



From the Battlefield to the Homefront: The Expanding Role of Mental Health Professionals in the Military

A Review of

Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military
by Amy B. Adler, Paul D. Bliese, and Carl Andrew Castro (Eds.)

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One can argue that more attention has been paid to mental health issues of military personnel during the wars in Iraq and Afghanistan than at any other time in the history of warfare. Incidents of violence, directed at self and others, have led to a whirlwind of coverage in the media, which in turn has led to the allocation of more than \$900 million to the military for additional mental health interventions and research. Mental health issues have been prominent throughout the wars, with suicides outnumbering combat deaths in both 2009 and 2010 (Donnelly, 2011).

The focus of *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military* is on U.S. Army research. Many of the chapters highlight studies conducted by the Walter Reed Army Institute of Research. Although the focus is on army research, military psychologists from all of the services will find much of value.

An important theme of this book is that to moderate the impact of combat on the mental health of service members, mental health professionals need to be concerned with more than the traditional tasks of assessment and treatment. Adopting an occupational health model, the authors emphasize the importance of moderating the impact of combat through "individual screening, training, peer support, leadership, and organizational policies" (p. 5). That is, service members will be less likely to develop mental health problems if they receive training to build coping skills, support from fellow service members, strong leadership that fosters a supportive environment, screening that can lead to appropriate referrals, and organizational policies that help to create optimal levels of support for service members.

Thus, the book is about how mental health professionals can try to create organizational change. It does not focus on the nuts and bolts of evaluating or providing treatment for a single client. Although it is not meant as a guide for a clinician seeing clients in a mental health clinic, it does address mental health issues that are of critical importance for the mental health of service members.

The book is divided into two main sections. The first, Supporting Resilience in a Deployment Context, describes approaches within the army to support soldiers and units while they are deployed. The goal of the second section is to describe approaches for helping deployed soldiers and units with the transition and adjustment home.

Historically, research assessing the impact of wartime military service on mental health has been conducted years or decades after the transition home. This is not the case with the present wars. The first chapter, by Hoge, describes the application of epidemiological methods to assess the mental health impact of deployment. New questionnaires were developed and studies conducted during the wars in Iraq and Afghanistan.

For example, in one study (Bliese, Wright, Adler, Thomas, & Hoge, 2007), soldiers returning from deployment reported

two to five times more mental health problems on the Post-Deployment Health Re-Assessment (PDHRA), a screen administered three to four months after their return from deployment, than on the Post-Deployment Health Assessment (PDHA), a screen administered immediately after their return. The goal is for service members who report many problems to be referred for mental health services, leading to a reduction in symptoms. However, studies have not yet demonstrated the utility of postdeployment screening for reducing the mental health impact of combat.

The second chapter, by Warner, Appenzeller, Breitbach, Mobbs, and Lange, presents guidelines and recommendations for mental health professionals in deployment settings. The biggest change from previous wars has been an increasing focus on (a) prevention and (b) providing consultant services to commanders.

Combined, the authors were deployed for more than 85 months as mental health providers in a combat environment, and this chapter will be most helpful to clinicians who are likely to follow them in that role. The authors acknowledge that limited evidence is available to guide practice. For example, although there is a tradition of debriefing in the military following a traumatic event, considerable debate exists among military and civilian mental health providers about the value of debriefings.

Greenberg and Jones discuss the role of peers and leaders in optimizing mental health support. They helped to implement the Trauma Risk Management (TRiM) System that was first implemented by the UK Royal Marines Commandos and subsequently rolled out across the majority of the UK Armed Forces, with the exception of the Royal Air Force. The system is run not by mental health professionals but instead by line officers, with support from mental health professionals who provide audits and quality assurance for the training courses.

TRiM practitioners are embedded in units and provide ongoing mentoring, which is important in part because it allows them to act as the eyes and ears of the medical and mental health services and to identify who might benefit from formal assessment or treatment. Although TRiM appears to be a useful tool, empirical evidence supporting its use is mentioned only in passing.

Bliese, Adler, and Castro describe research-based preventive mental health care strategies. Large randomized trial studies have been conducted. Resilience training interventions have been found to lead to statistically significant outcomes, but the effects have been small in size. For example, Adler, Bliese, McGurk, Hoge, and Castro (2009) reported an effect size of $d = 0.21$ for a high-combat group. This is equivalent to a correlation of 0.10. Although the effect size is small, an hour-long intervention that yields significant results months afterward can arguably be worthwhile.

The impact of combat deployment on military families is discussed by Riviere and Merrill. That military families are at increased risk for mental health disorders is illustrated by a survey of 940 military family members (Eaton et al., 2008). Twenty percent of the spouses reported symptoms meeting the criteria for current major depressive disorder or generalized anxiety disorder, and 10 percent reported symptoms meeting the criteria for posttraumatic stress disorder (PTSD). This is a growing area of research, and future results will help us better understand the impact of stressors on military families and the utility of early interventions.

The transition home and the efficacy of military decompression programs are described by Adler, Zamorski, and Britt. Decompression programs last typically for three to five days and take place in a location other than the country of deployment or the country of return. Across several studies, service members have generally reported liking these programs, and they have been more favorable toward them after having actually gone through the programs. Whether transition programs have positive long-range effects on psychological functioning is unknown.

Mental health screening is discussed by Bliese, Wright, and Hoge, and although they encourage screening service members upon their return from deployment, they argue vociferously against using mental health screening to select applicants for entry into the military. In fact, they argue that this is a hopeless task: "In the end, one simply runs into a mathematical reality that any attempt to develop selection-based screens for psychological vulnerability would produce too many rejections of individuals who would have otherwise performed well" (p. 179).

However, it is not appropriate to suggest that science should not be used to address such an important problem. If one

can identify applicants with a history of significant mental health or behavioral problems, then it will be worthwhile to share this information with the medical officers at enlistment stations (Garb & Cigrang, 2008).

Roy and Francis examine the bidirectional impact of comorbid physical and psychological injury in combat veterans. They review pathophysiological explanations, as well as the impact of coping style and functional status on recovery. In particular, they focus on the interaction between PTSD, traumatic brain injury (TBI), and limb amputation, often considered the “signature” wounds of the current conflicts.

The review reveals significant gaps in the research literature, particularly with regard to the differentiation of PTSD and mild TBI. Nonetheless, the authors make a strong argument in favor of concurrent psychological treatment rather than waiting to address mental health needs until after physical injuries have been resolved.

Anyone who has worked with combat veterans struggling with PTSD can attest to the difficulty many experience in trying to identify a single, discrete traumatic event. This is just one of the many differences that Castro and Adler argue differentiates combat-related PTSD from the more traditional “victim-based” model of PTSD (p. 218). They make a compelling argument for reconceptualizing combat-related PTSD using an occupational model, which recognizes that many service members do not initially respond to traumatic events with “fear, helplessness, or horror” (p. 218) and that many PTSD symptoms (though not all) can be adaptive for extended periods of time during deployment.

This reconceptualization leads to recommendations for population-level preventive training and for targeting “high risk” units for early intervention. While these are worthy endeavors, it remains to be seen whether this approach will lead to significant improvements in the treatment of combat-related PTSD.

In the final chapter, Keane, Niles, Otis, and Quinn present a more traditional model of PTSD that highlights the role of individual risk and resiliency factors, such as level of combat exposure, biological vulnerability, and availability of social support. The authors describe evidence-based treatments for PTSD, including cognitive processing therapy and prolonged exposure, as well as the challenges of disseminating manualized treatments. This chapter stands in contrast to the rest of the book because it serves as a guide for clinicians seeing clients in a mental health clinic.

As this book illustrates, mental health professionals in the military can no longer confine themselves to working with individual clients in the clinic. Instead, working with commanders, developing programs to enhance peer support, guiding organizational policy change, and developing population-wide programs have become important tasks for mental health professionals in all of the services.

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Footnotes

The views expressed in this review are those of the authors and are not the official policy of the Department of Defense.