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Military Strengthens Effort to Solve Growing MH Crisis

Aaron Levin

Severe stress is inevitable for troops going off to war, so the military services have to plan for it, including how to lessen the stigma of seeking mental health care.

Imagine if the governor of your state focused every day on mental illness, Robert Ursano, M.D., suggested to his audience at APA's 2009 annual meeting last month in San Francisco. The thought alone is so unlikely that it sounds shocking, but that is what the top ranks of U.S. armed services are doing now.

"Never before in our history has there been such leadership concern as now in the Department of Defense and the Department of Veterans Affairs," said Ursano, a professor of psychiatry and neuroscience and chair of the Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Md., and director of its Center for the Study of Traumatic Stress.

That concern is buttressed at the other end of the spectrum by research teams—like the Army's Mental Health Assessment Team and the Navy/Marine Corps' Behavioral Health Assessment Team—that go into the field in war zones to evaluate needs and develop information that will improve services to troops.

With almost eight years of war behind them, members of the U.S. Armed Forces have had to face repeated deployments with attendant combat, family separation, injury, and the deaths of comrades.



**Navy Capt. Paul Hammer, M.C.,
tells annual meeting attendees**

that civilian clinicians may need to learn more about military life and culture to better connect with service members seeking care.

Credit: David Hathcox

Each service has its own approach to preparing for and dealing with the stresses of military life, said Navy Capt. Paul Hammer, a psychiatrist and director of the Naval Center for Combat and Operational Stress Control in San Diego.

The Navy, which also provides medical services for the Marine Corps, has its "stress continuum" model that places a sailor's or Marine's psychological status along a line from "Ready" to "Reacting" (mild, transient, "common" stress reactions) to "Injured" (severe, persistent symptoms) to "Ill" (major depression, anxiety, or PTSD).

The service tries to build a culture of resilience, defined as "adapting to a challenging new situation, establishing a 'new normal,' and realizing how to grow," said Navy Capt. Edward Simmer, M.C., a psychiatrist.

Training needs to be realistic, but that means more than learning about weapons and small-unit tactics, said Simmer.

"We work on self-care and buddy care," he said. "Somebody—a sergeant, a buddy—sees fellow service members every day and can make sure they're OK. Sailors and Marines are trained not only to watch out for their unit members but to apply simple interventions like sleep or decent hot meals."

In the field, Simmer and his colleagues don't wait for Marines to appear at their tent door. They spend half of their time in Iraq or Afghanistan walking around, visiting troops at guard stations, simply talking. "Education can happen anywhere," he said.

To prepare for deployment, the Navy provides comprehensive combat and operational stress training "from boot camp to war college," said Hammer. "Troops face danger even if they are not in combat."

When he teaches at the service's senior enlisted academy, Hammer avoids psychological jargon and makes combat stress training relevant to the small tactical units his students will lead.

Like the Army, the Navy is hiring more mental health professionals and training general health personnel in the basics of mental health care. It is also expanding its telehealth capabilities and hiring and training mental health case managers; it also has begun substance abuse training based on the Hazelden model.

All of this has to be provided in the "unique context of the Navy" and its culture, Hammer emphasized.

"If you don't speak Navy or Marine Corps, sailors or Marines won't talk to you," he said. The divide isn't just military/civilian. Even Navy physicians detailed to serve on Army bases in Iraq or Afghanistan have to overcome these initial cultural differences.

The hurdle may be a little higher for civilian clinicians without military experience who see military personnel or veterans in their practices. They may not understand the military world as a distinct culture and assume that they are more familiar with it than they are and make some missteps, Hammer said in a follow-up interview.

"I think we need to have some sort of military primer for training clinicians," he suggested. "It is important for clinicians to think of military personnel as they would people from another culture that is unfamiliar to them: be respectful, ask appropriate questions, and clarify."

In any case, any service member who has decided to seek help is probably ready to bridge the gap. The Navy has a Web page explaining what to expect and what to do when seeing a therapist, he said.

All the services are now trying to overcome stigma by featuring senior leaders (including at least several generals) who talk about their own psychological stress reactions and their decisions to seek help. Public service announcements send a message that "it's a duty to seek care."

Another way of overcoming stigma is to encourage troops in distress to visit their chaplains. Historically, conversations with chaplains have been subject to complete confidentiality, while other counselors and medical personnel have been required to report any impairment to the chain of command.

Stigma may be the biggest problem in the realm of military mental health, said Ursano, in summing up the session.

"In mental health we don't have a common cold," he said. "Everything is perceived as a major illness, but not all of our illnesses are cancer. We need care across the whole spectrum of our diseases."

Finally, diagnostic standards for the psychiatric disorder most commonly associated with war, PTSD, will have to be rethought in the light of actual military experience, said Ursano.

"The A2 criterion for PTSD will have to be addressed," he said, echoing other speakers at the session. "A2 deals with fear and helplessness. However, trained soldiers engaged in battle don't always say they are frightened, helpless, or anxious, yet a percentage returns home and develops PTSD. Something's wrong with our criteria."