

## CHAPTER 9

## COMBAT STRESS CONTROL RECONDITIONING

9-1. **Reconditioning Treatment Program**

a. *Overview of Reconditioning.* Reconditioning programs are intensive efforts to return BF casualties to duty when they have not improved sufficiently with 1 to 3 days of restoration. In the corps area these programs are normally 7- to 14-days long but can be as short as 3 days, depending on the corps evacuation policy. Reconditioning may continue as long as 28 days in the COMMZ, depending on the theater evacuation policy. These programs are conducted in a nonpatient care setting by medical CSC, NP, and mental health personnel. Reconditioning also can include rehabilitation of those BF casualties who were evacuated to a hospital without receiving restoration treatment. It can include NP and alcohol/drug patients and minor misconduct stress cases with good potential for RTD. Conducting reconditioning programs is a mission of the medical company, CSC. Reconditioning can also be provided on a small scale by the medical detachment, CSC under special circumstances. Reconditioning is also provided by the combined NP ward and consultation services, the OT/PT sections, and the clinical psychologist of FHs in the COMMZ.

b. *Priority of Reconditioning Programs.* Reconditioning programs have lower priority than restoration programs. This is because they are manpower intensive and have a lower return of RTD for the effort invested. When the number of BF cases who may need 1 to 3 days of restoration treatment is high, additional CSC personnel should be sent forward from reconditioning programs to reinforce forward restoration teams. The reconstitution support mission may also need to draw upon reconditioning program staff.

(1) If a shortage of reconditioning staff is only temporary, it may not be necessary to evacuate the excess caseload. They may be

maintained on a less-intensive program. This program would entail more work details and less individual and group therapy until staffing ratio can be restored.

(2) At times when reconditioning cases far exceed the staff available to treat them, reconditioning may be limited to fewer days per soldier or may be discontinued altogether. This change will effect some of those soldiers in the reconditioning program who might be returned to duty with additional treatment (and might be protected from subsequent PTSD). They will be evacuated to the COMMZ and/or CONUS to maximize RTD of those soldiers with the best potential.

(3) Reconditioning, like restoration, can be provided by successive echelons. Treatment facilities in the COMMZ or corps rear should continue to treat the evacuees with relentless positive expectation. This is called second-line reconditioning. The program should continue as third-line reconditioning for those evacuated to CONUS.

9-2. **Reconditioning Program Methods**

a. *Reconditioning Extends Restoration.* Reconditioning is similar to restoration but more orchestrated over longer periods of time, is more intensive, and it requires a higher staff-to-case ratio. Reconditioning puts special emphasis on a highly structured military unit environment and schedule of activities. Treatment strategies assist recovering soldiers in regaining skills needed for combat duty. These skills and abilities include concentration, team work, work tolerance, psychological endurance, and physical fitness.

b. *Military Unit Structure.* As in restoration, the soldiers are not treated like patients

on a ward under the care of therapists. Rather, the BF casualties are treated like other soldiers assigned to a military unit which requires—

- Assignment to a squad or team with a staff member as squad or team leader.

- Wearing the prescribed uniform and appropriate LBE.

c. *Physical Replenishment.* Reconditioning continues to provide physical replenishment (food, hydration, sleep) and hygiene (shower), especially in the first few days. Later in the program, the comfort factor may be intentionally decreased; for example, by substituting MREs for some A-ration meals and by assigning recovering soldiers to night duties. These duties may include fire watch, perimeter or gate guards, or radio watch.

d. *Unit Formations.* Unit formations are held on a regularly scheduled basis. The purpose of the formation is to—

- Disseminate information.
- Account for all personnel.
- Announce the daily work and training plan or changes.
- Break out or cross-attach sub-elements into small groups for activities or details.
- Introduce new unit members.
- Brief on the tactical and world situation, especially as it relates to the soldiers' units of origin.
- Assign physical and occupational activities.

## NOTE

Display of unit emblems, mottoes, streamers, and other distinctive devices should be encouraged to focus the soldier's attention on his unit of origin and his identification with it.

e. *Physical Reconditioning Activities.* Physical reconditioning activities may include—

- Calisthenics and stretching exercises.
- Running in formation.
- Competitive sports.

f. *Individual Counseling and Therapy.* Individual counseling and therapy may include—

- Abreaction (redescribing and remembering the traumatic events in detail and releasing pent-up emotions).
- Working through personal grief, guilt, and home-front issues.
- For some cases, psychotherapeutic drugs for brief symptom relief, or tapering off drugs used in stabilization or detoxification.
- For some cases, hypnosis or amytol interviews to uncover repressed memories.

g. *Group Sharing and Validation.* Group sharing and validation of common experiences and issues include—

- Restoration of perspective through realistic reappraisal of the traumatic events.
- Cognitive reframing.

*h. Group Training in Relaxation Techniques.* Group training in relaxation techniques is provided and includes—

- Abdominal breathing.
- Breathing for meditation.
- Progressive muscle relaxation/autogenic training.
- Focused imagining of relaxing situations.

*i. Group Training in Life Skills.* Group training in life skills is provided to assist with—

- Control of impulses and anger.
- Appropriate assertiveness in the military context.

*j. Common Soldier Task and Survival Skill Drills.* Common soldier task and survival skill drills may be provided as individual and as team competition.

*k. Drug and Alcohol Abuse Counseling.* Drug and alcohol abuse counseling may be provided through individual or group work sessions as indicated.

*l. Reconditioning Program Work Projects.* Reconditioning program work projects may include—

- Improving and reinforcing defensive positions such as entrenching and sandbagging.
- Improving living conditions such as making furniture or installing packing crate floors.

- Building better showers or latrines.

*m. Work Assignments.* Work assignments to medical units for real work details are—

- Coordinated and monitored by the reconditioning program OT staff.
- Increased over the course of the program and gradually displace most of the therapy and training sessions.
- Considered protected status since they are patients.

*n. Temporary Reassignment to Combat Support or Combat Service Support Units.* When recovering soldiers are temporarily assigned as part of their reconditioning program to CS or CSS units for work, the—

- Assignment of the soldier is for 24 hours of each day.
- Soldiers are no longer in a protected status under the Geneva protocol.
- Combat stress personnel continue to work with the soldier in preparing him for RTD to his original unit, or reassignment to a new unit.

### 9-3. First-Line Reconditioning Centers

*a. Combat Fitness Reconditioning Centers.* Combat fitness reconditioning centers in the corps are staffed by task-organized CSC elements from the medical company, CSC. In OOTW, a reconditioning center could be established by a task-organized CSC element from one or more detachments, CSC. This is done only if the medical company, CSC has not been deployed. Also, if the inpatient NP work load is

light, a small reconditioning program may be staffed by personnel from the NP ward and consultation service of a CSH. A reconditioning center usually collocates with a CSH but must maintain its separate, nonhospital identity.

*b. Area for Establishment.* While the hospital is often in the open, the combat fitness reconditioning centers should be in or close to the tree line or under camouflage. It should not be situated near the morgue, triage area, or helicopter pad. It should be placed in an area where incoming ambulances are not seen as they off load their patients. Often the best area for establishing the combat fitness reconditioning centers is next to the CSH staffs' quarters tents (not among the wards). This is normally close to the food service kitchen, the showers, and the laundry. There the BF casualties receive replenishment and perform work details. The CSC unit (CSC restoration and CSC preventive teams combine as a task-organized CSC element) can provide their own tents for staff quarters and the operations center. They can accommodate a moderate number of soldiers in their own tents for reconditioning (20 per GP large tent in the task-organized CSC element). If the reconditioning case census exceeds the capability of the task-organized CSC element to provide tentage, the additional tents are requested from the medical company, CSC headquarters. If tents cannot be provided, additional shelters and sleeping facilities are requested from the host CSH. In some situations, local buildings may be used or other arrangement made through host-nation agreements. The combat fitness reconditioning centers may be augmented by an element from the medical company, holding. The patient care providers of the holding facility can also be trained (under the supervision of mental health/CSC personnel) to serve as squad leaders, each supervising six to ten BF soldiers.

*c. Working with the Supporting Hospital.* The combat fitness reconditioning center

is dependent on the supporting hospital for communications, food services, shower facilities, and other areas of support. The combat fitness reconditioning center works with the supporting hospital by sending work parties of recovering soldiers to assist in food preparation and delivery and cleanup chores. The recovering soldiers from the reconditioning center may also be used for assisting with work details throughout the hospital but must be under direct supervision of either hospital or mental health/CSC personnel.

*d. Medical Records.* The combat fitness reconditioning center uses the supporting hospital's medical records section to maintain the permanent case records.

(1) Cases who were initially admitted to a hospital ward for stabilization are transferred to the combat fitness reconditioning centers, and the combat fitness reconditioning centers staff continues to keep the standard hospital chart. The soldier is given any personal effects that were secured by the patient administration section at the time of his initial admission.

(2) Cases who are "transferred" from a restoration facility go directly to the combat fitness reconditioning center. They should not be admitted through the supporting hospital's admission area. However, all patient admission steps except securing personal items and affixing a hospital identification wrist band are done upon their arrival at the combat fitness reconditioning center. These steps are accomplished or monitored by the patient administration specialist assigned to the medical company, CSC. The combat fitness reconditioning center also initiates a hospital chart on each case.

(a) Cases in the combat fitness reconditioning center are counted as patients in the reconditioning center on the daily hospital census.

## NOTE

These cases are counted as patients on the daily hospital census. The cases are not counted as occupied beds when reporting the hospital bed occupancy.

(b) Upon disposition from the combat fitness reconditioning center, whether for RTD, retraining for other duty, or evacuation, the combat fitness reconditioning center's psychiatrist prepares the chart for further evacuation or writes the discharge summary and closes the hospital's chart.

e. *Stabilization.* Stabilization of seriously disturbed NP or BF casualty cases should be the responsibility of the collocated hospital's organic NP personnel and NP care ward. Neuro-psychiatric ward cases should not disrupt or infect the combat fitness reconditioning center's nonpatient status, RTD-oriented activities, and atmosphere. Cases can be transferred easily between the hospital's inpatient NP ward and the tents of the combat fitness reconditioning center.

f. *Multiple Small Reconditioning Centers.* The preferred option in a corps-sized operation is to have a separate, small reconditioning center collocated with a hospital behind each division. That combat fitness reconditioning center treats soldiers from that division plus supporting corps units located in its AO. This maintains the principle of proximity and favors immediacy and simplicity by avoiding prolonged transportation of cases. The maintenance of unit identification (most soldiers wearing the same division patch) also aids the positive expectation. Limited resources or geography, however, may require use of consolidated reconditioning centers, which would each support several divisions.

g. *Mature Theater.* In a mature theater, once action in the corps has stabilized,

coordination should be conducted to move the combat fitness reconditioning centers to collocate with (and receive logistical support from) a quartermaster or personnel unit. Hospital charts/medical records would continue to be kept by the nearby CSH.

h. *Division Fatigue Center.* Under special circumstances in OOTW, a division "fatigue center" with few cases in need of restoration could change mission to become a small reconditioning center. Under these special circumstances the medical detachment, CSC personnel could staff a very small reconditioning program. Any patient admitted to this program would be carried as an admission to the supporting CSH. Inpatient records are initiated and maintained by CSC personnel. Upon completion of the reconditioning program, the inpatient record is forwarded to the supporting CSH.

## 9-4. Disposition of First-Line Reconditioning Cases

a. *Status of Reconditioning Cases.* Some reconditioning cases will be able to return to far-forward CS or CSS duty. However, many of the soldiers who need reconditioning will be unable to return to their original unit. This could be a result of combat operations or the nature of their symptoms which prevent their return to original units.

(1) Ideally, BF casualties who undergo a 14-day restoration program in the corps should not be crossed off the division's personnel rolls (as specified in AR 40-216). However, in high casualty situations, the division commander will be unwilling to wait two weeks on the uncertain chance that he will get his old BF soldier (now improved) back again. The commander will want to count soldiers as losses to the division if they are gone more than 3 days in order to requisition replacements. Even when BF casualties

are no longer on the division's rolls, every feasible effort should be made to return those BF cases who recover fully to their original units. This is desirable even if that unit has already received a replacement and is technically not eligible to receive another. Most units in combat are chronically understrength and they can also anticipate more losses in the near future. An overly strict interpretation of the replacement policy should not prevent the mutually beneficial return of a recovered soldier to his unit. The division psychiatrist and the CSC unit teams who are attached to reinforce that division should maintain frequent contact with the combat fitness reconditioning centers which supports the division (as specifically directed in AR 40-216). Coordination efforts, through the DMOC and the personnel replacement system by division mental health/CSC personnel, should attempt to facilitate return of recovered soldiers to their original units.

**NOTE**

The CSC consultant should also ensure that everyone knows that it is just as important (if not more so) to return recovered WIA and DNBI soldiers to their original units whenever possible.

(2) More commonly, reconditioned soldiers may need reassignment (and perhaps reclassification into new MOSS) and/or on-the-job training into new combat, CS, or CSS roles. If recovered BF casualties cannot be returned to their previous small unit, they should be formed into small (two to five persons) cohesive groups or teams which can be reassigned to a new unit together (or to the unit of one of those soldiers). The combat fitness reconditioning centers must coordinate with the personnel replacement system and nearby CSS units to find a suitable

assignment for these newly formed two- to five-person teams.

(3) For some cases, it may be best to have the recovering BF casualty (as part of their reconditioning program) visit with nearby units during the day (returning to the combat fitness reconditioning center at night) before being returned to duty for assignment. Any work performed during such visits must conform to the Geneva Conventions (see Appendix D). Alternatively, the recovering BF casualty may be assigned to the CSS unit 24 hours/day on temporary duty as a REST BF casualty until he is ready for reassignment (preferably in pairs or groups) to other units.

*b. Evacuation Policy.*

(1) Army Regulation 40-216 specifies that there should be a 14-day reconditioning program in the corps. This recognizes the fact that the additional days substantially increase the RTD rate. At the NP clearing companies in WWII, the average length of stay was 11.4 days. The corps evacuation policy is at the discretion of the theater commander. In some situations, the maximum length of stay may be set by the theater commander at 7 days.

(2) If the corps evacuation policy is less than 14 days, the mental health/CSC staff psychiatrist of the medical brigade should request an exception for BF casualties in reconditioning programs. He submits the case via the commander, medical brigade, through the corps surgeon to the corps commander. The following facts apply:

(a) The reconditioning program, because of its austerity, is not a significant logistical burden to the corps—it requires only food, water, and shelter for the cases, plus the supplies and equipment from quartermaster units

that rearm the recovered soldier for combat or other duties.

(b) Because the combat fitness reconditioning center maintains a military setting, it is not a conspicuous target. Its case-load performs useful work details and perimeter defense, either for medical units or for all type units, depending on its chosen Geneva Conventions status (see Appendix D).

(c) The increase in RTD of BF casualties (mostly to CSS units) frees assigned soldiers for other duties, reduces the accumulation of cases with poorer prognoses in the COMMZ, and minimizes chronic disability.

c. *Evacuation.* Reconditioning cases who do not recover sufficiently to return to some duty within the designated evacuation period are evacuated from corps to COMMZ. They are best transported in GP trucks and buses, bus ambulances, or an ambulance train. In the latter two cases, they should be assigned helper tasks. Use air evacuation if there is no other alternative.

## 9-5. Second-Line Reconditioning in the Communications Zone

a. *Option 1—Field Hospital.* Establish reconditioning programs in the COMMZ at one or more FH. The FH is preferred to the GH because it is dedicated to RTD of convalescing cases. It has a psychologist and OT personnel assigned to the hospital unit's medical holding. These personnel are in addition to the NP ward and consultation service personnel assigned to the hospital unit base.

(1) The FH has sufficient mental health staff to conduct a small reconditioning program, provided it is not preoccupied with NP cases. However, most of its recondition-

ing capability will be required for the estimated 10 percent of the RTD wounded who also have significant BF. This capability could be improved somewhat by attaching a platoon of the medical company, holding.

(2) It is still important to minimize the hospital atmosphere and to treat the cases not as patients but as soldiers being reconditioned for combat-related duties. (The same is true for the convalescing WIA with concurrent BF.) The facility should be in a separate building with its own rigorous schedule of therapeutic activities, physical training, and work projects.

b. *Option 2—Combat Stress Control Units.* A medical company, CSC may be allocated to the COMMZ and assigned to the medical brigade. The medical company, CSC, reinforced with a patient-holding capability, may establish separate "nonhospital" reconditioning centers in the COMMZ.

(1) In OOTW, task-organized CSC elements of a medical company or a medical detachment, CSC combine with a 240-cot platoon of the medical company, holding. Attach this combat fitness reconditioning center to a FH or GH.

(2) Limited conflict is defined here as either—

(a) A relatively small conflict which does not require all CSC units in the forward areas of the corps.

(b) The late stages of a larger war when fighting has stabilized or ceased, so that CSC units can be withdrawn from forward areas to provide reconditioning in the COMMZ. In the latter (late in the war) situation, some of the work load may include cases who have accumulated in the COMMZ. These cases may

not have received mental health/CSC treatment because there were insufficient evacuation assets to transport them to CONUS along with the wounded and the true NP cases. These would make a difficult, but still potentially rewarding caseload.

*c. Second-Line Reconditioning Cases.* Most second-line reconditioning cases will no longer need much physical replenishment. The combat fitness reconditioning center programs continue to emphasize physical fitness, soldier skills, work details, and individual/group counseling/psychotherapy. Cases will be retrained for CSS duties in COMMZ and corps. As soon as the recovering soldiers are ready, the retraining site can shift to on-the-job training at a nearby CSS unit. This training begins as a day job, returning each night to the combat fitness reconditioning center. Later, the soldier may be placed full time in the new unit (as DUTY BF) while being followed-up periodically by the combat fitness reconditioning center's staff.

## 9-6. Third-Line Reconditioning

*a. Battle Fatigue Casualties That Fail to Improve.* Those BF casualties who do not improve sufficiently to RTD in the COMMZ are sent to CONUS. If these BF casualties have not been found to have some NP or physical disorder, they should be transferred to a third-line reconditioning center in CONUS. If they have NP or physical disorders which warrant discharge from the Army, they are sent to the Department of Veterans Affairs for additional treatment and follow up. The facilities for the reconditioning centers should be located at MEDDACs or medical centers which are on active Army posts that provide the military atmosphere and the opportunity for job retraining in actual units.

*b. Sending to Appropriate Reconditioning Center.* The BF casualty should be sent to the reconditioning center which is best suited for the retraining to be done. This center is often not the one that is nearest the soldier's home of record.