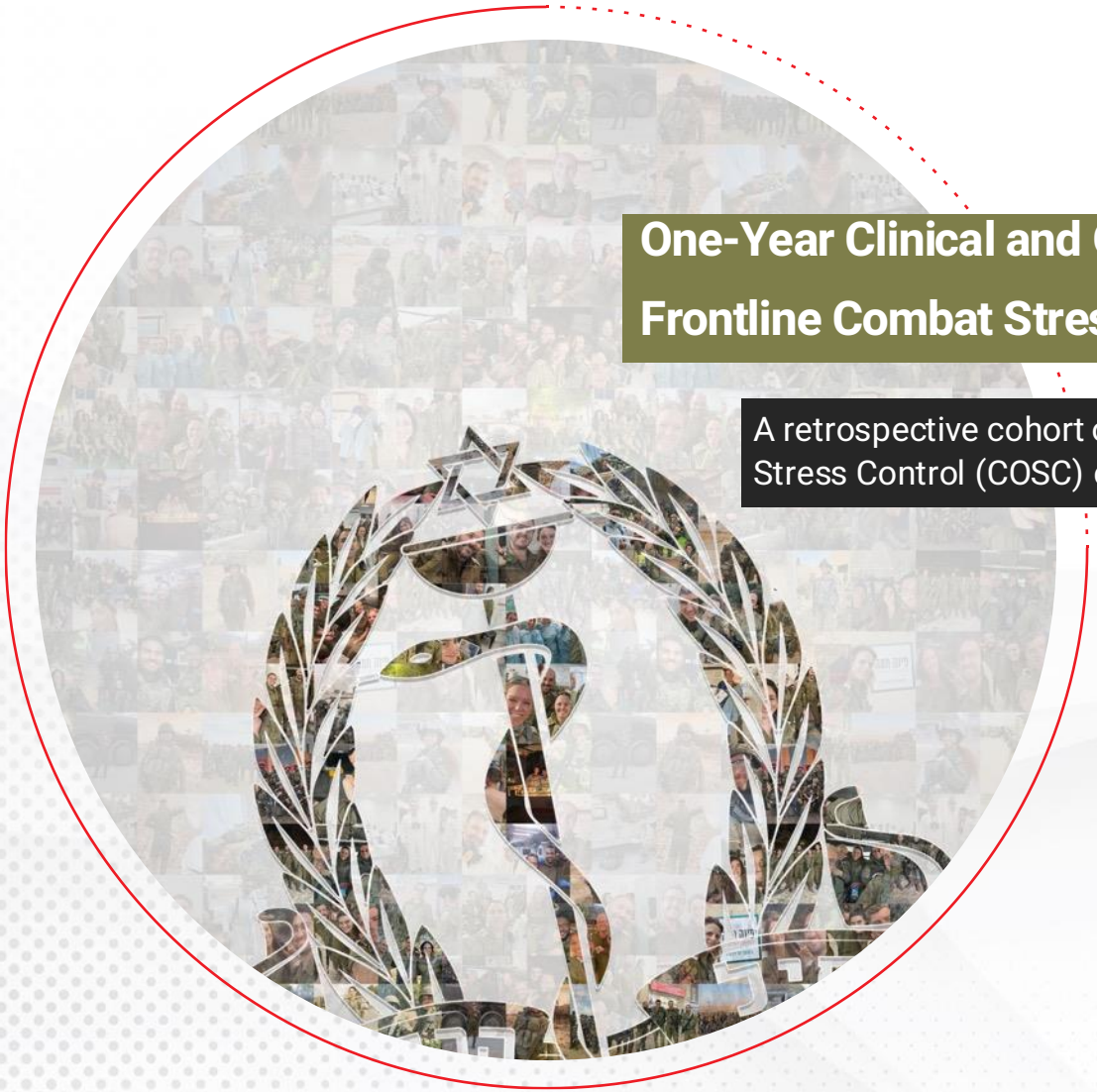

One-Year Clinical and Operational Outcomes After Frontline Combat Stress Care

A retrospective cohort of soldiers treated at Combat Operational Stress Control (COSC) centers

MHSRS 2026

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CONFLICT OF INTEREST DISCLOSURE

MHSRS 2026 • ABSTRACT MHSRS-26-4544

Daniell Agaev, MD has no relevant financial relationships to disclose.

OFFICIAL SCIENTIFIC DISCLOSURE

BACKGROUND & OBJECTIVE

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COSC SYSTEM

Combat Operational Stress Control (COSC) is the primary frontline system for managing acute combat and operational stress reactions.

PIE PRINCIPLES OF CARE:

P	I	E
Proximity	Immediacy	Expectancy

KNOWLEDGE GAP

Evidence on longer-term clinical and operational trajectories following initial frontline care remains limited.

STUDY OBJECTIVES

Describe one-year outcomes and identify predictive characteristics for:

- **Return to Unit (RTU):** Successful operational reintegration.
- **Medical-Board Referrals:** Need for formal administrative review.
- **Profile Changes:** Shifts in medical eligibility and fitness for duty.
- **Psychiatric Diagnosis:** Persistence of clinical impairment (e.g., PTSD).

2023–2024 cohort · N = 996 · one-year outcomes

METHODS AND DATA

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Study Design

Cohort N = 996

Retrospective cohort study of all soldiers soldiers attending COSC centers.

Timeframe: October 7, 2023 through through January 9, 2024.

Includes mandatory, career, and reserve reserve personnel.

Data Collection

15-Month Follow-up

Source: Computerized medical and administrative records.

Variables: Personal demographics, referral context, and clinical symptoms.

Main data extraction performed in **January 2025**.

Analytics

Statistical Rigor

Chi-square tests emphasizing Cramer's V and Odds Ratios (OR).

Survival analysis of time from COSC to medical-board decisions.

Data cleaning to harmonize equivalent formulations.

COHORT AT A GLANCE

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SAMPLE SIZE

996

Total participants treated at COSC

Male (797)	**80.0%**
Female (199)	**20.0%**

SERVICE STATUS

Mandatory (707)	**71.0%**
Reserve (263)	**26.4%**
Career (15)	**1.5%**

PRIMARY REASON

82%

The dominant driver for COSC clinical outreach and frontline intervention.

AGE DISTRIBUTION

Mean Age	**22.8 yrs**
Standard Deviation: 5.3	
Median Age	**20.8 yrs**
Range	**18.6 – 55.4**

MILITARY ROLE

Combat Role (622)	**62.4%**
Rear / Support (369)	**37.0%**

REFERRAL SOURCE

Medical / MH Officer	**75.7%**
Commander	**19.2%**
Self-Referral	**5.1%**

Cohort predominantly consists of young, male mandatory-service soldiers in combat roles, referred by clinical staff following direct combat exposure.

ONE-YEAR OUTCOMES

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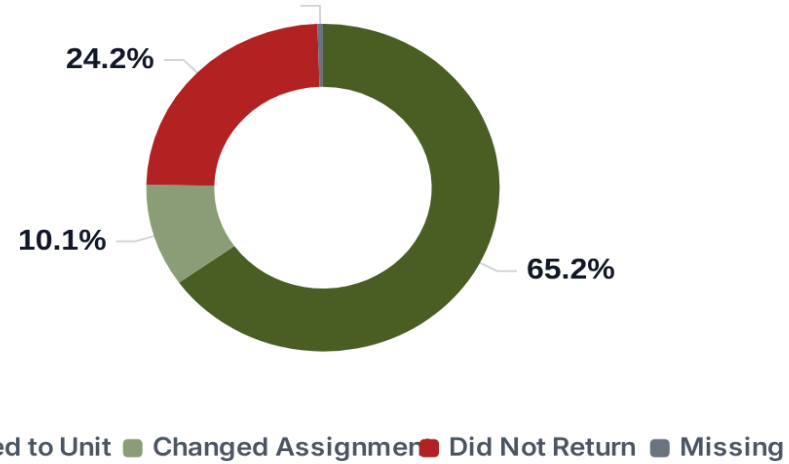
65.2%
RETURN TO UNIT

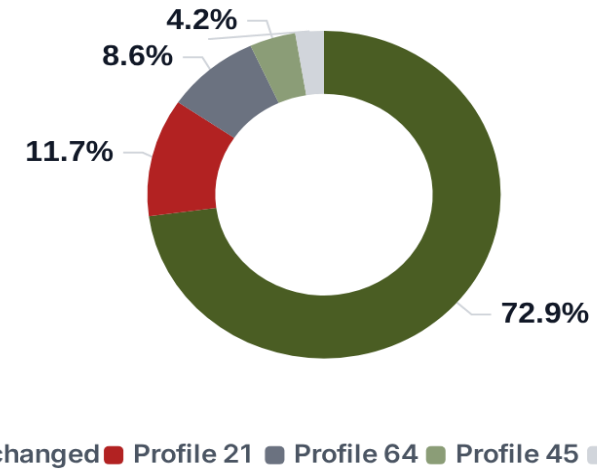
74.7%
NO PSYCHIATRIC CODE

24.2%
MED-BOARD REFERRAL

Operational Assignment Status



One-Year Medical Profile



Central Message: Most soldiers returned to their units and retained an unchanged profile, while a clinically important minority (approx. 1 in 4) had persistent trauma-related or administrative consequences.

TIMING OF PROFILE CHANGES

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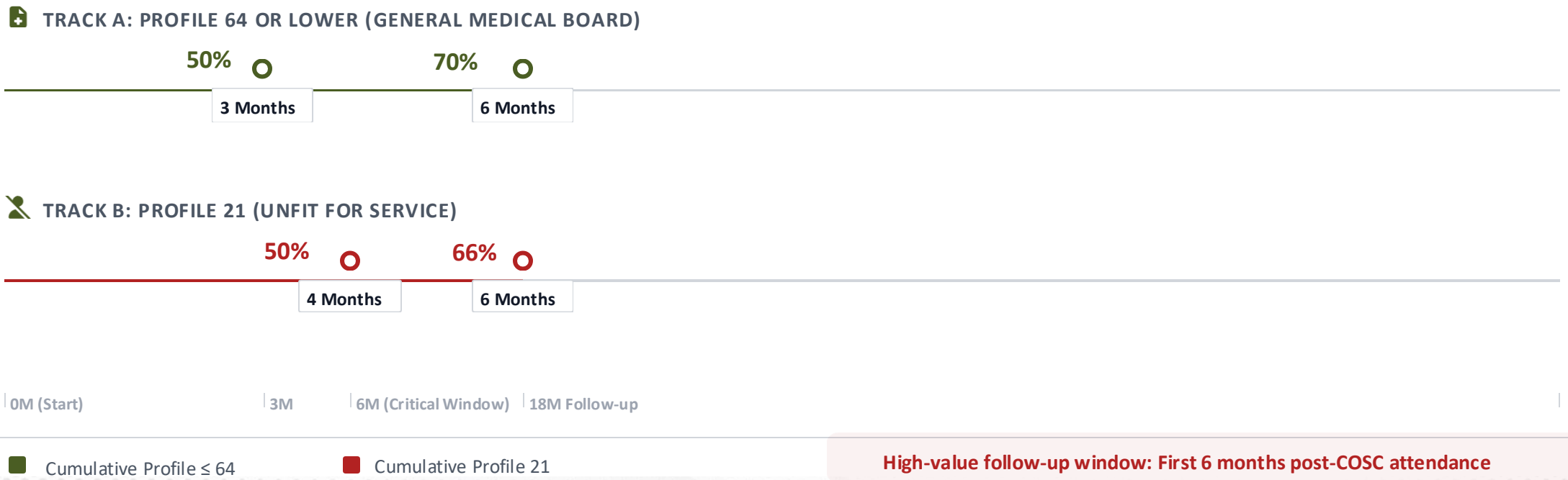
Profile reductions are **front-loaded**: Analysis of 244 soldiers (Profiles 64, 45, or 21) shows that the majority of clinical and administrative decisions administrative decisions occur within the first 6 months.



High-value follow-up window: First 6 months post-COSC attendance

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PREDICTORS OF CLINICAL & OPERATIONAL OUTCOMES

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STRONG SIGNAL

Service Status

Primary differentiator for nearly all longitudinal outcomes. Active-duty personnel show significantly higher administrative and clinical risk.

Med-Board OR=12.84 • Prof 21 OR=8.84

LIMITED SIGNAL

Combat Role

Predicts diagnostic pattern (PTSD overrepresentation) but does **not** predict return-to-unit status.

PTSD: p=.043, V=.185

Gender

Weak association with unit return; no significant differentiation in major diagnostic categories.

Return: V=.11 • Diag: p=.126

Referral Source

Statistically significant but practically negligible impact on final placement outcomes.

V=.08, p=.010

NO SIGNAL

Initial Referral Event

The specific nature of the combat exposure or referral circumstances did not predict one-year placement.

p=.608, V=.039

Combat vs. Support (Return)

Counter-intuitively, unit type (Combat vs. Rear) had no predictive value for whether a soldier returned to their unit.

p=.675, chi-sq=0.79

Note: Statistical significance (p) and effect size (Cramer's V) were prioritized to determine practical clinical utility.

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CONCLUSIONS & IMPLICATIONS

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CORE OUTCOMES AT ONE YEAR

65.2%
Return to Unit Rate

72.9%
Unchanged Profile

The majority of COSC-treated soldiers maintained operational stability, though a clinically significant minority experienced persistent trauma-related consequences.

CRITICAL FOLLOW-UP WINDOW

Adverse profile outcomes are heavily front-loaded.

The first **6 months** post-event represent the highest-value window for clinical intervention and administrative decisions.

KEY DIFFERENTIATORS

- **Service Status:** Strongest differentiator; active-duty personnel had markedly higher odds of medical-board referral (OR=12.84) and Profile 21 assignment (OR=8.84) than reservists.
- **Combat Role:** Primarily associated with diagnostic patterns (PTSD) rather than unit-return status.
- **Limited Signals:** Gender, referral source, and initial reason showed weak or negligible predictive power.

STRATEGIC ACTION

PRACTICAL IMPLICATIONS

Pair frontline combat stress care with **risk-stratified follow-up** during the first six months.

- Focus monitoring on active-duty and combat personnel.
- Prioritize PTSD screenings for those in combat roles.
- Avoid overinterpretation of gender or referral source.

STUDY LIMITATIONS

- Retrospective observational design using medical records.
- Missing data causing variable cohort sizes (N).
- Associations do not establish direct causality.

PS.

WITH APPRECIATION

Thank you to the study contributors

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CONTRIBUTORS

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- Jacob Rotschield
- Carmel Kalla

Thank you for listening!

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