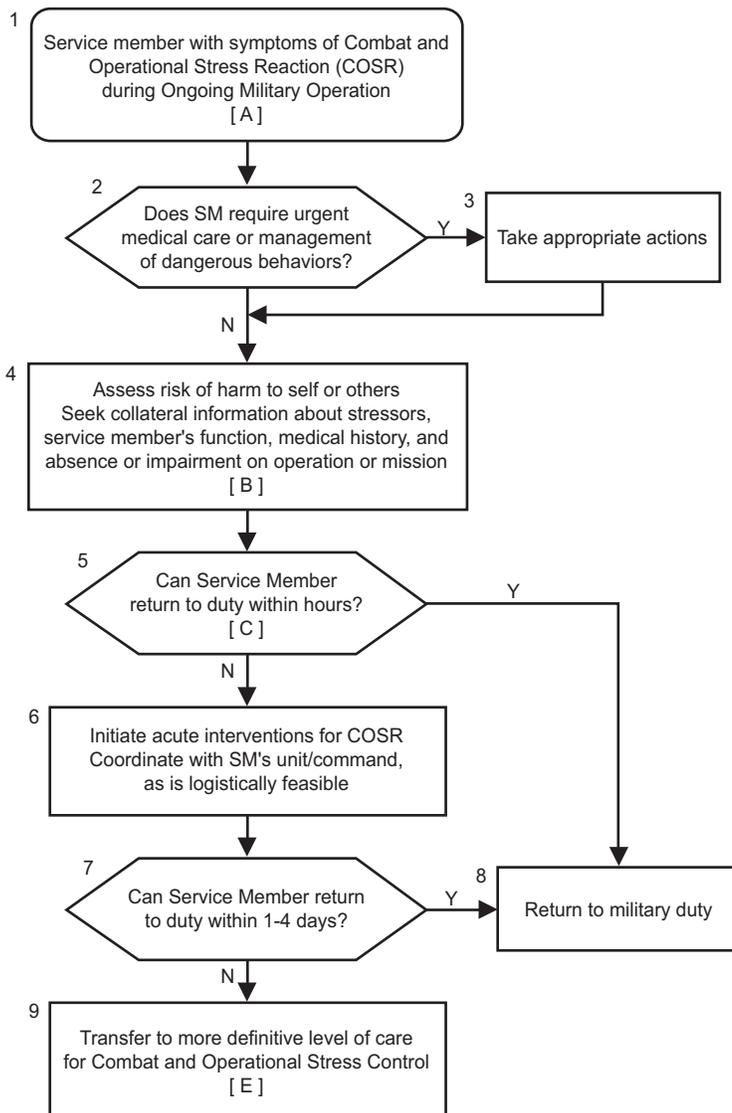


# VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS

## Module A2 Summary

### MANAGEMENT OF STRESS REACTIONS COMBAT AND OPERATIONAL STRESS REACTION (COSR) DURING ONGOING MILITARY OPERATIONS

# A2



#### COSR SYMPTOMS

Possible Syndrome:

- exhaustion/burnout
- hyperarousal and anxiety
- somatic complaints (GI, GU, MS, CV, respiratory, NS)
- depression/guilt/hopelessness
- conversion disorder symptoms
- amnesic and/or dissociative symptoms
- behavioral changes
- emotional dysregulation
- anger/irritability
- brief, manageable "psychotic symptoms" (e.g., hallucinations due to sleep deprivation, mild "paranoia")

COSR does not require a specific traumatic event and can be a result of accumulating stress

#### COSR ACUTE INTERVENTIONS

Treat according to service member's prior role and not as a "patient"; avoid hospital setting  
Assure or provide the following, as needed:

- Reunion or contact with primary group
- Respite from intense stress
- Thermal comfort
- Oral hydration
- Oral food
- Hygiene (toileting, shower, shave, and female needs)
- Sleep (to facilitate rest and restoration)
- Encourage talk about the event with supportive others

Reserve group debriefing for members of pre-existing and continuing groups (voluntary attendance)

Assign appropriate duty tasks and recreational activities that will restore focus and confidence and reinforce teamwork

Avoid further traumatic events until recovered for full duty  
Evaluate periodically

Consider using a short course of medication targeted for specific symptoms

## INTRODUCTION

*The approach to triage in the immediate response to traumatic exposure for service member (SM) with symptoms during Ongoing Military Operations is directed by dual sets of objectives:*

### Military Considerations

Management of combat and operational stress reactions (COSR) during ongoing military operations is targeted to preserve the fighting force and return the SM to functional status. Context and setting of care delivery may vary markedly.

### Military Clinical Objectives

1. Prevent exacerbation of symptoms / mitigate symptoms of acute stress
2. Prevent development of traumatic stress sequelae (e.g., Acute Stress Disorder [ASD], Post Traumatic Stress Disorder [PTSD], depressive disorders, anxiety disorders, and substance use disorders)
3. Keep SM with his/her unit and prevent unnecessary medical evacuation
4. Return SM to duty as soon as possible
5. Maintain and enhance unit capabilities and readiness.

For further discussion of the key elements, please see the VA/DoD Guideline for Management of Post Traumatic Stress Reaction: Module A1: Acute Stress Reaction

## ANNOTATIONS

### A. Service Member With Symptoms Of Combat And Operational Stress Reaction (COSR) During Ongoing Military Operations

#### BACKGROUND

Traumatic events are events that cause a person to have the experience that he or she may die or be seriously injured or harmed. These events also can be traumatic when the person witnesses them happening to others. Such events often create feelings of intense fear, helplessness or horror for those who experience them. Among the common kinds of traumatic events are:

- Combat in the war zone
- Rape and sexual assault

- Natural disaster (e.g., hurricanes, floods or fires)
- Motor vehicle accidents
- Exposure to the sudden or unexpected death of others
- Intense emotional demands (e.g., rescue personnel and caregivers searching for possibly dying survivors or interacting with bereaved family members)
- Extreme fatigue, weather exposure, hunger, sleep deprivation
- Extended exposure to danger, loss, emotional/physical strain
- Exposure to toxic contamination (e.g., gas or fumes, chemicals, radioactivity)

COSR does not require a specific traumatic event, but may result from cumulative exposure to multiple stressors.

## RECOMMENDATIONS

1. Identify service member with symptoms compatible with COSR. Symptoms are not attributed to identified medical/surgical condition requiring other urgent treatment (a service member can have COSR concurrent with minor return-to-duty [RTD] wounds/illness).
2. Evacuate to next level of care, if unmanageable.
3. Screen service member for symptoms of COSR, which include:
  - Exhaustion/burnout
  - Hyperarousal and anxiety
  - Somatic complaints (GI, GU, MS, CV, respiratory, NS)
  - Depression or guilt/hopelessness
  - Conversion Disorder symptoms
  - Amnestic or dissociative symptoms
  - Behavioral changes
  - Emotional dysregulation
  - Anger/irritability
  - Brief, manageable “psychotic symptoms” (e.g., hallucinations due to sleep deprivation and mild “paranoia”)

4. Address the underlying cause of symptoms (e.g. sleep deprivation) in brief restoration program. Advise service member's Commander, chaplain, etc., on follow-up actions. Document symptoms and observations.

### **B. Assess Risk Of Harm To Self Or Others**

Seek collateral information about stressors, and service member's function, medical history, and absence or impairment on operation or mission.

#### **OBJECTIVE**

Obtain information to assess service member's condition and triage for appropriate care.

#### **RECOMMENDATIONS**

1. Arrange for a safe and comfortable environment to continue the evaluation. Secure any weapons and explosives.
2. Medical triage to rule out:
  - Neurotoxicant exposure
  - Head injury
  - Undetected wounds
  - Acute physical illness (e.g., infectious)
3. Document symptoms of COSR, obtain collateral information from unit leaders and assess service member's function, to include:
  - Any changes in productivity?
  - Co-worker or supervisor reports of recent changes in appearance, quality of work or relationships?
  - Any tardiness/unreliability, loss of motivation or loss of interest?
  - Forgetful or easily distracted?
  - Screening for substance use.

### **C. Can Service Member Return To Duty Within Hours?**

#### **OBJECTIVE**

Identify service members who can rapidly resume effective functioning in the unit.

#### **BACKGROUND**

Ideally, service members who become ineffective as a result of COSR will be returned to duty at the earliest possible time. This is necessary, as stress-related casualties can constitute an important source of fully trained replacements for battlefield losses.

#### **RECOMMENDATIONS**

1. Consider the service member's role, functional capabilities and the complexity and importance of his/her job when determining when to return the service member to duty.
2. The continuing presence of symptoms of COSR alone should not constitute a basis for preventing a return to duty.
3. Educate and "normalize" observed psychological reactions to the chain of command.

### **D. Initiate Acute Interventions For COSR**

Coordinate with service member's unit/command. Treat within closest proximity to service member's unit, as is logistically feasible

#### **OBJECTIVE**

Initiate acute symptom management.

#### **BACKGROUND**

Acute interventions should be tailored to address the individual service person, unit and military force needs and characteristics. Early interventions should typically seek to address diverse outcomes, with the aim of promoting normal recovery, resiliency, and personal growth. Collective outcomes should also be addressed, such as social order and community/unit cohesion.

#### **RECOMMENDATIONS**

1. Maintain sense of unit integrity:
  - Normalization
  - Validation
  - Keep positive approach
  - Set up expectation for recovery and return to duty (role)

2. Keep treatment consistent with the “PIES” principle:

- *Proximity*: Prevention and treatment are conducted in proximity to the battlefield or the origin of the stressor. Treatment proximate to the member’s unit where he can be visited by fellow military members is ideal. Consider all options for proximate treatment; strive to maintain connection to unit to maintain unit integrity
- *Immediacy*: Treatment should begin as soon as tactically and logistically possible
- *Expectancy*: From the outset, the expectation is that the SM is experiencing a normal reaction to an abhorrently abnormal situation and will return to duty following resolution, restitution and adaptation
- *Simplicity*: All modalities of prevention and treatment are simple and clearly understood. No dynamic therapy. No medical model. The only “model” is the military model—military members caring for military members.

3. Initiate treatment:

- Treat according to service member’s prior role and not as a “patient;” avoid a hospital setting
- Assure or provide the following, as needed:
  - Reunion or contact with primary group
  - Respite from intense stress
  - Thermal comfort
  - Oral hydration
  - Oral food
  - Hygiene (toileting, shower, shave, and feminine)
  - Sleep (To facilitate rest and restoration, use anxiolytic medication judiciously and sparingly in the acute setting)
  - Encourage talk about the event with supportive others.

4. Reserve group debriefing for members of pre-existing and continuing groups at appropriate time and setting. Attendance should be voluntary and only be conducted by personnel trained in debriefing methods.

5. Assign job tasks and recreational activities that will restore focus and confidence and reinforce teamwork (limited duty).
6. Avoid further traumatic events until recovered for full duty.
7. Evaluate periodically.
8. Consider using a short course of medication targeted for specific symptoms (see Pharmacotherapy for COSR).

### **E. Transfer To More Definitive Level of Care For Combat And Operational Stress Control**

#### OBJECTIVE

Transfer service member for treatment augmentation or mental health treatment or referral.

#### BACKGROUND

Some patients with an acute stress response may benefit from augmentation of the acute intervention and additional follow-up. Because people recover from traumatic stress at different rates, some individuals may require more time or an adjustment of the treatment prior to improvement.

#### RECOMMENDATIONS

1. Service members who do not respond to first line supportive interventions may warrant a transfer for treatment augmentation or mental health treatment or referral.
2. Transfer to a more definitive level of treatment may include more intense or prolonged treatment at a combat refresher training facility. Service members should be prepared for the transfer with continued positive expectation of recovery from their symptoms and return to normal level of functioning.
3. Ensure that casualties being transferred due to other medical conditions (e.g., wounded in action) receive psycho-education relating to anticipated psychological changes, provide positive expectations, and offer support prior to departure from area of transfer.