

Operational Stress Control and Readiness (OSCAR): The United States Marine Corps Initiative to Deliver Mental Health Services to Operating Forces

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ABSTRACT

Combat/operational stress control, defined as programs and policies to prevent, identify, and manage adverse combat/operational stress reactions, is the primary responsibility of military commanders. The role of military mental health professionals in combat/operational stress control is to adapt scientific tools for prevention, identification, and treatment for use by military leaders at all levels. The historical gap between military cultures and those of mental health professions has been an obstacle to the full partnership of psychiatry and the military. Differences in how stress is perceived, and problems with the conceptualization of adverse stress reactions have contributed to the marginalization of military psychiatry in theatre, and a widening gap between stress problems identified in theatre and those surfacing after deployment. The U.S. Marine Corps Operational Stress Control and Readiness (OSCAR) program is an innovation that attempts to bridge the gap between mental health science and the art and science of military operations by embedding mental health professionals at the level of infantry regiments, air wings, and logistics groups. OSCAR mental health professionals are not primarily clinical health care providers, but rather combat/operational stress control specialists who educate and are educated by their Marines through repeated contact in the field and the sharing of adversity, before deployment, during deployment, and after deployment. The OSCAR program shows promise as a line military tool to reduce stigma, increase awareness among warfighters of combat/operational stress control principles, provide effective care within the small unit, increase access to care, and reduce long-term deployment-related stress problems.

1.0 COMBAT/OPERATIONAL STRESS CONTROL: WHOSE RESPONSIBILITY?

In the wake of the first Gulf War, the Inspector General of the United States Department of Defense conducted an evaluation of the depth and breadth of programs in U.S. military services to manage and mitigate the stress of combat and other military operations. The Inspector General's report, published in 1996, defined combat/operational stress control as the prevention, identification, and management of adverse reactions in military operations [1]. This is not a novel concept, of course. The management and mitigation of stress through prevention, identification, and treatment have always been significant factors promoting success in military operations. Both the readiness of military units to perform their operational missions and the long-term health and well-being of individual troops depend on the efficacy of

Nash, W.P. (2006) Operational Stress Control and Readiness (OSCAR): The United States Marine Corps Initiative to Deliver Mental Health Services to Operating Forces. In *Human Dimensions in Military Operations – Military Leaders' Strategies for Addressing Stress and Psychological Support* (pp. 25-1 – 25-10). Meeting Proceedings RTO-MP-HFM-134, Paper 25. Neuilly-sur-Seine, France: RTO. Available from: <http://www.rto.nato.int/abstracts.asp>.

combat/operational stress control. But the report by the U.S. Department of Defense's Inspector General in 1996 drew into sharp focus the many diverse elements of combat/operational stress control, as well as where the responsibility lay for their planning and implementation.

1.1 The Responsibility of Military Leaders for Combat/Operational Stress Control

The prevention, identification, and treatment of adverse stress reactions seem, on the surface, like health care functions that should be the primary responsibility of medical personnel. However, medical personnel can never assume primary responsibility for combat/operational stress control because stress is not an unintentional by-product of military training and operations, but an integral characteristic of both realistic training and operations. Military commanders intentionally impose stress on their troops during training to familiarize them with the essential nature of combat and to make them more capable and resilient to the challenges they will later face during actual operations, and commanders lead their troops through sometimes extreme stress on their way to victory on the battlefield. The fundamental tools for prevention—selection, training, leadership, and unit camaraderie and esprit de corps—all lie in the hands of military leaders at all levels. Early identification of adverse stress reactions depends largely on the awareness and attitudes promoted in a military unit by its commander. And effective management of adverse stress reactions, once identified, is best delivered by military leaders at the lowest possible level. Therefore, military commanders bear primary responsibility for combat/operational stress control in their units, and their subordinate military leaders, at all levels, are responsible for continuously implementing their commanders' combat/operational stress control policies and procedures. This has always been the case in military forces, since long before the term "stress" was first used to describe the response of warriors to military operations.

1.2 The Responsibility of Medical Personnel for Combat/Operational Stress Control

Less clear is the responsibility borne by military health care personnel for the prevention, identification, and treatment of adverse stress reactions. As members of scientific communities, psychiatrists, psychologists, and other medical professionals are beneficiaries of the explosion in research in recent decades on the biology, psychology, and sociology of severe stress. And as practitioners of healing arts, members of these professions are capable of providing direct treatment for those military service members whose adverse stress reactions cannot be managed by their military leaders, alone. But should health care personnel operate only on the sidelines, without a more direct role in combat/operational stress control? Do health care personnel—most especially mental health professionals—have no more to offer military commanders in their management of combat/operational stress than treatment of combat/operational stress control failures? Answering these questions requires a brief survey of the relationship between psychiatry and the military, including a look at some of the forces that have impacted on this relationship.

2.0 THE RELATIONSHIP BETWEEN PSYCHIATRY AND THE MILITARY

A number of excellent reviews of the history of psychiatry in the military have been published in recent years [2, 3, 4]. A recurring theme in these reviews is the tension and mistrust that has long existed between mental health professionals and military leaders. Rather than viewing mental health professionals as allies in their pursuit of military goals, commanders have too often seen psychiatrists as adversaries or impediments. In U.S. military services, a common derogatory term for psychiatrists and psychologists among the troops is "wizard," referring disparagingly to mental health professionals' one consistent trick of being able to make service members with problems disappear from the ranks of their services.

Two factors have likely contributed to a continued estrangement between psychiatry and the military. One is the fundamental difference in the way stress is perceived by military service members and mental health professionals. The other is an ongoing uncertainty over whether adverse stress reactions should be conceptualized as medical problems at all.

2.1 Attitudes About and Perceptions of Combat/Operational Stress

Whereas mental health professionals tend to consider stress, particularly intense and persistent stress, as a toxic agent to be minimized in order to prevent stress-induced disability, military service members often hold differing views about stress [5]. Military cultures embrace traditional views of stress as (1) a weapon to be used against opposing forces, (2) merely “friction” to be overcome on the way to victory, (3) a challenge to leadership, and (4) a test of personal mettle. Especially in all-volunteer military forces, recruits are drawn to military service not in spite of the stressors they will face, but *because* of the unique and powerful stressors of combat and operational deployment. War has always been considered one of the greatest tests of character, “manhood,” and the ability to lead others. And since military operations, by definition, are always opposed by others, stress is always among the weapons used to reduce the will and effectiveness of opponents. In this milieu, mental health professionals who view stress as an irritant that should be avoided can have little to offer military commanders.

2.2 The Rise and Fall of Medical Labelling of Combat Stress Casualties

Over the past three centuries, prevailing views in western military organizations of emotional and behavioral reactions to the stress of war have swung, like a pendulum, first toward, then away from their conception and labelling as medical disorders. The rate at which adverse combat and operational stress reactions have been identified and, therefore, offered treatment has followed shifts in how they have been understood and labelled.

2.2.1 The Application of Medical Science to Adverse Stress Reactions

Characteristic reactions to the terror, horror, and loss of war are apparent in the literature of antiquity [6, 7]. Prior to the Age of Enlightenment, however, mental problems of all kinds, on and off the battlefield, were ascribed not to injury or illness but to fate or the intercession of spiritual forces, including as punishment for wrongdoing [8]. Warriors who were not physically incapacitated yet who failed to perform their duties on the battlefield were often believed to suffer not from a mental disorder but from the vice of cowardice.

As the scientific method was first applied to the observation and classification of mental problems in the 18th century, military surgeons began to view certain predictable syndromes of maladaptive emotions and behaviors on the battlefield as health problems. The first medical diagnosis applied to troops suffering from incapacitating depression or anxiety during a military campaign was “nostalgia,” a disorder that could be far more debilitating than the mere homesickness the term implied. In the 19th century, as the science of medicine found increasing connections between physical illness, emotions and behavior, military surgeons gave stress problems on the battlefield a variety of medical diagnoses. During the American Civil War, for example, a significant number of soldiers were treated for insanity, “soldier’s heart” (paroxysms of uncontrollable, rapid heart rate), and overexertion, in addition to nostalgia [2]. In the early years of the First World War, the view of stress casualties as medical disorders reached its zenith as tens of thousands of troops were medically evacuated for “shell shock” or *Nervenshock*, both initially believed to be due to physical damage to the brain secondary to nearby artillery shell blasts [3].

2.2.2 Factors Opposing the Medical Conception of Adverse Stress Reactions

During the early 20th century, however, three factors began to discourage the medical labelling of combat stress casualties. The first was theoretical, the other two were pragmatic. From a theoretical standpoint, the growing popularity of the psychology of Sigmund Freud convinced increasing numbers of military leaders and medical personnel that warriors with disabling stress symptoms were not really wounded by their stress. Rather, stress-disabled warriors were increasingly believed to be unconsciously seeking an honorable exit from the dangers of combat through the volitional (though unconscious) production of their

symptoms. The failure of medical specialists to find physical evidence of brain injury in combat stress casualties, using the technologies available in the 19th and early 20th century, reinforced the view that “shell shock” was not a medical disorder but symptomatic of an unresolved unconscious conflict (neurosis).

From a pragmatic point of view, the medical diagnosis and evacuation of shell shock cases became less popular during World War I because they led to an epidemic of stress casualties and a manpower crisis on both sides of the war. It became apparent that the further from the front lines stressed warriors were evacuated for treatment, the less likely they were ever to return to duty. Furthermore, psychiatric labels such as “neurotic” and “psychotic” carried increasing burdens of stigma, promoting shame and a loss of self-confidence in those so diagnosed.

2.2.3 “Forward Psychiatry” as the Marginalization of Psychiatry In Theater

These factors led to the development by the French, and elaboration by the British and Americans during World War I, of the principles of “forward psychiatry” [4]. These principles included affording warriors with persistent, adverse stress reactions brief periods of rest and restoration in their parent military units, “within the sound of the guns” and continuously under military discipline; avoiding medical labelling and the “patient” role; and continuously communicating to stressed warriors the expectation that they would recover and return to the fighting. “Forward psychiatry,” as thus defined, was actually more an extension of military leadership than a medical or mental health treatment procedure.

Refinement of the principles of forward psychiatry during the many wars of the 20th century brought increasing success at returning stressed warriors to combat, and avoiding their medical evacuation. These principles also probably contributed to the decreasing prevalence of diagnosed in-theater stress casualties among U.S. forces since World War Two, as depicted in figure 1 (blue bars). There are several other reasons for the rate of in-theater stress casualties to have declined significantly since WWII, including shorter operational tour lengths, all-volunteer forces, and better selection and training. Mental health professionals deployed with U.S. forces to Korea, Vietnam, and Iraq have also certainly contributed to the declining rates of serious combat stress casualties diagnosed in theatre. But increasingly, the only stressed warriors who have received a formal diagnosis have been those who failed to respond to management in their units by their officers and non-commissioned officers, with or without the aid of mental health professionals.

3.0 THE WIDENING GAP BETWEEN THE IDENTIFICATION OF STRESS PROBLEMS IN THEATER AND AFTER DEPLOYMENT

The declining rate of in-theater combat stress casualties depicted in figure 1 would be worthy of congratulations all around except for the evidence that low rates of identification of stress problems in theater seem not to directly correlate with the rates of stress problems experienced after returning from deployment. The magenta bars in figure 1 depict the estimated rates of just one post-deployment stress problem—posttraumatic stress disorder (PTSD)—in veterans of the Vietnam War and the initial ground offensive in Iraq in 2003. The former data are from the National Vietnam Veterans Readjustment Study, conducted in 1983 [11], and the latter data are from the study by Hoge et al. from the Walter Reed Army Institute of Research, published in 2004 [12]. Not included in the magenta bars of figure 1 are other post-deployment stress problems such as depression disorders, anxiety disorders, and substance use disorders. Hoge et al.’s data have not yet been confirmed by other studies of Iraq War veterans, and there are reasons to question the generalizability of their data, since the battalions they surveyed after returning from Iraq were heavily-engaged infantry units. Regardless, the experience of mental health facilities supporting returning Iraq War veterans suggests that the prevalence of post-deployment stress problems in that population is far greater than a fraction of one percent, as Army evacuation rates from Iraq might have

suggested [10]. It is not known how many U.S. Army soldiers received mental health treatment during their deployments to Iraq. Prevalence rates of adverse combat/operational stress reactions among U.S. Marines deployed to Iraq have not been published.

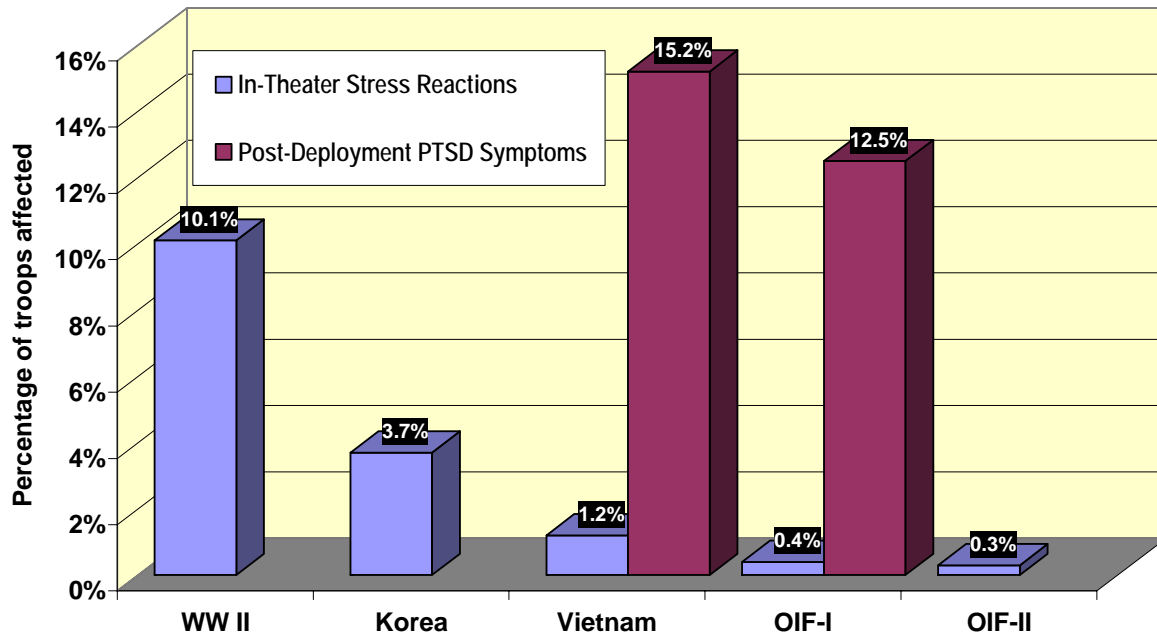


Figure 1. Comparison of the prevalence of in-theater stress reactions among U.S. troops in World War II, Korea, and Vietnam [9]; U.S. Army behavioral health evacuation rates during Operation Iraqi Freedom-I (OIF-I, 2003-2004) and Operation Iraqi Freedom-II (OIF-II, 2004-2005) [10]; and significant post-deployment posttraumatic stress disorder (PTSD) symptoms in Vietnam veterans [11] and veterans of OIF-I [12].

3.1 Why the Disparity between In-Theater and Post-Deployment Stress Problems?

This apparent disparity between the rates of stress problems in theater and after deployment has three possible sources. The first is that post-deployment stress problems such as PTSD most commonly spring from the ground in full bloom sometime after return from deployment, and are, therefore, truly delayed in onset. If this first possibility were true, those who would later develop a delayed stress problem after deployment might not be identifiable in theater. The second possibility is that post-deployment stress problems are not real, but are feigned by returning service members for some purpose other than genuine distress and disability. Although deployment-related stress disorders such as PTSD can be feigned, and litigation or disability compensation can be motives for malingering [13], there is no evidence after a number of studies that more than a small minority of veterans feign their post-deployment stress problems [14]. The third possibility—the most likely one—is that many or most of the warfighters who develop significant stress disorders after they return from deployment also had signs or symptoms of incipient stress problems while deployed, only they were either not recognized or reported. Accumulating research on PTSD and acute stress disorder, for example, suggests that characteristic symptoms such as dissociation and physiological hyper-arousal are often observable in the immediate aftermath of traumatic experiences involving terror, horror, or loss [15]. But the stigma associated with admitting to stress problems in the military may have discouraged many warfighters from asking for help [12].

3.2 The Need for a Genuine Partnership between Military Leaders and Mental Health Professionals

In order to improve prevention, early identification, and optimal management of adverse stress reactions, both in training and during operational deployments, a closer partnership is needed between the military leaders who bear primary responsibility for combat/operational stress control, and the military mental health professionals who can fit scientific tools for combat/operational stress control into the hands of those leaders.

4.0 THE U.S. MARINE CORPS OPERATIONAL STRESS CONTROL AND READINESS (OSCAR) PROGRAM

Beginning in 1999, in the 2d Marine Division at Camp Lejeune, North Carolina, the U.S. Marine Corps developed and fielded a new type of partnership between warfighters and mental health professionals—the Operational Stress Control and Readiness (OSCAR) program. OSCAR differs from any previous military mental health effort in that OSCAR ideally embeds mental health expertise directly in operational units at the level of the regiment, rather than attaching mental health personnel to external medical treatment facilities or external combat stress teams. OSCAR psychiatrists, psychologists, and psychiatric technicians are organic to the military units they support in the same way battalion surgeons, corpsmen, and chaplains are organic to their operational units in the Marine Corps. OSCAR mental health providers train with their Marines prior to deployment, they accompany their Marines into forward operational areas during deployment, and they continue to provide support to their Marines after they return from deployment. OSCAR builds a bridge across the cultural gap between warfighter and mental health professional the only way such a bridge can be built—by drawing the mental health professional as fully as possible into the culture and life of the military unit to be supported. As one commander of a Marine infantry battalion said to his newly-assigned OSCAR psychiatrist, “I am never going to live in *your* world, so it’s a good thing that you are here to learn about mine.”

An additional feature of OSCAR, as developed in the 2d Marine Division, is the assignment of full-time Marine staff non-commissioned officers (E6 and above) to the OSCAR teams attached to infantry regiments. OSCAR staff non-commissioned officers serve to further integrate the mental health efforts of the OSCAR mental health professionals with the line non-commissioned officers who are the “center of gravity” of combat/operational stress control in the Marine Corps. OSCAR non-commissioned officers are not corpsmen or medics, but experienced warfighters who help build and maintain bridges between the science of psychiatry and the art and science of military operations.

In 2003, the Medical Officer of the Marine Corps championed the expansion of the OSCAR program to include all three Marine infantry divisions, including the 1st Marine Division before it returned to the Al Anbar province of Iraq in February 2004. Now, after two years of development in the ground combat element of the Marine Corps, the Marine Corps is currently evaluating ways to expand the OSCAR concept to support all communities and commands within the Marine Corps, including air wings, logistics groups, and reserve forces.

4.1 Functions of OSCAR Teams

Although embedded at the level of the Marine regiment (or air wing or logistics group), the OSCAR team ideally does not remain at the level of the regiment. OSCAR psychiatrists and psychologists are not primarily clinicians, so they do not wait in clinics for patients to walk through their doors. OSCAR mental health providers, corpsmen, and Marine non-commissioned officers are required to spend as much time as possible with the battalions and companies in their regiment, as far forward as is feasible. Prevention, early identification, and effective treatment at the lowest level possible are the goals of the OSCAR program.

The functions of OSCAR team members accompanying their Marines during training and into forward operational areas includes:

- To become known to their Marines and trusted by them through repeated contact and the sharing of adversity
- To learn as much as possible about the stressors their Marines face, how they normally cope with their stressors, and how Marine leaders manage and mitigate those stressors.
- To learn how their Marines perceive themselves, including how they perceive their own stress and stress reactions.
- To educate and train Marines and Marine leaders in evidence-based methods for preventing, identifying, and managing adverse stress reactions.
- To consult with primary care medical officers and independent duty corpsmen on the management of adverse stress reactions that require further care.
- To consult with Marine Corps chaplains in their stress management functions.
- To consult with military leaders on the management of unit-level stress challenges.

4.2 Evidence for the Effectiveness of the OSCAR Program

Since the goal of the Marine Corps OSCAR program is to place scientific tools for the prevention, early identification, and effective treatment of adverse stress reactions in the hands of Marines and Marine leaders, the best evidence for the program's effectiveness would be data documenting increased use of such tools by Marines. The Marine Corps and its partner in the OSCAR program, the U.S. Navy, are currently developing measures to collect data on the effectiveness of the OSCAR program.

Even at this early stage in the implementation of the OSCAR program, however, one measure of the effectiveness of the program is the extent to which the concept of embedding mental health professionals in Marine units has been embraced by Marines. All three Marine Expeditionary Forces have become enthusiastic about OSCAR, and Marine air wings and logistics groups have requested their own OSCAR teams. Furthermore, as of October, 2005, the Marine Corps now has an OSCAR psychiatrist "embedded" in its Manpower & Reserve Affairs department at Headquarters, Marine Corps, to coordinate combat/operational stress control efforts Marine Corps-wide. In the Marine Corps, combat/operational stress control programs fall under the direction of the Deputy Commandant for Manpower & Reserve Affairs, not the Marine Corps' medical support agency, the Navy Bureau of Medicine and Surgery. Since the Marine Corps does not currently own all the Navy medical expertise attached to OSCAR teams, ongoing operation of the OSCAR program depends on a full partnership between Marine Corps Manpower and Health Services, as well as the Navy Bureau of Medicine and Surgery.

4.3 Costs of the OSCAR Program

The OSCAR program is not without costs. The principle costs are personnel opportunity costs, since mental health professionals and Marine non-commissioned officers assigned to OSCAR teams are not available to perform other important duties. In the case of mental health providers, valuable clinical time is sacrificed in order to allow OSCAR team members to perform their outreach functions. Likewise, Marine non-commissioned officers assigned to OSCAR teams are not available to perform their primary functions as enlisted leaders of Marine in operational units.

Another, less tangible cost of the OSCAR program is the challenge it presents to both the mental health professional and the Marine non-commissioned officer embedded in an OSCAR team. In order to meet OSCAR goals, both are required to operate well outside their zones of comfort. To be effective, the

OSCAR psychiatrist or psychologist can not retreat to a clinical setting, surrounded by medical and mental health colleagues. The OSCAR mental health provider must learn to be comfortable in the world of the Marine warfighter. And the OSCAR non-commissioned officer must learn to think and communicate as a mental health para-professional, without losing his or her primary identity as a warrior. But it is only through mastering such challenges that the all-important bridges can be built between warfighters and mental health science.

Because of the shortage of valuable manpower resources, the OSCAR program, in practice, has not always lived up to its ideal. OSCAR mental health providers have not consistently been embedded down to the level of regiments, and clinical duties, especially in garrison after returning from deployment, have too often trumped outreach to units in the field. And non-commissioned officers have not always been available for full-time attachment to OSCAR teams. Full implementation of OSCAR, as the Marine Corps' model for integration of mental health services into military operations, will take time and further investments.

5.0 CONCLUSIONS

The U.S. Marine Corps' Operational Stress Control and Readiness program is an innovation designed to improve combat/operational stress control by embedding mental health professionals and non-commissioned officers on outreach teams at the level of infantry regiments, air wings, and logistics groups. Although still early in its implementation, the OSCAR program shows promise for promoting the prevention, early identification, and optimal management of adverse combat/operational stress reactions in Marines. Reduced stigma, more effective care within small units, increased access to needed specialty care, and lower rates of long-term deployment-related stress disorders may result.

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