Chapter 9 – BATTLEMIND RESILIENCE TRAINING OVERVIEW

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The Battlemind (BM) training system is the US Army's resilience training system. BM Training is a comprehensive integrated psychological training program targeted for the entire deployment cycle. It is being scientifically validated with current research.

We begin in the first week of basic training through the point where commanders take control of battle commands. The system includes pre-deployment and post-deployment. The goal is to help the soldiers face the demands of combat with courage, confidence and resilience. Warriors are the target audience (but the Navy and Marines have their own training for this and the Air Force is adopting Battlemind). It is important to take care of warriors' mental health post-deployment with their families, leaders.

The principles used are for any training – for any operations – not just terrorism, but stability operations, etc. The focus is on the individual's strength, to prevent problems, not just dealing with problems after they occur. It is based on research as well as experience, using examples warriors can relate to. The major principles of the system are that it is strength-based, evidence-based, experience-based, explanatory and team-based. It is team-based in order to enable teams to discuss what will happen on missions prior to deployment and to facilitate discussion throughout – with actions they can take personally and to help their teammates with specific actions and behaviours to help, use group and buddy aids at the platoon level. The system is action focused, integrated into military culture and timed to appropriate phases in military life cycle since stress varies in pre-deployment, post-deployment and during deployments.

We start to build resilience at the start, at Basic Training at Ft Jackson, to give skills they will need throughout their military career. We want to give them the skills to build resilience. There are modules designed for leaders, beginning in the first leader course (for new sergeants and new officers). Then, there is intermediate Battlemind training in the appropriate courses (for Non-Commissioned Officers (NCOs) and Captains) and then advanced Battlemind and Command Level training. Each of these phases of training is very different. We don't show numbers as often to the junior military, but the senior military want to see them. All soldiers are required to have Battlemind before deployment, then debriefing with Battlemind principles after critical events or time-driven milestones (at 4 months and 8 months to process the events during periods), then post-deployment Battlemind training in their first week home. Mental health problems tend to emerge in first 6 months after their return from deployments. Right after, the focus is on safety and common problems (sleep problems). Three to six months post-deployment the focus is on normalization and identifying signs of problems (e.g., drinking to get to sleep) and understanding strategies for helping buddies, these are Battlemind "checks".

There is a course for health providers – medics. There is only one psychologist for every 3500 soldiers versus one medic for every 50 soldiers. We teach the medics signs to look for and referral techniques. There is also debriefing of providers after deployments. Training is provided for families as well. Some soldiers change a lot during combat. The training for spouses is held both pre- and post-deployment and teaches them how to be independent, how to reintegrate.

We are scientists; therefore, we do validation of the one-hour training with group randomized trials. One platoon gets Battlemind training and another gets a control training course (e.g., military history training) and then follow-up with the individuals three to six weeks later. Dr. Amy Adler has published research on the setting/group size used in the training (e.g., small group versus large auditorium). Battlemind has been shown to be better than stress education. We reinforce that warriors are not unique in having (mental health) problems. The effects of just one hour training were significant. The normal pattern

for soldiers is that the more events experienced, the more likely they're to have mental health problems (PTSD, sleep problems, depression, etc.). Battlemind trained soldiers did not exhibit the typical pattern and experience reduced mental health stigma.

The Battlemind system does not prevent PTSD – but does reduce stress and then makes it so those that need help can get it. The replication study involved 1500 soldiers with Battlemind training their first week back and then four months later, with both large groups and small, and stress education (as a control). One key thing that Battlemind trainees express is the feeling that the Army cares about the soldiers. There is a "booster effect" for Battlemind training at 4 months and 6 months after deployment (with a survey only). We found, regardless of experience, that those with Battlemind training at 4 months (post-deployment) were doing better than those without Battlemind training. Significant differences were seen on the PCL scale (Robert Hare's Psychopathy Checklist Revised, PCL-R, is a diagnostic tool).

We are evaluating all the training, pre-deployment, during and post-deployment. The Australians are also conducting training of the Battlemind system. There is a United Kingdom replication (validation) study of the Battlemind post-deployment training. We are exploring augmenting Battlemind training with mindfulness training. Soldiers in the Reserves complete their training (post-deployment) by telephone because they go back to their civilian jobs right away. We are interested in assessing the efficacy of in-theatre psychological debriefings. Other enhancements to Battlemind training being explored include an assessment of intrusive thought control training as well as the practice of expressive writings to help both soldier and spouse. We are also exploring giving advanced Battlemind training for units with lots of combat experience (e.g., giving six hours of Battlemind training instead of one hour). We are working with other countries to share ideas: United Kingdom (replication study as well as an assessment of translated training), Canada (exploration of Battlemind during Cypress decompression), Australians (e.g., developed basic combat training study), Baltic (Battlemind program development), as well as participation on NATO Research Task Group under the Human Factors Panel, HFM-104 (chaired by Carl Castro (USA)).

The Battlemind website is http://www.battlemind.army.mil. All soldiers and providers have access to the website and can get the training. The website also provides the ability to relook at the material after receiving training. Some Battlemind material may not be available to those outside the US – please ask if you are interested.

9.1 DISCUSSION

(Tarabrina) What is the training of the specialists who conduct the Battlemind training (are they psychologists, social workers)? It's known by researchers that when dealing with PTSD there are biological prerequisites. How can you use this information to diagnose those that come for training (trainees, etc.)? How do you differentiate the responses? Can you predict the further development of the PTSD symptoms in the vulnerable group? Our professionals all do the normal civilian training, and then they go through special training when they come into the military. In addition, all providers go to a course entitled, "Combat and Operational Stress Control". It's required before deployment and taught by those who have deployed. For providers, the course is tailored to teach them how to communicate with soldiers and leaders and establish expertise.

(Tarabrina) My second question is related to differential diagnostics – those who are prone and stable. The Army has a routine screening program – there are periodic health assessments each year and then warriors talk to providers before deployment too. Sometimes they make you take, i.e., deploy someone with issues, but they are monitored. With the biological markers, we don't have a way to predict who might have problems. Much is driven by an individual's combat experience. We do have the means to identify who we'll want to keep a closer eye on (leaders and peers can provide cues). When soldiers come back, they receive a post-deployment assessment and then three to six months later a reassessment. Sometimes, problems emerge after two years.

(Tarabrina) There was a special study after the Vietnam War that looked at PTSD displayed by Vietnam veterans. Can you say after the Battlemind program and screening, etc., several years after the mission, will you get positive results in terms of decreased levels of PTSD? I'm referring to postponed and repeated evaluations. We've learned that we need to evaluate people after they come back. I hope what we're doing will result in less PTSD, but we'll have to see. We need to follow up.

(Shamrey) About the technology to measure stress before and after mission. Do you have equipment/ instruments beyond surveys? Do you have aspects of stress – is it typical to see alcohol and drug addiction? Are there different versions of Battlemind for pre-training and the different military specialities? A differentiated approach to soldiers and leaders is needed. Servicemen often don't want to give interviews or talk freely, is this accounted for? Is there a difference in military specialties? In Estonia, Latvia – was there any training for the Georgian military and, if so, how do you assess the efficacy? All soldiers are required to do ANAM (Automated Neuropsychological Assessment Metrics), a neurological test. This may not have the resolution to detect stress; it's more applicable for the detection of brain injuries. It may not detect if there is a concussion or not. There are certainly a few cases (of individuals) with drug and alcohol problems. We hear about self-medication for poor sleep and/or stress. We train that that doesn't help. We train to look for signs of problems (family problems, work problems). In terms of specific military specialty vulnerabilities? It's really more a factor of the level of combat experience. Special Forces personnel see a lot of combat, but they have few mental health problems due to selection, screening and extensive training in resilience; they are resilient to start with and then they get additional training. Otherwise, it depends on combat experience. We can't identify what the other factors are (childhood experiences, etc.). Also, we also have realistic training and Battlemind training to prepare the soldier. What are the criteria of efficiency? We measure the number of servicemen that don't display PTSD. We assess using clinically validated scales for PTSD, measure anxiety and depression using the Patient Health Questionnaire, or PHQ, look at morale and cohesion in the unit, alcohol use, family functioning (e.g., marital problems).

(Varus) Who is responsible for the training of Battlemind in the Army? In which detachment of the operational plan is this Battlemind training specified? Training Doctrine Command (TRADOC) does life cycle training. Chaplains often do deployment training. However, it is up to the commander who gives it; sometimes it is a behaviour health/mental health professional. Often it is useful to have a combat veteran help the mental health person give the training. This starts the dialogue of how do I prepare for combat and deal with casualties? How do you prepare leaders to write the letter about a fatality? We are now getting better at preparing mentally. We have specific operational orders that mandate the training and it depends on the commander when they (the soldier) get the training.

(Varus) Battlemind is not listed in the content of the Joint Operation Plan. The Surgeon General of the Department of Defense (DoD) has quick response teams to take care of mental stress. It is the main unit responsible for providing stress education. What kind of training do these quick response teams provide? I don't know. This is an Army program, not DoD wide. I know what [kind of training] Quick Reaction Teams (QRT) receive.

(Varus) What's the role of the family in pre deployment training? Is this separate? We have special training for spouses, sometimes separate from the military member, sometimes together (prefer this on communication skills, etc.) for pre- and post-deployment.

(Rybnikov) How do you measure the Battlemind? What is the methods/measuring tape to measure morale, the mind? How do you measure if the mind is ready for battle? We measure by performance and then by assessment of mental problems after deployment.

What's the level of suicides? Do you use [the number of] suicides as a criterion? No. We assess suicides in theatre, but the training is not designed as suicide prevention training. I'm not aware of scientifically validated training for suicide prevention. It is the highest suicide rate ever this year, but this is a difficult problem to prevent and Battlemind is not designed for this. We have other training for this.