"PSYCH-FORCE 90": The OM (Combat Stress) Team in the Gulf

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The activation of the 528th Medical Detachment (OM) marked the first time that the US Army has fielded an OM unit in a combat operation. The author describes the experiences of the unit from activation through redeployment, and offers lessons learned by the unit in the practice of combat psychiatry.

Combat psychiatry has been a recognized discipline in the United States Army since World War I. While the basic principles of treatment have been well established since that time, the means to apply them in the form of development of doctrine, selection of psychiatric personnel and combat organization have undergone continual change. This problem-solving process has been seriously hindered by the inter-war tendency to minimize the impact of human factors on combat effectiveness. Between wars military medicine tends, like the Army as a whole, to become increasingly technology-centered. This takes the form of an increasing, and somewhat exclusive, emphasis on surgical capability. Once again, in 1990 in Saudi Arabia, Army surgeons found themselves treating a large population of soldiers with non-surgical medical and stress-related complaints.

The OM Team is the existing TO&E unit with the organization and assigned mission of stress casualty prevention and treatment. Early deployment of the 5th Mobile Area Surgical Hospital (MASH) and the 28th Combat Support Hospital (CSH), neither of which had the organization or mission to provide for the evaluation or treatment of stress casualties, led to the activation and eventual deployment of the 528th Medical Detachment (OM).

Predeployment Operations

"PSYCH-FORCE 90" was the banner chosen by the members of the 528th Medical Detachment upon its activation for Operation Desert Shield. The 528th is an ALO-Z (unmanned) active duty unit based at Ft. Benning, GA, and was activated on Sept 9, 1990 with the arrival of the first personnel. This activation marked the first time the US Army has fielded a unit of this kind. Officer personnel were assigned from the Professional Filler System (PROFIS), and enlisted personnel were tasked from the Health Services Command. The 52 personnel ultimately assigned represented 23 different CONUS medical facilities.

A commander for the unit was belatedly designated on Sept 17 and did not arrive until Sept 19, ten days after most other unit members arrived at Ft. Benning. The MTOE organization and manning are at Figure 1. When the unit deployed to Saudi Arabia on Oct 26, 1990, there were only 38 personnel assigned. The unit was short one psychiatrist and nine enlisted psychiatric specialists: therefore only two of three consultation teams were capable of fully independent operations. An active duty occupational therapist and an OT technician had also been added.

These circumstances presented the unit with five major challenges: (1) to establish a command and control structure in spite of the late designation of a commander; (2) to build a cohesive, functional unit from scratch and do it quickly; (3) to define the mission and a mode of operation that would accomplish that mission; (4) to equip and train for the mission; and (5) to develop an organization that could compensate for current personnel shortages but also be capable of rapid expansion upon the arrival of fillers. These circumstances also pointed to obvious deficiencies in the mobilization planning for such units.

These challenges were met with varying success in ways which will be described in detail in further publica-

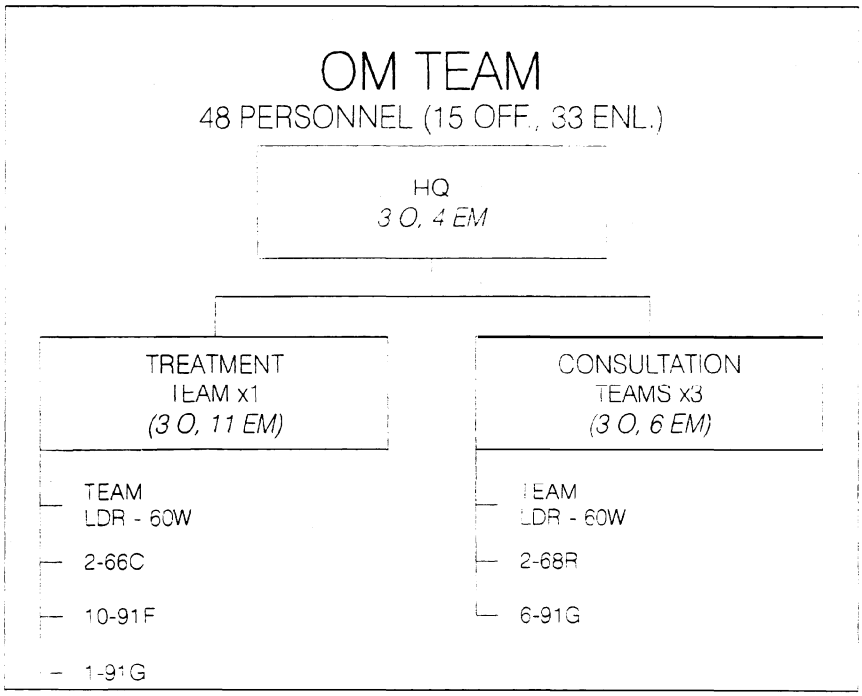

Figure 1. *The MTOE organization and manning of the 528th Medical Detachment.*

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tions. The greatest obstacle was the lack of information regarding the medical context in which the unit would be expected to operate in Saudi Arabia. This was a direct result of the inability to communicate with the headquarters which would receive the unit upon deployment. We prepared by directing training efforts at what were considered to be the most likely scenarios. A great deal of training time was also dedicated to the acquisition of "field soldier" skills, which were notably lacking in these peacetime hospital-based personnel. Training, work and information flow were largely directed through the small team leadership in order to maximize cohesion building, role differentiation and team identity.

By the time the unit deployed on Oct 26, 1990, "PSYCH-FORCE 90" had been born. A unit identity had emerged, esprit-de-corps had developed and soldiers had bonded to their new unit. Confidence and motivation were high.

Operation Desert Shield

Arrival in Saudi Arabia was disorienting, and there were still no instructions from any higher headquarters concerning expected actions upon arrival. A chance conversation over the first meal at Cement City led to a break in the vacuum and an introduction to the Commander of the 44th Medical Brigade of the XVIII Airborne Corps. The 528th was the only psychiatric entity in theater, save the division mental health teams of the 1st CAV, 101st AA, 24th INF (Mech) and 82nd ABN divisions. On Oct 28, mission taskings were assigned based on the distribution of troops in theater and the capabilities of the 528th.

By Nov 3, the detachment had 20 holding cots operational and had begun command consultation and outpatient triage in the Dhahran area. By Nov 14, two consultation teams were operating in the forward area of the corps, approximately 150 miles from Dhahran. Between Nov 3 and Jan 10, the detachment logged 600 unit consultations and 387 psychiatric evaluations, and held 123 soldiers for treatment.

Throughout the period encompassed by Operation Desert Shield, the energy of the detachment was directed toward two priorities: the first was sustainment of day-to-day operations; the second, further preparation for war.

Day-to-day operations of the consultation teams consisted of two primary activities: command consultation and psychiatric triage. The conduct of command consultation consisted of actively seeking opportunities to advise and educate commanders and soldiers on the identification, command management and "buddy aid" of stress-induced dysfunction. Both patient referrals and "critical incidents" were followed up by team personnel with offers of consultation and combat stress training. "Critical incidents" consisted of a variety of circumstances which might be expected to induce stress-related dysfunction (like training accidents) or which might be manifestations of high unit stress (like the discharge of a weapon in anger). Consultations with command were aimed at identifying correctable sources of stress (like unrealistic work-sleep schedules) and advising on their management. Combat stress training (non-combat stress associated with the deployment was also addressed under this title) was directed at increasing the adaptive capability of individuals and units in response to those stressors which were not readily correctable (like heat stress or continuous operations). The availability and effectiveness of command consultation was quickly advertised by word-of-mouth, resulting in far more requests for consultation and combat stress training than the detachment was able to fulfill.

The second primary day-to-day activity of the consultation teams was triage and treatment of dysfunctional soldiers. Conditions dictated that these interventions usually be conducted in a single session. The purpose of triage was to identify major mental illness which necessitated consideration of evacuation from theater, and imminent life-threatening behavior which necessitated consideration of holding for treatment. Otherwise soldiers were provided an opportunity to ventilate and the problem was refocused in terms of those elements within their power to influence here and now. Their chain of command was consulted on unit actions both in theater and, when the problem involved family issues, at home station.

The day-to-day activity of the treatment team was to hold for treatment those soldiers who exhibited imminent life-threatening behavior, and were too disruptive to remain in their units or were awaiting aeromedical evacuation from theater. This group was held on cots in tents in a military atmosphere which emphasized healthy functioning through an intensive work therapy program and promoted adaptation through psycho-educational classes and small group therapy. Here, too, the emphasis was on the limited ventilation of emotions, restructuring of the problem into here-and-now resolvable issues, and the acquisition of adaptational skills combined with active command consultation.

Overall, the detachment's approach to its mission was highly successful during Operation Desert Shield. The total number of soldiers who benefitted directly or indirectly from unit consultations, while unknown, certainly numbers at least several thousand. Only 15% of the soldiers held for treatment were ultimately evacuated from theater. These soldiers constituted less than 6% of all soldiers triaged by the detachment. It should be understood that, for the most part, those soldiers brought to the detachment for triage had already failed unit attempts at problem resolution and, in many cases, had also failed interventions at other echelons of medical and/or mental health care. They represent, therefore, only a small and more dysfunctional portion of the total number of soldiers who were temporarily dysfunctional within the theater during the operation.

In addition to day-to-day operations, the detachment was also very actively preparing for war. These preparations continued through the weeks of the air campaign of Operation Desert Storm. During November, preparations focused on intensive nuclear, biological, and chemical (NBC) defense training, combat stress casualty management skills, further acquisition of field operating skills, environmental threat management (physiological adaptation and preventive medicine) and equipment familiarization and maintenance. As offensive plans took shape in December, the focus of preparation shifted to functional reorganization of the detachment, cross-training of organic personnel, combat role definition and the development of standard operating procedures for management of large numbers of combat stress casualties.

Reorganization for combat was critical to the success of our plan for the treatment of combat casualties in the numbers estimated under the planning guidance provided by Corps. By MTOE, the detachment's holding capability was 25 cots; that had to be expanded to 240 cots! Mission success would require reorganization of the treatment and consultation specialty teams into hybrids that could each perform consultation, triage, treatment and holding. It called for cross-leveling of critical nursing and occupational therapy personnel and cross-training of all enlisted personnel. It required the acquisition of tentage, vehicles and other equipment needed to support the additional patient load. Efforts were also launched to obtain personnel and equipment augmentation from within theater by tapping other mental health assets with less critical missions. These initiatives did not come to fruition until just weeks, in some cases just days, before the ground war commenced.

The most nagging problem for the detachment was its inability to perform certain daily survival functions for itself. The MTOE does not include personnel for vehicle maintenance or food service. The command and staff element was also inadequate. A single field Medical Service Corps officer, a personnel clerk and a supply clerk comprised the entire administrative staff of the unit. The decision was made to augment this staff by using the senior Medical Service Corps officer, a social worker, as the executive officer; however this reduced clinical capability considerably.

Coordination of mess and vehicle maintenance support for the widely dispersed detachment elements required constant attention. Unfortunately, a "look out for Number 1" attitude often prevailed in supporting units, which resulted in recurring denials of access to dining facilities, unwillingness to issue MREs and water, low priority or outright refusal to assist the detachment with vehicle maintenance or to provide spare parts and reluctance to provide all manner of essential day-to-day support. The detachment eventually acquired some autonomy in the supply area when it was granted purchasing authority and allowed to requisition directly from the various supply points. Consequently, supply and equipment status gradually improved. Stabilization of relationships with supporting units throughout the period also helped the messing problem but vehicle maintenance and access to spare parts continued to be a nuisance.

On the positive side, the competence and maturity of personnel continued to improve, as did their versatility due to cross-training. Morale and cohesion remained high in spite of the rigors of daily living and the anticipation of war. As experience was accumulated, the unit became increasingly effective in its mission. This effectiveness was recognized by its "consumers," whose praise and confidence in the "product" served to further boost morale and fuel efforts to achieve the highest levels of competence.

Operation Desert Storm

This phase opened with the staged repositioning of the detachment's teams to the tactical assembly areas of the XVIII Airborne Corps far to the west of our original positions and up against the border of Iraq. The reorganized teams were now under the operational control of surgical task forces hybridized from the CSHs and MASHs in the 44th Medical Brigade. With the entire Central Army on the move and the clear message to US troops that the way home lay through Iraq, requirements, as well as opportunities, for patient care and unit consultation diminished. The central focus of the detachment during the 43 days of the air campaign was final preparation for war.

In addition to continued unit training, preparations now broadened to include three new tasks: the training and integration of augmentees and filler personnel, coordination of the corps combat stress plan, and cross-training of non-psychiatric medical personnel to assist with the combat stress mission. The first of these tasks fell to the team leaders who became responsible for the intensive effort required to bring 21 new members to a state of confident readiness. They had only a few days to achieve what had taken four months to instill in the original 38 personnel. Moreover, the natural reluctance of original team members to incorporate strangers into their tightly cohesive groups on the eve of war had to be worked through.

The second task, coordinating the corps combat stress plan, was self-inflicted. As advice had not been specifically solicited by many of the players in the plan, it was also a time-consuming task which required a great deal of tactful interaction at command levels. It seemed logical and necessary, though, that someone attempt to integrate the efforts of the Corps' many combat stress assets. These included the Division Mental Health Sections of the three assigned divisions, the 528th and the Psychiatric Sections of the five evacuation hospitals assigned to the Corps. They were spread over 200 miles of desert, requiring several hours of on

and off-road travel to negotiate. Many mental health personnel at the evacuation hospital level had little concept of their potential role in case of combat, and they required both consultation and intensive training. At the division level, most were at a high level of readiness and only coordination was required to integrate Division Mental Health Sections with their supporting corps elements, primarily consisting of the teams of the 528th.

The third task, cross-training of nonpsychiatric medical personnel from corps clearing companies, was part of the plan to expand the combat stress casualty treatment capability in the forward area of the Corps in order to maximize soldiers' return to duty. This capability is critical to execution of combat stress control doctrine. Clearing companies have an additional mission, by doctrine, of augmenting combat stress control. Once the decision was made by the group commander to assign this contingency mission to the 85th Medical Battalion, training was coordinated and begun with the designated clearing platoons. Clearing personnel were generally receptive and could have provided augmentation had the contingency been required.

By the early hours of Feb 24, the 528th was as ready as it could get under existing constraints. It was with a mixture of relief and disappointment that our readiness was never put to the test. After 60 to 80 hours of continuous movement, the teams of the 528th were established across central and southern Iraq in the XVIII Airborne Corps area of operations. By integrating into the ambulance and litter-bearing teams and circulating through the patient triage and treatment areas of the medical task forces, team members were ideally situated to provide continuous informal consultation to medical staff and to screen incoming casualties. Spontaneous informal consultative interventions were made in a variety of contexts, from a shaken aircrew which had just delivered a load of badly injured Iraqi children, to a minimal care ward staff split very emotionally by the need to care for wounded POWs. Screening and preventive debriefing of US wounded, identification and treatment of the few cases of typical battle shock and debriefing of English-speaking POWs was also accomplished. These activities continued during the retrograde operations with identification of "critical incidents" followed up by unit debriefings and command consultation.

Redeployment

All 528th personnel had been extracted from Iraq by March 10. The period from March 10 to April 20, the date the unit deactivated at Ft. Benning, Georgia, was occupied with the mundane tasks of preparing personnel and equipment for shipment home. There was ample time and opportunity for detachment members to process their own experiences, both internally and with their peers. Increased access to telephones allowed for the initiation of reunions with family and friends. There were few requests for patient screening or treatment in a Corps giddy with success and extremely happy to be headed home. The detachment continued to seek out "pockets of trauma" for early intervention and became actively involved, along with chaplains and others, in providing "reunion briefings." These clinical activities were relatively limited, however, by the generally happy state of affairs and, probably, by the difficulty units had in locating us, and us in locating them, in a Corps rushing pell mell for home.

Clinical Review

During 171 days in theater, the 528th conducted 514 psychiatric evaluations of soldiers, of which 124 (24%) were held for treatment and 18 (3.5%) were evacuated from theater. All those not evacuated were returned to their units for duty. Command consultations totaled 811. Only a few unwounded soldiers were seen specifically for combat related stress reactions; however, more than 100 soldiers wounded or injured during the invasion of Iraq were screened in preventive interventions.

The 528th made its greatest impact during Operation Desert Shield. Based on observations by the theater neuropsychiatry consultant, the deployment of the detachment at the end of October reduced the overall psychiatric evacuation rate by at least 50%. The portion of psychiatric evacuations consisting of personnel with adjustment disorders fell by approximately 50%; the portion consisting of personnel with personality disorders fell by more than 50%. Consequently, personnel evacuated for psychiatric reasons were more likely to carry a major psychiatric diagnosis. Indeed, these are just the results sought when deploying mental health assets early and forward. They argue strongly for even earlier deployment of mental health assets in future operations. They also argue for greater attention to the readiness and deployability of the active Army's single OM Team. Psychiatric evacuation was much more likely to result if a soldier sought mental health consultation from the Psychiatric Section at an Evacuation Hospital than if he or she first presented to a Division Mental Health Section or OM Team.

During Desert Shield, the majority of soldiers triaged were suffering adjustment difficulties. The most commonly associated factor was having been deployed to SWA within 90 days of assignment to a new unit. This fact once again underlines the importance of group membership in preventing stress-related dysfunction and points to a major cost of extensive cross-leveling and use of "filler" personnel.

Most soldiers presented for treatment within the first month of arrival in theater. This is no surprise but points to the need for active consultation with commanders and stress management training **prior to** deployment. It also reinforces the requirement for putting mental health personnel in theater early and focusing some of their efforts on in-country

assembly areas. Finally, since many of these early adjustment problems stemmed from problems at home rather than from problems in theater, continued improvement must be made in family support programs.

Other special "clusters" which require consideration in planning for future deployments included mothers of small children who suffered deeply both the loss of their own bond to their child as well as the knowledge of the loss suffered by the child. A second cluster consisted of soldiers, largely reservists and guardsmen, who suffered chronic psychiatric disabilities and required psychotropic medications not available in theater or contraindicated due to their potential impairment of heat tolerance. This latter group accounted for a sizeable portion of those evacuated from theater. A third special group was made up of veterans of prior combat, usually senior non-commissioned officers, who experienced exacerbation of combat-related trauma from prior wars. Medical personnel were over-represented among soldiers triaged but this was largely due to their proximity to sources of psychiatric care. And finally, neurologic skills possessed by psychiatrists were found to be particularly important in identifying a number of personnel whose behavioral dysfunction was secondary to a previously undiagnosed organic condition.

Lessons Learned

The primary lesson learned was the confirmation of the basic principles of combat psychiatry: proximity, immediacy, expectancy, simplicity. Psychiatric teams were deployed close to troop concentrations (proximity), where command education and consultation could be applied and dysfunctional soldiers could be rapidly evaluated (immediacy). The expectation that psychiatric symptoms would result in early return home was removed and confidence was exhibited by psychiatric personnel that most problems could be effectively managed in theater (expectation). The application of practical crisis intervention techniques, occupationally-oriented therapy and command consultation (simplicity) resulted in a marked decline in psychiatric evacuations from theater in November and December as compared to September and October. While the impact of preventive efforts is difficult to quantify, it is the conviction of many observers and participants that extensive unit training concerning combat and precombat stresses, as well as reunion stresses, significantly reduced the incidence of stress-related dysfunction. No doubt the absence of alcohol and street drugs from the environment also contributed to this result.

The OM Team, as structured by MTOE, is not flexible enough to meet the demands of AirLand Battle doctrine. Patient holding capability must be decentralized if it is to be done in the forward area of the Corps, and it must be done in the forward area if return to duty is to be effected. Multiple small teams, each with consultation, triage and holding capabilities, are required to support the Corps. The 528th achieved such a configuration through reorganization and cross-training. This deficiency will be corrected by the fielding of combat stress control company and detachment MTOEs in the next few years.

Much has been made of the preference for ground evacuation of combat stress casualties. This preference was not supportable in Operation Desert Storm. The rapidity of movement of combat forces, the great distances over which battles were simultaneously fought by Corps elements and the difficulty of land navigation all mitigated against use of ground evacuation. A compromise must be struck between the principle of proximity and the requirement for conditions under which a combat stress casualty may be held for up to 72 hours. The air ambulance has, perhaps, created a **psychological** proximity that must replace the old concept of geographical proximity in combat stress casualty care.

CONCLUSION

"PSYCH-FORCE 90," the 528th Medical Detachment, successfully deployed to Southwest Asia for Operation Desert Shield in support of the XVIII Airborne Corps. By applying the basic principles of combat psychiatry, it proved again that significant combat power can be conserved. It tested many of the concepts inherent in the development of new combat stress control organizations and doctrine, like the efficacy of occupational therapists in a combat stress control function. Through reorganization, cross-training and ingenuity, the detachment expanded its combat stress casualty treatment capability ten-fold in preparation for Operation Desert Storm and the ground offensive, though this was not tested. In spite of mistakes and some outright failures, "PSYCH-FORCE 90" deserves the careful study of leaders of combat stress control units facing deployment in future conflicts. ●