

Chapter 4

COMBAT AND OPERATIONAL STRESS CONTROL

EDWARD A. BRUSHER, LCSW, BCD*

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**Lieutenant Colonel, Medical Service Corps, US Army; Deputy Director, Behavioral Health Proponency, Office of The Surgeon General, 5109 Leesburg Pike, Skyline 6, Suite 693, Falls Church, Virginia 22041-3258; formerly, Combat Operational Stress Control Program Manager, US Army Medical Command, Fort Sam Houston, Texas*

INTRODUCTION

Combat and operational stress includes all the physiological and emotional stresses encountered as a direct result of the dangers and mission demands of combat and other military operations. Combat and operational stress control (COSC) in the US Army may be defined as programs developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress behavior (COSB) in units. These programs optimize mission performance; conserve fighting strength; and prevent or minimize adverse effects of combat and operational stress reaction (COSR) on soldiers and their physical, psychological, intellectual, and social health. COSC's goal is to return soldiers to duty expeditiously. COSC activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during, and after deployment; and continual assessment and consultation with medical and other personnel from garrison to the battlefield.

Within US military operations historically, COSRs (negative reactions in the spectrum of COSB), have accounted for up to half of all battlefield casualties, depending upon the difficulty of the conditions. Al-

though rates of COSR casualties have remained high in 21st century wars, losses due to COSR have significantly decreased as a result of institutionalizing COSC into military operational functioning. In today's combat environment, military leaders can expect to retain and return to duty (RTD) over 95% of service members who experience COSR. COSC is a tactical consideration that must not be overlooked or minimized. COSC is one of ten identified medical battlefield operating systems (the other nine being command, control, and communication; hospitalization and surgery; preventive medicine; veterinary services; laboratory, blood, and dental services; health service logistics; combat stress control; patient evacuation and regulation; and area medical support).

Service members—especially military leaders—must learn to recognize COSR's symptoms and prevent or reduce its disruptive effects. This chapter provides an overview of the US Army Combat and Operational Stress Control Program as outlined by Field Manual 4-02.51, *Combat and Operational Stress Control* (July 2006)¹ and Field Manual 6-22.5, *Combat and Operational Stress Control Manual for Leaders and Soldiers* (March 2009).²

COMBAT AND OPERATIONAL STRESS THREAT

In today's battlefield, everyone is a soldier. Whether serving in the infantry, providing healthcare, or providing logistical support, all military personnel face the threat of attack from a dedicated enemy force. Routine existence in a combat zone places all service members at risk for exposure to a range of significant stressors. In peacetime as well as war, the effects of combat and operational stress are experienced by all soldiers in every type of military operation, including combat-like conditions present throughout the entire spectrum of military operations. These operations range from training, all phases of deployment, peacekeeping, humanitarian missions, stability and reconstruction, and government support missions, to missions that may include weapons of mass destruction or chemical, biological, radiological, nuclear, and explosive weapons.

It is important to understand that combat and operational experiences affect all soldiers and reflect all activities soldiers are exposed to throughout the length of their military service, whether a complete career or single enlistment. Service members continually face the potential for deployment and combat, long and arduous training missions, and separations from families. These stressors are greatest during actual combat, but often begin with notification of a deployment. Combat and operational

stress often continues after the fighting is over as the participants deal with the aftermath of deployment, whether they served in support or combat units, were prisoners of war, or experienced severe injuries.

Rigorous research conducted explicitly on the mental health and well-being of service members and families during periods of major military operations is scarce,³ and most studies on the mental health effects of combat were conducted among veterans years after their military service ended.⁴ However, deployment-related stressors have been linked to increased rates of subsequent health problems. Studies have found exposure to severe combat stressors relates to the subsequent development of a range of physiological diseases.⁵ Other studies have documented the association between exposure to deployment-related stressors and the development of psychiatric disorders.^{4,6-8} Deployment is also associated with increased symptoms of posttraumatic stress disorder,⁴ depression,^{4,6} and anger problems.^{9,10} Furthermore, although symptom reports may be low during the immediate postdeployment period, studies with soldiers have found that these symptoms increase 3 to 6 months later.^{11,12} In all, an estimated 20% to 30% of US military personnel returning from current combat operations report significant psychological symptoms.¹²

EXHIBIT 4-1

COMBAT AND OPERATIONAL STRESSORS

Combat Stressors

- Personal injury
- Killing of combatants
- Witnessing the death of an individual
- Death of another unit member
- Injury resulting in the loss of a limb

Operational Stressors

- Prolonged exposure to extreme geographical environments such as desert heat or arctic cold
- Reduced quality of life and communication resources over extended period of time
- Prolonged separation from significant support systems such as family
- Exposure to significant injuries over multiple missions such as witnessing the death of several unit members over the course of many combat missions

Sources of Stress

Combat stressors come from a range of possible sources, including singular incidents with potential to significantly affect the unit or soldiers experiencing them, multiple combat incidents, or prolonged exposures due to continued operations in hostile environments. The effects of these stressors are experienced prior to, during, and after military operations and missions. Sometimes stressors are related to a significant or multiple potentially traumatic events (PTEs). A PTE is an event that causes an individual or group to experience intense feelings of terror, horror, helplessness, or hopelessness, and is perceived and experienced as a threat to one's safety or to the stability of one's world. Guilt, anger, sadness, and dislocation of world view or faith are potential emotional and cognitive responses to PTEs. The combined effect of combat and operational stressors results in COSB (see Exhibit 4-1 for examples of both combat stressors and operational stressors).

Although many stressors in combat situations result from deliberate enemy actions aimed at killing, wounding, or demoralizing US soldiers and US allies,

other stressors are due to the natural environment, such as intense heat or cold, humidity, or poor air quality. Still others result from leaders' own calculated or miscalculated choices (for example, decisions about unit strength, maneuvers, the time of an attack, and plans for medical and logistical support). Sound leadership works to keep operational stressors within tolerable limits and prepares troops mentally and physically to endure them. In some cases, however, excessive stress can affect the decision making and judgment of both leader and soldiers, resulting in missed opportunities, or worse, in high casualties or failure to complete the mission.

Finally, some of the most potent stressors are interpersonal in nature and can be due to conflict in the unit or on the home front. Extreme reactions to such stressors may involve harm to self (as in the case of a soldier who becomes suicidal on discovering his wife wants a divorce) or to others (as in the case of a soldier who impulsively fires a weapon at the unit noncommissioned officer out of rage over perceived unfairness). These stressors must be identified and when possible, corrected or controlled.

Mental and Physical Stressors

A mental stressor is one in which the brain receives information about a given threat or demand, but this information results only in indirect physical impact on the body. Instead, its primary effect is to place demands on and evoke reactions from the perceptual, cognitive, or emotional systems of the brain (eg, information overload, perceived lack of control, or grief-producing losses). A physical stressor has a direct, potentially harmful effect on the body. These stressors may be external environmental conditions (such as temperature) or the internal physiologic demands required by or placed upon the human body (such as the need for hydration or an immune response to a viral infection).

Exhibit 4-2 provides examples of the two types of physical stressors (environmental and physiologic) and the two types of mental stressors (cognitive and emotional). Also, physical stressors cause mental stressors when they result in discomfort, distraction, and threat of harm, as well as when they directly impair brain functions. Mental stressors can lead to adaptive or maladaptive stress behaviors that decrease or increase the exposure to physical stressors.

COMBAT AND OPERATIONAL STRESS BEHAVIOR

Stress has both physical and behavioral effects. Stress may increase disease rates by disrupting hygiene and protective measures, as well as impairing

the body's immune defenses. Stress may progress to behavioral health disorders, including suicidal or homicidal behaviors. Some stressors contribute to

EXHIBIT 4-2

EXAMPLES OF COMBAT AND OPERATIONAL STRESSORS

Physical Stressors

- Environmental
 - Heat, cold, wetness, dust
 - Vibration, noise, blast
 - Noxious odors (fumes, poisons, chemicals)
 - Directed-energy weapons/devices
 - Ionizing radiation
 - Infectious agents
 - Physical work
 - Poor visibility (bright lights, darkness, haze)
 - Difficult or arduous terrain
 - High altitude
- Physiologic
 - Sleep deprivation
 - Dehydration
 - Malnutrition
 - Poor hygiene
 - Muscular and aerobic fatigue
 - Overuse or underuse of muscles
 - Impaired immune system
 - Illness or injury
 - Sexual frustration
 - Substance use (smoking, caffeine, alcohol)
 - Obesity
 - Poor physical condition

Mental Stressors

- Cognitive
 - Information (too much or too little)
 - Sensory overload or deprivation
 - Ambiguity, uncertainty, unpredictability
 - Time pressure or waiting
 - Difficult decision (rules of engagement)
 - Organizational dynamics and changes
 - Hard choices vs no choice
 - Recognition of impaired functioning
 - Working beyond skill level
 - Previous failures
- Emotional
 - Being new in unit, isolated, lonely
 - Fear and anxiety-producing threats (of death, injury, failure, or loss)
 - Grief-producing losses (bereavement)
 - Resentment, anger, and rage-producing frustration and guilt
 - Inactivity, producing boredom
 - Conflicting/divided motives and loyalties
 - Spiritual confrontation or temptation causing loss of faith
 - Interpersonal conflict (unity, buddy)
 - Home-front worries, homesickness
 - Loss of privacy
 - Victimization/harassment
 - Exposure to combat/dead bodies
 - Having to kill

misconduct that requires disciplinary action and may take a soldier from duty for legal action and incarceration. Stress can also result in battle and nonbattle injuries through inattention, clumsiness, and reckless behavior, including equipment loss and friendly fire incidents. Excessive stress in combat contributes to lapses in operational and tactical judgment and to missed opportunities that could increase the numbers of soldiers injured over time.

“COSB” is the term used to describe the range of reactions, from adaptive to maladaptive, to the full spectrum of combat and operational stress soldiers are exposed to throughout their military experience.¹⁻¹⁴ Figure 4-1 shows how combat and operational stress and PTEs can lead to both adaptive reactions and COSR, as well as postcombat and operational stress (PCOS), which may include either posttraumatic growth (PTG) or posttraumatic stress disorder (PTSD).

Combat and operational experiences impact every soldier in some way, although not everyone handles the stress in the same way. Soldiers surveyed in Iraq indicate that those who experienced the most combat were the most likely to screen positive for a behavioral health (BH) problem, including PTSD. Nearly one third of soldiers operating “outside the wire” (ie, outside the secure area of the base camps) may be experiencing severe negative symptoms related to combat and operational stress exposure, which can potentially affect the unit’s mission capability.¹⁴

In fact, current research shows that soldiers continue to struggle with PCOS symptoms long after deployment. Soldiers *do not* reset quickly after coming home, and up to 17% of returned veterans may continue to struggle with negative PCOS effects even 12 months after coming home.¹⁴ Leaders and soldiers must recognize the continued effects of combat and operational exposure. Understanding these effects will help sol-

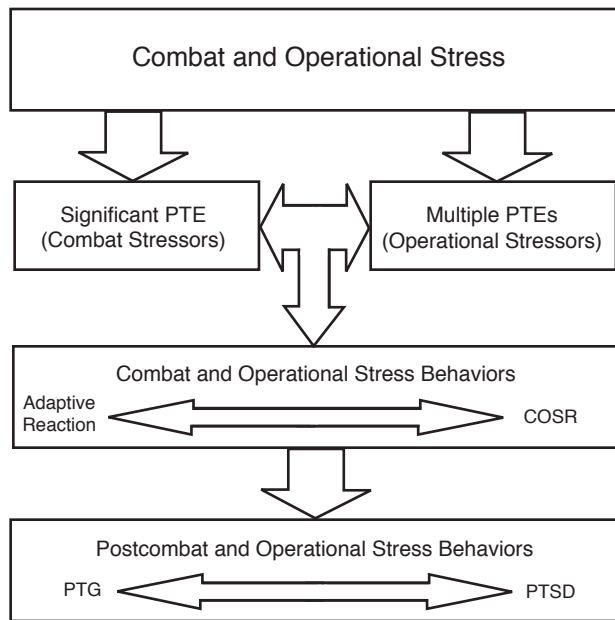


Figure 4-1. Model of stress and its potential soldier and family outcomes.

COSR: combat and operational stress reaction
 PTE: potentially traumatic event
 PTG: posttraumatic growth
 PTSD: posttraumatic stress disorder

dieters plan accordingly to support each other and those entrusted to them. This is especially important while sustaining prolonged or multiple deployment rotations as well as combat operations.

Adaptive Stress Reactions

With effective leadership and strong peer relationships, stressors can lead to adaptive stress reactions that enhance individual and unit performance. Examples of adaptive stress reactions include

- horizontal bonding—the strong personal trust, loyalty, and cohesiveness that develop among peers in a small military unit;
- vertical bonding—personal trust, loyalty, and cohesiveness that develop between leaders and their subordinates;
- esprit de corps—a feeling of identification and membership in the larger, enduring organization with understanding of its history and intent (organizations may include the unit [battalion, brigade combat team, regiment, or division], the branch [infantry, artillery, or military police], and the Army); and
- unit cohesion—the binding force that keeps soldiers together and performing the mission

in spite of danger and adversity.

Cohesion is a result of soldiers knowing and trusting their peers and leaders and understanding their dependency on one another. It is achieved through personal bonding and a strong sense of responsibility toward the unit and its members. The ultimate adaptive stress reactions are acts of extreme courage and almost unbelievable strength. They may even involve deliberate heroism resulting in the ultimate self-sacrifice.

Combat and Operational Stress Reaction

Focused stress is vital to survival and mission accomplishment. However, stress that is prolonged or too intense results in COSR, which impairs the ability to function effectively. The Army uses the term “COSR” (approved by the Department of Defense) in official medical reports in reference to negative adaptation to high-stress events and PTE exposures. When coded (ie, diagnosed), COSR represents individuals in need of formal or informal COSC support and interventions to identify, treat or normalize, and transition the negative effects of combat and operational stress. Although many reactions look like symptoms of mental illness (such as panic, extreme anxiety, depression, hallucinations), they are actually transient reactions to the traumatic stress of combat and the cumulative stresses of military operations.

Military leaders, soldiers, and medical providers must understand the difference between COSR and PTSD. COSR is *not* the same as PTSD. COSR, representing negative adaptation to high-stress and potentially traumatic events, is considered a subclinical diagnosis with a high recovery rate if appropriate attention and time is provided. PTSD, on the other hand, is an anxiety disorder associated with serious traumatic events and characterized by such symptoms as survivor guilt, reliving the trauma in dreams, numbness and lack of involvement with reality, or recurrent thoughts and images. PTSD is a clinical diagnosis as defined by the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Statistical Classification of Diseases and Related Health Problems*. PTSD is one of many possible long-term outcomes resulting from combat and operational stress exposure (collectively classified as PCOS).

COSR and PTSD may share some common symptoms in presentation; however, COSR is recognizable immediately or shortly after exposure to traumatic events and captures any recognizable reaction resulting from this exposure. PTSD has specific chronological requirements and symptom markers that must be satisfied to diagnose the disorder. PTSD is diagnosable only by a trained and credentialed healthcare provider.

Military personnel and providers must focus their efforts on the management of COSR in an effort to shape the long-term reactions of individual soldiers and their units. Individuals with behavioral disorders that existed prior to deployment or first appeared during deployment may need BH support beyond the interventions for COSR.

Misconduct Stress Behaviors

Misconduct stress behaviors range from minor breaches of unit orders or regulations to serious violations of the Uniform Code of Military Justice and the law of land warfare.¹ Misconduct stress behaviors are most likely to occur in poorly trained, undisciplined soldiers under extreme combat stress. Misconduct stress behaviors may also become a major problem for highly cohesive units with strong esprit de corps. Such units may come to consider themselves entitled to special privileges and, as a result, some members may relieve tension unlawfully when they stand down from military operations. They may resort to illegal revenge when a unit member is lost in combat. Stress-control measures and sound leadership can prevent such misconduct stress behaviors, but once serious misconduct has occurred, soldiers must be punished to prevent further erosion of discipline. Combat stress, even with heroic combat performance, cannot justify criminal misconduct.

Postcombat and Operational Stress

PCOS describes a range of possible outcomes along the continuum of stress reactions that may be experienced weeks or even years after combat and operational stress exposure. PCOS may include PTG (the adaptive resolution), mild COSR, or the more severe symptoms often associated with PTSD. It is imperative to understand this continuum and know the difference between adaptation, COSR, and PTSD.

Posttraumatic Growth

PTG refers to a phenomenon in which positive outcomes occur among survivors of traumatic experiences such as car accidents, fires, sexual abuse or assault,

military combat, and being a refugee.¹⁵ PTG among trauma survivors has included improved relationships, renewed hope for life, an improved appreciation of life, an enhanced sense of personal strength, and spiritual development.¹⁶

Continuum of Combat and Operational Stress Behaviors

The distinctions among adaptive stress reactions, misconduct stress behaviors, COSB, COSR, PTG, and PTSD are not always clear. Indeed, the categories of combat and operational stress behaviors may overlap. Soldiers with adaptive stress reactions may also suffer from COSR. Soldiers in combat experience a range of emotions, usually outside of their daily experience, and their behavior influences the immediate safety of the unit and mission success. Combat and combat-related military missions can also impose combinations of heavy physical work; sleep loss; dehydration; poor nutrition; severe noise, vibration, and blast; exposure to heat, cold, or wetness; poor hygiene facilities; and perhaps exposure to infectious diseases, toxic fumes, or harmful substances. These ranges of emotions and mission-related conditions in combination with other influences, such as concerns about problems back home, affect the ability to manage perceived or real danger, and diminish the skills needed to accomplish the mission. Some reactions sharpen abilities to survive and win; other reactions may produce disruptive behaviors and threaten individual and unit safety. Outstanding combat soldiers who have exhibited bravery and heroism may also commit misconduct stress behaviors.

PCOS may develop after someone has experienced or witnessed an actual or threatened traumatic event. It is common for stress reactions to persist or arise long after exposure to distressing events. If PCOS interferes with the ability to do jobs and enjoy life, and it seems to continually get worse, it could lead to PTSD. Most soldiers do well, but for some, persistent symptoms of postcombat stress may require support or medical care. When there is impairment in social or occupational functioning, a clinical assessment is warranted. COSC is important to sustaining Army strength over the long term and reducing the costs to society, the Department of Defense, soldiers, and families.

COMBAT AND OPERATIONAL STRESS CONTROL

COSC is a full-spectrum behavioral health support program that spans all military operations and deployment cycles, not just in the theater environment. The goal of COSC is to enhance unit cohesion and combat capability in the face of high-stress operational environments and to maximize PTG. COSC is effective

when it incorporates not only soldiers but also their extended support system, including significant relationships, families, and external resources. COSC is a comprehensive process that identifies soldiers, Army civilians, and their families who may need assistance with the challenges of deployment, and ensures that

they are better prepared and sustained throughout the deployment cycle.¹⁷ Figure 4-2 illustrates the seven stages of deployment cycle support.

The purpose of COSC is to promote soldier and unit readiness by:

- enhancing adaptive stress reactions,
- preventing maladaptive stress reactions,
- assisting soldiers with controlling COSR, and
- assisting soldiers with behavioral disorders.

Battlemind

The term “Battlemind” represents the US Army psychological resiliency building program (see also the attachment to this chapter). The term describes a soldier’s resiliency skills or inner strength to face fear and adversity during combat with courage. Battlemind training enhances the psychological readiness of every soldier for a stronger and more resilient force. It targets successful individual and organizational recognition of traumatic brain injury, PTSD, suicide risk, and other predictable stressors from military operations to mitigate the effect on mission and readiness. There are four main objectives of Battlemind training for soldiers and their families: (1) mental preparation for the rigors of combat and military deployments, (2) successful transition back home, (3) effective assistance for “Battlemind buddies” during the transition home, and (4) preparation for

the likelihood of deploying again. Battlemind meets these objectives by applying a three-pillar systematic approach: (1) life cycle, (2) deployment cycle, and (3) soldier support.⁸

Life-cycle training is the long-term institutional initiative to help soldiers and leaders reduce existing behavioral health barriers. It facilitates organizational growth by targeting stigma and institutional barriers through cohesion and progressive leader development training during critical points in a soldier’s military career. Deployment-cycle training targets each phase of deployment and builds upon techniques learned during life-cycle training. Combat skills and the battle mindset are what the soldier utilizes to sustain and survive in high-stress operational environments. Battlemind skills help soldiers survive; however, those same skills must be adapted as soldiers transition from a combat or operational mission back to garrison and home environments. Although each soldier makes individual adjustments, the key to a successful transition home is to adapt combat skills so they are just as effective at home as they were in combat. Soldier support training is tailored to special populations, including family systems and military communities. Present day COSC builds on Battlemind skills as proven strengths in the transition to postcombat or operational functioning.

Cohesion and Morale

Cohesion, or the bonds among soldiers, has traditionally been posited as the primary motivation for soldiers in combat.¹⁸ High cohesion and morale enhance adaptive stress reactions in soldiers and organizations and are the best predictors of resiliency within a unit or organization. Units with high cohesion tend to experience a lower rate of COSR than those with low cohesion and morale. Esprit de corps can transcend the problems of race and prejudice. The upkeep of morale and cohesion in combat is recognized as a vital element in the production of combat power in tactical units.¹³ Supportive leadership, regardless of whether a soldier has been to combat or not, is related to how well soldiers fare, both at a personal level (personal morale) and at a unit level (unit morale, cohesion, and combat readiness). This is good news for the military, because leaders can be trained to be more supportive and increase the chances of soldiers having higher personal morale, higher unit morale, better unit cohesion, and higher perceptions of combat readiness.¹⁹ In fact, if unit leaders do nothing more under COSC programs integrated in their organization than focus on unit cohesion and morale, they will have met what is known in the US Army as the “80% solution.”¹⁸



Figure 4-2. Deployment cycle support phases.

Combat and Operational Stress Control as a Function of Leadership

COSC is a command-driven program at all levels. Commanders are assisted by their staff, unit leaders, unit chaplains, and organic medical personnel (ie, those behavioral health and medical personnel assigned directly to the unit). The commander may also receive assistance from organic COSC personnel at brigade level and above, and from corps-level and above medical company or detachment BH personnel. The key concern to combat commanders is to maximize the RTD rate of soldiers who are temporarily impaired or incapacitated with stress-related conditions or diagnosed behavioral disorders.

Combat and Operational Stress Control Professional Disciplines

Five BH professional disciplines and two enlisted specialties support the COSC mission. The professional disciplines include social work, clinical psychology, psychiatry, occupational therapy, and psychiatric or BH nursing; the enlisted specialties are BH and occupational therapy. Although much of the COSC

knowledge base and most of the skills are shared by all BH personnel, each discipline brings a unique perspective from its professional training, skills that can only partially be taught to others, and in some cases unique credentials to conduct specific assessments and treatments.

Religious Support for Combat and Operational Stress Control

The US Army Chaplain Corps is an invaluable asset in ongoing COSC support operations. Soldiers often approach chaplains first to obtain resources to address identified COSRs. Soldiers' inner resources are generally rooted in religious and spiritual values. In combat, soldiers often show increased interest in religious beliefs. When religious and spiritual values are challenged by the chaos of combat, soldiers may lose connection with the inner resources that previously sustained them. The unit ministry team is the primary resource available to soldiers experiencing such dilemmas, providing assistance as they seek to re-focus their spiritual values. The ministry team provides preventive, immediate, and restorative spiritual and emotional support to soldiers experiencing COSR.

COMBAT AND OPERATIONAL STRESS CONTROL INTERVENTIONS

COSC is performed during all phases of combat operations, stability and reconstruction operations, and support operations. COSC assessments, performed at both the unit and individual level, consider a range of variables according to a model (Figure 4-3) that recognizes the interrelationship of biological, psychological, and social factors. This figure is a conceptual model of stress, its mitigating and aggravating factors, and potential outcomes for soldiers and families. Reviewing these interactions systematically, the COSC assessment identifies which variables can be modified to improve coping or outcome. Based on these assessments, COSC personnel recommend courses of action to the commander to improve unit effectiveness and soldier efficiency and well-being. The stress model can be helpful for designing COSC interventions to improve short-term and long-term outcomes.

Soldier and unit readiness is best achieved through an active, prevention-focused approach. COSC interventions are tailored to the needs of the population, and their application may differ based on a particular level of care and other factors pertaining to the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations (METT-TC). However, all preventive interventions seek to reduce the occurrence or severity of COSR and behavioral disorders, thereby sustaining soldier and

unit readiness. COSC interventions can be divided into four categories:

1. **universal** interventions are targeted to the general population or an assigned AO (area of operations);
2. **selective** interventions are targeted to a unit or soldier whose risk is higher than average;
3. **indicated** interventions are targeted to soldiers with COSR or indications of a potential behavioral disorder, and to units showing signs that mission effectiveness is being affected by combat and operational stressors; and
4. **treatment** interventions are targeted to treat and follow up with soldiers with behavioral disorders to prevent their loss from duty.

COSC personnel must identify life- or function-threatening medical, surgical, or psychiatric conditions as soon as possible and provide emergency treatment for those patients.

Combat and Operational Stress Control Management Principles

COSC utilizes the management principles of brev-

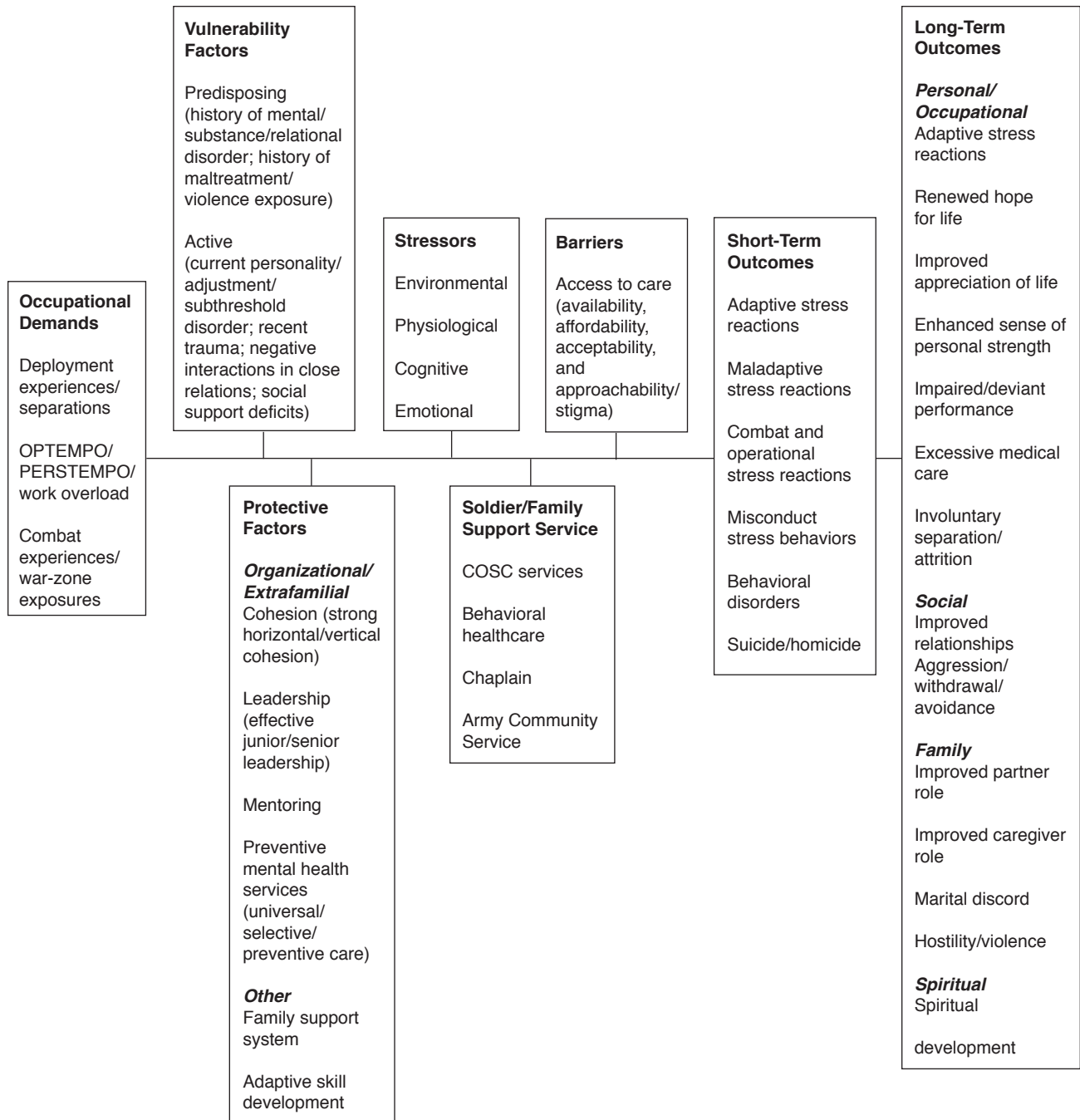


Figure 4-3. Combat and operational stress intervention model. OPSTEMPO: operations tempo; PERSTEMPO: personnel tempo; COSC: combat and operational stress control

ity, immediacy, contact, expectancy, proximity, and simplicity (BICEPS). Using BICEPS is extremely important in the management of soldiers with COSR or behavioral disorders. COSC personnel in all BH/COSC elements apply these principles to all COSC interventions or activities in theater, although they may be applied differently based on a particular level of care and other METT-TC factors, as described below.

Brevity

Initial rest and replenishment at COSC facilities located close to the soldier’s unit should last no more than 1 to 3 days. Those requiring further treatment are moved to the next level of care. Because many soldiers require no further treatment, military commanders expect their soldiers to RTD rapidly.

Immediacy

It is essential that COSC measures be initiated as soon as possible (as soon as symptoms appear) when operations permit.

Contact

Soldiers must be encouraged to continue to think of themselves as warfighters, rather than as patients or sick persons. The chain of command remains directly involved in soldiers' recovery and RTD. The COSC team coordinates with the unit's leaders to learn whether individuals in treatment were good performers prior to the COSR. Whenever possible, representatives or messages from the unit tell these soldiers that they are needed and wanted back. The COSC team coordinates with the unit leaders, through unit medical personnel or chaplains, any special advice on how to assure quick reintegration when the soldier returns to the unit.

Expectancy

Individual soldiers are explicitly told that they are reacting normally to extreme stress and are expected to recover and return to full duty in a few hours or days. A military leader is extremely effective in this role. Of all the things said to a soldier suffering from COSR, the words of the small-unit leader have the greatest effect because of the positive bonding process that occurs. Small-unit leaders should tell soldiers that their comrades need and expect them to return. When they do return, the unit treats them the same as every other soldier and expects them to perform well.

Proximity

Soldiers requiring observation or care beyond the unit level are evacuated to facilities in close proximity to, but separate from, the medical or surgical patients at the battalion aid station or medical company nearest the soldiers' unit. COSRs are often more effectively managed in areas close to the soldier's parent unit. On the noncontiguous battlefield characterized by rapid, frequent maneuvers and continuous operations, COSC personnel must be innovative and flexible in designing interventions that maximize and maintain the soldier's connection to the parent unit. It is best to send soldiers who cannot continue their mission and require more extensive intervention to a facility other than a hospital, unless no other alternative is available.

Simplicity

Brief, straightforward methods should be used to

restore physical well-being and self-confidence.

Combat and Operational Stress Control Functional Areas

Combat and operational stress control interventions and activities are organized into nine functional areas. These areas cover the full spectrum of BH care from preventive measures through clinical intervention.

Unit Needs Assessment

Unit needs assessment is the systematic and frequent assessment of supported units to determine the priority and types of BH interventions required.

Consultation and Education

Consultation involves liaison with and preventive advice to commanders, staff of supported units, and soldiers. Education involves training in concepts and skills for increasing soldier resilience to stress.

Traumatic Events Management

Traumatic events management (TEM) blends other COSC functional areas to create a flexible set of interventions specifically focused on stress management for units and soldiers following PTEs. Like other functional areas, COSC providers must tailor TEM to the needs of the unit and the soldier. For military units, TEM is active in all phases of the deployment cycle and across the continuum of military operations, both in garrison and in deployed environments. TEM is a structured unit process designed to mitigate the impact of PTEs and to accelerate normal recovery of personnel involved. The goal of TEM is to enhance PTG and reestablish unit cohesion and structure. Examples of PTEs that might result in a TEM assessment and intervention include

- heavy or continuous combat operations,
- death of unit members,
- accidents,
- serious injury,
- suicide/homicide,
- environmental devastation or human suffering,
- significant home-front issues, and
- operations resulting in the death of civilians or combatants.

If a unit experiences a PTE, unit leadership may request a TEM assessment to determine potential

impact. It is recommended that leadership request TEM assessments as close to the specific PTE as practically possible, but there are no time limitations to conducting assessments and implementing TEM interventions in response to PTEs that have had a significant impact on the performance, morale, and cohesion of the effected unit or organization. When requested, the identified TEM team will coordinate an assessment resulting in specific recommendations to address the identified PTE as effectively and efficiently as required. TEM is normally conducted by a team composed of medical officers, chaplains, behavioral health professionals, and other trained unit members.

TEM's main value is to quickly restore unit cohesion and readiness to return to action, through clarifying what actually happened and clearing up harmful misperceptions and misunderstandings. It may also reduce the possibility of long-term distress through sharing and acceptance of thoughts, feelings, and reactions related to the PTE. The TEM process incorporates multiple interventions and clinical strategies to aid the military leader in managing and mitigating the impact of PTEs. TEM responses include

- a needs assessment of the impact of the identified PTE;
- command consultation and education;
- unit and individual education;
- individual supportive intervention and counseling;
- psychological debriefings; and
- leader-led after-action debriefings.

Reconstitution Support

Reconstitution is extraordinary action that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources. Reconstitution transcends normal daily force sustainment actions, but it uses existing systems and units to do so; no resources exist solely for this function. In reconstitution support, COSC personnel are responsible for providing restoration for soldiers and conducting COSC functions. This support is provided to units following traumatic events and during reconstitution, redeployment, and transition among levels of operational tempo.

COSC is a joint-service program that affects all service members and their extended support systems in the US military. COSC remains an effective combat multiplier, as it has been in past conflicts. Present-day

Combat and Operational Stress Control Triage

Combat and operational stress control triage is the process of sorting soldiers with COSR or BH disorders based upon where they can best be managed.

Combat and Operational Stress Control Stabilization

Stabilization is the initial management of soldiers with severe COSR or behavioral disorders. Their safety is ensured and they are evaluated for RTD potential or prepared for further treatment or evacuation.

Soldier Restoration

Soldier restoration involves the 1- to 3-day management of soldiers with COSR or behavioral disorders, normally near a medical treatment facility in close proximity to the unit. This approach uses the "5 Rs":

- Reassurance of normality.
- Rest (respite from combat or break from the work).
- Replenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep).
- Restore confidence with purposeful activities and contact with the soldier's unit.
- Return to duty and reunite the soldier with the unit.

Behavioral Health Treatment

Patients with identified behavioral disorders receive ongoing evaluation, treatment, and follow-up. This functional area implies a therapist-patient relationship, clinical documentation, and adherence to clinical standards of care.

Soldier Reconditioning

Reconditioning is an intensive program of work therapy, military activities, physical training, and psychotherapy. Reconditioning programs are conducted up to 7 days (or more) in the corps area. Additional reconditioning may be provided in theater outside the combat zone.

SUMMARY

COSC continues to evolve, incorporating both the lessons of past history and the experiences of current combat. It is strength based, utilizing objective and empirically validated current best practices to

enhance and adapt the “battlemind” of the human weapons system. Battlemind is essential to successful military operations, as well as individual adaptive stress reactions and posttraumatic growth. Modern COSC requires close collaboration between military

leaders, doctrinal COSC disciplines, chaplains, and the extended medical community. True COSC is only obtained by leadership integration of COSC concepts with the supporting efforts of medical providers and religious support assets.

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BATTLEMIND TRAINING: THE DEVELOPMENT OF THE US ARMY'S INTEGRATED SYSTEM OF MENTAL HEALTH TRAINING

Background

Battlemind training is the US Army's integrated mental health training program. The Battlemind training system encompasses training targeted to all phases of the deployment cycle, as well as to the soldier lifecycle and medical education system. Training is designed for soldiers, leaders, and military spouses. Battlemind training uses a strength-based approach, incorporating "buddy aid" and focusing on the leader's role in maintaining the mental health of all soldiers.

The word "Battlemind" was coined by General Crosby Saint, Commander-in-Chief, US Army, Europe, in a 1992 message titled "Battlemind Guidelines for Battalion Commanders." General Saint's message described Battlemind as "a warrior's fortitude in the face of danger." Thus, Battlemind was originally a concept created by the warfighter for the warfighter. In 1998, then-Major Carl Castro, as commander of the US Army Medical Research Unit–Europe, an overseas laboratory of the Walter Reed Army Institute of Research (WRAIR), read about Battlemind and recognized its relevancy for the Army at large.

Command-Requested Mental Health Training

In 2005 the brigade commander of the 3rd Infantry Division asked Castro (at that time Chief, Department of Military Psychiatry, WRAIR) to present a talk on preparing leaders for combat. Castro's presentation, "10 Tough Facts About Combat and What Leaders Can Do to Mitigate the Risk," incorporated the concept of Battlemind in what later emerged as a module of Battlemind training. This speech was so well received that the brigade developed a brochure summarizing the main points for all its leaders.

Soon after, recognizing the need for training designed for soldiers as well as those in leadership positions, Castro and Colonel Charles Hoge (Director, Division of Psychiatry and Neurosciences, WRAIR) began planning mental health training for soldiers returning from Iraq and Afghanistan. In fact, Castro and Hoge first conceptualized this training, the impetus for what is now Battlemind, while on a plane ride back to Washington, DC, following a briefing to senior Army leaders. Postdeployment Battlemind training, including the creation of the Battlemind acronym, topic areas, and actions, was then developed by Castro, Hoge, Dr Amy Adler (US Army Medical Research Unit–Europe), and Dr Steven Messer (Department of Military Psychiatry, WRAIR).

Postdeployment Battlemind Training Initiated

The first two Battlemind training modules were validated under a WRAIR scientific protocol with soldiers returning from a combat deployment in Iraq. Battlemind training for reintegration (the original Battlemind training) and the postdeployment Battlemind psychological debriefing were both validated in a group randomized trial conducted with a brigade combat team in 2005.¹ Soldiers with high levels of combat experience who received Battlemind training reported better mental health adjustment 4 months after returning from deployment compared to those receiving standard postdeployment stress education. Soldiers in the Battlemind sessions frequently requested that their spouse receive the same training. This led to the development by Castro and Lieutenant Colonel Anthony Cox (Department of Military Psychiatry, WRAIR) of the spouse Battlemind training program (predeployment and postdeployment training designed for individuals or couples).

The original Battlemind training efficacy study was replicated in 2006 with another brigade combat team.² Results confirmed that Battlemind training reduced adjustment problems 4 months postdeployment. In addition, while conducting the initial postdeployment Battlemind training, Castro and Adler recognized the need for follow-up training 3 to 6 months later. This recognition was fueled by the intensity with which soldiers described the transition process as well as WRAIR data demonstrating that symptoms increase between return from deployment and 3 to 6 months postdeployment.³ Battlemind training for the 3- to 6-month postdeployment period was assessed in a group randomized trial in 2005 and 2006.⁴ Again, results demonstrated the efficacy of Battlemind training in reducing mental health symptoms. Thus, Battlemind quickly evolved from a one-time intervention to a full program with multiple training modules designed for different points in the deployment and career life cycle.

In addition to PowerPoint presentations, Castro and Colonel Charles S Milliken (Division of Psychiatry and Neurosciences, WRAIR) and Walter Reed Army Medical Center Television created a training video with four

scenarios supporting Battlemind training designed for 3 to 6 months postdeployment. Furthermore, Battlemind psychological debriefing techniques were adapted for implementation in-theater and provided to the Army Medical Department Center and School (AMEDD C&S) in February 2007.⁵ A Battlemind psychological debriefing training video was then developed by Castro and Major Dennis McGurk (then at the Department of Military Psychiatry, WRAIR), demonstrating the techniques. Battlemind psychological debriefing was integrated into the AMEDD C&S's combat operational stress course by Major Todd Yosick in February 2007. This course is designed for all behavioral health providers and chaplains deploying to Iraq or Afghanistan.

Broadening Battlemind Training

At the same time that postdeployment Battlemind training modules were being studied, predeployment modules were also being developed. Based on perceived need and the findings of the WRAIR Land Combat Study⁶ (which evaluated prevalence of posttraumatic stress disorder [PTSD], alcohol abuse, and relationship problems; the impact of operational tempo/combat on these problems; what factors decreased the risk; and the proportion of soldiers and families who are not receiving services for these problems), predeployment training was fielded and assessed for user satisfaction in 2007. Results from the Mental Health Advisory Team (MHAT) V report assessing soldier well-being in Iraq found that those who reported receiving predeployment Battlemind training also reported better mental health adjustment in theater.⁷

As deployment cycle and deployment support cycle programs were being phased into soldier training, other Battlemind modules were also being developed. Specifically, in 2007, Milliken initiated the development of Battlemind First Aid, a training program to provide medics with fundamental skills for identifying mental health and referral needs. This program became the blueprint for what is now Battlemind Warrior Resiliency Training, which targets all Army medical personnel as of 2007.

Each of the new Battlemind modules followed the same fundamental principles. Each module is research-based and rejects a medical or deficit model, focusing instead on soldier strengths. Using examples soldiers can relate to, modules are designed to address misunderstood or conflicted reactions. Each module also identifies specific actions that soldiers can take to maintain their "Battlemind," and emphasizes looking out for oneself, buddies, and subordinates. All training modules were finalized by a team of researchers from both the Department of Military Psychiatry and the US Army Medical Research Unit–Europe.

Battlemind Training and the Army Medical Department

In October and November 2006, a WRAIR team led by Castro and McGurk conducted an MHAT IV assessment of the mental health and well-being of troops deployed to Iraq. A key recommendation of the MHAT IV report was to mandate predeployment and postdeployment Battlemind training. This recommendation was accepted by the US Army surgeon general, the chief of staff of the Army, and the secretary of the Army.

Battlemind training proponentcy was handed to AMEDD C&S in an operations order (Army Directive 2007-02) signed by the surgeon general on March 26, 2007.⁸ Under the provision, the AMEDD C&S officially developed the Battlemind Training System Office to train and maintain the Battlemind mission for the US Army during deployment, the lifecycle, and the soldier support cycle. The office was launched by Major Yosick, Colonel Brian Scott, Colonel Joseph Pecko, and Major Edward Brusher. The operations order also called for the creation of a transition office to serve as an ongoing partner in the continued research and development of Battlemind content; this role was maintained by WRAIR under Lieutenant Colonel Sharon McBride. WRAIR researchers continue to lead the development and validation of Battlemind training.

Current Status

Since the two Battlemind offices were established, other initiatives have been launched, including (a) Basic Battlemind, designed for basic training; (b) the US Army Training and Doctrine Command's development of "Steel Your Battlemind," a training video for advanced individual training; and (c) Battlemind for Leaders, which provides junior leaders with key leadership skills and behaviors and is taught at the Basic Officer Leadership Course and the Warrior Leader Course. As of 2008, other modules under development include (a) Battlemind training for senior leaders, (b) Battlemind training for Warrior Transition Unit cadres, and (c) community Battlemind. Other nations have adapted Battlemind training as well, including Canada (which integrated the training into its Third Location Decompression program) in 2006, and the Netherlands in 2007.

The fact that Battlemind has been readily accepted within the US Army and by other nations reflects the degree to which the training fills an essential need. To remain relevant, the Battlemind system continues to be a dynamic program, creating new modules using the same fundamental principles. Moreover, Battlemind research initiatives at WRAIR are focused on ways to increase the efficacy of the training and ensure its adaptation to operational realities such as multiple deployments. Researchers at WRAIR, WRAIR's transition office, and the AMEDD C&S's Battlemind Office work as a team to ensure the development and implementation of an integrated mental health training program ("armor for the mind") designed to help service members throughout their military career. The evolution of Battlemind concepts continues to influence new initiatives such as the Army Comprehensive Soldier Fitness Office, established in November 2008 under the leadership of Brigadier General Rhonda Cornum, to research resiliency training throughout the Army.

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