Lessons from a Combat Operational Stress Control (COSC) Unit

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Introduction

As part of the final withdrawal of all US personnel from Afghanistan, service members (SMs) from two Army divisions, a Special Purpose Marine Air Ground Task Force, a Marine Expeditionary Unit (MEU), and other units were tasked with security operations at Hamid Karzai International Airport (HKIA). As the situation for Afghan civilians became more desperate, U.S. coalition forces were exposed to human misery, desperation, and trauma culminating with a suicide bomber killing 13 SMs and at least 169 civilians.

The mission of an Army Combat Operational Stress Control (COSC) unit is to conserve fighting strength as it relates to behavioral health. A typical COSC will concentrate on resilience, therapy, medical management, and medical evacuation when appropriate. A COSC deploys with 44 assigned soldiers. From these 44 personnel, there will be 12 credentialed providers consisting of physician psychiatrists, psychologists, licensed clinical social workers, occupational therapists, and psychiatric nurse practitioners. Around 20 unlicensed enlisted behavioral and occupational health technicians, unit ministry (chaplains), and the command team filled the rest of the deployed COSC roster. Additionally, as the only currently deployed COSC during the summer of 2021, the 1493rd had commissioned providers and enlisted technicians assigned to support forward sites in Jordan, Saudi Arabia, Qatar and Iraq while providing over the horizon (OTH) behavioral health (BH) coverage for all other locations within the Central Command (CENTCOM) area of operations (AO). The main body located in Camp Arifjan, Kuwait, consisted of four providers and 10 enlisted soldiers, was tasked with seeing and evaluating the majority of the thousands of SMs retrograded from Afghanistan. Since seeing all of these individual SMs would be impossible, the COSC, in cooperation with embedded behavioral health officers (BHO) from the two affected Army divisions, came up with an effective way to screen SMs in mass.

The 1493rd COSC was tasked with screening every SM redeploying through our area of operations (AO) before those SMs departed theater. This presented us with logistical and capability challenges resulting in a 600% increase in workload lasting three weeks. Our challenge was in not only fulfilling the letter of our mandate but the intent as well.

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The danger being that we would generate a mound of unusable data without a nuanced approach to this situation.

Moral injury occurs in traumatic or unusually stressful circumstances in which people may perpetrate, fail to prevent, or witness events that contradict deeply held beliefs and expectations[i]. Basically, moral injury is the behavioral, emotional, and spiritual response to events well outside of what someone considers normal or morally acceptable. Survivor's guilt and an inability to self-forgive may progress into maladaptive and self-sabotaging behaviors[ii]. Established rules of engagement for SMs at HKIA resulted in SMs being unable to intervene with situations happening before their eyes. Violence against civilians (women and children) in particular begets feelings such as "I am a bad person because I let this bad thing happen."

Adaptive and maladaptive stress occurs as a result of exposure to operational stressors. Examples of positive adaptive stress reactions are horizontal and vertical bonding with peers, superiors, and subordinates, in addition to increases in unit cohesion and esprit de corps. Focused stress is vital to survival; however, stress which is prolonged or too intense results in the maladaptive combat operational stress response (COSR)[iii]. COSR impairs functional ability and places the mission at risk. Usually transient, the symptoms mirror those of diagnosable mental illnesses such as panic, depression, and anxiety. COSR is different from post-traumatic stress disorder (PTSD) which may only be diagnosed by a trained and credentialed healthcare provider in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). COSR is considered a sub-clinical diagnosis and can be made with the presence of symptoms listed above.

Barriers to care

Ronald Reagan once said, "the nine most terrifying words in the English language are 'I'm from the government and I'm here to help.'"[iv] If Soldiers believe that speaking to behavioral health will, in any way, delay their departure from theater, those soldiers will not engage providers. Once you have "going home" on the mind anything which could delay departure is viewed as a threat. Furthermore, the persistent urban legend in which seeking assistance will negatively impact one's military career further decreases the likelihood of honest responses to any sort of survey or request.

The majority of the affected SMs were young male Marines and combat arms Soldiers for whom the drive to not appear weak before peers leads to a potentially dangerous internalizing of fears and emotions. Leadership from these units consist of SMs who have come up through the ranks and share many of these beliefs. Leaders, although well intentioned, may not know how to talk to their subordinates about things which they themselves are not comfortable addressing. If the narrative were to become "do this thing so we can leave" no data of value would be generated. This would result in the COSC failing command intent when we were instructed to screen these SMs.

The Plan and Implementation

COSC and BHO providers held classes designed for leaders (both enlisted and commissioned) from the platoon level up to, and including, division commanders. The classes, each approximately 60 minutes in length, focused on education for identified leaders. Take away points focused on:

- Normal responses to stress and moral injury such as heightened alertness, disrupted sleep, moodiness, and reliving recent (disturbing) events. Immediately following events such as those occurring at HKIA most people will experience these symptoms. SMs can believe they are broken when in fact they are experiencing the body healing. Much the same way as a laceration will turn red, swell, and be tender, the brain will progress through transient stages of healing.

- Abnormal and maladaptive responses (COSR) to stress such as radical mood swings, extreme isolationism, an inability to focus, or conversely obsessing over trivial matters. Leaders are taught that signs of COSR should be reported to behavioral health, leadership, or chaplains for further evaluation.

- How to have these discussions with junior soldiers and among each other. Begin with the premise that Soldiers want to talk about what they have gone through and are experiencing, but either do not know how or feel unable to approach first-line leaders. Changing the narrative in which seeking counseling has a negative impact on one's military career is crucial to ensure honest responses. SMs may know anecdotally of someone who was medically retired from service against their will for a behavioral health issue. Explaining the nuance between certain organic disorders which are incompatible with military service such as psychosis and delusions and those relevant conditions such as depression, anxiety, and PTSD which do not (if managed) necessitate removal from the military can change people's preconceived notions about behavioral health. One battalion commander from one of the Army divisions shared his experience with behavioral health in which his spouse insisted that he seek counseling. The commander described it as a positive experience that benefited his marriage and did not adversely affect his professional career. Leaders are counseled to begin by talking to their subordinates about how they feel about their own recent combat actions then allow for time and space to listen to their Soldiers.

- Understanding signs of PTSD which may present in the future. SMs were instructed how to look for signs of long-term maladaptive behaviors such as relationship problems and substance abuse. Understanding that most, if not all, SMs will feel "different" for a finite amount of time but that after a period, these normal reactions may remain and progress into PTSD is important in reducing the long-term risk for self-harm in this population.

SMs were then gathered at the platoon level and addressed by BHOs, unit ministry, and COSC staff, and given an abridged course on moral injury and stress responses. The

BHO staff then stepped back and allowed platoon-level leadership the space and time to dialogue among themselves while remaining available if needed. At the end of the platoon-level discussions, SMs completed two surveys, the results of which were used to assess risk. The two surveys were chosen for their brevity and focus on PTSD symptoms and suicidality risk. Both assessments have high reliability and have been validated through multiple research studies.

The Columbia-Suicide Severity Rating Scale (C-SSRS) uses six questions focused on acute and recent suicidal ideations. The PTSD Checklist for DSM-5 (PCL-5)[v] is a 20-item survey that directly assesses the 20 symptoms listed in the DSM-5. Each symptom may be reported on a scale from zero (not at all) to four (extremely). When added cumulatively, values greater than 40 are suggestive of maladaptive adjustment and require further evaluation. SMs reporting values between 30 and 39 are considered borderline and identified for monitoring. All affected Army Soldiers who redeployed from HKIA were screened using these two surveys in combination with small-group discussions (platoon) while at Camp Arifjan, Kuwait. The results of these surveys became property of the division and returned to Continental United States (CONUS) with the division to be used with future evaluations in an effort to spot trends.

During this time, the COSC clinic experienced a 600% workload increase resulting from the Soldiers and Marines returning through our areas of operation (Kuwait, Saudi Arabia, Jordan and Qatar). The noncommissioned officers in charge (NCOICs) of each clinic performed a juggling act in which every COSC member increased their workday and eliminated scheduled days off. After this period, the COSC was able to decompress and spent time focusing on their own resilience.

Conclusion

Thirteen Army Soldiers were identified using the C-SSRS as being a positive risk and were further individually examined by behavioral health providers the same day. Two questions on the PCL-5 were considered red flags and resulted in immediate interventions much as with a positive C-SSRS. Questions number 9 and 16 deal with negative beliefs about self, and engaging in actions that can cause self-harm. Any positive response to numbers 9 and 16 was considered positive for risk, no matter the severity reported. Results from the PCL-5 showed greater than 60% of screened Soldiers as having a score greater than 40. These results are indicative of transient COSR and are being used in comparison with follow-on testing to ensure a return to baseline. SMs who continue to display elevated PLC-5 scores in the future are further evaluated for a possible diagnosis of PTSD.

Previously, SMs experiencing classic signs of PTSD such as a decrease in performance, relationship difficulties, and substance abuse were frequently removed from the military. There exists a proactive approach designed to shift the narrative from “this soldier is a dirt bag” to “there may be something living in their head rent-free”, we should get them assistance. In the same spirit as an injured joint leads to an

orthopedist, and a cavity results in a visit to the dentist, behavioral health is being utilized as a tool for force preservation.

It is expected that some of the service members involved will develop maladaptive stress responses; however, when a two-star division commander sets the tone for taking behavioral health seriously, that initiative flows downward, and goes a long way to giving service members the best chance at a healthy and well-adjusted future. Screening SMs following the withdrawal from HKIA was a massive undertaking which was successful as a direct result of the hard work and dedication by members of the 1493rd COSC, in cooperation with embedded BHOs and Marine Operational Stress Control and Readiness (OSCAR) forces. The lessons learned during this time will shape military operational stress doctrine moving forward.

About the Author: LTC Kevin Ponder is the Commander of the 1493d Medical Detachment (MED DET) (COSC). The deployed COSC recently returned from a successful deployment within the CENTCOM region. He is a certified registered nurse anesthetist (CRNA) who holds an Associate of Arts from Miami University (Ohio), a Bachelor of Nursing from the University of Michigan and a Master's of Nurse Anesthesia from the University of Pennsylvania.

ENDNOTES:

[i] Department of Veterans Affairs – National Center for PTSD. https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp

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[iii] Textbook of Military Medicine – Combat and Operational Behavioral Health. Chapter 4. Combat and Operational Stress Control. Brusher, E. A. LCSW. Pg. 63, 2011

[iv] Ronald Reagan Presidential Foundation & Institute. https://www.reaganfoundation.org/ronald-reagan/reagan-quotes-speeches/news-conference-1/

[v] Department of Veterans Affairs, National Center for PTSD. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp