Building Psychological Resiliency and Mitigating the Risks of Combat and Deployment Stressors Faced by Soldiers

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ABSTRACT

Combat is arguably the most mentally, physically and emotionally demanding enterprise that a Soldier engages in. Combat is sudden, intense, and life-threatening. A Soldier in combat encounters numerous traumatic events to include, among others, killing an enemy combatant, knowing someone seriously injured or killed or handling or uncovering human remains. All of these events can have deleterious effects on the mental health and emotional well-being of the Soldier. Yet, there are things that Soldiers, leaders and the Army can do to mediate or attenuate the impact that the stressors of combat and deployment produce. In this presentation we will provide an overview of our three intervention strategies involving (1) the development and testing of the Psychological Readiness in a Deployed Environment (PRIDE) training modules that provides both information about how combat impacts on the mental health of the Soldier and the specific behaviors that Soldiers and leaders can engage in to mitigate the stressors of combat and deployment, (2) the development and validation of the Unit Needs Assessment, created to determine trends in the mental health and well-being of Soldiers to guide the delivery of mental health care support to meet the unique needs of the unit, and (3) the improvement and validation of the psychological screening instrument to identify Soldiers experiencing psychological distress as early as possible and to ensure they receive the help they need. We believe that this multi-level strategy will maximize Soldier resiliency and mitigate the risks of stressors faced by Soldiers during combat.

1.0 INTRODUCTION

Combat is a mentally, physically, and emotionally enterprise. The stressors of combat are sudden, intense, and life-threatening, which can significantly impact on the mental health and well-being of those exposed. Combat in Iraq is no different. Soldiers and Marines deployed to Iraq face a variety of deployment and

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combat stressors. For instance, nearly 90% of Soldiers deployed to Iraq reported that they were attacked or ambushed, with over 60% reporting that they were in a threatening situation were they were unable to respond due to rules of engagement. At a more personal level, 85% of Soldiers reported that they personally knew someone who was injured or killed and nearly three-quarters of deployed Soldiers reported that they had a member of their own team become a casualty. Over one-half of deployed Soldiers reported that they handled or uncovered human remains.

That these combat experiences, as well as others, can produce deleterious effects on the mental health and well-being of Soldiers is undisputed. We have found that over 15% of Soldiers and Marines returning from combat duty in Iraq met screening criterion for post-traumatic stress disorder (PTSD), a rate significantly higher than pre-deployment rates. Increases in depression and anxiety rates were also observed 12 months post-deployment (6.3% versus 12.0% for depression and 7.9% versus 11.5% for anxiety). Over 15% of Soldiers reported that they were interested in seeing someone for an alcohol, stress, family or emotional problem, but only about 40% of those who screened positive for a mental health problem actually sought help, due primarily to psychological stigma and organizational barriers associated with receiving mental health support. Psychological stigma includes concerns that they would be seen as weak, their leadership would have less confidence in them, and/or their leaders would blame them for the problem. Organizational barriers include issues such as Soldiers not knowing where to go to get help, difficulty scheduling an appointment and/or not being able to leave work to get work.

Thus, the critical question is what can be done to ensure that Soldiers, who need help, receive help. We believe that the solution will involve a multi-level strategy, involving both Soldiers and leaders. In this paper, we will present three initiatives aimed at minimizing the risks associated with combat, as well as ways that Soldiers and leaders can build psychological resiliency as they prepare to deploy to a combat environment or have recently returned from combat duty in Iraq. We will begin by discussing our Battlemind Training modules, which are designed to prepare Soldiers, leaders and helping professionals for the psychological rigors of combat and to facilitate their psychological return from combat. Next, we present our unit needs assessment, a tool designed for use by mental health care providers to assess the mental health and well-being of units in order to develop mental health prevention and early intervention strategies to meet the unique needs of the unit. Finally, we introduce our psychological screening instrument, intended to be used as an early identification tool for Soldiers experiencing psychological distress requiring mental health support.

2.0 BATTLEMIND TRAINING

Battlemind is a Soldiers inner strength to face adversity, fear, and hardship during combat with confidence and resolution. In essence it is psychological resiliency. The objective of battlemind training is to develop psychological resiliency which contributes to a Soldiers will and spirit to fight and win in combat, thereby reducing combat stress reactions and symptoms. Based on results from the WRAIR Land Combat study, using both quantitative and qualitative methodology, we summarize these research findings into easily teachable principles that are behaviorally anchored in what Soldiers, Leaders and Spouses can do to counter the stressors of combat and deployment.

This approach led to the development of a series of training modules that we entitled “Battlemind Training.” For training prior to deployment we developed training modules entitled “Psychological Readiness in a Deployment Environment (PRIDE)”. These pre-deployment training modules focused on four distinct populations: Soldiers, Leaders, Spouses, and National Guard/Reservists. Battlemind training for Soldiers returning from combat was entitled “Transitioning from Home to Combat.” Below we outline the key components of involved in Battlemind training.

2.1.1 Pre-Deployment: Psychological Readiness in a Deployed Environment (PRIDE)

2.1.1.1 Leader Training

The Leader Training module is focused on the ten tough facts that leaders face and what actions that they can take to address these ten facts. The ten tough facts include:

Fact 1. Fear in combat is common.

Fact 2. Unit members will be injured or killed.

Fact 3. Combat impacts every member both physically and mentally.

Fact 4. Soldiers are afraid to admit that they have mental health problem.

Fact 5. Soldiers frequently perceive failures in leadership.

Fact 6. Breakdowns in communication are common.

Fact 7. Deployments place a tremendous strain upon families.

Fact 8. The combat environment is harsh and demanding.

Fact 9. Unit cohesion and stability are disrupted by combat.

Fact 10. Combat poses moral and ethical challenges.

Research findings are presented that support each of these facts along with specific actions that leaders can take to mitigate these facts. For example, the findings that support Fact 4, Soldiers are afraid to admit that they have a mental health problem, include 10-20% of Soldiers report post-traumatic stress disorder symptoms following combat, combat stress leads to excessive alcohol use and aggression, and earlier treatment leads to faster recovery. What leaders can do to combat these facts include establishing a command climate where leaders acknowledge that Soldiers are under stress and that they might needs help, co-locating mental health assets with the unit, and insisting that mental health outreach be provided to each battalion.

2.1.2.1 Soldier Training

The Soldier Training module includes 6 Tough Facts about Combat, which are similar to the 10 Tough Facts about Combat for leaders presented above. The Soldier facts include:

Fact 1. Combat is difficult.

Fact 2. The combat environment is harsh and demanding.

Fact 3. Fear in combat is not a sign of weakness.

Fact 4. Soldiers are afraid to admit that they have a mental health problem.

Fact 5. Deployments place a tremendous train upon families.

Fact 6. Unit cohesion and team stability are disrupted by combat.

Similar to the leader training module, findings that support each of these facts and actions Soldiers can take to mitigate these facts are presented.

2.1.3.1 Helping Professional Training

2.2.1 Post-Deployment Training: Transitioning from Combat to Home

The focus of post-deployment Battlemind training is to assist the Soldier in the transition and reintegration process following combat. The objective is the re-setting of Battlemind for home. The major content areas of post-deployment Battlemind training include: Soldier safety and personal relationships, normalizing combat-related stress reactions and symptoms, and teaching Soldiers when they should seek mental health support for themselves or for their buddies.

The post-deployment Battlemind training discusses the key skills that Soldiers have mastered in combat, demonstrating how these skills can be used to help Soldiers transition back home. The goal is to build on existing Soldier strengths. The training also includes specific actions for Soldiers to take to guide them in their transition home process.

The combat skills emphasized in the post-deployment Battlemind training include:

Buddies (cohesion)

Accountability

Targeted Aggression

Tactical Awareness

Lethally Armed

Emotional Control

Mission and Operational Security

Individual Responsibility

Non-defensive (combat) Driving

Discipline

As you can see, these skills also spell out the acronym BATTLEMIND.

3.0 UNIT NEEDS ASSESSMENT

A unit needs assessment is an assessment of a command's behavioural health status using interviews, focus groups, and anonymous Soldier surveys. A unit needs assessment of a unit should be conducted within 30 days of having behavioral health assets joining a unit or periodically thereafter, on a as needed basis. Findings from a unit needs assessment are use to develop an assessment-based mental health prevention and early intervention action plan.

- **Anonymous**.
  - Importance is on aggregate well-being not on individuals. No one will be named or identified.

- **Confidential**:
  - Commanders "own" their assessment. It is not releasable to anyone without their express permission.
  - Subordinate commanders will not be "dimed out" – All results are pooled at the level of the commander being briefed. That is, BN commanders only see aggregate for the BN – not individual company results.
- Once the BH Needs Assessment is complete, the results are used to develop a unit-specific action plan.
- Action Plan will contain:
  - Plan to mitigate BH risk factors.
  - Recommended BH training.
  - Availability schedule for BH personnel.
  - Evaluation methodology.

The UNAT was developed from a much larger survey querying Soldiers on their perceptions of operations tempo, combat exposure, unit climate, and mental health. A panel of subject matter experts reviewed the larger survey and retained those questions that were applicable to soldiers in combat while yet covered the key construct domains. Because the UNAT is anonymous, interventions can not occur at the individual level. Rather, the UNAT is administered at the unit-level in order to best direct limited BH resources to the level of intervention most accessible in the Army, the unit. Soldiers in units share the same social reality (e.g., climate, experiences) which makes the unit level practical for intervention. Analytically, data aggregation statistics are calculated to ensure that units experiencing problems are systematically different than units not experiencing problems. The UNAT also ensures that individual confidentiality is protected and may even provide more accurate assessments of problem rates in units than using non-anonymous surveys (Thomas, Wright, Adler and Bliese, 2004).

5.0 PSYCHOLOGICAL SCREENING

The U.S. military has been conducting psychological screening of deploying and redeploying troops since 1996. The goals of screening are to provide an easy means for Soldiers to identify mental health problems and receive care. Current screening of Soldiers redeploying from Iraq has raised two issues that have both practical and theoretical implications. These issues are (a) timing of post-deployment screening and (b) content domains screened for in current instruments.

In terms of timing, post-deployment screening has been conducted anywhere from the immediate reintegration period to several months post-reintegration. Recent work by the US Army Medical Research Unit – Europe (USAMRU-E), however, has shown an increase in psychological symptom levels at 90 to 120 days post-

reintegration in Soldiers returning from combat in Iraq. In a matched sample of 509 Soldiers providing data both immediately post-reintegration and at 120 days post-reintegration, USAMRU-E found reports of depression increased from 6.9% to 14.3%; reports of PTSD increased from 1.2% to 4.3%; Soldiers exceeding criteria for anger problems increased from 3.3% to 10.6% and relationship problems increased from 4.7% to 5.5%.

In terms of timing, these findings suggest screening may be most efficacious three to four months post-deployment. Theoretically, the findings highlight the need for a model explaining the evolution of psychological problems over time. A second issue is that Soldiers returning from Iraq are reporting sleep concerns. Practically, this suggests that it may be important to screen for sleep problems at post-deployment; theoretically, the findings highlight the need to identify the prevalence of post-deployment sleep disorders. For instance, research is needed to determine whether sleep disturbance is an early indicator of more severe problems and/or whether reporting sleep disturbance is a less stigmatizing way Soldiers identify psychological symptoms such as depression or traumatic stress.

6.0 DISCUSSION

For psychological research findings to produce immediate benefits they must be quickly and easily summarized. Further, any recommendations derived from the findings must be fairly easily to implement. Our research suggests that recommendations that are based on specific behaviors that one can engage are ideal. We have developed a series of training modules that we call “Battlemind Training” that we believe meets these requirements. We are currently in the process of validating this approach to enhancing Soldier and leader resiliency.

The unit needs assessment is another tool that leaders can use to assess the mental health and well-being of their Soldiers. The findings allow behavioural health personnel the ability to tailor prevention and early interventions to the unit-level while protecting the identity of individual Soldiers.

Finally, the psychological screening tool can be used by leaders for early identification of Soldiers with mental health symptoms requiring follow action. Since psychological screening is not anonymous, care must be taken to ensure that Soldiers who are identified requiring follow-up are not stigmatized and otherwise adversely impacted. It is critical that leaders establish an environment where Soldiers can obtain mental health support in a non-stigmatizing manner.