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The **International Journal of Emergency Mental Health** provides a peer-reviewed forum for researchers, scholars, clinicians, and administrators to report, disseminate, and discuss information with the goal of improving practice and research in the field of emergency mental health.

The **International Journal of Emergency Mental Health** is a multidisciplinary quarterly designed to be the premier international forum and authority for the discussion of all aspects of emergency mental health.

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ORIGINAL ARTICLES

EMERGENCY MENTAL HEALTH UPDATES - Jeffrey M. Lating, Associate Editor

BOOK AND MEDIA REVIEWS - Daniel Clark, Reviews Editor

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Editorial

LTC Daniel Clark
Guest Editor

In this special issue of IJEMH, we address crisis intervention and mental health services in the military. I am very pleased to present you with eight articles exploring different facets of this contemporary issue. As an Army Reserve Officer, combat veteran, and practicing mental health professional myself, I want to thank these authors for their insight, their resourcefulness, and their support of our military personnel.

We are all aware of the tragedy at Fort Hood, TX in 2009, where 13 died and 31 were wounded. Strand, Felices, and Williams report on providing a multicomponent CISM response to the investigators and their spouses as the inquiry unfolded. They emphasize the importance of working within the military structure, plus being accessible, credible, and adhering to the basic principles of CISM.

The next two articles report on intriguing post-deployment programs. Boscarino describes the Reaching Rural Veterans Initiative, surveying primary care providers treating military personnel and their family members in rural communities. The most common mental health problems reported include anxiety disorders, depression, and marital problems.

Castellano and Everly describe the creation and implementation of a "60 Day Resiliency & Reintegration Program" led by the New Jersey Veterans program. This program is modeled on the successful "Cop 2 Cop Helpline" and Crisis Management Briefings. They emphasize the importance of a multicomponent response, providing continuity of care, a resiliency focus, and using teams of peers and clinicians in the group interventions provided.

Miller reviews effective psychological treatment modalities for military service members based on treating the related populations of law enforcement and emergency services personnel. He encompasses crisis intervention modalities such as PIES, BICEPS, and CISM as well as constructive psychotherapeutic principles for service members and their families.

Holloway and Everly recommend including redeployment screening for military personnel returning from humanitarian aid missions similar to that done for those returning from combat missions. They discuss the potential mental health impacts of humanitarian assistance missions, and recommend implementing the "resistance, resilience, and recovery" model.

MacDermott continues the focus on resiliency, and adds the concepts of psychological hardiness and finding meaning in trauma to our treatment tool kits. He asserts that both mental health professionals and military leaders can cultivate these positive traits in military personnel.

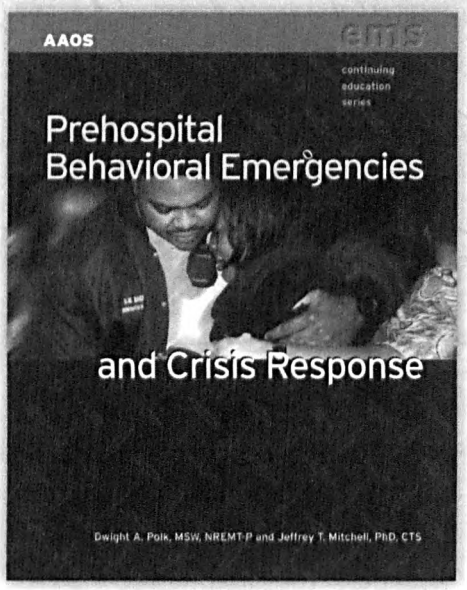
Honig provides a brief review of trauma-related mental health diagnoses, then focuses on potential future challenges to the continued mental health of veterans. Drawing heavily on the Mental Health Advisory Team reports VI and VII (pending), she stresses the importance of education and training, reducing stigma, and early intervention on behavioral health issues.

Valdez uses his experiences working with Marines to provide a closing editorial. He suggests a Battle Plan for saving warriors, employing a variety of recommendations.

Finally, please don't overlook the media reviews at the end of this issue. There are many insightful, notable resources available to assist both the returning combat veteran and those who wish to help and support them. From guidebooks available free from the International Association of Chiefs of Police on hiring combat veterans to the most recent contribution by COL Hoge on the transition from combat to home, the breadth and depth of these resources is remarkable.

From those of us who serve in the military in support of our Country, thank you for your continued support.

A Resource for All Health Care Providers Responding to Mental Health Emergencies



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Prehospital Behavioral Emergencies and Crisis Response

American Academy of Orthopaedic Surgeons, **Dwight A. Polk**, and **Jeffrey T. Mitchell**

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After serving as a firefighter /paramedic, Dr. Mitchell developed a comprehensive, systematic, integrated and multi-component crisis intervention program called "Critical Incident Stress Management." He has authored over 250 articles and 10 books in the stress and crisis intervention fields. He serves as an adjunct faculty member of the Emergency Management Institute of the Federal Emergency Management Agency.

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Critical Incident Stress Management (CISM) in Support of Special Agents and Other First Responders Responding to the Fort Hood Shooting: Summary and Recommendations

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Abstract: *On November 5, 2009, an individual entered the Fort Hood Soldier Readiness Processing (SRP) site and opened fire with a handgun. The result of the shooting was a total of 13 people killed and 31 wounded. A two-person critical incident peer support (CIPS) team from the United States Army Military Police School (USAMPS) provided critical incident stress management (CISM) in the forms of critical incident stress debriefings (CISD) and one-on-one crisis intervention for investigators and their spouses. This article provides a summary and discussion of the results of the interventions that were conducted. Key results for successful CISM were accessibility of CIPS team, the credibility of trained peers and the development of supportive relationships, the reduction of stigma by requiring attendance at interventions, and the commitment of the CIPS team to the principles of CISM (e.g., homogenous groups, utilizing a multicomponent approach, and facilitating the normalization of emotional reactions to the crisis). Recommendations include mandating critical incident peer support cells for Criminal Investigation Division (CID) units, Director of Emergency Services (DES) on military installations, and Military Police units; providing a pool of trained peers in the above-mentioned organizations; providing permanent funding for USAMPS' CIPS Course; and recognition of CIPS/CISM as an essential element of Comprehensive Soldier Fitness and Army Human Capital in promoting Soldier, Family, and Civilian well-being and resiliency. This article would benefit leaders, chaplains, mental health professionals, and emergency services personnel in investigative, operational, and U.S. Army Garrison units. [International Journal of Emergency Mental Health, 2010, 12(3), pp. 151-160].*

Key words: *critical incident peer support, critical incident stress management, crisis intervention, critical incident stress debriefing, one-on-one intervention, peer supporter*

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On November 5, 2009, a lone gunman entered the Soldier Readiness Processing (SRP) site at Fort Hood, Texas and began to fire a handgun at personnel inside and outside the site. The results of the gunman's actions were 12 Soldiers and one civilian killed and 31 wounded. This has been described as the worst mass killing on a military installation in the history of the United States Department of Defense. On November 6 and 7, the United States Army Military Police School (USAMPS) received a request from the Commander of the 11th Military Police (MP) Battalion, Criminal Investigation Division (CID) for Critical Incident Peer Support (CIPS) for the unit. On November 7, USAMPS also received a request from the Fort Hood Director of Emergency Services (DES) for CIPS support. These requests were strongly supported by the Commander of the 6th MP Group (CID) and the Commandant of USAMPS. This paper provides a description of the actions of the CIPS team during the days that followed the shooting. The description includes a discussion of the interventions that were conducted, the results of the interventions, and provides recommendations for establishing policies, procedures, and programs of Critical Incident Stress Management (CISM) and peer support programs, such as CIPS, in preparation for critical incidents.

Description of Interventions

A two-person CIPS team from USAMPS arrived at Fort Hood on the evening of November 6. The CIPS team provided an initial in-brief to the Commander of the 11th MP Detachment (CID). The in-brief included roles, responsibilities, and capabilities of the CIPS team. Following the in-brief, the Commander mandated all Battalion personnel, including CID agents, support personnel and unit leaders, participate in a critical incident stress debriefing (CISD) led by the CIPS team.

The CIPS team coordinated with several organizations at Fort Hood, including Department of Social Services and the III Corps Mental Health cell that was activated following the shootings. As a result of this coordination, III Corps included the USAMPS CIPS team in their mental health operational plan (OPLAN). The team also coordinated with the Chief, Fort Hood Social Work Services who was informed the USAMPS CIPS support team was on the ground augmenting their mission. This coordination was important to assist local mental health experts in understanding the CIPS team role and to obtain support for additional mental health referrals should the need arise during CIPS one-on-one interventions and debriefings. The team also coordinated with the Chief, DES who requested CIPS for firefighters, emergency medical services (EMS) personnel, and other first responders. On November 7, 2009, the CIPS team received a guided briefing through the crime scene to obtain a sense of understanding of the nature of the incident. This walk-through turned out to be crucial for the CIPS team during subsequent debriefings and individual interventions as agents and other first responders described where they were when the events unfolded. It was also essential for the CIPS team to have a better sense of the magnitude of the tragedy in preparation for the debriefings and one-on-one interventions, and also provided a good basis for follow-on questions during the thought and reaction phases of the debriefings. This walkthrough also assisted the CIPS team in gaining credibility with the participants of the debriefings and the one-on-one interventions because they knew the team shared some of their experiences and understanding of the events that transpired.

Definitions of Key Terms

Critical Incident: "an event which is outside the usual range of experience and challenges one's ability to cope... and has the potential...to overwhelm one's usual psychological defenses and coping mechanisms" (Everly & Mitchell, 2000, p. 212).

Critical Incident Peer Support (CIPS): the U.S. Army Military Police School program for training MPs and CID agents to serve as peer supporters following critical incidents.

Critical Incident Stress: the intense emotional reaction to experiencing a critical incident.

Critical Incident Stress Debriefing (CISD): "a highly structured form of group crisis intervention and represents a discussion of the traumatic, or critical, incident" (Everly & Mitchell, 2000, p. 212). The CISD model follows seven phases – introduction, fact, thought, reaction, symptom, teaching, re-entry (Mitchell & Everly, 1997).

Critical Incident Stress Management (CISM): pre-crisis preparation and training, post-operation intervention (referred to as *demobilization* in civilian arenas), crisis management brief, defusing, CISD, one-on-one intervention, pastoral crisis intervention, family intervention, organizational consultation, and follow-up and referral (Everly & Mitchell, 1999, 2000).

Defusing: "a 3-phase, 45-minute, structured small group discussion provided within hours of a crisis for purposes of

assessment, triaging, and acute symptom mitigation" (Everly & Mitchell, 2000, p. 215).

One-on-one Intervention: the most-used element of CISM interventions, it consists of "1 to 3 contacts with an individual who is in crisis [and] may last 15 minutes to more than 2 hours depending upon the nature and severity of the crisis" (Everly & Mitchell, 2000, p. 215).

Peer Support: "the provision of crisis intervention services by those other than mental health clinicians and directed toward individuals of similar key characteristics as those of the providers, e.g., emergency services peer support, student peer support, etc." (Everly, 2004, p. 43).

Peer Supporter: "a member of the workplace who has been specially selected and trained to provide a first line of assistance and basic crisis intervention to fellow workers" (Robinson & Murdoch, 2003, p. 1); "any person who is engaged in the provision of mental health support, but does not possess a professional degree in mental health services" (Everly, 2002, p. 91).

Between November 7 and 12, the CIPS team conducted numerous interventions which are listed in Table 1.

Efficacy of Critical Incident Stress Management

A detailed analysis of the efficacy of CISM is beyond the scope of this paper. However, it is appropriate to present an overview. The use of CISDs is controversial and has been highly scrutinized. Several studies (Devilly & Cotton, 2003; Mitchell, 2003) have questioned its efficacy. However, it has been noted that these studies have utilized questionable research procedures (Mitchell, 2003, 2004; Robinson, 2004) such as using subjects that CISD was not designed to support and conducting CISDs inconsistent with standardized guidelines and protocols. This brings into question those studies that are critical of the use of CISD and CISM. Based on these studies, some mental health professionals in the Army have discounted the effectiveness of CISD and CISM for use with Army personnel. However, the other branches of service (Air Force, Navy, Marines, and Coast Guard) have used CISD and CISM with success (Department of Defense, 2010).

The efficacy of CISM is based on its use as a comprehensive system of interventions. CISD is not intended to be a stand-alone intervention, but is to be used in conjunction with other elements of CISM (Everly & Mitchell, 1999). When implemented as a comprehensive system, CISM has proven to be highly effective in mitigating CIS and facilitating a return to normal functioning (Mitchell, 2003). Several organizations have developed programs and policies that implement CISM, such as the Federal Bureau of Investigation (Kureczka, 2002; McNally & Solomon, 1999), emergency medical services (EMS; Volkmann, 2003), fire departments (Fire Engineering, 2004), law enforcement (Levenson, 2007; Ussery & Waters, 2006; Waters & Ussery, 2007), Employee Assistance Programs (EAP; Masi, 2006; Tyler & Rogers, 2005), Assaulted Staff Action Programs (ASAP; Flannery, Hanson, Rego, & Walker, 2003), and other entities and workplaces exposed to critical incidents (Everly et al., 2006). Numerous local agencies ranging in size from small towns to large cities have adopted policies and procedures for

Table 1.
Interventions Conducted by the CIPS Team

Intervention	Target Group	# of Events/Attendees	Duration
CISD	CID/DES	32/135	60-150 min
One-on-one intervention	CID	114	10-60 min
CISD	Spouses	2/6	60 min

Note: CISDs were conducted for CID special agents, CID support personnel, CID leadership, firefighters, EMS, DA Police, MPs, detectives, and one FBI analyst. The one-on-one interventions included an extremely traumatized shooting victim and a witness, as well as several CID agents who were attending the memorial service for the victims.

implementing CISM as a multicomponent system (Levenson & Dwyer, 2003). The comprehensive use of the components of CISM has been shown to increase resiliency and mitigate intense CIS reactions (Freeman & Carson, 2006; Roberts & Everly, 2006).

In addition to conducting interventions, the CIPS team provided literature to all the participants of interventions. The team sent literature overnight from USAMPS to Fort Hood. Other literature was obtained from local social work services. Literature that provided information on typical reactions, coping skills, and local support agencies was highly beneficial. The materials provided by the CIPS team provided personnel with referral information they otherwise may not have received. Several participants reported that they read through the materials and self-referred themselves to other helping agencies.

Results of the Interventions

Timing

Initially, leaders expressed concern about the timing of CIPS support. The concern focused on the possibility that interventions would interfere with the investigation. The CIPS team noted the concerns and presented to the chain of command the premise that early intervention could serve to mitigate intense stress reaction and restore rational thinking. The result could be a higher quality investigation. The CIPS team made every effort to be accessible and to coordinate interventions at times that were convenient to personnel. Numerous agents, first responders, and support personnel commented on how important it was for them to see peer supporters in the area doing an initial assessment. The visibility of the CIPS team developed trust between personnel and the team, and laid the foundation for subsequent debriefings and one-on-one interventions. In fact, the mere presence of the team in the investigative work areas and at the crime scene encouraged several agents to seek out immediate one-on-one interventions which had a direct positive impact on their ability to continue with their emotionally difficult mission.

Additionally, personnel stated that it was essential for them to receive the support earlier rather than later and that early intervention assisted them in continuing their difficult tasks. The CIPS team was proactive, present, and accessible. The timing of the team's arrival and early intervention facilitated emotional and mental adaptive response which was necessary for effective debriefing. Early intervention also provided personnel the opportunity to process what happened as soon as possible and to be made aware of signs and symptoms they might not yet be experiencing.

Location

Due to the ongoing nature of the investigation, meeting space was limited. All available space was being used by additional CID agents, Texas Rangers, and FBI agents. The CID Battalion arranged for the delivery of a portable building (MILVAN) to be used for the specific purpose of conducting CISDs. The MILVAN was placed adjacent to the CID detachment. The location of the MILVAN, near but separate from the unit's operation, greatly facilitated access by personnel to the CIPS team and decreased disruptions to the investigation.

Comfort with Peer Supporters

The CIPS team consisted of two experienced individuals, both retired from the military after more than 20 years of service. One is a retired CID agent, and the other is a retired MP. Both have extensive experience in critical incidents and criminal investigations. Both are trained in Critical Incident Stress Management (CISM). The use of trained, experienced peer supporters fosters a high level of trust in responders, which in turn facilitates seeking help (Levenson, 2007).

The personnel being supported (firefighters, EMS, MPs, DA Police, CID agents, and other first responders) demonstrated openness and a high level of comfort in interacting with the CIPS team. CID agents stated that they would not have shared as much information with someone who did not have CID experience. Due to the sensitive nature of this particular investigation, many agents related they would have been hesitant to share information with someone who wasn't an agent or former agent. Numerous personnel stated that their experience with participating in "text-book" type debriefings was not beneficial. In the case at hand, participants stated that the interventions conducted by trained peers were much more practical and beneficial. In fact, following the debriefings conducted by the CIPS team, most of the participants of the debriefings were required to undergo mental health screenings. Following the mental health screenings, several participants of both the CIPS debriefings and mental health screenings commented the debriefings were more helpful in contextualizing the critical incidents they experienced. Some commented the mental health screening

was too clinical and impersonal, making them feel like they were merely being examined which made them suspicious of that process.

It was beneficial for the CIPS team to have specific first responder experience. The team was seen as approachable and capable of understanding. Several DES personnel returned for a second CISD. These personnel commented that the CISDs conducted by the CIPS team had more meaning and made a significant difference in their ability to cope with the critical incident. Numerous personnel sought out CIPS team members to talk repeatedly about some of the difficulties they were having as a result of this event. In some cases, supervisors brought personnel to the CIPS team and asked the team to talk with them again.

Relationship

Having the CIPS team on the site was very beneficial. Close proximity enhanced the development of caring relationships. Accessibility was of utmost importance in that all personnel who received support were working shifts and found it much easier to attend CISDs anytime throughout the day or evening versus being forced into a scheduled time slot. Numerous participants commented that it was very helpful for them to get to know the CIPS team prior to the CISD instead of being placed in a room and introduced to the peer supporters for the first time at the beginning of the CISD.

Mandatory attendance

Leaders and personnel expressed some initial concern about mandatory attendance at CISDs. After participation in a CISD, many of the personnel commented that they would not have attended debriefings unless it was mandated and all but a few stated they were glad that they attended. Mandatory attendance may reduce the stigma associated with seeking help. If all those who have been involved in a critical incident are required to participate in a CISD, then no one is singled out as "having a problem." Also, even if someone does not need an intervention, that person's presence may provide support to the others in the group, as well as build cohesion within the group. Participants reported that the confidential nature of the debriefings was beneficial.

Multicomponent

The CIPS team conducted two types of interventions – CISDs and one-on-one interventions. CISM is not a unilateral activity but is a multicomponent system. The combination of interventions conducted by the CIPS team served to facilitate adaptive rational thinking and to mitigate intense stress reactions. The team practiced flexibility and intentionality as they conducted the appropriate intervention given the availability and needs of personnel.

Trauma and grieving is a process – not an event. Numerous personnel disclosed some trauma before, during, and after CISDs. Peer support availability between debriefings was essential for personnel who needed to share some of their trauma response individually. Small debriefing groups were preferred to larger groups by the participants. Due to the nature of the investigation, some personnel desired but did not have time for a CISD. These personnel participated in a one-on-one intervention.

Homogenous groups

A key element of crisis intervention is conducting interventions with homogenous groups. The term *homogenous group* indicates that those with similar level of contact with the crisis or those having similar roles are grouped together for the intervention. For example, a group formed for an intervention should consist of all CID agents, or all firefighters, or those directly involved versus those indirectly involved. The CIPS team was careful to follow this principle. Also, the team conducted separate debriefings for supervisors and non-supervisors.

Several participants stated that they were more at ease discussing their reactions to the event being in the room with "peers" as opposed to being in a mixed group of supervisors and non-supervisors. Senior personnel received separate debriefings which enabled them to disclose more information. The first debriefing included leaders and subordinates which appeared to hinder disclosure and discussion even though all agreed to keep matters shared confidential. The CIPS team observed increased interaction and discussion when leaders and subordinates were debriefed separately. The subordinates appeared to speak more freely without the fear that their supervisor may see them as weak or problematic. Additionally, the leaders opened up more without fear that their subordinates may see them in a more negative light because of their emotional and physical reactions to the critical incidents they experienced.

Spouse response

At the request of several agents and leaders, the CIPS team provided interventions for spouses who had intense reactions to the crisis. The spouses who attended the CISDs were open and expressive in disclosing their significant reactions to the event. All spouses who attended stated that the CISDs were of great benefit, saying that the discussion of their reactions provided understanding, insight, and instilled a better sense of teamwork and partnership with their spouse. The CISD was the first time that many of the spouses had met each other. They committed to developing relationships and to creating a phone chain in the event of another critical incident.

Stigma

The actions of the CIPS team and unit leaders reduced the stigma of seeking help, according to feedback stated by the participants. The presence, visibility, and accessibility of the CIPS team served to promote the fact that crisis intervention is an integral element of a critical incident. The team's presence reinforced the notion that there was nothing wrong with those who were involved with the event. The team's presence did promote the principle that those who were involved in the event would most likely have a typical reaction to an atypical event.

Initially, several personnel voiced their perception that the presence of the CIPS team would be just another "check the block" suicide awareness class. However, once participants attended one-on-one interventions and CISDs, they stated that it was clear that the CIPS team was there because their supervisors cared for the participants' well-being. As stated above, making attendance at interventions mandatory served to reduce stigma, according to statements of the participants. Since all were required to attend, no one was singled out as having a problem. It was also very important for the participants to know that their supervisors and leaders also attended debriefings.

Team facilitated and mitigated

The various interventions conducted by the CIPS team had a positive impact on personnel and their continuing mission, according to the participants. Many participants shared their traumatic experiences, both from this event and previous critical incidents. Participants began learning and attempting to cope with the effects of this event as well as previous incidents. Participants shared their experiences and reactions with each other which began their process of providing mutual support with their coworkers. The vast majority of participants who participated in interventions reported the following benefits:

- Debriefings provide understanding of individual emotional, psychological, and physical impact of trauma.
- Personnel who have undergone previous debriefings from previous incidents reported that the information they received heped them prepare for future stress and trauma.

The Director of Emergency Services offered positive feedback regarding the support of the CIPS team. He stated, "From my perspective the USAMPS CIPS support team was very responsive to the needs of the DES from the very instant that I contacted them. They were extremely flexible and understanding of our work schedule and in fact spent the better part of three days (working from at least 0900-2100) in our building ensuring all large and small groups of personnel received CIPS debriefs."

One of the key actions of the CIPS team was referring personnel for additional support. A secondary goal of crisis intervention is the identification of those who need a higher level of care. The CIPS team identified several personnel who needed a higher level of care. These individuals were referred in a confidential and respectful manner to local mental health providers.

Care of the CIPS Team

Conducting CIPS/CISM can be very demanding and draining on the emotional reservoirs of peer supporters. Just as those who experience a critical incident first-hand need crisis intervention, so do those who provide support experience *secondary traumatization*, the trauma that occurs when being exposed to and hearing the experiences of others who have been involved in a critical incident. Upon the return to USAMPS, the CIPS team received a debriefing, referred to as Post Action Staff Support, from an experienced, trained professional in CIPS/CISM. This intervention enabled the CIPS team to diffuse the stress they had accumulated in the course of providing support.

Summary of Results

The effectiveness of the interventions conducted by the CIPS team was due to several key factors. The CIPS team was available and accessible due to a focus on early intervention and establishing a base of operations in close proximity to the personnel being supported. The CIPS team provided a level of comfort and reduced stigma by having credibility as experienced peer supporters and by focusing on developing relationships with those they were supporting. Unit leaders further reduced stigma by requiring attendance at interventions and by participating in intervention themselves. The CIPS team demonstrated effectiveness and competence in providing individual and small group interventions, by forming homogenous groups, and by being flexible and adaptable. The care that the team provided to spouses served to nurture family relationships, to provide insight, and to mitigate the stress reaction of spouses. The overall results of the support provided by the CIPS team include facilitating the expression of emotional and mental reaction to the event and the mitigation of intense stress reaction. This enabled the personnel to continue with their mission.

Recommendations

Policy

It was the consensus of unit leaders and personnel that CIPS and CISM should be official policy. Addressing the emotional and mental reactions of critical incident stress should be a normal and intentional element of the operational response to a critical incident. The incorporation of multicomponent interventions should be an automatic response such that personnel become comfortable with and accustomed to the use of crisis interventions. The interventions should not be an isolated, singular activity. Instead, interventions should utilize the full range of interventions in a tiered response according to need, the quality of the reaction, and the nature of those involved. A policy should also provide for interventions for family members of affected personnel.

Policy, procedures, and programs of CISM must outline a proactive stance toward addressing CIS. Rather than waiting for a critical incident to occur and providing only counseling by mental health professionals, units and installations must implement all elements of CISM. A policy should include establishing a unit or installation Critical Incident Stress Team (CIST) to oversee the program and the training of personnel, establishing procedures for response to a critical incident, establishing guidelines for selection and training of peers, and establishing guidelines for coordination among the various agencies on an installation (Everly & Mitchell, 1999; Robinson & Murdoch, 2003).

This recommendation addresses the concern and mirrors the recommendation of the Department of Defense (DOD) study of the Fort Hood shooting. The DOD study identified the lack of policy regarding implementing strategies for addressing traumatic stress as the result of critical incidents. The DOD study recommends developing and implementing policy, programs, and procedures that provide preventive and restorative care for traumatic events in domestic environments, using "best practices inside and outside the Department of Defense" (Department of Defense, 2010, p. 50). As mentioned above, the principles of CISM have been shown to be effective in mitigating CIS reaction and enhancing resilience among personnel affected by traumatic events.

Trained Peers Supporters

A policy of CIPS or CISM should include the provision of trained peers at various levels of a unit, organization, or command structure. Peer supporters have been highly effective in addressing mental health issues, reducing absenteeism, providing support for families, and reducing the suicide rate of personnel in the civilian arena (Levenson, 2007). Several studies have demonstrated the benefits of peer supporters among federal (Sheehan, 1999) and local law enforcement (Chamberlin, 2000; Freeman, 2002; Greenstone, 2000).

Trained peer supporters should be utilized at platoon, company, battalion, and Group levels. Just as units have combat lifesavers trained in first aid for physical injuries, units need peer supporters trained in first aid for mental injuries. These trained peers would function as support to others within their unit on a one-on-one basis. However, in the event of a critical incident, trained peers should not facilitate interventions for their own units. This key principle of CISM ensures that personnel who are experiencing a stress reaction themselves can deal with their own issues and not have to deal with others' issues as well. A trained peer must be able to focus on the needs of others and not be influenced by their own stress reaction.

Stigma and Confidentiality

A policy of CIPS or CISM should include provisions for addressing the stigma of seeking help. While some may resist

mandatory attendance at interventions, such a policy serves to reduce stigma as no one is singled out as being weak or having a problem. Also, facilitators and participants must stress confidentiality. Participants must be sure that the thoughts and reactions that they share will not become public knowledge. A key to restoring rational thinking and mitigating the stress reaction is personal discussion in small groups. The fear of being singled out as having a problem, coupled with the fear of having one's personal reactions shared in public may create a barrier to open sharing and hinder the intervention process. The focus of interventions should be on the critical incident stress reaction, not the operation. A CISD is not an operational after action review (AAR) in which personnel's actions are scrutinized. Personnel must not be required to critique one another's performance during interventions. Information disclosed in CISDs should be exempt from being reported in investigations of agent misconduct.

Training

Another key to the effectiveness of CIPS and CISM is pre-incident training. Just as units conduct operational rehearsals of critical incidents such as mass casualty and active shooter, units should also rehearse and conduct training on the psychological interventions that will be used following a critical incident. As one element of the CISM, trained peers and personnel should conduct mock CISM interventions, such as debriefings and defusings, in order to become familiar with the processes. Such rehearsals and training will provide information on typical stress reactions and expectations of interventions. Also, those who are selected to serve as peer supporters must receive specialized training in crisis intervention. They should be skilled in providing the multiple components of CIPS and CISM, including CISDs, defusings, one-on-one interventions, pre-incident training, and family interventions.

Follow-up

Follow-up is essential. The CISD process enables peer supporters to identify those who need additional support. Crisis intervention in general, and CISM specifically, are not isolated, singular actions. Both are most effective when CISM Team members use multiple interventions at various times in the aftermath of a critical incident (Everly, 2004; Everly & Mitchell, 2003; Robinson & Murdoch, 2003). Therefore, peer supporters must plan for the ability to contact personnel following specific interventions for assessment and referral if necessary.

Summary of Policy Recommendations

The CIPS team recommends that the U.S. Army Provost Marshal General (PMG) and the U.S. Army Criminal Investigation Division Command (USACIDC) develop an official policy for CIPS/CISM. A policy should include:

- Mandated CISM interventions following specific types of critical incidents.
- Confidentiality of information disclosed during interventions.
- Critical incident peer support team program management and implementation.
- Mandated critical incident peer support cells.
- Incorporation of lessons learned in policy.
- Required attendance of the USAMPS CIPS course for all peer supporters.
- USAMPS further develop and maintain CIPS support team deployment capability in the event of major critical incidents.
- Provide on-scene support within 8-12 hours following event if possible.
- Permanent funding for USAMPS CIPS training and direct unit support program.
- Recognition of CIPS/CISM as an essential element in supporting the Army Human Capital capabilities in promoting Soldier, Family, and Civilian well-being and resiliency.

Conclusion

The use of CIPS and CISM may be an intentional and effective response to address the potentially intense stress reactions of personnel and their family members to critical incidents. This paper has outlined the specific actions of the USAMPS CIPS team in providing support to the CID unit and DES members who responded to the Fort Hood shooting and the subsequent investigation. The results of the actions and interventions of the CIPS team demonstrated that, when conducted according to the principles of crisis intervention

and CISM, such interventions may have a significant effect on facilitating the restoration of rational thinking and normal functioning, and on mitigating the effects of critical incident stress reaction.

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Mental Health Experiences and Needs Among Primary Care Providers Treating OEF/OIF Veterans: Preliminary Findings from the Geisinger Veterans Initiative

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Abstract: *This study describes the results of the Reaching Rural Veterans Initiative (RRVI) funded by the Commonwealth of Pennsylvania and the Federal Government. The purpose of this project was to address the needs of veterans and their family members in rural communities who were seen by non-VA primary care providers. As part of this project, an assessment of healthcare providers' knowledge and awareness of mental health-related issues and experiences with veterans' healthcare services was conducted. Following this assessment, an education program was developed and implemented at primary care sites within the Geisinger Health System and also made available to other area providers. The survey indicated that Geisinger's primary care providers are currently involved with providing mental health care to area service members and their families. It was estimated that these providers saw about 1,200 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) patients and 3,600 of their family members in clinics over a 6 month period. A significant number of these persons had mental health problems. About two-thirds (65.4%) of providers reported having a mental health professional onsite and nearly 23% reported that over one-third of their patients have mental health problems. Significant mental health gaps discovered indicated that providers lacked knowledge of PTSD and other combat-related stress disorders, as well as knowledge of VA resources. In addition only 20% of the providers rated their mental health treatment skills as high and only about 8% reported that they had adequate knowledge of current mental health treatment strategies. Based on this needs assessment and the results of the provider intervention, further service improvements are planned. [International Journal of Emergency Mental Health, 2010, 12(3), pp. 161-170].*

Key words: *Veterans Health; PTSD; OEF/OIF; Combat Stress Injury; Needs Assessment; Primary Care; Mental Health.*

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Initial post-deployment research following service in Afghanistan (Operation Enduring Freedom, OEF) and Iraq (Operation Iraqi Freedom, OIF) has suggested that significant numbers of military personnel have screened positive for major depression, generalized anxiety or posttraumatic Stress Disorder (PTSD) upon return (Hoge et al., 2004). In addition, recent research suggests that the prevalence of PTSD may be as high as 20% among these service personnel (Booth-Kewley, Larson, Highfill-McRoy, Garaland, & Gaskin, 2010; Ramchand et al., 2010). It has been suggested that the burden of providing care for veterans with combat stress injuries, such as PTSD, will likely be heavier among providers in rural settings (Wallace et al., 2010; Weeks, et al., 2004). Increasingly, military recruits in the US are drawn from rural areas (Kane, 2006), raising the potential mental health burden in these regions (Wallace et al., 2010). This burden is increased due to the fact that VA healthcare facilities tend to be located within larger population centers (Wallace et al., 2010). Compared to urban and suburban veterans, rural veterans tend to live greater distances from both private sector and VA hospitals, visit their providers less frequently, have access to fewer mental health and specialty services, and have more physical and mental health problems (Weeks et al., 2004). While studies show that many mental disorders initially present in the primary care setting (US Public Health Service, 1999), these settings are typically ill-equipped to address these issues (Laraque et al., 2004). This is especially true, however, in the rural setting (Hanrahan and Hartley, 2008). Given these findings and the fact that the majority of veterans do not use VA health care services (US Department of Veterans Affairs, 2002), non-VA primary care providers in rural areas should be trained to diagnose PTSD and related disorders, should increase their clinical knowledge and skills related to PTSD and associated disorders, and they should be aware of the local and regional mental health resources in their area for this at-risk population.

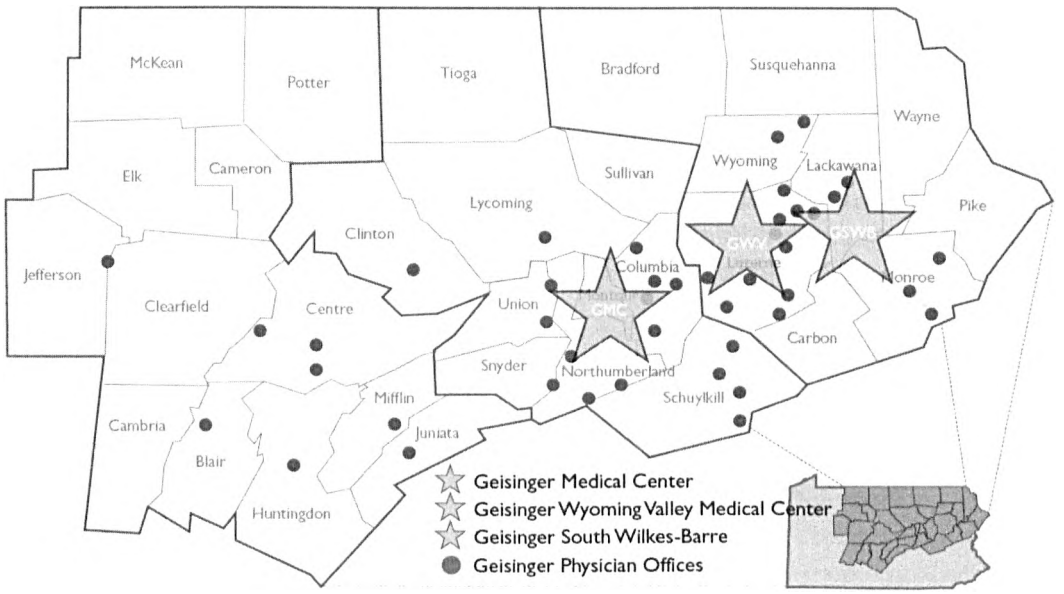
To address these potential needs, Geisinger's Reaching Rural Veterans Initiative (RRVI) was funded in 2009 by grants received from the Commonwealth of Pennsylvania (Pennsylvania Department of Health, SAP# 4100047760) and the Federal Government (Human Resources and Services Administration, Grant# 1-D1ARH-16053-01-00). The RRVI was developed to address the needs of veterans and their family members in rural communities who were seen by non-VA primary care providers. As part of this project, an assessment of healthcare providers' knowledge and awareness of mental health-related issues was conducted. Following this assessment, an education program was developed. This intervention program was presented at primary care sites within Geisinger and was also made available to other providers both inside and outside the Geisinger Health System (GHS). This initiative also permitted the purchase of tele-psychiatry equipment that allowed Geisinger's psychiatrists and psychologists to have visits with patients in geographically distant primary care sites. In addition, this funding also allowed the Geisinger staff to meet with and assess school guidance counselors' needs in Central Pennsylvania related to the families and children of active duty and returning service personnel. The main objectives of the RRVI project were to:

- Survey Geisingers' primary care providers;
- Develop an intervention focused on identifying, treating, and referring OEF/OIF veterans and family members to appropriate providers;
- Identify gaps in service delivery;
- Provide support and referral information to veterans and family members;
- Network with VA, military, and civilian organizations;
- Develop a website for veterans and their family members; and,
- Develop a deployment-focused electronic "toolkit" for providers.

Geisinger Health System

The Geisinger Health System is a vertically integrated system that provides health services to more than 2.6 million persons in 43 counties in Pennsylvania. GHS employs 12,717 persons, including over 700 physicians with more than 75 specialties, more than 2,400 registered and licensed practical nurses, and more than 43 non-physician scientists, making it one of the largest employers in Pennsylvania (see Figure 1). The mission of GHS is to enhance quality of life based on a balanced program of patient care, education, research, and community service. Commitment of GHS to the health and well being of the rural and underserved population in Pennsylvania is demonstrated through its focus on excellence in clinical services, clinical, basic and health services research, and its significant community outreach programs and involvement. The RRVI program was part of this commitment. Geisinger is one of the country's most advanced

Figure 1. Geisinger System Service Area showing Location of Practice Sites in Pennsylvania



health care organizations, with an electronic health record (EHR) in all outpatient clinics, patient portal, and other digital means of delivering care. These electronic records are utilized by clinicians for both in-patient and out-patient care with integrated electronic scheduling, clinical lab, radiology, and other system (see: www.geisinger.org).

METHODS

Needs Assessment Survey

In the Fall of 2009 a needs assessment survey was conducted by the RRVI Study Team among all primary care providers employed in the Geisinger System. One purpose of this assessment was to evaluate service utilization at Geisinger among recently returning veterans and their family members. The other purpose was to evaluate the mental health services needs of primary care providers as this related to providing care for returning OEF/OIF service personnel and their family members. To conduct the provider survey, all 363 primary care providers at Geisinger were sent emails with a link to an electronic needs assessment survey through the Geisinger email system. These primary care providers included physicians (n=285), physician assistants (PAs) (n=44), certified nurse practitioners (CNP), and other non-physician providers (n=34). This email was sent with a message from Geisinger's Chief of Psychiatry introducing the study. Three emails were sent approximately two weeks apart in order to encourage providers to respond to the survey. As a final reminder, a message was sent through the Geisinger clinical order-entry system. A small financial incentive was also used to encourage participation ($10). At completion of the survey timeframe, 155 providers had returned surveys, representing a completion rate of 43%. This survey research project was approved by the Institutional Review Board of the Geisinger Health System.

Clinical Areas Assessed

For the survey instrument used in the RRVI study, we adopted survey items from a provider assessment instrument used in a project designed to evaluate the needs of primary care providers following the World Trade Center Disaster in New York City (Laraque et al., 2004; Laraque et al., 2009). The RRVI online survey was designed to take 10-15 minutes to complete and included reported estimates of OEF/OIF personnel and family members seen in the past 6 months, the most common mental health problems seen among OEF/OIF personnel and family members, the estimated prevalence of mental disorders seen at the primary care site, specific mental health services provided at each care site, and use of standard mental health screeners. It also included self-ratings of mental health knowledge, diagnostic and treatment skills, self-ratings of knowledge related to mental health treatment strategies, the availability of onsite mental health personnel,

mental health referral options, use of psychotropic medicines, and provider awareness of local mental health services for OEF/OIF personnel and family members.

Statistical Methods

Following completion of data collection and data cleaning, potential provider response bias was assessed by gender, age, and provider type (i.e., MD/DO, PA, CNP/other). A statistically significant response bias was detected for provider type ($p < 0.05$), but not for age or gender. Since physicians were less likely to complete the survey than non-physicians, survey weights were developed to correct for this bias, as is typically done in survey research (Boscarino, Adams, & Figley, 2004). Following this adjustment, there was no statistically significant difference ($p > 0.05$) detected by provider type, age, or gender. Next, four multi-item survey scales were developed from the survey to assess mental health knowledge (7 items), mental health diagnostic skills (7 items), mental health treatment skills (7 items), and common mental health treatment strategies (8 items). For these measures, providers were asked how they would rate their knowledge about typical mental health problems seen in primary care (e.g., substance abuse, depression, anxiety disorders, PTSD, suicidal behavior, etc.), rate their diagnostic skills in these areas, rate their treatment skills in these areas, and their knowledge of common mental health treatment strategies. All of these items had response categories ranging from 1 (not very skilled/knowledgeable) to 10 (very skilled/knowledgeable). Missing items for these scales were coded at the population median value for that item, respectively. The Chronbach's alpha for each of these rating scales was good (alpha = range 0.77-0.89), suggesting internal scale consistency, as has been previously reported (Laraque et al., 2004; Laraque et al., 2009).

For our analyses, we first present descriptive statistics revealing the demographic and mental health profile of the study population, followed by the overall results of service utilization by OEF/OIF personnel and family members. Next, we present the mental health services typically provided at these primary care sites and the overall results related to providers' self-rated mental health knowledge and skills. For analysis purposes, we defined higher self-rating on the multi-item scales as an average score of 7 or higher, similar to what had been previously reported (Laraque et al., 2004; Laraque et al., 2009). For the single-items scales, a score of 7 was used to define a higher self-rating. Finally, using logistic regression, we present multivariate results predicting overall mental health knowledge, diagnostic skills, treatment skills, clinical treatment knowledge, awareness of area mental health resources, and OEF/OIF service utilization at the care sites. It is noted that in addition to weighting the survey data for non-response bias, the data were adjusted for data clustering, since more than one provider could be surveyed at each primary care site. All statistical analyses were conducted using Stata, version 11 (Stata Corporation, 2010).

RESULTS

The demographic and practice characteristics of the study population are shown in Table 1. As seen, most providers were less than 55 years of age (80.2%) and they were about equally female and male providers (50.3% vs. 49.7%, respectively). In addition, most providers tended to

Table 1.
Provider Demographics and Practice Characteristics
(N=155)*

Age	**Percent**	**(*n*)**
Less than 35	24.0	38
35-54	56.2	88
55+	19.8	31
Gender		
Female	50.3	81
Male	49.7	76
Provider Specialty		
MD	51.2	77
DO	21.1	32
PA	14.5	25
CNP/Other	13.4	23
On-site Mental Health Provider		
At Practice Site	65.4	103
Not at Practice Site	34.6	54
% Patients Seen with Mental Health Problems		
Less than 35% of Patients	77.1	121
35% or more of Patients	22.9	36
Practice Location		
Less than 20 Miles from Main Campus	56.7	90
More than 20 Miles from Main Campus	43.3	67

*Data are weighted for non-response bias and adjusted for provider clustering in clinic sites. Ns may not total to 155 due to data weighting.

be physicians (72.3%) compared to PAs and CNPs (27.9%). Furthermore, the majority of providers (65.4%) reported the availability of an onsite mental health professional. Finally, 22.9% of providers reported that more than a third of their respective patients had a mental health disorder and the majority of their clinic sites (56.7%) were within 20 miles from the main hospital campus, where the Department of Psychiatry is located.

In terms of OEF/OIF personnel seen at the clinic sites, the majority of providers (55%) reported that they saw one or more service members within the past 6 months, with an average of 3.5 (SD = 5.9) seen per provider during this period (Table 2). However, in terms of family members of OEF/OIF service members seen, a significant majority of providers (77.3%) reported having these patient contacts, with an average of 10.9 (SD = 16.0) family members seen in the past 6 months. In addition, 28% of service members and 59% of family members of these personnel were reported to have mental health problems (Table 2). When asked to report the top three mental health problems seen among OEF/OIF personnel and their family members, providers reported, in order, generalized anxiety disorder (49.5%), family and marital problems (39.6%), and major depression (35.2%). Interestingly, only 12% of providers specifically mentioned PTSD as being one of the more common mental health problems seen among these patients. Given the average number of OEF/OIF service personnel (about 3) and the average number of family members seen (about 10) and the number of primary care providers at Geisinger (~ 360) this calculates into approximately 1,200 OEF/OIF patients and 3,600 OEF/OIF family members seen in primary care in the past 6 month. As noted above, since 28% of OEF/OIF service members and 59% of their family members had mental health problems, this translates into 336 OEF/OIF service persons and 2,124 of their family members, respectively, seen at Geisinger clinics in the past 6 months with mental health problems.

Table 2.
OEF/OIF Veterans and Family Members Seen in Practice in Past 6 Months (*N*=155)*

Deployed Veterans Seen in Past 6 Months	**Percent**	**(*n*)**
No	45.0	70
Yes	55.0	87
Mean (SD)	3.5	5.9
Deployed Veterans Seen in Past 6 Months with Mental Problems	**Percent**	**(*n*)**
No	72.0	113
Yes	28.0	44
Family Members of Deployed Veterans Seen in Past 6 Months	**Percent**	**(*n*)**
No	22.7	35
Yes	77.3	122
Mean (SD)	10.9	16.0
Family Members of Deployed Veterans Seen in Past 6 Months with Mental Problems	**Percent**	**(*n*)**
No	41.0	64
Yes	59.0	93
Top 3 Mental Health Problems Seen among Veterans/Family Members in Past 6 Months	**Percent**	**(*n*)**
Generalized Anxiety Disorders	49.5	78
Family & Marital Problems	39.6	62
Major Depression	35.2	55

*Data are weighted for non-response bias and adjusted for provider clustering in clinic sites. Ns may not total to 155 due to data weighting.

Table 3 shows the general practice patterns related to mental health issues seen in the primary care clinics. Noteworthy is that bereavement issues (29.9%) and PTSD (27.7%) are less frequently assessed during the general medical evaluations, compared to other mental health problems (Table 3). In addition, PTSD was the least likely to be treated and managed at the primary care setting (35.4%). Nevertheless, the majority of providers (59.6%) used diagnostic mental health screeners and the majority of them prescribed psychotropic medications for patients at least "occasionally" or "frequently" (Table 3).

In terms of the self-rating of mental health knowledge, diagnostic and treatment skills, knowledge of current mental health treatment strategies, and awareness of local/regional mental health resources, the survey results suggested that the providers lacked confidence in current mental health

Table 3.
General Practice Procedures at Office related to Mental Health (*N*=155)*

As part of health history, ask patients about:	Percent	(*n*)
Alcohol or Substance Abuse	85.6	134
Generalized Anxiety Disorder	59.9	94
Bereavement Issues	29.9	46
Major Depression	67.6	106
Posttraumatic Stress Disorder	27.7	43
Suicidal Behavior or Thoughts	61.4	96
Family or Marital Problems	57.6	90
Typically treat and manage in your practice:	**Percent**	**(*n*)**
Alcohol or Substance Abuse	43.6	68
Generalized Anxiety Disorder	71.5	112
Bereavement Issues	51.3	80
Major Depression	63.8	100
Posttraumatic Stress Disorder	35.4	55
Suicidal Behavior or Thoughts	42.9	67
Family or Marital Problems	56.7	89
Refer patients out for diagnosis and treatment:	**Percent**	**(*n*)**
Alcohol or Substance Abuse	70.5	111
Generalized Anxiety Disorder	80.3	95
Bereavement Issues	45.6	72
Major Depression	67.4	106
Posttraumatic Stress Disorder	67.3	106
Suicidal Behavior or Thoughts	75.1	118
Family or Marital Problems	62.4	98
Currently use standard diagnostic screeners in your practice for mental health problems:	**Percent**	**(*n*)**
No	40.4	64
Yes	59.6	93
Prescribe psychotropic drugs for mental health issues occasionally or frequently:	**Percent**	**(*n*)**
No	22.4	36
Yes	77.7	121

*Data are weighted for non-response bias and adjusted for provider clustering in clinic sites. Ns may not total to 155 due to data weighting.

Table 4.
Knowledge, Skills, Clinical Ratings, and Awareness of Area Mental Health Services (*N*=155)*

High Overall Rating of Mental Health Knowledge†	Percent	(*n*)
No	68.9	109
Yes	31.1	48
High Overall Rating of Mental Health Diagnostic Skills†	**Percent**	**(*n*)**
No	59.5	94
Yes	40.5	63
High Overall Rating of Mental Health Treatment Skills†	**Percent**	**(*n*)**
No	80.0	126
Yes	20.0	31
High Overall Rating of Mental Health Clinical Strategies†	**Percent**	**(*n*)**
No	91.6	144
Yes	8.4	13
High Awareness of Mental Health Services in Area‡	**Percent**	**(*n*)**
No	66.6	105
Yes	33.4	52
High Awareness of VA Services in Area‡	**Percent**	**(*n*)**
No	96.8	152
Yes	3.2	5

*Data are weighted for non-response bias and adjusted for provider clustering in clinic sites. Ns may not total to 155 due to data weighting.

†Defined as an average score of 7 or higher on a 7-item or 8-item rating scale ranging from 1-10.

‡ Defined as a score of 7 or higher on a single-item rating scale ranging from 1-10.

treatment interventions, with only 8.4% scoring high on this self-rated knowledge measure (i.e., having a mean score of 7 or higher on these rating scales). These providers also scored lower (only 20% had a mean score of 7 or higher) in terms of their self-assessment of mental health treatment skills (Table 4). In addition, while 33.4% of providers had higher awareness of area mental health services, only 3.2% had higher awareness of the treatment resources provided by the VA.

Detailed multivariate results predicting mental health knowledge and skills, mental health service awareness, and providing care for OEF/OIF personnel in the past 6 months are shown in Table 5. Each of the seven outcomes shown are simultaneously adjusted for all seven covariate variables shown (i.e., age, gender, provider type, etc.). As can be seen,

Table 5.
Multivariate Logistic Regression Results Predicting Higher Mental Health Knowledge, Diagnostic Skills, Treatment Skills, Clinical Strategies, Awareness of Services, and Care for OEF/OIF Veterans (*N*=155)

Study Variables Assessed*	Higher Overall Knowledge †		Higher Diagnostic Skills †		Higher Treatment Skills †		Higher Clinical Knowledge ‡		Aware of Area Mental Health Services †		Aware of Area VA Mental Health Services ‡		Provided Care for OEF/OIF Veterans	
Provider Age	**OR**	***p*-value**	**OR**	***p*-value**	**OR**	***p*-value**	**OR**	***p*-value**	**OR**	***p*-value**	**OR**	***p*-value**	**OR**	***p*-value**
Under 35 (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
35-54	3.93	0.025	4.22	0.022	2.47	0.258	1.36	0.574	1.68	0.415	1.38	0.450	3.36	<0.001
55+	4.65	0.015	9.62	<0.001	4.82	0.041	4.08	0.050	2.49	0.183	1.70	0.514	5.25	0.001
Provider Gender														
Male (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
Female	0.50	0.026	0.32	0.001	0.30	0.017	0.85	0.676	0.58	0.168	0.86	0.726	0.41	0.108
Provider Type														
Non-Physician (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
Physician	1.96	0.202	0.87	0.763	1.04	0.945	0.85	0.754	0.94	0.842	1.62	0.491	0.23	0.002
Onsite MH Prof.														
No (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
Yes	0.63	0.509	0.82	0.635	0.86	0.846	0.75	0.685	1.61	0.140	2.90	0.022	0.79	0.552
Higher % MH Cases														
No (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
Yes	2.65	0.039	3.06	0.092	3.57	0.013	3.62	0.003	0.93	0.857	2.27	0.187	1.51	0.368
MH Screeners Used														
No (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
Yes	1.01	0.963	1.79	0.202	1.15	0.771	2.75	0.039	0.51	0.227	0.77	0.689	0.85	0.653
Psychotropics Used														
No (ref)	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--	1.00	--
Yes	4.06	0.032	4.73	0.012	4.63	0.032	2.27	0.220	4.71	0.003	3.22	0.298	2.94	0.044

*Note: All 7 predictor variables shown are included in the regression analyses simultaneously.
†Higher ratings classified as a mean score of 7 or higher on a multi-item scale, with items coded 1-10 or a score of 7 or higher on a single item score, coded 1-10.
‡Due to skewed data that limited multivariate analyses for these measures, these outcomes were re-coded to a score of 6 or higher.
OR = odds ratio; MH = mental health; Ref = reference group.

compared to younger providers, those 55 and older tend to report higher mental health knowledge and skill levels ($p < 0.05$). Compared to the younger providers, these older providers were also more likely to have seen OEF/OIF service members ($OR = 5.25$, $p = 0.001$). In addition, female providers were less likely to report higher mental health knowledge, treatment skills, and diagnostic skills ($p < 0.05$), compared to male providers, while physician providers were significantly less likely to treat OEF/OIF service personnel ($OR = 0.23$, $p = 0.002$), compared to non-physician providers. Furthermore, having an onsite mental health provider was associated with higher awareness of VA health services ($OR = 2.90$, $p = 0.022$), while practice sites with a higher percentage of mental health cases had providers with higher mental health knowledge, treatment skills, and mental health clinical experience ($p < 0.05$). Finally, reported use of psychotropic medicines was associated with providers who rated their mental health knowledge, diagnostic skills, and mental health treatment skills higher and who also had higher awareness of area mental health resources ($p < 0.05$). Psychotropic medicine use was also associated with a greater likelihood of treating OEF/OIF service personnel ($OR = 2.94$, $p = 0.044$).

DISCUSSION

As suggested, the RRVI project was launched in 2009 with grants from the Commonwealth of Pennsylvania and the Federal Government. The RRVI project attempted to address the needs of veterans and their families from rural communities who might be seen by primary care doctors in non-VA facilities. Studies of recently returning OEF/OIF veterans suggest co-occurring mental health diagnoses and psychological problems were being detected in VA primary care facilities in substantial numbers (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). An assessment of provider awareness of combat stress-related issues was conducted through the RRVI initiative and an education program was developed, based on this research. This educational program was presented to primary care providers within the Geisinger System and also available to other primary care providers outside of Geisinger. This program included training to help providers in detecting and managing posttraumatic stress disorders and other combat-related mental health problems. It also included the provision of screening tools to be used in clinical practice and provided resources for providers, veterans, and families through web-based sites. This initiative also allowed Geisinger to purchase telepsychiatry equipment that allowed psychiatrists and psychologists to visit with patients in geographically distant primary care sites. In addition, this funding allowed Geisinger staff to meet with and assess the needs of area school counselors as this pertained to the families and children of active duty and returning OEF/OIF personnel.

Noteworthy is that providers who completed the RRVI training session indicated that they would recommend this training to colleagues, that the information presented was highly useful, and that the session enhanced their medical knowledge in this clinical area. Furthermore, 90% reported that they planned to make practice changes following completion of the training session, including routinely screening patients, using referral resources, using follow-up mental health appointments, and other significant practice changes. The clinical areas that the providers tended to rate the lowest following these sessions were their skills and knowledge related to pain management, the treatment and diagnosis of concussions, and knowledge of traumatic brain injuries, considered the signature wound of the current conflicts (Hoge et al., 2008).

The provider needs assessment survey we conducted was insightful and provided the basis for the RRVI interventions, as indicated. In light of the overrepresentation of returning veterans to rural settings, these findings should be considered important. Psychological distress and mental illness as well as family distress appear to occur at a relatively high rate in veterans and their families and it appears that many primary care providers believe that they are not adequately prepared to identify and treat these problems. A model is presented here for providing initial training and support to primary care providers. Clearly, further assessment of this model should be conducted in a non-integrated health system in order to understand the generalizability of this program to train providers. Recently, a similar intervention effort was undertaken among children's primary care providers in the New York City area following the Word Trade Center disaster, which demonstrated some success (Laraque et al., 2009), so the preliminary results are encouraging.

As was seen, Geisinger's primary care providers are currently involved with providing mental health care to area OEF/OIF service members and their families. The most common mental health problems reported by providers for OEF/OIF service personnel and their family members include anxiety disorders, depression, and marital problems. Altogether 28% of providers reported seeing OEF/OIF

service members with mental health problems in the past 6 months and 59% reported seeing family members with these problems during this same timeframe. It was estimated that primary care providers saw about 1,200 OEF/OIF patients and 3,600 OEF/OIF family members in Geisinger's primary care clinics over a 6 month period. A significant number of these persons had mental health problems. Nearly 60% of providers have used mental health screener instruments and the majority prescribed psychotropic medicines. In addition, about two-thirds (65.4%) of providers reported having a mental health professional onsite and nearly 23% of them reported that over one-third of the patients seen have mental health problems of some type.

Significant mental health gaps discovered in the RRVI needs assessment study indicated that providers lacked knowledge of PTSD and other combat-related stress disorders, as well as knowledge of VA healthcare resources. In addition only 20% of the providers rated their mental health treatment skills as high and only about 8% reported that they had adequate knowledge of current mental health clinical strategies. Significant differences were also discovered in terms of provider demographics and practice characteristics. Older providers reported greater mental health knowledge and skills, as did male providers. In addition, practice sites with greater numbers of mental health patients had providers that reported higher levels of mental health knowledge, as did those providers who prescribed psychotropic medicines.

This study has several limitations that should be noted. One is that our study response rate was 43%, suggesting that our survey results may be biased. Another is that the results reported were based solely on self-reported information. Thus, these results may be biased due to faulty recall. No attempt was made to validate provider recall related to their patient contacts. However, we did use a survey instrument that had been previously validated and this, hopefully, limited study bias. In addition, we compared providers' responses in the current study to those surveyed in the New York City metropolitan area several years earlier related to the September 11 attacks (Laraque et al., 2004; Laraque et al., 2009). Interestingly, the service gaps and knowledge issues found among Geisinger's providers were similar to those found in New York after the World Trade Center among children's primary care providers. Our plan is to reassess Geisinger's providers in the future to track improvements in mental health knowledge and clinical practices skills over time.

In conclusion, the scope of mental health problems that will emerge among OEF/OIF veterans is unclear at this time, but may be as high as 20%. Since most of these veterans will not likely be seen by VA providers in the future, preparing non-VA providers in primary care to diagnose, treat, manage, and refer these patients is paramount and will improve the quality of care for these patients and their family members. This problem may be especially prevalent in rural areas for the reasons discussed above (Wallace et al., 2010; Weeks, et al., 2004). Given better understanding of combat-stress injuries and the treatment modalities available for veterans today (Figley and Nash, 2007), there is little excuse for a repeat of the Vietnam tragedy that occurred among an earlier generation of war veterans (Boscarino 1995: Boscarino 2008; Kulka, et al., 1990). The veteran community deserves better health care and community support.

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Large Group Intervention for Military Reintegration: Peer Support & Yellow Ribbon Enhancements

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Abstract: *University Behavioral HealthCare, University of Medicine and Dentistry of New Jersey in partnership with the New Jersey Department of Military & Veterans Affairs established a program entitled the "New Jersey Veterans Helpline," modeled after the "Cop 2 Cop Helpline," in 2005 to assist veterans and their families within the state. The events of September 11, 2001, demanded an unprecedented response to address the behavioral health care needs of first responders in New Jersey and highlighted the similarities amongst the military population in their response. Although the New Jersey Veterans Helpline program was initiated as a peer based helpline, the need for support in pre- and post-deployment quickly emerged. This paper describes the application of the Cop 2 Cop interventions with the Port Authority Police Department (PAPD) entitled "Acute Stress Management Reentry Program." This program was adapted and combined with Yellow Ribbon Guideline enhancements to create a "60 Day Resiliency & Reintegration Program" led by the New Jersey Veterans program to over 2,400 soldiers returning from war. [International Journal of Emergency Mental Health, 2010, 12(3), pp. 171-178].*

Key words: *Military stress; military reintegration; military resilience; Yellow Ribbon Reintegration*

One of the many overwhelming tasks associated with attempting to provide effective behavioral healthcare support to the military populations is access to those most in need. In response to the September 11 attacks, an adaptation of a Crisis Management Briefing (CMB) was utilized for access to first responders; it applies a conceptual framework to a chaotic and unpredictable environment (Castellano & Everly, 2004). The CMB is a large group crisis intervention tactic developed by Everly (2000) as a means of providing anxiolytic information, controlling rumors, and providing guidance in the wake of large scale critical incidents.

On September 11, 2001, the Cop 2 Cop program (a psychological crisis intervention program established by the New Jersey state legislature) experienced an approximate 300% increase in calls and responded to primarily high risk issues. Amongst the most impacted were the Port Authority Police Department (PAPD), who suffered the largest loss of life of police officers in a single incident in the history of the United States (37 officers died in the September 11 attacks).

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Many personnel served their tour of duty at "Ground Zero" and related venues in excess of eight months. Therefore, it is conservatively assumed that Port Authority officers met the criteria for high risk/high exposure to trauma. The success of the PAPD "Re-entry" intervention (Castellano & Everly, 2004) became the impetus for the "60 Day Resiliency & Reintegration Program" for 2,400 soldiers returning to New Jersey in 2009. This paper describes the large and small group intervention effort initiated by the New Jersey Veterans helpline program in support of our returning troops.

Program Development

In January 2008, the New Jersey Department of Military & Veterans Affairs appointed the New Jersey Veterans Helpline leadership staff to co-chair the state's ongoing PTSD Task Force for the Military. This opportunity allowed for a formal planning venue and assessment of resources in preparation for the largest deployment in our state's history, scheduled for June 2008, since WWII.

New Jersey helpline program data indicated an unusual increase in reports of suicidal thoughts from callers. The Deputy Commissioner of New Jersey Department of Military & Veterans Affairs (NJDMAVA) utilized this data to request that we provide training on suicide intervention for the senior military staff involved in this large deployment. The importance of addressing the senior leadership was magnified when the presentation was scheduled for thirty minutes and extended into more than ninty minutes based on the questions and scenarios offered by the participants. Drawing on the years of collaboration in pre- and post-deployment activity, a plan developed to enhance the already well established "yellow ribbon guidelines," created by the Department of Defense years earlier, for the reconstitution process with a "Welcome home" project, and then interventions at the 30-, 60-, and 90-day points. The New Jersey Veterans helpline staff identified the "Welcome Home Project" and the 60-day reintegration as the events at which mental health issues would be most active. In addition, we were able to plan the support for families and returning veterans by identifying the top ten counties in which these soldiers would be leaving and returning home in order to ensure services were accessible.

After engaging the veteran, we sought to identify those most at risk and provide immediate access to services in the Welcome Home project. The New Jersey National Guard and our veterans had several support systems to access: Veterans Affairs, Veteran Service Organizations, New Jersey Department of Military & Veterans Affairs, a Military PTSD counseling network, Military One source, Military Family Life consultants and Family Assistance Centers to name a few. Increasing accessibility to these resources was a primary focus of our helpline work.

The most sophisticated intervention utilized was an adaptation of the PAPD 9/11 Re-entry program now redesigned as the "60 Day Resiliency & Reintegration Program."

Welcome Home Project

In the Welcome Home Project, the 2,400 soldiers were all seen in 1:1 sessions over the course of the preparation for their deployment and were provided a confidential survey by the New Jersey Department of Veteran Affairs through a contractual agreement with NJDMAVA. Our "team" utilized our data and the expertise of the members of the PTSD Task Force to establish a multidisciplinary plan for the "Welcome Home Project," scheduled for June 2009. As leaders of the New Jersey Veterans helpline, we utilized our roles as chairpersons of the New Jersey DMAVA PTSD Task Force to model a peer/clinician collaboration. We began a structured planning process within our internal helpline program using veteran peers serving as a "focus group" regarding their experience with the welcome home thus far. We also simultaneously attempted to engage and identify roles for the task force members as a constituency group of both veterans and providers of service to service members and their families. Through an outreach effort and overview of the project scope, we recruited and utilized 200 volunteer peers and clinicians from UMDNJ and the PTSD Task Force to provide 1:1 structured psychoeducational fifteen minute sessions for all 2,400 soldiers at Fort Dix over a 16-day period of time.

We standardized, integrated, and trained (both "live" and web-based) these 200 volunteers in a collaborative training event with experts from our program, the New Jersey Veteran Affairs unit, the PTSD provider network, the New Jersey National Guard, and NJDMAVA to ensure that each intervention had the same focus. The training event served three needs prior to the intervention. We created group cohesion and a meet and greet opportunity for our volunteer consortium, provided logistical and practical information, and offered a peer/clinician framework through a series of presentations from both peers and experts to create a joint experience. Speakers were informed that highlighting the

military culture, and gratitude and respect for the military population were essential elements to success. Data from the New Jersey Veterans helpline program was presented to share a voice from this group as well as to share "lessons learned." A final focus was placed upon resiliency.

The Welcome Home Project intervention instructional focus was as follows: know the military population deployment experience as much as possible, share your gratitude for their service, assess for suicidal risk, and advise them of the resources available to them. We provided QPR material (Question, Persuade and Refer; Quinnett, 1998) as our suicide prevention focus for the military suicide warning signs document and New Jersey Veterans helpline brochure. A detailed volunteer database and daily schedule allowed for pre- and post-briefings by the peer clinician from the New Jersey Veterans program. In addition, a coordination of urgent care needs, direct links to military family life consultants, and a clinician to "float" as needed was established. Over a sixteen day time period at Fort Dix in a room set up with cubicles, registration table and material distribution post, the interventions began.

Approximately 2,400 1:1 sessions were conducted. Therein, 199 soldiers were identified as needing follow up, some immediate, most within one week of the contact. We provided callbacks and outreach through a follow up form that identified basic clinical need and contact information. More than 60 soldiers remain in treatment at this time based on our helpline data and follow up. The feedback from both the forms and anecdotal reports from the team was that the "Welcome Home" clinical issues report included anger, anxiety, depression, marriage and family concerns, finances, and concerns about redeployment.

The volunteer staff, using feedback survey forms, reported that their experiences were "extremely positive." Over 70% agreed to be utilized in the next intervention, and most explained the opportunity to work with these returning soldiers was a highlight of their careers.

The "60 Day Resiliency & Reintegration Program"

Based on the positive feedback from the Welcome Home Project, NJDMAVA leadership approved our request to lead the 60-day reintegration as an opportunity to enhance the Yellow Ribbon Guidelines and replicate the 9/11 PAPD re-entry program. Dr. George S. Everly, Jr. joined our team at the New Jersey Veterans Helpline for the reintegration adaptation as he was a consultant to the 9/11 PAPD re-entry project.

We created another standardized integrated training event for the peers and clinicians volunteering for this 60-day intervention in which we shared data from the Welcome Home Project, helpline calls, expert insights and role plays for the small groups. Each team was comprised of both peers and clinicians, and co-facilitated a group using some components reflecting a critical incident debriefing, a psychoeducational group and a psychodynamic group process. Our direction to the team was to focus on initiating group discussion within a framework of the resiliency theme and to identify an ice breaker to prompt open dialogue. Co-facilitators were provided discussion questions and asked to cover the Yellow Ribbon Guideline topics, but not to "preach or teach."

In addition to highlighting the clinical data collected on the New Jersey Veterans Helpline on this population, we also shared data collected through the pre-deployment survey, entitled "Overview of the Health Needs Assessment Survey of the New Jersey National Guard 2007-2009 Department of Military and Veterans Affairs VA New Jersey Health Care System Bloustein Center for Survey Research, Rutgers University," funded by NJDMAVA. A focus was to review the history of previous deployments to Iraq and/or Afghanistan and mental health problems encountered after previous tours. Social stressors associated with deployment were also reviewed, such as the relationship between pain/physical functioning and PTSD. Key reported findings were:

- Veterans with mental health problems are at higher risk for physical health problems as well as for family and financial problems
- Stigma is a serious barrier to veterans reporting and seeking treatment for mental health and substance abuse problems
- Alcohol problems are rarely treated and may require intensive outreach to impaired veterans
- Access is essential to avert crisis
- CONFIDENTIALITY MUST BE STRESSED

We began planning the event logistics, which can be found in the following schedule below, to include a breakdown of soldiers by unit.

SAMPLE AGENDA
60 day Resilience & Reintegration Event

- 8:30 a.m. – 9:45 a.m. 60-day Team Orientation/Briefing Overview-ALL 60 day Team
- 9:45 a.m. – 10:00 a.m. 15 Minute Break
- 10:00 a.m. – 10:45 a.m. Military Large Group Briefing
- 10:45 a.m. – 11:00 a.m. 15 Minute Break
- 11:00 a.m. – 12:00 noon Keynote Lecture - "Resiliency in the Military"
- 12:00 noon – 12:45 p.m. Lunch

Small Group Break Out Sessions

- Yellow Ribbon Topics - Anger Management, Substance Abuse, PTSD/Compulsive Behavior
- 1:00 p.m. – 2:00 p.m. Introduction - "What one issue regarding the deployment would you like to share?"
- 2:00 p.m. – 2:15 p.m. 15 Minute Break
- 2:15 p.m. – 3:00 p.m. Evaluation collection/ Wrap up

Four dates were selected with approximately 600 soldiers scheduled per day for this large and small group multidisciplinary intervention. The theme of "resilience in the military" was the topic of the large group presentation for the morning session provided by Dr. Everly. We provided background information for his lecture, data about the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) caller's clinical issues and the nature of the deployments of each group. Three undred soldiers attended the large group intervention while the other 300 received a NJ VA/NJDMAVA post-deployment survey similar to their pre-deployment survey to compare and contrast their experience. They switched sessions, ate lunch and were broken down into small groups (fewer than 20), co-facilitated by veteran peers and clinicians. The Yellow Ribbon Guidelines recommended the following topics be reviewed at the 60-day event historically: anger management, substance abuse, PTSD, and compulsive behaviors.

Both veteran peers and culturally competent clinicians offered anecdotal stories regarding their previous experiences in the vast amount of reintegration activity in which they had participated over the previous year, and answered questions to complete the training day.

When the four days were completed, the feedback from more than 1,300 soldier surveys was extremely positive. Some logistical complaints were highlighted based on one venue which had some facility problems, but the comments were overwhelmingly positive regarding the resiliency large group event and the small group discussions, especially regarding the peers.

The volunteer participants again expressed their positive experiences and shared insights to the effectiveness of this process. Many had seen these same soldiers in the Welcome Home Project and would be seeing them as providers of care in the soldier's prospective communities. This element of continuity between the New Jersey Veterans helpline, the PTSD Task Force, NJ VA, and community providers in the 60 day Resiliency and Reintegration event maximized our capacity to serve the soldiers' needs.

Our New Jersey Veteran's helpline staff unanimously believes that peers, access, and continuity of care are the key elements to the success of this initiative. We also believe that our peer-based helpline creates an opportunity to inform the soldiers that we will maintain strict confidentiality of the information shared.

A significant lesson learned from 9/11 and the Cop 2 Cop program staff was the value of retired law enforcement staff and volunteers genuinely sharing their lives and resiliency with their "brothers and sisters in blue." The PAPD leaders asked us to create a "voice" from the officers to meet their needs in the 9/11 re-entry program.

Similarly, the veteran peer-based helpline, collaborations throughout the state through the NJ PTSD Task Force, and the support of the NJ VA allowed these interventions to provide a "voice" for the soldiers' needs. An openness and the value of peer support are part of our culture of service delivery at University of Medicine and Dentistry of New Jersey – University Behavioral Healthcare (UMDNJ-UBHC) and that value was translated in every aspect of this process. Also throughout this process was the utilization of the group intervention format (as opposed to teaching format/interventions) as an important addition to our overall strategic service plan. The groups were seen as not only logistically efficient, but were more effective in normalizing manifest responses, building informal support networks, teaching practical coping skills, and assisting in psychological triage (see Everly, 2000).

Perhaps most importantly, however, the group format acts to directly attack the sense of social alienation that often typifies posttraumatic distress. Another element unique to our collective intervention experience at the Yellow Ribbon Guideline enhancements was the importance of separating the units based on their deployment experience to foster a continuity of group cohesion.

Results

More than 13,000 New Jersey National Guard men and women have been deployed to combat theater with a zero suicide rate. Compared to neighboring states with similar deployment numbers, we remain dramatically unique, as neighboring states have experienced multiple suicides. Perhaps our ongoing assessment, access, outreach, and follow up have contributed to this outcome, perhaps not.

Clinically, our staff and volunteers took the best practices of all of the resources throughout the state to establish the curriculum, process, and focus on service provision persistently, including suicide prevention awareness. The original group process of Crisis Management Briefings (Everly, 2000) served as a model for adapting the program to reflect re-entry as a unique intervention based on our 9/11 experience with PAPD.

Our 60 Day Resiliency & Reintegration Program for this full-day therapeutic group process was perceived as a success due to the structure and content, as well as the credibility derived from the veteran peers and national expertise that were tasked with this unique event.

One special challenge was the difficult task in processing with the group the reality of unattended depression, marital discord, and substance abuse often connected to their heightened exposure to trauma.

Resilience

The primary difference in our 60 Day Resiliency & Reintegration Program vs. the PAPD re-entry program vs. the large group crisis intervention model described by Everly (2000) and referred to as the crisis management briefing (CMB) is that we had the pre- and post-deployment 1:1 sessions to engage and provide a continuum of care. Resilience was the primary theme for all interventions. In addition, integrating VA, Vet Center, academic and community mental health volunteers with veteran peers also expanded the scope of service presented in this intervention.

The educational/fact outlines for discussion questions and the icebreaker "Tell us your name, number of deployments and, if you are comfortable, something you want to share with the group regarding your deployment" was well received. Integrating peers experienced with small group crisis intervention sessions (Critical Incident Stress Debriefing or CISD) as part of their everyday response at Cop 2 Cop was helpful. Peer support integrated with clinicians fosters a focus on resiliency in first responders and the military.

Reflections: Military Psychological Body Armor

As we immunize children against physical pathogens that might cripple them in later life, should we not immunize military members against psychological pathogens that might cripple, or even lead to a loss of life through suicide, substance abuse, and domestic violence? Should we not provide them with the support that will help them rebound from adversity when it is unavoidable? Most would agree the answers to these questions are "yes!"

In order to best provide such protection, we must first understand where human resilience resides. The answer appears in psychology. It is often said, "It's not what happens to you that matters, it's how you take it." The meaning is simple. We cannot always control what happens to us in life, but we can control how we react to it.

This conclusion is important to discovering the secret of human resilience. Research has indicated (see Everly, 2009 for a review) that positive interpretations (optimism) and a sense of self-confidence, called *self-efficacy*, are associated with positive outcome. Self-efficacy may be conceived of as confidence, or the belief that one can affect change. In other words, it's the belief that one can make a difference in one's own life and perhaps the lives of others.

Michael Rutter (1985), writing in the British Journal of Psychiatry more than two decades ago, noted that a sense of "self-esteem and self-efficacy" increases the likelihood that a person will exhibit successful coping, while "a sense of helplessness" increases the chances of failed coping and, thus, repeated adversity. He notes that such an overarching belief is not a static personality trait. It can be altered. He suggests the inclination to act in the face of adversity, rather than react, is a critical factor in predicting resilience. Some

people might see this as a tendency to act to win, rather than to react in order not to lose.

These themes were emphasized during the aforementioned interventions and we believe they are essential "take home" messages. The resiliency component of the aforementioned interventions further carried the theme of resilience as described in the ancient manuals of war as summarized by Everly (2010). The personal characteristics of resilience underscored were:

- Integrity
- Optimistic actions
- Perseverance
- Taking responsibility for one's actions

Resilient Systems

In order to build resiliency in military personnel, a resilient system must be established. The goal of the system is to promote increased identification with the military unit and its mission, and to increase unit cohesion. This can be achieved by (Everly, 2010):

- Fostering unit-oriented routines without presumption of impairment as in the 60 Day Resiliency and Reintegration Program
- Establishing unit pride and traditions by giving a "voice" to all served in an ongoing process
- Nurturing a realistic sense of unit optimism and self-confidence (self-efficacy) utilizing peer support
- Establishing a belief in and reliance upon mutual support ("No one left behind")
- Teaching psychological first aid (PFA) to NCOs (Everly, 2005).
- Teaching resilient leadership to NCOs and commissioned officers (Everly, 2010).

Post-deployment Resilience

Resiliency can be fostered by establishing a post-deployment intervention system as outlined below.

- Simplify access to care – Establish a 24-hour peer-support telephone hotline utilizing military veterans specially trained in crisis call models, psychological first aid, peer support with case management, and clinical supervision to ensure success (see Everly & Mitchell, 2007; Sheehan, et al., 2004).
- Customize choices for veterans & their families – Establish a referral system to mental health clinicians specially trained in crisis intervention and treatment of post-deployment depression and posttraumatic stress disorder (see Everly & Lating, 2004). Cultural competency in military service members is essential to maximize the chance to engage a soldier in need.
- Within 7 days post-deployment all personnel should be medically and psychological screened for any evidence of disease, distress, or dysfunction.
- Yellow Ribbon Guideline Enhancements – Welcome Home 30, 60, and 90 days post-deployment, service members should be provided with customized adaptations of the federal guidelines based on the population's needs. Our Welcome Home Project or our 60 Day Resiliency & Reintegration Program provide specific information on adaptive and maladaptive reactions to deployment with a focus on resiliency and confidential support. Reservists and National Guard personnel should be encouraged to join family members who will have their own informational sessions wherein such reactions are discussed and resources identified. All of these sessions should have three components: peer and clinician collaboration, structured didactic elements, and less structured interactional sessions (group debriefings).

In sum, resiliency may be thought of as psychological body armor. It is as necessary as physical body armor. We now believe we have the technologies that can foster the ability to adapt to and rebound from the stress of combat and adverse deployment.

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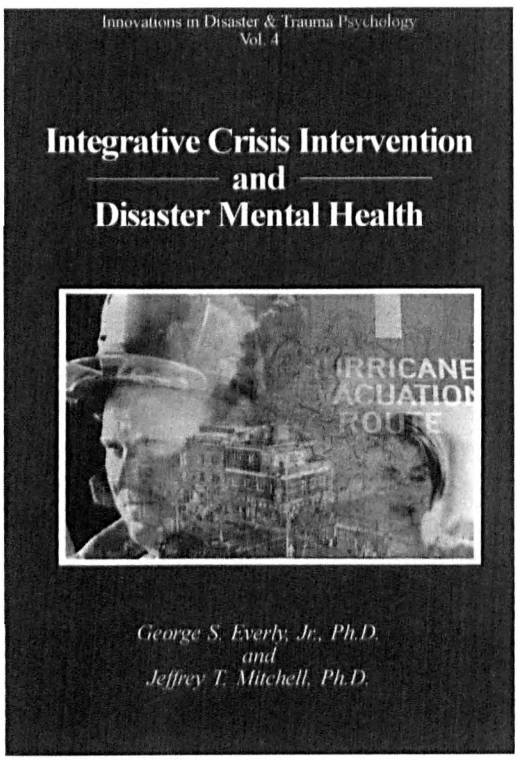

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Psychotherapy with Military Personnel: Lessons Learned, Challenges Ahead

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Abstract: *Increasingly, civilian mental health clinicians will be enlisted to evaluate and treat active duty and post-deployment military service members of the OIF/OEF theaters, as well as veterans of previous wars. This article provides a summary of some of the effective psychological treatment modalities for military service members that can be adapted to outpatient psychotherapeutic practice, including structured psychological interventions and specialized techniques of individual psychotherapy, with special applications for dealing with combat stress, depression, suicidality, conflicts over killing, brain injury effects, family issues, post-deployment readjustment, and long-term problems. By adapting and integrating psychotherapeutic lessons learned from treating related populations of law enforcement and emergency services personnel, clinicians who treat military service members and vets can become more flexible, well-rounded, and effective clinicians for a wide variety of high-need service members.[International Journal of Emergency Mental Health, 2010, 12(3), pp. 179-192].*

Key words: *Combat stress; military psychology; military veterans; psychotherapy integration*

Psychological traumatic disability syndromes have always been a part of warfare, whether termed *irritable heart* (Frazier & Wilson, 1918; Mearburg & Wilson, 1918), *war neurosis* (Kardiner, 1941), *shell shock* (Southard, 1919), *battle fatigue, combat stress, posttraumatic stress disorder* (PTSD), or *Gulf War syndrome* (APA, 2000; Pizarro, Silver, & Prouse, 2006; Ritchie & Owens, 2004; Rosen, 1975; Sherman, 2005; Trimble, 1981; Wessely, 2006; Wilson, 1994), and generals have always pressed clinicians into service to diagnose and treat soldiers with the aim of getting them back to the front lines as quickly as possible. It has yet to be determined what the eventual psychological casualty rate from the current OIF/OEF (Iraq and Afghanistan) theaters will be, but a growing consensus seems to be that psychological stress syndromes are being underdiagnosed and undertreated (Christian, Stivers, & Sammons, 2009; Clary, 2005; Corbett, 2004; Galovski & Lyons, 2004; Hoge, 2010; Nordland & Gegax, 2004; Paton & Smith, 1999; Tyre, 2004).

As increasing numbers of military service members return to civilian life between and following their deployments, the need for qualified psychotherapists to deal with the overlapping syndromes of posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, suicidality, substance abuse, and family problems will grow exponentially. During active service, the psychological needs of soldiers are dealt with primarily by military psychologists and psychiatrists on base or in their theaters of deployment.

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But returning stateside, there will simply not be enough military mental health personnel or Veterans Administration (VA) facilities to go around. Hence, the need for properly trained civilian mental health professionals to meet the needs of returning service members will grow (APA, 2007; Hall, 2008; Hoge, 2010; Maguen et al., 2010).

Ralph and Sammons (2006) recently commented that "the military is where much of the most progressive work in psychology is taking place" (p. 375). However, fruitful insights and clinical applications to military psychotherapy can also be adapted from work with other fields where high stress and working with death are part of the job description. This article provides a summary of the main principles of psychotherapy with military personnel, drawing from direct experience with these men and women, as well as from related experience with civilian public safety and emergency services personnel, such as police officers, firefighters, paramedics, disaster responders, and others in high-intensity, life-and-death fields of work (Miller, 1993, 1995, 1998, 2006c, 2008a, 2008b). Indeed, many law enforcement officers have enlisted in the armed services, and many more returning young veterans seek and obtain employment as police and public safety personnel (IACP, 2009).

Structured Psychological Interventions for Military Personnel

In an effort to disseminate psychological treatment applications as widely as possible to the military service members who need them, the U.S. Armed Forces have developed a number of treatment protocols for use by military mental health clinicians. These modalities are mainly targeted at treating combat stress with the goal of returning service members to active duty as quickly as possible, as well as minimizing long-term psychological disability. The primary goal is to depathologize these stress responses by framing them as normal responses of normal people to abnormal or "extra-normal" events (Brickman, 1982; Campsie, Geller, & Campsie, 2006; Freeman & Moore, 2009; March & Greenberg, 2007; Nash, 2007; Nash & Baker, 2007), as well as to reinforce resilience by proper training and a positive service philosophy which has variously been characterized as *battlemind* (Brusher, 2007; Castro, 2006; Moore, Hopewell, & Grossman, 2009) or *mettle* (Miller, 2008b), among other terms. Some of these principles and procedures can be adapted to the civilian psychological treatment setting for military veterans.

PIE

Quick and effective psychological treatment of military personnel is not a brand new concept, however, and one of the most widely used treatment protocols, the PIE model (Artiss, 1963; Campsie et al., 2006; Jones, Kennedy, & Hourani, 2007; Ritchie & Owens, 2004), dates back to World War I (Salmon, 1919), where it was ahead of its time in anticipating many of the principles of the strength and resiliency movement in modern psychotherapy (e.g. Duckworth, Steen, & Seligman, 2005; Rashid & Osterman, 2009). In the PIE model:

P = Proximity. Provide care as close to the unit as possible. Removing a soldier from his or her unit implies that the trauma must be a severe one, otherwise, why would he or she be placed "out of commission?" Keeping treatment near the front lines reinforces the idea that the psychological injury is a temporary and recoverable one and that, following a brief period of psychological first aid, the soldier will return to service.

I = Immediacy. Offer treatment as soon as possible. Like a physical trauma, don't let a psychological wound fester. Immediate treatment may prevent the development of a range of secondary traumatic stress reactions, and also conveys to the service member that a psychological injury is taken as seriously as a physical one, again, with the expectation in most cases of recovery and return to duty.

E = Expectancy. Convey the expectation of return to full duty. This is the corollary of the above two principles. Of course, this must be tempered by clinical reality. Just as some physical wounds require additional treatment, in a number of cases, the psychological trauma may be severe enough to warrant more long-term treatment, necessitating a longer separation of the service member from his or her unit. In such cases, care should be taken not to stigmatize the affected service member as weak or irresponsible.

BICEPS

Currently, the U.S. Department of Defense's protocol for management of combat stress (Brusher, 2007; Campsie et al., 2006; Munsey, 2006) is based on the original PIE model, but has been adapted into the BICEPS model, where:

B = Brevity. Treatment is short-term, addresses the problem at hand, and is focused on return to service.

I = Immediacy. Intervention begins as soon as possible, before symptoms have a chance to worsen.

C = Centrality. Psychological treatment is separated from medical facilities to reduce the stigma soldiers might feel about seeking mental health services. This, however, may be a two-edged sword, in that the very sequestration of "mental cases" implies that there is something unnatural and creepy about these syndromes that sets them apart from the "real" wounds of soldiers in medical units. A number of military mental health authorities are instead recommending that education about the psychological syndromes of war be utilized to reduce the stigma of help-seeking.

E = Expectancy. A service member experiencing problems with combat stress is expected to return to full duty.

P = Proximity. Soldiers are treated as close to their units as possible and are not evacuated from the area of operations in order to enhance expectations of recovery.

S = Simplicity. Besides formal therapy, the basics of a good meal, hot shower, and a comfortable place to sleep ensure that a soldier's basic physical needs are met.

Critical Incident Stress Debriefing (CISD)

Originally developed to address the special needs of civilian law enforcement and emergency services personnel, the concept of *critical incident stress management* (CISM) has incorporated the basic philosophy and methodology of the PIE and BICEPS models and has expanded and refined the methodology, which has, in turn, been adopted back into the military (Borders & Kennedy, 2006; Campsie et al., 2006; Dyregrov, 1989, 1997; Everly & Boyle, 1999; Everly & Mitchell, 1997; Everly, Flannery, & Mitchell, 2000; March & Greenberg, 2007; Miller, 1999; 2006a; Mitchell & Everly, 1996, 2003). One application, *critical incident stress debriefing* (CISD), is a structured small group intervention designed to promote the emotional processing of traumatic events through the ventilation and normalization of reactions, as well as to facilitate preparation for possible future crisis experiences. A CISD is a peer-led, clinician-guided, group process, which takes place within 24 to 72 hours of the critical incident and consists of a single group meeting of approximately 8-20 personnel. Where large numbers of service members are involved, as in large-scale demobilizations, several debriefings may be held successively over the course of days to accommodate all the personnel involved, or a briefer form of *critical incident demobilization* may be employed (Everly & Mitchell, 1997; Mitchell & Everly, 1996, 2003).

The formal CISD process consists of seven key phases, designed to assist cognitive and emotional integration and mastery, beginning with more objective and descriptive levels of processing, progressing to the more personal and emotional, and back to the educative and integrative levels. These include:

Introduction. The team leader introduces the CISD process, encourages participation by the group, and sets the ground rules of confidentiality, attendance for the full session, unforced participation in the discussions, and the establishment of a noncritical atmosphere.

Fact phase. The group members are asked to briefly describe their activity during the critical incident and some facts about what happened; the basic question is: "What did you do?"

Thought phase. Group members discuss their initial and subsequent thoughts during the critical incident: "What was going through your mind?"

Reaction phase. This begins to move the group from a predominantly cognitive mode of processing to a more expressive emotional level: "What was the worst part of the incident for you?"

Symptom phase. This begins the movement back from the predominantly emotional processing level toward the cognitive processing level. Participants are asked to describe their cognitive, physical, emotional, and behavioral signs of distress: "What have you been experiencing since the incident?"

Education phase. Continuing the move back toward intellectual processing and normalization of the experience, didactic information is provided about the nature of the stress response and the expected physiological and psychological reactions to critical incidents.

Re-entry phase. During this wrap-up, any additional questions or statements are addressed, referral for individual follow-ups are made, and general group bonding is reinforced: "What have you learned?"

On this basic model, there have been a number of specialized adaptations of the CISD/CISM protocol for military personnel. These include the Navy's *Special Psychiatric Response Intervention Teams* (SPRINT), the Army's *Special*

Medical Augmentation Response Team-Stress Management (SMART-SM), the Air Force's *Critical Incident Stress Teams* (CIST), and the British Royal Marines' *Trauma Risk Management* (TRiM) program (Campsie et al., 2006; March & Greenberg, 2007). Whether explicitly or tacitly, all of these programs incorporate important elements of the military PIE/BICEPS and law enforcement-emergency services CISD/CISM models.

Psychotherapy for Military Service Members and Veterans

Mental health services in the military are not limited to combat stress or PTSD, however (Budd & Kennedy, 2006). Service members can be affected by a wide variety of problems that include depression, suicidality, substance abuse, work stress, family problems, and additional post-deployment challenges. Others may have long-lasting physical, cognitive, or emotional sequelae and/or identity-challenging existential crises that cannot be effectively ameliorated with the types of brief interventions described above (Litz et al., 2009). In such cases, the challenge for psychotherapists is to develop and utilize interventions that preserve the restrengthening orientation of positive psychotherapies (Duckworth et al., 2005; Maddi, 2007; Rashid & Osterman, 2009), while at the same time allowing for deeper and ultimately reintegrative exploration of the personality, psychopathology, and personal history issues that may be impeding recovery. In addition, these modalities have to be effective not just for young soldiers in various stages of their service, but for long-time veterans who are still struggling with the aftereffects of past wars (Bonwick & Morris, 1996; Bramsen, Deeg, van der Ploeg, & Fransman, 2007; Hamilton, 1982; Hunt et al., 2008; Kaup, Ruskin, & Nyman, 1994; Markowitz, 2007; McLeod, 1994; Potts, 1994; Solomon, Mikulincer, & Waysman, 1991). In these efforts, I have found it useful to adapt many of the principles of psychotherapy for law enforcement and emergency services personnel (Miller, 2006c) to the clinical practice of psychotherapy for military active service members and veterans.

Basic Principles of Psychotherapy with the "Wounded Warrior"

The convergences of theory and technique across the domains of military and law enforcement psychotherapy should not be surprising, inasmuch as police work has been characterized as "civilian combat" (Violanti, 1999), and that both fields attract service members with similar "tough guy/gal" mindsets. Accordingly, effective psychological interventions with military and law enforcement personnel share in common the following elements (Ball & Peake, 2006; Blau, 1994; Budd & Kennedy, 2006; Fullerton, McCarroll, Ursano, & Wright, 1992; Miller, 1995, 1998, 2006c, Peake, Bourdin, & Archer, 2000; Rudofossi, 2007, 2009; Wester & Lyubelsky, 2005) which are already familiar from the PIE/BICEPS model discussed earlier:

Briefness. Utilize only as much therapeutic contact as necessary to address the present problem; the service member does not want to become a "professional patient."

Limited focus. Related to the above, the goal is not to solve all the service member's problems, but to assist in restabilization and provide stress-inoculation for future crises.

Directness. Therapeutic efforts are focused on resolving the current conflict or problem to reach a satisfactory short-term conclusion, while planning for the future if necessary.

Psychotherapy with Military Personnel: Basic Strategies

The following is a brief summary of the models and techniques from the field of law enforcement psychotherapy (Blau, 1994; Miller, 2006c) that can be productively adapted to the treatment of military service members and veterans during active duty or post-deployment, and can be conducted in the civilian office-based psychotherapy setting. In all cases, it is important that the first meeting between the therapist and the service member establish a safe and comfortable working atmosphere, fostered by the therapist's articulation of a positive endorsement of the service member's decision to seek assistance (or, in some cases, obedience of an order to do so), a clear description of the therapist's responsibilities and limitations with respect to confidentiality and privilege, and an invitation to the service member to state his or her concerns.

A straightforward, goal-directed, problem-solving therapeutic intervention style includes the following elements:

Create a sanctuary. The service member should feel safe that what he or she says will be used primarily for the purposes of his or her healing and strengthening, not as part of a disciplinary process.

Focus on critical areas of concern. Therapy should be goal-directed and focused on resolving specific adaptation and recovery issues related to the crisis at hand.

Specify desired outcomes. In the early phases, the clinician may have to help the service member sort out, focus, and operationalize his or her goals so that there will be a way of measuring whether the therapy process is accomplishing them.

Develop a general plan. From the first session, develop an initial game plan that can be modified as you go along.

Identify practical initial implementations. Begin intervention as soon as possible to induce confidence and to allow the clinician to get feedback from treatment efforts that will guide further interventions.

Review assets and encourage self-efficacy. Consistent with the overarching aim of military and law enforcement psychotherapy as a strengthening, not weakening, process, it is vital to assist the service member in identifying and utilizing his or her strengths and capabilities as coping resources.

Blau (1994) has delineated a number of effective individual psychotherapeutic strategies for police officers that can be applied to therapy with military service members:

Attentive listening. This includes good eye contact, appropriate body language, genuine interest, and interpersonal engagement.

Being there with empathy. This conveys availability, concern, and awareness of the disruptive emotions being experienced by the distressed service member.

Reassurance. This means realistically reassuring the service member that routine matters will be taken care of, deferred responsibilities will be handled by others, and that the member has administrative and command support.

Supportive counseling. This includes active listening, restatement of content, clarification of feelings, and validation.

Interpretive counseling. While still keeping the process short-term and focused on the immediate problem, interpretive counseling can stimulate the service member to explore underlying emotional or psychodynamic issues that may be intensifying a naturally stressful traumatic event (Horowitz, 1986).

Humor. When used appropriately and respectfully, therapeutic humor may help to bring a sense of balance, perspective, and clarity to a world that seems to be warped by malevolence and horror (Fry & Salameh, 1987; Fullerton et al, 1992; Henry, 2004), as long as the therapist keeps a lid on destructive types of self-mockery or inappropriate projective hostility and is careful that well-intentioned kidding and cajoling not be interpreted as dismissive of the seriousness of the service member's plight.

Another therapeutic strategy that is especially useful for law enforcement and military service members is training in the adaptive *utilization of cognitive defenses* (Janik, 1991). Traditional psychotherapists are used to conceptualizing defense mechanisms as mental stratagems the mind uses to protect itself from unpleasant thoughts, feelings, impulses, and memories in order to avoid conflict and ambiguity and allow the person to maintain some consistency to their personality and belief system. Much of traditional psychotherapy involves carefully helping the patient to relinquish pathological defenses so that he or she can learn to deal with internal conflicts more constructively.

However, in the face of the kinds of immediately traumatizing critical incidents that confront military and law enforcement personnel, the proper utilization of psychological defenses can serve as an important psychological splint or emotional field dressing that enables the person to function in the immediate posttraumatic aftermath and eventually be able to resolve and integrate the traumatic experience when the luxury of therapeutic time can be afforded (Durham, McCammin, & Allison, 1985; Henry, 2004; Janik, 1991; Taylor & Brown, 1988; Taylor, Wood, & Lechtman, 1983). Examples of adaptive cognitive defense strategies include:

Denial: "Put it out of my mind; focus on other things; avoid situations or people who remind me of it."

Rationalization: "I had no choice; things happen for a reason; it could have been worse; other people have it worse; most people would react the way I'm doing."

Displacement/projection: "The bad intel on this mission left us underequipped; the ordnance never works properly in this climate."

Refocus on positive attributes: "Hey, that miss was a fluke – I'm usually a great marksman; I'm not going to let one mistake jam me up."

Refocus on positive behaviors: "Okay, I'm going to get more training, increase my knowledge and skill so I'll never be caught with my pants down like this again." In the short

term, clinicians can actively support and bolster psychological defenses that temporarily enable the service member to continue functioning. Later, when he or she is making the bumpy transition back to normal life, potentially maladaptive defenses may be revisited as possible impediments to progress toward a satisfactory recovery.

Special Applications of Military Psychotherapy

Depression and Suicide

Both law enforcement and military service tend to attract individuals who have high expectations of themselves, little tolerance for weakness, and often a black-and-white, all-or-nothing view of success and failure. For these service members, self-perceived failure may lead to depression and suicidality, often commingled with alcohol and substance abuse. In addition to service-related factors, law enforcement and military personnel may become despondent and suicidal for reasons related to their family or personal lives (Jones et al, 2006; Miller, 2005, 2007a; Rudd, Joiner, Jobes, & King, 1999). Curiously, higher rates of suicide are seen in military personnel who work in security or law enforcement specialties within the armed services (Jones, Thomas, & Ironside, 2007).

Suicidal crises tend to be short, which means that timely intervention can literally make a life-or-death difference. With appropriate treatment, the vast majority of depressed, potentially suicidal persons improve considerably within a few weeks (Bongar, 2002; Maris, 1981; Reinecke, Washburn & Becker-Weidman, 2007). In this respect, the military has been proactive in education and training about recognizing and reporting depression and suicidality, and a variety of programs have been developed in different service branches.

One example is the Air Force's LINK (Staal, 2001), which stands for:

L = *Look* for possible concerns or signs of distress.

I = *Inquire* about those concerns.

N = *Note* the level of risk.

K = *Know* the appropriate referral sources and strategies.

Similarly, the Navy and Marine Corps have adopted a program called AID LIFE (Jones et al, 2006), which stands for:

A = *Ask,* "Are you thinking of hurting yourself?" or "Are you thinking about suicide?" Remember that asking a suicidal person about his or her thoughts will not impel them to do it, and may in fact save their life.

I = *Intervene immediately.* Don't wait to take action. Let the person know that he or she is not alone and that someone cares enough to do something.

D = *Don't keep it secret.* Silence can only lead to increasing isolation and deterioration.

L = *Locate help.* Seek out a superior officer, chaplain, medical or mental health corpsman, crisis line worker, or other person who can intervene.

I = *Inform* the chain of command, so that they can arrange for long-term assistance, if necessary.

F = *Find someone.* Don't leave the person alone.

E = *Expedite.* Get help now. You may save someone's life.

However, effective treatment protocols targeted for depression and suicide among military personnel have lagged behind detection efforts. In this respect, military psychologists can apply some of the lessons learned in treating depression and suicidality in law enforcement officers, which in turn are based on some of the foundational principles of crisis intervention and trauma therapy (Allen, 1986; Cummings, 1996; Gilliland & James, 1993; Greenstone & Leviton, 2001; Kleespies, 1998; Miller, 1998, 2005, 2006c; Mohandie & Hatcher, 1999; Quinnet, 1998; Rodgers, 2006; Rudd et al., 1999). These include: (1) recognizing the warning signs of suicide; and (2) implementing effective strategies for: (a) prevention of suicidal crises; (b) interventions for safe resolution of a suicidal crisis; and (c) recovery and relapse prevention strategies for dealing with future depressive episodes.

Psychological Aspects of Killing

It has been said that the primary occupation of a soldier is to "kill people and break things." While many professionals undertake dirty, demanding, and/or dangerous work – firefighters, paramedics, rescue workers, airline pilots, and so on – only police officers and soldiers share the distinction of having the ability, authority, and in many cases the obligation to kill other human beings as part of their job description. One important difference is that while police officers may have to fire their weapon in the line of duty, killing another

person in these circumstances is generally regarded as a last resort and the overall emphasis is on maintaining order without the use of deadly force. Military service members, however, know that they are trained precisely for the purpose of killing the enemy and they may have to do so on a regular and large-scale basis. Even for highly trained soldiers, the taking of human life can be a profound experience that may contribute to combat stress and behavioral problems. Finally, for both military and law enforcement service members there is the ever-present risk of losing comrades to battle (Campsie et al.; Clary, 2005; Cohen, 1980; Corbett, 2004; Friedman, 2004; Galvoski & Lyons, 2004; Grossman, 1996; Grossman & Christensen, 2007; Jelinek, 2007; Miller, 2007b; Murphy, 2007; Nordland & Gegax, 2004).

Thus, there may be much that law enforcement and the military can learn from each other in dealing with the effects of killing as a vocation. Ongoing and developing clinical work in this area involves: (1) technical refinements in killing efficiency; (2) analysis of perceptual and cognitive distortions during a firefight; (3) post-shooting reaction phases and syndromes; and (4) specialized psychotherapeutic strategies for dealing with post-shooting response syndromes (Artwohl, 2002; Bohrer, 2005; Geller, 1982; Henry, 2004; Honig & Roland, 1998; Honig & Sultan, 2004; IACP, 2004; McMains, 1986a,1986b, 1991; Solomon & Horn, 1986; Toch, 2002; Wittrup, 1986; Zelig, 1986).

For example, I have found it useful to adapt a therapeutic protocol developed for law enforcement officers (Miller, 2006b, 2006c) to the needs of military service members who continue to struggle with conflicts around having killed in combat. The basic recommendations can be summarized here.

Review the facts of the incident with the service member. This allows for a relatively nonemotional narrative of the traumatic event and also helps clarify cognitive and perceptual distortions that may impede the service member's ability to remember and work through the episode(s), especially where the service member is experiencing conflict about his or her actions. Just being able to review what is known about the facts of the case in a relatively safe and nonadversarial environment may provide a needed dose of mental clarity and sanity to the situation. Solomon (1991, 1995) describes one such therapeutic format as going over the incident "frame by frame," which allows the service member to verbalize the moment-to-moment thoughts, perceptions, sensory details, feelings, and actions that occurred during the shooting incident. This format helps the service member become aware of, sort out, and understand what happened.

Review the service member's thoughts and feelings about the deadly force incident. Give him or her extra time or extra sessions to express his or her thoughts and feelings, and be sure to monitor the reaction so as neither to force the service member to divulge more than they are ready to do, nor encourage unproductive spewing or loss of control. One of the most important things the psychotherapist can do at this stage is to help modulate emotional expression so that it flows as a relief, not gushes as an oppressive added burden.

Provide authoritative and factual information about psychological reactions to a deadly force incident. The kinds of cognitive and perceptual distortions that take place during the incident, the posttraumatic symptoms and disturbances, and the sometimes uncaring or hostile reactions of service comrades or civilians may be especially distressing to the soldier, and might be interpreted by him or her as signs of going soft or crazy. Normalize these responses for the service member, taking into account his or her unique personality and set of experiences. Often, just this kind of authoritative reassurance from a credible mental health professional (and in the active military setting, a superior officer) can mitigate the service member's anxiety considerably.

Provide the opportunity for follow-up services. These may include additional individual sessions, group or family therapy, referral to support services, possible medication referral, and so on. Just as service-related psychological disability is often all about comorbidities and vicious cycles (see below), effective psychotherapy for even one piece of the problem may give the service member the confidence he or she needs to come back and address other issues that may have stayed below the surface and continued to plague his or her post-deployment adjustment. Thus, psychotherapists can encourage "positive cycles" of restrengthening and recovery.

Family and Relationship Issues

As with law enforcement officers (Miller, 2007a), special stresses and challenges apply to military service members who must transition from high-alert, life-and-death situations to more mundane family concerns, while trying to maintain a sense of perspective and balance. The difference is that while most police officers get to go home every day, military service members may be deployed for many months at a time, half a

world away. Although improved communication technology makes keeping in contact with family easier, this too can be a double-edged sword, as now the service member must deal with the threats and responsibilities of being a soldier, while simultaneously fretting over real or imagined problems on the home front. In addition, post-deployed service members may need the help of mental health practitioners in dealing with family reconnection issues, as well as problems related to intimate partner violence and/or child abuse. Finally, the special needs of children in military families are just beginning to be systematically addressed (Cohen, Goodman, Campbell, Carroll, & Campagna, 2009; Collins & Kennedy, 2008; Erbes, Polusny, MacDermid, & Compton, 2008; Hall, 2008; Lincoln, Swift, & Shorteno-Fraser, 2008; Lyons, 2009; Mabe, 2009; Marshall, Panuzio, & Taft, 2005; Palmer, 2008; Williams, 1999).

Traumatic Brain Injury, Other Injuries, and Comorbidities

Adding another level of complexity to the recovery and psychosocial adjustment of returning service members is the issue of *traumatic brain injury* (TBI), whose physical, cognitive, and emotional effects can overlap with those of PTSD, depression, and other syndromes, and compound the clinical challenges of treating military veterans (French & Parkinson, 2008; Hoge et al., 2008; Howe, 2009; Nash & Baker, 2007; Vasterling, McDonald, Ulloa, 2010; Vasterling, Verfaellie, & Sullivan, 2009). Fortunately, both military and civilian neuropsychologists are responding to the call for their expertise in evaluating, rehabilitating, and psychotherapeutically treating this special group of vets. Many of the effective modalities come from earlier work with brain-injured patients (Langer, Laatsch, & Lewis, 1999; Miller, 1993; Prigatano, 1999; Small, 1980; Wilson, 2007), while new models and methodologies continue to be developed (Barth, Isler, Helmick, Wingler, & Jaffee, 2010; Kreutzer Marwitz, Godwin, & Arango-Lasprilla, 2010; McCrea, Iverson, & McAllister, 2009; Pickett, Bender, & Gourley, 2010) for this high-need population.

Even more daunting are the treatment challenges posed by what has been, and will continue to be, the normative clinical presentation of returning veterans: comorbidities among PTSD, brain injury, chronic pain, depression, substance abuse, employment problems, family dysfunction, and even criminal behavior (Beckerman & Fontana, 1989; Bernhardt, 2009; Boscorino, 2007; Brenner, Homaifar, Adler, Wolfman, & Kemp, 2009a; Brenner, van der Ploeg, & Terrio, 2009b; Calhoun et al., 2004; Collins & Kennedy, 2008; Friel, White, & Hull, 2008; Giardino, 2009; Knack, 2009; Koren, Hilel, Idar, Hemel, & Klein, 2007; Lande, Marin, Chang, & Lande, 2008; Monson, Taft, & Fredman, 2009; Moore et al., 2009; Taft, Monson, Hebenstreit, King, & King, 2009). Mental health professionals will find themselves juggling therapeutic problems related to cognitive impairment, emotional instability, and impaired social functioning, requiring innovative treatment approaches and expansion of the traditional psychotherapeutic roles.

Conclusions

Increasingly, civilian mental health clinicians will be enlisted to evaluate and treat active duty and post-deployment service members of the OIF/OEF theaters, as well as veterans of previous wars. This article has provided a glimpse of some of the effective psychological treatment modalities that can be adapted to outpatient psychotherapeutic practice. Some of these strategies reflect the general approaches of effective psychotherapy, others draw more specifically from the lessons learned in treating law enforcement and emergency services personnel, and still others focus even more sharply on the special needs of military service members. By encouraging flexibility and adaptability in the context of a commitment to excellence in clinical care, such cross-fertilizations will hopefully make us better practitioners in providing psychological services to those who have served with honor.

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Mental Health Considerations for Military Humanitarian Aid Personnel

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Abstract: *Mental health services for veterans of humanitarian assistance (HA) missions is a critical and growing need within the United States military. The mental health impacts of such missions are both similar to and different from those experienced on combat missions, and may have an equally significant impact on the health and wellness of our troops. As the US military increasingly deploys humanitarian teams on both peacetime and contingency missions, this need can be expected to grow and must be addressed with more research and more attention to prevention, screening, and treatment. In this paper we will present a brief summary of the possible mental health effects of military HA missions, and propose remedies to address the adverse conditions that may arise in the pre-deployment, deployment, and redeployment settings. [International Journal of Emergency Mental Health, 2010, 12(3), pp. 193-198].*

Key words: *Humanitarian assistance, peacekeeping, military mental health, resilience, psychological first aid, crisis intervention, disaster mental health, counterterrorism*

Background

Non-combat missions of the United States military featuring charitable and humanitarian efforts include a wide range of activities and go by many names: humanitarian assistance, foreign disaster relief and emergency response, and peacekeeping operations, to name a few (Defense Security Cooperation Agency, 2010). Further, many humanitarian efforts fall under the larger umbrella of what the Department of Defense (DoD) calls *stability operations*; that is, "Military and civilian activities conducted across the spectrum from peace to conflict to establish or maintain order in States and regions" where "the immediate goal is to provide the local populace with security, restore essential services, and meet humanitarian needs" (DoD, 2009). The differences in the definitions, applications, and appropriateness of these missions is beyond the scope of this paper; for our purposes we will simply acknowledge that these missions take place, and refer to them as *humanitarian assistance*, or HA.

When correctly employed, HA provides many benefits not only to the host population, but also for the military. It provides the opportunity for personnel to gain valuable ex-

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perience and training, which may further prepare them for combat missions; an opportunity to engage and work with other US and host government organizations and non-governmental organizations (NGOs); a valuable public relations opportunity for the military; and fulfillment of moral obligations and humanitarian imperatives (Ritchie & Mott, 2003).

Incorrectly applied, however, HA can present many difficult challenges and problems, some of which may have deleterious impacts on the providing service member's mental health. Some potential complications include: overemphasis on quantity rather than quality of aid provided; frequent unrealistic expectations, by both patients *and* providers, of Americans' ability to solve complicated medical or other problems; and a short-term focus and obviously temporary solutions. Finally, HA providers must always face the sheer difficulty of operating in environments that are often austere, pose significant language and cultural barriers, may be vulnerable to security threats, lack proper equipment and tools, present challenges that some service members may have little experience with, and where the understanding and compliance of aid recipients may be questionable (Ritchie & Mott, 2003).

Mental Health Impact of HA Missions

The weariness that comes from operating in an austere environment with potential security threats is the first and most obvious stressor for HA providers. The mental health effects of such a mission may be similar to those experienced by combat troops: edginess, hypervigilance, aggression, withdrawal, sleep disturbances, feelings of guilt for unavoidable losses or failures, and more (see Danieli, 2002).

As mentioned previously, HA missions may exist in conjunction with contingency operations or as their own separate projects conducted during peacetime. In either situation, the Geneva Conventions forbid attack on medical providers and, if captured, spare them from treatment as prisoners of war (International Committee of the Red Cross, 2010). Unfortunately, these protective terms rarely matter in today's wars, as the military finds itself engaged with insurgent groups that are neither formal nations nor respectful of the Conventions. Further threats of violence, rioting, or theft may come from the local population itself in some environments, such as those in states of complex humanitarian emergency, and aid providers may understandably resent feeling vulnerable and threatened by the very population they are trying to help.

Military medical providers may be especially frustrated in tense security situations such as these. While allowed to carry weapons for their own personal defense and the protection of their patients, the unfamiliar and awkward juxtaposition of stethoscope and sidearm may make medical personnel uneasy. Military medical physicians, for example, may find themselves as servants of two very different oaths: their Hippocratic oath to "first do no harm" and their military oath (Sidel, 1997). This unique dilemma most certainly has the ability to produce anxiety, self-doubt, and other long-term mental health effects long after the mission is over.

HA missions also pose unique threats to military members who, because they are not focused on simply surviving, may develop more introspective, and potentially harmful, thoughts. HA providers are frequently thrust into environments where they may have little or no experience with the problems endemic to that area, and may lack the proper tools or training to address those problems; consequentially, crises of self-confidence and self-efficacy may arise when they realize the quality of care they are used to providing is simply not possible in disaster and other relief settings. Even when they are able to make small positive impacts on a local community, they may later become disillusioned when they realize the overall futility of their efforts if the mission took place in an area lacking the proper infrastructure to continue provision of services after their team departs (Ritchie & Mott, 2003).

Although the examples we use here are mostly slanted toward medical HA missions, it is important to point out that these threats are not unique to medical providers only. Support staff such as pilots, drivers, security forces and military police, and interpreters may also be struck by the unique difficulties and the accompanying mental health threats of HA missions.

Finally, the long-term mental health ramifications of bearing witness to mass suffering, disaster, and death of civilians are not to be underestimated, especially for a population for which such exposure is somewhat atypical. Much research exists on mental health effects on disaster victims and workers, and even for United Nations peacekeeping troops (Danieli, 2002), but little exists on the mental health effects of HA missions for US military professionals. This population may not have joined the military to be a disaster or humanitarian aid worker, but nonetheless may some day find themselves in those mentally challenging and troublesome environments. Just as combat troops may seek to hide their

battle experiences from family and friends who "just won't understand" or who may be "disturbed" by such stories, HA workers may also withdraw and neglect to tell their stories for the same reason, creating feelings of alienation, aloneness, and even anger towards those closest to them.

Addressing mental health on HA missions becomes especially significant when the military participates in short-notice disaster relief missions, such as their recent response to the January 2010 earthquake in Haiti. During this response, Marine units preparing for imminent combat deployment to Afghanistan were suddenly informed of their change in mission and given only 24 hours to change their gear, plans, and mindset. Their unit commander spoke of the urgent need to help his troops "(get) out of the combat mindset" and one Marine was quoted as saying, "It's one thing to see a dead body in combat. It's another thing to see dead bodies being pulled from rubble" (Talton, 2010).

In summary, despite the good intentions and high hopes behind medical and other HA missions, the military is creating an emerging class of HA veterans at high risk for mental health complications and who have very unique and special needs. Many may return home being less confident in their own abilities, more frustrated, and haunted by moral and ethical dilemmas than they may have expected from a non-combat mission (Ritchie & Mott, 2003). These traumatic experiences may prove to be no less toxic than combat exposure for the long-term mental health of our men and women in uniform. A special and urgent obligation exists to address this need for prevention, screening, and treatment.

Efforts to Address the Need

Prevention of negative mental health consequences from HA missions is both possible and highly beneficial, sparing veterans years of potential disability and the costs of psychiatric care. There exist many proven, simple techniques that may be used before and during a mission to lessen the mental health impact of traumatic exposures, and to identify personnel who may require additional follow-up with a trained mental health professional. The redeployment and reintegration periods are also critical times for interventions that will help HA veterans readjust to garrison lifestyle and retain a healthy mental state.

The military has made significant strides towards addressing the stresses and mental health effects of combat: today's soldiers are required to participate in routine mental health screenings upon redeployment (Department of Defense, 2006) and, despite the likely high false negative rate of these surveys, this is at least a step in the right direction for catching many of the cases that need clinical attention. It seems clear that if HA missions are to be conducted using military resources, there must be the same obligation to provide psychological support for HA troops, and this obligation is just as compelling as the obligation to support those in the field of combat. The adjustment and application of battlefield psychology to HA missions is, however, still in development, and for that we propose the following recommendations.

Recommendations

Borrowing from the field of physical healthcare, we recommend the utilization of a continuum of supportive care. The most widely used post-trauma continuum of care in response to crisis and disaster is referred to as Critical Incident Stress Management (CISM; Everly & Mitchell, 1999; Everly & Langlieb, 2003). CISM has been shown to be empirically effective when competently applied (Everly & Mitchell, 2007; Boscarino, Adams, & Figley, 2005; Boscarino, Adams, Foa, & Langrigan 2006).

Another potential framework that may assist mental health interventionists in the military HA setting to plan and structure an intervention program encompasses the concepts of *resistance, resilience, and recovery*. The impetus and foundation for that formulation is found in Kaminsky's (Kaminsky, 2003; Kaminsky, et al., 2007) call for a paradigmatic shift away from previous disaster mental health practices that were: (1) void of adequate assessment, (2) reactionary instead of proactive, (3) predicated upon one-time, univariate, clinical interventions, (4) confounded by the quest for clinically appropriate outcomes, and (5) practiced in a morass of confusing acronyms in the absence of a standard nomenclature.

The resistance, resilience, recovery formulation represents an outcome-driven approach to critical incident and disaster management. Basically, this model assists in strategic planning by both considering multiple intervention perspectives and subsequently aligning the tactical interventions most suited to achieve the desired outcome, that is, building resistance, enhancing resilience, or facilitating the recovery of those affected by the disaster. This intervention model is applicable to a wide variety of settings at risk for emotional crises resulting from disasters: workplaces such as hospitals, industrial organizations, educational institu-

tions, and transportation industries. Similarly, the model is especially applicable to combat and non-combat HA deployments as it addresses the need to develop protective factors pre-deployment (resistance), the need to provide in the field crisis intervention services (resilience), as well as the need to provide, in some cases, treatment and rehabilitation services (recovery). Bosacrino and Adams (2008) have suggested that the timing of service provision is essential by noting that acute phase psychotherapy in the aftermath of the terrorist attacks of 2001 was less effective than crisis intervention services and actually the psychotherapy resulted in an adverse iatrogenic effect in a virtual dose-response relationship.

Pre-deployment Protective Factors

A large burden of mental health maladies may be prevented simply by helping troops to develop more realistic expectations about the HA mission on which they are about to deploy. Battle simulation training has long been used in military and paramilitary organizations to acclimate warriors to the physical and mental challenges that are likely to be encountered in combat. While it may not be possible to simulate the exact conditions troops may encounter on HA missions, we can nonetheless provide them with accurate and realistic examples from prior missions. HA veterans could be an invaluable source of guidance in this process, helping to clarify expectations by giving briefings, sharing their stories and photos, and serving as mentors to future HA troops. Anything that enhances a sense of self-efficacy should prove useful in promoting resistance (Bandura, 1977); to this extent, training, practice, and pre-deployment cultural immersion could prove very valuable.

During Deployment

Resiliency is too often referred to as a "phenomenon that occurs after bad stuff (happens)" and thought of as special gift that only some people possess (Alvarez & Sanders, 2008). This view is both short-sighted and counter-productive to supporting troops through the mental rigors of deployment.

Interpersonal support may be the single most effective variable that promotes resilience (the ability to bounce back from adversity), but it must be applied systematically (Everly & Mitchell, 2007; Regel, 2007). For this purpose, selected unit leaders should be trained in Psychological First Aid (PFA) before deploying on HA missions. This tool, recommended by the World Health Organization (WHO, 2003) and The US Institute of Medicine (IOM, 2003), can be applied to individuals as well as small groups. It is not designed as a treatment for PTSD, but is instead a simple set of guidelines and procedures for addressing those affected by traumatic events in the acute phase. It does not require extensive psychological training to employ and can be used in virtually any environment, making it ideal for use in the acute post-exposure setting by unit leaders and other trusted team members, such as chaplains. By mitigating acute distress reactions and assessing the need for further psychological care via active listening, assessment of needs, prioritization of care and planning interventions, and help for affected persons in regaining function, the proper use of PFA could make an enormous impact on protecting HA troops from potential long-term deleterious mental health effects (Everly, 2005).

The timely and proper use of PFA after disaster and other traumatic exposures is just one intervention that we recommend for military HA units. The "buddy system" and suicide prevention efforts (US Army, 2010) employed by the US Army should be no less equally applied to HA missions. Finally, adequate periods of rest and respite must be ensured for all HA staff at regular intervals during the mission to allow for mental decompression and optimal mental health.

Post-deployment

As mentioned previously, the same redeployment screening used for combat troops should be applied to all veterans of HA missions, and new HA veterans should be paired with HA veteran mentors to encourage the normalization of reactions and ensure a continual support system.

Common reactions among returning humanitarian workers are feelings of disappointment and the relative unimportance of their garrison jobs compared to those they may have been performing on the HA mission. Many HA workers become "addicted to the high" that relief work often provides, and may feel dissatisfied and frustrated by anything less (Ritchie & Mott, 2003). For these veterans, we should provide continued opportunities for them to volunteer at home on meaningful projects that continue to let them "make a difference" and experience the same satisfaction and gratification. These veterans should be invited to brief other HA teams on the nature and consequences of an HA mission, creating a community of "comrades in arms" that would benefit both them and the outgoing team.

HA workers should be greeted upon redeployment and welcomed into the readjustment phase with the same

recognition and ceremony extended to returning combat troops. "Welcome home" parties and unit reunions should be considered integral capstone elements of all HA missions; specifically, unit reunions several weeks or months after redeployment would not only continue the sense of community and support born on the mission, but would also give mental health professionals a chance to screen HA veterans for delayed traumatic responses and signs of mental health pathology. Unit leaders and mental health professionals must facilitate access to continued care as indicated for veterans who are experiencing adverse mental health effects as a result of their mission, and their coworkers, friends and families must be included in the "net" of support that is cast around each returning HA veteran.

Summary

A cultural shift must occur regarding mental health risks and interventions for military HA providers. Mental health, like vaccinations and physical fitness, must be considered a critically important facet of force readiness and warrior care. Mental health interventions must be promoted as positive and beneficial services, and never portrayed as punitive action forced onto troops who "can't take the stress" of an HA (or any other kind of) mission. The importance of this cannot be overstated, and must be translated into policies that will prevent mental health services from having stigmatizing effects on troops' actual or perceived fitness for duty, and their quality of life inside and outside the military. If this is not ensured, the mental health vulnerabilities and services outlined in this paper will not be recognized, and the military will be doing a great disservice to this new and noble class of veteran.

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Psychological Hardiness and Meaning Making as Protection Against Sequelae in Veterans of the Wars in Iraq and Afghanistan

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Abstract: *Veterans of the wars in Iraq and Afghanistan are at an increased risk of suicide and other serious psychological sequelae following deployment. Mental health professionals must seek to detect and understand the presence of risk and resilience factors in this vulnerable population so that early intervention and treatment can prevent long-term suffering and suicide. This article explores both psychological hardiness and finding meaning in trauma as factors that can reduce the risk of pathology. Particularly when deployment-related stressors are high, these protective processes may be crucial in fostering hope and resilience. A traumatized individual may interact with the meaning-making process in one of three ways: searching for and finding meaning in the trauma, searching for and never finding meaning in the trauma, and never searching for meaning. These three styles may have a direct effect on a veteran's sense of hope or hopelessness, which likely will strongly influence suicidal tendencies and mental health. [International Journal of Emergency Mental Health, 2010, 12(3), pp. 199-206].*

Key words: *meaning making, resilience, psychological hardiness, OEF/OIF, veterans, suicide, hopelessness*

War can take a heavy toll on deployed military personnel. The wars taking place in Iraq and Afghanistan have prompted a spike in military psychological sequelae that has been rarely seen. Upon enlistment in the military, its personnel are, as a group, more intelligent and more psychologically healthy than their counterparts in the general population (Gahm, Lucenko, Retzlaff, & Fukuda, 2007). However, during wartime, military personnel experience extreme stressors that can lead to heightened psychological pathology and distress (Maguen, et al., 2008).

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Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom (OEF/OIF) have led to a drastic increase in posttraumatic stress disorder (Bartone, 2006; Gahm, et al., 2007; Lapierre, Schwelger, & LaBauve, 2007), suicide (Alvarez, 2009,), and depression (Gahm, et al., 2007; Lapierre, et al., 2007). In 2008, the suicide rate per capita in the Army rose above the national average for the first time since the Vietnam War (Alvarez, 2009). This trend continued into 2009 with the number increasing by an additional 14 deaths to total 211 Army suicides (Mount, 2009). These changes are indicative of a serious problem faced by military personnel.

Despite the recent increase in suicides and diagnoses of serious mental illness in the military, there are many perceived barriers to these individuals seeking psychiatric treatment. For some veterans, the culture of the military can discourage admission and treatment of mental illness

on both an individual and organizational level (Alvarez, 2009). Military personnel, therefore, may be surrounded by a stigmatized view of mental illness and its treatment. This stigma can worsen when a military member is mentally ill. Two independent studies found that military personnel who meet criteria for a mental illness are twice as likely as those who do not meet criteria to view mental illness as stigmatized and perceive personal barriers to obtaining mental health treatment (Hoge, et al., 2004; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). These barriers to care included embarrassment, fear of being perceived as weak, and not knowing where to get help (Pietrzak, et al., 2009). The individuals who could benefit the most from psychiatric help, therefore, are the ones who are least likely to seek it out.

The wars in Iraq and Afghanistan bear many similarities to the Vietnam War in both combat characteristics and the outcomes endured by military personnel (Hoge, et al., 2004). OEF/OIF veterans are the first United States military members since Vietnam to engage in sustained ground combat (Hoge, et al., 2004) and, therefore, may be on a trajectory similar to that endured by Vietnam veterans. Veterans of Vietnam still suffer tremendous psychological distress even though their combat experiences ended four decades ago. A comparative study found that when a sensitive set of criteria are used, the modern prevalence rate of posttraumatic stress disorder for Vietnam veterans is between 12.2% and 15.8% (Thompson, Gottesman, & Zalewski, 2006). If veterans of Iraq and Afghanistan continue without intervention, they may experience similarly long-lasting psychological pain.

Suicide is among the most serious and irreparable of psychological outcomes facing OEF/OIF veterans. In a population-based study, it was found that male veterans are twice as likely to die from suicide as their peers in the general population (Kaplan, Huguet, McFarland, & Newsome, 2007). Suicide is an act that is often difficult to predict and suicidal ideation may be easy to hide when the suicidal individual is not seeking mental health counseling. Therefore, supervisors, peers, and treatment providers of OEF/OIF veterans need a better way to detect those at risk for suicide and other serious psychological sequelae.

The causes of these problems faced by military personnel are not well understood. One contributing factor may be that military personnel have gone through a traumatic experience and are unable to make sense of it; they may find that their war experience lacks meaning. Others, however, may be able to process their traumatic experience effectively and find meaning in their deployments. *Meaning making* is the act of purposefully engaging in cognitive processing about a traumatic event in order to understand its significance (Joseph & Linley, 2005). Bartone (2005) described a lack of meaning in deployments as one of the six most important stressors affecting OEF/OIF military personnel. Meaning making is especially relevant for military personnel because of their increasing suicide rate. Hopelessness is one of the risk factors that is most closely tied to suicide (Smith, Alloy, & Abramson, 2006) and "is an even better predictor [of suicide] than depression" (Peruzzi & Bongar, 1999, p. 580). When a traumatic event is interpreted negatively, hopelessness often follows (Joseph & Linley, 2005). Therefore, having a negative outcome of one's search for meaning may be a warning sign that an individual is at increased risk for suicide.

It is essential that mental health professionals more fully understand the risk and resilience factors tied to suicide and other psychological sequelae following stressful deployments. Psychological hardiness (also referred to as psychological resilience) and one's ability to find meaning in trauma (often called meaning making) may be two essential methods of rebounding from stressful deployments. As mental health professionals understand the effects of these factors, they can better detect and intervene with those at risk for sequelae and foster further strength in those exhibiting greater resilience. Additionally, mental health professionals and military superiors may be able to cultivate these positive traits in suffering veterans.

Veteran suicide is often difficult to predict. Certain diagnoses (including substance abuse/dependence, major mood disorders, schizophrenia, and anxiety disorders such as PTSD) lead to increased risk of completed suicide based on examination of death registries (Ilgen, Conner, Valenstein, Austin, & Blow, 2010). An examination of suicidal ideation revealed similar results: veterans who screened positive for PTSD, depression, and psychosocial difficulties were at increased risk for suicidal ideation (Pietrzak, et al., 2010). This study also found that stronger social support during post-deployment and a greater sense of meaning and control were protective factors against suicidal ideation. Researchers must strive to more fully understand meaning making and psychological hardiness as protective factors so as to increase the safety of OEF/OIF veterans and be more fully prepared to screen and treat future combat veterans.

Psychological Hardiness

Despite the challenges faced by deployed military personnel, many of them are able to emerge relatively psychologically unscathed. Research seeks to understand the circumstances that lead to these individuals' resilience and how it can be fostered in those who suffer pathology.

Personality hardiness is the disposition of being open to challenges, committed to life, and feeling an internal locus of control (Kobasa, 1979). This disposition was found to protect military personnel against both physical and psychological illness when situational stress was high (Adler & Dolan, 2006; Bartone, 1999). Adler and Dolan (2006) examined 629 US Army soldiers who were deployed to Kosovo for a six-month peacekeeping mission. The authors found an interaction effect between level of hardiness and level of deployment stressors as it affected psychological health. When both hardiness and deployment stressors were high, depression levels were lower following deployment as compared to individuals with low levels of hardiness and high deployment stress. However, when deployment stressors were low, the level of hardiness had no impact on depression levels following deployment. Therefore, hardiness was most protective from psychological sequelae when deployment stressors were high. As a result of this study, Adler and Dolan described a kind of hardiness, coined *military hardiness*, that is a context-specific, military-adapted version of psychological hardiness.

An investigation of risk and resilience factors in Vietnam veterans elucidated the utility of hardiness following combat trauma. King, King, Fairbank, Keane, and Adams (1998) found that not only does level of hardiness influence reaction to life stressors but also that life stressors influence one's level of hardiness. Stressful life events, such as combat deployments, deplete hardiness and its associated coping mechanisms. This finding is doubly important: veterans with histories of multiple or intense life stressors are at increased risk for lacking hardiness and all veterans are at risk for depleted hardiness during post-deployment.

Psychological hardiness likely correlates with explanatory style (Peterson, McClellan-Buchanan, & Seligman, 1995). *Explanatory style* refers to an individual's pattern of attributions for life situations. The characteristics are internal/external, stable/unstable, and global/specific attributions. Those that are psychologically hardy are likely to have a more positive, more adaptive explanatory style. Hardy individuals may attribute negative events as being specific to that event, unlikely to occur again, and due, in part, to environmental influences. Non-hardy individuals may have trouble making these resilient attributions which can contribute, in turn, to hopelessness following trauma (Peterson, et al., 1995).

A longitudinal investigation of 276 Israeli Army recruits engaging in a challenging, four-month long training program found that hardiness protected against pathology through increasing the likelihood of problem-focused coping and encouraging support seeking, while discouraging avoidance and emotion-focused coping (Florian, Mikulincer, & Taubman, 1995). Two of the three hardiness factors, commitment and control, indirectly increased mental health via pathways related to perceiving less threat in the training program and increasing support-seeking and problem-focused coping.

During a peacekeeping deployment, hardiness was found to encourage engagement in meaningful work (Britt, Adler, & Bartone, 2001), which can lead military personnel to find positive meaning in their stressful experiences. During Operation Joint Endeavor, 161 US Army soldiers were assessed twice: once during deployment and again four or five months post-deployment. Hardiness indirectly influenced the participants' ability to find benefits in their deployment during post-deployment via finding meaning in their deployment work. The hardy soldiers identified more strongly with a peacekeeper identity, believed their job was more important, and engaged in their work more than their less hardy counterparts. The soldiers that had more contact with the local population and engaged in a more "hands-on" manner perceived greater benefits in their work post-deployment. The authors referred to this as *contextual experiences* because it helped the soldiers have a more relevant context in which to understand their peacekeeping mission. The authors mention that these contextual experiences would likely have the opposite effect (in terms of perceiving benefits during post-deployment) were the deployment a combat mission. The authors propose this difference because contextual experiences from a peacekeeping mission are by and large positive and involve helping needy others while combat-related contextual experiences are usually violent and frightening. Finding benefits in combat experiences, they propose, may be unlikely.

Bartone (2006) conducted a review of theoretical models and empirical studies of hardiness and determined that one's level of hardiness (particularly in military contexts) can be influenced by one's leaders. A West Point cohort of 435 cadets was administered several measures of performance

and success, including a measure of psychological hardiness. Hardiness was the strongest and most consistent predictor of success within the school and potential as an effective leader, as judged by peers and superiors. Bartone concludes that hardy leaders are partially rated as such because of their ability to inspire hardiness in the people they lead by encouraging high performance in stressful situations.

Military hardiness may mediate the relationship between stressors and affective states during deployments (Adler & Dolan, 2006) and can be fostered by superiors (Bartone, 2006). However, many studies of the positive, resilient psychology of veterans have used non-deployed personnel or personnel who are deployed to peace keeping missions. When on a peacekeeping mission, 32% of the benefits that veterans derived were due to the meaning that they made of that deployment (Britt, et al., 2001). This information is promising but cannot be generalized to sustained combat missions because the contextual factors for finding value in those experiences are different.

Psychological hardiness can intervene during stressful deployments and serve as a protective factor. This ability to enjoy challenges, persevere through difficulties, and attribute success to internal sources can be fostered by superiors and encouraged by engagement in meaningful work. However, hardiness can be endangered by stressful events. Therefore, military personnel who are at risk for low psychological hardiness but must endure highly stressful deployment experiences should be identified for early screening and treatment aimed at maintaining health and decreasing risk for suicide.

Coping by Meaning Making

Meaning making is usually conceptualized as the process by which an individual's global meaning and appraised meaning of a trauma are made to agree (Park & Folkman, 1997). *Global meaning* consists of one's stable beliefs about the world, which usually emphasize that the world is a safe place and one is in control of the environment. When a trauma occurs, the situational meaning of the trauma is often disparate with and threatening to the individual's global meaning. The resolution of this disagreement is similar to cognitive dissonance in that the disparity is emotionally uncomfortable for the traumatized individual and the individual attempts to make the two meanings agree in order to reduce that disparity.

In their theoretical work on meaning making, Park and Folkman (1997) proposed an exact model of the process and differentiated the outcomes of the process from the process itself. The authors asserted that traumatic experiences often reveal to the sufferer that the world is not always safe and that they lack control over preventing disaster (Park & Folkman, 1997). These violations of one's belief in a just world (Janoff-Bulman, 2006) can lead the traumatized individual to search for meaning in their experience.

Joseph and Linley (2005) proposed a model of growth following adversity that emphasized positive changes in psychological health. They asserted that during the meaning making process, the individual is searching for meaning as significance (Davis, Nolen-Hoeksema, & Larson, 1998; Joseph & Linley, 2005). Finding *meaning as significance* is, essentially, determining the value of the traumatic event in one's life and stands in contrast to *meaning as comprehensibility*, which emphasizes a basic understanding of the event as opposed to the event's impact and effect on the person (Janoff-Bulman & Frantz, 1997). Comprehension is the factor most often analyzed in studies of pathology whereas "it is meaning as significance that is necessary for growth" (Joseph & Linley, 2005, p. 268) following trauma.

One of the areas in which the search for meaning has been most thoroughly studied is traumatic bereavement. The level of distress after a loss, particularly during the initial grieving period, is likely mediated by the surviving individual's ability to makes sense of the loss (Davis, et al., 1998). However, if an individual persists in trying to find meaning in trauma for an extended period of time, their search for meaning is associated with poorer emotional adjustment without any additional gains in wellbeing. Specifically, one study of traumatic bereavement found that if an individual is unable to find meaning in their traumatic loss after six months then they are unlikely to succeed at meaning making at a future time (Davis, Wohl, & Verberg, 2007).

Traumatized individuals usually develop one of three types of relationships with the meaning making process (Davis, et al., 2007). These three possibilities include successful navigation of the meaning making process that leads to improved psychological wellbeing, a continuing and unsuccessful search for meaning that often damages psychological wellbeing, and never searching for meaning, which often has no effect on psychological wellbeing. Davis, Wohl, and Verberg (2007) conducted a study using a numerically-aided phenomenological approach with 52 adults who had lost a significant other in the Westray mine explosion 8 years earlier. Following their analyses, three clusters emerged that

described three distinct, exclusive types of meaning making. They named the first type of meaning making process "the rebuilt self." This cluster showed significant differences when compared with the other two clusters on several key variables. As a result of the death of their loved one, the participants in this cluster lost a central part of their life, made sense of or found meaning in their loss, gained inner strength, learned about themselves, and believed the changes in public policy that happened as a result of the mine explosion were positive changes. In other words, these individuals admitted that they lost something significant as a result of their trauma but, over time, were able to gain a sense of significance, which helped them understand why the traumatic event occurred. They found meaning. Individuals able to find meaning in their trauma are more likely to report positive shifts in their goals, life philosophy (Davis & Morgan, 2008), and quality of life (Russell, White, & White, 2006).

The second category, referred to as "no meaning, no growth" (Davis et al., 2007), consisted of individuals who felt that their beliefs in a just world were violated and searched for meaning in their trauma but could not find it. Davis and colleagues (2007) found that these individuals (when compared with the other two clusters) searched for meaning without finding it, changed their life philosophy for the worse, experienced shattering of their beliefs about justice and the benevolence of others, and believed that nothing good had come as a result of the mine explosion.

Curiously, it is often the individuals who never search for meaning that show the fewest pathological symptoms and are most accepting of the trauma (Davis, Wortman, Lehman, & Silver, 2000). Although these individuals experience little or no posttraumatic growth (Davis et al., 2007), they often show the greatest subjective adjustment. Most theories about this group of individuals posit that they never perceived their traumatic event as violating their just-world beliefs (Davis, et al., 2000). That is, their beliefs about the world already allow for the occurrence of terrible events. If they expect that sometimes very bad things happen, then traumatizing events never violate those expectations, which leaves no need to search for meaning. These "minimal threat, minimal growth" (Davis, et al., 2007) individuals often show a positive change in their life philosophy due to their trauma and exhibit a significantly lower level of subjective distress than those who continually search for meaning without finding it (Davis, et al., 2000). Davis and colleagues (2007) found that these individuals differed significantly from the other two clusters on not searching for meaning in the event, believing that nothing good had come as a result of the mine explosion, and asserting that their life philosophy had changed for the better.

Finding meaning in a trauma has been shown to have a large impact on the affected individual's functioning for years following the traumatic experience. However, no research has been conducted to determine how veterans of sustained combat deployments search for and assign meaning to their experiences. In practice, however, mental health professionals and military supervisors can utilize this information to assist their understanding of suffering in returning veterans. A service member's style of proceeding through the meaning making process will likely impact their tendency towards or away from suicidal ideation. If a veteran is able to find meaning in their deployment, they will experience a greater sense of control over and understanding of the world that will likely lead to increased hopefulness. In turn, greater hopefulness is a protective factor against suicide. Conversely, if a veteran is unsuccessful in navigating through the meaning making process, they will continue to feel a lack of understanding of and control over their trauma that will likely lead to increased hopelessness. This increase in hopelessness may be a strong predictor of psychological vulnerability and suicidal ideation.

Few researchers have investigated hope as a manifestation of psychological wellbeing following trauma. Hope following trauma is an essential variable to study because it is a form of psychological wellbeing that is less likely to be influenced by temporary affective states as it is the "interaction of a person's agency and pathways in relation to successful goal attainment" (McCarter, 2007, p.112). Furthermore, many traumatized individuals are at risk for feelings of hopelessness that can lead to depression and suicide. Since the meaning making process may adaptively shift one's conceptualizations of trauma and the world, a possible outcome would be increased hopefulness. Therefore, hope may be a natural manifestation of psychological wellbeing following successful meaning making.

Psychologically hardy individuals are, by definition, more open to challenges and more committed (Kobasa, 1979) to obtaining psychological well-being. Therefore, hardy military personnel may be more likely to engage in purposeful processing about deployment traumas. They may strive for meaning more than their less hardy counterparts. In fact, "a critical aspect of the hardiness resiliency mechanism likely involves the interpretation, or the meaning that people attach to events around them" (Bartone, 2006,

p. 138), which indicates that hardiness is likely to directly influence the amount of meaning that an individual is able to derive from a traumatic experience. This, in turn, may have a large impact on veterans' psychological health following a stressful deployment.

Clinical Utility and Conclusions

Clinicians and other mental health workers are an important component of veterans' mental health and safety, particularly during and following traumatic deployment experiences. Military superiors, therapists, and chaplains can seek to identify the veterans that are psychologically harmed by trauma and help these individuals as they search for meaning.

The veterans that may be most vulnerable to the effects of traumatic deployment experiences are those who are low in hardiness and/or struggling with finding meaning in their trauma. These individuals can be assessed by formal measures of the aforementioned constructs and/or by unstructured interviewing. There are many measures of psychological hardiness and one of the most highly regarded due to its sound psychometrics and strong conceptual foundation (Funk, 1992) is the Dispositional Resilience Scale (Bartone, 2006). An additional strength is that this scale was normed on members of the US Army.

Using an unstructured format, concerned parties can interview suffering veterans to understand their level of hardiness and level of success in the meaning making process. Hardiness is comprised of three facets: feeling an internal locus of control, being open to challenges, and having a commitment to leading a meaningful life. If a veteran appears to feel out of control of their world, uncomfortable with challenges, and unfulfilled they are likely low in psychological hardiness. Likewise, if a veteran has had many traumatic or adversarial experiences in the past, they may be at risk for a paucity of hardiness. Meaning making is best assessed directly (Davis & Morgan, 2008; Holland, Currier, & Neimeyer, 2006; Park, 2008) by inquiring about how much effort the affected individual has put into finding meaning in their traumatic deployment, and how successful they think they have been in finding meaning. If an individual has been expending considerable effort without congruent success, they may be at risk for struggling psychologically.

Once a veteran is identified as being at risk for psychological sequelae, thorough assessment is warranted. Suicidality should be monitored closely and areas of strength (including social support, spiritual support, and a routine that can foster safety) can be emphasized to maximize psychological health. Counseling with a focus on helping the individual find meaningful, healing endeavors may be helpful; for example, researchers have emphasized the importance of spirituality as a method of searching for and finding meaning following trauma. If the affected veteran can be helped to see genuine benefits in their deployment experiences, they may be able to more successfully navigate the meaning making process.

Clinicians and researchers should also seek to understand the traits of the veterans who are psychologically unharmed by trauma, or recover quickly from it, and determine if these traits can be fostered in at-risk veterans.

Veterans of the recent wars in Iraq and Afghanistan may be deeply affected by their deployment experiences as evidenced by the radical increase in war-related pathology; the most central and problematic issue affecting military personnel is suicide. The barriers to mental health treatment that military personnel are confronted with exacerbate these problems. The causes for suicide are not always well understood but a lack of meaning in traumatizing events and depleted levels of psychological hardiness may be contributing factors. These important concepts, however, have not been studied in veterans. Future research must seek to explore these constructs with veterans to improve the services delivered before, during, and after deployments.

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War Then and Now: From Surviving to Thriving

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Abstract: *Call it* Shell Shock, Battle Fatigue *or* PTSD. *Throughout history, war has produced, to one degree or another, an acute and chronic behavioral health condition amongst returning personnel. The lack and fluidity of a clearly identifiable zone of combat has placed more soldiers at risk. Changes in the nature of war have led to higher rates of both physical and mental injury, as well as improved treatment interventions. The fact that soldiers are surviving what in the past would have been deadly physical injuries has presented a greater need to address the emotional casualties that remain. Improved programs proactively emphasizing resiliency and stress inoculation as well as formal reintegration strategies, assessment, individualized treatment planning and follow-up, have resulted in improved outcomes. Future developments in the field of military psychology should only further improve the current situation. [International Journal of Emergency Mental Health, 2010, 12(3), pp. 207-212].*

Key words: *military, reintegration, PTSD, TBI, behavioral health programs, resiliency*

Reactions to war have been around as long as war itself (Cantrell & Dean, 2005). In World War I, it was known as *Shell Shock* and those so afflicted were ignored, labeled as lacking in courage or, if their symptoms were severe enough, they were evacuated from the scene and sent home to readjust on their own. Regardless of the "intervention," these soldiers were almost guaranteed that their condition would remain and, now frozen in time, likely become permanent. These "ticking time bombs" often walked unknowingly amongst the populace either ready to explode, given the right set of circumstances, or just gradually worsening with the passage of time, lacking the necessary coping skills to deal with what otherwise might have been seen as normal life stressors. Left to fend on their own, they frequently experienced a sense of generalized anxiety. The unlucky ones were also known to have periodic flashbacks and chronic, often debilitating, psychiatric conditions.

The advent of World War II, with its ineffective screening and little or no treatment, continued this trend. The addition of a new intervention, referred to as "three hots and a cot," did little to reduce the negative impact on those afflicted with what came to be known as *battle fatigue*. The temporary break

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in service from the front line to a rear post, frequently absent any other significant intervention, was hardly sufficient.

The Korean War initially produced a high rate of psychiatric casualties, followed by a dramatic decrease in chronic conditions. A more comprehensive and diverse intervention had been developed and came to be known as the principle of *PIES* and emphasized taking into account the factors of proximity, immediacy, expectancy, and simplicity when initially assessing those identified as emotionally impaired. While the program relied heavily on the skills of first line supervisors to assess and refer, little training was afforded those most likely to set the process in motion. Nonetheless, increased effectiveness was noted in reducing the long-term consequences of developing life-altering posttraumatic stress disorder (PTSD; Ritchie, 2010).

Vietnam veterans, victims of the social climate and a by-product of another new kind of warfare, brought high levels of alcohol and drug use amongst front line personnel and the identification of what came to be known as *posttraumatic stress disorder*. Few avoided the experience of at least acute reactions, including nightmares, flashbacks, hypervigilance or increased physiological arousal and increased irritability, numbing and avoidance or social isolation. Many more pushed these feelings underground only to resurface years later, triggered by some apparently unrelated event resulting in impairment in social or occupational functioning. Those not so lucky ended up on skid row, in rescue missions, or merely roaming the streets homeless and chronically mentally ill (Ritchie, 2010).

Persian Gulf syndrome, a consequence of Desert Shield/Storm, has been most notable for producing medically unexplained physical symptoms along with all the psychiatric problems previously discussed. Advancements in routine front line mental health treatment had become more commonplace following 9/11, with "therapy by walking around" and greater acceptance of these types of problems by those in leadership positions. Proactive interventions, while still a rarity, were becoming more commonplace (Mental Health Advisory Team VI, 2009).

Operation Enduring Freedom/Operation Iraqi Freedom have presented several new issues not encountered or at least not routinely addressed in previous wars. These include the activation of National Guard and Reserve personnel, many of whom never anticipated wartime activation or re-activation when they originally signed up so many years ago, though it was, of course, always a possibility; multiple and extended deployments; short dwell time between deployments; a variety of novel battlefield stressors for which personnel had not previously trained, including IEDs, "urban" ambushes, severe sleep deprivation and weather conditions; direct combat even for units previously designated as support and sustainment units; severely wounded soldiers, including those with diagnosed and undiagnosed traumatic brain injury (TBI); injured children and large numbers of detainees, along with a frequently changing sense of mission (Hosek, Kavanagh and Miller, 2006; Ritchie, 2010; MHAT VI, 2009; Tanielian, Jaycox, & Rand Corporation, 2008). Instead of a clearly defined war zone, combat interactions were commonplace in what would otherwise have been expected to be safety zones. Urban and guerilla warfare, previously unfamiliar to both those in charge and those on the ground, were the predominant environment and rules under which these wars would be fought (IACP, 2009).

Ritchie, in her preliminary report MHAT-VII (pending), found that on the positive side, soldiers were generally experiencing a strong sense of personal support from the American people. Training to provide monitoring and early intervention for those experiencing potential problems was more common amongst senior staff. Numerous newly created programs were in development and/or various stages of implementation, with the general intent of providing greater access to all forms of assistance including behavioral health interventions to soldiers and their families. Suicide prevention and issues surrounding relationship management were specifically identified and programs were developed to target increasing rates of suicide and decreasing rates of marital satisfaction and stability, particularly those rising to the level of heightened risk of domestic violence (Ritchie, 2010). More than any prior war, emphasis began focusing on the family and proactively intervening (DoD, 2010; IACP, 2010).

Stigma and other barriers to care continue to present as challenges. Notably, however, the Services have identified this as a problem and a priority for intervention. Inoculation training, with soldiers utilizing state of the art interactive computer technology (Hennigan, 2010) followed by scenario-based training in realistic appearing environments prior to deployment began several years ago. While interactive computer technology training is certainly of benefit and the more realistic the better, there is still nothing that compares to real life, with scenario-based training at least a good second best (Schmidt & Lee, 2005).

An expansion on this training theme is now being further explored to provide increased levels of emotional resiliency among deployed personnel. Training in early problem recognition and improved tools for assessing behavioral health difficulties have been identified as needs for further focus. While not everyone will go on to develop chronic PTSD, the key remains differentiating those at greatest risk. Statistics typically report a 25% to 30% rate of PTSD (Dingfelder, 2009) amongst returning personnel. For many returning personnel, there is a honeymoon period of 3 to 4 months followed by a period of increasing life dissatisfaction (Armstrong, Best, & Domenici, 2006). This can be either transient or the beginning of what may turn into full blown PTSD. This fact can result in our failing to adequately screen out those most at risk for development of PTSD, thereby potentially incurring organizational liability amongst personnel applying for employment in high risk professions. A six-month time delay between military discharge and the hiring of these personnel into high risk occupations would allow for greater ability to assess and intervene where necessary.

More soldiers are surviving greater levels of physical trauma than in any prior war due to advancements in emergency medicine (Regan, 2004). This has also resulted, however, in an increased population of personnel experiencing traumatic brain injuries (TBI) as well as other traumas known to place an individual at increased risk of behavioral acting out (Gladwell, 2006; LeDoux, 1996).

Deployment-related stress reactions range from mild to severe, including acute combat stress and operational stress reactions. They can be temporary or chronic, acute or long term posttraumatic stress reactions. Behavioral symptoms, such as irritability, bad dreams and sleeplessness, as well as a negative impact on family and friendships, can result from a host of behavioral difficulties including a lack of predictability. Combat soldiers themselves also report experiencing increased risk of alcohol abuse, compassion fatigue, and suicidal thoughts and behaviors. Those experiencing moderate to severe reactions are reported to exhibit increased risk-taking behaviors, as well as symptoms of depression, alcohol dependence, and higher rates of completed suicide (IACP, 2010).

Soldiers in Iraq and Afghanistan continue to face significant stress, particularly from repeated deployments and shortened *dwell time* or time between deployments (Hosek, 2006; MHAT VI, 2009). The latter, in fact, has a greater impact than the former, meaning that soldiers experience fewer symptoms of stress and strain the greater the length of time between deployments, even in the midst of repeated deployments. Combat units, also known as maneuver units, have also been found to experience greater behavioral health problems than individuals in sustainment and support units. After 24 months of dwell time, personnel return to close to baseline rates of pre-morbid behavioral health issues with a complete return to status quo at 30 to 36 months of dwell time (Ritchie,2010).

Personnel overall, however, report being more adequately prepared for the stresses of deployment as well as increased levels of morale. In contrast, more soldiers report marital strain and the intent to divorce or separate as a result of their deployments. Information was obtained from a randomized group of soldiers from maneuver platoons as well as those from support or sustainment units. Information was obtained via focus groups, interviews, and surveys (Ritchie, 2010). In terms of barriers to support, soldiers in support or sustainment units reported lower barriers to care and stigma than soldiers in combat units. National Guard and Reserve personnel serving in the role of "guards" were also found to have higher rates of psychological problems (Ritchie, 2010). Soldiers deployed in Afghanistan versus Iraq were found to experience more combat exposure and lower morale as well as a reduced ratio of behavioral health providers in forward positions, the latter likely at least partly accounting for this finding (Ritchie, 2010).

The variables most related to increased coping and resilience during and following deployment were factors related to strong leadership skills among first line supervisors and managers. All factors being equal, the perception of strong, positive officer leadership, particularly among NCOs, was most strongly associated with resilient platoons. Platoons with strong horizontal or collegial cohesion, as well as vertical bonding and trust, experienced increased esprit de corps, which is critical overall to a variety of improved mental health outcomes amongst deployed personnel (Dingfelder, 2009; Ritchie, 2010; Wright et al., 2009).

A final report of the Department of Defense task force on the presentation of suicide by members of the armed forces entitled, The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives (August, 2010), reflects a significant overall increase in the rate of suicide over the past decade; however the majority of the increase appears to be among those serving within two of the services, the Army and Marines. It is unclear, at this point, whether this

is due to the nature of the mission or a function of the differences in the personnel attracted to the various armed services. Agreement does exist that improved coordination and consistency of the efforts employed in and between the various branches of the military would have a significant effect on reducing the rate of completed suicides amongst personnel serving in all the armed forces. In fact, the report reflects 76 targeted actionable recommendations set for implementation in 2010/11. Particular emphasis is placed on the consistency and coordination of care over the continuum of a soldier's phases of deployment and re-integration (DoD, 2010; Knox et al., 2010). While active duty personnel employed by certain branches of the military have recently shown a particularly high rate of attempted or completed suicide, it should be noted that the overall suicide rate among all of the services remains comparable to that found among law enforcement personnel, a reasonably comparable group (Honig, 2009).

With deployments continuing to change over time, new issues are likely to continue to emerge. It is therefore critical to monitor the behavioral health status of the troops and evaluate our behavioral health delivery system. Early intervention, particularly in the case of individuals suffering concussions, typically result in improved outcomes and lower levels of traumatic brain injury (Ritchie, 2010; Warden, 2006). Use of proactive, diverse intervention teams may be a key to increased successful intervention, particularly in light of the perceived increased barriers to intervention and stigma associated with obtaining assistance (Armstrong et al., 2006; IACP, 2010; Ritchie, 2010: Warden, 2006). Education provided in the form of self help books, training of soldiers and family members in addition to supervisors, increased availability of trained behavioral health providers including those specialized in dealing with children of activated personnel, increased embedding of uniformed mental health providers into combat units, enhanced and improved access to internet resources, combined with gradual cultural change, from the bottom up, has often been found to be a significant key to overcoming these barriers (Armstrong et al., 2006; IACP, 2010).

Initially, the military began robust surveillance of personnel both in theater and upon their return home; however the numerous barriers to treatment and follow up, particularly as it relates to returning National Guard and Reserve personnel, quickly became apparent, particularly as it related to self identification of psychiatric symptoms. While a post deployment health assessment was initiated early on, numerous factors interfered with personnel self identifying symptoms of which they were aware. A temporary euphoria also often took hold, delaying intervention for months prior to the euphoria's dissipation and the settling in of long term symptomatology. Over time, improved assessment tools combined with greater educational and intervention efforts have begun dispelling the stigma associated with acute and/or chronic PTSD. Assessing and addressing the long term effects of TBI have also become more proactive. Greater emphasis on suicide prevention and peer to peer intervention has also begun to occur. Efforts to integrate the various helping agencies including medical, behavioral health, chaplains, and family programs, both pre- and post-deployment, are also on the rise. An evolving comprehensive behavioral health strategy is beginning to emerge, focusing on stress inoculation, proactive intervention and follow up in an effort to address risk reduction (Armstrong et al., 2006; DoD, 2010; Ritchie, 2010; Wright et al., 2009).

The Army alone has implemented 45 initiatives under the categories of access to care, resiliency, quality of care, and surveillance (Ritchie, 2010). The number of visits to behavioral health providers has more than doubled since 2003 with a 68% increase in behavioral health providers since 2007. Stigma reduction efforts have focused on "Battlemind" training with emphasis on inoculation and resiliency, as well as early problem identification and intervention. Many of the more effective programs have emphasized the use of peers helping peers, with assignment of a military liaison officer to provide prolonged outreach over the course of at least the first year transition back to civilian life. Research has shown personnel may be more likely to initially confide in another Vet versus a supervisor or behavioral health professional (IACP, 2009; IACP, 2010; Ritchie, 2010).

Improved policies to better screen for PTSD and TBI, in particular, have been implemented, as well as follow-up program evaluation to better provide a feedback loop to allow for modification of existing and new programs. Future efforts will hopefully include improved standardized assessments, both in theater and at regular intervals following discharge of both active duty and civilian-activated personnel and a strong virtual component to allow for personalized self assessment and intervention, including integrated behavioral health and primary care, as well as telemedicine implemented nationally and internationally. Training of soldiers, leaders,and family members to recognize and respond to issues is a critical component, as is program evaluation and modification (IACP, 2009; Ritchie, 2010).

In summary, with a high op-tempo and difficulties in providing behavioral health care to remote areas, continuing challenges are likely to remain for some time. These challenges include the ability to provide an array of services, reducing the stigma associated with help-seeking behavior, the need to increase the number of providers, particularly those experienced in treating soldiers with PTSD and/or TBI, as well as developing improved methods for addressing issues related to re-integration and pain control.

The next issue of great significance will likely involve legal complications associated with personnel diagnosed by the military as having symptoms of PTSD while at the same time those personnel may desire to return to former high risk occupations. Inherent in the diagnosis of PTSD, however, are symptoms that would interfere with the required emotional stability required of personnel in these types of occupations. More to come on this issue as the attorneys further address this very delicate area.

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America's Sons and Daughters

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Key words: *Marines, reintegration, PTSD, suicide, suicide prevention*

My reassignment to the desolate, harsh environment of the Mojave Desert came as quite a shock. Leaving my family to join sturdy, hard core Marines at the largest Marine Corps base in the world, all of whom were deploying to Operation Iraqi Freedom II was exhilarating and distressing. It was hard to believe that young men and women: warriors, olympians, and brave athletes in the prime of their lives could be so shattered by the horrors of war. Youthful and battle-hardened combatants returned from Iraq with Purple Hearts, Bronze Stars and battle decorations for bravery under fire while saving fellow Marines and serving their country. Many veterans returned without limbs. In their dreams and memories however, they relive the violent episodes of witnessing a 50mm round taking a life, the deadly effects of Improvised Explosive Devices (IEDs), and the all too familiar process of "clearing a room" of insurgents, where the first Marine entering a room was usually wounded or killed.

Being a registered trainer in Critical Incident Stress Management (CISM), to me this four-year assignment to the Marine Air Ground Combat Center, at Twentynine Palms, California would involve guiding Marines through combat nightmares while resolving multiple drug abuse issues, including prescription medications, alcohol, and illegal drugs. Even with my specialty in substance abuse, treating Snipers and Forward Assault Special Tactical Unit teams returning from Iraq proved to be a challenge. As a seasoned CISM trainer and therapist, all my skills and insights would be required of me. Hundreds of hours of group therapy and psycho-educational groups with hundreds of Marines resulted in my own secondary traumatization and Compassion Fatigue.

Many Marines had become frozen in their emotions and immobilized in their psyches, retreating into an emotional survival mode, burying their feelings, stuck in the emotional trenches of war. Stymied, they were afflicted by posttraumatic stress disorder (PTSD). But, where was the resiliency and psychological hardening training? Where were the Critical Incident Stress Debriefings (CISD) and tactical interventions? They were few to none. When I did conduct a Defusing, a CISD, or Crisis Management Brief for widows, parents of deceased Marines, and combat survivors it was a gut wrenching and emotionally draining experience. Attempting to put a layer of understanding on top of this emotional hemorrhaging is a challenge for any seasoned trainer. Even though their psychological wounds remained, the volume was turned down on the volatility. Hate was replaced by compassion, and grief with forgiveness and understanding.

Hilary Valdez, MS, is a Survivor Outreach Services Coordinator for the U.S. Army in Tokyo, Japan and provides services that support the Families of Fallen Soldiers. He conducts support groups and life skills training to the community and leadership.

I have seen absolute miracles occur in a CISD. Pain, agony, crying, survivor guilt, and profuse swearing have all segued into a sense of global understanding. So what does the treatment community offer a young female or male warrior upon their return from the emotional fragmentation and psychological paradoxes of combat? What other treatments do we have available for our heroes? Juxtaposed between fragility and strength, to whom could Marines turn? What could they turn to? Where could they go for help? Only in the company of fellow warriors and comrades in arms could they find temporary solace. But peace always seemed just beyond their grasp. It was a grueling psychological struggle, searching for the balance between nightmares and sanity, peace and violence, hope and despair, between trust and suspicion. Hypervigilance was a constant companion.

As the weeks and months pass, untreated symptoms can turn into depression, pathologies emerge, PTSD shows its ugly head, and maladaptive behaviors surface as Marines are forced to mask their emotions while hiding their haunting demons and the atrocities of war behind a veneer of normalcy. In the solitude of their homes, each Marine has to relive the pain and agony and actual horrors of seeing friends become a "pink cloud" (the result of a 50mm round with an explosive device that hits a human body and totally disintegrates the person into a vapor/spray). To live and tell about the event in a CISD takes emotional courage. It is hard to discount the traumatic effect and total psycho-biological shock of a traumatic death. Yet some, dare to dip their heads into the psychological pool of wellness to gain a deeper understanding into the healing power of the human spirit.

Is it treatment or punishment? Stoically, each Marine accepted his or her assignment to treatment, usually for an alcohol-related incident or a drug pop; some Marines choked back their resentment and anger while becoming compliant to an indifferent and punitive treatment regime. At times, accepting treatment meant losing a top secret clearance, a chance at a new duty station, orders to a school, going home on leave, or missing out on a dream duty assignment. Better to stay under the radar and not admit to any symptoms. Acknowledging "weakness" or a problem meant being admitted to in-patient treatment (Level Four) for a month or more, but it was the 4 - 6 month waiting list and being in limbo, which consisted of being separated from friends, living in transient quarters, and having a sense of isolation, that was truly debilitating. During this period of disconnection from a Unit, while attending either Level 1, 2, or 3 pre-hospital treatments, Marines had a chance to relive the stories of the violence of combat, shed tears, vent agony, pain, and humiliation, and reveal horror stories about man's brutal inhumanity. But for some Marines, all the violent episodes created a deadly mixture resulting in suicide and spousal abuse, while unleashing acts of uncontrolled spontaneous aggression, eventually leading to jail or an undesirable discharge from the Corps. They never made it to Level 4.

Why do some Marines choose suicide? What made them lose hope? What happened to the ray of brightness and belief in humanity that led them to join the Corps? Was it multiple deployments and the operational tempo? Relationship issues? Marines do not voluntarily identify themselves as suicidal at post-deployment screenings. So, how do we identify mental distress? In 2009 the Corps reported 24 suicides per 100,000, the highest rate throughout the military according to service statistics. In 2010, from January through October, 139 Marines attempted suicide. The Army's suicide completion rate last year was 22 per 100,000 while the Air Force's was 15.5 and the Navy's was 13.3. One of the hardest days for me was when a father grabbed me and began shaking me, repeatedly shouting, "Why is my son dead? Why are you alive?" while sobbing uncontrollably, then collapsing in my arms. It was humbling, sad, and painful. When it comes to fallen warriors, better have some psychological leadership skills under your vest. Better have some psychological muscles.

The Corps has numerous training programs on suicide prevention, but the motto "Suck-it-up Butter Cup" is the Marine slogan that remains today. No sissies here. No problems here. Everyone is fit to fight and combat ready. It does not matter that Marines are getting DUIs, popping positive for illicit drugs, fighting each other, abusing spouses and their kids, all the while becoming increasingly indifferent to military protocol and discipline. It does not matter if he or she has a Purple Heart, a Bronze Star and battle decorations for bravery. Treatment in many cases worked against Marines; it was career ending.

So, what is the Battle Plan for saving Marines? The concept is to salvage good Marines and preserve morale. Everyone makes poor decisions at times. But we learn from our mistakes. Mistakes give us wisdom. It's time for a cultural change. Make it okay to call for help and to receive assistance for the "hidden wounds" of combat. Currently, among the services of Marine Corps Community Services (MCCS) One Source supplements the existing support system for Marines and their families by providing assistance 24 hours a day,

7 days a week via toll free telephone and Internet access. Marines or family members seeking assistance can call 800-869-0278 in CONUS, or 800-8690-2788 OCONUS. MCCS One Source Online can be visited at www.mccsonesource.com; Userid - marines; password - semperfi.

Here's my Battle Plan – my recommendations.

1) It's time to modify the drug policy. If it's the first offense: treatment. No reduction in rank or Dishonorable Discharge. Second offense: discharge.

2) With alcohol, provide Courtesy Rides, but without any punitive action, reduction in rank or disciplinary action. A verbal warning off the record will suffice. But the second offense - reduction in rank and treatment.

3) Expand and modify post-deployment briefs and include a CISD and appropriate CISM interventions.

4) Release Marines early from work. Provide one half-day a week for family time.

5) Reduce the number of suicide workshops and improve their substance and content. Provide resiliency training, psychological hardening skills, mental fitness workshops, socialization training, coping with life, communications, and conflict resolution seminars.

6) Improve after-care services following in-patient treatment.

7) Include more suicide prevention and intervention small group role-playing scenarios.

8) Survey Marines at the Platoon level and ask for their input on suicide prevention.

9) Up-grade and improve gym facilities.

10) If the Base has a band, have them play colors once a week and perform John Philip Sousa military songs.

11) Have small unit discussions regarding Combat experiences.

12) Have a monthly bar-b-que.

13) Treat female Marines with respect. The Marine Corps is not exclusively a "Man's Corps." It's America's Corps.

14) Increase the mental health budget and mental health billets in the military services and at the Veteran's Administration.

15) Increase the basic pay for lower enlisted Marines.

16) Provide Family Readiness Group (FRG) Training to include ethics and cross-cultural training to help diminish the squabbles among wives of lower enlisted and Officer wives.

17) At the end of the day, don't choke back your feelings. If you can feel it, you can heal it. Volunteer to help yourself.

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For more information email George S. Everly, Jr., PhD, ABPP, RSI Executive Director at rsi@umbctrainingcenters.com.

Selected Annotated Journal Resources

Brynn Huyssen, M.S. and Elizabeth A. Bailey, M.S.

Hossain, M., Zimmerman, C., Abas, M., Light, M., & Watts, C. (2010). The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health, 100*(12), 2442-2449.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF ARTICLE

- To investigate the association among trauma experienced during trafficking and subsequent symptoms of depression, anxiety, and PTSD in a sample of adolescent girls and women who were receiving post-trafficking services.

METHODS

Participants

- Participants consisted of 204 women and girls (ages 15-45 years) who had experienced sexual exploitation through trafficking and were receiving post-trafficking services (medical care, mental health assessment, legal and immigration advice) through a nongovernmental or international organizations in Belgium, Bulgaria, the Czech Republic, Italy, Moldova, Ukraine and the United Kingdom
- Participants were interviewed only after they sought post-trafficking services and were not still involved in trafficking.

Materials and Procedure

- *Trauma Experience:* Participants were asked if they had experienced various forms of abuse that are associated with trafficking: sexual violence (defined as forced or coerced sex), physical violence (defined as being hit, kicked or physically injured), physical violence with a weapon, threats of harm against them or loved ones, restricted freedom, and severe injury.
- *Depression and Anxiety*: The depression and anxiety subscales of the Brief Symptom Inventory (BSI) were used to assess current depression and anxiety symptoms.
- *PTSD:* The PTSD subscale of the Harvard Trauma Questionnaire (HTQ) was used to assess current PTSD symptoms.

RESULTS

- While trafficking, 80% of participants reported experiencing sexual violence, threats of harm to themselves and restricted freedom.
- Of all participants, 80% met the cutoffs for at least one of the three disorders (55% met study criteria for high depressive symptoms, 48% met study criteria for high anxiety symptoms, and 77% reported PTSD symptoms). Of the sample, 57% met cutoff scores for all three of the disorders (depression, anxiety and PTSD).
- Experiencing sexual violence during trafficking was positively associated with PTSD symptoms. Experiencing physical violence during trafficking was positively associated with anxiety symptoms. Experiencing sexual violence and severe injury were associated with depression, anxiety and PTSD symptoms.

- Participants who had been trafficking for over six months were twice as likely to have high symptoms of depression and anxiety than were those participants who had been trafficking for less than six months.

CONCLUSIONS/SUMMARY

- There is an association between trafficking of adolescent girls and women and subsequent depression, anxiety and PTSD symptoms.
- Length of time spent trafficking may lead to a higher risk mental health symptoms in adolescent girls and women.

CONTRIBUTIONS/IMPLICATIONS

- Much research has been conducted on survivors of trauma and abuse, but less literature exists that addresses the needs of trafficking survivors. Further studies should be done to identify appropriate and effective interventions to assess and treat the mental health needs of trafficking survivors.

Harley, M., Kelleher, I., Clarke, M., Lynch, F., Arseneault, L., Connor, D., Fitzpatrick, C., & Cannon, M. (2010). Cannabis use and childhood trauma interact additively to increase the risk of psychotic symptoms in adolescence. *Psychological Medicine, 40,* **1627-1634.**

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF ARTICLE

- To explore whether there is a significant interaction among trauma experienced in childhood and/or adolescence and cannabis use on increased risk of psychotic symptoms in adolescence.

METHODS

Participants

- A total of 117 adolescents aged 12-15 years who were identified "at-risk" by scoring in the clinical range on the Children's Depression Inventory (CDI) and/or on the Strengths and Difficulties Questionnaire (SDQ) and/or if they endorsed Item 9 on the CDI ("I want to kill myself").
- Participants were part of a larger study ("The Challenging Times Study" conducted by the Child and Adolescent Mental Health Team in Dublin, Ireland) that investigated the incidence of psychiatric disorders among Irish youth in urban schools.
- A control group of 94 adolescents matched for gender and school was also used.

Procedure

- The Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime Versions (K-SADS-PL) was used to interview adolescents and parents separately.
    - The Psychosis section was used to inquire about psychotic symptoms, including hallucinations and delusions.
    - The Substance Misuse section was used to inquire about previous use of cannabis and frequency.
    - Childhood trauma (both physical and sexual abuse) was assessed by various questions on the K-SADS related to abuse.
    - The Posttraumatic Stress Disorder section was used to inquire about exposure to domestic violence.
    - Socioeconomic status of each participant was recorded by occupation of parents, as assessed by the Irish Social Class Scale.

RESULTS

- Adolescents who reported using cannabis were five times more likely to have experienced at least one psychotic symptom than those who reported no previous use.
- Adolescents who experienced trauma were almost five times more likely to use cannabis and also five times more likely to have experienced psychotic symptoms than those who did not experience trauma in childhood or adolescence.
- Previous trauma and cannabis use demonstrated an interaction for increased risk for psychotic symptoms in adolescence. Among adolescents who reported childhood trauma and cannabis use, it was estimated that 83% of the occurrence of psychotic symptoms could be attributed to an interaction between the two.

CONCLUSIONS/SUMMARY

- Cannabis use and childhood trauma increase the risk for psychotic symptoms in a sample of adolescents.
- There is a greater than additive interaction between cannabis use and childhood trauma with regard to development of psychotic symptoms in adolescence.

CONTRIBUTIONS/IMPLICATIONS

- Research has examined the association between cannabis use and psychotic symptoms, but additional research should be conducted that investigates how previous trauma and abuse impacts this association.
- Adolescents, especially those who experienced childhood trauma, may benefit from substance abuse education and interventions to reduce substance use and possible risk for the development of psychotic symptoms.

Sansone, R. A., Mueller, M., Mercer, A., & Wiederman, M. W. (2010). Childhood trauma and pain medication prescription in adulthood. *International Journal of Psychiatry in Clinical Practice*, *14*, **248-251.**

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF ARTICLE

- To determine if there is an association between five types of reported childhood trauma and prescription of pain medications in adulthood.

METHODS

Participants

- Participants consisted of 80 patients (21 men and 59 women) over the age of 18 years who were receiving outpatient medical care in an internal medicine clinic.
- Participants were excluded if they had cognitive, intellectual, medical, or psychiatric limitations that would impact their ability to complete a survey. Participants were also excluded if they had been receiving care from the clinic for less than four weeks.

Materials and Procedure

- Participants completed a survey that inquired about demographic information and five types of childhood trauma. Participants were asked if, before the age of 12 years, they ever experienced five types of trauma and responded in a yes/no format.
- The five types of childhood trauma were: sexual abuse (defined as any sexual activity against the participant's will), physical abuse (defined as any inappropriate physical assault that left physical damage or caused pain to the participant), emotional abuse (verbal and nonverbal behaviors that were meant to hurt or control the participant), physical neglect (not having basic needs met), and witnessing violence (that did not directly involve the participant).
- Participants' medical records over the past 4 weeks were reviewed to determine how many (if any) prescriptions for pain medication were written.
- Pain medications were defined as narcotic analgesics, non-steroidal anti-inflammatory drugs ("NSAIDs") and "other" (amitriptyline, duloxetine, gabapentin).

RESULTS

- The number of types of childhood trauma experienced correlated with prescriptions of pain medications classified as "NSAIDs, and "other", as well as with the total number of pain medications prescribed.
- The number of types of childhood trauma experienced did not correlate with narcotic analgesic prescription or dosing amounts.
- No specific type of childhood trauma was more strongly associated with pain medication prescription than another type of trauma.

CONCLUSIONS/SUMMARY

- Adults who reported experiencing childhood trauma are prescribed more pain medications in adulthood than those who reported that they did not experience trauma in childhood.
- Childhood adversity, in general, is related to prescription of pain medications in adulthood.

CONTRIBUTIONS/IMPLICATIONS

- Several previous studies have documented the association between experiencing childhood trauma and chronic pain in adulthood; however, most of these studies relied on participant self-reports of pain. This is the first study to assess pain more objectively (by number and type of prescription written).
- More controlled research is needed to investigate whether the association between childhood trauma and pain in adulthood is causal.

Harvey, S. T. & Taylor, J. E. (2010). A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents. *Clinical Psychology Review, 30*, 517-535.

TYPE OF ARTICLE

- Meta-analysis

OBJECTIVE/PURPOSE OF ARTICLE

- To systematically summarize findings from a number of studies on treatment outcome for sexually abused children, as well as apply more accurate meta-analysis techniques than previous studies.

METHODS

Participants

- The final analysis included 39 published and unpublished studies and represented 54 treatment conditions.
- All included studies met the following criteria: 1) intervention met definition of therapy, 2) the study examined treatment outcome with children (up to 18 years old) who had experienced sexual abuse, 3) the results were based on empirical measures, 4) the study was written in English, 5) the study was not a case study, 6) the majority of the treated sample had been sexually abused (at least 50%), 7) sufficient data was available for calculation of effect size, 8) studies reported independent data sets.
    - Therapy was defined as "Any intervention designed to alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior through counseling, structured or unstructured interaction, a training program, or a predetermined treatment plan" (p. 519).

Procedure

- The independent sample and repeated measures studies were analyzed separately, then all studies were pooled to maximize the moderator analyses.
- When calculating effect sizes, adjustments were made to correct for bias by using study sample sizes as weights. This was particularly important due to the smaller sample sizes of many included studies.
- Due to heterogeneity in effect sizes, a random effects model was used to reconcile disagreements on the magnitude of the effect size. Additionally, where heterogeneity occurred, potential moderating variables were assessed for the degree to which they might account for variability.
- Finally, effect sizes were averaged for measures of the same outcome so that each study contributed only a single effect size to the analysis for each outcome.

RESULTS

Outcome Variables:

Independent Samples

- An analysis of the independent samples studies found high success rates for treatment (vs. control group): externalizing symptoms (78.5% vs. 21.5%), self-concept/self-esteem (75% vs. 25%), social skills/competence (74% vs. 26%), and global outcomes (72% vs. 28%).

Pooled Data

- Effect sizes were found for 9 different outcome domains:
    - Large effect sizes were found for: global measures of outcome and PTSD outcomes.
    - Moderate effect sizes were found for: internalizing symptoms, self-esteem, externalizing symptoms, and sexualized behavior.
    - Small to moderate effect sizes were found for measures of coping/functioning, caregiver outcomes, and social skills/competence.
- Effect sizes indicated that post-treatment gains were maintained and in fact, increased at the final follow-up assessment.

Moderator Analyses

- PTSD/trauma symptoms:
    - Moderators included study design (experimental),

treatment type (larger effects for cognitive-behavioral or family/individual-focused), modality (family and individual had better effects than group), therapist experience (mixed students and practitioners), involvement of family (better if involved), structure (manualized), and source of information (child rather than parent).

- Potential moderators included number of sessions (more than 10 = bigger effect size), session length (within an hour), and context (some work done outside of clinic, i.e., homework).
- Patterns were shown for treatment setting, length of abuse, and number of abuse experiences, however limited data prevented further analysis of these trends.

- Internalizing symptoms:
  - Moderators included location (single setting better than combination of settings) and context (homework = larger effect size). Additionally, studies using a new target treatment had more favorable effects than those using typically or usual treatment options.
  - Other possible moderators were duration (over 20 weeks = bigger effect) and session length (under an hour = bigger effect).
- Externalizing symptoms:
  - Larger effect sizes were found for studies with non-random assignment; new or target treatments (compared to treatment "as usual"); treatment set in universities and agencies (rather than a combination); sessions that were up to an hour (compared to longer sessions); and approaches that were less structured (compared to manualized treatments).
- Sexualized behaviors:
  - Moderators included treatment type (new or target treatment better than "as usual"), age (majority of kids under age 6 showed better effect size than those w/ older children); and gender (larger effect size for studies with more male participants).
- Self-concept/ self-esteem:
  - Moderators include age (majority of adolescents= larger effect size); session frequency (one weekly better had larger effect than more frequent).
  - Possible mediators included treatment duration (more sessions = higher effect) and treatment structure (some instruction led to higher effect size when compared to an entirely interpersonal dialogue structure).
- Social skills/ competence:
  - Moderators include duration, structure (less structured led to higher effect size than manualized); and control (better effects for treatment with less strict controls).

CONCLUSIONS/SUMMARY

- The results of this meta-analysis indicate that psychotherapy for the effects of Childhood Sexual Abuse typically has lasting positive outcomes – symptom reduction, increased self–esteem and improved overall functioning.
- These results are mostly consistent with previous meta-analysis that used repeated measures effect sizes. However, this study found significantly larger effect sizes for PTSD/trauma symptoms and global outcomes than previous studies.

CONTRIBUTIONS/IMPLICATIONS

- This study supports the tenet that therapy has differing effects based on the outcome measured. These findings also suggest a need for therapy to be matched to an individual's particular symptom profile.
- Further research would ideally look at participant variables such as demographic and abuse-related factors. Presently, this research is limited due to inconsistently detailed reports.

Keller, S. M., Zoellner, L. A., & Feeny, N. C. (2010). Understanding factors associated with early therapeutic alliance in PTSD treatment: Adherence, childhood sexual abuse history, and social support. *Journal of Consulting and Clinical Psychology.* Advance online publication. doi: 10.1037/a0020758.

TYPE OF ARTICLE

- Original Empirical Investigation: Experimental Design

OBJECTIVE/PURPOSE OF ARTICLE

- To determine the relation among treatment adherence, childhood sexual abuse (CSA) history, and social support with the development of early therapeutic alliance for individuals with chronic PTSD.

METHODS

Participants

- The sample consisted of 232 individuals with a diagnosis of chronic PTSD. These participants were recruited for a larger treatment outcome study.
- The sample was 76.7% female. Average age was 37.1 years, and average time since trauma was 11.9 years. In the sample, 17.8% reported CSA as their primary trauma experience, while 43.6% reported a history of CSA.

Measures

Interview Measures

- PTSD diagnosis was determined using the *PTSD Symptom Scale- Interview Version* (PSS-I). The *PTSD Symptom Scale—Self-Report* (PSS-SR) and the *Beck Depression Inventory* (BDI) were administered to confirm the PTSD diagnosis and assess depression severity. The presence of other Axis I disorders was assessed using the *Structured Clinical Interview for DSM-IV* (SCID-IV).
- A standardized trauma history interview was conducted. Individuals were determined to have a history of CSA if they reported at least one experience before the age of 13 in which someone five or more years older than they were had sexual contact with them.

Pretreatment Measures

- The *Inventory of Socially Supportive Behaviors* (ISSB) was used to assess the level of social support received from others, with higher scores indicating more support. *The Social Reactions Questionnaire* (SRQ) was used to assess trauma-related support and generated two scores – the frequency of positive reactions and negative reactions.

In Session Measures

- During sessions, the *Working Alliance Inventory-short form* (WAI) was completed at the beginning of sessions 2 and 4 to assess client-rated therapeutic alliance.
- At each session, participants completed the *Usefulness of Techniques Inventory* to assess adherence to homework (including in vivo homework, Imaginal exposure homework, and breathing retraining homework) from the previous session. Medication adherence was measured using participant self-report. For both homework and medication adherence, a total adherence score was calculated by finding the mean across completed sessions.

Procedure

- All participants completed the PSS-I and SCID-IV to confirm chronic PTSD diagnosis. Eligible participants were randomly assigned to treatment conditions and completed self-report measures.
- Participants in the psychotherapy treatment condition were provided with 10 weekly sessions of pro-longed exposure psychotherapy. These sessions consisted of 90- to 120-minute sessions, which included Psychoeducation, breathing retraining, in vivo exposure and imaginal exposure. Clients were assigned weekly homework.
- Participants in the pharmacotherapy treatment condition were provided with 10 weeks of sertraline and monitored weekly by a psychiatrist.

RESULTS

- An ANOVA was conducted to examine differences in therapeutic alliance across treatment conditions.
- Those in the psychotherapy condition reported a significantly stronger early therapeutic alliance than those in the pharmacotherapy condition.
- In terms of adherence, early alliance was associated with psychotherapy homework adherence, but was not strongly associated for medication adherence.
- In term of psychopathology and social support, those with a history of CSA did not report any significant differences in psychopathology. However they did report a higher level of negative trauma-related support, (e.g., "how often has someone told you that you were to blame?").
- A regression analysis was conducted to determine if a history of CSA predicts the strength of the therapeutic alliance. The results indicated that positive trauma-related social support is the sole predictor of a strong early alliance, regardless of treatment condition.

CONCLUSIONS/SUMMARY

- It was determined that while those with a history of CSA do not appear to struggle to establish a therapeutic alliance, positive trauma-related social support predicts a strong early alliance.
- Additionally, it was identified that compared to other trauma-survivors, individuals with a history of CSA report a higher level of negative trauma-related support.

CONTRIBUTIONS/IMPLICATIONS

- It is encouraging that a history of CSA does not impact an individual's ability to form an early therapeutic alliance.
- This study also highlights the need for trauma-related social support for the development of a strong alliance. With this knowledge, clinicians may be well served by helping clients build strong social support networks outside of therapy.
- Additionally, with the finding that early alliance is associated with treatment adherence, clinicians may find it valuable to formally assess the alliance and implement it as an important component for effective treatment.

Fernando, G. A., Miller, K. E., & Berger, D. E. (2010). Growing Pains: The impact of disaster-related and daily stressors on the psychological and psychosocial functioning of youth in Sri Lanka. *Child Development, 81*(4), 1192-1210.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF ARTICLE

- To examine the relations and potential mediating effects between direct exposure to war- and tsunami-related stressors, exposure to significant daily stressors, and distress in children.

METHODS

Participants

- The sample consisted of students (n=427; 56% female) recruited from four Sri Lankan schools. Students identified as members of three ethnic groups- Sinhalese (n=223), Tamil (n=89), and Muslim (n=115). Ninety-seven percent of participants could be classified as low SES by Sri Lankan standards. Mean age was 14.5 years.

Materials

- The Demographic survey included questions about each participant's gender, age, and education, as well as parental factors, family structure, type of housing, and religiosity.
- The *Sri Lankan Index of Psychosocial Status for Children* (SLIPSS-C) is a 49-item measure that was used to assess multiple domains of psychosocial distress, including internalizing behaviors, externalizing behaviors, and withdrawal.
- The *War- and Tsunami-related Stressor Sc*ale (WTSS) is a 12-item scale used to measure exposure to potentially traumatic war- and tsunami-related events. A higher score indicates exposure to multiple events and a summative score on the WTSS was used in analyses.
- The *Children's Daily Stressor Scale* (CDSS) is a 20-item scale that was used to assess exposure to daily stressors. Focus groups were held to create this scale about common stressors faced while living amid poverty, war, and national disasters. The CDSS contains three subscales – Deprivation, Interparental Conflict, and Abuse.
- The *Child Posttraumatic Stress Scale* (CPSS) is a 17-item checklist used to assess the frequency of symptoms of posttraumatic stress in children exposed to a traumatic event.
- The *Birleson Depression Self-Rating Scale* (DSRS) is an 18-item scale used to assess depressive symptoms.
- The *Multidimensional Anxiety Scale for Children* (MASC) is a 41-item scale used to assess the frequency of symptoms related to anxiety.
- In selecting measures, investigators chose those validated for use in Sri Lanka; for the two measures (CPSS and DSRS) where validation had not occurred, care was taken to ensure appropriate translation and comprehensibility.

Procedure

- Students were recruited through the public school system. Four schools were chosen based on location and the probability of including children who were exposed to the war, the tsunami, or both.
- Intentional efforts were made to oversample the Tamil and Muslim ethnic minorities (more than 75% of the population identifies as Sinhalese).
- Data were collected during a 4-day period, with researchers working at each school one day. Children received a package of school supplies and piece of candy for their cooperation.
- Informed written consent was obtained from parents.

- 537 surveys were completed; 427 were complete and appropriate for analysis.

RESULTS

Age/Gender/Ethnicity

- Tamil and Muslim students' results indicated significantly higher exposure to multiple war- and tsunami-related stressors, as well as significantly higher deprivation, compared to Sinhalese youth.
- Being female predicted higher anxiety and internalizing; being male predicted higher externalizing.
- Correlational and regression analyses tested specific hypotheses.

War- and Tsunami-related stressors and daily stressors

- Children with greater exposure to conflict and disasters experienced higher levels of daily stressors.
- Exposure to war- and tsunami- related stressors was significantly related to increased PTSD. Exposure to these stressors also significantly predicted poorer psychological and psychosocial functioning.
- Exposure to daily stressors was significantly predictive of poorer psychological and psychosocial functioning, beyond that which can be predicted by exposure to war- and tsunami- related stressors.
- Daily stressors appear to at least partially mediate the relationship between exposure to war- and tsunami- related stressors and PTSD.
- Abuse and Deprivation were both shown to mediate the relationship between war- and tsunami-related stressors and PTSD, Anxiety, and Internalizing factors.

CONCLUSIONS/SUMMARY

- Findings demonstrate that daily stressors have a mediating effect on the relation between exposure to disaster-related stressors and psychological and psychosocial outcomes for youth in Sri Lanka.
- The inclusion of daily stressors in analyses limited the power of disaster exposure to predict the psychological and psychosocial distress of Sri Lankan youth.
- The daily stressors were stronger predictors of PTSD than direct exposure to conflict and the tsunami, and an equally strong predictor for other measures of distress.
- Daily stressors also partially mediated the relation among exposure to war- and tsunami-related stressors and resulting distress in youth.

CONTRIBUTIONS/IMPLICATIONS

- The authors acknowledge a growing debate between trauma-focused and holistic interventions with children in settings of conflict and natural disaster.
- This study demonstrated that with regard to PTSD specifically, daily stressors accounted for "significantly greater variance in PTSD levels, indicating that there are critical sources of traumatic stress" which affect Sri Lankan youth other than a history of exposure to conflict and natural disasters (p. 1206).
- These findings add credibility to the argument that a holistic approach may be necessary to alleviate distress in these types of situations.
- This point appears most salient when focus group discussions revealed that one of the greatest sources of stress for youth in refuge camps was the presence of poisonous snakes that restricted the ability to go for water or use toilets at night. The authors note: "This sort of proximal threat loomed considerably larger for children than memories of the tsunami that had occurred several months earlier" (p. 1206).

Employing Returning Combat Veterans as Law Enforcement Officers Project

International Association of Chiefs of Police
Download from http://www.theiacp.org

The International Association of Chiefs of Police (IACP) and law enforcement leaders across the country recognize the value of returning military combat veterans. To this end, the IACP has published four guidebooks on returning combat veterans:

"Employing Returning Combat Veterans as Law Enforcement Officers: Supporting the Integration or Re-Integration of Military Personnel into Federal, State, Local, and Tribal Law Enforcement (2009)" describes research collected from regional focus groups with veteran officers plus two surveys, one for law enforcement leaders and one for veteran officers. The results show that some departments have excellent transition programs in place, that returning veteran officers may have health and confidentiality concerns, and that veterans believe they bring positive skills (superior weapons and tactical skills, more discipline, improved decision making skills, etc.) which they developed in the military to law enforcement.

This document presents a series of recommendations and "best practices," including agency response suggestions, deployment cycle planning, training topics (reprogramming muscle memory, comprehensive driver training, battlefield to Main Street transitions), and a suggested timeline from immediate use to long-range development.

"Law Enforcement Leader's Guide on Combat Veterans: A Transition Guide for Veterans Beginning or Continuing Careers in Law Enforcement (2010)" and "Combat Veterans and Law Enforcement: A Transition Guide for Veterans Beginning or Continuing Careers in Law Enforcement (2010)" were developed from the research detailed in the document above.

The leader's guide contains basic information about the military: structure, governing law and documents, useful definitions, and information about the deployment cycle. In addition, an action agenda and draft training curriculum are included. Tips from returning officers and successful reintegration programs suffuse the pages.

The veteran's guide offers specific suggestions to implement throughout the deployment cycle, from personal and family tips to health concerns. The guide also offers suggestions for veterans who are now seeking employment within law enforcement. Several pages of military related Internet resources are included.

The "Guidebook for Families of Deployed Servicemembers (in press)" focuses on families and family issues, plus recommendations for law enforcement leaders, throughout the deployment cycle. Specific comments for spouses and law enforcement leaders are color coded to underscore important points or offer suggestions for each group. The guide provides suggestions and proven methods of assisting spouses and family members of those deployed and deployable servicemembers in an easy-to-navigate manner.

The family guidebook concludes with policy recommendations for law enforcement leaders, a list of terms and acronyms, a glossary, and a list of military related Internet resources.

Although these excellent resources were developed with law enforcement in mind, they would be very useful for returning veterans, family members, and employers, as well as peer supporters, mental health professionals, and Chaplains.

The Road Home: Smoothing the Transition Back from Deployment

By Elaine Gray Dumler

Frankly Speaking, Inc., 2009, 229 pages, Softcover, $14.95

The Road Home is full of intriguing and practical ideas to help deployed military and their family members remain close. The author, who speaks frequently across the US, collected ideas, stories and resources about reunions from her conference attendees, then organized and published them.

Reintegration is an important topic, and a critical part of the deployment cycle – from pre-deployment to deployment to reunion and reintegration. We visualize and dream that homecoming and reunions are happy, joyful events. While they certainly may be, there may also be a fair number of challenges as well. Whether you are a military member or a family member, or someone supporting one of these folks, the tips and insights contained in this unique book will be thought provoking and informative.

The author may be best known for her very popular "Flat Daddy" program. The idea started when a military family member, Cindy, wanted to help her daughter remember her daddy, Dave, while he was deployed. Cindy took a waist up photo of Dave to her local print shop, they enlarged the photo to life size, then mounted it on foam board – instant "Flat Daddy." Flat Daddy attended all manner of family gatherings and celebrations, and the resulting photos were sent to Dave to enjoy. This idea has become so popular, over 5700 Flat Daddies have been donated to military families. For more information, go to www.ImAlreadyHome.com.

She presents several interesting ideas about the actual homecoming. Many families recommend that only the immediate family attend this special moment, then have the grand homecoming party a few days later, so that the returning military member can be better rested and prepared for this big event. The author recommends discussing homecoming plans with the returning military member. What does s/he want? A big party? Family members and close friends only? Co-workers?

Another recommendation for families with children is a countdown jar. Take any kind of container, and help the kid(s) decorate it. Then, fill it with candy, fruit snacks, vitamins, etc. Every day, remove a piece, and when the jar is empty, mom/dad (sister/brother/son/daughter) is home. In the likely event that the actual homecoming date 'moves' a little, the adult can add or subtract pieces surreptitiously, as necessary.

The author includes a short section on children and reunion, describing typical reactions by age group, then suggesting how to respond to this behavior. For example, children age 1-3 who act shy and cling to the parent/caregiver may respond well to going slowly and letting the child set the pace. Also, getting on their level and getting involved in their play activity may be more helpful than trying to force holding or hugging.

Reunion is about change, and change can be challenging. The service member has changed while s/he has been deployed, whether within or outside the US. They have lived without family for 4-18 months, and developed their own routines. Family members have also changed. Children have grown and matured. The adults left at home have taken on new roles and responsibilities. Everyone is going to need to do some adjusting. "Be flexible, be patient and communicate" is a consistent theme throughout the book.

Additional interesting recommendations include helping children make a Mommy/Daddy box, and fill it with the things they want to share when their parent returns – schoolwork, artwork, pictures, awards, etc.. Someone suggested collecting and sending postcards to your kids. In addition to letters and emails, someone suggested mailing a journal back and forth, each person making comments then sending it back again. For smaller children, record yourself reading favorite books or stories. These recordings can be audio or visual, and give your child a chance to hear your voice or see your face when they want.

For adults, a useful suggestion was keeping notes on what happened while the military member was deployed. These notes can track daily events in the kid's lives (or the adult's), home/vehicle repairs made, personal insights you want to share, local changes, occupational events, etc. Along those lines, someone else suggested keeping a small notebook on "topics for the next phone call." Phone calls can be limited and sometimes sporadic, and it is easy to forget what you wanted to share. This list can be helpful in remembering those important details.

The author devotes a chapter to reunions complicated by Post Traumatic Stress Disorder, Traumatic Brain Injury, Wounded Warriors, and loss and grief. She recommends several excellent web sites for additional information, and encourages family members to consult with professionals if they become concerned about their loved one.

The author closes with almost 30 pages of resources, covering education, financial assistance, employment, medical and mental health, etc. She also lists State or military branch specific resources, plus a list of businesses providing military discounts.

This is a great book of ideas covering a wealth of topics. I highly recommend it for military families, peer supporters, mental health professionals, Chaplains, and anyone supporting a military family.

As a military "separations specialist," Elaine Dumler, aka "The Flat Daddy Lady," writes for military families and speaks at conferences. Her favorite thing to do is to help prepare families for deployment and the reunion/reintegration process. She has presented readiness training at installations all over the United States and has provided training materials to thousands of military families. She is the author of "I'm Already Home" and "I'm Already Home...Again" for families experiencing deployment. Elaine was honored with the CBS "7 Everyday Hero" award for establishing the "Free Flat Daddy®" program. She has been presented with 17 special challenge coins, including President George Bush's Commander in Chief coin.

Combat Stress Injury: Theory, Research, and Management

Edited by Charles R. Figley & William P. Nash
New York: Routledge: 2007
Reviewed by Laurence Miller, PhD

Military mental health experts have opined that the "signature injuries" of the Iraq and Afghanistan theater wars will be posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). If that's true, then the books reviewed in this section come at just the right time. Both editors of Combat Stress Injury have boots-on-the-ground military experience, as well as being a practicing psychologist (Figley) and physician (Nash), and it shows in their selection of chapters addressing PTSD and related mental health syndromes associated with combat.

The book is divided into three sections. The first covers the biological, psychological, and social aspects of combat stress. The level of detail in these chapters might overwhelm the average mental health clinician seeking a basic summary of stress and trauma psychophysiology, but the comprehensiveness of coverage provides a solid scientific foundation for anyone who still thinks that "stress" is some airy-fairy concept cooked up by shrink-types with too much free time. Indeed, a theme that runs through this book is that an adverse reaction to the experience of combat should not be seen as a "disorder," but rather represents a psychological injury as real as a busted head or amputated leg. Also covered is the individual variability of resilience: why some service members succumb to combat stress injury, while other seem to adapt, and a few even grow stronger.

Section II offers a set of studies illustrating, in one chapter, the delayed effects of combat stress on long-term mortality, i.e. combat stress can act as a sleeper weapon, coming back to bite the veteran at the back end of his/her life. Another chapter debunks the clinical myth that physical injury mitigates the effect of psychological trauma supposedly because the veteran now has something "real" to justify his disability. If anything, the research shows that physical and psychological injuries are additive: one worsens the effect of the other, and each needs to be taken seriously. Trauma leaves a wide wake, and a third chapter in this section reports on the effects of secondary traumatization on spouses of injured veterans.

Section III details a variety of prevention, intervention, and treatment programs for combat stress injury being field-tested for use with military service members. These include medication management, peer support programs, experiential

treatments for combat stress, virtual reality applications, a comprehensive trauma risk management (TRIM) program used by the Royal Marines, the utility of using friends and families as resources, and the role of spiritual counseling.

No book has everything, and I would have liked to see a chapter or two on applications of individual counseling and therapy approaches to combat stress, which would be of most interest to practicing clinicians who treat military veterans and service members. But this book is a great place to start for professionals who are serious about understanding the unique tribulations of our uniformed service members who live with the prospect of death and disablement to preserve what we all value.

Once a Warrior, Always a Warrior: Navigating the Transition from Combat to Home, Including Combat Stress, PTSD, and mTBI

By Col. Charles W. Hoge, MD
Guilford, CT: Globe Pequot Press, 2010
Reviewed by Laurence Miller, PhD

This is a soldier's book. Written by a military psychiatrist whose published research in scientific and medical journals has been on the cutting edge of military traumatic disability syndromes, Once a Warrior dispenses with the technicalese and is directed to the grunt at the front who is trying to come home – in every sense of the word.

Using a format that consists of both didactic, plain-talk instruction and a set of self-help exercises, this book addresses what have been called the "signature injuries" of the Iraq and Afghanistan theater wars, PTSD and traumatic brain injury – in the case of this book, specifically focusing on so-called mild traumatic brain injury (mTBI), which usually does not result in dramatic symptoms and impairments like loss of vision, impaired speech, or immobility, but which can produce a wide range of physical, cognitive, emotional, and behavioral symptoms. These include dizziness, sleep loss, fatigue, sensory hypersensitivity, impaired concentration and memory, irritability, impulsivity, and depression. In fact, many of the symptoms of mTBI overlap with those of PTSD, often confounding accurate differential diagnosis and appropriate treatment planning.

Early chapters describe the challenges of transitioning from a red-alert, war-zone mentality to the vagaries of civilian work and family life. Subsequent chapters provide practical strategies for dealing with tension and stress, improving sleep, avoiding overuse of alcohol and drugs, modulating anxiety levels, managing anger, dealing with irrational guilt and justifiable grief, and using meditation, mindfulness, and narrative approaches to lower stress. A separate chapter helps the veteran develop a sense of resiliency to deal with the range of annoying jerks who can often make the service member feel like he or she is about to blow up or implode.

An important chapter guides the military service veteran through the mental health care system. Recognizing the stigma that is often associated with seeking help for anything "psychological," this chapter describes the types of mental health professionals who provide care, the different settings where treatment may be offered, and the variety of medications and psychotherapeutic modalities that may be utilized. A separate section of this chapter is directed at mental health practitioners themselves in terms of advising them how to provide the kind of services best suited to military personnel.

A subsequent chapter focuses on accepting, living, and coping with major losses that occur as the result of military service, including grief, survivor guilt, and many of the unanswerable questions of war. The final chapter offers advice for military families in working with their service member to strengthen family bonds and aid in readjustment to civilian life.

Although specifically intended for military service members themselves, and despite a clear, crisp, and user-friendly writing style, this book may still be just a little too long and complex to hold the attention of many ordinary troops. But

every counselor and therapist who works with military personnel should definitely have this in their library. In fact, one productive use of this manual might be for the clinician to access the information about PTSD and mTBI in order to explain it to his/her patient, then adapt some of the book's exercises to that particular patient in that particular treatment setting. Overall, Once a Warrior, Always a Warrior is a book that helps clinician and patient work productively together.

Military Neuropsychology

Edited by Carrie H. Kennedy & Jeffrey L. Moore
New York: Springer, 2010
Reviewed by Laurence Miller, PhD

In addition to PTSD (see previous review), the other "signature injury" of the Iraq and Afghanistan theater wars is traumatic brain injury (TBI). As medical technology continues to advance with each conflict, more and more veterans are surviving what would previously have been fatal wounds, only to return to the world with disabilities and limitations that follow them the rest of their lives. In a curious twist, much of what civilian mental health clinicians know about peacetime PTSD comes from the study of psychologically injured military service members, and we've been able to extrapolate some of these models and methods to our work with victims of traffic accidents, criminal assault, natural disasters, and terrorism. In the case of TBI, the relationship is reversed. Civilian neuropsychologists have, for decades, been refining techniques of evaluation and treatment for brain-injured patients, and now some of these technologies and methodologies are being applied to military service members.

Military Psychology covers a wide range of topics, all informed by the practical need to treat legitimate injuries where they occur but, at the same time, maintain the integrity of a fighting force, and not let the system become overwhelmed or exploited by service members with misdiagnosed or nonveridical syndromes. There is no particular grouping or sectioning of chapter topics, which might have made for better continuity of subject matter, but everything you always wanted to know about military psychology is fairly well covered in these pages.

For example, at least one important lesson learned from civilian neuropsychologists, especially those involved in compensation cases, is how to screen for malingering and other noncredible syndromes in order to direct services most effectively to those who truly need them. Another chapter discusses the physical mechanics of blast-related concussion (historical note: "shell-shock," which was the WWI name for what we now would call PTSD, was originally thought to be caused by proximity to exploding artillery shells), while another describes a method of making rapid real-time assessments of battlefield concussions for purposes of evaluating return to duty. Relatedly, fitness-for-duty evaluations are covered in another chapter, while still another discusses cognitive rehabilitation of brain injured service members.

But military psychology is more than just treating acquired brain injury. In fact, in its broadest sense, neuropsychology encompasses all aspects of normal and disordered experience and behavior that are related to the functioning of the brain. Accordingly, subsequent chapters deal with attention deficit hyperactivity disorder (ADHD) in military service members and HIV-associated neurocognitive disorders. Even "normal" brains can be subjected to extraordinary stresses, and further chapters describe the neurocognitive effects of sustained combat operations, working in extreme environments, returning from having been a prisoner of war, and – coming full circle – the neuropsychology of PTSD.

As veterans return in increasing numbers with disabling TBIs or PTSD, their treatment needs will quickly exhaust the resources of military mental health clinicians and the formal Veterans Administration (VA) system. For this reason, civilian clinicians are now being recruited to fill the treatment gap. As foundational as this book and the previous one are in comprehensively covering the important topics in military neuropsychology and traumatology, the field still awaits a

book that will put the clinical wisdom of practicing clinicians together with the special challenges of treating military service members and veterans, and which can be a valid and practical guide for all qualified treatment providers to use.

In the meantime, Military Psychology, along with Combat Stress Injury, reviewed above, should be on the shelf of every mental health practitioner – civilian or military – who provides services to our men and women in uniform.

Counseling Military Families: What Mental Health Professionals Need to Know

By Lynn K. Hall
New York: Routledge, 2008
Reviewed by Laurence Miller, PhD

Increasing numbers of civilian psychotherapists and mental health counselors are working with military service members, their spouses, and families. More and more military families are going off base for assistance, either because they are dissatisfied with the service they receive in-house, or simply because they don't like the wait. Also, in response to the need for services to treat the growing population of veterans with service related brain injuries and stress disabilities, the military is actively recruiting qualified civilian mental health clinicians through employee-assistance-type programs (EAPs). However, until now, there has been no published resource for guiding these non-military treatment providers.

A welcome step in this direction is provided by Counseling Military Families, which is specifically intended to be a guide to the culture and ethos of military service that will necessarily inform how psychological treatment is regarded by, and provided to, military service members and their families. Although focusing on the family dimension, many of this book's lessons can be applied to the broader issue of civilian clinicians treating military personnel.

Quite usefully, the first two chapters in Part I orient the civilian clinician to military service and military culture, everything from how to understand ranks in different service branches, to comprehending the structure of an all-volunteer service. Part II focuses on the military family itself, covering such topics as spouses, children, extended families, soldiers as parents, double-military families, extended families and stepfamilies, and retired veterans.

Part III is devoted to treatment. The first chapter in this section delineates some of the common stresses of military families, including deployment stress, PTSD, family violence, and alcoholism. The next chapter focuses on a single program called the Transition Journey for coping with grief and loss, while the following chapter describes military applications of some of the more widely recognized intervention modalities, such as cognitive-behavioral therapy, solution-focused brief therapy, and family systems therapy. The chapter also tackles some special issues, such as deployment stress, military stepfamilies, and productive strategies for working with military men in the context of the military culture of honor. A final chapter contains two case studies.

Counseling Military Families is an important book both for the clinical insights it provides into this area of practice, and for making a conscious effort to help civilian practitioners feel a little more comfortable in treating military service members and veterans. As the wars of the past ten years wind down, a second battle for the minds and lives of those who served is just beginning, and they're going to need all the help they can get.

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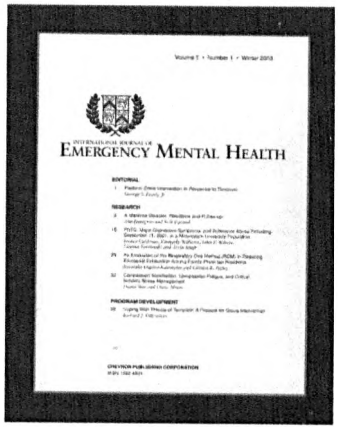

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