

CHAPTER 7

COMBAT STRESS CONTROL STABILIZATION

7-1. Priority for Stabilization

Combat stress control stabilization is the acute management of the small percentage of BF and NP cases who have severe behavioral disturbances. The behavior seriously disrupts the functioning of the unit and may even pose a danger to the soldier or others. In some cases, the underlying medical condition may also be a danger to the soldier's life. Combat stress control stabilization can be divided into initial emergency stabilization and full stabilization.

a. Initial Emergency Combat Stress Control Stabilization. Initial emergency CSC stabilization has been achieved when the disturbed soldier is in physical restraints, can be given an adequate physical examination, and may, if necessary, be sedated for evacuation. This may be all that can be done at forward echelons by nonpsychiatric personnel or by CSC personnel in a mass casualty situation. Stabilizing severely disturbed soldiers will always have an extremely high priority, especially when they become agitated or combative. Such cases can cause serious harm to others as well as to themselves, especially in a presence of loaded firearms, explosives, powerful machinery, and life or death missions.

(1) Violent behavior is quite rare in pure BF but is one form of misconduct stress behavior. Some NP disorders are prone to violence, especially paranoid psychotic states. Violence is also more likely with disruption of brain functioning due to organic factors such as intoxication, hyperthermia, or metabolic imbalance.

(2) Increased numbers of these severe BF cases can be expected during high NBC threat situations. This is due to increased organic brain syndromes caused by antidotes (such as atropine), heat stress, the heightened

physiological stress, and the possibility of direct NP effects of some NBC agents.

(3) Examples of these CSC casualties requiring immediate stabilization were provided in paragraph 6-3.

b. Full Stabilization. Full stabilization goes beyond securing the safety of the patient and those around him. It prepares the patient for an evaluation of his potential for RTD in the near future. If RTD within the evacuation policy is not feasible, it prepares the patient for safe, long-distance evacuation. Full stabilization is normally the responsibility of the NP ward and consultation service (module of the hospital unit base) in every CSH, FH, and GH.

(1) Full stabilization is desirable for the sake of the soldier's future treatment and for the potential of returning some soldiers to duty. However, full stabilization is personnel intensive with a relatively low RTD payoff. For that reason, full stabilization has the lowest priority of the six CSC functions. Providing only sufficient initial stabilization to allow evacuation from the theater may be accepted in order to maintain the other CSC functions.

(2) However, because of the low priority for evacuation of NP patients as compared to the large surgical caseload, it is quite likely that NP patients will accumulate in the CZ or COMMZ. Even adequate initial stabilization will require continued resources.

7-2. Use of Restraints in Initial (Emergency) Stabilization

a. Physical Restraints. Physically restraining soldiers with presumed BF goes against the treatment message of normality and positive expectation. However, some NP and a few BF cases may be—

- fused.
- Seriously disoriented and confused.
 - Paranoid.
 - Delusional.
 - Hallucinatory.
 - Suicidal.
 - Agitated and restless.
 - Manic and intrusive.
 - Threatening violence.

Restraining these soldiers may be necessary to ensure safety of the soldier and other personnel. Physical restraints also minimize disruptions of medical or restoration activities (especially when staff are few). It also permits medical evacuation by ground (preferred) or air ambulance.

b. Subduing and Restraining an Agitated or Disruptive Soldier. The best way to subdue and restrain agitated or disruptive soldiers is verbally, by reassurance and re-orientation. If that fails, a nonthreatening show of strength may suffice. Otherwise, decisive coordinated action by five helpers, one on each limb, one to hold the head, is preferred to get the soldier face down on the ground. More helpers get in each other's way. Fewer may be all that are available but risk more injury to the staff from bites, blows, or kicks. The patient also is more likely to be injured. It is inadvisable to attempt subduing an agitated case one-on-one. The restraining team should continue to talk with and provide reassurance to the resisting patient during the take-down.

c. Methods of Restraining. Once the soldier is face down, mechanical restraints can be applied if sufficient personnel are available.

Lockable, padded leather cuff restraints are safest but may be in short supply. Other methods such as using two litters (sandwiching the patient between the litters and using straps for securing) or straps, sheets, improvised strait-jackets or any other field expedients may be used. Regardless of the method, the soldier placed in restraints must be checked frequently. This is done to guard against nerve injuries or impaired circulation leading to skin ulcers or gangrene. It is also important to check that the soldier is not secretly escaping from restraints. The soldier is provided verbal reassurances with positive expectations for his recovery each time he is checked.

7-3. Use of Medication in Initial (Emergency) Stabilization

a. Administering Medication. Administering medication to an uncooperative and unrestrained severe BF soldier can be extremely difficult; unfortunately, the effects of the medication may act too slowly to be much help. Once the soldier is in restraints, the medication is no longer essential and serves mainly to reduce the risk of escape. Medications will reduce an agitated soldier's resistance to the restraints, thus diminishing the disturbance of other BF soldiers in the vicinity.

b. Observing for Reactions. The soldier is observed for any reactions. Be concerned that the medication does not interact badly with any biochemical already present in the disturbed soldier. Do not give chlorpromazine for anticholinergic delirium. If hallucinogenic drug intoxication is suspected, the use of any antipsychotic drug is contraindicated. The use of diazepam for pathological intoxication with alcohol or barbiturates is also contraindicated.

c. Rapid Sedation. Rapid sedation with antipsychotic drugs (repeating high doses every half hour until the patient is sedated) was

widely practiced in the early 1980s. This method did not improve overall recovery time significantly and did tend to cause more side effects such as dystonic spasms of the neck, back, or eye muscles. Now, even in known psychiatric patients who must be restabilized after stopping their previously successful medication, it is more common practice to build up antipsychotic drugs gradually. To achieve an antianxiety and sedative effect, the patient is initially treated with a benzodiazepine (such as diazepam or lorazepam). Lorazepam, if available, has the advantage of being more consistent when given intramuscularly.

d. Effects of Antipsychotic Drugs. Antipsychotic drugs can take several hours to days to take effect. Early administration of chlorpromazine or another antipsychotic drug may confuse the clinical picture for the next evaluator if the soldier is evacuated. The evaluator will not know whether any changes in the soldier's behavior over the next day or two was due to the reassurance, sleep, hydration, and reduced anxiety (from increasing distance from the battle), or whether it is just due to the medication. The medication must be discontinued if the soldier is to RTD. Therefore, the recommendation for most cases is to use no medication unless it is truly necessary for management. If medication is required, use as low a dose as is effective of a benzodiazepine (usually diazepam or lorazepam, although a shorter acting benzodiazepine, such as temazepam, would be better when available).

7-4. Full Stabilization in Combat Stress Control

Full stabilization in CSC includes adequate evaluation of RTD potential. This requires assessment of mental status and performance capability over time without excessive drug effects or limitations on activity. Contact with the soldier's unit may

be needed to get information on prior history and functioning. The further from the unit the soldier has been evacuated, the more difficult it is to contact the soldier's unit. Full stabilization normally takes several days.

a. Follow the Principles for Treating Battle Fatigue. To the extent compatible with safety, the stabilization program should adhere to the principles and methods for treating battle fatigue:

(1) PIES:

- Proximity to the soldier's unit.
- Immediate initiation of treatment.
- Expectation of rapid and full recovery.
- Simplicity of approach.

(2) The four Rs:

- Reassurance of normality.
- Rest.
- Replenishment of nutrition, hydration, hygiene, and sense of physical well-being.
- Restoration of confidence through talk and activities.

(3) Maintain and reinforce the soldier's identity as a soldier.

- Battle-dress uniform, not pajamas, as soon as they can be allowed safely.
- Rank distinctions and appropriate military courtesy.

- Responsible for self-care and helping others.

b. *Evaluation and Treatment Modalities.* The evaluation and treatment modalities include—

- Individual interviews for obtaining complete medical history.
- Mental status examination.
- Laboratory and x-ray workup, as indicated.
- Physical examination (should be thorough).
- Specialty consultations as indicated.
- Group sessions.
- Recreational activities.
- Occupational (work) history.

7-5. Stabilization Treatment Facilities

Stabilization Facilities. Ideally, stabilization is conducted by qualified mental health personnel in a nonhospital (medical company clearing station) military setting, to maximize positive expectation and minimize chronicity. However, it must be kept separate from the restoration or reconditioning facilities, as the presence of these dramatically symptomatic soldiers is very disruptive to the treatment of BF casualties. More sophisticated procedures and laboratory and x-ray capabilities may be required than is available at medical company clearing station (for example, lumbar puncture and cerebral spinal fluid examination and analysis).

For that reason, most full stabilization will be conducted in the CSH, FH, or GH. All of these hospitals have an inpatient psychiatric capability. Those soldiers who improve and have the potential for RTD are then transferred to a reconditioning program.

b. *Neuropsychiatric Ward.* Military hospital NP wards in the TO can be categorized as either in fixed/planned facilities, fixed/improvised facilities, or mobile facilities.

(1) Fixed/planned facilities are in buildings which were designed or premodified to serve as psychiatric wards. These could be in US Army fixed hospitals, allied military hospital, or host-nation civilian hospitals. Depending on degree of modernity and enlightenment of psychiatric treatment, these should provide—

- Security design for protection against suicide.
- Seclusion areas.
- Comfortable and reasonably civilized surroundings.

These can provide the safest setting for initial stabilization, or for holding cases until they can be evacuated. They may already be divided into maximum security closed wards and open wards which allow for more responsible self-controlling behavior. If such facilities are to be used for the treatment and evaluation of soldiers for possible RTD, it requires steps to maintain a military setting for the wards and the treatment routine.

(2) Fixed/improvised facilities are in buildings which were not designed or previously modified for use as psychiatric wards. These buildings have been taken over for this purpose. They will require assessment and usually some modification to make them safe, including—

- Impassable screens on the windows.
- Covering of electrical outlets.
- Removal of hazard for suicidal or violent acting out.

Separation of wards into closed and open is desirable if layout and staffing allows. Here, too, it is important to maintain a military environment and routine to the degree patient safety allows, especially on the open ward.

(3) Mobile facilities are those which are in tent, extendable, modular, personnel (TEMPER) or general purpose (GP) large tents. The principal advantage of the (hospital) TEMPER tents, as assembled into Deployable Medical System (DEPMEDS) hospitals, is their climate control capability. This may be a significant safety advantage for treating seriously disturbed patients in restraints with high-dose medication, which can disrupt normal thermal regulations. Both TEMPER and standard tents pose greater problems for security than do fixed facilities. The staff may, therefore, have to rely more than is ideal on physical and/or chemical restraints. Blankets or screens can be used to isolate or segregate problem patients from others. Such partitions reduce behavioral contagion but provide little true protection. Standard mobile hospital beds on high, lightweight metal legs must be replaced with standard low, stable cots to hold strong, agitated patients in restraints. The cots also make a more “military” setting and can be used as seats for group activities. As in the fixed facilities, it is best to have a separate “closed”

(high security) and “open” (moderate/minimal security area. The latter could be a standard GP large tent (the same as those of the minimal care wards [MCW]) located close to the TEMPER tent of the official NP ward. The specialists (MOS 91C and 91B) of the MCW could be given on-the-job-training in supervision and military group activities for the moderate/minimum security cases if the NP staff is too small.

c. *Mixed Neuropsychiatric/Medical Surgical Ward.* The NP ward may be expected to admit those NP cases with concurrent physical illness or injury and concurrent significant mental symptoms unless the patient’s condition requires that he be in the intensive care unit, or in isolation because of contagious disease. The mental symptoms could be—

- Caused by organic brain disruption (such as drug intoxication or withdrawal).
- Functional NP disorders which are coincidental to the illness or injury.
- Functional and in reaction to the traumatic situation which caused the injury.

The NP staff must be prepared to react therapeutically whatever the cause of the disturbed behavior. In the event of many medical/surgical cases, the NP ward could receive overflow medical/surgical cases. Therefore, NP ward staff must remain current in basic nursing and wound care skills.

d. *Combat Support Hospital Neuropsychiatric Ward Staff.* Definitive information is provided on the CSH NP ward staff capabilities in FM 8-10-14.