

Historical and Contemporary Perspectives of Combat Stress and the Army Combat Stress Control Team
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Introduction: Casualties of War

There are few things in life that are truly consistent and relatively predictable. The ability and desire of humans to wage war is one of them. From the primitive battles of prehistoric nomadic tribes to the politically and technologically orchestrated military operations of today, individuals are asked to perform incredible tasks that are often counterintuitive to the human psyche. As you are reading, there are countless epic tales being told in Americas' VFW's, barber shops, supermarkets and schools detailing the heroic and courageous feats performed by both men and women during times of war. Without doubt, stories are being told of the proverbial combat medic soldier that provides first aid to a fallen brother while shrapnel and bullets narrowly miss them. You will also likely hear of the Marine who rushes into an insurgent filled room and pulls his wounded buddy out of harm's way while disregarding his own safety. These stories intrigue us. They speak to the core of what we know about bravery and courage. They are so profound to us that they are mimicked in child's play and captured in numerous books and movies. Unfortunately, many of these same stories often conclude with the heroic and brave warrior suffering a fateful tragedy. Heroism is not without cost.

Traditionally, the price of war has been viewed primarily in terms of physical injury and death. It is easy to understand why. Consider that in the civil war alone, over 500,000 Americans perished by the hands of their fellow countrymen. In the 20th century, American families buried another 600,000 of their loved ones as a result of the

combined conflicts of this era (Dupuy & Dupuy, 1993). Not to mention that over twice that many suffered non-lethal injuries, many of which were lifelong disabling. It is no wonder why people measure the ill effects of war with a physical yardstick.

Most would certainly agree that death on the battlefield is the most noxious and unsettling outcome of war. However, some would contend that the emotional and psychological scarring that often occurs on the battlefield is a close second. Survey any American family and one would likely find an uncle, grandfather, or distant relative that served in combat. Sometimes, the inquiry would also evoke recollections from the family members about their relative coming back from the war “just not quite right”. Often times this is a result of the psychological cost of war.

For a moment, conjure up memories of yourself when you were 18 or 19 years of age. Many of us would immediately lock-on to reminiscences of how emotionally, psychologically and socially immature we were. Some of us would remember how devastated we became after the loss of our first love or would cringe when we mentally revisited our family conflicts, adolescent rejections, and social mistakes. In itself, early adulthood is a demanding developmental stage with a number of complex milestones to be achieved and psychological demands to be navigated. Young adults must negotiate the challenges of being adult children of their parents and balance increased autonomy with continued degrees of dependence. They take on new responsibilities related to finances, health care, and independent living. Interpersonally, they often seek romantic companionships and may consider marriage and families. Occupational decisions loom about long-term career choices, job training, or higher education. Given the numerous demands of this developmental stage and the additional stressors of military service, the

reliability and stability of most young soldiers, sailors, airmen, and marines is striking. Yet combat and combat related operations can be overwhelming for anyone and often interact with or complicate normal developmental stressors. Given service members' dedication to duty, it is incumbent upon behavioral health professionals to minimize service related stressors, prevent long-term difficulties, and provide treatment when combat and operational stress interferes with the daily life of a service member.

History of Combat Stress

The acknowledgement of the negative psychological impact of war on soldiers can be traced back to early cultural mythology. However, it wasn't until the late 17th century that an attempt was made to apply a diagnostic label to a breakdown on the battlefield - *nostalgia*. Originally called the "Swiss disease" due to its manifestation in Swiss villagers who were involuntarily placed in rogue armies, it eventually was acknowledged as a universal problem (Jones, 1995). Jones provided an excerpt from Rosen (1975) in his account of Leopold Auenbruger's 18th century description of this phenomenon. Auenbruger wrote:

When young men who are still growing are forced to enter military service
and thus lose all hope of returning safe and sound to their beloved homeland,
they become sad, taciturn, listless, solitary, musing, full of sighs and moans.
Finally, they cease to pay attention and become indifferent to everything which
the maintenance of life requires of them. (Rosen, 1975, p. 344)

Auenbruger's account of what these young men were going through from a psychological and behavioral standpoint is not far off the mark from what America's troops have dealt with throughout our national history. The cognitive shift that occurs with being faced

with ones own mortality and the realization that he or she may never see their family again can have a tremendous impact on the person.

Soldier's Heart

In 1871, a former Army psychiatrist during the US Civil War, J. M. Da Costa wrote about a cardiac condition known as "Irritable Heart". Also referred to as cardiac neurosis, neurocirculatory asthenia, nervous heart, and eventually soldier's heart, the syndrome was characterized by shortness of breath, sweating, nausea and diarrhea, dull aching of the chest, and a persistent tachycardia during mild levels of exertion. The soldiers also struggled with the reminders of combat (Wooley, 2002). Although Arthur Bowen Richards Myers (1870) originally described the syndrome one year prior in his book, *On the etiology and prevalence of diseases of the heart among soldiers*, Da Costa reported detailed cases of soldiers suffering from this ailment while fighting in the American Civil War. An interesting note about Da Costa's accounts is that the symptom presentations he details are very similar to what the psychological and psychiatric communities today call anxiety and more specifically, panic.

Another interesting point is that Da Costa noticed that many of the soldiers improved just by removing them from the forward lines and allowing them to rest. Although these accounts are not the first documented cases of combat stress and its treatment in soldiers, they are most likely the first with a sufficient level of description that allows us to make a comparison to our current nomenclature and knowledge about treatment. (Da Costa, 1871).

Shell Shock

The term “shell shock” was a product of the First World War. It was used to describe the psychological trauma that men suffered as a result of the intense combat prevalent throughout the European theater. Originally, men were believed to be suffering from the direct physical effects of shell blasts or poisoning due to the odd and unfamiliar symptom presentation. Over time, most cases were found not to have been close to exploding artillery, and were diagnosed as “war neurosis”. Some of the more common symptoms of this phenomenon were agitation, fatigue, increased startle response, loss of concentration, and mood lability. Conversion reactions with localized loss of sensory or motor function that resembled neurological damage were also common (J. Stokes, personal communication, June 7, 2005). Many of the fighters would flee the battle-site due to an overwhelming sense of fear and panic or become paralyzed and incapable of movement. Consequently, many of these warriors were labeled as cowards or “malingeringers” (Gilbert, 1994; Binneveld, 1998).

W. H. Rivers, a British psychiatrist during World War I studying the phenomenon of shell shock, presented a paper at the Royal School of Medicine in 1917 which was then published one year later in the journal *Lancet*. Rivers described a type of neurosis suffered by soldiers that he attributed to a form of repression. He argued that soldiers under intense stress would attempt to mentally withdraw from the adverse stimuli of war (Rivers, 1918). River’s explanation of the psychological mechanisms seen in these soldiers is similar to what most behavioral health professionals today would call dissociation. However, what made River’s work so important was that he was able to describe several cases in which there was successful amelioration of symptoms. It was at

this point that the area of combat stress casualty intervention really began to gain momentum.

Battle Fatigue

As the World War II successor to shell shock, battle fatigue became a popular term in military medicine that is still used in many of the discussions of combat stress today. Battle fatigue is considered to be caused by one (or usually a combination) of four contributing factors: sudden exposure, cumulative exposure, physical stressors, and home front issues (US Department of the Army, 1994a; US Department of the Army, 1994b). Its symptoms are similar to shell shock and soldier's heart in that the individual may experience fatigue, anxiety, loss of concentration and motivation, depression, memory loss, and disturbances in physical functioning.

During WWII, treatment for battle fatigue focused on returning the soldier to the front in order to keep fighting and keep the unit strong. Initially thought to be cruel and counterproductive, service members were found to be able to reintegrate back into their units and continue as productive warriors. This is consistent with what was found in the Russo-Japanese War, WWI, Korea, Vietnam, the Israeli Lebanon Incursion, and many others. Historical accounts suggest that it was the new replacement who is most likely to fail catastrophically and not the experienced soldier (J. Stokes, personal communication, June, 7, 2005).

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is one of the most well known and publicized mental health disorders in the world. It is characterized by an exposure to a traumatic event with symptoms from three different clusters: intrusive

thoughts/recollections, avoidant/numbing symptoms, and hyper-arousal (American Psychiatric Association, 2000). The disorder gained its widespread recognition as a result of the Vietnam War. After thousands of returning veterans lined the halls of VA hospitals, scientists began to take a closer look at this complex disorder (Dicks, 1990). Partly in response to the “social epidemic” of PTSD in America, the American Psychiatric Association listed it in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*; American Psychiatric Association, 1987) as an official diagnosis. Consequently, numerous research projects were undertaken to learn more about this disorder and how best to treat those affected by it.

To date, most of the major studies related to PTSD are with Vietnam veterans. One of the more influential of these studies was conducted in 1983 by the National Vietnam Veterans Readjustment Study which was mandated by the U.S. Congress. The aim of the study was to determine the prevalence of PTSD in returning veterans as well as identify any readjustment/reintegration problems that they faced. The investigators found that approximately 30% of males and 26% of females who participated in the Vietnam War had PTSD at some point during their lives. They also found that there was a higher incidence in minority populations (Kulka, 1990).

Only one large scale study (Hoge et al., 2004) has been conducted on the combat related mental health difficulties among service members deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom. These researchers found that 11-to-20% of 1709 redeployed soldiers and marines met broad screening criteria for PTSD three to four months after returning. This is intriguing considering that over 90% of service members deployed to Iraq reported being shot at. Based on these studies, it is

noteworthy that the vast majority of service members are quite resilient. Approximately 70% of Vietnam veterans and 80% of OIF veterans are not suffering from PTSD. Military personnel are tough, professional, and well trained and most apparently endure combat stress adequately. However, for the thousands who do suffer significant psychological or functional impairment, there remains an obligation as well as hope.

Probably the most important consequence of the vast research into PTSD is the continued development and refinement of treatment methods. There are literally dozens of scripted treatment programs for PTSD drawing from various theoretical backgrounds. It is safe to assume that as research into this area continues, more effective and targeted approaches to ameliorating the symptoms of PTSD will emerge.

Combat-Operational Stress Reaction

In February of 1999, DOD Directive 6490.5 (Department of Defense, 1999) mandated the use of the term Combat Stress Reactions. In the next 1-2 years, the Navy, Marines and Air Force wanted it changed to “Operational Stress Reactions”, based on the argument that service members were just as vulnerable to stress reactions during peacetime operations as they were during combat. An agreement was reached, and Combat-Operational Stress Reaction (COSR) has become the standard term used in all Services. However, it is still not official, pending revision of DOD 6490.5. The current authors believe that there is another important difference. COSR is a more inclusive term. The days of support troops with the “gear in the rear” are for the most part over. Linear battle fields are not likely to reemerge and combat support troops are often co-located with infantry soldiers and participating in tactical missions. Everyone is a potential stress casualty. Hence, the appreciated addition of operational in the

designation. The identifier of operational also makes it clearer that similar symptoms and sequelae can occur in the absence of combat during, for example, peace support operations, humanitarian assistance missions, grueling field exercises, and even under garrison stressors, (e.g. preparing for a major inspection).

COSR has been described as what happens when a person experiences a “normal” reaction to what would be considered an “abnormal” experience. COSR encompasses and illuminates the many different types of stress symptoms that a service member may manifest within four specific areas: physical, cognitive, emotional, and behavioral. With regard to physical signs, the service member may experience fatigue and exhaustion, numbness and/or tingling in extremities, nausea and vomiting, insomnia, and psychomotor agitation. Cognitively, it is not uncommon to see difficulties in concentration, memory loss, nightmares, flashbacks, and depersonalization. Emotionally, feelings of fear and hopelessness, mood lability, and anger are often present. And lastly, the service member may exhibit behavioral symptoms that could include misconduct, careless behavior, and impulsivity (US Department of the Army, 1994a; US Department of the Army, 1994b).

Summary

The reactions of troops to stressful events in combat and combat operations, for the most part, have stayed the same over the past several centuries. What has not stayed the same is how they are classified and understood. This is not a trivial difference. In order to develop preventative measures for warding off combat and operational stress reactions and to implement tested and effective treatment strategies, a thorough understanding of the process of combat-operational stress is crucial. As a result of this

understanding, the military has been able to develop successful programs in “combating” combat-operational stress.

The Army Combat Stress Control Team: A Look at its History, Mission, Configuration and Professionals

History

The primary purpose of any military force is to win war. Simply, in theory, the objective is to overwhelm the enemy with so much stress that they submit and surrender to their adversary. This includes not only the physical stress of injury and death, but the emotional and psychological stress that often plagues soldiers on the battlefield. The loss of personnel through emotional and psychological stress can be a war-stopper. Therefore, any successful army must have procedures and units in place to provide support and care to those in need.

In World War I, the US Army learned from their French and British counterparts that if combat stress cases were evacuated to the rear they seldom returned to their units. Moreover, these soldiers were more likely to become chronic and have difficulty readjusting upon their return home. Contrary to this, when treated close to the front the soldiers were more likely to return to duty. Consequently, the units could remain strong, which increased the chances for successful military operations. As a result, the US Army adopted a three-echelon system for prevention and treatment of combat stress casualties (Salmon & Fenton, 1929).

The first-echelon of care consisted of a psychiatrist positioned within the division. The job of the psychiatrist was to screen for those susceptible to combat stress, consult

with command on the prevention of combat stress casualties, triage cases just behind the front so that soldiers with simple exhaustion were rested by their units, and personally treat more symptomatic cases while supervising medical personnel in the division rear. This is where the importance of “treating far forward” can be seen for the first time within US Army medicine. The second-echelon of care consisted of a psychiatrist, psychiatric nurses, occupational therapy volunteers and trained medics (which included some clinical psychologists and social workers). These professionals formed specialized “neurological hospitals” in old French buildings, which treated exclusively the soldiers suffering from combat stress that the psychiatrist in division was not able to return to duty. After one to three weeks of rest and replenishment, most of the soldiers at this level were able to return to their units. This represented the emergence of rest and replenishment as concepts central to the fitness teams of the Army’s modern combat stress teams. Finally, the third-echelon of care consisted of a rear hospital whose only function was to provide several weeks to months of ongoing treatment to the soldier. Although many of the soldiers were able to return to their units after care at this level, it was considerably less than if they were treated at levels one or two, and most returned to rear area duties. (Salmon & Fenton, 1929).

Combat stress teams continued to develop throughout the Korean War, in which a clinical psychologist, a social worker and about six enlisted specialists were added to the division psychiatrist to form the Division Mental Health Section. Also, Korea saw the first autonomous, mobile psychiatric detachments. This mental health structure continued through Vietnam and the Persian Gulf War. However, in 1994 the Department of the Army published two comprehensive documents which were field manuals that

specify doctrinal guidelines for organization and implementation. The first, *Leaders' Manual for Combat Stress Control* (US Department of the Army, 1994a) is known within military circles simply as FM 22-51. FM 22-51 is the most current doctrine on combat stress control (a newer version is under construction) and provides in-depth explanations of causes, symptoms, and treatment of combat stress casualties. The other is *Combat Stress Control in a Theater of Operations—Tactics, Techniques, Procedures* (US Department of the Army, 1994b) or FM 8-51 which specifies the organization and tactical operation of division mental health sections and combat stress control units. Known as the “Bible of combat stress”, FM 8-51 is responsible for outlining the modern day combat stress teams mission and purpose and how they are configured and placed on the battlefield.

Mission and Purpose

The mission of the Army’s combat stress control teams (CSCs) is straightforward and simple; provide prevention and treatment as close to the soldier’s unit as possible for the purpose of keeping the soldier with the unit. The guidelines (“doctrine”) for treating soldiers suffering from COSR follows four basic principles: Proximity, Immediacy, Expectancy, and Simplicity (P.I.E.S.; US Department of the Army, 1994b).

Proximity is based on the principle of providing services to the soldier within his or her own unit, or as close to the unit as possible. The idea underlying this principle is that in order for the soldier to get better, he or she must negotiate the dichotomy of wanting to seek refuge from war and remaining loyal to his or her fellow soldiers. If the soldier is taken from the unit, the pull to flee from the battlefield grows stronger. If this happens, the soldier may see an exacerbation of symptoms and increase the potential for

a long-lasting psychiatric disturbance. For the Army, this means losing a much needed troop that impacts the units' strength and possible future missions.

Immediacy refers to intervening as soon as feasibly possible. If COSR symptoms go untreated, the potential for symptom exacerbation is increased as is the development of new symptoms. This is where a proactive approach by the CSC is crucial in that training command and leadership on how to recognize COSR signs allows for immediate action.

Expectancy is important as it does not focus on the soldier as a patient, but as someone that is having a normal reaction to an extreme circumstance or condition. This is much more than a "splitting of the cognitive hairs". If the soldier believes that he or she will get better and that the reaction will remit with time, the soldier is able to focus on the tasks required to function as a soldier and be able to perform well on missions.

Simplicity is based on assuring that the soldiers' first-order needs (sleep, rest, food, water, hygiene) are available and provided. Although short-term strategies are often employed such as informal counseling and the provision of sleep aids, this is done within the soldiers' unit and not via in-depth psychotherapy in a clinic setting.

Configuration of the CSC Teams

The configuration of the CSC team is based on striking a balance between positioning behavioral health assets as far forward as possible and maintaining assets in the rear to support the forward teams. If needed, in theory, the rear teams are capable of dispatching teams forward in case of a mass casualty (US Department of the Army, 1994b).

Each CSC team is either designated as a company or detachment sized element. The basic differences are the size of the unit, its resources, and whether the unit is active duty or a reserve component (detachments are active duty and companies are reserve). Detachment sized CSC units can possess anywhere from approximately 25 personnel to approximately 45 personnel. Company sized units may be twice that size. Even though there is specific doctrine and guidelines on how many soldiers are in a company or detachment team, size fluctuates depending on available resources and the most current doctrine at the time.

Prevention

The prevention teams' primary responsibility is the prevention, triage, and short-term treatment of COSRs. The prevention team typically consists of a psychologist, social worker, and two mental health specialists. However, it is not uncommon to find a psychiatrist in the place of a psychologist. As stated earlier, there is specific doctrine which outlines the team configuration; however, necessity often dictates configuration. The team is strategically placed with forward units in order to prevent stress breakdown and help keep unit manpower strong. This is done through a variety of means. One of the more common approaches utilized is command consultation.

Through educating unit command about COSR, prevention teams empower unit leadership with the ability to recognize the initial signs of COSR in their soldiers. This can be done simply by giving presentations at command meetings or informally through passing out fliers and brochures. Prevention teams are also able to conduct unit climate surveys. This application of psychometric and qualitative techniques is a very useful tool

for commanders in that specific issues that may contribute to decreased morale can be identified and subsequent recommendations for improved unit function can be provided.

Prevention teams also provide preventive measures to the soldiers themselves through providing briefings on suicide prevention, stress and anger management, homefront issues, and reintegration tips for returning home. Another important and effective strategy at the soldier level is what is referred to as “walkabouts”. A proactive prevention team will send at least one of its members out to different units to talk with soldiers on an informal basis. Typically this is done by an enlisted soldier from the team. Soldiers tend to be reluctant to seek out the formal services of a clinic based behavioral health program due to the fear of being stigmatized. With “walkabouts” the soldier can talk with the CSC enlisted member where they work, in their living quarters, or even in the dining facility. A major selling point to the soldier on this approach is that detailed records of the encounters are not kept and they don’t face the stigma of “mental health”. If a higher level of care is needed, the soldier can be referred to the licensed provider for more “in-depth” intervention, which may include two or three counseling sessions.

Another crucial service provided by prevention teams is crisis debriefings. After a traumatic event, CSC professionals can help soldiers normalize feelings and challenge distressing beliefs. Although not group therapy, crisis debriefings often times can become emotionally charged. The debriefing provides a safe environment for the soldiers to process what happened on several levels without the fear of reprimand or stigmatization from their command.

Fitness

The primary mission of the fitness team is to provide restoration for soldiers suffering from COSR. Staffed with a psychiatrist or psychologist, psychiatric nurse, occupational therapist, two mental health specialists, and two occupational therapy specialists, fitness teams provide basic services to aid in stress recovery.

The fitness concept is based on assuring rest and replenishment. If the soldier is in need of services greater than what can be provided by the prevention team, the soldier can be sent to the fitness team for as little as one day or up to several days depending on individual needs. While at fitness, the soldier is provided the opportunity for sleep which can be accomplished through providing basic sleep hygiene techniques or in more severe cases through medication. They can receive more intensive help with stress management, relaxation training, and home-front issues. If the soldier is dealing more with depressive or anxiety symptoms, brief psychotherapeutic interventions such as cognitive or solution-focused therapy can be provided.

The ultimate goal of fitness is to make sure the soldier's basic needs are met. This is often difficult to accomplish within the unit as the soldier may be needed to maintain a high operational tempo if he or she remains with the unit. With proper rest and replenishment, the vast majority of cases seen by fitness teams are returned to their unit and are mission capable.

Command

For prevention and fitness teams to be effective there must be proper assignment and placement of personnel. This is the role of command. As stated earlier, doctrine serves only as a guide for how CSC teams are structured and placed on the battlefield.

For a CSC team to be truly effective on the battlefield, command must be flexible and adapt to the needs of whatever unforeseen situation or situations may arise.

One way of ensuring that the CSC team is being utilized as efficiently and effectively as it possibly can is to keep track of workload numbers. By keeping track of the number of soldier contacts and intensity of services being provided in the different areas of operations, command can make informed decisions on team placement. If one area is suffering more casualties or has an inherently more difficult mission than others, command can strengthen assets in that region by pulling providers from areas with a lower casualty rate or operational tempo.

Another major role of command is to make sure that the morale of CSC team members remains strong. Behavioral health providers are not immune to the stressors of war. They often share the same environmental, physical, and emotional burdens with line soldiers. Moreover, being required to manage the emotional and psychological problems of others in such an intense and dangerous environment can take its toll. By maintaining strict lines of communication, coordinating mid-tour leave, staying in contact with family members back home, and providing overall adequate support and resources, command is able to buffer many of the stressors faced by the CSC team members.

Roles of the CSC Members

All team members, whether officers or enlisted, privates or commanders, participate in the CSC preventive mission. Command consultation, psychoeducational briefs, walkabouts, crisis debriefings, distribution of informational handouts, etc. are activities conducted by all personnel, regardless of specialty. The unique skills and

contributions of the various team members are described below. Note that many of these contributions refer to treatment when conducted as part of fitness.

Psychiatrists

Psychiatrists are responsible for diagnostic formulation, treatment, and disposition of soldiers with COSRs and psychiatric disorders. As a prescribing physician, the psychiatrist conducts medication consultations and prescribes psychotropics or other medications when appropriate. In addition, the psychiatrist assists with CSC triage by ruling out medical etiologies that may better explain a soldier's clinical presentation. Though rare, the psychiatrist typically assists in the coordination of air evacuation when necessary. In addition, the psychiatrist assists in the training of both CSC personnel and unit leaders regarding the identification and appropriate response to combat stress and psychiatric symptoms. If the psychiatrist is the senior clinical provider, he or she may supervise the unit's clinical work. The psychiatrist may also serve as the fitness or prevention Officer in Charge (OIC). When the CSC team is located near a combat support hospital or medical treatment facility, the psychiatrist may be consulted on injured soldiers with co-occurring psychiatric presentations (Moore, 2005a).

Psychologists

As experts in the assessment, evaluation, and treatment of psychological disorders, clinical psychologists are well suited to distinguish between COSRs and mental health disorders. Regarding triage, psychologists evaluate both soldiers and units using clinical interviewing and psychometric assessment tools. Such assessments assist psychologists in identifying combat stress and neuropsychiatric disorders and help guide recommendations to soldiers and commanders in prevention and treatment. Given the

frequency with which homefront concerns result in or exacerbate combat-operational stress, psychologists' familiarity with marriage and family counseling and interpersonal dynamics is also put to good use. When identified, soldiers with COSRs are treated with a variety of individual and group psychological interventions and techniques. In addition, the psychologist supervises subordinate personnel providing clinical services.

Occupational Therapists

The physical and mental demands of the combat zone can result in a variety of changes in behavior, affect, and cognitions. When these changes rise to the level of a COSR, a negative impact on work performance may result. Occupational therapists (OTs) are trained to assess and rehabilitate functional impairments affecting individuals' daily lives. By definition, this includes occupational performance. In CSCs, OTs utilize their skills and training to assess and improve occupational functioning among soldiers affected by combat-operational stress.

Although OTs participate in certain shared preventive and fitness related CSC tasks, they also bring unique skills to the mission. With individual soldiers, OTs assess duty task requirements and the soldier's current capabilities in order to structure therapeutic environments to recondition soldiers and return them to their place of duty. OTs may also consult with unit commanders on ways of minimizing the impact of combat stress on an entire unit's work performance. Though non-doctrinal, in practice OTs may also be consulted by combat support hospitals or medical treatment facilities when a patient's disease or injury necessitates upper extremity rehabilitation.

Social Workers

Social workers bring their unique psychosocial perspective to the CSC mission by examining COSRs and their prevention through the lens of systemic factors. They help to identify and resolve systemic risk factors for combat-operational stress and implement organizational preventive factors. Through command consultations and work with individual soldiers, social workers enhance the combat strength of supported units. They provide individual and group counseling and psychological assessment, if it is an area of clinical competence. In addition, CSC social workers are often the consulted professionals in the case of domestic violence or sexual assault in theater.

Psychiatric Nurses

CSC psychiatric nurses possess a variety of clinical skills and expertise that can be drawn upon in various ways depending upon the location and needs of a particular team. If the psychiatric nurse has prescribing privileges, he or she may assist the psychiatrist with medication consultations. In addition, the psychiatric nurse assists in the individual and group treatment of COSRs. This may include both preventive interventions as well as treatment. Another important role of the psychiatric nurse is assuming the command role. For example, in 2005-2006, psychiatric nurses were the commanders for all three CSC detachments during Operation Iraqi Freedom-3 (OIF3; Moore, 2005b).

Mental Health and Occupational Therapy Specialists

Paraprofessionals have a long and respected history of significant contributions to the discipline of mental health. Army combat stress control is no exception. Mental Health Specialists and Occupational Therapy Specialists are enlisted personnel who have

completed Army basic training as well as several months of specialized training in basic clinical skills and interviewing. In addition to all preventive activities, these specialists are trained to conduct intake interviews, participate in mass casualty interventions, structure and oversee occupational therapy programs, and escort psychiatric casualties during aero-medical evacuations. In addition, as enlisted personnel, they are technical and tactical experts and train the unit in numerous activities as diverse as driving tactical vehicles, responding to dismounted fire, and identifying and responding to nuclear, biological, chemical, radiological, or explosive attacks.

Summary

The history of Army CSC teams has its roots in the Army's recognition of the detrimental impact that COSR can have on soldiers and subsequent mission performance. As a result, the development and refinement of specialized behavioral health teams was undertaken. Through utilizing both professionals and paraprofessionals trained in combating stress reactions in soldiers, the Army has met the challenge of helping soldiers on the "front lines" deal with harsh and dangerous conditions. Although not a cure, when appropriately applied, CSC teams can restore the stress stricken soldier to their prior level of functioning in order to maintain unit and mission capabilities.

It is noteworthy that Operations Enduring and Iraqi Freedom have provided lessons that have continued to develop the Army model of combat stress control. These conflicts have no "front lines." As a result, modular preventive teams capable of performing a wide variety of combat stress control activities have emerged as a new aspect to the CSC model. While fitness teams and preventive teams continue to be utilized, organization and placement of these teams is no longer based on the location of

the forward line of troops. Instead, geographic areas are parsed and provided appropriate fitness and prevention coverage. Given the diversity of particular geographic locations, the units working within any given area are regarded as having unique characteristics that necessitate formal needs assessment and individualized combat stress control interventions.

Case Studies

CASE I – Preventing Exacerbation of Combat Stress Symptoms

At a small refueling point along a frequently traveled road in Iraq, a CSC prevention team conducted frequent walk-abouts with the numerous temporary residents. Convoys typically stopped for approximately 12-24 hours for rest, food, and fuel. During one such walk-about, SGT X and SPC Y, mental health specialists with the prevention team, introduced themselves to SPC Z, a truck driver who reported that she had witnessed the death of a unit member during a nighttime military vehicle rollover approximately 1 month prior. She was driving a 5-ton truck 30-meters behind the military vehicle when it suddenly swerved off the road and overturned in a ditch. As the convoy halted, SPC Z responded appropriately according to her convoy training. The reason for the loss of vehicle control was unknown.

Intervention

SGT X informally assessed for signs of combat stress. SPC Z generally denied current difficulties but admitted she was not sleeping as well as she used to and noted that she was less confident in her own abilities. “I’m always looking around now when I drive. I feel like I can’t relax. He was a good driver and if it happened to him, it could happen to me!” SGT X drew upon the CSC model and reassured her that her reactions

were perfectly normal and even adaptive. He highlighted her strengths (responding according to her training while under stress) and provided advice on sleep hygiene. Furthermore, he covered the different symptoms that often arise after a traumatic event so that she could be an active member in the monitoring of her emotional health. The role of the CSC team was explained and she was encouraged to seek further assistance, should the need arise.

Outcome

The following morning, SPC Y located SPC Z preparing to convoy out of the area. She reported feeling better after sleeping in a decent cot, getting a bit of rest, and having the chance to get her experiences “off her chest.” SPC Z thanked the mental health specialist for his help and concern and departed with the convoy.

Case Lessons

This case study demonstrates a typical interaction between service members and forward deployed prevention team members. These teams are often deployed to small, remote locations with limited available medical and psychiatric resources. They assist in appropriate triage of service members with symptoms of combat stress and provide support and help at the duty location. While prevention teams can support restoration and stabilization of service members assigned to their area of operations, it is not uncommon for such teams to capitalize on “one-shot” interventions, such as that described above.

In the combat zone, military bearing and adherence to the rank structure do not represent mere military courtesies. These are core organizational features with life and death consequences. However, these aspects of the organization can create barriers for CSC officers trying to informally assess service members. Although willing to “vent” to

fellow enlisted, the presence of an officer may result in professional, censored reports of current functioning.

Given this background, this case study highlights the contributions of the mental health specialist. Highly trained enlisted mental health specialists can provide the ability to make professional, interpersonal connections with fellow service members in order to accurately assess and assist at the place of duty. Such connections represent the “front line” of combat stress consultation.

Case II: Treatment in Theatre – Preventing Unnecessary Evacuations

The Improvised Explosive Device (IED) attack occurred during a routine convoy along a strip of highway on which previous contact with insurgents had occurred. Specialist X, a 27-year-old, married, African American National Guard .50 caliber machine gun operator, heard a massive explosion before briefly losing consciousness. As his perception cleared, he realized his charred truck had come to a stop against the highway median and other service members were assisting him out of the turret. Physically, he was not wounded. His truck commander, however, took shrapnel to his right leg. No one else in the convoy was injured. In the weeks to follow, the truck commander healed and was returned to duty.

During the CSC team’s group debriefing 2 days later, SPC X was quiet, reserved, and sullen. The prevention team assigned to his unit followed up with him the next day at his place of duty. He initially denied difficulties related to the IED and stated he just needed to “suck it up and drive on.” However, as the conversation evolved and rapport began to develop, the service member reported making superficial cuts on his wrist following the incident. He was having regular nightmares, crying spells while he

reflected on the attack, an exaggerated startle response, and increased irritability with others in his unit. Additionally, the service member suspected his wife of infidelity during the deployment and he was having difficulties concentrating on the job. His sleep was severely disturbed and he had developed dark circles under his eyes. He no longer worked out and he was eating only one meal a day. Tearful and agitated, his thoughts centered on ways to convince his wife that he loved her. Though he reported passive suicidal ideation (“I wish I hadn’t lived through the attack”), he denied a plan or intent to end his life. His past history reflected one incident in high school when he had also made superficial cuts on his wrist following an argument with a girlfriend. There was no other history of prior psychiatric treatment or mood difficulties that significantly interfered with social or occupational functioning. The SM was hesitant to meet with a psychologist but was willing to do so in order to focus on saving his marriage.

Intervention

The service member was referred to the CSC psychologist who combined the traditional CSC approach with other individualized psychological interventions. The service member was provided psychoeducation on the effects of sleep deprivation, nutrition, and exercise on mood. Simple, behavioral interventions related to these areas were planned and initiated. His COSRs were normalized and he was referred to a CSC psychiatrist with the fitness team to consider the possible role of medications to increase the likelihood of restorative sleep. A brief course of medications was prescribed. The service member was enrolled in a stress management and coping group and short-term, solution-focused individual therapy was initiated to address depressive and anxious symptoms related to his marital concerns. He was returned to his unit with the

recommendation of a temporary suspension of participation in convoys but continued meaningful work within the unit. The service member was given the expectation that his mood and his ability to work on his problems would both improve in a brief period of time, which would allow him to return to his job fully mission capable.

Outcome

Improved sleep resulted in almost immediate increases in concentration, energy, and motivation to work out his problems. Combat stress reactions progressively decreased in intensity and frequency and were no longer distressing the service member at 3 weeks. Individual therapy utilized an eclectic approach including cognitive-behavioral and existential interventions. Cognitive restructuring, development of improved problem solving skills, and an increased coping repertoire resulted in a stabilization of mood and full participation in his unit's missions in 3.5 weeks. There was no return of passive suicidal ideation. Improved communication skills and confrontation of self-defeating cognitions allowed the service member to accept reassurance from his wife. He went home for his scheduled two weeks of leave approximately two months later and returned to theater confident in his marriage and his ability to complete the deployment successfully.

Case Lessons

This case study illustrates several significant points related to the treatment of combat and operational stress. First, the interface between prevention and fitness teams is crucial to successful treatment. Prevention teams must appropriately triage identified service members in need of restoration or individual attention and successfully refer to this "higher" level of care. This transfer can be challenging. As discussed above, a

soldier may be comfortable with the informal, peer interactions of the mental health specialist. When referral is made to a CSC professional, new challenges and resistance are occasionally encountered.

Second, combat reactions do not occur within a vacuum. As with other forms of trauma, reactions to combat stress are shaped by numerous individual and organizational preventive and risk factors. Although prevention teams typically operate in small, briefly organized groups of soldiers that do not focus on the characteristics of individuals, treatment requires that these factors be taken into account. Factors unique to deployed military personnel that might be considered by providers include length of military career and amount of time in theater, past combat experiences in other conflicts, previous contact with the current enemy, access to and quality of communication with homefront social support, and environmental/cultural stressors in the area of operations.

Third, many soldiers have a tendency to “suck it up and drive on,” that is, to endure whatever challenges are presented and focus on mission completion. Professionals in the civilian sector might consider such a reaction to trauma to represent a lack of insight, denial, repression, or suppression. In contrast, such an attitude among soldiers is often predictive of a positive CSC treatment outcome. It is true that the soldier must become motivated to recognize their needs, accept help, and adopt new tools. However, if the “soldier-on” attitude is encountered initially it may indicate an individual with a personally meaningful mission, an internal locus of control, a supportive chain of command, or significant internal resources. Regardless, due to the prevalence of this attitude CSC teams provide services in a variety of relevant but non-stigmatized contexts

to be readily available and familiar resources to service members (e.g., smoking cessation, stress management, long distance marriage maintenance).

CASE III – Command Contributions – The Role of Leaders

in Managing Combat-Operational Stress

In preparation for his CSC team's deployment to Iraq the Commander of the unit, LTC X, had done his homework. He had 15 years of army leadership experience, not a moment of which was taken for granted as he led his unit into the combat zone. Prior to deployment, his training schedule was effectively and efficiently implemented by the unit's noncommissioned officers. The unit was tactically, technically, and clinically proficient. He had been briefed at length by the leadership of the unit he was replacing and he had a good understanding of the current situation on the ground.

There were 15 forward operating bases (FOBs) within the large geographic area for which the unit had CSC responsibility. These FOBs ranged in size and function from large logistical support areas to small FOBs that were little more than truck stops. Given the unit's personnel strength, the Commander had determined that he could forward deploy 6-12 teams depending on their size and composition. Based on intelligence reviewed, feedback from the outgoing unit, and the strengths and challenges within his own unit the Commander decided to deploy three, 4-person teams and four, 2-person teams to those seven FOBs with the greatest anticipated needs. COSRs identified in other areas would be brought to one of these seven locations.

Following one month in theatre, review of the recent CSC workload reports documented a dramatic increase in the number of COSRs. Examining the data closer, the Commander noted that the change was attributed primarily to soldiers from two FOBs,

currently unoccupied by the CSC team. The Commander quickly learned that IEDs had tripled along a particular stretch of highway not far from these two FOBs. As a result, LTC X assessed the distribution of his combat stress assets and reallocated one 4-man team to each of these two FOBs.

These teams initiated preventive and fitness activities within the area, including walk-about, crisis debriefings, force protection briefs, psychoeducation on combat stress, group treatment on stress/anger management, and individual treatment. In addition, a commander from a large unit at one of the FOBs sensed a dramatic decrease in unit morale and asked the psychologist to conduct a unit survey and make recommendations.

Outcome

Workload reports over the following weeks documented a slow decrease in stress reactions. Although IED attacks in the area continued, the reallocation of personnel reduced stress reactions to slightly above the original baseline by the end of six weeks.

Case Lessons

CSC commanders have a variety of responsibilities including planning, directing, and supervising the operations of the unit. When deployed, commanders must conduct on-going needs assessment within their area of operations and adjust operations as the needs of the mission dictate. The vignette above brings to light this crucial contribution. Without good leadership even world class mental health professionals will lack peak performance. Command decisions about team composition, placement, allocation, and reallocation are among the many key decisions related to successful combat and operational stress management.

This case also underscores the importance of available technologies in assisting commanders in important clinical decision making. The military is cognizant of the important role technology will play in preparing it for the unique war fighting challenges of the 21st century. This is true of the mission of the military behavioral sciences as well. Computerized workload tracking is just one example of many illustrating the mission enhancement available to commanders through technological advances.

Conclusion

The conceptual framework of how combat stress is understood has changed over the centuries. The ways in which the military has dealt with its service members suffering from combat stress has also changed. What has not changed is the impact that this inevitable cost of war has on the heroes that serve our country. At a minimum, we owe these brave men and women a return home and a future not plagued by emotional and psychological problems. However, the authors are not so naïve as to believe that these warriors will go completely unaffected by their experiences.

As has been previously noted, the resilience of the men and women serving in our Armed Forces is tremendous. The vast majority will reintegrate back into their civilian lives with relative ease. Unfortunately, history has shown us that thousands will not. Units like the CSC teams make it possible for behavioral health providers to mitigate the lasting effects of combat exposure. Let us continue to acknowledge and honor those that have fallen on the battlefield. Let us also provide for those that are still among us—the walking wounded.

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