

CHAPTER 12

COMBAT STRESS CONTROL SERVICES

Section I COMBAT STRESS

12-1. The Modern Battlefield

a. Advances in technology are continually changing the way warfare is conducted. The tempo of battle has increased dramatically. On the modern battlefield, US Forces will be required to fight around the clock in offensive or defensive operations. Leaders must, therefore, ensure that troops rest and resupply on the run. (See FM 21-10 for minimum sleep requirements.) They must think faster, make decisions more rapidly, and act more quickly than the enemy. Leaders must know the commander's intent. They must be able to act spontaneously and synchronously, even though the situation has changed and communications are disrupted. The demands on CSS units will be equally extreme. If NBC and DE weapons are employed, the stressors on the integrated battlefield will be incalculably greater. Exhausted and attrited units must be reconstituted and returned quickly to the battle.

b. In OOTW, the terrorist or guerrilla enemy also counts on causing stress to the enemy as his principal weapon and objective. Although the stressors of terrorism and/or guerrilla tactics are less overwhelming than those of war, they are deliberately designed to cause breakdown of professionalism and discipline.

12-2. Leader's Responsibility

It is the responsibility of leadership to control stress. Army Medical Department personnel in unit mental health (MH) sections and in specialized CSC units assist command in—

• Preventing battle fatigue and misconduct stress behaviors. Table 12-1 provides a classification of positive and dysfunctional combat

stress behaviors (CSBS), with examples of positive CSBS, battle fatigue, misconduct stress behaviors, and post-traumatic stress disorders (PTSDS).

- Treating patients suffering from battle fatigue or neuropsychiatric (NP) disorders.

- Returning soldiers to duty or determining their disposition.

- Evaluating soldiers who display misconduct stress behaviors.

- Evacuating patients with NP disorders who cannot RTD.

12-3. Combat Stress Behaviors

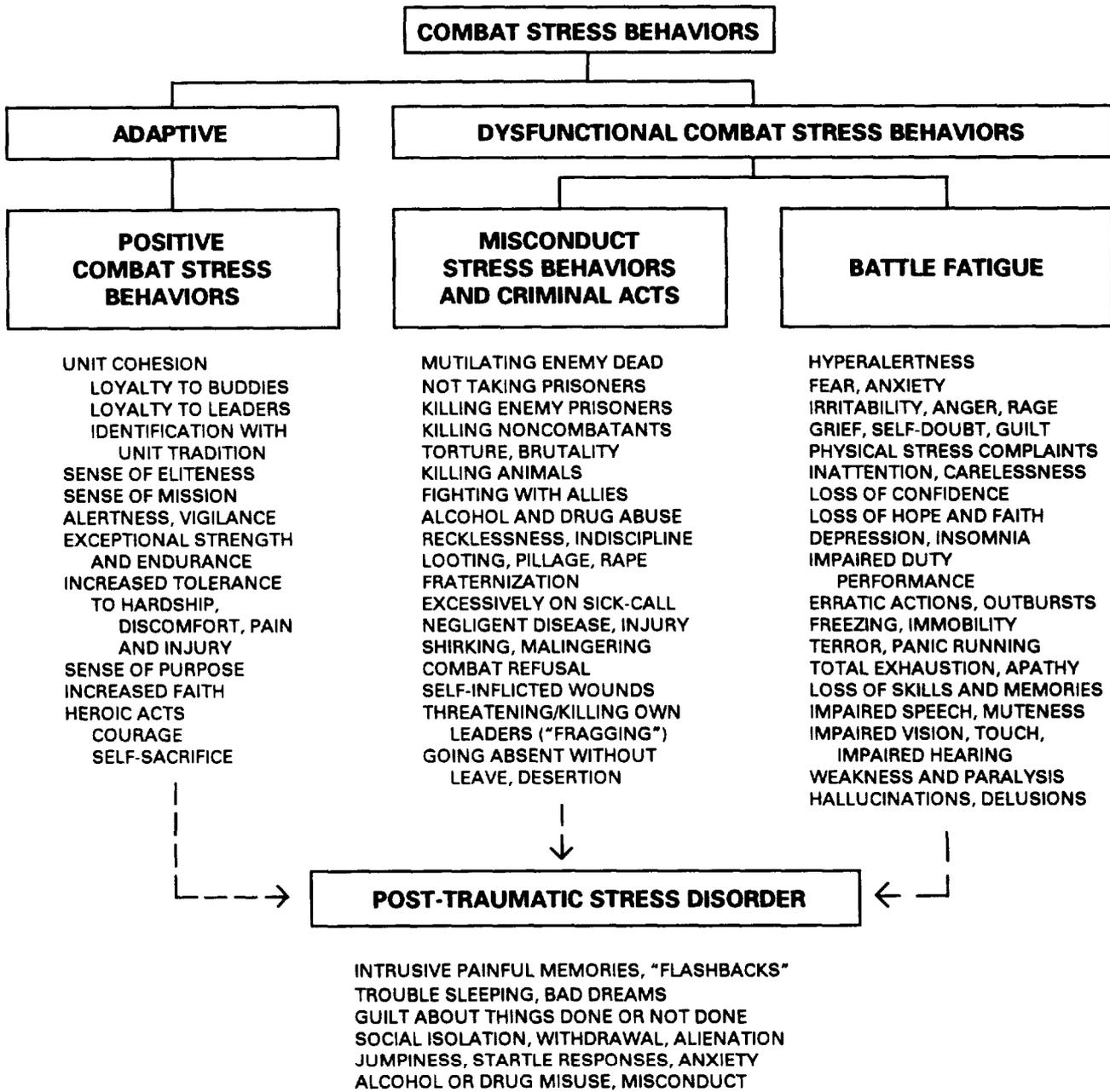
Combat stress behavior is the generic term which covers the full range of behaviors in combat, from highly positive to totally negative. See FM 22-51 for a comprehensive review of CSC.

12-4. Battle Fatigue

a. Battle fatigue is the approved US Army term for combat stress symptoms and reactions. (See AR 40-216.) These symptoms and reactions may be unpleasant feelings and may interfere with mission performance. They are best treated with reassurance, rest, replenishment of physical needs, and activities which restore confidence. (Brief tranquilizing or sedative medication and/or skilled counseling may be needed in some cases.)

b. Battle fatigue also occurs in soldiers who have been physically wounded, or who have

Table 12-1. Combat Stress Behaviors



other nonbattle injuries or diseases caused by stressors in the combat area. It may be necessary to treat both the battle fatigue and the other problems at the same time. Battle fatigue, by definition, does not require some other legal or disciplinary action.

12-5. Triage

The medical triager sorts the battle-fatigued soldiers based on where they can be treated.

Ž *Duty* cases apply to those soldiers who are seen by a physician or physician's assistant but who can be treated and released to duty to their small unit.

- *Rest* cases apply to those soldiers who must be sent to their unit's nonmedical CSS elements for brief rest and lighter duties, but who do not require continual medical observation.

NOTE

Duty and rest cases are not *medical casualties*, because they are still available for some duty in their units. However, those *heavy cases* who cannot RTD or rest in their unit the same day are battle *fatigue casualties* (BFCs).

- *Hold* cases apply to those BFCs who can be held for treatment at the triager's own MTF because both the tactical situation and the BFCs' symptoms permit. This should be done whenever feasible.

- *Refer* cases apply to those BFCs who must be referred (and transported) to a more secure or appropriate echelon of care. *Refer* becomes

hold when the soldier reaches an MTF where he can be held and treated.

12-6. Misconduct Stress Behaviors

Misconduct stress behaviors are not called battle fatigue, although battle fatigue may be present along with them if they truly are reactions to combat stress. The misconduct behaviors require different treatment than battle fatigue. They require administrative action and/or specific medical or surgical treatment.

12-7. Neuropsychiatric Disorders

Neuropsychiatric disorders include functional and organic mental disorders, but exclude battle fatigue cases unless they persist and require evacuation from the TO. Included under this label are—

a. *Post-Traumatic Stress Disorder*. This sublabel is a recognized NP disorder which shares many common features with battle fatigue. The BFC label should be used instead of PTSD while the soldier is in the TO, as that label more clearly implies the positive expectation of recovery and RTD without persistent problems. Post-traumatic stress disorder should be reserved for symptoms which persist and require evacuation from the TO, arise after hostilities end, or after returning to CONUS.

b. *Substance Misuse and Abuse*. This sublabel is discussed above under misconduct stress behavior, but is not necessarily a reaction to combat or deployment stress.

c. *Organic Mental and Neurologic Disorders*. This sublabel applies to physical diseases of the brain or body. The symptoms of organic mental disorders are primarily mental or behavioral; the diagnosis can be documented by neurological or laboratory examinations. Organic

mental and neurologic disorders are in the differential diagnosis of battle fatigue. Some cases

respond to the same treatment principles; others must be diagnosed and evacuated.

Section II. TREATMENT OF BATTLE FATIGUE

12-8. Experience in Treatment of Battle Fatigue

Historical experience in World Wars I and II, the Korean and Vietnam conflicts, and the Arab-Israeli and other wars has demonstrated the basic principles of "combat psychiatry." Applying these principles preserves the fighting strength by minimizing losses due to battle fatigue and NP disorders.

This paragraph implements QSTAG 909.

12-9. Principles for Treating Battle Fatigue ("PIES")

- *Proximity*—treat as close to the soldier's unit as the situation permits.

ƒ *Immediacy*—begin to treat immediately; treat quickly and briefly.

- *Expectancy*—express positive expectation for recovery and rapid RTD.

ƒ *Simplicity*—use uncomplicated, straightforward treatment methods.

12-10. Treatment Methods

a. *Separate Treatment Areas.* Battle-fatigued soldiers should be kept separate from

other patients. Association with serious medical, surgical, or psychiatric patients often worsens symptoms and delays recovery. Association with RTD cases who have minor injury or illness is not harmful indeed, many of those cases also have battle fatigue and should be treated according to the same principles. However, those few BFCs who show overly dramatic symptoms need to be kept separate from all other types of patients until those symptoms cease, lest they "infect" the others. Dramatic battle fatigue symptoms, like panic, can be contagious.

b. *Transportation.* Battle fatigue casualties will be transported in nonmedical or general purpose trucks whenever feasible. Air-ambulance transport will not be used unless there is no alternative. Ground ambulances will be used for those few who temporarily need sedation and/or physical restraints.

c. *Minimize Evacuation and Hospitalization.* Battle-fatigued soldiers will *not* be evacuated or hospitalized unless absolutely necessary. These actions delay recovery and significantly increase chronic morbidity, regardless of the severity of the initial symptoms. Those cases who require brief hospitalization for differential diagnosis should be transferred to a nonhospital treatment setting as soon as possible. Those who reach hospitals as an accident of evacuation should be told they only have battle fatigue and returned to the forward area to be treated in a nonhospital facility close to their units.

d. *Reassurance, Respite, Replenishment, and Restoration of Confidence (The Four Rs).*

(1) At every echelon, the BFC is given immediate, explicit reassurance that this is just battle fatigue," a temporary condition which will improve quickly. The BFC will be actively reassured that his condition is neither caused by cowardice nor sickness, and that it will improve quickly with rest, physical replenishment, and useful activities.

(2) Treatment for battle fatigue is deliberately simple and austere. The BFC will be provided relative *respite* from danger but in a field, military tactical atmosphere.

(3) The BFC will be provided physical *replenishment*: dehydration; an opportunity to sleep; "good food and plenty of it;" and an opportunity for self-hygiene.

(4) The BFC's confidence will be *restored* by structured military work details, tasks, honing soldier skills, and recreation, plus supportive counseling as needed to clarify memories, express feelings, and regain perspective. These activities must reinforce the soldier's identity as a soldier (not as a patient) and as a member of his unit.

12-11. Treatment Results

a. Overview. The severity of symptoms and the speed and extent to which they respond to treatment are directly related to the intensity, lethality, and duration of the battle incident which caused them. The following are only general rules of thumb which allow wide margins of variability.

b. Return to Duty in 1 to 3 Days. Fifty to eighty-five percent of hold and refer battle fatigue cases are restored to duty within 1 to 3 days if kept close to their units (for example, within the division). This brief treatment is called *restoration*. When returned to their original units and

welcomed there, recovered cases have no increased risk of relapse.

(1) In principle, the more intense the battle (with high casualty rates, especially from indirect fire and high explosives), the more effort needed to help BFCs to RTD.

(2) The difference between the high and low success rates can be due to several factors, and CSC planners must evaluate them critically. An 85 percent restoration rate could be due to effective far-forward treatment of truly "heavy" cases. Or it could result from the mismanagement of cases which could be easily restored. That situation, in turn, could be due to—

- Inadequate training and consultation to forward units, or

- A tactical situation which prevents maneuver units from resting any marginally effective soldiers.

c. Return to Duty Within 1 to 2 Weeks. Ten to thirty percent of BFCs do not recover within 72 hours, but do return to some duty within 1 to 2 weeks if they continue in structured, equally positive treatment at a *nonhospital* (tactical) facility in the CZ. This intensive treatment is called *reconditioning*. Premature evacuation of battle-fatigued soldiers out of the CZ must be prevented as it often results in permanent psychiatric disability. If the tactical situation permits, the evacuation policy in the corps should be extended from 7 to 14 days for the reconditioning program.

d. Return to Duty in the Communications Zone. Five to fifteen percent of BFCs *do not* improve sufficiently to RTD in the CZ. Further reconditioning treatment can return many of these to useful duty in the COMMZ. This further reduces the risk of chronic PTSD and disability. Final evacuation to CONUS should not exceed five percent of total BFCs.

Section III. THE COMBAT STRESS CONTROL OPERATIONAL CONCEPT AND RESOURCES

12-12. The Concept

The CSC concept updates the time-proven doctrine to new battlefield conditions. Combat stress control refers to a coordinated program to be implemented by MH personnel organic to units and by Echelon III specialized medical CSC units.

a. Organic Mental Health Sections. The organic MH personnel provide preventive consultation, training, technical supervision, staff planning, and clinical evaluation. They can provide forward treatment to small numbers of cases in slow-moving combat, but are not sufficient to provide treatment for large numbers of battle fatigue or NP casualties without sacrificing their other critical preventive and staff functions. Their most important mission is to develop the familiarity and trust with unit leaders which is necessary—

- For effective operational planning, consultation, and prevention.
- To serve as points of contact for reinforcing CSC teams.

b. Combat Stress Control Units. The medical CSC units—

- Operate restoration or reconditioning facilities in the corps.
- Provide support to corps units.
- Send teams forward for attachment to the division, brigade, or regiment to supplement the organic MH personnel.
- Send teams to support units at reconstitution sites.

c. Mental Health/Combat Stress Control Activities. Mental health/CSC activities usually collocate with or attach to other medical units. They must work closely (coordinate and synchronize) with other general medical personnel, chaplains, chaplain assistants, and available combat, CS, and CSS personnel of all types.

12-13. Combat Stress Control Assets in Table of Organization and Equipment Units

The following are the CSC assets:

a. Division Mental Health Section. Personnel assigned are the division psychiatrist (AOC 60W), social work officer (AOC 73A67), clinical psychologist (AOC 73B67), and six or seven behavioral science specialists (MOS 91G).

b. Mental Health Section in Medical Company, Separate Brigade. This company has three behavioral science specialists (MOS 91G). The noncommissioned officer in charge (NCOIC) must fulfill the same functions as in the divisional brigades and coordinate with whatever MH officers are providing backup support.

c. Medical Company, Armored Cavalry Regiment. There are no MH personnel in the new L-edition (1988) TOE.

d. Medical Company, Combat Stress Control, TOE 08-467L00.

(1) *Mission.* The mission of the medical company, CSC is to provide combat stress casualty prevention, treatment, and management on an area basis.

(2) *Assignment.* The medics] company, CSC is assigned to a MEDCOM, TOE 08-611L00, or Medical Brigade, TOE 08-422L100. It may be further attached to a Medical Group, TOE 08-432L000.

(3) *Capabilities.* This unit provides—

- Planning and staff advice to command and control headquarters regarding the stressors affecting the troops such as combat intensity and sleep deprivation; their mental readiness, morale, cohesion, morals, and spiritual welfare; and the potential for and status of treatment of battle fatigue and other NP and alcohol or drug abuse casualties.

- A preventive section (with psychiatrists and social work officers and enlisted) that may divide into six 4-person CSC preventive (CSCP) teams, each providing consultation, NP triage, reconstitution support, and medical supervision and RTD coordination for restoration and reconditioning programs.

- A restoration section (with psychiatric nurses, clinical psychologists, occupational therapy officers, plus enlisted) that may divide into four n-person CSC restoration (CSCR) teams, each providing stabilization and restoration or reconditioning for up to 50 BFCs, plus consultation, reconstitution support, and NP triage support.

(4) *Employment of teams.* The CSCP and CSCR teams may be employed separately, but more commonly are combined into task-organized sections to staff restoration or reconditioning facilities.

(5) *Mobility.* The CSC teams are 100 percent mobile and can provide austere shelter, heat tray packs, and water for field hygiene for limited numbers of BFCs. These teams

depend on the units to which they are attached for logistical and communications support. Large restoration or reconditioning centers require augmentation with patient-holding assets.

(6) *Basis of allocation.* A company is allocated to the corps on the basis of .5 per division supported. The headquarters section of the medical company, CSC usually collocates with its higher medical headquarters or with the headquarters and support company (HSC) of an evacuation battalion or area support medical battalion which provides staff coordination, communication, and logistical support.

e. Medical Detachment, Combat Stress Control, TOE 08-57LA

(1) *Mission.* The mission of the medical detachment, CSC is to provide forward combat stress casualty prevention, treatment, and RTD.

(2) *Assignment.* This unit is assigned to a Medical Group, TOE 08-432L0, or other medical command and control headquarters and may be further attached to supported medical company, or Medical Company, CSC, TOE 08-467L000.

(3) *Capabilities.* At full strength, this unit provides—

- Planning and staff advice to command and control headquarters regarding the stressors affecting the troops such as combat intensity and sleep deprivation; the troops' mental readiness, morale, and cohesion; morals and spiritual welfare; and the potential for and status of treatment of battle fatigue and other NP casualties including substance abuse casualties.

Ž A preventive section that divides into three CSCP teams; each provides consultation, combat NP triage, reconstitution

support, and medical supervision and RTD coordination for restoration in a BSA.

- One CSCR team that provides stabilization, restoration, and reconditioning for up to 50 BFCs, plus consultation, reconstitution support, and combat NP triage support, usually in the division support area (DSA).

(4) *Mobility*. This unit requires 100 percent of its TOE and common table of allowance equipment and supplies be transported in a single lift using its authorized organic vehicles.

(5) *Basis of allocation*.

(a) One medical detachment, CSC is allocated per division.

(b) One medical detachment, CSC is allocated per two to three separate brigade-sized forces not otherwise provided CSC support.

f. *Mental Health Section, Area Support Medical Battalion (Headquarters and Support Company)*. The MH section, area support medical battalion (HSC) is similar to the division MH section discussed above except that it does not have a psychologist assigned. It provides area MH/CSC support in the corps area and the COMMZ. (See Chapter 13.)

g. *Command and Control*. Command and control of CSC/MH activities will be coordinated by a small MH staff or consultant sections in the MEDCOM, medical brigade (corps and COMMZ), and medical group headquarters. The small MH staff or consultant sections also provide technical supervision of CSC/MH units.

h. *Hospital Staff/Neuropsychiatric Personnel*. These personnel are not technically a CSC resource, but must be considered by the CSC planner in deciding where to collocate

reconditioning centers and to evacuate cases who require hospital treatment. The CSH, FH, and GH will all have an NP service to provide consultation to the medical/surgical services and to staff a 20-bed ward.

12-14. Combat Stress Control Functions

There are six CSC programs or functions: consultation, reconstitution support, NP triage, stabilization, restoration, and reconditioning. The CSC planner must set priorities and allocate the necessary resources to each program. The programs have different relative importance in different situations. In principle, primary emphasis should go to proactive prevention (consultation and reconstitution support) over reactive treatment (restoration and reconditioning).

a. *Consultation to Leaders, Medical Personnel*. This function provides advice, assistance, and liaison to commanders and staff of supported units at the supported unit's location, or by telephone or radio. Primary emphasis is on prevention. Combat stress control personnel must be the organizational memory to line leaders and their medical counterparts for leadership and training measures which can reduce BFCs to fewer than one per ten WIA.

b. *Reconstitution Support to Attrited Units*. This function provides assistance (along with other medical and CSS contact teams) to units which have suffered heavy attrition. This occurs when the units are temporarily withdrawn from action to relatively secure field locations (reconstitution sites) to reorganize, receive replacements, and repair equipment. This can range in scale from deliberate reorganization of small units (platoons, companies, battalions) close behind the battle area for one or more days, to formal regeneration of small or large units (battalions, brigades, whole divisions) farther to the rear for days to weeks.

c. Neuropsychiatric Triage (Sorting).

This process is the diagnosing and sorting of battle fatigue, NP, and alcohol/drug misuse cases (including those with physical injury) based on how far forward they can be treated.

d. Stabilization of Disruptive Cases.

This is the acute management of the small percentage of battle fatigue cases and NP patients who have severe behavioral or medical disturbances and evaluation of their RTD potential.

e. Restoration (1- to 3-Day Treatment).

This brief 1- to 3-day treatment is provided at or near forward medical facilities.

(1) When BFCs are many, restoration will assume high priority. However, restoration should not be allowed to completely displace reconstitution support and essential staff coordination, operational planning, and preventive and RTD-related consultation.

(2) When total casualties are light, patient-holding facilities in Echelons II and III medical clearing stations provide resources where BFCs can be rested, fed, and restored. They can also provide enlisted general medical personnel to serve as treaters under the technical supervision of the MH or CSC team.

(3) These resources, however, are only available when WIA rates are low. Battle fatigue rates rise in direct proportion to the intensity of combat (as reflected in the WIA rate). Therefore, patient-holding resources cannot be relied upon for consistent Echelon II CSC support when MASCAL occur. It is at the times of heavy fighting, when the holding assets have been preempted for acute life support and minor surgical care, that it remains most important to restore BFCs close to their units.

f. Reconditioning (7- to 14-Day Treatment). This treatment is provided at a more stable

location, usually in the corps. This program also can include rehabilitation of those NP and alcohol/drug patients with good potential for RTD.

(1) Reconditioning is similar to restoration, but is more intensive and requires a higher staff-to-case ratio.

(2) A combat fitness reconditioning center (CFRC) is usually collocated with a Echelon III CSH, but must maintain its separate *non-hospital* identity. It may be staffed by teams from the specialized medical CSC units, or by consolidating the psychiatric staff from several hospitals in the theater.

(3) Combat fitness reconditioning centers may also be supported by elements of the Echelon III ASMC or medical company, holding. This will be necessary if the reconditioning case census exceeds the capability of the CSC company without posing an excessive burden on the host hospital.

(4) Many of the soldiers who need reconditioning will be unable to return to their original unit, either because of the flow of the battle or the nature of their symptoms. They may need MOS reclassification and on-the-job training into new combat, CS, or CSS roles.

(5) The preferred option is to have a separate, small reconditioning program behind each division to treat soldiers from that division plus those from nearby supporting corps units. This maintains the principle of proximity and favors immediacy and simplicity by avoiding prolonged transportation. The maintenance of unit identification (most soldiers wearing the same division patch) also aids the positive expectation. However, limited resources or geography may require the use of a consolidated CFRC which supports several divisions.

(6) Reconditioning programs have lower priority than restoration, reconstitution support, and consultation. When the number of cases who may benefit from the 1- to 3-day restoration treatment is high, additional CSC personnel should be sent forward from the reconditioning program to reinforce forward restoration teams. Reconditioning in the corps

area may be limited to an additional 3 days until the crisis passes, or it may be discontinued altogether. This accepts that some soldiers, who may have returned to duty with more effort (and have also been protected from subsequent PTSD), will have to be evacuated to the COMMZ in order to maximize RTD of those who have the best potential.

Section IV. THE COMBAT STRESS CONTROL ESTIMATE OF THE SITUATION

12-15. Combat Stress Control Estimate

The CSC planner must prepare the CSC estimate in cooperation with the senior staff surgeon who is responsible for preparing the overall health service estimate. The CSC estimate follows the standard format shown in Appendix B.

a. Some issues require that the CSC planner be authorized to work directly with the staff sections of the combat command: S1/G1, S2 (Intelligence Officer)/G2, S3 (Operations and Training Officer)/G3, S4 (Supply Officer)/G4 (Assistant Chief of Staff [Logistics]), and G5 (Civil Affairs). The staff chaplains (unit ministry teams) and the Judge Advocate General, provost marshal, and military police units are also important sources of information.

b. The level of detail of the CSC estimate depends upon which echelon is preparing it.

(1) The division MH section works with the division surgeon and PVNTMED section. The section is concerned with which brigades are likely to have the most battle fatigue cases or other combat stress and NP problems. This may determine how many assets are pre-positioned at which brigade support areas. Within the brigades (and in the DISCOM), the division MH section may need to identify specific battalions, companies, and platoons in order to focus preventive consultation or reconstitution support activities.

(2) The CSC units which provide backup support and reconditioning in the corps are concerned with which divisions, separate brigades/regiments, and other corps units are likely to generate the most stress casualties. The medical detachment or CSC unit—

- Receives the estimates from the division MH sections and coordinates directly with them.
- Develops its CSC estimate in conjunction with its higher medical command and control unit.
- Prepares to receive reconditioning cases at different regions of the battlefield.
- Sends CSC augmentation or reinforcements to the forward units in greatest need.

NOTE

The medical group and medical brigade headquarters will have a small MH staff section to help coordinate these activities.

c. The primary objective of the CSC estimate is to predict where and when the greatest need is likely to arise among the supported units. With this information, preventive efforts can be initiated early, limited resources can be allocated, and contingency plans prepared for their reallocation as needed.

(1) Quantification of the projected restoration and reconditioning caseloads will not be precise. Absolute values should not be given too much weight. However, quantification provides a useful analytical tool for estimating relative risk. The historical ratios of the incidence of BFCs to the incidence of WIAs provide a baseline for estimates in future operations.

(2) This analysis is most valid when applied to specific units in a specific combat operation. It is less precise when applied to larger, composite units. The analyst must estimate what percentage of subunits of different types (combat, CS, CSS) will encounter particular negative factors (stressors). He must also estimate what percentage will be protected by potential protective factors.

(3) To predict the incidence of BFCs, begin with the prediction of WIA cases who will require hospitalization.

NOTE

This requires estimating the incidence of new WIA cases, not the bed occupancy estimates usually used in medical planning. In moderate to heavy conventional fighting, the CSC planner can begin with the average ratio of one BFC for five WIA (1:5). Then he can examine the nature of the mission for each of the specific units involved and use *protective* (positive) and risk (negative) factors to judge whether 1:5 is likely to be an over- or underestimate.

(4) Paragraphs 12-16a and 12-16c discuss the protective and risk factors for battle fatigue. These factors are referred to by their parenthetical subparagraph numbers, preceded by a plus or minus sign, respectively; for example: +(6), -(18).

(5) Each of these factors could be given a numerical weight (0, +1, +2 for positive factors; 0, -1, -2 for negative ones). The factor scores are added algebraically to give a rough total score. The weight must be based on subjective expert judgment and experience.

(6) The same analyzing process used to estimate BFCS in relation to WIA patients can be applied to estimating the potential for substance misuse/abuse patients and other misconduct stress behavior compared with their normal rates of occurrence in the troop population.

(7) The protective and risk factors for misconduct stress behavior in paragraphs 12-17a and 12-17b will be similarly designated. However, the letter "m" (for "misconduct") will be used after the parenthesis; for example: +(5)m, -(11)m.

12-16. Estimating Battle Fatigue Casualty Work Load

a. *Protective (Positive) Factors.* The following protective (positive) factors reduce BFCS relative to WIA:

+ (1) High unit cohesion. Troops and their leaders have trained together (and, ideally, have been in successful combat) without continual turnover of personnel. For example, Cohesion, Operational Readiness Training (COHORT) companies and battalions are presumed to have high unit cohesion provided the leaders have had time and training to develop "vertical cohesion" through factors +(5) and +(6).

+ (2) History of very tough, realistic training (for example, militarily sound, uncomfortable, and dangerous, preparing troop for the stimuli of war). Successful combat in which there were few casualties is good training. Airborne and Ranger training and realistic live-fire exercises (both small arms and artillery) also help to “battle proof” soldiers.

+ (3) Unit leaders and medical personnel are trained in recognition of battle fatigue. They demonstrate ability to manage duty and rest cases at unit level and to reintegrate recovered hold and refer cases back into units.

+ (4) Units are withdrawn from combat periodically to rest, refit (reconstitute if necessary), and absorb new replacements. Replacements arrive and are integrated as cohesive teams, not as individuals.

+ (5) Leaders demonstrate competence, courage, and commitment. Leaders show caring for the soldiers and make provisions for physical and mental well-being as the tactical situation permits. Noncommissioned officers know and are given responsibility for *sergeant’s business* (taking care of their troops). An active sleep discipline and sleep planning program will reduce the risk of battle fatigue particularly when it is targeted towards officer and enlisted leaders. (See discussion in FM 22-51.) Command also shows concern for soldiers’ families.

+ (6) Leaders keep troops informed of the commander’s intent, the objectives of the operation, and the war. They focus the soldiers’ appraisal of the situational stressors to maintain positive coping.

+ (7) Victorious pursuit of a re-treating enemy. This reduces BFCs but may not inhibit misconduct stress behaviors unless command retains tight control.

+ (8) Hasty withdrawal. During hasty withdrawal, few BFCs enter medical channels. However, battle-fatigued soldiers may be lost as KIA, MIA, or captured instead of becoming medical patients, and other stressed soldiers may desert or surrender.

+ (9) Beleaguered unit which cannot evacuate any (or only the most severely wounded) casualties. Here, too, some soldiers may be combat ineffective due to battle fatigue or go AWOL without becoming medical patients.

b. *Assessment of the Positive Protective Factors.*

(1) Factors + (1) through + (6) can be assessed using standard questionnaire surveys of unit cohesion and morale, such as the Unit Climate Profile found in DA Pamphlet 600-69.

(2) Many leaders and soldiers want to believe that their unit is elite and will have far fewer than one BFC for ten WIA even in the most terrible battles. The CSC planner should not discourage this belief since it maybe a necessary first step toward becoming true. However, the CSC estimator should not make plans on the strength of the belief alone. Remember, CSC expertise is not being wasted if it is far forward, assisting command in proactive prevention rather than reactive treatment of BFCs.

(3) Even if tough realistic training, high cohesion, and fine leadership can be independently verified (as with unit survey questionnaires), the BFC estimate should not be too much below the average until the unit has proved itself in successful combat. Even then, estimates should continue to consider the potential negative impact of cumulative attrition, new replacements, and other adverse factors which may eventually overcome the positive factors.

(4) Factors +(8) and +(9) are, of course, not truly "positive." While they decrease the expected requirement to evacuate BFCs for treatment, they indicate a need to redouble efforts for prevention of misconduct stress behavior. Factor +(7) also should alert command to the need to maintain firm control to prevent misconduct stress behavior.

c. *Risk (Negative) Factors.* The following risk factors increase BFCs in relation to WIA:

- (1) Higher combat intensity—indicated by the rate of KIA and WIA (percent of battle casualties [out of the total troops engaged] per unit time).
- (2) Increasing duration of continuous operations—the number of days which the troops (small units) have been in action without respite, especially if there is little opportunity for sleep. The operation may begin significantly before the actual shooting. Preparation time and rapid deployment (jet lag) effects should also be considered.
- (3) Increasing cumulative combat duration—the total number of days (cumulated over days, weeks, months) in which the small units (platoons, companies) have suffered casualties.
- (4) Sudden transition to the horrors of war—many new troops with no prior combat experience; surprise attack or new weapons of mass destruction.
- (5) Extent to which the troops are subjected to artillery and air attack (with some allowance for the strength of their defensive fortification, dispersion, and concealment). This is especially true if it involves sudden mass devastation.
- (6) Heavy casualties from friendly fire (including direct fire, artillery, and air attack). This, of course, is not part of the plan of operation, but is a special hazard of the fast-moving battle. When such incidents are reported, CSC teams should respond immediately.
- (7) High NBC threat—a state of alertness requiring periods in MOPP 1 through 4; frequency of false alarms; and concern and rumors about escalation. Actual NBC use: What type agents? (Persistent contamination? Potential for contagion?) What casualties? What implications for increased MOPP levels, rumors, concerns of escalation, and worries about home?
- (8) Being on the defensive, especially in static positions (unless the fortifications are very strong and comfortable, in which case complacency may be a problem).
- (9) Attacking repeatedly over the same ground against a stubborn, strong defense.
- (10) Heavy casualties among armor or mounted infantry crews; armor in highly restrictive terrain.
- (11) Heavy casualties from mines or booby traps.
- (12) Extent and intensity of rear battle. Combat support/CSS when attacked and/or confronted with dangers and horrors of war for which they have not been adequately trained or mentally prepared.
- (13) Failure of expected support such as fire support, reinforcement, or relief; inadequate resupply; inadequate HSS.
- (14) High personnel turbulence, resulting in low unit cohesion and inadequate unit tactical training.

- (15) Loss of confidence in leaders, in supporting or allied units, and in equipment as compared to the enemy's equipment.

- (16) Popular opposition to the war at home; lack of understanding or belief in the justness of the effort.

- (17) Families left unprepared by rapid mobilization and deployment. Lack of a believable plan for evacuating families from the theater, and also for keeping them secure under a reliable authority if they cannot be evacuated. This can also contribute to misconduct stress behavior, especially AWOL.

- (18) Home front worries. Lack of visible command program for ensuring support to Army families.

- (19) Inadequate water available for drinking.

- (20) Adverse weather, especially cold-wet; any harsh climate if troops are not properly trained, equipped, and acclimatized.

- (21) Unfamiliar, rugged terrain (jungle, desert, mountain, urban) if troops are not specifically trained and equipped.

- (22) High prevalence of endemic minor illnesses, especially if this reflects inadequate command emphasis on self-aid and buddy aid preventive measures.

- (23) Last operation before units (or many soldiers in them) rotate home, or if the war is perceived as already won, lost, or in final stages of negotiation.

- (24) Many civilian women and children casualties in the fighting. This may be a stronger factor in OOTW than in war where the magnitude of the horror and the preoccupation with personal and unit survival may quickly harden soldiers to these casualties.

12-17. Estimating Substance Abuse and Misconduct Stress Behaviors

a. *Protective (Positive) Factors.* Factors +(1) through +(6) in paragraph 12-16a can also reduce alcohol/drug misuse and other misconduct stress behavior. They can be relabeled and reanalyzed as factors +(1)m through +(6)m.

+ (1)m High unit cohesion is positive if the unit's "identity" forbids abuse of substances and emphasizes adherence to the Law of Land Warfare, United States Code of Military Justice, and tolerance for cultural differences.

+ (2) m History of very tough and realistic training is positive if it includes faithful adherence to rules of engagement which support the Law of Land Warfare and cultural issues.

+ (3) m Unit leaders, medical personnel, and chaplains are trained to recognize battle fatigue and early warning signs of misconduct stress.

+ (4) m Units are withdrawn from combat periodically to rest, refit (reconstitute if necessary), and absorb new replacements who arrive and are integrated as cohesive teams, not individuals.

+ (5) m Leaders have demonstrated competence, courage, candor, and commitment. Leaders show caring for the soldiers and make provisions for their physical, mental, and spiritual well-being as the tactical situation permits.

+ (6) m Leaders keep troops informed of the objectives of the operations and war (including psychological operations and diplomatic, political, and moral objectives). They focus the soldiers' appraisal of the situation to maintain positive coping against the temptations to misconduct stress behaviors.

NOTE

These factors will protect only if leaders and troops maintain and enforce a unit's self-image that regards the misconduct behaviors as unacceptable. If that is lacking, these factors may even contribute to substance abuse and violations of the laws of war.

b. Risk (Negative) Factors Which Increase Substance Misuse and Other Harmful Combat Stress Behaviors.

- (1) m Permissive attitude, availability and use of drugs in the TO and also in the US civilian community, especially around posts/garrison areas and in the regions and age groups from which recruits are drawn.

- (2) m Inadequate enforcement of the unit's Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) before deployment in identifying and treating (or discharging) misusers.

- (3) m Availability and distribution networks (both legal and illegal) for alcohol and different types of drugs in the theater. Some drugs are much more available at lower prices in some foreign countries or regions.

- (4) m Unsupervised use of amphetamines and other strong stimulants to remain awake in continuous operations. This can produce dangerous (usually temporary) NP illness. Also, it may lead to dependency and addiction in originally well-intentioned, good soldiers, including leaders.

- (5) m Boredom and monotonous duties, especially if combined with chronic frustration and tension.

- (6) m High threat of nerve agent use with self-administration of atropine in false

alarms causing mental symptoms and perhaps temporary psychosis.

- (7) m Victorious pursuit of a retreating enemy. This reduces BFCs, but may not inhibit commission of atrocities (the criminal acts of killing EPW, raping, or looting) or alcohol/drug misuse (as supplies are "liberated") unless command retains tight moral control.

- (8) m Hasty withdrawal. Here, too, soldiers may loot or abuse substances to keep them from falling into enemy hands. Rape, murder, and other reprisal atrocities can occur if retreating troops feel hindered by EPW, or if the civilians being left behind are hostile. Leaders must not encourage too zealous a scorched-earth policy. This means that only those items (except medical) that could be of potential use to the enemy are destroyed. If leaders lose tight control, other overstressed soldiers may desert or surrender.

- (9) m Beleaguered unit which cannot evacuate any (or only the most severely wounded) casualties. Here, too, some soldiers may commit misconduct stress behaviors due to battle fatigue, or go AWOL without becoming medical patients.

- (10) m Commission of atrocities by the enemy, especially against US personnel but also against local civilians.

- (11) m Racial and ethnic tension in the civilian world and in the Army. Major cultural and physical/racial differences between US and the local population.

- (12) m Local civilian population perceived as hostile, untrustworthy, or "sub-human." Lack of education and understanding of cultural differences.

- (13) m Failure of expected support, such as reinforcement or relief; inadequate resupply; inadequate medical support and

evacuation. Soldiers who feel abandoned and on their own may resort to illegal measures to get what they think they need. Combat soldiers naturally tend to feel “entitled to claim what they have earned,” and this may lead to looting and worse.

- (14) m High personnel turbulence, lack of unit cohesion, especially “vertical cohesion” between leaders and troops. “Substance-of-choice” can become a “ticket” for inclusion into a group.

- (15) m Loss of confidence in leaders, in supporting or allied units, and in equipment as compared to the enemy’s. These produce the same effects as factors -(13)m and -(16)m.

- (16) m Popular opposition to the war at home; lack of understanding or belief in the justness of the effort. Some soldiers will find this an excuse to desert or refuse lawful orders. Others who continue to do their duty may show their

resentment by lashing out at the local population, or by using drugs and alcohol.

- (17) m Lack of a believable plan for protecting families in the theater, either by evacuating them or keeping them secure under reliable authority. Some soldiers may go AWOL to stay with them.

c. Use of Estimate of Substance Abuse and Misconduct Stress Behavior. The purpose of this estimate of potential substance misuse and other misconduct stress behaviors is the same as for the estimate of BFCs. It is to predict when and where (in which units) problems are most likely to occur so that preventive actions can be focused. Also, provisions can be made for the medical/psychiatric treatment of substance abuse cases in the TO. The CSC estimator must work closely with the Judge Advocate General staff, military police, and the chain of command to compare the projections with what is actually being found.

Section V. THE COMBAT STRESS CONTROL PLAN

12-18. Format

The format for the CSC plan is the standard outline shown in Appendix C. The CSC planner must analyze the OPORD and HSS estimate for direct or implied CSC missions. He must assess the available CSC resources and analyze alternative ways of using them to accomplish the missions. Frequently, it is necessary to prioritize the missions and recommend to the command surgeon which of the alternate courses should be taken.

12-19. Combat Stress Control Planning Considerations in Deployment and Combat

a. The requirements for each of the CSC program functions (consultation, reconstitution

support, NP triage, restoration, reconditioning, and stabilization) and the ability of CSC units to satisfy those requirements will be influenced by the factors listed below:

(1) The nature, mobility, and intensity of combat operations which influence the number of battle-fatigued soldiers; the severity of symptoms; and the feasibility of resting cases in or near their units.

(2) The type of threat force, especially the threat to CSC activities themselves. For example, the likelihood of air and artillery attack; the security of “rear areas” for rest; the electronic warfare threat and target detection capability for concentrations of troops; and the NBC and DE threat.

(3) The availability of other health service units on which the CSC elements can rely for local logistical/administrative support and for patient transportation or evacuation.

(4) The geographical AO, terrain, and climatic conditions which limit mobility of CSC units and require additional shelter for patients.

(5) The endemic disease, drug, alcohol, and environmental hazards which threaten resting battle fatigue cases and produce other preventable nonbattle injuries which, historically, have been a consequence and complication of battle fatigue.

b. The CSC planner must determine the actual strengths of the CSC resources in organic unit MH sections and specialized units. They may not be at the authorized levels for personnel or equipment. The level of training, degree of familiarity, and cohesion with the supported units must be assessed.

12-20. Combat Stress Control Planning Considerations in Deployment and Combat

a. The more intense the combat, the higher the rate of WIA and the higher the ratio of BFCs to WIAs. If the WIA rate doubles, there will be four times as many BFCs requiring treatment. Furthermore, high-intensity combat causes a shift towards more severe symptoms and slower recovery.

b. The CSC organization must achieve a balance between pre-positioning elements far forward and having other elements further to the rear that can take the overflow of cases and be redeployed to areas of special need.

c. In Army Operations, each maneuver brigade covers a larger and more fluid area, and

has greater firepower and responsibility than did a World War II division. Winning the first battle will be critical and can be accomplished only by reconstitution of attrited units and rapid return of temporarily disabled soldiers to their units. The division MH section must be reinforced if cases are to be restored in the BSA and DSA.

d. Small CSC teams must be pushed forward to reinforce the maneuver BSAs well before the fighting starts. Although BFCs will not be evenly distributed among all brigades, those cases which occur must be evaluated and treated immediately at that level.

(1) At the critical places, this will be under MASCAL conditions. Other logistical requirements and enemy activity may make it impossible to send CSC personnel quickly once the battle has begun. Any newly arriving CSC personnel who join anew unit under such circumstances will take critical hours to days to become efficient.

(2) The purpose of these CSC "preventive" teams is NOT to hold BFCs for treatment in the highly fluid BSA. Their purpose is to prevent the evacuation of DUTY and REST BFCs who could remain with their units. These teams also ensure correct initiation of treatment and transfer (not *evacuation*) of the refer cases to the division fatigue center in the DSA. If circumstances allow, they could hold a very small number for overnight observation/restoration.

(3) Combat stress control teams which are with a brigade not in action will use this time productively in consultation activities. These activities will reduce the incidence of stress casualties and better enable the unit to treat its cases far forward when the time comes.

e. Combat stress control elements in the DSA provide NP triage and prevent any unnecessary evacuation. They staff the division fatigue center which assures 2-to 3-day restoration within the division. They provide preventive consultation

and reconstitution support throughout the division rear. They can send personnel, tents, and supplies forward to reinforce the teams at the BSA.

f. Combat stress control elements in the corps area must provide the back-up “safety net” to catch the overflow from hard-pressed divisions, as well as providing reconstitution support to units which are withdrawn from battle and preventing and treating local rear-area battle fatigue cases. Those in the corps area can be transferred laterally within the corps, or temporarily sent forward to divisions which are in greatest need. With somewhat greater difficulty, these assets can be transferred from one corps to another.

g. Combat stress control teams need 100 percent ground mobility and adequate communications capability to function in their local areas. They need a small vehicle to circuit-ride the units in the BSA, DSA, or corps support area, and to deploy to reconstitution sites with other CS/CSS teams. Note that it is not recommended to send CSC teams wandering around the battlefield alone. When they move outside the defensive areas, they should be in convoy with other CSS vehicles or other elements.

h. Combat stress control units, however, provide the expertise of their personnel with little requirement for heavy equipment. Therefore, if time, distance, or the tactical situation prevents a CSC element from traveling by ground to reinforce another CSC element which is already in place, the key personnel and light, specialized equipment can be moved by air, if available.

NOTE

Combat stress control personnel can be sent forward in medical evacuation (MEDEVAC) helicopters that are going to the forward medical companies to evacuate the wounded.

Additional supplies, equipment, and vehicles can follow as prepackaged pallets or sling-loaded vehicle trailers. The key requirement is that a familiar CSC team with vehicle and preestablished contacts is already at the destination expecting to be reinforced.

i. If the division MH section or CSC unit is given the mission to support a separate brigade or ACR, it is important to establish contact and send a liaison officer or NCO to its medical company as much as possible before the battle.

NOTE

Because of their unique missions, armored cavalry units have special need for consultation, preventive education, and staff planning.

Because of their elite self-image, it is important that the liaison is someone who has trained with the unit and is known by its personnel. In some scenarios, cavalry units suffer extreme attrition in the first days of continuous operations, yet they are cited as prime candidates for reconstitution to return the survivors quickly to battle.

j. Combat stress control support is very inexpensive for its potential pay-off in returning to duty soldiers at crucial times and places in the battle and in reconstitution support after battle.

(1) If not required to treat BFCs and attrited units, the same few personnel will be active in consultation to unit leaders. This will improve prevention and readiness to return BFCs to duty.

(2) Combat stress control assets also assist with treatment of other WIAs and DNBI who have rapid RTD potential. Many of these will also have severe battle fatigue symptoms which require treatment.

(3) Finally, they have a crucial role in preventing future PTSD in all troops (including those who did not become casualties) by assisting command with after-action debriefings.

12-21. Combat Stress Control Planning Considerations in Operations Other than War

a. In OOTW, the total requirement for CSC support is less than in war. There is less need to pre-position CSC elements far forward except during specific operations which approach war.

(1) The total ratio of battle fatigue cases to WIAs may be high, but the average number of WIAs is below two per thousand per day, so there are fewer cases. Most battle fatigue cases can be managed in their units as duty or rest cases.

(2) Few of the cases are hold or refer casualties who need to be held under medical observation, so the BFC:WIA ratio is usually below 1:10. However, relatively more of those who are casualties will need stabilization on a hospital ward.

(3) Reconstitution support is still important for units following battle, but the units will usually be small (squad, platoon, company).

b. Contingency operations pose special problems if they involve rapid deployment to an undeveloped theater. The HSS plan for care of all wounded and sick who cannot return immediately to fill duty maybe to evacuate them as quickly as possible to the nearest COMMZ or CONUS MTFs. The tendency will be to err on the side of caution and evacuate anyone whose status is in doubt.

(1) This zero-day evacuation policy may continue for the duration of a brief operation,

or until formal medical holding facilities can be deployed behind the forward area surgical teams.

(2) Early deploying medical personnel, as well as CSC planners and treaters, must make a concerted effort to encourage units to keep soldiers with DUTY battle fatigue in small units, and to keep REST cases in their own CSS elements for a day or two of light duty, then return them to full duty.

(3) If at all possible, the plan should also hold BFCs at the forward medical facilities for 1 to 3 days of restoration as an exception to the usual evacuation policy. This holding can be done under very austere conditions and need not add significant additional logistical burden to the system. Failure to provide such inexpensive, proximate treatment will be paid for in greatly increased chronic psychiatric disability.

c. In OOTW, while the need for restoration of BFCs is less than during war, the incidence of misconduct stress behaviors increases, specifically—

Ž Behavior disorders, including indiscipline and violations of the Law of Land Warfare and the Uniform Code of Military Justice.

- Drug and alcohol abuse.
- Other disorders of boredom and loneliness.

There is still a need for a reconditioning program in the corps to salvage those cases who do not improve in the divisions. The preventive consultation programs remain important for corps-level CSS units with no MH sections.

d. Conflict requires rigorous preventive programs and after-action debriefings to minimize subsequent PTSD because of the ambiguous and often vicious aspects of enemy tactics and their effects on our soldiers.

12-22. Considerations When Units or Individual Soldiers Redeploy Home (After Military Operations)

a. Unit MH personnel and supporting MH/CSC units assist leaders in preparing soldiers for the transition back to garrison or civilian life. A period of several days should be scheduled for memorial ceremonies, group debriefings, and discussions of—

Ž What has happened in combat, especially working through painful memories.

- What to expect in the soldiers' own reactions on returning to peacetime.

Ž How family and society may have changed since deployment and how to deal with these changes constructively.

b. More intensive programs are scheduled for individuals or units with especially prolonged intensive combat or other adverse experiences. Coordination with the rear detachment and family support groups is required to schedule similar education briefings and working-through sessions at the home station, both before the unit returns and in combined sessions after the return. The debriefings should also address—

Ž How the soldier, spouses, children, and society as a whole may have changed.

- How to cope with those changes positively.

Welcome home ceremonies and memorial services provide a sense of completion and closure.

12-23. Combat Stress Control Planning Considerations in Peacetime

a. To be effective, CSC must form a continuum with the Army MH services. The

peacetime utilization and training of MH personnel must prepare them for their mobilization missions and develop strong unit cohesion among themselves and with supported units. Future operations may leave no time for on-the-job training, or to develop familiarity and cohesion before the crucial battle starts.

b. Army Regulation 40-216 states that patient care duties must not interfere with the division MH section's training with its division.

c. Echelon III psychiatric and MH personnel who will provide CSC support should have peacetime duties which bring them into close working relationships with the organic MH sections, chaplains, line commanders, and NCOs of the units they will support in war.

(1) Active Component CSC personnel should be assigned to the medical department activities (MEDDACs), community MH/community counseling centers, drug, alcohol, and family advocacy and exceptional family member programs at the posts or garrisons of the Active Component divisions, brigade, regiments, and corps units they will support. They should participate with those units in field exercises.

(2) Reserve Component CSC personnel should use weekend and annual training to train with and conduct stress control programs for the divisions, brigades, and corps units they will support on mobilization.

12-24. Briefing the Combat Stress Control Plan

a. Depending on the echelon, the CSC plan may be briefed to a senior medical commander or line commander for approval. In some headquarters, the CSC planner may give the briefing. In others, it may be given by the unit surgeon as part of the overall HSS plan.

b. In any case, the CSC briefing must be short and simple. The senior commander does not need all the details which went into the analysis (although those details should be available if asked for). The commander needs to know the “bottom line.” What will it cost? What is the return, especially in reduced casualties and rapid RTD? What is the risk if it is not done?

c. Many commanders are highly knowledgeable about the nature and importance of

combat stress reactions and home-front issues. However, many others are not. The CSC briefing may have to overcome the prejudice that MH (CSC) interventions pamper the troops and ruin them for combat or just burden the unit with ineffective troops who would be better purged from the Army.

d. Educating the senior commander, using language he knows and understands is the first, essential step of CSC.