CHAPTER 12

COMBAT STRESS CONTROL SERVICES

12-1. Prevention and Treatment of Combat Stress Casualties

Combat stress control (CSC) services are a separate AMEDD functional area. The mission of CSC services is to prevent or treat battle fatigue casualties, misconduct combat stress behaviors, and delayed post-traumatic stress problems.

a. The following are some examples of causes which make battle fatigue inevitable:

- Sustained operations.
- Weapons of mass destruction.
- Exposure to killed and wounded.
- The potential for forces to become intermingled in high-intensity conflict.
- A 360° battlefield with no defined boundaries.

b. In low-intensity conflicts, the guerrilla or terrorist enemy deliberately seeks to provoke misconduct combat stress behaviors. Some examples of misconduct combat stress behaviors are substance abuse, atrocities, and indiscipline. These behaviors impair the Army's will to fight and invalidate its cause.

c. After combat, training accidents, or disasters, CSC services provide sound "preventive maintenance" in resolving stress issues. These services decrease later post-traumatic stress problems that would otherwise diminish the Army's fighting strength.

12-2. Prevention

Prevention of battle fatigue is primarily a command and leadership responsibility. Medical and mental health personnel at all levels play important supporting roles. Active education and prevention programs–

- Control stressors.
- Promote unit cohesion and realistic training.
- Prepare unit leaders and medics to identify and manage stress and stress behaviors (battle fatigue) in the units.

These programs can reduce the incidence of stress casualties in high-intensity conflict from the common ratio of one per three wounded in action (WIA) to below one battle fatigue casualty per ten WIA. They also reduce the misconduct combat stress behaviors which interfere in completing the mission of a low-intensity conflict. Additionally, medical and mental health personnel must follow the principles of combat stress prevention for self-protection. They must first *protect* themselves from the effects of combat stress. This action will enable them to properly continue their mission to conserve manpower rather than to become casualties themselves.

12-3. CSC Functional Area

The AMEDD CSC functional area refers to a coordinated program for–

- The prevention of battle fatigue and other harmful combat stress behaviors.
- The treatment and RTD of those who become casualties.

Combat stress control is implemented by mental health personnel organic to units and by specialized medical CSC units which are corps-level (or echelon above corps) assets. There are six CSC missions: consultation, reconstitution support, combat neuropsychiatric triage, restoration, reconditioning, and stabilization. These missions have differing priorities in different situations, but their usual priorities are in the order described below.

a. The consultation mission includes preventive advice, education, and assistance to leaders and staff of supported units. The purpose of the mission is to–

- Control stressors.

- Keep stressed soldiers functioning in their units.

- Reintegrate recovered stress casualties quickly.

b. The reconstitution support mission is to deploy CSC teams to assist attrited units when they are withdrawn from action for reconstitution. The mission–

- Facilitates physical and psychological replenishment.

- Reintegrates surviving veterans and new replacements into cohesive teams.

c. The combat neuropsychiatric triage mission is to sort fatigue, stress, and neuropsychiatric cases based on where they can be treated to maximize RTD. The following are the neuropsychiatric triage categories–

- "Duty" (keep in original unit).

- "Rest" (rest in nonmedical support unit).

- "Hold" (hold for treatment at this medical unit).

- "Refer" (evacuate, but only to the next medical echelon for reevaluation).

d. The restoration mission is to treat with reassurance, rest, food, water, hygiene, and activities to restore confidence within one to three days at forward MTFs.

e. The reconditioning mission is to treat with physical training and an intensive program of psychotherapy and military activities for seven or more days. The treatment is provided in a nonhospital setting, usually in the corps. Additional reconditioning may be provided in the COMMZ.

f. The stabilization mission is to manage and evaluate severely disturbed battle fatigue and neuropsychiatric patients to–

- Determine RTD potential.

- Prepare for further treatment, administrative disposition, or evacuation to CONUS.

12-4. Treatment Principles

a. Successful treatment of battle fatigue casualties uses the PIES principle developed during World War I and II.

(1) Proximity. (Treat as close as possible to the soldier's unit and the battle; prevent overevacuation.)

(2) Immediacy. (Treat immediately, without delay.)

(3) Expectancy. (Treat with expressed positive expectation of full and rapid recovery.)

(4) Simplicity. (Treat using simple, brief, nonmysterious methods to restore physical well-being and self-confidence. Use nonmedical terminology and techniques.)

b. Treatment consists of–

- Reassurance.

- Rest.

- Physical replenishment (food and fluids).

- Hygiene (shower, shave, and a clean combat uniform).

- Psychotherapeutic activities (a chance to talk about events that occurred and to learn how to manage the stress in the future).

- Occupational activities which restore the soldier's identity and confidence as a soldier.

Treatment must be accomplished in a *nonpatient-care* military environment.

12-5. Treatment Effectiveness

With correct treatment, 50 to 85 percent (depending on the intensity of conflict) of soldiers RTD within

one to three days of brief *restoration* treatment. About 50 to 75 percent of the remainder RTD within one to three weeks of intensive reconditioning treatment. However, evacuation too far to the rear or to hospital wards increases morbidity, delays recovery, and often results in chronic disability.

12-6. Echelon II Services

Echelon II CSC support is provided by the division mental health section (DMHS) of the medical company, MSB, or the DMHS of the medical battalion. The psychiatrist, the psychologist, and the social work officer, assisted by enlisted behavioral science specialists, provide preventive consultation and education, staff planning, neuropsychiatric triage, and emergency stabilization. A DMHS NCO is routinely allocated to each maneuver brigade as its brigade combat stress control coordinator (BCSCC). The BCSCC coordinates all CSC activities within the brigade for the brigade surgeon. The DMHS NCO–

- Supervises restoration treatment in brigade and division medical companies (clearing) when patient work load permits.

- Coordinates the activities of reinforcing Echelon III CSC teams through the DMOC.

12-7. Echelon III Services

a. Echelon III CSC support is currently provided by psychiatric service (Team OM), TOE 08-620H00M. This unit has a headquarters section, a 25-cot treatment section, and 3 mobile consultation teams.

(1) The headquarters section consists of a psychiatrist (commander), psychologist, medical operations officer, and 5 enlisted members.

(2) The 25-cot treatment section consists of a psychiatrist, 2 psychology nurses, and 11 enlisted members.

(3) Each mobile consultation section consists of a psychiatrist, two social work officers, and six enlisted members.

b. This unit is 100 percent mobile. It collocates with a medical company (clearing) or hospital for administrative and logistical support, but must maintain its separate, *nonpatient-care* identity. It conducts brief restoration or reconditioning programs. Its mobile teams deploy to conduct preventive programs, provide support to units which are undergoing reconstitution, and reinforce Echelon III medical companies (clearing) or DMHSs to provide restoration treatment for large numbers of battle fatigue casualties.

12-8. Echelon IV Services

Depending on availability and phase of battle, a Team OM may be allocated to the COMMZ. This team–

- Assists in preventing combat stress casualties.

- Treats local stress casualties.

- Provides additional reconditioning for RTD of cases who must be evacuated from the combat zone.

If no Team OM is available, limited CSC support may be provided by the mental health staff of the general and station hospitals.

12-9. Medical Force 2000

Combat stress control units under Medical Force 2000 are discussed in Appendix H.