



The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report

American Psychological Association
Presidential Task Force on Military Deployment Services
for Youth, Families and Service Members
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THE PSYCHOLOGICAL NEEDS OF U.S. MILITARY SERVICE MEMBERS AND THEIR FAMILIES: A PRELIMINARY REPORT

EXECUTIVE SUMMARY

“ [L]et us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan...”

President Abraham Lincoln
2nd Inaugural Address

Since September 11, 2001, American military service personnel and their families have endured challenges and stressful conditions that are unprecedented in recent history, including unrelenting operational demands and recurring deployments in combat zones. In response to concerns raised by members of the military community, the American Psychological Association (APA) President, Dr. Gerald Koocher, established the Task Force on Military Deployment Services for Youth, Families and Service Members in July of 2006. This Task Force was charged with: identifying the psychological risks and mental health-related service needs of military members and their families during and after deployment(s); developing a strategic plan for working with the military and other organizations to meet those needs; and constructing a list of current APA resources available for military members and families, as well as additional resources that APA might develop or facilitate in order to meet the needs of this population.

At present, 700,000 children in America have at least one parent deployed. Having a primary caretaker deployed to a war zone for an indeterminate period is among the more stressful events a child can experience. Adults in the midst of their own distress are often anxious and uncertain about how to respond to their children's emotional needs. The strain of separation can weigh heavily on both the deployed parent and the caretakers left behind. Further, reintegration of an absent parent back into the family often leads to complicated emotions for everyone involved. This Task Force was established to examine such potential risks to the psychological well-being of service members and their families, acknowledging the changing context and impact of the deployment cycle, and to make preliminary recommendations for change and further review at the provider, practice, program, and policy levels.

To meet the Task Force charge, we will first provide an overview of what is currently known about the impact of military deployments on service members and their families (spouses, children and significant others). In addition, we will discuss a number of programs that have been developed to meet the mental health needs of service members and their families, and we will describe the significant barriers to receiving mental health care within the Department of Defense (DoD) and Veterans Affairs (VA) system. Finally, we will offer several general recommendations for improving the psychological care offered to service members and their

families, and we will outline some specific proposals for how existing APA programs and resources can be employed or modified to support military communities.

Limitations

A major limitation encountered by the Task Force in the preparation of this report was the scarcity of rigorous research conducted explicitly on the mental health and well-being of service members and families during periods of major military operations. Significant gaps exist in our understanding of the complex psychological and social effects on military personnel confronting the kinds of war zone exposures characteristic of the Global War on Terror, and, in turn the effects on their friends and family. Although several recent studies document the mental health impact and service needs of military personnel during and following combat deployments, the Task Force did not find evidence of comprehensive, system-wide research efforts to address questions of importance to the clinical needs and care of military personnel and their families. Also of concern is the absence of research examining the unique needs of special populations (e.g., female service members, National Guard members, reservists, and minorities). Given the limited research data available, we cite empirical studies whenever possible and augment these data with anecdotal evidence and clinical impressions. One of the desired outcomes of this report is to call attention to the paucity of research and advocate for the development of a focused research agenda.

Existing Programs

Even as the military continues to identify the deployment-related behavioral health needs of service members and their families, efforts are underway to address those needs. However, the Task Force was not able to find any evidence of a well-coordinated or well-disseminated approach to providing behavioral health care to service members and their families. This appears to be the case both across and within each of the military branches. Rather, installation-level military medical treatment facilities and the larger military medical centers and clinics rely on assigned psychologists or local civilian providers to develop and implement programs focusing on deployment issues. The availability, coherence, and quality of such programs seem to vary across various sites depending upon the number of mental health professionals assigned to the unit, their training and experience, and command support for behavioral health programs. It is the consensus of the Task Force that, overall, relatively few high-quality programs exist. In addition, while psychologists working for the military, i.e., uniformed, government service (GS), or contracted, are adapting evidence-based treatment programs from civilian treatment centers for application with military personnel, there is a shortage of evidence to support the utilization of these techniques with soldiers and their families around deployment issues. Finally, those programs that do exist are predominantly for service personnel rather than for their family members, who may also require treatment.

Despite local efforts to develop and implement behavioral health services for service members and their families, the Task Force is concerned about the apparent lack of centralized oversight and well-coordinated efforts throughout DoD's medical facilities to meet the broad range of needs. Another concern identified by the Task Force involves the care provided to service members as they transition from the Military Health System to the VA system.

Barriers to Care

A number of factors appear to reduce the likelihood that military personnel and their families will receive needed behavioral health care. Because little empirical evidence exists regarding barriers to care, the Task Force has incorporated other sources of information, including media reports, informal user surveys, and lessons learned from military psychologists. Potential barriers to effective military mental health treatment for both active duty members and their families can be divided into three broad categories: availability, acceptability and accessibility.

The task of ensuring an adequate supply of well-trained psychologists and other mental health specialists to provide services is a primary issue. There is a shortage of professionals specifically trained in the nuances of military life, and those who are highly qualified often experience “burn out” due to the demands placed on them. Another complex and challenging task is how to modify the military culture so that mental health services are more accepted and less stigmatized. This would greatly improve the probability that service members would seek care when needed, but even if providers were available and seeking treatment was deemed acceptable, appropriate mental health services are often not readily accessible. This is usually due to a variety of factors that include long waiting lists, limited clinic hours, a poor referral process and geographical location. None of this, however, takes into consideration the multitude of extenuating circumstances that may also be barriers to obtaining services, including the unique circumstances of National Guard and Reserve personnel, the issues that may arise for gay and lesbian personnel, and a military culture that often does not encourage an open dialogue about problems within the system.

Report Recommendations

The Task Force on Military Deployment Services for Youth, Families and Service Members noted many of the key issues and barriers to services for those in the military community. The final section of the Task Force Report provides these salient recommendations for further development and enhancement of mental health services available to members of the military and their families:

1. Policy and Systems

- 1.1 Centralized leadership of military mental health is crucial to allow for coordination of the services provided on military installations and in surrounding communities.
- 1.2 Increased education of military leadership at all levels regarding the value of mental health services is considered critical for expanding those services as well as reducing stigma associated with seeking those services.
- 1.3 Unrestricted access to high-quality mental health care should be made available to every active duty service member and his or her family members.
- 1.4 Policy and procedural development should take into account the diverse populations found within the U.S. military and be responsive to mental health needs based upon an individual’s situation and background.

2. Research

- 2.1 The paucity of research on mental health issues related to deployment in the military highlights the need for a well-developed and focused research agenda to guide policies, program development, and treatment plans for service members and their families.
- 2.2 Research focused on the specific mental health needs of the military community, barriers to accessing care, and the efficacy of existing prevention and intervention programs is critical to making mental health care in the military more relevant, available, and effective. Such research is essential to establishing evidence-supported services and eliminating inequity and inefficiency across military mental health care facilities.
- 2.3 Research is required to understand the toll that combat environments take on the mental health and effectiveness of military psychologists. Recently, military psychologists have been deployed as members of active combat units, small medical teams on the front lines, and as operational psychologists assigned to intelligence gathering or special operations units. There is virtually no research on the first-hand experiences of psychologists assigned to these jobs.

3. Clinical Services & Community Outreach

- 3.1 Continuity of care provided by programs such as the Operational Stress Control and Readiness (OSCAR) program, in which psychologists are embedded with units throughout the deployment cycle, should be evaluated and, if found effective, be expanded to all military units.
- 3.2 Family members' access to high-quality mental health services through TRICARE should be improved.
- 3.3 Mental health services should be available throughout the deployment cycle and include a focus on prevalent diagnoses /conditions such as adjustment disorder, substance abuse, PTSD, Traumatic Brain Injury (TBI), depression, grief/bereavement, and family violence. Further, mental health services through the deployment cycle should incorporate prevention and intervention strategies designed to help families.
- 3.4 Psychologists should partner with their primary care colleagues to integrate psychology into the primary care arena.
- 3.5 Outreach programs should be developed and fostered by both the military and non-military communities in order to ensure that—wherever possible—mental health problems among service members and their families are prevented rather than treated.

4. Service Providers

- 4.1 In order to reduce severe staffing shortages evident across all military services, an all-out effort should be made by the military to retain well-trained and experienced psychologists. Retention of seasoned experts is crucial to the provision of high-quality psychological services to military members and their families.
- 4.2 Efforts to recruit new psychologists into the military should be strengthened and informed by an understanding of the reasons for attrition among current practitioners. Because military psychologists often practice in isolated environments and shoulder significant responsibility for solo clinical decision-making, all military psychologists should be licensed (or license eligible), thereby ensuring that all those who provide services to military members and their families meet minimum standards of competency.

- 4.3 Because the well-being of families has a direct impact on the ability of service members to carry out their duties, there should be an increase in available psychological services for the families of service members across all phases of the deployment cycle.

5. Professional Education and Training

- 5.1 It is vital that the military maintains the integrity of psychologists' specialty training and ensures that this specialized training is appropriately utilized when assigning individuals to specific duty stations. Although the exigencies of wartime practice often require those with specialized training to fill generalist billets, such assignments should be the exception, not the standard.
- 5.2 Clinical supervision for unlicensed professionals is critical to ensure provision of high-quality services. Consultation and ongoing mentoring for military psychologists are also essential for professional development and continuous quality improvement.
- 5.3 Training and education regarding the unique needs of service members and their families who are faced with deployment must be on-going for all mental health service providers (military and civilian) who treat these populations. This should include training in the latest evidence-based treatment protocols to ensure the appropriate translation of contemporary research to clinical military practice, such as that offered by the Center for Deployment Psychology.

6. Budget

- 6.1 Budgetary resources within DoD need to be allocated to address problems such as the understaffing of psychologist billets, unmet clinical needs of service members and their families, and deficits in research bearing on the mental health needs of war-fighters, family members, and military psychologists.

7. APA Next Steps

- 7.1 The APA Council approves the establishment of a two-year task force to review this Task Force's preliminary findings so that a long-term plan of action with specific recommendations for APA regarding mental health services for military service members and their families may be developed and presented to the Association.

THE PSYCHOLOGICAL NEEDS OF U.S. MILITARY SERVICE MEMBERS AND THEIR FAMILIES: A PRELIMINARY REPORT

Introduction

In response to concerns raised by members of the military community, the American Psychological Association (APA) President, Dr. Gerald Koocher, established the Task Force on Military Deployment Services for Youth, Families and Service Members in July of 2006. This Task Force was charged with: identifying the psychological needs of military members and their families during and after deployment(s); developing a strategic plan for working with the military and other organizations to meet those needs; and constructing a list of current APA resources available for military members and families, as well as additional resources that APA might develop or facilitate in order to meet the needs of this population. This Task Force builds upon longstanding APA initiatives to address the psychological needs of U.S. military service members and their families, which include federal advocacy for increased services, research, and training programs.

Since September 11, 2001, American military service personnel and their families have endured challenges and stressful conditions that are unprecedented in recent history, including unrelenting operational demands and recurring deployments in combat zones. Approximately 1.5 million American troops have been deployed in support of the war effort; one-third of them have served at least two tours in a combat zone, 70,000 have been deployed three times, and 20,000 have been deployed at least 5 times. Moreover, even as this report is being prepared, President Bush has begun the process to significantly increase the number of troops serving in Iraq.

At present, 700,000 children in America have at least one parent deployed. Having a primary caretaker deployed to a war zone for an indeterminate period is among the more stressful events a child can experience. Adults in the midst of their own distress are often anxious and uncertain about how to respond to their children's emotional needs. The strain of separation can weigh heavily on both the deployed parent and the caretakers left behind. Further, reintegration of an absent parent back into the family often leads to complicated emotions for everyone involved.

Life within many military families is forever changed when a service member deploys to a combat zone. To date, more than 3,240 Americans deployed in support of the GWOT have been killed and over 23,000 have returned from a combat zone with physical wounds and a range of permanent disabilities (e.g., traumatic brain injury). In addition to these physical wounds, as many as one-fourth of all returning service members are struggling with less visible psychological injuries. A majority of those deployed to Iraq and Afghanistan report exposure to multiple life-changing stressors, and their wartime experiences often challenge their ability to easily reintegrate following deployment. Survival strategies, which are highly adaptive in a combat environment, are often disruptive to civilian life; interpersonal and family functioning is inevitably affected by combat exposure. It was out of a deep concern for the psychological well-being of returning service members and their families that this Task Force was established.

To meet the Task Force charge, we will first provide an overview of what is currently known about the impact of military deployments on service members and their families (spouses, children and significant others). In addition, we will discuss a number of programs that have been developed to meet the mental health needs of service members and their families, and we will describe the significant barriers to receiving mental health care within the Department of Defense (DoD) and Veterans Affairs (VA) system. Finally, we will offer several general recommendations for improving the psychological care offered to service members and their families, and present some existing APA programs and resources that could be employed or modified to support military communities. This report is meant to be an important next step in what is hoped will be additional APA initiatives aimed at improving mental health services for youth, families and service members impacted by reoccurring operational deployments, long separations, and, often, exposure to traumatic events. The overriding goal is to initiate a constructive and solution-focused dialogue which lays a foundation for collaborative efforts with other organizations committed to the psychological well-being of those who serve.

The work of this Task Force is taking place at a time of growing media and congressional interest in the mental health services being provided to returning service members and military families. At the direction of members of Congress, the Secretary of Defense established the Department of Defense Mental Health Task Force, which is charged with assessing the mental health services currently being offered to all beneficiaries of the military health system and developing recommendations for legislative and administrative action to improve those services. The Department of Defense Mental Health Task Force report will be completed in the spring of 2007. Another entity, the Department of Defense Investigator General, is observing the hearings being held by the Department of Defense Mental Health Task Force and is conducting an independent evaluation of the military mental health system and programs for youth and families. Both of these Department of Defense working groups, addressing closely related issues, have requested a courtesy copy of the Task Force report as soon as it is made available to the public. There will undoubtedly be congressional interest in the report as well.

The Twenty-First Century Military

It should first be noted that the demographics of the United States military have changed significantly since the last time the country became involved in a prolonged war. In the years following the Vietnam era, the United States military made great strides in increasing diversity throughout its ranks. Today there are approximately three million Americans serving their country in uniform, representing the Army, Navy, Air Force, Coast Guard, Marines, Reserves and National Guard. Over one-fourth of those serving on active duty today are members of an ethnic minority. Approximately a quarter of a million of our active duty troops, reservists, and National Guard members are either preparing to deploy or are deployed, and three out of every five of these deployed service members have family responsibilities (i.e. spouse and/or children). In addition, women now make up 16% of this all voluntary military force and are assigned to 90% of all military job categories. Military leaders continue to articulate the value of diversity. According to the Chief of Naval Operations, "We derive great strength from our diversity. To the degree we are not diverse, we are weak" (ADM Mike Mullen in 2005 All Hands Call).

Who are the clinicians responsible for caring for this increasingly diverse military community? The DoD and the VA are the largest trainers and employers of psychologists. Together, these two organizations are responsible for training approximately 375 psychology interns each year. In addition, every year approximately 70 psychologists receive post-doctoral training through either the military or VA. Currently, there are 1,839 psychologists employed by the VA, charged with serving more than 24.3 million veterans from previous wars as well as a rapidly growing number of GWOT veterans.

In years past, there have been approximately 450 active duty licensed clinical psychologists serving their country in uniform. Today, that number has shrunk to less than 350 (a 22% decrease), and the rate of attrition continues at an alarming pace. Never before have so many psychologists been deployed alongside the war fighters. Every day, psychologists are proving their value at forward operating bases in Iraq and Afghanistan, on aircraft carriers and amphibious ships, and accompanying Special Forces units on operations around the globe. The unrelenting operational demands presented by the GWOT have taken a toll on the military psychology community, leading to significant staff shortages and diminished morale. There is increasing recognition that the demands placed on the military's mental health system, exacerbated by the war, greatly exceed the capabilities of that system. The shortage of psychologists within the uniformed military who are trained to address the deployment-related needs of military personnel and their families creates several negative outcomes including reduced access to care, increased stress among those psychologists remaining on active duty, and, consequently, reduced retention rates. The strain on the military psychology community and military mental health system will be one focus of the report.

Limitations

A major limitation encountered by the Task Force in the preparation of this report was the scarcity of rigorous research conducted explicitly on the mental health and well-being of service members and families during periods of major military operations. Given that our country has been at war for nearly six years, the absence of systematic research examining the psychological consequences of this war and controlled studies to inform deployment-related mental health care is striking. Other related topics (e.g., the effects on family members, the effectiveness of various prevention and intervention efforts, the effects of serving in a combat zone on psychologists themselves) have received even less attention.

Significant gaps exist in our understanding of the complex psychological and social effects on military personnel confronting the kinds of war zone exposures characteristic of the Global War on Terror and in turn, their friends and family. Although several recent studies document the mental health impact and service needs of military personnel during and following combat deployments, the Task Force did not find evidence of comprehensive, system-wide research efforts to address questions of importance to the clinical needs and care of military personnel and their families. Also of concern is the absence of research examining the unique needs of special populations (e.g., female service members, National Guard members, Reservists, and minorities). Given the limited research data available, we cite empirical studies whenever possible and augment these data with anecdotal evidence and clinical impressions. We attempt to distinguish between empirical and experiential information throughout this report. One of the desired

outcomes of this report is to call attention to the paucity of research and advocate for the development of a focused research agenda.

Key Studies and Surveys

Given the limited research available to address topics covered in this report, the Task Force relied heavily upon a few relevant studies that have been published over the last four years. As these studies and surveys will be cited throughout this report, a brief summary of the methodology will be provided below.

Charles Hoge, MD, and his colleagues from Walter Reed Army Medical Center and the Uniformed Services University of the Health Sciences have published three seminal studies (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004; Hoge, Auchterlonie & Milliken, 2006; Grieger, Cozza, Ursano, Hoge, Martinez, Engel, & Wain, 2006) that provide empirical data on the combat experiences of troops serving in Iraq and Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) and their associated mental health concerns.

The first study, published in the *New England Journal of Medicine*, focused on members of four combat infantry units (three Army and one Marine Corps). Anonymous surveys were administered either before being deployed to Iraq (2,530 people) or 3-4 months after returning from Iraq or Afghanistan (3,671 people). The data were collected from January to December 2003. Command leaders held meetings at which the researchers solicited participation; methods used to ensure anonymity were explained to potential subjects. In all, 58% of the soldiers and Marines from the designated units attended the recruitment meetings. Among those who attended the meeting, 98% participated in the study.

Mental health functioning was assessed using standardized screening questions targeting diagnostic criteria for major depression, generalized anxiety (Patient Health Questionnaire, Spitzer, et al., 1999), and PTSD (National Center for PTSD Checklist, Weathers et al., 1993). In addition, subjects were asked about their level of stress and emotional problems, use of alcohol, family problems, interest in receiving mental health care, past use of mental health care, and perceptions about barriers to accessing mental health care.

The second Hoge study, published in the *Journal of the American Medical Association* in March 2006, was a descriptive study of all Army soldiers and Marines who had completed a Post-Deployment Health Assessment (PDHA) from May 1, 2003 until April 30, 2004. In all, 303,905 subjects completed the survey after returning from deployment during this time period, including 16,318 from Afghanistan, 222,620 from Iraq and 64,967 from other locations. All subjects were followed up via the Defense Medical Surveillance System (DMSS) database for one year after deployment. The DMSS is an integrated public health database that includes demographics, information about military careers (e.g., rank, occupation, dates of entry and separation, and deployment history), and data on health care visits within the Military Health System.

The third study, published in *The American Journal of Psychiatry* in October 2006, was a descriptive study analyzing the rates, predictors, and course of posttraumatic stress disorder and depression among seriously injured soldiers. The subjects were 613 injured Army personnel

admitted to Walter Reed Army Medical Center from March 2003 to September 2004 who were capable of completing the screening battery. Soldiers were assessed at approximately one month after injury and were reassessed at four and seven months either by telephone interview or upon return to the hospital for outpatient treatment. Two hundred and forty-three soldiers completed all three assessments. Posttraumatic stress disorder was assessed with the PTSD Checklist; depression was assessed with the Patient Health Questionnaire. Combat exposure, deployment length, and severity of physical problems were also assessed.

The Mental Health Advisory Team (MHAT) reports provide comprehensive assessments of the mental health status of Army personnel serving OEF and OIF (MHAT-I, U.S. Army, 2003; MHAT-II, U.S. Army, 2005; MHAT-III, U.S. Army, 2006). The MHAT, consisting of mental health specialists from the Army, was responsible for evaluating the mental health services available to soldiers in Iraq and Kuwait, soldiers' access to those services in theater and after evacuation, and the suicide prevention measures for soldiers in active combat. The MHAT was also tasked with recommending improvements to the mental health system within the Iraq operational area.

The MHAT traveled throughout the Kuwait and Iraq operational theaters and administered surveys and conducted focus groups. Samples of soldiers were drawn from targeted companies, based on mission availability. Participants were briefed on the purpose of the MHAT's mission, the anonymity of the questionnaire, and the fact that participation was voluntary. More than 99% of the soldiers briefed agreed to complete the survey. The sample sizes ranged from 756 for the MHAT-I (U.S. Army, 2003) report to 1,124 for the MHAT-III (U.S. Army, 2006). Most of the participants were male (86%); 47% of the sample were married and 46% had one or more children. Factors assessed included soldier well-being, knowledge and utilization of behavioral health resources, data on suicides committed by soldiers, and suicide prevention activities. Mental health providers, primary care providers, and chaplains were also surveyed about standards of care, services provided, skills and training of providers, provider well-being, stigma, and barriers to care.

The National Military Family Association (NMFA), a non-profit informational and educational organization, has been responsible for producing two documents which were also important sources of data used in this report. The report, *Serving the Home Front: An Analysis of Military Family Support from September 11, 2001 through March 31, 2004* (NMFA, 2004), was based on data derived from an online survey of 2,500 respondents (military spouses), focus groups representing fourteen active and reserve groups from all branches of the military, personal interviews, anecdotal information gleaned from periodicals, and information from congressional testimony and military briefings. The second report, *Cycles of Deployment: An analysis of survey responses from April through September 2005* (NMFA, 2005), presents data from another online survey. This survey had 1,592 respondents (military spouses) from both active and reserve components of the Army, Navy, Air Force, Marine, Coast Guard and Public Health Service, with half of the respondents having a service member currently deployed. The goal of the NMFA is to promote the interests of military families by influencing the development and implementation of legislation and policies affecting them.

Definition of Terms:

Here we make an attempt to familiarize the audience with terms and acronyms that will be used throughout this report.

Behavioral Health: The military term for mental health and related problems.

Billet: A job position in the military.

DoD: Department of Defense. A Federal government office that oversees all U.S. military service branches.

Dependents: Family members of a uniformed service sponsor (active duty, reservists or retired) who are eligible to receive care through the Military Health System.

FRG: Family Readiness Group. An Army-supported system for families of deployed service members that provides information and practical assistance.

GS Psychologist: Government Service Psychologist. A psychologist who is an employee of the Federal government. They are non-military but are often assigned to specific military installations and clinics.

GWOT: Global War on Terror. This term refers to the global efforts to address threats to national security, often involving military manpower and resources.

MHS: Military Health System. A Federal government office whose mission is to “enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.” The MHS controls the TRICARE program providing health services to military members and their families.

MilitaryOneSource – A DOD program that provides on-line educational assistance, 24-hour phone consultation, and free brief counseling services to service members and their families.

MTF: Medical Treatment Facility. These military hospitals and health clinics vary in size and specialty care available. They are located on military bases world-wide.

OEF: Operation Enduring Freedom—the war in Afghanistan.

OIF: Operation Iraqi Freedom—the war in Iraq.

Operational: This is a term used to refer to activities in support of a military mission.

OPTEMPO: Operational Tempo is the pace of military operations and the ratio of time a unit spends at home to the time they are deployed.

PDHA: The Post-Deployment Health Assessment is a questionnaire used by the DoD to screen OEF/OIF service members at the end of a deployment outside the United States. Service members are required to complete the survey before being reunited with families. The questionnaire assesses service members' physical and mental health and includes two stem questions that are used to identify depression (i.e., "felt down, depressed, or hopeless"; "little interest or pleasure in doing things"). In addition, the questionnaire includes a four-item screen for PTSD. The four questions cover the key domains of PTSD, including re-experiencing trauma, numbing, avoidance and hyperarousal.

PDHRA: The Post-Deployment Health Reassessment is the questionnaire used by the DoD to assess service members' physical and mental health three to six months after the member returns from a deployment outside the United States. For specific mental health related questions, please see above.

Theater: This is a term used to refer to areas where military operations are taking place. It is often used to refer to the combat zones in Iraq and Afghanistan.

TRICARE: The Military Health System's community-based services.

VA: The U.S. Department of Veterans Affairs is a Federal government agency whose sole mission is to provide for the health care of U.S. military veterans.

Section I: Current Mental Health Needs Within Military Communities Related To Deployment

“ [L]et us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan...”

President Abraham Lincoln
2nd Inaugural Address

Deployment can be a complex and sometimes overwhelming process for military service members and their families. The stress associated with extended separations, increased workloads, shifting demands, and unstable deployment schedules can be difficult to manage under any circumstances. Add to these stressors the fact that many of our service members are deployed to combat zones where their lives are threatened, and the situation is primed for the development of significant emotional problems for military personnel and their families.

The Cycle of Deployment

The adverse effects of military deployment have been well documented. The RAND report, “How Deployments Affect Service Members” (Hosek, Kavanagh & Miller, 2006), provides a wealth of information on the deployment cycle process and the adverse impact deployments have on service members and families. The Cycle of Deployment first proposed by Logan (1987) and refined by others (Pincus et al., 1999; Pincus et al., 2001) is divided into four distinct phases including: (1) Pre-Deployment (from notification to departure), (2) Deployment (the period from departure to return), (3) Reunion (often termed redeployment in the military) and (4) Post-Deployment.

The pre-deployment phase consists of the “ramping up” period preceding actual deployment of military personnel. During this phase, service members are often occupied with training for the upcoming mission and preparing equipment for deployment. The deployment phase covers the period when the service member is away from his or her family, often working in a dangerous and stressful environment. During the reunion phase, both the service member and family prepare for his or her return home. During post-deployment, the service member returns home and is reunited with his or her family and community. In the past, this phase was seen as the terminal phase of the deployment cycle; however, contemporary military operations (e.g., OEF, OIF) have required that units be deployed repeatedly into combat theaters. Thus, many service members and families are faced with the stress of preparing for a second, third, or even fourth deployment soon after reunion.

Service Members - General

While the stress of repeated deployments alone can contribute to significant behavioral health and relationship problems, it is clear that the unique stressors associated with military combat exposure are primary risk factors for psychological impairment among military personnel. For instance, Hosek et al. (2006) documented the psychological stressors related to combat exposure and length of deployment. These authors reported that 11% to 18% of personnel exposed to

combat experience symptoms of increased stress reactions and mental disorders compared to only about 9% of those without combat experience. The RAND report also found that as the duration of the deployment tour increased, so did the rate of adverse stress reactions (Hosek et al., 2006). This is consistent with previous research showing that posttraumatic stress disorder (PTSD) symptoms are more prevalent among personnel deployed for longer than four months (Adler & Castro, 2001). Research on PTSD arising from either civilian or combat trauma consistently shows that the severity of trauma exposure is directly related to the persistence and extent of posttraumatic symptoms (Brewin et al., 2000; Ozer et al., 2003). Reports from veterans of recent conflicts also indicate that soldiers involved in non-traditional combat duties, such as handling dead bodies and disarming civilians, are also at greater risk for subsequent emotional problems (Adler & Castro, 2001).

Given the risks associated with the stress of deployment and exposure to combat, it is not surprising that military service members and their families may be suffering significant mental health problems in the wake of current military operations. A substantial number of anecdotal reports from psychologists in the military tell of increased behavioral and mental health problems among combat personnel. In addition, preliminary epidemiological research seems to support concerns about increased rates of mental disorders and relationship dysfunction among these service members (c.f., Hoge et al., 2004; 2006). However, much of this research employed brief screening instruments (e.g., Post-Deployment Health Assessment [PDHA], Post-Deployment Health Reassessment [PDHRA]), rather than more formal diagnostic criteria. It should also be noted that, with few exceptions, the majority of studies bearing on combat-related trauma and mental disorder come from peacekeeping operations, the Gulf War, and the mental health experiences of Vietnam veterans.

Spouses and Children - General

In this section we discuss the effects of deployment on families. In order to be as concise as possible, the term “spouse” will be used to refer to any adult in a committed relationship with a service member. We will use the term “families” to refer to both traditional and non-traditional families, including extended and binuclear families. It is worth noting that there is very little research on the impact of deployment upon nontraditional partners and extended family members.

Resilience plays a major factor in all phases of deployment. Weins and Boss (2006) noted that most families of deployed service members “rise to the occasion” and adapt successfully to this stressful experience. Family readiness is considered to be a key factor in resilience, with family preparedness serving as a protective factor when deployments are announced. Spouses who function most effectively during this time are those who use active coping styles (Jensen & Shaw, 1996), those who “make meaning” of the situation (Hammer et al., 2006), those who receive community and social support (Weins & Boss, 2006), those who accept the military life style, are optimistic and self reliant (Patterson & McCubbin, 1984), and those who adopt flexible gender roles (Kelley et al., 1994).

Some common factors that can put military families at risk for difficult transitions include a history of rigid coping styles; a history of family dysfunction; young families—especially those

experiencing a first military separation; families having recently moved to a new duty station; foreign born spouses; families with young children; those with lower pay grades; families without a unit affiliation; and National Guard and Reserve families (Blount & Curry, 1992; Frankel et al., 1992; NMFA, 2005; Norwood, et al., 1996; Segal & Harris, 1993; Stafford & Grady, 2003; Weins & Boss, 2006; Wexler & McGrath, 1991). Other families at risk are those with a disabled child (Fallon & Russo, 2001, 2003), where there is a pregnancy or where the family now has a reduced income (Weins & Boss, 2006). Dual career and single parent families face special stressors (Huffman & Payne, 2006) when child care arrangements must be made for the period of deployment (Kelley, 2006). (See Figure 1 for a summary of the literature on the impact of military deployment on families.)

Figure 1
Impact of Military Deployment on Families
(Pincus et al., 2001; Pincus et al., 2005; Stafford, 2006)

Pre-Deployment

- Anger and protest
- Emotional detachment
- Family stress
- Marital disagreements

Deployment

- Emotional destabilization and disorganization
- Sadness, depression, disorientation, anxiety, loneliness
- Sleep disturbances
- Health complaints
- Financial problems
- Some find the midpoint of deployment as the time of greatest stress
- Fear for safety of deployed service member

Reunion

- Apprehension over redefined roles and power dynamics

Post-Deployment

- Honeymoon period
- Resentment over loss of independence
- Insecurity about place in reconfigured system
- Service member may have difficulty disengaging from combat mission orientation
- Domestic violence

Pre-Deployment

Service Members

Service members often describe their workload and stressors as tripling in the pre-deployment phase. Each command utilizes a process for ensuring that service members are adequately prepared to leave for an extended deployment. In most cases, this requires service members to perform their normal duties while managing a wide variety of additional tasks such as performing necessary military training requirements, completing wills and powers-of-attorney, arranging child care, updating all immunizations, and completing numerous screenings and evaluations. At the same time, each service member must also continue to address his or her family's needs, which include preparation of the family for separation and increased independence – a daunting and potentially emotionally overwhelming process.

In focus groups conducted for the RAND report, participants described working 12 to 16 hours per day during this period. One serviceman asserted “doing the deployment is better than working up to the deployment” (Hosek et al., 2006, p. 37). Some focus group participants indicated that poor planning and organization in the military community during the pre-deployment phase contribute to increased family stress. Some focus group members also cited increased operational tempo (OPTEMPO) – more frequent deployments, longer deployments, and less time between deployments – as a major source of stress and as contributing to negative attitudes and low morale. Although most service members are resilient and excel in the arduous military environment, it is clear from the RAND data that “uncertainty” leads to negative emotional consequences for service members. Poor communication coupled with a complicated military personnel system frequently results in the service member not knowing prior to deployment when he or she will return home; many Army personnel are informed by superiors that deployment could last anywhere from 180 days to one year. In addition, deployments may be extended when replacements do not arrive on post as scheduled and some personnel are involuntarily extended beyond their six-month or one-year cycle. These issues were among the chief complaints of family members who responded to the National Military Families Association (NMFA) survey (2005).

RAND study participants as well as service members surveyed for the MHAT-II (U.S. Army, 2005) and MHAT-III (U.S. Army, 2006) studies described family separations as a significant and negative component of deployment (Hosek et al., 2006). Hardships vary for each service person, but may include marital problems, financial difficulties, de-stabilization of family relationships, potential infidelity, mental health issues, academic problems for the children, and substandard communication conditions while deployed. Although the military has created Internet cafes, Internet connections are poor and often limited due to power outages and security measures. The phone system is intermittently available, and service members often have to wait a long time to access a phone line. Slow and unpredictable mail service also compounds family stress.

The “work-up cycle” begins with increasing demands on the service member who, out of necessity, needs to focus on the mission while the spouse attempts to deal with the anticipated loss (NMFA, 2005). The service member is considered to be “physically present while psychologically absent” (Weins & Boss, 2006). The anecdotal- and observation-based literature

suggests that significant marital disagreements are common during this period, especially in young enlisted families (Stafford, 2006; Pincus et al., 1999, 2001; Logan, 1987). While service personnel may intend to enjoy the pre-deployment time and prepare the family for the upcoming separation (e.g., by preparing “honey do” lists, educating the spouse on financial matters, spending more time with children), the service member may be too involved with deployment preparation to follow through with such plans. Anecdotally, it is often noted that a service member’s emotional withdrawal and “mission focus” exacerbates family stress.

Spouses and Children

According to the Cycles of Deployment Survey conducted by the NMFA, notification of a pending deployment initiates a time of significant stress. Based on these survey data, the pre-deployment phase is reportedly the most stressful period for 15% of military families (NMFA, 2005). During this phase, separation and loss are anticipated. There may be a period of anger and protest (Peebles-Kleiger & Kleiger, 1994) followed by emotional detachment (Pincus et al., 2001; MacDermid et al., 2002) from the service member by the family.

National Guard and Reserve families face a unique set of stressors related to comparatively short periods of preparation. For example, the unit surveyed by MacDermid (2006) had only two weeks between notification and troop departure. Spouses of these service members are not typically integrated into the military culture and may lack community support. These families desperately need information, not only about deployment but also finances, TRICARE, and social support resources for military families (NMFA, 2005). Finances may also be a significant source of stress for these families, as military pay may not match civilian pay. There may also be concern that the service member’s job will not be available upon return, despite federal legislation designed to ensure job protection for reservists.

Deployment

Service Members

The deployment phase begins with the departure of the service member. As noted in the introduction to this report, only a few studies have examined the behavioral health issues that arise for service members during deployment to a combat zone (Hoge et al., 2004; Hoge et al., 2006; U.S. Army, 2003, 2005, 2006; Prigerson, Maciejewski & Rosenheck, 2002). From this research, it is clear that a substantial proportion of service members experience traumatic events while deployed. Hoge et al. (2004) found that 95% of respondents reported seeing dead bodies and remains, 95% had been shot at, 89% had been ambushed or attacked, 86% knew a fellow service member who was shot or wounded, and 69% injured a woman or child and felt that he or she could not provide assistance. These difficult events are quite likely to produce the intense feelings of fear, horror, and helplessness required for a diagnosis of PTSD. Also, the unpredictable nature of many of the attacks faced by our service members makes it difficult to emotionally prepare for the combat environment.

The impact of these traumatic events is magnified by the harsh living conditions in combat, including 130 degree temperatures, unrelenting noise, lack of privacy, and the constant threat of being attacked by mortar rounds, rocket propelled grenades, or biological and chemical agents. In addition, living conditions in combat zones have at times been unsanitary. This was particularly true during the early phase of OIF. Insufficient facilities at some posts resulted in some service members not having regular hot meals and warm water for showering. Though the impact of such circumstances on personnel deployed for OEF/OIF has only been reported anecdotally, data from Vietnam veterans indicate that stressful environmental conditions as well as exposure to a specific variety of traumas contribute to the persistence and severity of PTSD symptoms (King et al., 1999).

Reports from the MHAT-III (U.S. Army, 2006), which surveyed soldiers serving in Iraq, revealed that a substantial number of military personnel were experiencing emotional problems. For example, 14% of those surveyed screened positive for acute stress symptoms and 17% screened positive for acute stress, depression, or anxiety. These rates are essentially similar to those found in the MHAT-I (U.S. Army, 2003), where 16% of those surveyed screened positive for acute stress and 19% for overall symptoms. Rates of acute stress symptoms were higher among soldiers who had at least one prior deployment (18.4%) than among those on their first deployment (12.5%). In addition, 14% of the soldiers surveyed for the MHAT-III reported using medication for a mental health, combat stress, or sleep problem. Finally, the MHAT-III survey reported a substantial number of confirmed suicides among Army personnel in the OIF theater of operations (19.9 per 100,000 soldiers) that was comparable to the rate found in MHAT-I (18.8 per 100,000) and somewhat higher than the rate for the overall Army (13.1 per 100,000). Based on these data, it is apparent that many of our service members are experiencing significant levels of emotional distress while actively serving in a combat zone; and for those who have been deployed multiple times, the likelihood of having mental health problems increases.

Spouses and Children

Many of those left behind during the deployment phase experience a period of emotional destabilization and disorganization (MacDermid et al., 2002; Pincus et al., 2001; Pincus et al., 2005) characterized by reports of: sadness, depression, disorientation, anxiety, loneliness, feeling overwhelmed, numbness, anger, and relief (Pincus et al., 2001; Wexler & McGrath, 1991). Physical reactions such as sleep disturbances are common, and health complaints may emerge (Frankel et al., 1992, Woods et al., 1995; Wright et al., 2006). There are added family responsibilities for the remaining spouses, and those spouses with children basically become single parents. Everyday problems such as car repairs, household maintenance, and yard work can suddenly become overwhelming (Rosen et al., 1993). Finances can also become an issue when remaining spouses do not have experience dealing with bills and banking, and despite combat pay, family income may be negatively impacted, especially in Reserve and National Guard families.

As the deployment progresses, families typically go through a period of recovery and stabilization characterized by a reconfiguration of the family (reassignment of authority and duties), development of new routines, and an increasing sense of independence and self-confidence. New support systems are developed (Pincus et al., 2001; Stafford & Grady, 2003),

such as new friends through community organizations, Family Readiness Groups (FRG) arranged by the military, and religious groups. FRGs were established to provide support for Army spouses and families and are often successful in their mission. However, Orthner (2002) and MacDermid (2006) report that FRGs are not uniformly helpful. Spouses of enlisted personnel do not perceive them to be as useful as do spouses of officers, and overall, less than half of spouses found FRGs “helpful or beneficial” (MacDermid, 2006). In 2001, only 25% of enlisted wives participated (Drummet et al., 2003). FRGs may be particularly unhelpful to Reserve and National Guard units, since the FRG leaders may have insufficient training, resources or command support (MacDermid, 2006). Overall, the “installation-based” services for military families are less accessible for families of reservists (MacDermid, 2006; Pryce et al., 2000).

During deployment, communication between the service member and family is of critical importance (NMFA, 2004, 2005; Bell et al., 1999). Contact with a deployed service member has taken on new dimensions due to technological advances and is considered crucial to morale and to family support (NMFA, 2004). Phone, cell phone, fax, video calls, and email are all part of this critical link between service member and family. However, as Pincus et al. (2005) note, near-instant access has both positive and negative effects. For the family, this keeps the service member “psychologically present while physically absent” (Weins & Boss, 2006, p. 32), while for the service member, family matters and crises at home may create distractions that reduce his or her ability to focus on the mission. Problems may also arise when the service member is not able to stay in touch as often as expected due to mission demands or technological difficulties. According to the NMFA publication (2005), 17% of respondents identified “communication with service member” as the greatest challenge of deployment. Data suggest that this is especially problematic for National Guard and Reserve families who often have less access to existing technologies (Huebner & Mancini, 2005; MacDermid, 2006). The NMFA survey “Serving the Home Front” (2004) notes that families also need open lines of communication with the command, FRGs, and with other families and spouses.

While most families seem to adjust as the deployment proceeds, the NMFA survey (2005) found that 29% of respondents identified the midpoint of deployment as the time of greatest stress. This finding may be due to the accumulation of the stressors discussed above as well as the ongoing, obvious fear of the service member’s injury or death (Segal & Harris, 1993; Wright et al., 2006). Media coverage of combat and the progress of the war may also be contributing factors. Some families evidence denial about the real dangers of deployment by failing to update the will or the power of attorney for the deployed spouse (Wright et al., 2006).

Reunion

As the deployment ends, the reunion phase begins. In anticipation of homecoming, both excitement and apprehension increase (Logan, 1987; Pincus et al., 2001; Pincus et al., 2005; Weins & Boss, 2006). Roles have been redefined, new family systems have developed, and both service members and their spouses have inevitably changed (Segal, 2006). NMFA (2005) noted that rather than a cycle of deployment, there is a spiral: “Families never come back to the same place they started” (p.14).

Post-Deployment

Service Members

Hoge et al. (2006) documented the psychological problems service members report within weeks of their return from the combat zone. In this study, over 19% of OIF veterans and almost 12% of OEF veterans reported some mental health concerns (e.g., PTSD, depression, and anxiety). Nearly 10% of OIF veterans and 5% of OEF veterans reported symptoms of PTSD. Using data collected from the PDHRA administered several months following return from deployment, Hoge et al. (2004) found somewhat higher rates of mental health problems. Even when using a “strict” definition of anxiety, depression, and PTSD, they found that 8% of those surveyed reported anxiety, 8% reported depression, and 13% acknowledged PTSD-type symptoms.

Reports indicate that military personnel’s symptoms often increase between the time of homecoming and three to four months post-deployment (Hoge et al., 2004; Grieger et al., 2006). This trend is consistent with data from Vietnam veterans which suggest that mental health problems may emerge over time. The National Vietnam Veterans Survey (Kulka et al., 1990) found that 15% of veterans surveyed could be diagnosed with PTSD at the time of the survey, but that as many as 30% of veterans eventually developed PTSD at some point following their combat experience.

An additional challenge faced by large numbers of military personnel returning from combat involves the serious physical injuries they sustained while deployed. Physical injuries are typically associated with traumatic events and the interaction between combat exposure, pain and concern over long-term disability often leads to a complex recovery process. Grieger et al. (2006) found that the rates of depression and PTSD among severely wounded service members increased significantly between the initial 1-month post-injury assessment (where 4.2% had PTSD symptoms and 4.4% had depression) to seven months post-injury (where 12.0% had PTSD and 9.3% met criteria for depression).

One of the more prevalent injuries associated with the current military operations is Traumatic Brain Injury (TBI). Okie (2005) reported that, on average, 22% of all OEF/OIF wounded have a traumatic brain injury. Okie also reported that the rate of TBI is higher than in previous wars, indicating that the recovery process will have no clear end for many of the men and women injured in combat. Warden (2006a; 2006b) described “polytrauma” found in closed head injuries and diffuse or “tertiary” neurological symptoms observed in blast injuries. OEF/OIF veterans experiencing blast injuries have reported cyclical depression, psychomotor coordination problems, hearing loss, affective instability, memory problems, and a decreased ability to concentrate.

Spouses and Children

Post-deployment tends to be a complex phase with a unique timeline for individual families (MacDermid, 2006). It starts with the homecoming, which is typically an exciting and joyful event. Often a “honeymoon” period follows the actual reunion (Amen et al., 1988; Drummet, 2003; MacDermid, 2006; Pincus et al., 2005), and it is not uncommon for both the spouse and

service member to have unrealistic expectations of the other, such as a rapid return to “normal.” However, the decreased time between leaving theater and coming home results in less time to process and digest experiences and to make psychological space for reunification.

During the post-deployment period, family roles and routines must be renegotiated. The service member must be reintegrated into a family that is not the same as the one that was left. Spouses and service members may resent the loss of independence and may be insecure about their places in this reconfigured system (Blount et al., 1992; Drummet et al., 2003; Logan, 1987; Pincus et al., 2001; Stafford & Grady, 2003). Service members may also have difficulty disengaging from combat and readjusting to family life. Weins and Boss (2006) characterize service members as being “physically present while psychologically absent,” just as they were during the pre-deployment phase. MacDermid (2006) suggests that the reunion and post-deployment processes are poorly understood and more complex than previously believed, especially when the possibility of redeployment looms (Morris, 2006).

Service members experiencing post-combat stress and PTSD may find reunification notably stressful (e.g., being startled by loud noises and disturbed by the chaos of a family with young active children). Thorough attention to service members and their family members’ levels of stress and trauma is important for several reasons. First, increased stress in the family (especially tension and hostility) can trigger the veteran’s PTSD symptoms. High levels of expressed emotion in the family have been shown to impede improvement in patients with PTSD (Solomon, Mikulincer, Fried & Wosner, 1987; Tarrier, Sommerfield & Pilgrim, 1999). Second, family members who are hurt by the service member’s behavior are often less supportive. This loss of social support is critical, as intimate relationships are a primary source of support for most people (Beach, Martin, Blum & Roman, 1993), and high levels of social support have been associated with decreased intensity of PTSD symptoms at two and three years post-combat (Byrne & Riggs, 2002; Solomon, Mikulincer & Avitzuer, 1988; Tarrier et al., 1999).

There is also some concern in the reunion phase about the risk of domestic violence. Clark and Messer (2006) highlighted risk factors in the military population which may contribute to increased domestic violence. These include: frequent moves associated with decreased social support; multiple separations—including deployments; long work hours; and inherently dangerous work environments (Rentz et al., 2006; U.S. DoD Task Force on Domestic Violence, no date). Clark and Messer (2006) also cite literature suggesting that exposure to military violence increases the risk of domestic violence. It is important to note that no clear connection between deployment and levels of domestic violence has been established in the literature. Further, research efforts have not yet addressed rates of domestic violence among military families associated with OIF and OEF.

One glaring deficit in the extant literature on military mental health is the question of the specific mental health needs of dual-career families and single-parent service members (Segal, 2006). Because the post-deployment mental health status and needs of these groups have not yet been well defined, it is difficult to assess how well they are being addressed. Another complicating factor is that the military often loses track of the family members of National Guard and Reservists as they quickly blend back into the civilian community following deployment. Mental health professionals in the civilian sector are often the ones who identify and respond to the

needs of these families. To date there is not a comprehensive DoD effort to provide outreach and post-deployment services for these unique groups.

Injury/Death of Service Member

In one of the few papers on OIF, Cozza et al. (2005) described the notification process for when a service member is injured. This procedure may itself exacerbate stress in the family as full details may not be known or may be intentionally withheld. Family disruption occurs when a family member is required to be present at Military Treatment Facilities (MTFs), often not located at or near the family's station. In these instances the spouse may be caught between the needs of the service member, the needs of the children, and his or her own emotional needs. When a service member is killed, a number of military support services are available; however, the death inevitably leads to more family disruption. The family must leave base housing within six months to one year, and they usually relocate closer to other sources of support or extended family. The resulting loss of the military support system is significant, as is the change in accessibility of medical and mental health services and other accustomed benefits such as the Commissary (Cozza et al., 2005).

The inherent danger to deployed service members adds to children's stress while the parent is gone. Further, the return of an injured parent is not something for which a child of any age can be fully prepared. Injuries include not only wounds but also amputations, disfigurements, TBI, and mental health disorders, including PTSD. Treatment of injuries may necessitate the family traveling or relocating to a distant MTF which disrupts children's lives more by requiring them to leave school, friends, and activities (Cozza et al., 2005). The service member's own level of adjustment or grief, as well as the spouse's reaction to the injury, undoubtedly impacts their abilities to relate to their children and care for their emotional needs. Providers have scant literature to guide them in these instances.

Although there is a significant body of literature on the effects of parental death on children, there is no specific study examining the impact of injury or loss of a parent through war (Cozza et al., 2005). By using some commonly known statistics, however, we may gain some indication of the number of children who have lost a parent serving in war. There have been 3,416 U.S. military fatalities as of January 26, 2007; if we multiply that number by .8, the average number of children per active duty member (MFRI, 2004), we can draw the conclusion that approximately 2,733 children have lost a parent in OIF/OEF. This means that thousands of children have had their lives turned upside down because, as noted above, when a service member dies, the family leaves base housing and often relocates. Thus, children who have lost a parent through war often lose their homes, their schools, and their friends, as well as other supports, such as churches, school counselors and pediatricians.

Relevant Research with Vietnam Veterans and their Partners

In light of the paucity of research bearing on mental health needs associated with deployment among OIF/OEF personnel, we now turn to a brief summary of research with Vietnam veterans with PTSD and their partners. Although the current war is clearly distinct in many ways, the

research base from Vietnam provides some useful lessons related to stress and the deployment cycle.

The National Vietnam Veterans Readjustment Survey (NVVRS) (Kulka et al., 1990) involved interviews with 3,016 American veterans who had served during the Vietnam era. Interviews were conducted between November 1986 and February 1988. The survey documented lifetime prevalence rates of PTSD of 30.9% for men and 26.9% for women. An additional 22.5% of men and 21.2% of women showed symptoms of the disorder. These rates are almost three times higher than the lifetime prevalence rates of PTSD in the general population, which is estimated to be approximately 8% (Kessler et al., 1995).

These NVVRS interviews also identified numerous psychosocial problems among these veterans. For example, 40% of all male veterans had been divorced at least once; 14% experienced significant marital discord; and 23% reported difficulties with parenting. Lifetime prevalence rates of substance abuse and dependence were also high, with almost 40% of the male veterans reporting alcohol problems and about 6% reporting drug problems. Further, of the men living with PTSD, almost half had been arrested at least once.

Research with Vietnam veterans clearly documented the adverse effects of PTSD on intimate relationships. Combat veterans experience a high rate of marital instability (Kessler, 2000), and veterans with PTSD and their spouses describe their marital problems in more severe terms than non-PTSD veterans (Riggs, Byrne, Weathers & Litz, 1998). Veterans with PTSD perpetrate domestic violence at greater rates than comparable veterans without PTSD (Sherman, Sautter, Jackson, Lyons & Han, 2006). Further, Vietnam veterans with PTSD are twice as likely as non-PTSD veterans to have been divorced and three times as likely to experience multiple divorces (Jordan et al., 1992). These relationship problems among PTSD veterans appear to be chronic, as suggested by a recent study of WWII ex-prisoners-of-war (POWs) (Cook, Riggs, Thompson, Coyne & Sheikh, 2004). Ex-POWS with PTSD reported poorer relationship adjustment, poorer communication with partners, and more difficulty with intimacy than those without PTSD.

Partners of Vietnam veterans with PTSD report lower overall satisfaction (Jordan et al., 1992), more caregiver burden, and poorer psychological adjustment (Beckham, Lytel & Feldman, 1996; Calhoun, Beckham & Bosworth, 2002) than partners of veterans without PTSD. Recent research has also documented that these partners of PTSD veterans are highly distressed. For example, a recent phone survey of 89 PTSD veterans' significant others (Manguno-Mire et al., in press) found that the average Global Severity Index (GSI) of the Brief Symptom Inventory-18 (BSI-18) (Derogatis, 1993) exceeded the 90th percentile.

The Impact of Military Deployment on Children and Adolescents

“Military service is a reciprocal partnership between the Department of Defense, service members and their families” (Department of Defense, 2002).

The military culture has evolved considerably from the World War II mindset characterized by the popular slogan, “if the Army wanted you to have a family, they would have issued you one!” Leaders now recognize that supporting families and children is key to the readiness and retention of service members, and there is widespread acknowledgement that, in their own way, families also serve. In 2002, the DoD published the following statement: “A Social Compact promotes the advancement of the military community through the reciprocal ties that bind service members, the military mission, and families by responding to the quality of life needs.” This document specifically states that one of the Quality of Life areas “of particular importance” is “support during the deployment cycle” (DoD, 2002, p.60).

The active duty force (1.4 million) is outnumbered by the associated dependent family members (1.8 million). Among these family members, 1.2 million are children and adolescents (up to age 23). The Reserve and National Guard forces number nearly 900,000 with over 700,000 dependent children (Military Family Research Institute, 2004). At any one time, over half a million children have one or more parents deployed in support of the GWOT. Clearly, the number of children who have been affected by reoccurring deployments is significant.

Before specifically addressing the consequences of deployment, the unique constellation of stressors on military children must first be acknowledged. It is generally agreed that geographic mobility (multiple moves) and isolation, frequent separations, and the normative constraints of the military culture impact children in military families (Drummet et al., 2003; Ender, 2000, 2006; Finkel et al., 2003; Segal, 2006; Watanabe & Jensen, 2000). The repeated and extended separations and increased hazards of deployment (i.e., injury and death) compound these stressors in military children’s lives. However, despite these significant stressors, levels of psychopathology in military children have been found to be at or below those in the civilian population (Jensen et al., 1991; 1995), thus attesting to their resilience.

It should be recognized that children’s responses to deployment are variable and depend on age and developmental stage, in addition to family and individual factors (Amen et al., 1988; Murray, 2002; Pincus et al., 2005; Stafford & Grady, 2003). In the pre-deployment phase infants have been observed to be fussy and change their eating habits. Preschoolers can be confused and saddened by pending changes in the family. School-aged children will also be saddened, but may also become angry and experience anxiety. In addition to these mood states, adolescents may withdraw and deny feelings about the upcoming separation.

In the deployment phase, preschoolers may display sadness, tantrums, changes in eating and elimination habits, and separation anxiety in regard to the remaining caretaker. School-aged children may experience more somatic complaints, changes in mood, and a decline in school performance. Adolescents may be angry, aloof, and apathetic; they may act out more or lose interest in their usual activities and experience school problems. Others may embrace the new

independence and try to assume the role of the missing parent (Amen et al., 1988; Blount et al., 1992; Pincus et al., 2001; Stafford & Grady, 2003).

The post-deployment phase can lead to powerfully ambivalent emotions in both children and adolescents. High expectations and behavior changes in the returning service member contribute to the challenges of readjustment. Very young children may not recognize the service member and may be afraid of him or her. Preschoolers, while happy and excited, may also display anger about the separation. Likewise, school-aged children may be simultaneously excited and angry. They may act out their anger or may require unsustainable levels of attention. Adolescents may be defiant and disappointed by the difficulty the service member has acknowledging the changes the adolescent made in his or her absence (Amen et al., 1988; Blount et al., 1992; Pincus et al., 2001; Stafford & Grady, 2003). The responses by children to deployment are summarized in Table 1.

Table 1. Deployment Stages and Children’s Responses (Amen et al., 1988; Murray, 2002; Pincus et al., 2001; Stafford & Grady, 2003)	
Pre-Deployment	
Infants	Fussy, changes in eating habits
Preschoolers	Confused, saddened
School-Aged	Saddened, angry or anxious
Adolescents	Withdrawn, deny feelings about pending separation
Deployment	
Infants	No research
Preschoolers	Sadness, tantrums, changes in eating/elimination habits, symptoms of separation anxiety may appear
School-Aged	Increased somatic complaints, mood changes, decline in school performance
Adolescents	Angry, aloof, apathetic, acting out behaviors may increase, loss of interest in normal activities, decline in school performance
Post-Deployment	
Infants	May not recognize returning service member and be fearful of him/her
Preschoolers	Happy and excited, but also experience anger at separation
School-Aged	Happy and angry, often leading to acting out behaviors
Adolescents	Defiant, disappointed if their contributions at home are not acknowledged

Adolescents’ adaptation to their parents’ deployment has been recently studied by Huebner and Mancini (2005). Participants reported depression and changes in school performance, as well as an awareness of the dangers associated with parents’ deployments. The study also found that adolescents tried to protect those remaining at home from stress and negative emotions and were wary of media coverage of the war. The authors concluded that deployment often has detrimental effects on adolescents’ lives, and that these stressors may “overtax the adolescents’ limited coping resources beyond their capacity” (p. 11). While some adolescents seek social support during a parent’s deployment, others become socially isolated.

Most studies on deployment stress and families do not specify the gender of the service member (Jensen, 1996; Rosen et al., 1993) or include only deployed mothers or fathers in their sample (Amen et al., 1988; Kelley et al., 2001; Pierce et al., 1998). Although a rich theoretical literature on attachment and loss abounds (c.f., Bowlby, 1969, 1973, 1980; Vormbeck, 1993), research in this area is sparse. Only one study was identified (Applewhite et al., 1996) that directly examined differences in child reactions to maternal vs. paternal separation. This study found that children with mothers deployed had problems in certain areas, such as peer relationships, emotional expression, handling learning problems and physical health. No other published studies were found that addressed the effects of deployment on children in single-parent families or children in dual-career families.

In general, research on parental deployment and the mental health of children and adolescents indicates that while a parent's deployment is clearly stressful, children and adolescents evidence a wide range of responses—often impacted by numerous contextual variables. As Watanabe and Jensen (2000) note, “[t]he circumstances surrounding a given separation may be more relevant to the question of untoward effects on the child rather than the simple separation itself” (p. 213). Across various studies, depression, anxiety, and internalizing disorders have been found to be related to deployment (Jensen et al., 1989, 1996; Hillenbrand, 1976; Huebner & Mancini, 2005; Kelley et al., 2001). Boys seem to suffer more effects than girls (Jensen et al., 1996), and younger children overall are more susceptible to the effects of longer deployments. Older studies also suggest that academic grades can be negatively affected (Hillenbrand, 1976; Yeatman, 1981). It has often been noted that a spouse's (notably mother's) coping style and level of psychopathology are important factors (Blount et al., 1992; Huebner & Mancini, 2005; Jensen et al., 1991, 1996; Watanabe & Jensen, 2000). In the civilian literature, maternal depression has been found to contribute to children's behavior problems (Barry, Dunlap, Cotton, Lochman & Wells, 2005) because of the disruptive effect of maternal depression on the ability to be consistent in parenting practices (Barry, Dunlap, Lochman & Wells, in press).

Two studies by the Military Family Research Institute at Purdue University (MacDermid, 2006), one using semi-structured interviews assessing the reunion process in reserve families, and the other using focus groups of both military members and service providers, found that active duty families did not believe that children received sufficient support during deployment. This is important since National Guard and Reserve children and families have less access to and knowledge of supports than do active duty families.

Another post-deployment concern is the possibility of an increased risk of child abuse. The cohort of families with service members who are experiencing combat-related stress and PTSD may be at risk for increased violence against children (Prigerson et al., 2002; Rentz et al., 2006). Although the literature regarding overall higher baseline incidence of child maltreatment in military versus civilian populations is equivocal (Brewster, 2000; Rentz et al., 2006), military communities often include a number of risk factors for child abuse (e.g., occupational stress, frequent separations, geographic isolation, young families living apart from their own social supports) that warrant careful future study.

Opportunity for Growth

Although much of this report focuses on the various negative sequelae of combat and trauma, it is important to also note the possibility of psychological growth. A growing area of research has focused on posttraumatic growth (PTG), a phenomenon in which positive outcomes occur among survivors of a wide range of traumatic experiences, such as car accidents, fires, sexual abuse/assault, military combat, and being held as a refugee (Tedeschi & Calhoun, 2004). Posttraumatic growth among trauma survivors has included improved relationships, renewed hope for life, an improved appreciation of life, an enhanced sense of personal strength, and spiritual development (Calhoun & Tedeschi, 1998). Although no published reports on PTG for the OIF/OEF war were identified by the Task Force, it is expected and hoped that our military service personnel will also experience such positive outcomes.

In sum, military personnel and their families experience a wide range of stressors throughout the deployment experience. Everyone in the family is impacted at each stage of deployment, and each family's experience is unique. However, the numerous challenges outlined in this section make it clear why many of our service members and their families are struggling at this period in our nation's history.

Section II: Existing Programs to Benefit Military Personnel and their Families

Introduction

Even as the military continues to identify the deployment-related behavioral health needs of service members and their families, efforts are underway to address those needs. However, the Task Force was not able to find any evidence of a well-coordinated or well-disseminated approach to providing behavioral health care to service members and their families. This appears to be the case both across and within each military branch. Rather, installation-level military medical treatment facilities and the larger military medical centers and clinics rely on assigned psychologists or local civilian providers to develop and implement programs focusing on deployment issues. The availability, coherence, and quality of such programs seem to vary across various sites depending upon the number of mental health professionals assigned to the unit, their training and experience, and command support for behavioral health programs. It is the consensus of the Task Force that, overall, relatively few high-quality programs exist. In addition, while military and civil service psychologists are adapting evidence-based treatment programs from civilian treatment centers for application with military personnel, there is a shortage of evidence to support the utilization of these techniques with soldiers and their families around deployment issues. Finally, those programs that do exist are predominantly for service personnel, rather than for their family members who may also require treatment.

These concerns within the military's direct care system are likely to be magnified when considering services provided outside the direct care system. For instance, MilitaryOneSource serves an important need by providing educational and brief intervention services for service members and their families; however, the scope of these services is limited (e.g., individual services for children under 12 are not available; the focus is on prevention and early intervention versus treatment of psychological disorders). Another resource for families, TRICARE, varies in quality from location to location depending upon provider availability, and TRICARE mental health care is not available for families stationed overseas. Additionally, there appears to be no empirical evidence supporting the effectiveness of these civilian services for deployment-related problems. Impaired providers are not required to have any specific training in deployment-related behavioral health interventions.

Despite local and individual efforts to develop and implement behavioral health services for service members and their families, the Task Force is concerned about the apparent lack of centralized oversight and well-coordinated efforts throughout DoD's medical facilities to meet the broad range of needs. Specifically, the Task Force is concerned about the absence of a unified vision across commands and service branches, poor dissemination of promising programs, redundant and inefficient use of resources, and stress and professional dissatisfaction among clinicians—many of whom feel that they must start from scratch in creating deployment-related services for military members and families. Other variables that might interfere with quality behavioral health service delivery include relatively limited staff training in appropriate evidence-based treatment models, limited staff time to attend trainings or develop systematic and programmatic approaches to identified treatment needs, and a shortage of research regarding the effectiveness of programs tailored to a military population.

Another concern identified by the Task Force involves the care provided to service members as they transition from the Military Health System to the VA system. Anecdotal evidence indicates that service members needing psychological care may, at times, “fall through the cracks” when transitioning from active duty to veteran status. Some of the problems are associated with breakdowns in communication between the DoD system and the VA system, while others are due to information not reaching transitioning personnel. Other challenges include the need for some veterans to travel long distances to obtain treatment and long wait lists in certain locations. Thus, it is important to note that even when programs exist, service members may not be able to access them for a variety of reasons including lack of information, inconvenience, and timely availability.

Programs for Military Personnel

Psychologists within each military service have attempted to develop programs focusing on deployment-related behavioral health concerns. These programs typically adapt preexisting behavioral health programs to a military population. Thus, promising programs exist within each service, with the Army having the greatest number of programs, which is understandable given its mission in the current conflict and the high numbers of personnel deployed from that particular service. While examples of some of these programs are offered below, inclusion of a particular program does not constitute an endorsement by the Task Force. Rather, the goal of the following section is to provide a sample of some of the programs that are currently being utilized. While many of these programs show promise, there is little data available to verify their efficacy. Please note that although the programs mentioned herein were created by psychologists, we do not mean to imply that psychologists are the only professionals working to address deployment-related mental health issues. Also, given the limited time frame, the Task Force was not able to perform an exhaustive review of all the programs available to service members and their families during and after deployment. However, we highlight some of the key programs that have been developed.

Screenings

Behavioral health screening is a DoD-wide early detection and prevention initiative. As described earlier in this report, the DoD utilizes the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) questionnaires to screen soldiers for behavioral health concerns. The goal is to screen all service members pre- and post-deployment to determine if they have physical and mental health concerns and to connect them with intervention services as needed. A recent GAO (2006) report, however, suggests that implementation of this program tends to vary among military installations and the reviewing providers may lack the necessary training to detect and address pathology.

BATTLEMIND Training

Another program is BATTLEMIND Training. This modular psycho-educational program was developed by behavioral health specialists from the Army. This post-deployment training is provided in a large group setting and all Army personnel returning from deployment are required

to attend. The goal is to educate soldiers regarding the impact of deployment on psychological, social-emotional, and behavioral functioning, and ensures service members are cognizant of the mental health resources available should they have difficulties readjusting. The effectiveness of this training has yet to be evaluated.

SWAPP

Several military installations have developed and implemented installation-wide programs. Ft. Lewis in Washington state, for example, implemented an innovative approach in 2005 which expands upon the PDHA/PDHRA process. This program, the Soldier Wellness Assessment Pilot Program (SWAPP), focuses on the preventive aspect of behavioral health care. All soldiers deploying and redeploying from Ft. Lewis participate in the SWAPP evaluation process. SWAPP's behavioral health assessment includes a computerized multi-dimensional survey and an individualized clinical interview conducted by a credentialed behavioral health care provider. The desired outcomes of this program include: (1) educating soldiers regarding available social and behavioral health services, (2) reducing stigma associated with mental health visits, (3) intervening before serious behavioral problems develop, and (4) improving continuity of care by placing intervention services within the same locale as the screening and assessment program. More than 10,000 soldiers have participated in this program which closely tracks the proportion of soldiers who screen positive for particular diagnoses and levels of impairment (Gahm et al., 2006). Research is currently underway to assess the program's efficacy.

SAFAC

The 25th Infantry Division at Schofield Barracks, Hawaii, with support from Tripler Army Medical Center (TAMC), has focused on improving efficiency through creation of a single organization capable of providing comprehensive mental health services. The Soldier and Family Assistance Center (SAFAC) offers child and adult services, marriage and family counseling, substance abuse counseling, and neuropsychological assessment. In addition, post-deployment screening and comprehensive mental health care for soldiers assigned to the 25th infantry division are typically provided at SAFAC rather than at TAMC, making these services more convenient to access.

Informational Handouts

In addition to the installation-wide programs identified above, many other military installations have also developed specific briefings, handouts, guides, and educational materials for deploying service members. The focus of most of this information is to raise awareness about potential adjustment issues, reduce stigma associated with behavioral health care, and provide education about effective coping tools. These materials are primarily focused on prevention. Since the information does not come from a central source, the quality varies, as does the consistency of dissemination to service members across units. We were unable to locate efficacy data related to these informational efforts.

In conclusion, while numerous efforts are being made to provide resources and services to service members, it appears that system-wide and evidence-based programs are quite limited. Further research and development of such programs are urgently needed.

Programs for Children and Families

Similar to deployment related behavioral health care for service members, the Task Force was not able to find evidence for a well coordinated, coherent approach to behavioral health care for family members (spouses and children). Given the military mission and limited behavioral health resources, the direct care system has understandably made care for service members the top priority. However, the Task Force was concerned with the limited number of programs currently focused on families and children. Once again, we identify some promising programs, but do not intend to provide an exhaustive list of those available within the system. The initiatives below borrow from evidence-based programs, and attempt to adapt these programs to address deployment-related concerns. However, research examining the effectiveness of these modified programs with this particular population is lacking.

Resiliency

“Adjusting to a Family Member’s Deployment: A Resiliency Program for Children and Adolescents” is a program developed at Madigan Army Medical Center that has been utilized within the elementary schools and day care/youth centers at Ft. Lewis, Washington and Ft. Wainwright, Alaska. It is a 4-week, school-based, group intervention program in which children and young teens with a deployed parent learn to identify their feelings about that parent’s absence and ways to cope effectively with these feelings. The goal is to help these young people build “resiliency” skills. The modules are crafted from existing evidence-based cognitive-behavioral strategies and incorporate the APA resilience materials as well. The program, which has been tailored for a military child population and focuses primarily on teaching coping skills for dealing with a parent’s deployment, has been well-received and anecdotally appears to offer a number of benefits. Efficacy data are not available for this program.

Multimedia Resources

Another program, “Finding My Way: A Teen’s Guide to Living with a Parent Who Has Experienced Trauma” (Sherman & Sherman, 2006), was developed to help teens cope with having a parent who has experienced trauma. This interactive workbook is currently being used by a number of military families and behavioral health specialists who are working with military populations. However, a systematic evaluation of the utility of this program has not yet been performed.

Several DVD resources have been developed to assist children and adolescents coping with deployment-related stress. MilitaryOneSource, in conjunction with the Children’s Television Network, developed the Sesame Street video entitled “Talk, Listen, Connect: Helping Families During Military Deployment” to assist preschool children. Several organizations and APA members participated in the development of this video. The Army Pediatric community has also

been active in developing DVDs for elementary age children (Mr. Po and Friends) and teens (Youth Coping with Military Deployment: Promoting Resilience in Your Family). These materials are available for free download via the American Academy of Pediatrics website. Research is currently being conducted to assess their utility and efficacy.

Community Efforts and Outreach

Several civilian and community based organizations have initiated programs to address the unique needs of military children and families. The Military Family Research Institute at Purdue University (whose research on adjustment among adolescents with a deployed parent was described above: Huebner & Mancini, 2005) hosts a website with information available to military families. Two groups have focused efforts on school adjustment and school success: the Military Child Initiative (MCI) based out of Johns Hopkins University, and the Military Child Education Coalition (MCEC). Both of these organizations provide resource material to educators and families working with military children. Strategic Outreach to Families and All Reservists (SOFAR) is a program that coordinates pro bono psychotherapy and psycho-educational services to OIF/OEF reservists and National Guard members and their families in the greater Boston area (Darwin & Reich, 2006). No empirical data have been reported to date on this program. Finally, Operation: Military Kids is a collaborative effort, involving a number of community agencies (i.e., Boys and Girls Club of America, 4-H, American Legion, MCEC, and Military Child and Youth Services). The focus of this program is on providing outreach services to reservists, National Guard members, and their families.

In conclusion, while efforts are underway within both the military and civilian communities to provide resources and services to families, the efforts do not appear to be well coordinated or widely disseminated. In addition, evidence-based programs for family members are quite limited. Further research and improved coordination are warranted.

Education and Training Programs for Health Professionals

Center for Deployment Psychology

A relatively new, but promising program serving all military service branches is the Center for Deployment Psychology (CDP), an APA-endorsed initiative. This congressionally-funded program, initiated by APA's advocacy efforts, represents a coordinated effort across military services (Army, Navy, Air Force, and Marine) to train military and civilian psychologists, psychology interns and residents, and other behavioral health professionals to provide high-quality deployment-related behavioral health services to military personnel and their families. The CDP is headquartered at the Uniformed Services University of the Health Sciences (USUHS) with satellite sites at each of the ten Military Medical Centers that house APA-accredited psychology internship programs. The CDP has developed a two-week intensive training course and a series of seminars. The CDP is planning to establish outreach programs, including an Internet site devoted to the psychology of deployment, public outreach efforts to promote awareness of psychological issues related to deployment, and a virtual library of resources available for behavioral health professionals seeking information on the deployment-

related needs of service members and their families. The CDP will also be engaging in independent and collaborative research efforts documenting the deployment-related needs of service members and their families, as well as interventions aimed at addressing these needs.

Programs for Veterans and their Families

As previously noted, there appear to be systemic challenges in the coordination of care as service members move from active duty to veteran status. The DoD and VA are working to remedy some of these challenges. Further, the VA has established some treatment programs specifically targeting OIF/OEF veterans.

The VA system has recognized the large number of service members sustaining multiple severe injuries as a result of explosions and blasts. In response to this significant issue, the VA system created four polytrauma rehabilitation centers in April 2005, in Palo Alto, California; Minneapolis, Minnesota; Richmond, Virginia; and Tampa, Florida. These centers provide a full array of inpatient and outpatient services, with specialized programs for TBI, spinal cord injury, blind rehabilitation, and PTSD. In addition, the Seamless Transition Office has been established to help OIF/OEF service members' transition from health care in the DoD to the VA system. Each VA facility now has a designated case manager who helps new OIF/OEF veterans to enroll in the VA system and gain access to care.

Regarding mental health services specifically, some VA medical centers have received additional funding earmarked to provide care for OIF/OEF veterans. However, many sites are adding this new population of veterans to existing caseloads without the addition of personnel, creating long waitlists for some veterans seeking mental health care. Vet Centers also provide outpatient "readjustment counseling" and are often more accessible and convenient (i.e. there are more Vet Centers than VA Medical Centers and the Vet Centers have evening hours). In all, the 207 Vet Centers across the country provide more than one million appointments for veterans annually (Kudler, 2006).

Until recently, mental health care for family members in the VA health care system had been quite limited. The Support and Family Education (SAFE) Program (Sherman, 2003a; Sherman, 2003b) is the only family intervention program created for the VA system. SAFE is an 18-session curriculum designed to support adults who care for someone living with PTSD or another mental illnesses, and is available for free download on the Internet (w3.ouhsc.edu/safeprogram). The SAFE Program is being used in many private and public settings across the country, and initial 3- and 5-year evaluation data are promising (Sherman, 2006). The SAFE Program has recently been modified to specifically address the needs of the OIF/OEF population; this new curriculum is called Operation Enduring Families (Bowling & Sherman, 2006), and evaluation is currently underway. The VA has provided even fewer services for children of veterans. However, the VA recently put forth a mental health strategic plan which recommended that each VA facility provide some "family education program" or partner with a community program that supports families (Recommendation 2.2.11-12). It is hoped that in the future the VA will expand its focus to include the children and families of OIF/OEF veterans.

APA Resources

The Task Force noted that there are many APA programs and resources that could prove useful if made accessible to the DoD and any practitioners working with service members and their families. While most of these resources have not yet been tailored to specific military populations, it would be easy for individual psychologists or groups to amend and modify them for a military population experiencing deployment-related mental health problems. Examples of key APA resources include:

APA Public Education Campaign materials

Over the last decade, APA's Practice Directorate has developed several different public campaigns in order to educate and provide resources about psychology to the American public. Beginning with the "Talk to Someone Who Can Help" campaign, APA next created the "Warning Signs of Youth Violence" campaign. "The Road to Resilience" campaign materials centered on developing and enhancing resilience skills with adults, which quickly led to the "Resilience for Kids and Teens" and "Resilience in a Time of War" materials. The current campaign focuses on Mind/Body health and highlights psychology's unique role at the intersection between mental and physical well-being.

APA Public Education Web Site (www.apahelpcenter.org)

Intimately tied to the APA Practice Directorate's Public Education Campaign materials is the APA's Public Education website. This website has information and resources about various psychology topics that were written expressly for the public. They are organized around four areas: Work & School, Family & Relationships, Health & Emotional Wellness, and Disasters & Terrorism. Topics that are currently covered include controlling anger, anxiety disorders, coping with death of a coworker, managing traumatic stress, stress's effects on body/mind, resilience, and understanding alcohol use disorders and their treatments. All the information is free to the public and accessible via the website.

APA Psychologically Healthy Workplace Awards Program (www.phwa.org)

The Psychologically Healthy Workplace Awards program is designed to recognize organizations that make a commitment to programs and policies that foster employee health and well-being while enhancing organizational performance and productivity. The Practice Directorate's award program has both state- and national-level components. When organizations such as military units, installations or service branches begin the process of applying for a Psychologically Healthy Workplace Award, they find resources, directions, and support for creating an environment that will promote psychological health amongst their employees while reducing stigma. (More information about the Psychologically Healthy Workplace Awards program and resources can be found on the program's web site.)

Adults & Children Together Against Violence (<http://actagainstviolence.apa.org>)

APA's Adults and Children Together (ACT) Against Violence is a violence prevention project that focuses on the adults who raise and care for children from birth to 8 years old. It is designed to prevent violence by teaching the adults how to be positive role models for young children and create environments that teach nonviolent problem-solving. The project has a national media campaign and includes training for community professionals.

APA Specialty Divisions Resources (www.apa.org/about/division.html)

Several APA membership divisions focus directly on psychologists working both within military settings and with populations affected by military service. The APA Society of Military Psychology (Division 19) presents information about what military psychology is and the important role it plays in the testing, evaluation and clinical treatment of military personnel. Psychologists in Public Service (Division 18) has a VA section dedicated to providing information on clinical practice within the VA and resources to those practitioners. APA's newest Division, the Division of Trauma Psychology (Division 56), provides scientific, clinical and educational information and support to psychologists working with survivors of trauma. At the 2006 Convention in New Orleans, this Division held a symposium entitled "Treating Traumatized Children and Families;" the audio and slides of VA psychologist Terrence Keane's presentation, "Innovations in Treatment of Returning OIF/OEF Combat Veterans and Their Families," are accessible via the Division's website.

In addition to these ample resources, many other APA Specialty Divisions cater to clinicians and researchers whose work is directly related to this Task Force's mission. For example, there is the Society of Clinical Psychology (Division 12), Division of School Psychology (Division 16), Society of Counseling Psychology (Division 17), Society for the Psychology of Women (Division 35), Family Psychology (Division 43), the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (Division 44), Society for the Psychological Study of Ethnic Minority Issues (Division 45), and Society of Clinical Child and Adolescent Psychology (Division 53). The APA web site (www.apa.org/about/division.html) lists all 54 divisions of the APA as well as links to each Division's home web pages and resources.

Graduate & Postgraduate Education & Training (www.apa.org/ed/)

The APA Education Directorate's Office of Graduate and Postgraduate Education and Training works to develop and disseminate information about graduate and postgraduate education and training in psychology; support the development and coordination of national initiatives on quality enhancement in graduate and postgraduate education and training; and encourage, recognize and support innovative practices in education.

APA's Advanced Training Institutes (www.apa.org/science/ati.html)

APA's Science Directorate conducts the Advanced Training Institutes (ATIs) in order to expose psychological scientists to emerging technologies and the most current research methodologies.

ATIs provide training and hands-on experience in a variety of areas, including longitudinal methods, modeling, and measurement, and conducting Internet-based research.

Work, Stress and Health (www.apa.org/pi/work)

The APA Public Interest Directorate works on initiatives focusing on issues regarding work, stress and health. Resources are available on its web site. In 2006 the Sixth Interdisciplinary Conference on Occupational Stress and Health was jointly convened by the American Psychological Association, the National Institute for Occupational Safety and Health, and the National Institute of Justice. The conference proceedings contain the latest information regarding stress and health in the work environment.

Psychology in the Workplace Office (www.apa.org/science/workplace.html)

The mission of this office staffed by the APA Science Directorate is to support research psychologists working within various areas of the field of applied psychological science. Its primary goal is to develop and implement initiatives that facilitate the growth and progression of the field of applied psychological science.

Civic Engagement and Service-Learning (www.apa.org/ed/slce/home.html)

The APA Education Directorate's Civic Engagement and Service-Learning web resources are for faculty, teachers, students, researchers, clinicians, and community partners in order to develop connections between psychological work, promoting the development of service-learning, and issues of civic engagement.

APA Policy Document Publications

One example of a recent APA policy document related to psychologists serving in the military is the *APA Presidential Task Force on Psychological Ethics and National Security* (PENS) report (2006) (www.apa.org/releases/PENSTaskForceReportFinal.pdf). This task force report is now an APA-adopted policy document that focuses on the direct relationship between the APA Ethics Code and the ethical dimensions of psychologists' involvement in national security-related activities.

Section III: Barriers to Behavioral Health Care for Military Personnel and Their Families

A number of factors appear to reduce the likelihood that military personnel and their families will receive needed behavioral health care. Because little empirical evidence exists regarding barriers to care, the Task Force has incorporated other sources of information, including media reports, informal user surveys, and lessons learned from military psychologists. Given the potential importance of these barriers in limiting the provision of care, the Task Force believed it was essential to include a discussion of these factors. The lack of an empirical examination of these constraints constitutes a significant oversight on the part of DoD.

Hoge's 2004 landmark study found that among soldiers who met screening criteria for mental disorders, only 38-45% expressed interest in getting help through the military system, and only 23-40% of them had gotten any professional help in the past year. The MHAT-I (U.S. Army, 2003) found that only 27% of the soldiers who screened positive for depression, anxiety, or traumatic stress received help at some time during the deployment. Although this figure increased to 41% in MHAT-II (U.S. Army, 2005), there remained a significant number of deployed service members who indicated some level of emotional disturbance but did not receive substantial mental health care. Furthermore, these numbers do not reflect two additional groups of service members who may be in need of mental health services: those who underreport mental health problems and those whose problems develop subsequent to their return from deployment. It is important to note that many factors can contribute to the failure of service members to obtain needed mental health care, particularly those in deployed settings. Some may seek help but be unable to access it, whereas others may not seek care for their symptoms and still others may not identify the symptoms as problems in need of care. Although all of these factors may function to interfere with necessary care, interventions to overcome barriers related to stigma experienced by individual service members may be quite different from those designed to ensure that mental health care providers are available when needed.

Data from the Army's MHAT-I (U.S. Army, 2003) and MHAT-II (U.S. Army, 2005) and the Hoge et al. (2004) study of recently returned combat veterans revealed significant barriers to mental health care (see Tables 2 and 3). These barriers resulted from both the military culture and the state of the military mental health care system; they can adversely impact service members and their families who seek needed services.

Although we will discuss barriers in general terms, it is important to emphasize emphatically that the lack of coordination—both across and within military services—results in great variability in quality, availability, and utilization of mental health care.

Potential barriers to effective military mental health treatment can be divided into three broad categories: availability, accessibility, and acceptability. Each of these includes a number of specific obstacles to obtaining appropriate care that can impact both active duty members and their families.

Table 2. Perceived Barriers to Behavioral Health Services on the Part of Returning Service Members (Hoge et al., 2004)	
<i>Statement</i>	<i>Positive Responses</i>
I don't know where to get help	22%
Difficult to get time off from work	55%
Mental health care costs too much	25%
It would be too embarrassing	41%
It would harm my career	50%
Members of unit would have less confidence in me	59%
Unit leadership might treat me differently	63%
My leaders would blame me	65%
Mental health care does not work	25%
I don't trust mental health professionals	38%
I don't have adequate transportation	18%
It is difficult to schedule an appointment	45%

Table 3. Perceived Barriers to Behavioral Health Services – Deployed Service Members (U.S. Army, 2003; 2005)		
	MHAT I (2003)	MHAT II (2005)
Difficult to get time off from work	43%	39%
I don't know where to get help	24%	22%
Behavioral health services not available	24%	n/a
I would be seen as weak	59%	54%
Unit leadership might treat me differently	58%	53%
Members of unit would have less confidence in me	n/a	49%
My leaders would blame me	46%	n/a
Difficult to get to location where behavioral health care provided	26%	20%
NOTE: n/a responses indicate that the item was not included in the questionnaire during its administration.		

A. AVAILABILITY

Several potential barriers to quality mental health care fall under this category.

A.1 There is a shortage of uniformed behavioral health professionals.

At present, approximately 40% of the active duty licensed clinical psychologist billets in the Army and Navy are vacant. Similarly, there is a shortage of Air Force psychologists and shortages of uniformed providers in other specialties, such as clinical social work and psychiatry. General shortages of uniformed behavioral health care providers are exacerbated by the need to deploy significant numbers of these mental health assets into the war zone to provide direct support to service members in theater. Although this has led to an increase in behavioral health assets available to deployed personnel (U.S. Army, 2005), it has contributed to significant shortages of qualified uniformed psychologists available to care for service members who have returned from deployment, as well as their family members. Where available, GS psychologists and/or civilian contract employees provide mental health services within the military's direct care system, but there has been an increased demand for their services as well. Therefore, some military clinics have had to temporarily (or indefinitely) refer all military family members requiring mental health care to local area civilian services via TRICARE. As a result, many family members incur additional costs such as co-pays, face long wait times for care in civilian settings, and receive care from civilian providers who may be unfamiliar with military life and the unique stresses experienced by these patients.

A.2 Psychologist shortages are aggravated by factors such as competing demands placed on providers, professional "burn out," and high attrition rates

The MHAT-II identified significant indications of professional burn-out and compassion fatigue among behavioral health care personnel in deployed settings (U.S. Army, 2005). Specifically, 33% of Army behavioral health personnel surveyed reported high burn out, 27% reported low motivation for their work, and 22% reported low morale. Perhaps more troublesome is the finding that 15% indicated that these problems were impairing their ability to provide care to their patients.

Anecdotal reports indicate there are also high levels of work-related stress among behavioral health care personnel who are not currently deployed. This stress results, at least in part, from the overall shortage of behavioral health professionals and the increased workloads they face due to the deployment of their colleagues. Another contributing factor is that many military behavioral health professionals are faced with the personal and familial stress of their own deployment and possible repeated deployments.

High levels of work-related stress and burn out contribute to difficulties retaining well-trained behavioral health professionals. Subsequently, lower retention rates and increased difficulty recruiting professionals into the military worsen the staffing shortfall. Thus, a vicious cycle has formed that will probably continue to worsen before it improves.

A.3 Even when behavioral health professionals are available, they often lack the necessary training to address the deployment-related needs of service members and their families.

The shortage of military behavioral health professionals is further complicated by the fact that many clinicians in the military lack training in specific techniques necessary to address the needs of military personnel and families. As an example, surveys of military behavioral health providers indicate that only 10% to 20% have been trained to deliver any of the four treatments for posttraumatic stress disorder deemed to be best practices by the VA/DoD consensus panel. This is not to say that military behavioral health professionals are poorly trained. Rather, it appears that the specific training pertinent to the treatment of military personnel, particularly those who are or have been deployed, has not been widely disseminated in military and VA training programs. Thus, clinicians with excellent general clinical skills or specialty expertise in one area (e.g., child psychology) are placed in positions where they must provide care to personnel suffering from PTSD without the appropriate training or supervision in this specialized area. Further, previous efforts to disseminate evidence-based treatments targeting specific problems suggest that it is seldom sufficient to provide instruction alone; the addition of trained supervisors or mentors who can provide consultation and guidance to trainees can be invaluable as they hone their skills (Edna Foa, personal communication, September 2006). However, the declining pool of seasoned military psychologists and the barriers to retaining these senior clinicians limit the opportunities for such supervision and mentoring.

A.4 The shortage of behavioral health professionals within the military services is exacerbated by difficulties in referring military personnel and family members to civilian behavioral care professionals. This problem is further complicated by a shortage of qualified civilian professionals who are trained to take into account the unique aspects of military life.

The use of civilian behavioral health care providers outside of the military's direct care system to fill the gap resulting from the shortage of military providers is complicated by several factors. First, the referral process can be cumbersome and result in substantial delays in treatment. Second, in many locations there is a shortage of TRICARE approved civilian providers. Although specific reasons for these shortages of mental health providers are not clear, common complaints on the part of civilian mental health providers are the low reimbursement rate for behavioral health services and the additional burden associated with excessive documentation and paperwork required by TRICARE. The shortage of qualified professionals who accept TRICARE reimbursement results in limited openings for civilian clinicians to see military personnel or their families.

Just as there are specific problems with the availability of military behavioral health care, the degree to which there are problems obtaining care from civilian providers varies dramatically across communities. Anecdotal reports from providers affiliated with MTFs indicate that some communities have adequate numbers of providers who are well-qualified to care for military personnel and their families. Unfortunately, shortages of qualified providers in other communities raise significant barriers to the provision of needed care. These shortages may be most notable around OCONUS duty stations (Outside the Continental United States) where language barriers may further limit the use of civilian providers, or around duty stations in

remote or rural areas. Finally, the co-pay costs for some families seeking care through the TRICARE system may also limit their ability to access these services.

B. ACCEPTABILITY

Data from the MHAT surveys (U.S. Army, 2003; 2005; 2006) and Hoge et al.'s (2004) study highlight the importance of stigma and other acceptability factors as important components limiting the use of needed behavioral health care by military personnel. The primary issues in this category fall under the general heading of stigma associated with mental health care and the enduring perception that government health services are of poor quality.

B.1 The stigma, real or imagined, related to receiving a mental health diagnosis can be a deterrent to seeking out behavioral health care – especially for service members.

A significant barrier to seeking mental health services – for both military personnel and civilians – is the stigma that surrounds mental illness and accessing needed care. When Hoge et al. (2004) asked soldiers and Marines about the barriers to seeking mental health care, their concerns pertained to internalized shame (e.g., “it would be too embarrassing,” endorsed by 41% of the participants), peers’ judgments (e.g., “members of my unit would have less confidence in me,” 59%; “I would be seen as weak,” 65%), and the effects on one’s military career and leadership’s reactions (e.g., “It would harm my career,” 50%; “My unit leadership might treat me differently,” 63%; “My leaders would blame me for the problem,” 51%). These worries may be particularly salient for individuals most in need of services. The proportion of individuals who endorsed stigma concerns was about two times higher among service members who met screening criteria for a mental health disorder in comparison to those who did not.

Data from the MHAT-I survey (U.S. Army, 2003) of deployed soldiers indicated that stigma was the most frequently identified barrier to care. Particular concerns surrounded how the need for behavioral health care would be viewed by unit members and commanders. There was no significant difference in perceived stigma related to behavioral health care across military rank. Although more soldiers sought mental health care between 2003 and 2005 (U.S. Army, 2003; 2005), “there was no evidence of changes in perception of stigma and other barriers among these soldiers” (U.S. Army, 2005, p. 13).

While there are no empirical data to support service members’ beliefs that their career will be damaged for seeking appropriate behavioral health care, there are anecdotal reports that appear to support this concern. For example, news reports about soldiers seeking care for PTSD indicate that unit leaders do sometimes treat those soldiers poorly “because they don’t belong in the Army” (www.NPR.org, 12/5/2006).

Another issue yet to be addressed in the published literature is the concern about one’s medical records being easily accessible. Service members may worry about having mental health care documented in their medical record, given that these records (hard copy and electronic) remain with them throughout their military careers and may be easily accessed by commanding officers and medical personnel. The perception that confidentiality within the system is limited,

combined with the real concern that having a mental health diagnosis documented in one's medical record may disqualify a service member from being considered for certain jobs within the military, often deters service members from accessing available mental health care.

The potential influence of military rank on individuals' willingness to seek and participate fully in treatment is an additional barrier to treatment. Although we were unable to identify studies that have examined this particular issue, anecdotal reports suggest that some service members are reticent to participate in treatment groups that include members of significantly disparate ranks (i.e., groups that mix officers and enlisted personnel or groups that include senior and junior enlisted personnel).

Although stigma among military family members who are in need of behavioral health care has not been examined systematically, studies of non-military samples suggest that the stigma related to behavioral health problems is a significant deterrent to seeking necessary care (Faye, 2005; Kirkwood et al., 2004). There is every reason to believe that the same would be true among military families, especially given the lack of anonymity within some military communities. These problems may be further exacerbated by service members' concerns that mental health problems identified in their family members may harm a military career.

B.2 Negative attitudes toward behavioral health care available through military and VA facilities can also deter help-seeking behavior.

The perception among some potential users that the care available through VA and DoD facilities is of poor quality can create a significant barrier to the provision of excellent behavioral health care. There are undoubtedly many reasons for these attitudes, ranging from historical reports of the treatment of veterans to personal experiences of poor treatment. Problems related to perceived quality of care at VA and DoD facilities appear to have been diminishing over recent years. However, news reports that focus on the difficulties some service members face when seeking care (e.g., www.NPR.org, 12/5/2006) and potential problems facing the VA mental health care system to address the increased demands (e.g., *The Washington Post*, Friday, December 8, 2006; Page A37) may serve to renew these negative perceptions.

C. ACCESSIBILITY

A number of potential barriers to care have been identified that involve difficulties accessing the care that is available. For example, the limited services available to family members and the long wait lists found in some behavioral health care clinics are attributable, at least in part, to the shortage of qualified behavioral health professionals. Despite attempts to facilitate treatment of OEF/OIF veterans at VA facilities, these problems are present at some VA treatment centers as well as MTFs.

C.1 There are often long wait lists for behavioral health care appointments.

Hoge et al. (2004) reported that almost one-half (45%) of the service members who screened positive for mental health problems felt that it would be difficult to schedule an appointment for treatment. In many care settings, wait lists for behavioral health services can result in treatment

delays that may extend for weeks or even months. Unfortunately, these delays may also result in people not obtaining treatment at all. At times, motivation for treatment is diminished during the waiting period. At other times, job demands or deployments make it difficult to attend regular appointments. The availability of treatment at the time it is sought is also important. Clients' "readiness for change" (Prochaska & DiClemente, 1982) has been associated with success in treatment for many of the problems that manifest in recently deployed service members and their families, including PTSD (Murphy et al., 2004), anger and violence (Daniels & Murphy, 1997; Rosen et al., 2001), and alcohol and drug use (Prochaska, DiClemente & Norcross, 1992). In many cases, the delay in treatment can exacerbate the behavioral problems that led the individual to seek care in the first place. In cases of PTSD, depression, and other serious mental disorders, the exacerbation of symptoms during a treatment delay may have serious or even catastrophic results, including increased problems related to substance use and suicide (www.NPR.org, 12/5/2006).

C.2 Behavioral health services through the MTF may not be available to family members.

Also related to the shortages of qualified professionals noted earlier are limitations on access to services for family members at MTFs. Such circumstances often require family members to seek services from civilian providers in the TRICARE system, with its own associated problems around quality and availability.

C.3 Clinic hours are limited.

In many DoD and VA behavioral health care settings, outpatient hours typically overlap with standard workdays (i.e., 0730 – 1630 or 0800 – 1700). This means that service members or their family members must take time from their work schedules to attend appointments. As noted in the Hoge et al. (2004) study of barriers to care, being unable to take time off from work to attend appointments was the most frequently cited (55%) accessibility issue that interfered with obtaining necessary behavioral health care. Although similar problems may arise in civilian settings (indeed many civilian practices have evening hours for just such reasons), the problem may be particularly salient in military settings where commanders might be hesitant to release personnel from training exercises or other duties to attend behavioral health care appointments. Military personnel, fearing stigma, may be reluctant to make such a request.

C.4 There are breakdowns in the referral processes.

The military has instituted a policy that requires service members to complete a questionnaire at several points in the deployment cycle in order to improve identification of personnel who are potentially in need of behavioral health care. The questionnaires are the Pre-Deployment Health Assessment (PHA), administered shortly before deployment, the PDHA, administered shortly before the service member returns home from a deployment, and the PDHRA, administered approximately 180 days following the service member's return from deployment. The result of these efforts is increased awareness of the potential impact of deployment and combat on mental health. Unfortunately, the identification of potential problems does not necessarily lead to needed treatment. A recent GAO report concluded that only about 22% of those who screened positive for PTSD actually received a referral to treatment. Similar issues occur regarding broader mental

health concerns. Hoge et al. (2006) found that about 23% of the OIF veterans and only about 18% of the OEF veterans who screened positive for mental health concerns were actually referred for treatment.

It is not clear why there was a lack of follow through in making referrals, but the GAO report concludes that the DoD cannot provide reasonable assurance that personnel who need referrals for mental health problems actually receive them. Based on anecdotal reports, it seems likely that the PDHRA referral system suffers from the same inconsistencies across facilities and services as are observed in mental health care more generally. That is, at some locations most service members who require referrals will receive them, whereas at other facilities this is not the case. This problem may be exacerbated by the lack of any specific guidelines or training requirements for personnel who are conducting the screenings.

C.5 Difficulties in transitioning between DoD and VA mental health care systems.

As is the case with the identification of mental health needs, efforts have been made to reduce difficulties in the transition from the DoD to the VA health care system. These efforts have occurred on various levels and include changes in processes (e.g., establishing referral procedures for transferring injured service members from DoD facilities to VA care), outreach to service members (e.g., systematic briefings on VA benefits), and training of VA personnel (e.g., education about OEF/OIF veterans' eligibility for VA care). These efforts have greatly improved the transition between health care systems, but significant difficulties remain, such as problems in transferring electronic medical records from DoD to VA systems (GAO testimony before the House Committee on Veterans' Affairs, GAO-05-1052T), delays in processing and long waitlists to see a specialist. Problems with the system may be particularly salient for service members with mental health concerns, whose coping and problem-solving abilities may already be compromised.

Although steps have been taken at the system level to facilitate the transition of physically injured service members to VA care, the transition of mental health care continues to rely heavily on the service member him- or herself to follow through on a referral. Many of the reasons that contribute to difficulties seeking mental health care within the military (e.g., stigma, shortage of providers, and limited appointment times) can also make it hard for individuals to obtain mental health care through the VA. In addition, the fact that many service personnel do not obtain needed mental health care while in the military means that there is often no formal referral made to the VA.

C.6 Practical limitations, such as transportation and childcare needs, also may decrease accessibility.

There are a number of practical issues that can serve as barriers to seeking and obtaining behavioral health care. For example, the lack of reliable transportation or available child care can make it impossible to attend appointments regularly. These issues were among the least frequently endorsed barriers in the Hoge et al. (2004) study of service members. However, such issues may be more problematic for military family members, particularly when service members are deployed. Also, it is likely that these issues will be more germane to members of

Reserve units and the National Guard, as well as for their family members, who are more likely than active duty personnel to live some distance from care providers.

D. OTHER COMPLICATING FACTORS

In addition to the barriers identified above, there are a number of other issues that complicate the delivery of quality behavioral health care to military personnel and their families. Although not direct barriers to delivery of care, these factors likely contribute to difficulties faced by service members and their families when they seek behavioral health care.

D.1 The treatment of National Guard and Reserve personnel adds unique, complex issues.

The large number of National Guard and Reserve personnel who have been activated and deployed to OEF/OIF raises significant complexity in the provision of behavioral health care. Because National Guard and Reserve troops are often dispersed within the civilian community and live some distance from MTFs and VA Medical Centers, outreach efforts and mental health services are difficult to deliver. Additionally, these individuals and their families may not qualify for the same services as active duty personnel who receive comprehensive care through the military's direct care system. While all personnel who have been deployed to a combat zone in support of OIF/OEF and have an honorable or general discharge are eligible for two years of health care through the VA, VA medical centers and clinics do not provide individual therapy for family members, regardless of previous military status.

D.2 Gay and lesbian personnel with mental health problems.

Military life can pose additional challenges for gay, lesbian, bisexual, and transgender (GLBT) personnel. Despite the "don't ask, don't tell" policy espoused by the military, it is clear that many non-heterosexuals are serving in uniform and their sexual orientation is known to others. A poll of 545 troops who served in Iraq and Afghanistan conducted in October 2006 revealed that 23% said they knew for sure that someone in their unit was gay or lesbian. More than half (55%) of the troops who knew a GLBT peer said the presence of gays or lesbians in their unit was well known by others (Zogby Interactive Poll conducted in conjunction with the Michael D. Palm Center at the University of California, Santa Barbara; http://www.palmcenter.org/press/dadt/releases/dont_ask_dont_tell_isnt_working_survey_reveals_shift_in_military_attitudes).

Although research done in the civilian sector has found that hostility toward gay men and lesbians has decreased in recent years (Herek, 2002), there are no comparable data for active duty personnel (Herek & Belkin, 2006). A very recent decision by the DoD to include homosexuality in a list of "conditions, circumstances and defects" in a recently-revised military instruction has raised concern among the APA and other groups about the military's attitudes toward non-heterosexual people (http://www.palmcenter.org/press/dadt/releases/military_document_suggests_that_homosexuality_is_a_defect).

As a result of the attitudes toward GLBT persons within the military, these service members may struggle with several issues beyond the typical challenges faced by military personnel in a combat zone (Johnson & Buhrke, 2006). These include the psychological toll of secrecy, judgments and negative attitudes by others, and fears of the consequences of disclosing their orientation (possibly including dismissal from the military).

D.3 Racial/ethnic minority military personnel with mental health problems.

It is worth noting that over 30% of active duty military personnel are members of racial/ethnic minority groups (MFRI, 2004). Like minority group members in other contexts, racial/ethnic minority service members continue to experience varying degrees of discrimination and racism. The military has worked diligently to create a fair and non-discriminatory environment, and military psychology training programs, in particular, place a strong emphasis on developing cultural competence. However, because members of racial/ethnic minority groups may have experienced discrimination prior to military service and because minority group membership may be associated with alienation or discrimination within certain military units, having access to culturally astute clinicians is essential. Given the shortage of well-trained uniformed mental health providers within the military, however, there is concern about whether civilian providers filling these vacancies will have the cultural awareness and competence required to integrate relevant cultural variables into effective prevention and treatment services.

D.4. There is a paucity of data on the psychological needs of female military personnel.

Female military personnel, while increasing in numbers, continue to be a significant minority in the total military force. Whereas military leaders remain committed to recruiting, retaining, and promoting women within the military, our understanding of how females are uniquely impacted by the military environment is quite limited. The members of the Task Force are concerned about the limited knowledge we have regarding how females are uniquely affected by deployment and their experiences in war zones. Of particular concern is the lack of information on how a woman's combat experiences affect her ability to readjust to family life upon return from deployment. Does a woman's front line exposure impact her ability to care for the emotional needs of her children following the reunion phase? How does bearing children and the subsequent demands of parenting impact career opportunities and promotion rates for women when compared to men? Clearly, more research is needed in order to provide for the needs of women in military services.

D.5 The VA system is adapting to a new influx of patients who are generally younger than the existing VA patient populations.

An interesting challenge to the provision of mental health care relates to the complications of integrating the new, oftentimes young, veteran population with the current aging populations within the VA health care system. For the past decade, the VA system's prototypical patient has been a Vietnam-era male who is facing mid-life and retirement issues, often with accumulating physical health challenges. As described above, the newer generation is distinct in many ways, and mental health providers may not be accustomed to treating this cohort. Furthermore, some

OIF/OEF veterans may feel “out of place” being in mental health treatment with other veterans who are much older and who are struggling with different experiences.

D.6 Difficulties can arise from working in the military health care setting.

There are aspects of serving as a military behavioral health professional that may limit the availability of care for service members and their families. Some of these problems are unique to (or more likely to arise in) the military setting whereas others also occur in civilian care settings. For example, in many civilian and military settings there are strict expectations for workloads (e.g., contact hours) placed on behavioral health care professionals. Unfortunately, the guidelines may exclude potentially valuable work, such as outreach or prevention efforts, from workload calculations. As a result, proactive professionals may not receive “credit” for such valuable activities.

It is also important to realize that as military officers, uniformed behavioral health care providers have a number of obligations and job requirements that are not shared by their civilian colleagues. Such obligations may limit the time that these professionals are available to provide care to military personnel or their families. Chief among these duties is the obligation to deploy to combat environments during time of war. This reduces the number of professionals available at the MTFs, and serves as a detriment to provision of continuous care to service members and their families. It should also be noted that criteria for career advancement (i.e., promotion) within the military may depend on many aspects of job performance other than expertise or performance in the area of clinical care. As a result, military behavioral health care professionals hoping to move up the ranks may find it necessary to allocate more time to these other tasks than to clinical care.

D.7 The military culture often prevents open discussion of problems related to behavioral health care.

There is a strong sense among uniformed military behavioral health professionals that raising concerns about the quality or quantity of care available for military personnel will not be well-received up the chain of command. The hierarchical rank structure within the military often inhibits junior officers from bringing problems to the attention of senior officers, who have significant influence over their careers. The suppression of ideas and opinions is both subtle and overt, and the effect is the reduced likelihood of finding or sharing solutions to pervasive obstacles to health care delivery. It is also likely that discomfort associated with revealing or discussing problems with the design or delivery of behavioral health care contributes to lower morale among behavioral health care providers.

CONCLUSION:

The Task Force believes that the barriers discussed in this report would be best addressed by a strong, centralized leadership structure that clearly values open exploration of both the problems and solutions associated with mental health care delivery. Further, these leaders need to formulate a clear and coherent plan for systemic change that is compatible across service branches. By developing a well-coordinated, well-reasoned, tri-service approach to the mental health challenges posed by OEF/OIF and providing careful oversight, behavioral health leaders could begin to reduce the barriers to quality care associated with availability, acceptability and accessibility. The urgency with which this should be done cannot be overstated. Never before has our nation been engaged in a conflict requiring redeployment of service members who have already been diagnosed with PTSD to the same combat zone where they were originally traumatized. This policy, recently announced by the Assistant Undersecretary of Defense responsible for Health Affairs (Winkenwerder, 2006), allows service members with a previous mental health diagnosis and service members on psychotropic medication to be redeployed in support of OEF/OIF operations. Given that the demands on our military members are unprecedented and the long-term impact is still largely unknown, it is imperative that the DoD move quickly to examine empirically the mental health needs of service members and their families and assume full accountability for ensuring every service member and military dependent has easy access to high-quality, evidence-based, behavioral health care.

Section IV: Recommendations

Support for building and maintaining the positive mental health of our nation's service members and their families is crucial in order for the United States military to fulfill its mission. The mental health needs of service members and their families are often misunderstood, ignored, and underserved due to inadequate resources, poor planning, and lingering stigma associated with mental health care. However, there are many positive military mental health programs currently in place, as well as an increased awareness by the military regarding the need to improve these services. The Task Force on Military Deployment Services for Youth, Families and Service Members noted many of the key issues and barriers to services for those in the military community. The final section of the Task Force report provides salient recommendations for further development and enhancement of mental health services available to members of the military and their families:

1. Policy and Systems

1.1 Centralized leadership of military mental health is crucial to allow for coordination of the services provided on military installations and in surrounding communities.

APA advocates for centralized leadership of military mental health services—particularly those delivered by psychologists—and the coordination of those services across communities and military installations. A consistent and accountable leadership structure is vital to improving both morale among military psychologists and service delivery to service members and families. APA's Psychologically Healthy Workplace Program may be useful in identifying both the strengths and areas for improvement at all levels of management within military health care organizations.

1.2 Increased education of military leadership at all levels regarding the value of mental health services is considered critical for expanding those services as well as reducing stigma associated with seeking those services.

APA encourages efforts to inform military personnel at all levels regarding the nature, prevalence, and importance of mental health needs and mental health care as they relate to mission achievement. Incorporation of this education should occur in enlisted and officer training schools and should be publicly supported by top military leaders and APA.

1.3 Unrestricted access to high-quality mental health care should be made available to every active duty service member and his or her family members.

APA believes there should be high-quality and easily accessible mental health resources available to U.S. military service personnel and their families within the military's direct care system. APA recommends that appropriate funding for high-quality mental health care be a top DoD priority.

1.4 Policy and procedural development should take into account the diverse populations found within the U.S. Military and be responsive to mental health needs based upon an individual's situation and background.

Psychology's research base and APA's resources for practicing psychologists (e.g., "Guidelines on Multicultural Education, Training, Research, Practice;" "Organizational Change for Psychologists;" and "Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients") offer guidance on the provision of appropriate mental health services to various populations.

2. Research

2.1 The paucity of research on mental health issues related to deployment in the military highlights the need for a well-developed and focused research agenda to guide policies, program development, and treatment plans for service members and their families.

APA recognizes a need for and would support a focused research agenda that is clinically relevant to military members and their families (e.g., examining the psychological impact of deployment on military personnel and their families during the various phases of deployment, stress/anxiety/depression amongst children/spouses of active duty military members compared with children/spouses of Reserve/National Guard members, etc.) and encourages the DoD to develop such an agenda with input from military psychologists and relevant APA divisions.

2.2 Research focused on the specific mental health needs of the military community, barriers to accessing care, and the efficacy of existing prevention and intervention programs is critical to making mental health care in the military more relevant, available, and effective. Such research is essential to establishing evidence-supported services and eliminating inequity and inefficiency across military mental health care facilities.

APA believes it is imperative that research is conducted to evaluate the effectiveness of current and future military mental health care prevention and intervention programs. DoD, with the support of APA, should fund more research focused on access and outcome and establish clearer guidelines bearing on standards of practice for assessing and treating specific problems and disorders in military mental health facilities.

2.3 Research is required to understand the toll that combat environments take on the mental health and effectiveness of military psychologists. Recently, military psychologists have been deployed as members of active combat units, small medical teams on the front lines, and as operational psychologists assigned to intelligence gathering or special operations units. There is virtually no research on the first-hand experiences of psychologists assigned to these jobs.

APA is particularly concerned about the mental health of psychologists who serve in combat environments and recommends concerted attention on the part of both APA and DoD to better understand the experiences and needs of these psychologists (e.g., what is the prevalence of stress-related disorders among psychologists in combat environments,

what is the military currently doing to screen and treat military psychologists for these disorders, and how have repeated deployments and associated stressors impacted the careers, practice efficacy, and family lives of those psychologists?).

3. Clinical Services & Community Outreach

3.1 Continuity of care provided by programs such as the Operational Stress Control and Readiness (OSCAR) program, in which psychologists are embedded with units throughout the deployment cycle, should be evaluated and, if found effective, be expanded to all military units.

The limited research evidence related to OIF and OEF combatants demonstrates that significant mental health problems emerge across all phases of the deployment cycle; it appears most appropriate to create programs centered on providing continuous care at each phase of deployment.

3.2 Family members' access to high-quality mental health services through TRICARE should be improved.

There is a tremendous amount of anecdotal information regarding families having limited accessibility to TRICARE Mental Health Services. As a primary health resource for families, it is imperative that TRICARE be universally available, easily accessible, and tailored to the mental health needs of military family members. It is particularly important that TRICARE employ an appropriate number of child psychologists to meet these needs and to identify them as such in the referral process.

3.3 Mental health services should be available throughout the deployment cycle and include a focus on prevalent diagnoses/conditions such as adjustment disorder, substance abuse, PTSD, Traumatic Brain Injury (TBI), depression, grief/bereavement, and family violence. Further, mental health services through the deployment cycle should incorporate prevention and intervention strategies designed to help families.

A wide variety of symptoms and disorders have been identified as negatively impacting the mental health of service members and their families. APA believes it is important that the range of routine services available to service members and families incorporate evidence-supported interventions.

3.4 Psychologists should partner with their primary care colleagues to integrate psychology into the primary care arena.

APA recognizes that primary care providers (PCP) provide "front line" health care to service members and their families. Increasing PCP awareness of deployment-related mental health issues, prevention strategies, primary care intervention strategies, and appropriate mental health referrals is a critical role for psychologists. By integrating into primary care, psychology can increase its impact upon the well-being of service members and their families.

3.5 Outreach programs should be developed and fostered by both the military and non-military communities in order to ensure that—wherever possible—mental health problems among service members and their families are prevented rather than treated.

APA recognizes the need for outreach activities by psychology to military communities, and agrees to help facilitate a collaborative activity designed to share the Association's Public Education Campaign resilience materials with military psychologists. Furthermore, APA advocates system-wide education on the value of mental health services as well as efforts to reduce stigma associated with seeking and receiving mental health care.

4. Service Providers

4.1 In order to reduce severe staffing shortages evident across all military services, an all-out effort should be made by the military to retain well-trained and experienced psychologists. Retention of seasoned experts is crucial to the provision of high-quality psychological services to military members and their families.

APA recommends deliberate study of the problem of attrition among military psychologists and assertive steps by DoD to curb the loss of key mental health professionals. APA further advocates for the development of a military psychologist support program within the military to provide prevention, support, and intervention services for psychologists impacted – either directly or vicariously – by stress and trauma associated with combat. APA's Advisory Committee on Colleague Assistance is one resource that could be useful in addressing professional burnout and attrition issues.

4.2 Efforts to recruit new psychologists into the military should be strengthened and informed by an understanding of the reasons for attrition among current practitioners. Because military psychologists often practice in isolated environments and shoulder significant responsibility for solo clinical decision-making, all military psychologists should be licensed (or license eligible), thereby ensuring that all those who provide services to military members and their families meet minimum standards of competency.

APA recommends that mental health services in the military be provided by psychologists who meet the minimum standards of practice within their profession as determined by the licensing standards established by state psychology licensing boards.

4.3 Because the well-being of families has a direct impact on the ability of service members to carry out their duties, there should be an increase in available psychological services for the families of service members across all phases of the deployment cycle.

APA believes the U.S. military should consider making a concerted effort to recruit, train and retain experienced psychologists in order to ensure military personnel and their families are receiving appropriate mental health services. Continuing to add more civilian

(non-military) positions within the military direct care system will likely be an important part of the strategy for addressing the current deficit of uniformed psychologists.

5. Professional Education and Training

5.1 It is vital that the military maintains the integrity of psychologists' specialty training and ensures that this specialized training is appropriately utilized when assigning individuals to specific duty stations. Although the exigencies of wartime practice often require those with specialized training to fill generalist billets, such assignments should be the exception, not the standard.

The skills and training of psychologists with specialty training (e.g., family psychology, child/adolescent psychology, and neuropsychology) are best utilized when their work assignment is tailored to their unique skills.

5.2 Clinical supervision for unlicensed professionals is critical to ensure the provision of high-quality services. Consultation and ongoing mentoring for military psychologists are also essential for professional development and continuous quality improvement.

APA believes that it is vital for all psychologists, both military and civilian, to have access to appropriate clinical consultation. Psychologists must be given the opportunity to consult with their peers and be provided with professional development opportunities in order to further enhance clinical skills, avoid burnout, and reduce instances of undetected vicarious traumatization.

5.3 Training and education regarding the unique needs of service members and their families who are faced with deployment must be on-going for all mental health service providers (including all military services and civilians) who treat these populations. This should include training in the latest evidence-based treatment protocols, such as that provided by the Center for Deployment Psychology, to ensure the appropriate translation of contemporary research to clinical military practice.

APA recognizes that it is vital for the latest research developments and newest evidence-based practices to be disseminated to all psychologists providing treatment to military personnel and their families as soon as such information is available.

6. Budget

6.1 Budgetary resources within DoD need to be allocated to address problems such as the understaffing of psychologist billets, unmet clinical needs of service members and their families, and deficits in research bearing on the mental health needs of war-fighters, family members, and military psychologists.

APA supports a funding increase in budget lines, both within the U.S. Department of Defense and the U.S. Department of Veterans Affairs, to provide the financial support

necessary for the development and expansion of mental health services for U.S. military personnel and their families.

7. APA Next Steps

7.1 The APA Council approves the establishment of a two-year task force to review this Task Force's preliminary findings so that a long-term plan of action with specific recommendations for APA regarding mental health services for military service members and their families may be developed and presented to the Association.

Due to the time sensitive nature of many of the aforementioned recommendations, and the likelihood that APA will need to take programmatic action prior to 2009, this proposed task force would also be charged with presenting short-range action plans periodically to the APA Board of Directors. These plans will eventually tie into the final plan submitted at the completion of the two years.

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