* In 1917, before sending the American Expeditionary Force to Europe, the US Army sent a medical team to see what our new allies had learned from hard experience about casualty care. Based on the finding of this team in the combat psychiatry area, The Surgeon General of the Army recommended that we adopt a three-echelon system similar to that of the British Army. He also recommended that we implement their policies to return soldiers with “war neurosis” (commonly mislabeled *shell shock*) to duty. Accordingly, in WWI, we assigned a psychiatrist to each division (first echelon) to train the unit leader and medical personnel. The psychiatrist trained unit leaders and medical personnel to recognize and treat simple fatigue cases in their own units. Many US stress casualties were returned to duty after resting a few days in the 150-cot field hospital which was located in the division rear. By direction of The Surgeon General’s NP consultant, the official diagnostic label for these types of cases while the soldier was still in the division area was “Not Yet Diagnosed, Nervous,” (also adapted from the British and abbreviated NYDN). The psychiatrist screened out and evacuated soldiers with serious NP disorders. Behind the division (second echelon), we had special neurological hospitals (150-bed facilities with psychiatrist supervisors). They treated the relatively few NYDN cases who did not RTD within the division in a few days. They also treated some soldiers with “gas mania,” who believed they had been gassed when in fact they had not been. Further to the rear, we had Base Hospital 117 (third echelon), staffed by psychiatrists, nurses, specially trained medics, and occupational therapists. These medical professionals salvaged many soldiers who did not fully recover in the neurological hospitals. This three-echelon system worked well. However, on occasions when the tactical situation interfered with forward treatment, it clearly showed the importance of treating the soldiers close to their units. Overall, a large percent of WWI “war neurosis” cases were RTD.

b. *World War II.* During the time between WWI and WWII, CSC insights and the principles learned were forgotten. It was believed that prior screening could identify and exclude most of the soldiers who would be prone to psychoneurosis and breakdown in combat. That screening was glaringly unsuccessful. The WWI system was reinstated during the Tunisia campaign, and the condition formerly identified as “war neurosis” was officially labeled *combat exhaustion*. By late in the war, the Mediterranean and European theaters again had psychiatrists assigned to each division. Most maneuver battalions had “rest centers” in their “kitchen trains” (where recovering soldiers were monitored by the battalion surgeon). There were “exhaustion centers” in the regimental or combat team trains area, monitored by the regimental surgeon. The division psychiatrist trained the regimental and battalion surgeons in combat psychiatry. During combat, the psychiatrist triaged and treated combat exhaustion cases at the division clearing company and supervised their further rehabilitation for 3 to 5 days at the division’s “training and rehabilitation center.” There were also (once again) Army NP centers (clearing companies with psychiatric supervisors and specially trained staff) behind the divisions. Psychiatric consultants were at Army level, and specialized base hospitals were located in the COMMZ. In heavy fighting during WWII, some divisions had one BF casualty for every five, three, even two WIAs. However, highly trained and cohesive units rarely had more than one BF casualty for ten WIA. That ratio illustrated the value of strong leadership in preventing BF even under conditions of extreme stress.

c. *Korea.* In each division, the division psychiatrist was assisted by a social work specialist and a clinical psychologist specialist (initially, enlisted specialists; later officers). These professionals functioned very effectively in treating combat exhaustion (what is now referred to as BF). It should be stated that there was

some confusion during the initial hasty mobilization and deployment and many combat exhaustion cases were inadvertently evacuated to Japan. The lessons of WWII were institutionalized in a specialized unit, the "KO Team" (medical detachment, psychiatric). The primary mission of this mobile unit was to augment a medical clearing company and make it into an NP center. Late in the conflict, 85 percent of the BF cases returned to combat within 3 days. An additional 10 percent returned to limited duty in several weeks, and only 5 percent were evacuated to CONUS.

d. Vietnam. In Vietnam, division mental health sections were located and worked at the main base camp areas. They sometimes sent consultation teams or enlisted behavioral science specialists to visit base camps and fire bases. Many of these draftee mental health personnel were professionals with masters- or doctorate-level degrees. Traditional "combat exhaustion" was rarely seen, and most cases of BF were handled within the units. Substance abuse, the lack of discipline, and even commission of atrocities were significant problems but were not clearly recognized as misconduct stress behaviors. By mid-1971, 61 percent of all medical evacuations from Vietnam were NP patients (mostly substance abuse). Two KO Teams served with distinction in Vietnam, but because of the different nature of war, functioned mostly as psychiatric augmentation to an evacuation hospital and as mobile consultation teams. In 1972, based on the Vietnam experience, the KO Team was redesigned into the OM Team.

e. Operation Desert Shield/Storm. Beginning in September of 1990, stress assessment teams from the US Army Medical Research and Development Command were deployed in support of Operation Desert Shield. These teams conducted surveys of many combat, CS, and CSS units in the TO. These stress assessment teams used small group interviews and questionnaire

surveys to assess the soldiers' level of unit cohesion and their self-perceived readiness for combat. The stress assessment teams provided feedback to units and to the Army Central Command on how to control stress and enhance morale and readiness. They also provided training to leaders and troops on stress control. Corps- and theater-level OM Teams reached the theater in late October and December. The mobile teams actively undertook the command consultation and training mission to corps and echelon above corps units. They reinforced the activities of the division mental health sections. During Operation Desert Storm, division mental health/CSC teams were deployed forward. These teams worked with units who had suffered casualties. Combat stress control teams from the corps were deployed behind the brigades. These teams saw few stress casualties during the ground offensive because of its rapid and highly victorious pace which lasted only 100 hours. During demobilization after Operation Desert Storm, a systematic effort was conducted by chaplains and mental health personnel to prepare soldiers and their families for the changes and stressors of reunion. Some units which had especially difficult experiences received special debriefings.

1-7. Principles of Combat Psychiatry

The basic precepts of combat psychiatry have been documented in every US war in this century. Our allies through similar experiences have further documented these basic precepts. The principles of combat psychiatry are—

a. Maximize Prevention.

(1) Achieve primary prevention. Control (and when feasible, reduce) stressors which are known to increase BF and misconduct stress behaviors. Some of the factors which increase stress and stress casualties include—

time in combat) in a unit.

- Being a new soldier (first time in combat) in a unit.
- Home front worries.

killed in action (KIA) and WIA.

- Intense battle with many killed in action (KIA) and WIA.

tic training.

- Insufficient tough, realistic training.

- Lack of unit cohesion.

equipment, and supporting arms.

- Lack of trust in leaders, equipment, and supporting arms.

- Sleep loss.

ing (dehydration, malnutrition).

- Poor physical conditioning (dehydration, malnutrition).

tal exposure.

- Debilitating environmental exposure.

- Inadequate information.

tainty and ambiguity.

- High degree of uncertainty and ambiguity.

end of the mission in sight.

- Absence of an achievable end of the mission in sight.

pose.

- Inadequate sense of purpose.

(2) Achieve secondary prevention.

Minimize acute disability (morbidity) by training leaders, chaplains, and medical personnel to—

signs and symptoms of BF/combat stress or misconduct stress.

- Identify early warning signs and symptoms of BF/combat stress or misconduct stress.

with the soldiers to treat the warning symptoms and control the relevant stressors.

- Intervene immediately with the soldiers to treat the warning symptoms and control the relevant stressors.

Prevent contagion by rapidly segregating and treating dramatic BF casualties and disciplining minor misconduct stress behaviors.

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Reintegrate recovered BF casualties back into their units.

- Reintegrate recovered BF casualties back into their units.

Taking and publicizing appropriate disciplinary actions for criminal misconduct stress behaviors.

- Taking and publicizing appropriate disciplinary actions for criminal misconduct stress behaviors.

(3) Achieve tertiary prevention.

Minimize the potential for chronic disability (PTSD), both in soldiers who show BF and those who do not. This is done by—

Having an active preventive program (debriefings) during and immediately after combat and/or traumatic incident.

- Having an active preventive program (debriefings) during and immediately after combat and/or traumatic incident.

Conducting end of tour debriefings for units and unit members' families.

- Conducting end of tour debriefings for units and unit members' families.

Remaining sensitive to delayed or covert post-traumatic stress signs and symptoms and providing positive intervention. (This is primarily the role of leaders, chaplains, and health care providers.)

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b. Treat Battle Fatigue. Proximity, immediacy, expectancy, and simplicity (PIES) are all extremely important in the treatment of BF.

(1) Proximity. Proximity refers to the need of treating soldiers as close to their units and the battle as possible. It is a reminder that overevacuation should be prevented.

(2) Immediacy. Immediacy indicates that BF requires treatment immediately.

(3) Expectancy. Expectancy relates to the positive expectation provided to BF casualties for their full recovery and early RTD.

(4) *Simplicity*. Simplicity indicates the need for using simple, brief, straightforward methods to restore physical well-being and self-confidence by using nonmedical terminology and techniques.

c. *Make Differential Diagnosis, But Defer Psychiatric Diagnosis*. Distinguish life- or function-threatening medical or surgical conditions as soon as possible and provide those patients emergency treatment. Treat all others using PIES to the safest maximum extent possible. Let the response to treatment sort out the true NP disorders. The nonresponders should be evacuated to the echelon of care appropriate for their treatment (either COMMZ or CONUS facilities) where treatment continues and the final diagnosis is determined.

1-8. Generic Treatment Principles for Battle Fatigue

The generic treatment principles provided below apply at all echelons throughout the TO. Their applications may differ based on a particular echelon and other factors pertaining to the mission, enemy, terrain, troops, and time available (METT-T).

a. *Initial Assessment*. In the initial assessment, a brief but adequate medical and mental status examination is performed. This examination should be appropriate to the echelon of care and should rule out any serious physical mental illness or injury. Always consider the possibility of trauma to the head or trunk. Other surgical, medical, NP, and drug and alcohol misuse disorders may resemble BF, but they require emergency treatment. It is important to recognize symptoms to avoid performing unnecessary tests. Often it is best to treat for BF while covertly observing for other more serious conditions.

b. *Reassure*. At every echelon, give immediate, explicit reassurance to the soldier. Explain to him that he has BF and this is a temporary condition which will improve quickly. Actively reassure everyone that it is neither cowardice nor sickness but rather a normal reaction to terribly severe conditions. Provide these soldiers with the expectation that they will be RTD after a short period of rest and physical replenishment and involve them in useful activities, as appropriate.

c. *Separate*. Keep BF soldiers separated from those patients with serious medical, surgical, or NP conditions. This is done because association with serious medical, surgical, or psychiatric patients often worsens symptoms and delays recovery. Those few BF casualties who show overly dramatic symptoms of panic anxiety, depression, and/or physical or memory problems need to be kept separate from all other types of patients (including other BF casualties). This is done until those symptoms cease so as not to adversely affect other BF soldiers.

NOTE

Association of recovering BF casualties with *hold for treatment* (patients expected to RTD within 72 hours) cases who have minor injury or illness is not harmful.

No sharp distinction should be made between other convalescent soldiers and those recovering from BF. Indeed, many of the soldiers with minor wounds or illnesses also have BF and should be treated with the principles of PIES. These soldiers can be treated together provided they are not in their "contagious" stage and RTD for both is imminent.

d. *Simple Treatment with Rest and Replenishment*. Keep treatment for BF deliberately

simple. Provide relative relief from danger but maintain a tactical atmosphere which is not too comfortable. Provide rehydration, sleep, and hygiene.

e. Restore Confidence. Restore confidence by structured military work details, physical exercise, and recreation. Get the soldier to talk about what happened to him. Provide supportive counseling as needed to clarify memories, to provide the opportunity to express feelings, and to regain perspective. Reinforce the soldier's identity as a soldier and a member of his unit, not as a patient.

f. Avoid Sedatives and Tranquilizing Medications. Avoid sedative or tranquilizing medication unless essential to manage sleep or agitated behavior. The BF soldier needs to maintain a normal state of alertness, coordination, and understanding. If the BF soldier is not medicated, he can take care of himself and can respond to and accept his treatment.

g. Evacuation and Hospitalization. Do not evacuate or hospitalize BF casualties unless absolutely necessary. Evacuation and hospitalization delay recovery and significantly increase chronic morbidity, regardless of the severity of the initial symptoms. It is better to transport BF casualties in general-purpose vehicles, not ambulances (and especially not air ambulances), unless no other means of transportation is feasible. Evacuation should be approved by a single qualified authority (for example, if the soldier is to leave the division, by the division psychiatrist, in accordance with AR 40-216).

h. Unmanageable Cases. Soldiers whose BF (or psychiatric) symptoms make them too disruptive to manage at a given echelon should be evacuated only to the next higher echelon with the expressed positive expectation of improvement. The next higher echelon will reevaluate the soldier for manageability. However, be

careful not to let "unmanageability" become well-known as the criteria for "escape by evacuation," since that could lead others to follow the bad example.

i. Manageable Battle Fatigue, but Unresponsive to Initial Treatment. Those manageable BF casualties who (after initial treatment) do not improve sufficiently within the allotted time to RTD are also sent unobtrusively back to the next higher echelon, with expressed positive expectations for further treatment. This sustains the positive expectation of rapid recovery for BF casualties who are just arriving.

j. Hospitalization. As stated above, do not hospitalize a BF casualty unless absolutely necessary for safety. Those BF casualties who do require brief hospitalization for differential diagnosis or acute management should be transferred to a nonhospital treatment setting as soon as their conditions permit. Those who reach hospitals as an inappropriate evacuee should be told they are only experiencing BF; they should be returned to their unit area or other forward area as soon as possible to recover in a nonhospital facility.

k. Restoration and Reconditioning. Ideally, BF casualties are not evacuated to CONUS without having had an adequate restoration and/or reconditioning trial in both the combat zone (CZ) and the COMMZ. The treatment strategies of these programs assist recovering BF soldiers in regaining skills and abilities needed for combat duty. These skills and abilities include concentration, team work, work tolerance, psychological endurance, and physical fitness. Restoration is a 1- to 3-day program which is conducted in both the division and the corps areas. Restoration is normally conducted by the medical detachment, CSC and/or the mental health section in the division. In the corps area, restoration is conducted by the medical detachment, CSC and/or the mental

health section of the ASMB. Reconditioning is a 7- to 14-day program that requires hospital admission for accountability of BF cases. It is conducted in a nonhospital setting by the medical company, CSC in both the corps and COMMZ.

1-9. Combat Stress Control Functional Mission Areas

a. *Functional Roles.* The principles of combat psychiatry and the methods for prevention and treatment of BF are exercised in six functional mission areas for mental health/CSC personnel and units. These functional mission areas have differing priorities depending on the situation. They are defined below and are analyzed in detail in subsequent chapters of this manual.

(1) *Consultation.* Consultation involves the liaison and preventive advice and assistance to commanders and staff of supported units (see Chapter 4).

(2) *Reconstitution support.* Reconstitution support is that assistance provided to attrited units at field locations. Reconstitution is an extraordinary action that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources according to FM 100-9. Reconstitution is a total process which involves the sequence of reorganization, assessment, and regeneration. Mental health/CSC personnel support reconstitution as a part of a consolidated team (see Chapter 5).

(3) *Combat neuropsychiatric triage.* Combat NP triage (as distinguished from surgical triage) is the process of sorting combat stress-related casualties and NP patients into categories based on how far forward they can be treated. These categories are DUTY (RTD immediately), REST (light duty for 1 to 2 days in

their unit's own CSS elements), HOLD (requires medical holding at this echelon for treatment), and REFER (requires evacuation to the next higher echelon for further evaluation and treatment) (see Chapter 6).

(4) *Stabilization.* This function provides stabilization of severely disturbed BF and NP patients. They are evaluated for RTD potential or prepared for further treatment or evacuation, if required (see Chapter 7).

(5) *Restoration.* Restoration involves treatment with rest, food, water, hygiene, and activities to restore confidence within 1 to 3 days at forward medical facilities. Between 55 and 85 percent of BF casualties should RTD with restoration treatment (see Chapter 8).

(6) *Reconditioning.* Reconditioning involves treatment with physical training and an intensive program of psychotherapy and military activities. Reconditioning programs are conducted for 7 or more days in a nonhospital setting in the corps area. Additional reconditioning may be provided in the COMMZ (see Chapter 9). No more than 5 to 10 percent of BF casualties should eventually be evacuated to CONUS.

NOTE

All CSC functions since WWII except reconstitution support were successfully demonstrated repeatedly. Although the terminology has changed, the functions remain the same. Reconstitution support has been identified as a separate mission to meet the special hazards and requirements of war.

b. *Priority of Functional Mission Areas.* The six functional mission areas listed above are in the usual order of their doctrinal

priority for allocation of assets when workloads exceed resources. However, the functions have different relative importance in different scenarios or phases of the operation. The CSC commander must set priorities and allocate resources to accomplish missions in each program based

upon the total situation. Subsequent chapters of this manual will discuss each of the functional areas and provide basic TTP for accomplishing them. These chapters will also address how CSC functional areas interface with other functional areas.