UNITED STATES MARINE CORPS

FIELD MEDICAL TRAINING BATTALION-EAST
Camp Lejeune, NC 28542-0042

FMSO 207

RECOGNIZE COMBAT STRESS DISORDERS

TERMINAL LEARNING OBJECTIVE

(1) Given personnel in any environment, Manage Combat and Operational Stress to strengthen, mitigate, identify, treat, and reintegrate personnel. (8404-COSC-2001)

ENABLING LEARNING OBJECTIVES

(1) Without the aid of reference, given a description or list, define the functions of OSCAR Team Members,within 80% accuracy, per the COSC Program 6490. (FMSO-COSC-2001)

(2) Without the aid of reference, given a description or list, differentiate between Combat Stress and Operational Stress, within 80% accuracy, per the COSC program (FMSO-COSC-2001a)

(3) Without the aid of reference, given a description or list, list the five core leader functions of Combat Operational Stress Control, within 80% accuracy, per the COSC. (FMSO-COSC-2001c)

(4) Without the aid of reference, given a description or list, describe the four stress Zones that make up the Combat Operational Stress Control Continuum, within 80% accuracy, per the COSC program. (FMSO-COSC-2001d)

(5) Without the aid of reference, given a description or list, describe how to use the Combat Operational Stress Flow Chart, within 80% accuracy, per the COSC program. (FMSO-COSC-2001e)

(6) Without the aid of reference, given a description or list, define the two Primary Aid aspects of Combat Operational Stress First Aid, within 80% accuracy, per the COSC program. (FMSO-COSC-2001f)

(7) Without the aid of reference, given a description or list, define the three Secondary Aid aspects of Combat Operational First Aid, within 80% accuracy, per COSC program. (FMSO-COSC-2001g)

(8) Without the aid of referencs, given a description or list, define the four sources of help in dealing with Combat Operational Stress Control, within 80% accuracy, per the COSC program. (FMSO-COSC-2001h)

(9) Without the aid of referencs, given a description or list, define the importance of an After Action Review, to reduce further injury or illness, per MCBUL 6490. (FMSO-COSC-2001i)

1. **FUNCTIONS OF OSCAR TEAM MEMBERS** (MIN) OSCAR teams are formed at the battalion level (units of app. 1000 Marines) across the Corps. Each unit trains a team of approximately 50 OSCAR mentors, derived from both the battalion headquarters unit and subordinate units. It is also supported by extenders and MHPs from internal or local sources, as available. The team's task is to help the unit commander prevent, identify, and manage COS problems as early as possible. The member of the OSCAR team are:

a. **Mentors** – consist of selected Marines with combat zone deployment experience, who are strong role models and are willing to assist and montor other Marines with COS problems. The battalion headquarters element would typically assign its executive officer, sergeant major, and selected Marines to serve as OSCAR mentors; likewise, each company in the battalion would typically assign its executive officer, first sergeant, and selected Marines. Mentors are responsible for identifying, supporting, and advising Marines with COS issues as early as possible, providing leadership through example and referring them to OSCAR extenders and MHPs when problems persist. The reason for putting Marines on the front line is not only to empower leaders to help Marines recognize and recover from stress problems and get back in the fight more quickly, but also to free up MHPs from taking care of cases not requiring mental health treatment. Putting Marines on the front line also reduces stigma by giving Marines initial contacts they can trust—their brothers in arms who have "been there and done that."

b. **Extenders** - consist of medical staff, chaplains, licensed counselors, corpsmen, religious program specialists, and other professionals who "extend" the capabilities of OSCAR Mental health professionals (MHPs) by bridging the gap between MHPs and Marine mentors. The individuals assigned or invited to be part of the battalion team will depend on the type of unit and local support available. For example, OSCAR teams in infantry battalions have battalion medical and religious ministry assets plus company corpsmen organic to them; these would typically be assigned to participate with their respective battalion OSCAR teams. Most supporting establishment commands, however, do not have such assets organic to their command and must rely on external resources, such as installation medical and religious ministry services, for support. Some remote commands must rely on other military services or civilian resources to assist these battalions would be advised to invite providers with whom they have or would like to have a good working relationship to be part of their OSCAR team to facilitate familiarization and mutual understanding of missions. Extenders provide professional support within their respective scopes of practice. Examples include medical treatment of sleep problems, anxiety, depression, counseling for marital problems, anger management, burnout, loss, inner conflict,

anxiety, depression, and other non-complicated mental health issues commonly addressed by primary care physicians, chaplains, and licensed counselors. Corpsmen and religious support specialists have limited specialty skills as extenders but function as peer mentors alongside their Marines, being similar in age and rank and closely trusted their teams.

c. **Mental Health Personnel** - consists of psychiatrists, psychologists, mental health nurse practitioners, and licensed clinical social workers embedded in operational units to provide formal mental health services. The individuals assigned or invited to be part of the battalion team also depend on the type of unit and support available. Each infantry division generally includes three mental health professionals and four psychological technicians on their table of organization. Each infantry regiment typically includes two mental health professionals and two psychological technicians, all available on a shared basis to their respective battalions. However, outside of the infantry divisions, commands must generally rely on external mental health resources, such as installation mental health services, for support. Some remote commands must rely on other military services or civilian resources to assist their teams. In such cases, these commands would be advised to invite external MHPs with whom they have or would like to have a good working relationship to be an informal part of their OSCAR team and facilitate familiarization and mutual understanding of missions. Mental health personnel assigned to operational units provide not only direct clinical services, but also spend a significant portion of their time in the field with the Marines they support during training and deployment.

(1) Organic OSCAR mental health personnel augment the following capabilities for their commanders:

(a) Psychological health surveillance of unit members and units as a whole.

(b) Preventive psychological health training. Early interventions to promote recovery for individuals and units from life-threat or losses.

(c) Clinical mental health services in forward operational environments where such services would be otherwise unavailable.

(d) Professional coordination of comprehensive mental health care services in garrison before and after deployments to ensure readiness.

(e) Clinical mental health services in garrison as an adjunct to those provided by medical treatment facilities.

(f) Psychological health support for medical and religious ministry personnel who are at high risk for stress-related problems.

(2) The OSCAR mental health personnel also support their command's psychological health through the following specific functions and tasks:

(a) Advise commanders and other members of the chain of command on their leadership of psychological health, resilience, and COSC.

(b) Become known to their Marines and trusted by them through repeated contact and the sharing of adversity.

(c) Learn as much as possible about the stressors their Marines face, how they normally cope with stressors, and how Marine leaders manage and mitigate stressors.

(d) Educate and train Marines and Marine leaders in evidence based methods for preventing, identifying, and managing
adverse stress reactions.

(e) Consult with primary care medical officers and corpsmen on the management of adverse stress reactions that require further care.

(f) Consult with Marine Corps chaplains regarding their stress management functions.

(g) Consult with military leaders on the management of unit-level stress challenges.

(h) Work closely with their command element, maintaining an awareness of ongoing operations and paying particular attention to events and operations likely to generate COS casualties.

(3) To be effective, the OSCAR MHPs cannot retreat to a familiar clinical setting surrounded by medical and mental health colleagues. The OSCAR MHP must learn to be comfortable in the world of the Marine. Similarly, Marine leaders must learn to communicate with their mental health professionals, consider heir guidance, and incorporate the information and technologies they bring into the culture of the unit. Because of the shortage of mental health manpower resources, OSCAR team members must also balance the competing priorities of providing preventive services in operational or training environments with providing direct clinical care.

2. SOURCES OF COMBAT AND OPERATIONAL STRESS(COSC)

a. **Operational Stress** - is defined as Changes in physical or mental functioning or behavior resulting from the experience or consequences of military operations other than combat, during peacetime or war, and on land, at sea, or in the air.

b. **Combat Stress** - Changes in physical or mental functioning or behavior resulting from the experience or lethal force or its aftermath. These changes can be positive and adaptive or they can be negative, including distress or loss of normal functioning.

Shell shock, as combat stress was called during World War I, often was viewed as a coward's reaction to fighting. There were little or no selection process to filter out those with psychiatric illnesses before entering the military. Men were killed by firing squad that today would never have been admitted into the military. The few men who were diagnosed with combat fatigue were evacuated home, often when it was too late for recovery. Many developed chronic psychiatric conditions. However, World War II changed a few things. In the US, there was more pre-recruitment screening. The problem of combat stress was grudgingly accepted as part of warfare and by the end of WWII, psychiatrists were stationed within many units. Another major change was men were no longer moved away from the front to receive treatment, except for logistical reasons or in severe cases. In Korea there was even a mobile psychiatric unit conducting "stress control operations" near the front.
Male culture still had difficulty dealing with man's emotional response to war. Vietnam underlined this. Despite progress, there remained little acknowledgement of combat stress. Many men turned to drugs such as marijuana, heroin, and alcohol. The lack of engagement with such a central issue cost many men their lives on the battle field, in conflict zones, and with post traumatic disorders ending in suicide after the war ended.

3. **FIVE CORE LEADER FUNCTIONS OF COSC**

FIVE COSC CORE LEADER FUNCTIONS. Commanders and leaders will employ the five COSC core leader functions: Strengthen, Mitigate, Identify, Treat, and Reintegrate to increase individual and unit readiness. Employing the five COSC core leader functions and utilizing the Stress Continuum provides the Marine Corps framework for understanding, recognizing and dealing with combat and operational stress reactions. Methods for incorporating the COSC core leader functions are as follows.

a. **Strengthen**. Strengthening Marines enhances resilience against combat and operational stress and aids in the prevention of stress injuries and illness. Individuals enter military service with a set of pre-existing strengths and vulnerabilities based on genetic makeup, prior life experiences, personality style, family support systems, among other factors. Commanders of military units can do much to enhance the psychological resilience of unit members and their families. Strengthening falls into three main categories: training, social/unit cohesion and leadership aligned to physical, mental, social and spiritual domains.

b. **Mitigate**. Mitigation is the use of techniques to minimize the impact of stressors that cannot be removed including balancing the need to intentionally stress Marines during training and missions with reducing stressors that are not essential to training or mission accomplishment.

c. **Identify.** Since even the best preventive efforts cannot eliminate all stress reactions and injuries that might affect occupational functioning or health, effective COSC requires continuous monitoring of stressors and stress outcomes.

(l) Leaders must know the individuals in their units, including their specific strengths and weaknesses, and the nature of the challenges they face, both in the unit and in their personal

lives. Most importantly, leaders must monitor which stress zone of the Stress Continuum unit members are in on a day-to-day basis. Marines and Sailors should recognize their own stress reactions, injuries, and illnesses; and they must be able to recognize small changes in behavior that may indicate a stress reaction. Leaders must recognize when a Marine's confidence in him or herself, or his or her peers or leaders is shaken, or when units have lost effectiveness because of challenges to the unit.

(2) Stigma, particularly self-stigma, can be a barrier to acknowledging stress injuries or illness and seeking assistance. Therefore, the best and most reliable method of ensuring that everyone who needs assistance gets it is for small unit leaders to continually monitor the personal and professional performance of their subordinates, and for peers to watch out for each other.

d. **Treat.** While Marine leaders do not provide direct clinical treatment, they are responsible for leadership interventions including facilitating discussions and knowing appropriate resources, as well as referring to the appropriate level of care those affected by stress. The tools available for the treatment of stress reactions include: self-aid, peer-to-peer, support from a Marine leader, chaplain, corpsman, or medical officer and definitive medical or psychological treatment. Although some forms of treatment can only be delivered by trained medical or mental health providers, others require little special training and can be applied very effectively by a peer, family member, leader, or chaplain. Regardless of what level or type of treatment is available for any given Marine or Sailor, the overall responsibility for ensuring appropriate and timely care for injuries or illnesses rests with leaders and their commanders. This is done through coordination with appropriate level of care and follow-through with the Marine or Sailor and the care provider including maintenance and after-care.

e. **Reintegrate.** Commanders support Marines and Sailors during reintegration back into the force following formal mental health treatment. Reintegration is aligned to the maintenance of all Marines but includes two important factors: addressing command climate regarding stigma and establishing confidence. This includes continually monitoring fitness for duty and worldwide deployment, and mentoring the Marine during their recovery process by restoring the confidence of the stress-injured Marine, his or her peers and the unit. Reintegrating Marines preserves the investment made in the training of the individual and upholds our Core Values. Stigma is dispelled when other members of the unit see previously injured Marines return to full duty

4. COMBAT AND OPERATIONAL STRESS CONTINUUM

a. The Stress Continuum (see figure 4) is a model that identifies how Sailors and Marines react under stressful situations. It is the foundation of Navy and Marine Corps efforts to promote psychological health.

b. The continuum is a color-coded map to identify behaviors that might arise from serving in combat, in dangerous peacekeeping missions and in the highly charged day-to-day work that is

required of today's military. While its primary use is for individual service members, the continuum also is a valuable tool to track behaviors of military families and commands.

c. **Common Behaviors of the Four Zones**

(1) GREEN (READY): Not stress-free, but mastering stress with good coping skills. Ready to go!

-Remain calm, steady, confident
-Exhibit ethic and moral behavior
-Eat healthfully, exercise regularly and get proper sleep
-Keep a sense of humor and remain active socially, spiritually
-Use alcohol in moderation, if at all
-Get the job done and show respect for fellow warriors

(2) YELLOW (REACTING): Reacting to life's normal stressors. Mild and reversible!

-Feel anxious, fearful, sad, angry, grouchy, irritable or mean
-Cut corners on the job
-Are negative or pessimistic
-Lose interest, energy or enthusiasm
-Have trouble concentrating
-Become excessive in spending, Internet use, playing computer games, etc.

(3) ORANGE (INJURED): Stress injuries damaging the mind, body or spirit. Temporarily non-mission ready!

-Lose control of emotions or thinking
-Have nightmares, sleep problems, obsessive thinking
-Feel guilt, shame, panic or rage
-Abuse alcohol or drugs
-Change significantly in appearance or behavior
-Lose moral values

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(4) RED (ILL): Stress injuries that become stress illnesses. Only diagnosed by health professionals! These are Orange Zone behaviors that persist, get worse, or get better and then come back worse. The service member cannot function properly.

(a) All medical disorders in individuals exposed to combat or other operational or traumatic stress are found in the Red Zone. These include posttraumatic stress disorder (PTSD), major depression, certain anxiety disorders and substance abuse disorders. The distinction

between Orange Zone stress injury and Red Zone stress illness can only be made by a medical or mental-health professional.

(b) Red Zone illnesses are very treatable. The majority of Sailors and Marines who are treated finish their tours of duty and many continue to serve. Early treatment is the key.

d. Resilience to stress is the underlying theme of the continuum— building it, maintaining it and restoring it when necessary. The more resilience shown by a service member the easier it is to stay in the Green Zone.

e. The American Psychological Association has identified some individual attributes, or personal skills, that may contribute to an individual's ability to cope with life stressors. These attributes include:

- The capacity to make realistic plans and take steps to carry them out. (Judgment, and Decisiveness)
- A positive view of yourself and confidence in your strengths and abilities. (Bearing)
- Skills in communication and problem solving.(Tact, Knowledge, and Initiative)
- The capacity to manage strong feelings and impulses. (Dependability, Tact, Selflessness)

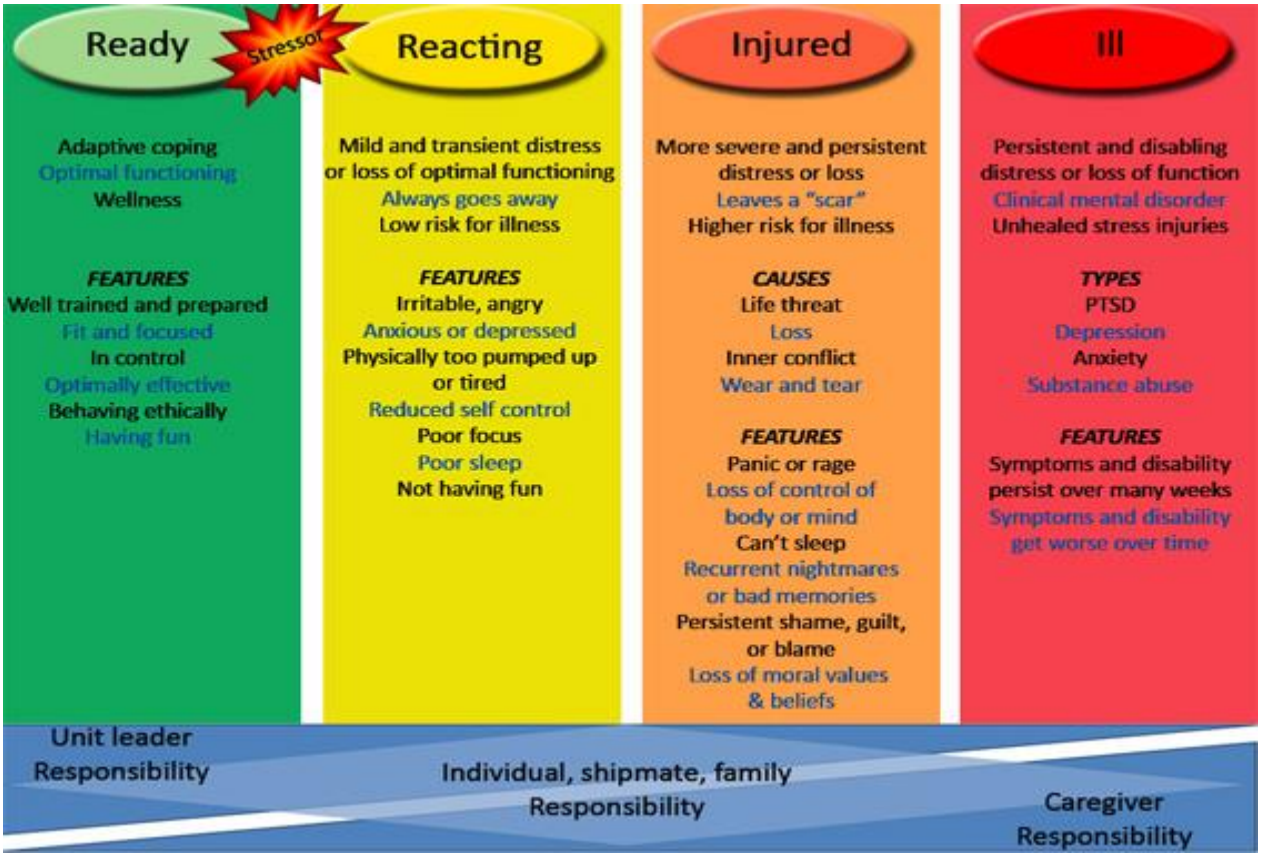
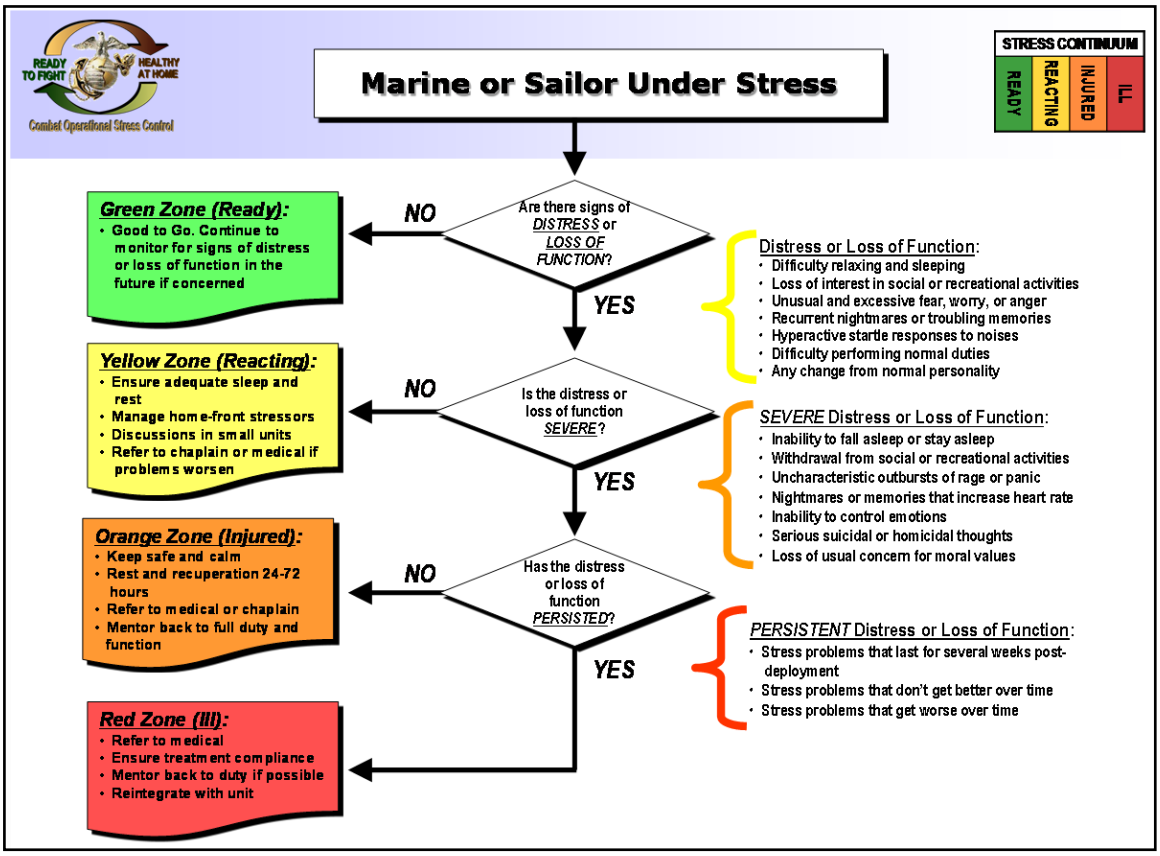


Figure 4. Combat and Operational Stress Continuum

f. **COSC Decision Flowchart** (see figure 5) is a simple tool for leaders to determine where a Marine fall on the stress continuum and shows what to do to mitigate or, if necessary, treat the injury or illness. The Decision Flowchart is applicable at all stages of the deployment cycle. The lists of stress symptoms on the far right, highlighted by the Yellow, Orange, and Red brackets, give the leader or Marine some indications of typical problems at each level of function. The diamonds in the middle specify decisions needed to determine the severity of the stress problem, and the boxes on the left indicate what action needs to be taken for each level of severity. It can also be used by individual Marines to evaluate themselves or their buddies who have symptoms



of deployment-related stress. This is used by leaders to determine what actions should be taken with Marines experiencing combat stress problems.

figure 5. Combat Operational Stress Decision Flowchart

5. **FOUR SOURCES OF HELP IN DEALING WITH COSC**

a. There are four sources to help with Combat and Operational Stress Control. Leaders at all levels are responsible for preserving the psychological health of their Marines, Sailors, and family members, just as they are responsible for preserving their physical health. This responsibility applies to every link in every chain of command from fire team leaders and work center supervisors to combatant commanders and commanding officers. Medical, religious ministry, and other support personnel can help with this task, but only line leaders can balance combat and operational requirements that expose warriors to risks with the imperative to preserve health and readiness.

1. Chain Of Command

    a. Will provide the beginning stages of OSCAR and asses service member if they are fit to deploy, stay deployed or provide necessary mentoring interventions. Experienced peers can be utilized as a source of reassurance and mental support.

2. Medical Department

    a. Involves Medical officers, IDCs, Corpsmen to provide primary medical care for evaluation and treatment of COS. May refer to Psychiatrics or Mental Health providers if needed.

3. Religious Services

    a. Are normally Chaplains or can be a Religious Personnel specialist. They can provide spiritual guidance, counseling or referrals.

4. Family/Family Readiness Officer (FRO)

    a. Family or FRO can assist the service member in managing matters at home to aid stress relief. FROs provide with guidance on the integration of family readiness/wellness programs with the organization's overall strategy for managing the effects of COS in preparation for, sustainment of, and recovery from combat deployments. Risks associated with failure to thoroughly address family readiness/wellness in the organizational COSC strategy extend beyond the negative impact on unit readiness those results from family disintegration. They bore directly into the personal lives, well-being, and safety of Service members, spouses, children and other relationships.

6. **AID ASPECTS**

B. **Primary**
C. **Secondary**

8. **PRIMARY AID ASPECTS** (See figure 3)

a. Check to see if action is required. This is the initial estimation of the reaction and includes asking the Marine if they need assistance. Those who are injured by stress may not be aware of their reaction, so it might be necessary for someone else to ask. In addition, stigma can be an obstacle to asking for assistance. Stress zones and needs change over time and risks from stress injuries may last a long time after the event, so this is a step that is applicable away from immediate danger.

b. Coordinate the next steps. This could include calling someone over to assist or informing those who need to know. It is also the first step to obtaining other needed sources of support or care.

c. Seek cover and get to safety. Get out of the line of fire, if needed, or away from the stressor. This may be necessary if a person in an immediate life-threatening situation is impaired in decision making or has frozen or panicked. This sense of "freezing" may put themselves or other people in danger. They may require someone else to make decisions on their behalf until they can recover.

d. Calm the Marine. The Marine will refocus more quickly if they are calm. Also, the longer stress hormones remain elevated, the more potential damage there is to the brain. Lowering stress hormone levels decreases the risk of long-term stress injury. The Marine providing assistance should create an environment of safety to promote recovery. Methods of calming include tactical breathing and progressive muscle relaxation.

9. **SECONDARY AID ASPECTS** (See figure 3)

a. Connect with the Marine. Bring the Marine back to reality in order to obtain mission focus. This also prevents the sense of isolation that allows negative feelings to continue and hamper future recovery. The goal is to avoid alienation that can cause a loss of trust, energy and self-confidence. Leaders can utilize AAR as supporting tools after the event.

b. Restore competence and ability. Stress injury or illness causes loss or a change in normal functioning and abilities. At a minimum, this step should enable the Marine to move under their own power and care for themselves safely. Higher-level skills can be exercised and restored once the immediate issue is addressed.

c. Restore confidence. Allow the Marine to resume the mission when they are ready to do so. Encourage the Marine in order to restore his or her sense of self-confidence; these are critical steps that will help ensure that the Marine will be a valuable team member in the future.

d. Secondary aid may occur quickly during the event, but may also occur in more detail over time if required.

Figure 3. 7 C's of Stress First Aid

10. AFTER ACTION REVIEWS

Every leader will ensure their Marines are afforded the opportunity to discuss with their peers and immediate supervisors, in an atmosphere of trust and honesty, perceptions and reactions after significant operational or training events. Such discussions promote recovery from combat/operational stress reactions and can prevent them from developing into long-term issues. AAR is a tool for small unit leaders to identify Marines who might be in need of individual support.

AAR Goals

(1) Reviewing the facts, as best known to members of the small unit, surrounding operational or training events particularly where there have been casualties or loss of life. This promotes a common perception and understanding of the action and facilitates the sharing of lessons learned.

(2) Encouraging (but not forcing) Marines to share their personal experiences with each other of the action under discussion, including what they believe they did well and what they could improve.

(3) Relieving, as much as possible, inappropriate or excessive self-blame or anger among unit Marines for unavoidable failures.

(5) Establishing common perceptions among unit members of the meaning of what happened, and what purpose was served by the unit's actions and sacrifices.

(6) Restoring any damaged confidence among unit members in their leaders, equipment, peers or themselves through honestly and tactfully evaluating events and what will be done to prevent similar situations in the future, where possible.

(7) Identifying Marines according to the Stress Continuum, including those who show signs of a stress injury, so progress toward healing and recovery can be monitored, and a referral to resources can be initiated if required.

AAR Procedures

(1) Conduct AAR at the small unit level, such as squads or other similarly sized team.

(2) Facilitated by the small unit's senior leaders, such as a squad leader, who should be OSCAR trained.

(3) Conduct AAR within 72 hours of each action, but not before post-action rest and replenishment.

(4) No one outside the small unit should be present during an AAR, other than members of the immediate chain of command who were involved in the action or the unit chaplain if requested.

(5) All Marines should be required to attend every AAR their unit conducts, but they should not be required to speak if they choose not to.

(6) Each AAR should take between 15 to 60 minutes to conduct; but be flexible, do not rush or artificially prolong it.

AAR Responsibilities. Leaders are responsible for conducting AAR. The following considerations apply:

(1) Listen to your Marines and try to understand their experiences and perceptions.

(2) Provide positive mentoring by honestly sharing experiences with subordinates, in a calm and self-controlled manner.

(3) Assist junior Marines make sense out of what happened, including why sacrifices were made, and what good came from their efforts.

(4) If a Marine leader feels unable to conduct an AAR in their unit for whatever reason, he or she should discuss this with their most trusted superior. After the most stressful operational events, then an AAR may be most difficult to conduct, is exactly when Marines need it most.

(5) Memorials - In addition to the critical role of memorials as tribute and remembrance of the fallen, memorials are important events for identifying stress reactions, honoring sacrifice and core values, building unit cohesion, and supporting Marines and their families.

REFERENCE:

Combat Operational stress Control Program (COC)	MCBUL 6490
Combat Stress	MCRP 6-11C
Combat Operational Stress Control Program	MCO 5351.1
Policy Guidance for Management of Traumatic Brain Injury in the Deployed setting	DTM 09-033