

CHAPTER 4

COMBAT STRESS CONTROL CONSULTATION

4-1. Priorities and General Principles

a. *Primary Emphasis of Combat Stress Control.* The primary emphasis of CSC is on the enhancement of positive, mission-oriented motivation and the prevention of stress-related casualties. Combat stress control personnel provide consultation and training (either formal or informal) on many topics including—

- Enhancement of unit cohesion, leadership, and readiness.
- Risk factors (stressors).
- Recognition signs of stress symptoms and behaviors.
- Leaders' actions to control stressors and stress.
- Individual stress management techniques and skills.

b. *Combat Stress Prevention.* Combat stress prevention programs reduce the incidence of new combat stress-related casualties. These programs promote the early recovery and RTD of stress casualties. They reduce the cases which could otherwise overload the CHS system. Overall, combat stress prevention programs are significant combat multipliers which enhance the Army's fighting strength and its ability to perform its mission while significantly reducing the number of casualties.

NOTE

Overall, consultation has the highest priority among the CSC functions.

If consultation is deferred due to tactical or other critical situations, consultation services should be

reinstated at the earliest possible time. If not quickly reinstated, other functions could soon be overwhelmed by the casualty caseload.

(1) *Army operations during war.*

During war, the primary efforts are toward the prevention of and successful RTD of BF casualties. Historically, BF casualties have represented from one-sixth to one-third of all battle casualties in high-intensity wars. Failure to reduce/prevent BF casualties or RTD a large numbers of these cases could affect the outcome of key battles. The fast pace of the high-technology battle requires that CSC preventive consultation be ongoing before the fighting starts.

(2) *Operations other than war.*

In conflict and peacetime contingency operations, CSC consultation activities are more focused toward prevention of misconduct stress behaviors and on maintaining unit cohesion, morale, and esprit de corps than on preventing BF casualties. This is done because BF casualties are rarely seen in OOTW, but the reported incidence of misconduct stress behaviors are relatively frequent. The enemy in OOTW may deliberately use stress to try to provoke our soldiers to commit misconduct. Misconduct, especially commission of atrocities, not only endangers mission accomplishment but can severely damage US or allied national interests.

(3) *All intensities of conflict.*

Psychologically, traumatic and catastrophic events occur in war and OOTW. Combat stress control personnel must be prepared to provide CSC intervention. Combat stress control preventive programs and CSC intervention for catastrophic events will assist in protecting soldiers from PTSDs.

c. *Modes of Combat Stress Control Consultation.* Combat stress control consultation is defined as providing expert advice, education,

training, and planning assistance. The objectives of consultation are the improvement of psychological readiness and the prevention and treatment of BF, misconduct stress behaviors, PTSDs, and all stress-related problems. This consultation support is provided to commanders, leaders, and the staff and medical personnel of supported units. Consultation on all topics related to the prevention, treatment, and RTD (or other disposition) of BF casualties, misconduct stress behaviors, PTSDs, and NP disorders is provided.

(1) Combat stress control personnel are the primary resource for advice and training on ways to control stressors and stress. Supporting CSC personnel interface with—

- Unit commanders.
- Staff elements.
- Leaders.
- Chaplains (very important contact).
- Medical personnel (other than mental health/CSC personnel).
- Other personnel.

Leaders at all levels must be made aware that CSC measures can reduce BF casualties to fewer than one per ten WIA and can expedite the early return of BF casualties to full duty (see FM 22-51). These measures also help in reducing problem behaviors and incidents which detract from the overall readiness of a unit. Some of these detractors include—

- Substance abuse.
- Suicides.
- Home front problems.

- Misconduct.
- Other stress disorders.

(2) Consultation may be provided in response to a specific request or be initiated by mental health personnel. Methods for providing consultation and training include—

- One-on-one.
- Small discussion group.
- Large groups.

Consultation is an ongoing process which is performed in both peacetime and wartime. It is conducted before, during, and after combat.

(3) Consultation is best initiated through face-to-face contact, preferably at the supported unit's location. Telephone and radio may be used to set up further sessions or to provide follow-up consultation. Audio tapes and videotapes may also be used if the unit or meeting site has the equipment to play them. Follow-up consultations also works best when the face-to-face contact method is used.

(4) Successful consultation is dependent on trust and the familiarity established between the consultant and the soldier(s) with whom he is working. Especially in a hierarchical, high-stress, time-pressured setting like the Army, the consultant must possess a credible military bearing. He should have a thorough knowledge of the military (the units, missions, vocabulary, acronyms, and skills involved). He must be realistic and self-confident about the accomplishment of his work. In some instances, sufficient rank may also be necessary. These visible military features are often more important in establishing credibility than are academic or clinical credentials. In a peacetime environment, academic and clinical credentials are important for long-term credibility.

(5) Therefore, when possible, the consultant should establish contact and rapport with the personnel of supported units long before action becomes imminent. In general, the longer the relationship is established prior to the onset of tactical operations, the greater the effectiveness of the consultation.

d. Consultants. All mental health/CSC professional disciplines and enlisted MOSS may serve as consultants in mental health/CSC areas.

(1) There are five disciplines in the mental health/CSC area and each one has specific subject areas. These disciplines include—

- Psychiatry.
- Psychiatric nursing.
- Clinical psychology.
- Social work.
- Occupational therapy.

Consultants will naturally rely and focus on their specific specialty. Each of the disciplines should also be able to provide routine consultation for all basic topics. Therefore, it is essential that information be shared ongoing among the five mental health disciplines and between officers and their enlisted assistants. This mutual understanding also expedites the appropriate referral to the relevant specialist, as required.

(2) Experience shows that the CSC consultation mission (and to a lesser extent, the treatment mission) is functionally divided into professional mental health-credentialed officer responsibilities and experienced mental health NCO responsibilities. Since each has a unique role, neither officer nor NCO can do the other's business with full effectiveness. The solution is to form cohesive officer/NCO teams. The officer

and especially the NCOs must have sufficient rank and experience to establish face-to-face validity as advisors and counselors to line officers and senior NCOs. Similarly, each mental health discipline (psychiatry, clinical psychology, social work, psychiatric nursing, and OT) has areas of unique professional expertise. A multidisciplinary approach is required which provides mutual access to each discipline at key levels in the CSC unit organization. There must also be sharing of information within the CSC units to increase the areas of shared expertise.

(3) Other personnel will be involved in recognition and control of stress as a result of their position or duty assignments. Consultation and training to develop them into effective CSC consultants is a high priority for mental health/CSC personnel. These personnel will include—

- Unit leaders.
- Chaplains and chaplains' assistants.
- Other physicians and physician assistants.
- Combat medics.
- Other supporting medical personnel.

NOTE

The role of a good consultant is to train others to use his knowledge rather than to guard his information as a trade secret.

e. Audience for Consultation. The target audiences for consultation vary, depending

on location and mission. Consultation and training activities should be identified, prioritized, and scheduled to achieve maximum participation from all supported units. Depending on the units in the area of support, broad types or categories of personnel are considered for consultation activities. These personnel may include—

- The command or unit surgeon and his staff.
- Staff chaplain and unit ministry team.
- The senior commander and the senior NCO (of the unit or the command sergeants major of the corps, division, brigade, and/or battalion).
- Staff officers and NCOs, including adjutant and personnel (S1/G1), intelligence (S2/G2), operations (S3/G3), logistics (S4/G4), civil affairs (G5), DMOCS, and the judge advocate general (JAG).
- Company-grade leaders, especially company commanders, executive officers, first sergeants, platoon leaders, and platoon sergeants.
- Assembled troops of combat, CS, and CSS units.
- Medical personnel including physicians, physician assistants, dentists, nurses, practical nurses, medical specialists and NCOs, and the nursing services of CZ and COMMZ hospitals.

Some of these medical personnel may be recent additions to their units who are likely to be from the Professional Filler System (PROFIS) or Individual Ready Reserve. Such individuals may have special need for quick education in CSC principles.

NOTE

A critical issue is to ensure that medical personnel do not overdiagnose stress casualties.

Stress cases should not be diagnosed as NP or physical disability cases. Stress cases should not be prematurely evacuated out of the theater without adequate trial of the CSC restoration and reconditioning program.

4.2. Consultant Activities During Pre-deployment and During Buildup and Waiting Phases in the Theater of Operations

a. *Knowledge of the Supported Units.*

The mental health/CSC personnel should train in the field with the units they will support during combat. They must become knowledgeable of these units and familiar with their personnel. Through contact with supported units and involvement in training activities, mental health/CSC personnel gain the trust and confidence of those personnel. The trust, confidence, and familiarity of unit personnel will significantly enhance mental health/CSC personnel's ability to perform their mission. All available time during pre-deployment and build up in the TO should be utilized to gain familiarity with any new units. Mental health/CSC personnel must also make an effort to maintain relationships already established through training. Some of the information provided below pertains to establishing relationships with the new unit and may apply to maintaining relationships.

(1) Present a briefing on the mental health/CSC mission and its relevance at commander calls, officer/NCO professional development sessions, and as part of the combat orientation of new replacement units arriving in the TO.

(2) Arrange to visit unit leaders and work areas. Choose times when they can explain and demonstrate their mission. Participate as an observer at the crew and team level in maneuver or live fire training exercises. Emphasize that the purpose of the visit involves the mental health/CSC mission to support them during combat. Explain to them that the mental health/CSC mission requires that mental health/CSC personnel be knowledgeable of what they do; that the mental health/CSC personnel need to be aware of stressful conditions associated with their mission.

(3) Attend ceremonies of supported units and participate in their unit activities such as physical training.

(4) Provide briefings, classes, information papers, and more importantly practical exercises in topics which are relevant to the mission scenario. Topics should include—

- Combat stress/BF recognition and management (appropriate for the branch, rank, and duties of the audience).
- Techniques for building unit cohesion.
- Performing stress management and relaxation techniques.
- Maintaining performance in continuous and sustained operations.
- Ensuring psychological preparation for NBC defense.
- Preventing BF and misconduct stress behaviors by defending against the stresses of terrorism, guerrilla operations and restrictive rules of engagement.

- Treating EPWs according to the provisions of the Geneva Conventions.

- Orienting soldiers to the customs, traditions, religion, and other socioeconomic values of the civilian population.

- Recognizing the overstressed soldier.

- Recognizing signs of substance abuse and preventing, treating, and rehabilitating abusers.

- Improving leadership skills for interviewing, counseling, and assisting problem soldiers.

- Developing leadership skills to conduct after-action debriefings (routinely and for serious accidents, or combat situations).

- Conducting grief management (the chaplain should be included).

- Improving time management, organizational skills, and leisure time skills.

- Controlling family issues, including how to access supporting agencies such as—

- Red Cross.
- Army Community Service.
- Army Emergency Relief.
- Exceptional Family Member Program.
- Family Advocacy Program.

- Medical care and the Civilian Health and Medical Programs of the Uniformed Services and Delta Dental Plan.
- Preparing families for deployment of the service member's unit.

NOTE

Time invested in consultation is never wasted. New knowledge, insight, and points of contact are always worth gaining. Just ask questions and listen.

b. *Conduct Unit Survey and Focus Interviews.* Interview 8 to 12 soldiers as a group and ask a series of general or structured questions. Survey interviews use open-ended questions and seek answers to a wide range of issues. Focus interviews use more direct questions to answer a specific issue; for example, the adequacy of the unit's sleep plan. In both types of interviews, the responses are recorded and trends are identified. These interviews can be done in the field as battlefield interviews and can be used to debrief and to gather data. Collected data is then used as a basis to train or provide consultation.

c. *Administer Survey Instruments (Questionnaires).* Survey questionnaires are normally used in conjunction with briefings, focused interviews, classes, or field exercises. They are used to assess unit cohesion, confidence, readiness for combat, and familiarity with stress control, or to identify areas which need further training or command attention. Surveys may also be conducted to answer specific command questions about unit morale and readiness. Survey results and recommendations are provided to unit leaders.

(1) Such surveys work best when they are endorsed (and perhaps mandated) by higher command, but are advertised and implemented as an aid to the junior leaders, not a pass-fail test.

(2) Results should be shared with the junior leaders first and should be worded in positive terms: "Here is what looks good, here is what needs more work, and here are some ideas (not orders) for how to do it."

(3) The questionnaire should be administered in a way that guarantees anonymity to the responders: It is best to administer it all at one time and to have it handed out and collected by the mental health/CSC surveyors, not the unit leaders.

(4) Questionnaires need to be brief, simple, unambiguous, and easily hand- or machine-scored to provide quick feedback. Standardized, well-documented survey instruments are best. Sharpened pencils and firm writing surfaces must be supplied. Shelter from adverse weather (or water-resistant questionnaire sheets) may be necessary when surveys are conducted in the field.

NOTE

Survey instruments which are currently being used include Department of the Army Pamphlet (DA PAM) 600-69. Currently under development and testing by Walter Reed Army Institute of Research is another survey titled "Psychological Readiness for Combat Survey" (see Appendix B).

d. *Monitor Stress Risk Factors (Stressors) and Indicators of Stress in Units.* Information about stressors and stress in a unit may be obtained by coordinating with various sources. These sources of information include—

- S1/G1, S2/G2, S3/G3 staffs, commanders, command sergeants major and first sergeants,
- Military police blotter reports.

- Unit surgeons.
- Preventive medicine (PVNTMED) reports and personnel.
- Chaplains.
- Judge advocate general.

NOTE

Information obtained from the above sources involves the statistical implications without violation of AR 340-21, The Army Privacy Act Program.

Stress on the home front may be monitored by the unit's rear detachment, keeping in touch with the post's Deputy for Personnel and Civilian Affairs (DPCA) and various medical department activity (MEDDAC) mental health and patient care services.

(1) Monitor known stressors such as—

- Number of days/months
- Substandard living conditions.
- Social isolation from surroundings due to distance, climate, foreign culture, and hostile locals.
- Inspector general (IG) or very important person visitor.
- Insufficient facilities or funds for mission training or morale/welfare/recreation support.

● Commission of terrorism or atrocities by the enemy.

● Likelihood of temptations for substance abuse.

● Recent losses and/or new replacements in the unit.

● Change in leadership.

(2) Monitor indices of excessive stress in units. Mental health/CSC personnel monitor known warning signs of excessive stress to identify units which need special consultation. Some of these warning signs are—

● Many disciplinary actions in a unit.

● High absent without leave (AWOL) rates.

● Inspector general complaints.

● Increased requests for transfers.

● Alcohol or drug intoxication and driving while intoxicated charges.

● High sick call rates.

● Preventable diseases (sexual misbehavior).

● Fights, minor injuries, and self-inflicted wounds.

● Suicide gestures/attempts/completions.

● Homicide threats, attempts, and completions.

(3) Monitor home front (rear detachment) indices of excessive stress, such as—

- Spouse and child abuse.
- Bad checks.
- High numbers of separations and divorces.
- Significant numbers of couples in counseling.
- Family members caught shoplifting or an involvement in other crimes or misdemeanors.
- Financial problems.

e. Conduct Transition (Change of Command) Workshops. Mental health/CSC personnel conduct transition (change of command) workshops for supported units. These workshops are normally requested by the incoming commander. The primary purpose of these workshops is to—

- Facilitate staff discussion of what the staff sees as the unit's (and staffs) strong points and the areas needing more work.
- Provide the new commander the opportunity to discuss his leadership style and his expectations and set priorities for the staff.

f. Conduct Personal Reliability Screening. Personal reliability screening is required by AR 40-501, or it may be command directed.

g. Supporting and Assisting Alcohol and Drug Prevention and Control Programs. In the TO, there are no formal alcohol or drug support groups. Therefore, mental health/CSC personnel promote the establishment of ad hoc alcoholic support groups or other support groups. They evaluate cases of alcohol/drug abuse and

recommend rehabilitation, medical treatment, or administrative disposition.

4-3. **Combat Stress Control Consultant Activities for Staff and Operational Planning**

a. Planning. It is important that CSC personnel be involved in the overall planning process. Combat stress control personnel provide advice and assistance to commanders and staff on CSC issues. These issues may include—

- Providing measures for monitoring and controlling stressors.
- estimates.
 - Providing stress casualty
- reconstitution support.
 - Providing CSC input for
- preventive operations.
 - Conducting CSC preven-
- ward to provide immediate restoration support.
 - Deploying CSC assets for-
- Establishing procedures for CSC reconditioning, including resource and coordination requirements.
 - Establishing procedures with supporting battalion S1s for transporting BF casualties who are able to RTD to their units.
- Providing input on using mental health/CSC asset for supporting host-nation or humanitarian civil assistance operations.

(1) Combat stress control personnel provide the command surgeon input for inclusion in the CHS estimate and plan. Combat stress control personnel are included early in the

mission planning process to ensure adequate CSC resources are included in the CHS plan.

(2) To enhance the performance of CSC personnel in the decision-making and planning process, they should be provided realistic training. This training can include participation in activities such as field training and CP exercises. Additionally, mental health/CSC personnel must be given the opportunity to learn, practice, and perfect their skills for providing unit consultation and the other five functional mission areas associated with CSC and mental health. This is accomplished through their participation in various training exercises.

b. *Combat Stress Control Staff Planning in Combat.* The CSC consultant must assure that staff planners keep in mind that CSC must be proactive and rapidly reactive.

(1) *Proactive measures.* Proactive measures include the pre-positioning of CSC personnel to the maximum extent possible to support those units that are most likely to experience combat actions. This will change from day to day. In order to anticipate and prioritize, the planner should also evaluate the likelihood that the combat action will involve the special risk factors for BF casualties and misconduct stress behaviors (see Appendix B). Pre-positioning may include—

- Deploying organic CSC personnel far forward to areas of need.
- Sending CSC personnel to an AXP behind the battalion entering combat.
- Sending CSC personnel to a BAS in the combat trains,
- Sending additional organic CSC personnel to the BSA with the supporting FSMC.

- Attaching corp-level CSC teams base on casualty estimates to the supporting medical company in the BSA, DSA, or corps area.

- Providing warning orders to backup CSC teams in the division rear or corps area.

The warning orders alert CSC teams to prepare to deploy forward or to detach personnel to reinforce the teams already forward. This forewarning is especially important if the backup teams need to reduce their ongoing treatment caseload.

(2) *Rapid reaction.* For rapid reaction, CSC personnel and teams require staff actions to identify where they need to move once the actions have started. The staff must also coordinate this move. Certain events should be recognized and reacted to when they occur. These events include—

- Having high numbers of WIAs and stress casualties at a location which was not anticipated or covered by CSC resources.
- Receiving reports that a unit has experienced an especially traumatic incident (such as casualties from friendly fire).

It would be helpful for CSC personnel to participate in the unit's after-action debriefing (see subsequent paragraphs and after-action debriefing in Chapter 5). Definitive information on CHS planning is found in Appendix B and in FMs 8-10, 8-10-5, 8-42, and 8-55.

4-4. Consultation During Mobilization and Deployment

a. *Planning and Consultation Activities.* During mobilization, contingency plans are reviewed and updated, as required, Combat stress

control elements provide any revised information to the command surgeon for inclusion in CHS estimates and plan. In addition to mobilizing their own assets, CSC elements will initiate consultant functions immediately. All command and staff briefings should have a CSC representative present to ensure CSC personnel are aware of developing situations. Supported units are informed as necessary on changes/updates to the CSC operating procedures.

b. Coordination with Supported Units. All supported units are contacted by CSC personnel to confirm preestablished points of contact (POCs) or to identify new POCs. Coordination visits to newly supported units must be brief to ensure they do not hamper the unit's mobilization process. Only essential information pertaining to CSC consultation and support should be discussed. Liaison consultants can also gain valuable information and insight about the unit by listening and observing without being in the way.

c. Home Station Support. During mobilization, the disruption of the family, finances, and other personal matters can adversely affect the morale of the deploying soldier. It is important, therefore, to facilitate the transition from home station to the deployment area. Combat stress control personnel should—

- Remind commanders and leaders of the importance of these issues.
- Work toward greater participation of family members in established family support groups.
- Assist with the activation of family support groups and coordinate home station command support when possible.
- Ensure commanders provide the locations of established family assistance centers to family members.

4-5. Consultation Support During Combat

a. Establishment. The CSC consultant (or team or unit) needs a secure base camp from which to operate. Small consultation teams may be able to integrate themselves into the quarters of the supporting unit. Large CSC teams will provide their own shelter. Combat stress control teams are usually either assigned or attached to medical units for support.

(1) Depending on the echelon, the supporting medical unit may be an FSMC (in the BSA), an MSMC (in the DSA), or an ASMC (operating within a base cluster in the corps and COMMZ). Combat stress control teams or units may also collocate with a CSH, FH, GH, or a medical headquarters unit (ASMB, medical group, medical brigade, MEDCOM). Combat stress control personnel with primary consultation missions are organic to the above hospital and medical headquarters. In other cases, the CSC personnel are attached to the medical unit for support, either as individuals or as teams composed of 1 to 15 or more personnel.

(2) Attachment of CSC elements must be coordinated with the supporting medical unit by the headquarters issuing the attachment order. Coordination must include provision for quarters, food, and fuel. After attachment, the command surgeon will brief the CSC element on the threat, SOI procedures, and other pertinent information as required by the situation.

b. Continuation of Consultation and Training Activities. During combat, consultation and training activities are continued. These activities may be curtailed or suspended as a result of the tactical situation but are continued as soon as the situation permits. The consultant coordinates with the command surgeon on CSC information to be presented to the commander. If possible, the CSC personnel accompany the command surgeon when this information is briefed.

It is important that senior commanders and staff are briefed on the CSC operation. When the senior leadership understands the importance of CSC consultation and prevention programs, maximum participation within the command is achievable.

(1) Movement outside of secure areas such as BSAs, DSAs, or base clusters will be restricted. Any movement outside of secure areas involves increased risk and requires prior coordination. The increased threat brought on by combat requires that all CSC personnel be proficient in performing their common soldier skills. Any CSC support mission requiring ground movement outside the secure area must be coordinated and approved. This coordination is accomplished with either the tactical operations center (TOC) or base cluster operations center. In most cases, preferred movement outside a secure area is done by convoy and has MP or other security elements. Some main supply routes (MSRs) may be considered secure during daylight hours after they have been cleared by security forces. In other situations, CSC personnel may follow returning ground ambulances to their destination. In all cases, CSC personnel must have approval prior to departing any secure area.

(2) Priority for CSC consultation during combat focuses on those areas with greatest, immediate potential to conserve fighting strength. These areas include—

- Implementing the CSC support plan.
- Assisting units with resting of DUTY and REST category BF cases in their units when possible.
- Advising and assisting with medical triage to prevent unnecessary evacuation of BF cases.

- Facilitating RTD and reintegration of recovered cases into units by coordinating with patient administration, the S1/GI, and directly with soldiers' unit leaders, chaplains, and medics,

c. *Staff Planning.* Staff planning is conducted in coordination with the unit surgeons (medical company commander). As new operations or changes in the tactical situation evolve, estimates and plans must be reviewed and updated as required.

d. *Periodic Visits to Supported Units.* The CSC consultant conducts periodic visits to supported units. These visits should occur on a predictable, recurring basis. The objective is simply to maintain contact and find out what is really happening. Once the pattern is established, field phones or radio contact can fill the gaps when visits are impractical.

(1) It is essential that the consultant (or consultant officer / NCO team) establish a communications network so that he can be contacted quickly anywhere in the course of making rounds. If the consultant does not have a radio, it is important that he keep the supporting medical unit headquarters informed of his location and schedule. This is accomplished by passing a message through the supporting unit headquarters. The consultant uses brevity code messages (in accordance with TSOPs) which can be transmitted quickly by host-unit signal personnel. If the schedule changes, he informs the supporting medical unit of the change.

(2) Visiting supported units in the immediate vicinity (within the BSA, DSA, or base cluster) is accomplished on a daily basis when REST BF cases are being held in their unit areas for light duty or rest. In most instances, the units visited will be headquarters and headquarters companies (HHCs) or CSS units. It is required that CSC personnel know the location of all BF cases and monitor their status on a daily basis.

(3) Each consultant when visiting a unit first makes contact with the previously identified POCs. If the consultant team includes an officer and an NCO, they naturally divide the people to be talked with according to officer/NCO status and rank. The consultant speaks with the junior leaders who have BF casualties in their sections. If advice or assistance is needed, this facilitates the identification of problem areas. He speaks with the BF casualties as necessary to monitor their progress. These “work-ups” are brief and factual, with only sufficient items recorded in the consultants notebook to remind the CSC provider of important details. These consultation cases are “carded for record only” on DD Form 1380. (For additional use of DD Form 1380, refer to AR 40-66 and FMs 8-10-6 and 8-230.)

(4) The consultant advises unit leaders on the care and handling of BF casualties. Potential subject areas will include how to—

- Talk with soldiers experiencing BF.
- Provide reassurance.
- Ensure rest/sleep requirements are met.
- Provide adequate nourishment and fluid replenishment.
- Practice personal hygiene.
- Conduct work activities.
- Provide recreation (if possible).
- Initiate after-action debriefings.

(5) When BF casualties appear unmanageable, they are not held in their unit

area. The consultant should advise unit medical personnel or the commander to send any BF casualties judged to be at risk of serious medical/emotional illness to the supporting MTF for NP evaluation. At the supporting MTF, the BF casualty receives further NP triage, stabilization, restoration, or evacuation.

e. Initial Evaluation at a Medical Treatment Facility. At the MTF, REST, HOLD, or REFER BF cases are evaluated by general medical personnel (for example, at the clearing station). This evaluation may include advice and an interview by the CSC consultant, when present. If the CSC person is a psychiatrist, he may elect to perform the examination and triage of the BF casualty.

(1) Battle fatigue cases that require medical observation and treatment are managed as discussed in Chapters 8 and Chapter 9.

(2) Battle fatigue cases judged able to RTD to their unit areas include those soldiers—

- Treated and returned to duty immediately (category DUTY).
- Placed on limited or light duty for 1 to 3 days of rest under the control of the soldier’s own battalion HHC or the brigade S1 (category REST).
- Given light duties.

NOTE

Maneuver units positioned in forward areas only have those personnel who are fit for full duty. Limited or light duty is nonexistent in these units. If BF cases are sent directly to these units, they must be able to perform full duties for their own and the unit’s safety.

If limited or light duty cases (REST category) are members of maneuver units operating in forward areas, alternative units are used. Alternative units may include the battalion's HHC which is positioned with the field trains. Under some circumstances, CSS units (such as a headquarters and headquarters detachment [HHD], maintenance, or supply company of the FSB) may be used temporarily for REST BF casualties. Alternative units out of the BF casualty's organizational structure are not usually preferred, as the individual soldier does not have any social, emotional, or administrative ties with the unit.

(3) Transportation of BF cases returning to their units from the supporting medical company may require coordination. The patient administration specialist of the medical company may be required to contact the brigade S1 of the soldier's unit and request the unit provide transportation. In other instances, transportation for the BF cases back to their unit may be coordinated through the support operations section, movement control officer, or the TOC. These sections can identify any vehicles going to the soldier's unit area. The use of ambulances or medical vehicles (such as the CSC vehicle) to transport soldiers back to their unit is not permitted under the Geneva Conventions (see Appendix D). The transporting of soldiers to their unit area could cause a loss of protected status for those medical personnel involved. For additional information pertaining to the Geneva Conventions, see Appendix D.

f. Monitoring the Progress of REST Battle Fatigue Cases. As previously discussed the progress of soldiers returned to or held in their unit for rest or light duty is monitored by the CSC consultant.

(1) When those soldiers being held in temporary units for quarters, rest, or light duty are ready to return to the original duty unit, the

headquarters element of the temporary unit coordinates for transportation. Logistical vehicles supporting forward areas are the most likely means for returning soldiers to their units.

(2) Combat stress control personnel may be required to enter forward areas to provide special reintegrating instructions for a BF casualty that is returning to duty. Commonly, a brief note or oral instructions provided to the soldier or the unit leader are the methods used to get instructions to unit commanders and first sergeants. Special instructions may also be sent forward via the chaplain/unit ministry team or ambulance drivers relaying instruction to the BAS. These instructions will assist medics and unit leaders on how to maximize successful reintegration of the recovered soldier.

g. Reevaluation of REST Battle Fatigue Cases Who Do Not Improve. Soldiers who fail to improve sufficiently to return to their original duties and unit in several days must be reevaluated. During this evaluation, the CSC consultant attempts to rule out malingering, situations with too much "secondary gain," or other physical and mental disorders (see the combat NP triage functions, Chapter 6).

(1) Advising the supervisors to increase positive expectation, reduce the comfort of the facility (the secondary gain), and/or having the first sergeant or other members of the unit visit the soldier may be sufficient to achieve full RTD.

(2) A few cases may be recommended for reassignment to CSS jobs in the same battalion. However, this must be kept to a minimum so as not to undermine positive expectation of full recovery and lead to resentment or imitation by other soldiers. If job reclassification and reassignment is judged necessary, it will usually be to another unit.

(3) Cases of REST BF who fail to respond after 1 to 3 days of rest are reevaluated. Based on the reevaluation, these BF cases are either held for restoration treatment at the supporting MTF or evacuated one echelon for more intensive restoration or reconditioning treatment (see Chapters 8 and 9).

h. Debriefings. Combat stress control consultation following potentially traumatic events involves three types of debriefings. The three types of debriefings are—

- After-action debriefings.
- Large group debriefings.
- Critical event debriefings.

(1) After-action debriefings should be conducted by all leaders of small units after all operations. After-action debriefings are especially important after a difficult action. The leader(s) extend the lessons learned orientation of the standard after-action review (AAR) to include sharing and recognizing the feelings, emotions, and thoughts of team members. (See Chapter 5 for after-action debriefings.)

(2) Large group debriefing may be an expedient method when small group debriefings are impractical. Alternatively, the large group debriefing may be the culmination of the after-action debriefing or critical event debriefing of the component squads, platoons, or small groups. The leader may be either the unit's leader or a facilitator from outside the unit. Since everyone cannot be encouraged to take an active part, the leader encourages representatives of the formal or informal subgroups to review their subgroup's actions and experiences. Expressions of feelings are again encouraged, respected, and validated. Individuals who were not specifically asked to speak are encouraged to speak up if they feel there is more that needs to be said. Information by the

leader about the normal stress process and reactions may have to take the place of the sharing of personal experiences.

(3) Critical event debriefings are reserved for exceptionally traumatic events. They are lead by trained critical event debriefers, usually in teams of two to four persons. The teams are led by CSC personnel but may include trained chaplains, medical personnel, and line officers and NCOs. The participants in the critical event debriefing may be members of the same unit; they may include strangers thrown together by chance by a highly traumatic event (for example, members of a unit responsible for a "friendly fire" incident).

(4) After-action, large group, and critical event debriefings share common features but differ from each others in significant ways. Each type of debriefings is preferred for a particular situation, but a combination of these debriefings may be used for some situations. The CSC consultant should be prepared to—

- Teach other personnel how to lead or facilitate the above debriefings.

- Facilitate each type.
- Lead or conduct each type.
- Know when each is appropriate.

Combat stress control debriefings are described in Chapter 5.

4-6. Consultation to Medical Treatment Facilities

a. Providing Consultation to Medical Treatment Facilities. Consultation for hospital and Echelon II MTF staffs is provided by organic.

attached, or collocated CSC units or elements. Hospital neuropsychiatry staffs provide consultation primarily to hospital staffs but also advise MTFs and nonmedical units operating within their area of support. Consultation assistance may include—

- Evaluating newly arrived cases to rule out BF or NP disorders or triaging for possible admission or retention and disposition.
- Evaluating cases already on the wards or in a holding section with medical/surgical diagnoses that include BF or NP disorders.
- Providing consultation and training for medical staff on combat stress prevention and methods of controlling stressors.

NOTE

Stress reaction in medical personnel is often denied or overlooked. Thus, the consultant's efforts may have to be active during consultation to medical personnel.

b. Evaluating and Triaging New Patients. The majority of these patients will be seen in triage or the emergency medical treatment area of a hospital or medical company. When providing CSC training to personnel working in these areas, the consultant should—

(1) Emphasize the importance of giving immediate reassurance to the unwounded BF (stress) cases and moving them away immediately from the surgical holding or emergency medical treatment areas.

(2) Emphasize that even those cases who cannot be returned to their units

quickly and must be held temporarily “for rest” are not being “admitted” or “hospitalized,” (their medical records may show that they technically are admissions).

(3) Coordinate and organize a non-patient area for placement of these cases. Life support and administrative support is provided by the MTF. Nonmedical personnel may be used to staff this area and provide supervision for cases in a nonpatient status. The selected area should be quiet and away from high traffic areas. A relatively quiet area will afford these cases the opportunity to rest and sleep. Personnel that are providing supervision for these cases should be briefed on handling and caring for these soldiers. It is important that these soldiers be provided the opportunity to talk about what has happened to them. It is also important that these soldiers be given useful light duties which reaffirm their nonpatient status.

(4) Monitor the progress of all cases and determine their disposition in accordance with corps and theater evacuation policies. These cases are either returned to their unit after sufficient time of rest (1 to 3 days) as DUTY or REST BF casualties, or they are transferred to an MTF established for restoration or reconditioning of BF casualties.

c. Consultation for Medical and Surgical Patients with Neuropsychiatric Conditions. Neuropsychiatric personnel may be requested to evaluate medical and surgical patients who are being held at MTFs. These medical and surgical patients when suffering NP disorders can be divided roughly into five overlapping groups.

(1) Organic mental disorders which may include conditions such as—

- Disruptive confusion.
- Disorientation.

- Hallucinations and agitation after high fever, or metabolic disruption of brain functions.

- Amnesia and poor impulse control following head injury.

The consultant recommends psychiatric treatment modalities (for example, drugs and restraints) and nursing measures which are compatible with the underlying diagnosis and treatment.

(2) Major psychiatric illness coincidental to a medical or surgical condition, or perhaps responsible for it, as in serious suicide attempts. The consultant recommends NP treatment which is compatible with the illness or injury and the treatments prescribed for it.

(3) Patients with ongoing or potential psychiatric reactions to their injuries or the circumstances of the trauma. Many soldiers experience initial relief and even euphoria on being wounded. They may feel a sense of relief because they are honorably out of action and in the care of the medics. They may sense this feeling of euphoria as a result of receiving morphine. Only later may the implications of a life of physical disability begin to depress them. Some of these patients may be willing and even desperate to tell the story of what happened. Other patients may exhibit signs of depression, hostility, agitation, or other behaviors as a reaction to their situation and injuries. Potential psychiatric reactions may occur in any patient, but soldiers with some types of wounds and injuries are considered to be at special risk. These wounds or injuries include—

- Genital wounds.
- Major amputations.
- Serious disfigurement.
- Blindness.

- Any condition that causes paralysis,

Empathic management by all health care providers is critical and can greatly facilitate rehabilitation and minimize PTSDs. This is important even if the patient appears to be unconscious.

(4) Patients with wounds that require hospitalization but will be returned to duty within the theater. Some of these patients have residual BF and reactions to the circumstances of trauma. A few of these patients experience anticipatory BF at the prospect of returning to combat. These patients should be placed in a minimal care area as soon as their condition permits and be provided treatment which is similar to that provided to BF cases.

(5) Soldiers reacting to home front problems unrelated to their combat duties or injuries. The consultant helps identify problems, provides guidance as appropriate, and mobilizes social service support agencies, if applicable.

d. Providing Combat Stress Control Consultation to Medical Personnel. Medical personnel are not immune to the increased stress associated with supporting combat operations. It is important that medical personnel are not overlooked and that CSC consultation support be provided to all MTFs, medical units, and medical elements in the theater.

(1) Neuropsychiatric and CSC consultation personnel advise the chain of command and supervisors about general measures to buffer the intense stressors associated with providing combat medical care. These stressors may include—

- Providing round-the-clock emergency care for severely injured patients.
- Facing the moral dilemma of placing patients in the surgical triage

“Expectant” category (these patients receive only supportive care as time permits).

- Facing the moral dilemma of saving the grossly, lamentably disabled when there is not a mass casualty situation and they do not have to be placed in the surgical “Expectant” category. This is even more difficult if the patient is asking to be euthanatized.

- Facing the moral dilemma of placing patients in the surgical “minimal” or RTD category. Those soldiers are expected to return to the horrors and dangers of combat; most medical personnel are not subjected to similar risk.

- Treating and providing care for wounded soldiers who are related or someone whom they know.

- Maintaining appropriate interpersonal relationships when everyone is under extreme stress.

- Knowing how to unwind during lulls in the action without slipping into misconduct stress behaviors.

- Dealing with the boredom when patient activities come to a halt for long periods of time.

(2) Combat stress control consultants’ recommendations for resolving or reducing those stressors identified above include—

- Establishing a sleep plan and shift schedules.

- Developing time-management skills.

- Building team and unit cohesion.

- Providing leisure time and recreational activities, if possible.

- Training on how to conduct routine and special after action debriefings or rap sessions (and to use shift changes constructively for these purposes).

(3) Remember, it is not only direct patient care givers who undergo extreme stress. Do not forget food service, laboratory, maintenance, and administration personnel. Mortuary affairs personnel also require special support and consideration.

(4) The NP/CSC consultants work closely with MTFs’ and commands’ chaplains on these issues that create stress in health care providers and other medical personnel. The chaplains also deserve help in dealing with their own emotional responses. The CSC consultants themselves are not immune to stress and must rely on each other and the chaplains to share the strain. A plan for care of CSC personnel should be in place. The plan should provide for assessment of the emotional well-being of the CSC consultant. Use a rotating roster to assure that the mental health professionals are aware of the status of other team members.

(5) The consultant provides one-on-one or small group therapy when appropriate.

4-7. Consultation During Demobilization and Homecoming

At the conclusion of the conflict, as military activities phase down or as units or individuals rotate home, CSC personnel advise command on stress issues.

a. *Scheduling Considerations.* The consultant strongly recommends that some free time be scheduled for all soldiers who are

deploying home. During this time, these soldiers are provided the opportunity to talk about their experiences with their comrades or with others who experienced similar stressors.

(1) These times when soldiers discuss experiences should be initiated days before departure by air. If sea transport is used, this could be accomplished during travel.

- Keep this time as free as possible from mission duties.

- Keep teams, squads, and platoons together.

(2) Keep unit personnel together for several days after reaching the home station.

- Do not immediately grant block leaves to the unit.

- Maintain a half-day, light-duty schedule.

- Grant soldiers liberal commander's time, as needed, to resolve personal problems.

(3) Appropriate memorial ceremonies and celebrations are recommended, both in the TO before departure and at the home station. These events recognize and provide comfort to those who have suffered. Such rituals give a sense of closure. These events should—

- Encourage grass roots participation rather than being dictated from above.

- Use or adapt traditional ceremonies.

b. *Postcombat Debriefing.* Combat stress control personnel will participate in formal

debriefings for leaders of small units, chaplains, and others, or for ad hoc collections of individuals with similar combat experiences. The CSC consultant may conduct or participate in such debriefings for units or individuals at special risk, such as former prisoners of war (POW) or victims of friendly fire. The debriefings for units or individuals begin while they are still in the TO, if feasible, and may continue soon after return to CONUS.

(1) The debriefings focus on the common experiences of war. These events may include—

- Traumatic experiences (death of buddies).

- Morally conflicting issues (death of noncombatants).

- Frustrations (rules of engagement, errors of leadership, and perceived failures of support).

- A feeling of loss at the breaking of the bonds formed with the combat unit.

- Delay in the rebonding with home and family.

(2) The soldiers are forewarned of the normal, common symptoms which combat veterans experience on return to a peacetime environment. Normal, common symptoms may include—

- Bad dreams.

- Alerting reactions to stimuli or situations similar to those of combat.

- A sense of being different and alienated from others who have not been through combat (including spouse and family).

This can lead to social withdrawal and perhaps a sense of letdown and boredom.

c. Reunion Briefings. Combat stress control personnel, chaplains, and others give group briefings to all soldiers and units. The briefers forewarn of the common strains that often develop in relationships between spouses and their families during long separations.

(1) Soldiers are prepared for the ways that their families, friends, and society may have changed since they were deployed. Special attention may be needed to explore popular feelings about the war and how veterans can expect to be treated by civilians. If this is likely to be negative, ways to cope are illustrated.

(2) While troops are being debriefed in the theater, similar debriefings should be conducted with families in CONUS to prepare them for the returning soldiers.

(3) When feasible, unit families are included in the later home station debriefings.

d. Noncombat Debriefings. Similar debriefing procedures are equally important following noncombat deployments such as 6-month peacekeeping rotations or prolonged training missions. Issues discussed are different.

e. Continuing Debriefings. A continuing debriefing process may extend over weeks or months in some special cases. Follow-up debriefings will be especially relevant when—

- Reserve Component units are demobilized after a prolonged period of active duty.
- Units are deactivated as a result of reduction in force.
- Large numbers of personnel are being considered for reduction in force. Such major changes are in themselves highly stressful and can lead to much inefficiency, distress, and long-term problems unless the personnel are supported and aided with coping skills and procedures.