

# Soldier Peer Mentoring Care and Support: Bringing Psychological Awareness to the Front

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Since the Persian Gulf War of 1990-1991, the operational tempo for soldiers has steadily increased, whereas the numbers of soldiers available to fulfill these missions has decreased. As a result, soldiers and their families are experiencing increased levels of stress that continue to manifest in ways that can often be destructive for the soldiers, their families, and the Army community. Current mitigation and identification support systems such as the Chain of Command, non-commissioned officer leadership, chaplains, and family support systems have all provided critical services, but may not be expected to optimally perform necessary early risk management assessment. Behavioral health care as a self-referral system is often still perceived as career ending, shameful, or even culturally unacceptable. Our allies have also experienced similar family, operational, and combat concerns. In 1996, at the direction of their Commandant General, the British Royal Marines developed and instituted a peer-driven risk management and support system that has experienced a high degree of success and acceptance among its forces—enough so that the Royal Navy is now in the process of implementing a similar program. The Soldier Peer Mentoring and Support program, as part of the proposed deployment Cycle Support Program, is a model for peer group assessment based on the British Royal Marines psychological risk management and support system. This article presents and describes this project, which has been considered for use within the U.S. Army, as a potential augmentor of existing behavioral health support assets as a culturally acceptable, company-level support program in deployment and home stations.

## Introduction

Since the Persian Gulf War of 1990–1991, the operational tempo for soldiers has steadily increased, whereas the numbers of soldiers available to fulfill these missions has decreased. From 1989 to 1996, the active Army numbers were reduced by 262,000 soldiers, and the Army Reserve and Army National Guard reduced its total force by an estimated 111,000 and 90,000 soldiers, respectively.<sup>1</sup> During the same period, operational deployments increased by about one-third.<sup>1</sup> Fewer re-

sources and expanded missions such as the Global War on Terror are all factors affecting today's soldiers and their families. These factors, in addition to the inherently stressful nature of military duty, leave military personnel vulnerable to potentially severe psychological distress and adverse psychological outcomes.<sup>2</sup> The scientific literature has consistently provided evidence that adverse psychological outcomes such as post-traumatic stress disorder (PTSD), depression, family violence, and substance abuse are significant problems within fighting forces, leading to profound occupational disability and early military attrition.<sup>3</sup> As such, there are strong moral, legal, economic, and mission-related reasons for the military to do everything that is reasonably practical to mitigate the adverse effects of potentially traumatic events. The very significant costs involved in recruiting and training military personnel make it all the more viable to invest in psychological support systems in an effort to avoid loss of valuable personnel to the effects of psychological trauma.

Significant obstacles to this worthwhile preventive mission exist. First, although many organizations that place their personnel in situations in which they may be predictably exposed to intense psychological stressors (e.g., rescue/relief workers, military members, and diplomatic corps members to name a few) have used critical incident stress debriefing (CISD) and psychological debriefing programs, their effectiveness and even safety as single interventions have become a matter of some controversy.<sup>4–6</sup> These have been used as standard psychological management strategies by military forces and emergency services. Because it has become increasingly clear that early identification and treatment of psychological illness or distress may prevent progression to more chronic and severe psychopathology such as PTSD,<sup>7–9</sup> it has become necessary to examine other ways of capitalizing on the strengths of CISD and psychological debriefing (early identification of psychological distress) while delivering postincident support that avoids the possibility of further traumatizing personnel.

A second problem exists in the form of what has been described by Deahl et al.<sup>10</sup> as a “lack of status and recognition” for mental health professionals among operational units. Providers of mental health care often face reluctance—or even outright antipathy—from the very individuals who may benefit most from their services. Behavioral health as a self-referral system in the military may all-too-often be perceived as “career ending” or shameful as one possible explanation. Current mitigation and identification support systems such as the chain of command, noncommissioned officer (NCO) leadership, chaplains, and other family support systems provide essential services and do an excellent job given the scope of their practices, but may not be able to optimally reduce levels of incidents related to intense

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psychological distress.<sup>11,12</sup> And although existing field manuals such as FM 22-100 and FM 22-101 address leadership principles of counseling, coaching, and mentoring, they do not go far enough to adequately provide the mentoring unit member with the necessary skills to be effective in the role of mentor or early risk management assessor. Given the obstacles placed before mental health care assets to delivery of their services, the sheer necessity of these services and the limitations of more “organic” mitigation and support systems, ways of augmenting—but not replacing—existing mental health services into a more culturally acceptable format, merits serious consideration.<sup>13</sup>

### **The British Solution: Project TRiM (Trauma Risk Management)**

These problems have not been unique to the U.S. Military. In 1996, at the direction of the Commandant, the British Royal Marines developed and instituted a peer-driven risk management and support system, dubbed TRiM. The program aims to ensure that initial psychological support is available to all personnel and, since its implementation, it has experienced a high degree of success and acceptance<sup>14</sup> (P. Quinn, personal communication). The model, also in use with other organizations such as the U.K. Foreign and Commonwealth Office and the British Broadcasting Company, uses peer group practitioners to identify psychological risk factors that might go otherwise unnoticed until later in a pathological process. Once identified, personnel deemed to be at psychological risk are managed effectively by their managers and, where necessary, are referred for appropriate treatment at an early stage. Due, in part, to the success of TRiM among the Royal Marines, the Royal Navy is now in the process of implementing a similar program, and a British pan-military stress committee has dictated that the TRiM program is an acceptable model of post-trauma psychological management.<sup>14</sup>

### **A Potential U.S. Solution: Soldier Peer Mentoring Care and Support (PMCS)**

The proposed PMCS program, modeled after TRiM, is designed to use a peer-driven psychological risk management and support system to provide the earliest possible identification, mediation, and referral for family, operational, and combat-related behavioral health and stress management. The program, under consideration for use in the U.S. Army, may be regarded as the behavioral health equivalent to the Combat Lifesaver and Combat Medic model by providing unit-based critical early identification, mitigation, and referral of soldiers with personal, family, operational, and combat stress issues as part of the first layer of a multilayered, redundant behavioral health care system.

A peer-delivered system that operates in concert with more formal mental health assets has certain advantages over one delivered exclusively by the latter. In the military, adequate mental health support may be difficult to deliver because of logistical constraints, difficult terrain, wide dispersal of personnel, combat contingencies, and a limited number of mental health practitioners who may not always be as well integrated with their specific brigades or divisions,<sup>15</sup> although this is not

always the case.<sup>16</sup> Practitioners, uniformed or not, who possess an inadequately intricate organizational understanding of the units they serve with may find that post-trauma interventions are poorly received. These types of constraints have been described among other organizations.<sup>17</sup> Finally, if mental health assets are relatively scarce, individuals may need to be treated away from their primary group setting, a situation that may result in more harm than benefit.<sup>18</sup> Several of these concerns were illustrated by the recently released Operation Iraqi Freedom Mental Health Advisory Team report (December 16, 2003), which documented that almost 50% of soldiers surveyed were unaware of how to obtain mental health services, and that only one-third of individuals desiring such services actually received them. Of those soldiers who were screened positive for depression, PTSD, and other forms of anxiety, only 27% reported receiving mental health services at any point during their deployment. Interestingly, 37% of individuals sampled who sought care reported reliance upon other nonmedic service members (their peers) for support, which contrasted with reported rates of help seeking from chaplains (12%), behavioral health providers (10%), general medical providers (9%), or unit medics (7%).

Under PMCS, identification of cases and uncomplicated intervention begin at the unit level, by unit members, preserving unit self-reliance and cohesion without the aforementioned logistical concerns. The program's similarity (essentially, equivalence) to the Combat Lifesaver model ensures cultural acceptability, and would serve as an extension of formal behavioral health resources. Finally, the program's approach of normalizing and therefore de-stigmatizing responses to stressful events would result in delivery of vital services at the earliest possible point in time while minimizing the possibility of further traumatizing personnel, and its conceptualization as a useful extension to effective personnel management—and therefore not a purely clinical enterprise—may further reduce stigma.

This article presents the PMCS model for peer group risk assessment. The PMCS strategy for psychological threat and risk assessment based on established risk factors for, primarily, PTSD is presented, followed by an outlining of the proposed management protocol for early intervention. We close by forecasting and proposing areas requiring further study.

## **The Strategy**

### **Psychological Threat and Risk Assessment**

The central objectives of the PMCS strategy are to provide managers with information to allow effective personnel management of those exposed to potentially traumatic events and, where required, to facilitate an early referral for specialist mental health care. Although, at the time of this writing, there is no clear profile of the individual that is most likely to develop severe psychological problems, a growing body of research has identified certain risk factors that have been linked to post-traumatic psychological illness (see below). Although many of these factors may be difficult to ascertain within a peer group risk assessment setting, a risk assessment checklist has been developed for those that can be assessed and it is relatively straightforward for use by someone with the appropriate training (Table I).

TABLE I  
RISK ASSESSMENT CHECKLIST

<ol style="list-style-type: none"> <li>1. The person felt that he/she was out of control during the event.<sup>19,21-25,27,29-34</sup></li> <li>2. The person felt that his/her life was threatened during the event.</li> <li>3. The person blamed others for what happened.</li> <li>4. The person feels shame about his/her behavior during the event.</li> <li>5. The traumatic event involved death, serious injury, or a "near miss."</li> <li>6. The person experienced acute stress after the event.</li> <li>7. The person had psychological problems before the event.</li> <li>8. The person has been involved in previous traumatic events.</li> <li>9. The person has poor social support (very little support from family, friends, or unit).</li> <li>10. The person has been drinking alcohol or using other substances excessively to cope with his/her distress.</li> </ol>
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### The Risk Factors

Studies of PTSD suggest that the intensity and duration of the traumatic event can influence the development of post-traumatic illness,<sup>19</sup> and the correlation between the intensity of combat and the development of psychiatric casualties has approached a strength of 0.9.<sup>20</sup> Previous psychological problems and acute stress disorder can act as predisposing factors in the development of PTSD.<sup>21-24</sup> Because acute stress disorder is one of the most robust predictors of later psychological problems, this is emphasized during practitioner training. Individuals who feel that their life is threatened,<sup>25</sup> who have a strong sense of shame,<sup>26</sup> or who blame others for the trauma are at risk for developing longer-term psychological problems.<sup>22</sup> Appraising the traumatic event as uncontrollable or unpredictable may also lead to psychological problems,<sup>27,28</sup> and a history of previous significant traumatization increases the risk of developing post-traumatic illness when exposed to further traumatic events.<sup>29,30</sup> One central and robust finding from research into trauma and general mental health is that accessible social support that is perceived as being useful is associated with lower levels of psychological illness.<sup>31-33</sup> It therefore follows that isolated employees who have poor family and social support are at risk for developing a psychological illness. Alcohol misuse is common in people who have developed PTSD and, although it is not clear whether this is primarily a coping method or an epiphenomenon of illness, it is associated with a range of psychological problems after a trauma and may develop as a disorder in its own right.<sup>34,35</sup>

### The Management Protocol

Although risk assessment is at the heart of the proposed strategy, it is important that the entire intervention be suitably planned. The timing of specific interventions has been allocated to allow for sufficient planning, as shown in Figure 1. The 3-day period before the initial risk assessment is a minimum, and, in many cases, practical requirements may dictate that the initial risk assessments occur later, or as soon as reasonably practicable.

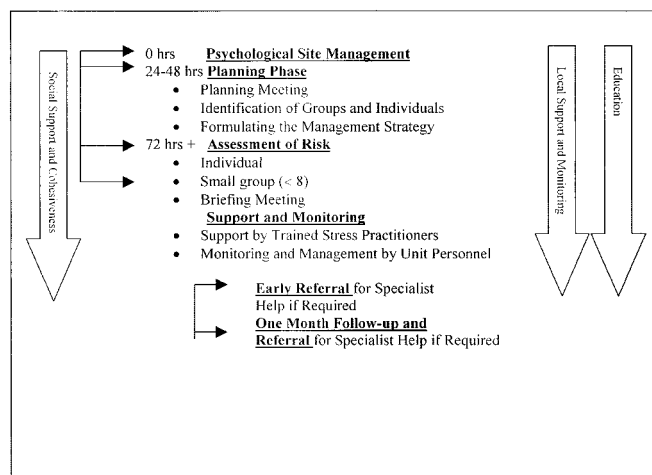


Fig. 1. Specific strategies that are carried out after a traumatic event.

### Selection of Risk Assessors and Their Training

An effective strategy requires selection of personnel suitable for training as risk assessors. Within project TRiM, all potential risk assessors among the Royal Marines are at least of corporal rank and will have been selected by a senior person who has a detailed understanding of the risk assessment process. As a corporal, these individuals will have been in the services for at least 5 years and will have been promoted (which requires being successful in a competitive selection process) at least once. Attendance at the training course is voluntary. Similar contingencies would be operative in PMCS to ensure that risk assessors possess the organizational knowledge and experience required for the job, as well as the motivation for this specific duty. Without this level of experience and motivation, it may be more difficult to help distressed individuals who may be subject to potentially conflicting demands from within the military organization or units in which they serve. However, it must be emphasized that although military systems have what may be considered a mentoring process already in place (e.g., NCOs), the functions that risk assessors perform are different. Not every NCO or leader, by virtue of rank, will be qualified to serve as a mentor under the PMCS model.

The training package aims to educate nonmedical personnel within organizations, ideally junior and "middle management," to be effective in (1) carrying out effective psychological management at the site of a traumatic event; (2) conveying and conducting a meeting with key unit managers to plan a response; (3) analyzing traumatic events and allocating personnel to group or individual risk assessment; (4) conducting a trauma risk assessment interview; (5) conducting a briefing meeting; and (6) facilitating a timely referral to an appropriate agency for treatment.

The training consists of didactic teaching and realistic role playing scenarios. The course describes the rationale for risk assessment and gives a basic understanding of traumatic stress psychology and the practicalities of carrying out risk assessments. Training is conducted at introductory and consolidation levels, with additional regular update training and attendance at other appropriate courses.



## The Specific Management Strategies

### Effective Site Management

The purpose of this strategy is to reduce exposure to the traumatic event wherever possible to minimize adverse psychological outcomes on an organizational level. During the course, trainees are taught the benefits of rotating personnel through tasks and ensuring the provision of adequate rest and sleep. There is also teaching into aspects of dealing with human remains, a particularly poignant stressor,<sup>36</sup> and the front line combat stress treatment doctrine using the principles of proximity, immediacy, and expectancy<sup>37,38</sup> as examples of site management after a traumatic event.

### The Planning Meeting

Careful planning is required for any effective intervention. Within 48 hours after an incident, a meeting is arranged to engage the organizational management structure and to examine who was involved. Key organizational personnel need to attend who know about the event and about those exposed to the event. Additionally, the meeting should include representatives from the organizational medical and welfare system (including the occupational health department) and risk assessors. The support of line managers is instrumental to ensure that the strategy is implemented. Traumatic events vary and it is essential that a flexible approach to planning should be taken.<sup>39</sup>

### Analyzing Traumatic Events and Allocation of Personnel

At a planning meeting, it is important that a decision is made as to whether any intervention is required. Preliminary field research<sup>40</sup> has shown that certain events are more likely to cause psychological distress, including experiencing or witnessing serious injury to others, particularly colleagues, and vulnerable groups such as women, children and the elderly; complex or prolonged trauma; "near miss" events that could have resulted in serious consequences; and immediate overwhelming distress experienced by personnel.

Many traumatic events involve relatively small numbers of personnel and, thus, the analysis is quite straightforward. Larger events, which can include personnel from different organizations, are more complex. Figure 2 illustrates the structure used to filter the event.<sup>41</sup> Use of the filtering template ensures consideration of all personnel potentially affected by the trauma, although it does not always follow that everyone will require risk assessment. If the decision is made to intervene and

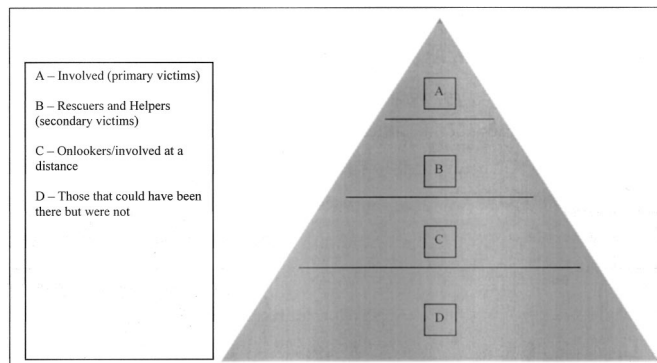


Fig. 2. Analysis tool for traumatic events.

the filtering process has been completed, it is then necessary to decide between carrying out individual or small group interviews (Fig. 3). Before conducting risk assessments, the 10 risk factors described previously (Table I) are discussed within the confines of the planning meeting. This information is coupled with other preliminary information as it becomes available.

### Trauma Risk Assessment Interview Structure

A structured interview format, referred to as the Before, During, and After (BDA) model, is used to conduct risk assessment interviews with groups and individuals. The model is based on the work by Braddon and Tate,<sup>42</sup> and exists for the sole purpose of allowing the interviewer to identify those who may be at risk for developing psychological problems (not to prevent post-traumatic stress reactions). Risk assessors use the BDA grid (Fig. 4), which also describes the interview structure as focusing on the individual's perception of the event and their emotional and cognitive reactions to it. In this simple model, the interviewer works through the numbered grid and inquires as dictated by the row and column headings for that box. This assessment tool appears, based on preliminary study,<sup>43</sup> to display good inter-rater reliability that increased significantly after the training

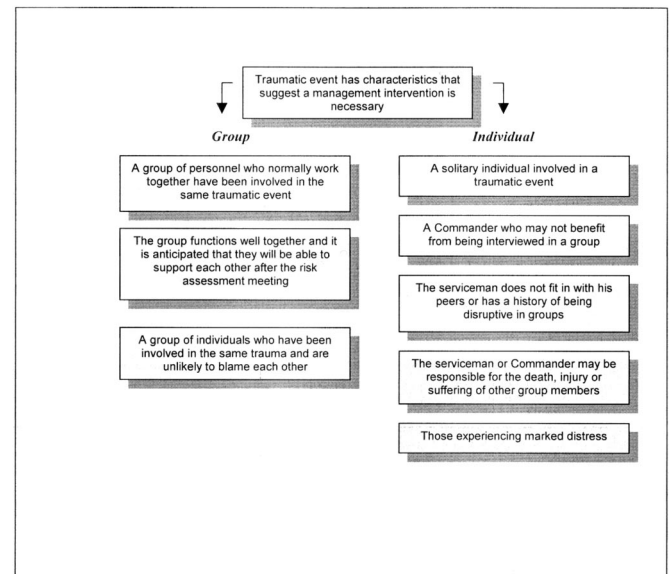


Fig. 3. Decision tree for group or individual assessment.

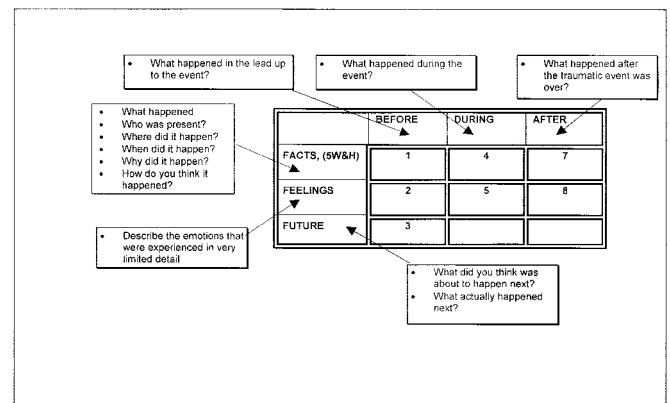


Fig. 4. The BDA grid.

course described herein. The trainees carried out risk assessments for a number of standardized video presentation scenarios of soldiers' responses to a traumatic event, and a significant increase in score consistency between test subjects and score accuracy among subjects compared to the test "standard" was observed as training progressed. Figure 4 relates only to the basic interview structure, which allows personnel who have limited experience in conducting interviews to take a logical approach to talking to potentially distressed personnel. During training, it is made clear repeatedly that the "feelings" portion of the interview is a passive one, in that forced emotional expression is discouraged. At the same time, some "natural" catharsis would be expected to be involved in any discussion about critical events, the expression of which would not be specifically disallowed. This is in clear contrast with some other models of postincident interviewing, such as CISD.

For group risk assessment, every attempt is made to encourage individuals to support one another in an effort to capitalize on strengths inherent to the group and identification with that group;<sup>28</sup> however, risk assessor training emphasizes the avoidance of excessive exploration of emotions, as risk assessment does not require—nor encourage—emotional ventilation as is the case with other forms of psychological debriefing. This is in keeping with the conclusions of a recent Cochrane systematic review that suggests that it may be the exploration of an exposed person's feelings toward the traumatic event that may be, in part, responsible for the worsening of symptoms seen in some cases after psychological debriefing.<sup>4</sup>

Information disclosed during the interview is considered to be confidential; the only caveat to this (as explained to the interviewees) concerns information that causes a serious concern for the safety of the interviewees or others. These include suicidal ideation, homicidal ideation, directed threats of serious violence, or other safety concerns. With permission, risk assessors are required to briefly inform managers to allow effective treatment of such risks and to seek assistance from existing mental health care assets if they are unclear as how to further proceed at any point in the assessment process. Consistent with this policy of confidentiality, managers are only given information that is relevant to managing their staff.

Regardless of the outcome of the interview, a 1-month postevent assessment is employed as an additional means of improving case findings. The importance of this procedure rests upon three main points. First, some exposed personnel may develop psychological problems after a delayed period of time.<sup>7,44</sup> Such a lag time to potentially clinically relevant early signs of illness may not be detected using a stand-alone interview. Second, some individuals may continue to experience psychological distress after the initial interview and may be at risk of developing long-term psychological problems.<sup>45</sup> Finally, an individual's adjustment to the traumatic event can be gauged by comparing their initial psychological and behavioral state (and risk assessment score) with that observed at the 1-month follow-up.

### The Briefing Meeting

Where a planning meeting decides that the event is relatively minor or that some groups of personnel were only marginally involved in the event, it may not be appropriate to initiate a formal assessment procedure. In such cases, it may be more appropriate to carry out a two-stage briefing. This consists of a

factual brief about the event to clarify details, and a psycho-educational briefing to ensure that personnel are aware of the usual sorts of post-traumatic reactions and some basic coping strategies.<sup>46</sup> Such briefings may be supported with a psycho-educational leaflet.

### Personnel Management and Referral

After the initial risk assessment meeting, managers are informed about the degree of psychological distress that exposed personnel have assimilated. This is done collaboratively with the interviewee. After the 1-month follow-up interview, personnel are encouraged to seek help if their distress is not settling (as indicated by persistently raised scores or scores that have increased). During the assessment process in its entirety, risk assessors are also encouraged to be vigilant for signs of marked changes in behavior indicative of significant distress (e.g., substance abuse, poor work performance, and social withdrawal, to name a few).

In the first instance, it is intended that psychologically informed managers will be able to manage their staff effectively. Clearly, occupational health departments will be able to assist with this. Additionally, other organizational sources of help may be available (for example, employee assistance programs, or other useful resources such as the chaplaincy, welfare staff, or formal mental health services). Individuals who do not wish to participate in PMCS would be encouraged to seek help from such programs. Where such management strategies are ineffective, referral to a specialist is encouraged. The actual source of additional help will depend upon available resources (an "in-house" psychiatric service may not always be at the ready) and the wishes of the distressed individual.

### Documentation

Information from the initial assessment is securely stored and used when conducting the follow-up interviews. After completion of the 28-day follow-up, only a simple record is kept in the form of a log entry of who was assessed, their scores, and a brief management plan. This information is kept separately from other personnel health records. From a legal perspective, it is important to record the names of those that were offered the procedure but declined to take part. As mentioned previously, confidentiality is assured in most cases, unless clear threats to safety or other emergencies exist. If a legal investigation is likely after a specific traumatic incident (e.g., a shooting accident during a training exercise), PMCS mentors are encouraged to liaise with the investigating police before any risk assessments are carried out.

### Future Research

Field trials of the Royal Marine system, upon which PMCS is largely based, appear to be successful and organizations that use this model of post-traumatic personnel management report that it is well received. Preliminary data from British field trials have shown moderate inter-rater reliability after just 2.5 days of training using the risk assessment tools presented in this article (N. Greenberg, unpublished data). For TRiM and PMCS, future research is required to ensure that the use of this strategy is

effective. Work is currently under way to compare the use of the TRiM model to "normal practice" within the United Kingdom armed services. The study will examine two groups of trauma-exposed personnel, one who will have had risk assessments and a group who will not. Outcome measures will include measurements of post-traumatic stress, activities of daily living, and use of medical services. Other studies are being conducted to test the concurrent validity of the risk assessment checklist in comparison with other well-validated measures such as the Impact of Events Scale.<sup>47</sup> It is only by rigorous scientific investigation that the validation of this strategy will be achieved. Such research will also ensure that the strategy is not potentially harmful, as has been found with some methods of psychological debriefing. Qualitative investigation concerning the "neatness of fit" with existing behavioral health services and what types of units may benefit most from this peer-driven model will be of secondary future interest, as some existing systems have their own highly specialized mental health delivery teams organic to and fully integrated with their units, however large or small. Finally, the beneficial effects of peer support and mentoring programs reported in the business psychology literature on job satisfaction, perceptions of being successful, and having a sense of collegiality among coworkers may have direct implications for today's military units, who are exposed to rapidly changing organizational structures and the expectation of rapid adjustment to these forces.<sup>48-51</sup> This position also awaits systematic study.

### Conclusion

This article presents a post-traumatic management strategy based upon peer group risk assessment and follow-up care and support. The primary aim of the PMCS strategy is the prevention of PTSD and other adverse psychological outcomes after critical events. A second key aim of the PMCS strategy is to increase the likelihood of personnel being able to access help by overcoming some well-documented obstacles that those in need often encounter. Its effectiveness relies on sound personnel management by psychologically informed managers and early referral when necessary. It builds upon the positive aspects of psychological debriefing, namely the use of an interview as an opportunity to detect those who are suffering from considerable degrees of post-traumatic stress while aiming to avoid deep emotional exploration related to the traumatic event and thereby minimizing chances of harm. It endeavors to also take the fullest possible advantage of other critically important factors such as unit cohesiveness, structure, support, and resilience to avoid unnecessary "medicalization" of human distress. The proposed PMCS format differs from CISD and similar post-critical incident interventions in that PMCS aims to identify need and to ensure that already established personnel management strategies are implemented after traumatic events for those who require them. For the relatively few who develop acute psychological syndromes, PMCS aims to detect these individuals early in their illness course and to insure that they are appropriately referred.

PMCS does not claim to be a cure, nor does it attempt to replace formal mental health services. It exists to ensure that sound personnel management occurs and early referral to specialist care is implemented when necessary. Although an "opti-

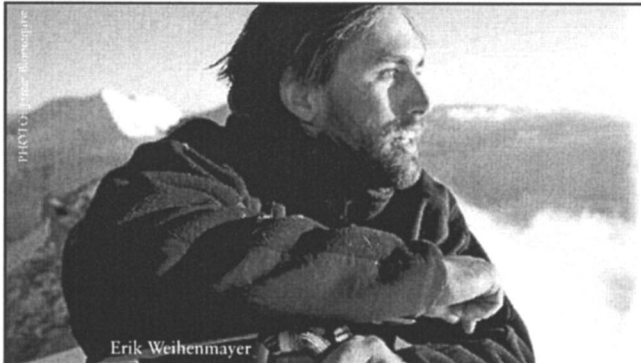
mal" approach for post-traumatic intervention has yet to be identified, there is ample evidence that no matter how bad the trauma, most individuals cope effectively.<sup>52,53</sup> Peer group support and sound leadership practices may be a critical factor in this "natural" pattern favoring recovery.<sup>54-56</sup> It must be emphasized that PMCS is not primarily a medical program. It is a personnel management tool based upon a peer-group risk assessment program used by the British military and other hierarchical organizations<sup>57</sup> that relies on support from and liaison with mental health services.

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