General

‘Lessons learnt from America’ - Reflections from a fellowship examining the prevention, recognition and treatment of operational stress injuries in US Army serving personnel

Matthew Wesson

Background
The Winston Churchill Memorial Trust awards 100 fellowships a year over 10 distinct categories to members of the UK that can demonstrate how their travels can benefit themselves, their community and the country. Fellows receive a travel grant to cover return and internal travelling, daily living and insurance within the countries visited. In 2009 I was awarded a Winston Churchill Travelling Fellowship under the category ‘The treatment and rehabilitation of traumatic injuries’ and was able to spend this 4 weeks working in military facilities in Washington DC and San Antonio, Texas with the aim of broadening my knowledge in this area and to bring back what I learnt for the benefit of myself and the UK Defence Mental Health Service.

I am a Cognitive Behavioural Psychotherapist, EMDR Consultant and Registered Mental Health Nurse. I have been in the Royal Navy for nearly 18 years and am a Lieutenant within the Queen Alexandra’s Royal Naval Nursing Service. My clinical role is to provide mental health assessment and treatment to serving military personnel. I have completed operational tours of Op Telic (Iraq) and Op Herrick (Afghanistan). Since the late nineties I have had a particular interest in the treatment of traumatic stress. I have presented at international conferences and been published on the issue.

Fellowship Aims
When I applied for the fellowship my original aims were as follows:

1. To learn more about how the US Army Medical and Behavioural Health Services prevent and treat post traumatic stress injuries in their serving personnel.
2. To exchange ideas, knowledge and information with my American colleagues around the prevention and treatment of post traumatic stress injuries in armed forces personnel.
3. To spend time with the US Army’s Medical and Behavioural Health Services and other related agencies in achieving the aim.

Traumatic Stress Injuries and the Military
Military personnel who are exposed to traumatic events during operations are at risk of developing symptoms of traumatic stress. Such psychological reactions have a long history within the military. They have been recognised as far back as the American Civil War as ‘irritable heart’, in World War I as ‘soldier’s heart’ or ‘shell shock’, and in World War II as ‘combat neurosis’ (1). The Vietnam War caused record numbers of soldiers to develop traumatic stress problems as a result of their experiences in combat (2). However, Post Traumatic Stress Disorder (PTSD) was not officially recognised until the third edition of the Diagnostic and Statistical Manual (3) where it was classified as an anxiety disorder. PTSD is thought to develop
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when the person processes the traumatic event and its consequences in a way that generates a sense of current and serious threat (4). More recent research in military personnel has shown that soldiers who have deployed to Iraq or Afghanistan are at a high risk of developing mental health problems including traumatic stress injuries such as PTSD (5,6).

Now that traumatic stress injuries and PTSD are recognised as inevitable consequence of modern warfare there is much interest into how this can best be managed. A two-prong approach is often taken. The importance of early detection in PTSD has been widely acknowledged (7,8,9) and authors have indicated the potential benefits of early intervention (10,11.12). Therefore, education and briefing programmes are often used to improve the recognition of post-traumatic stress reactions to ensure prompt treatment where appropriate. They are also used to encourage help-seeking behaviour and reducing the stigma often experienced when asking for help. Once diagnosed, facilities should be set up to provide the most effective treatments to serviceman or women, hence giving them the best chance of recovery.

Within the UK the National Institute for Health and Clinical Excellence (13) has issued PTSD treatment guidelines detailing which approaches have the strongest research base demonstrating their efficacy. These include Cognitive Behavioural Therapy (CBT) models and Eye Movement Desensitisation & Reprocessing (EMDR). The US produce a lot of the research in the area of combat-related PTSD and their military are pioneers in the prevention of traumatic stress injuries, so it was my first choice as the location for my travelling fellowship.

Itinerary Outline

Sat 14th Nov  Depart UK / Arrive Washington DC
Mon 16th Nov  Walter Reed Army Institute for Research (WRAIR), Silver Spring
Tue 17th Nov  Prince George’s County Police Department Mental Health Team
Wed 18th Nov  Defense Center of Excellence (DCoE), Rosslyn and Silver Spring
Thu 19th Nov  National Naval Medical Centre (NNMC), Bethesda
Fri 20th Nov am  National Intrepid Centre for Excellence (NICOE), Bethesda
Fri 20th Nov pm  Centre for the Study of Traumatic Stress (CSTSI), Uniformed Services University of Health Sciences (USUHS), Bethesda
Mon 24th Nov am  Chaplaincy Department, Walter Reed Army Medical Centre (WRAMC), Silver Spring
Mon 24th Nov pm  Outpatient Psychiatry, Ward 53, WRAMC
Tue 25th Nov  Trauma Recovery Programme, Outpatient Psychiatry, Ward 53, WRAMC
Wed 26th Nov  Trauma Recovery Programme, Outpatient Psychiatry, Ward 53, WRAMC
27th - 30th Nov  Thanksgiving Weekend
Mon 1st Dec  Psychiatry Consult Liaison Service (PCLS), WRAMC
Tue 2nd Dec  WRAIR
Wed 3rd Dec  Travel to San Antonio (SA), Texas
Thu 4th Dec  Battlemind Training Office, Army Medical Department Center & School, (AMEDDC&S), Fort Sam Houston, SA
Fri 5th Dec am  Department of Community Mental Health, Warrior Transition Unit (WTU), Fort Sam Houston
Fri 5th Dec pm  Center for the Intrepid, Fort Sam Houston
Thu 10th Dec pm  Army Center for Enhanced Performance (ACEP), Fort Sam Houston
Mon 7th Dec  Combat Operational Stress Control (COSC)
Fri 11th Dec  course, Hilton Doubltree, San Antonio
Sat 12th Dec  Depart SA, Texas
Mon 13th Dec  Arrive UK
Reflections and Recommendations

Operational Stress Briefings. The area I was most impressed with when investigating the US Army’s strategies around the prevention of traumatic injuries was the Battlemind project (soon to become Sustainment Resilience Training under the Comprehensive Soldier Fitness Programme). Battlemind brings together all educational aspects of traumatic and deployment stress in a single, coordinated and corporate approach. The Battlemind approach encourages the utilization of a soldier’s resilience instead of being based on an illness model that is the basis for many other stress education lectures. Elements of the Battlemind programme have been shown to be effective at reducing post traumatic stress and depressive symptoms and lower levels of stigma (14). The UK mental health services are now trialling the postdeployment Battlemind briefings with troops returning from operations and we await the outcome.

All the Battlemind presentations and associated materials are standardised and professionally produced. The accompanying website is modern and engaging. They have produced briefs not only for pre and post-deployment but also ‘life-cycle’ briefs for delivery through the service person’s career, and also briefs for families to help with post-deployment transition. As a result the Battlemind product is known and accepted throughout the Army as standard procedures in the management of traumatic and deployment stress.

The US Army now has a Battlemind training office based in the Army Medical Department & School aimed at training fellow mental health practitioners how to deliver these briefs. However, an acknowledged drawback is that they do not have a system currently in place to monitor the ongoing delivery of these briefs once the initial training is complete. Therefore, they can not guarantee ‘quality control’ of the briefs. UK research has shown that poorly delivered briefs are worse than no brief at all (15).

Recommendation: The UK Defence Mental Health Services develop a standardized, corporate and professional package which incorporates all briefings involved in operational stress management along with associated materials (e.g. handouts, leaflets, and website). Once this is implemented the delivery of the briefs are regularly monitored and evaluated to ensure that high standard presentations are maintained.

Traumatic Event Debriefing. Following some research that showed individual psychological debriefing is not effective and can even be harmful to victims of traumatic events (16,17,18). In 2000 the UK Surgeon General decreed that debriefings should not be used in the UK military (19). However, in contrast, group debriefings are still widely used in the US military after traumatic events and are usually facilitated by US military mental health practitioners. Within the Army this is usually in the form of a Battlemind Debriefing. They point out that the previous research was carried out following debriefing of individuals and that there are significant benefits to using group debriefing within a military environment. It is seen as being consistent with the occupational context of the armed forces, can enhance the group support process, it normalises responses and takes a recovery model approach. There is also now evidence pointing to the effectiveness of Battlemind debriefing in reducing post traumatic stress and depressive symptoms and sleep problems with military personnel (20,14).

In the UK military the equivalent of Battlemind debriefing is Traumatic Risk Management or TRiM. This is a peer-led risk assessment process and is similar to Battlemind debriefing in many ways. They both minimise the degree to which the traumatic event are recounted (therefore reducing the chances of retraumatising) but instead focus on resilience and recovery from the traumatic event. Research of TRiMs effectiveness has showed that it is neither harmful nor beneficial to psychological health or stigma but there were some modest occupational benefits, however the trial was not carried out in a hostile environment where it is likely to be of most benefit (21).
TRiM risk assessments are usually carried out by fellow peers and not medical or mental health practitioners. This has the advantage that service personnel are more likely to speak openly in front of peers and also avoids medicalising normal post-trauma responses. However, peer risk assessment is not always appropriate and available on operations. Anecdotal evidence from my operational experience is that sometimes there is not a peer available because the entire unit has been affected by an incident. Sometimes personnel prefer to have a ‘professional outsider’ facilitate the debrief instead of a ‘peer’ from HQ who they may worry is more concerned with whether correct protocols were carried out during the incident than how the team is coping. In addition, often medical personnel are involved in traumatic events and will seek the support of their mental health colleagues who they consider their peers. Therefore, it may be time to broaden the potential scope of TRiM to include the training of all deployable military mental health practitioners to advanced and preferably instructor level. This would enable them to be able to provide knowledgeable input to traumatic event management including, where appropriate, TRiM risk assessments.

Recommendation: The feasibility of training all deployable military mental health practitioners to an advanced or instructor level in TRiM should be investigated.

Mental Health Practitioners Pre-deployment training. During my travelling fellowship I was lucky enough to attend the Combat Operational Stress Control Course. This is the pre deployment training that all their Behavioural Health (Mental Health) clinicians attend including psychiatrists, psychologists, social workers, psychiatric nurse, and psychiatric technicians amongst others. It even includes Chaplains and Chaplains assistants. It was a week long course that involved many aspects of providing mental health care on operations.

Although I don’t think we would require a week long training package for our Field Mental Health Team members prior to deployment, I do think we should have more formalised pre-deployment training than is currently offered. The new operational competencies should help with pre-deployment training. I am also aware that there are now more mental health scenarios within the pre-deployment medical exercise at Strensall Camp, which is definitely a good thing. Those scenarios should also include not just the medical management of issues but how to liaise effectively with command on how to manage personnel with mental health problems in theatre. This can be particularly useful for junior staff in an FMHT or for reservists who may not have experience from their NHS work in the types of liaison required on operations.

Also, from my experience of the pre-deployment training at Strensall Camp, there are aspects of the week’s programme which are not particularly relevant to members of an FMHT. Therefore, there may be the possibility to include specific pre-deployment briefs for the FMHT during these slots instead. Standardised pre-deployment reading material could be provided to the FMHT as well to assist in their professional and personal preparation. I acknowledge that there is the Operational Mental Health course available for military nurses, however this is not delivered as a pre-deployment programme and is only attended once in the person’s career. Pre-deployment training has the benefit that it is delivered very soon before the nurse’s operational tour.

Recommendation: To investigate into whether there can be more specific and standardised pre-deployment training for members of an FMHT each time they deploy.

Mental Health Training and Education. Along with Battlemind the US Army’s training of personnel on mental health issues appeared to be far more centrally coordinated and professionally produced than that of the UK military. In addition to Battlemind they have other projects that aim to increase soldier’s knowledge and recognition of mental health problems, as it is acknowledged that stigma is
a major reason why service personnel do not seek help. One such project is the Soldier 1st programme. This is similar to TRiM in that it is a peer-led system but it goes beyond traumatic stress. It involves training non-medical personnel in being able to spot difficulties in their colleagues and signpost them towards help. This is in recognition of the limited number of behavioural health providers in the US Army compared to the amount of troops, and is another way of helping getting soldiers the right kind of help when needed.

The UK may not need to go as far as this system but we should certainly be looking to increase the knowledge and skills of our medical assistants as they are in the front line of medical support to service personnel. They should be able to better recognise mental health problems and know when and how to signpost them to the appropriate help. Current tri-service education of medical professions on issues around military mental health is ad hoc and varies in quality and content. There is a need to standardise the content and structure of the briefs so we can ensure parity across all of the UK Defence medical services. Now with a lead service heading up UK Defence mental health, this may be the time that we have the coordination across the three services to make this possible.

**Recommendation:** The training of medical professionals in military and operational mental health needs to be standardised.

**In-theatre Operational Mental Health Surveys.** One tool that an Operational Stress Control Team (Field Mental Health Team equivalent) has is the ability to carry out simple in-theatre surveys of mental health issues in units at the request of Command. This allows them to give feedback to the executive on issues such as morale and the current concerns amongst their troops during stages of a deployment. If requested by Command they can then offer suggestions or resources to help improve these areas. Due to the limited numbers of clinicians in a FMHT this may be more difficult to put in place for the UK. However, it is worth investigating whether something could be designed which is not too labour intensive (e.g., using analysis software) but can still give useful and current feedback to Command. If we have this facility it could help to create positive links to the Command, which is an important role for any operational mental health team.

**Recommendation:** The feasibility of designing and carrying out in theatre FMHT surveys should be investigated.

**Warrior Adventure Quest.** This is a project that uses high-adrenaline adventure training opportunities coordinated with mental health input to help improve morale, unit cohesion and teamwork and manage risky behaviours. It is used both pre and post deployment and importantly it includes mental health aspects like homecoming/readjustment briefs and practicing after-action debriefs. Adventure training is often carried out by UK units when they return from post-deployment leave. This could provide another good opportunity to incorporate TRiM strategies or mental health briefs into this evolution.

**Recommendation:** Incorporate aspects of WAQ into unit's post-deployment adventure training.

**Positive Psychology and Enhanced Performance.** Overcoming the stigma of mental health and help seeking have been shown as significant issues for US and UK armed services (5,22) with many service personnel not even knowing that a Defence Mental Health service exists. My visit to the Army Centre for Enhanced Performance demonstrated to me that this is an area that defence mental health could exploit to improve our profile and publicise our services in a positive light. Many practitioners in defence mental health already have skills in areas such as visualisation, relaxation, stress management, goal setting and mindfulness, and therefore courses or briefs in positive mental health and performance enhancement could be generated and delivered with our current expertise. I realise many clinicians
already struggle with high workloads and caseloads, however if resources were increased in the future this could be an area of potential development.

*Recommendation:* UK Defence Mental Health services to consider offering briefs and education in positive psychology and performance enhancement to help reduce stigma around mental health and advertise the UK Defence Mental Health service.

**Evidence-based treatment approaches.** I was impressed that both countries' mental health facilities were largely providing evidence based treatment for PTSD. However, I did get the impression that the US clinicians were more committed to regularly reviewing those individual and group treatments and altering them in line with new research and also in using their clinical findings or outcomes to publish their own research findings. They also had their own trainers that could run courses in the military versions of Eye Movement Desensitisation and Reprocessing, Cognitive Processing Therapy and Prolonged Exposure. In spite of this, they did acknowledge they struggle to ensure clinicians facilitating groups or carrying out individual therapy were consistently delivering high standards of care in accordance with treatment protocols.

I feel we should have mechanisms in place to ensure that evidence based approaches are being used and that there is some quality control to ensure treatment fidelity. Regular use of live supervision of clinician's treatment sessions should be mandated to help with this. The new NHS Improving Access to Psychological Therapy (IAPT) programme (23) has shown that this is possible and we could look to mirror their processes to assist in setting this up. Also, regular and centralised guidance should be issued to DCMH on developments in traumatic stress injury treatment approaches.

*Recommendations:* The use of live supervision should be mandated for PTSD treatment sessions to ensure treatment fidelity. Regular, centralised guidance should be issued on developments in PTSD treatment. The UK Defence Mental Health Service should be giving clinicians the opportunity to become trainers in PTSD treatment so we no longer have to buy in that training. Opportunities should be to carry out PTSD treatment outcome research within DCMHs.

**Outcome measures.** The treatment facilities and programmes that I visited during my fellowship were clearly committed to monitoring outcomes. This was usually using standardised and empirically validated questionnaires. The practice in the UK is much more variable and usually dependent on the individual clinician or local DCMH policy. I am aware that this issue is currently being investigated however; we could potentially start collecting useful outcome data now. This could easily be done by mirroring the free measures currently being used within IAPT services (24). These simple questionnaires measure symptoms as well as occupational and social functioning. We could quickly produce valuable data on the effectiveness of interventions which could help to shape the future provision of services.

*Recommendation:* All DCMHs should start to collect uniform outcome measures in line with IAPT services, whilst we await more formal guidance on this issue.

**Wounded Warriors.** An interesting observation from my visit was that the US Army split their military medical services, including their mental health services, between deployment and non-deployment related injuries and conditions. Their deployment related injuries are all under the umbrella of the 'wounded warrior' services and are clearly very well supported and funded. Their non-deployed services include care for families and dependents. I did not spend any time with the latter services so cannot comment on their standard or provision, but they weren't as well advertised as wounded warrior services. In the UK we could consider whether post-traumatic injuries from operations have priority on
mental health treatment waiting times. Splitting services is an interesting concept. In reality I think they are probably benefits and disadvantages for both systems but perhaps this does warrant some consideration.

**Recommendation:** Consideration given to the prioritisation of operational mental health injuries over non-operational mental health problems.

**m-TBI.** This is a potentially controversial area. There has been research both in the US and UK stating that although m-TBI or mild concussion syndrome symptoms are common, their associations are complex and involve more than just blast exposure (25, 26). Numerous associations with other disorders such as PTSD, depression and physical health problems have been shown, therefore screening is not recommended. However, the efforts and finance that are going into the area of m-TBI in the US is staggering. As stated earlier, they consider m-TBI as one of the signatures of the wars in Iraq and Afghanistan. Whether they are creating a potential problem for themselves is yet to be seen.

Due to the high profile of m-TBIs this might be leading veterans to convincing themselves that they have an m-TBI and subsequently seek treatment or compensation for it, where they may be suffering another condition that could be effectively treated. Even using the term m-TBI alludes to a serious condition that may not occur if the term concussion was used instead. However, it is important that we watch US developments in this area. Gulf War syndrome showed us that issues such as this (which often originate in the US) can be seized on by the UK media causing significant problems for our military medical services.

**Recommendation:** The UK management of m-TBI or mild concussion syndrome should not change at this time but we should keep track of the research and developments coming out of the US due to this condition’s high profile.

Sleep research. Sleep is a vital part of a service person’s functioning whilst on operations. The WRAIR sleep laboratory has been producing important research that has been used to generate guidance and policy on sleep management for use throughout the US Army. This has then helped to dispel certain myths often held by those in command around sleep. For example, their research has shown that ability to carry out mental and physical tasks decreases significantly if someone is consistently getting less than 7 hours sleep per 24 hours (27), which is contrary to the widely held belief amongst Command that soldiers can effectively function on 4 hours sleep per night. They also demonstrated that banking sleep prior to subsequent sleep restriction periods reduces impairment and improves recovery (28). These are important findings that Command should be made aware of. Future sleep research at WRAIR will be looking at what are the optimum times to get this sleep within a 24 hour period (e.g., 2 x 4 hours which are line with a person’s circadian rhythms).

**Recommendation:** The development of standardised Sleep Management guidelines for use within the UK military based current research and the recommendations of WRAIR and the US Army.

**Formalised Restorative Packages.** The US Army’s Combat Operational Stress Control teams offer formalised in-theatre restorative (24-72 hours) and reconditioning (up to 7 days) packages to those suffering the effects of combat stress injuries or combat fatigue. Both allow short term rest and recuperation but focuses strongly on returning the soldier to duty afterwards. This may be useful to include similar guidance within the standard operating procedures (SoPs) of a FMHT.

**Recommendation:** Consideration given to the inclusion of Restoration and Reconditioning programmes into the SoPs of the FMHT.

**Bio-feedback.** Although relaxation techniques are not a recognised treatment of PTSD, the
ability to self-sooth is an important skill for many patients to master before embarking on PTSD treatment. Bio-feedback is used a lot in the US as an adjunct to PTSD treatment and all the clinicians that use it were very enthusiastic about its benefits for patients. The utility of this technique in the UK should be further investigated, with at least one DCMH trialling the equipment and reporting back on their findings.

Recommendation: Bio-feedback machines to be trialled in a DCMH as an adjunct to evidence based PTSD treatment to see if it increases their efficiency and effectiveness.

Virtual Reality PTSD treatment. This is currently being trialled in the US and it may have utility with combat-related PTSD as a novel and effective treatment. The findings of the trial will be published in due course.

Recommendation: We should consider the recommendations and conclusions of this trial to see whether we should consider using it in the UK as an adjunct to other PTSD treatment or as an approach in its own right.

Hypnotherapy. This was used heavily by the Psychiatric Liaison Team in the management of pain and anxiety in physically injured service personnel. Clinicians and patients alike were very positive about its use.

Recommendation: The evidence base for the use of hypnotherapy for pain relief in physically injured patients should be reviewed to see whether the military community mental health nurses working at places like Queen Elizabeth Hospital Birmingham and DMRC Headley Court should be trained in this technique.

Group Therapy. Group therapy was used a lot in the treatment facilities in the US alongside individual exposure work for PTSD. They provided peer support and a psycho-educational aspect to individual treatment plans. It is doubtful whether any UK DCMH receives enough PTSD referrals to run a trauma recovery group but some DCMHs do run groups of other kinds. For example, DCMH Portsmouth run structured closed groups for anxiety and anger management. They also run an open and unstructured support group. There is a lack of evidence for the effectiveness of the latter type of group. What the Trauma Recovery Groups in the US demonstrated to me is that you can have effective open but structured group therapy which can be based around a fixed weekly programme incorporating evidence based approaches.

Recommendation: Consideration should be given to making the DCMH Portsmouth Support Group an open but structured weekly group programme based on evidence-based approaches such as CBT in helping people manage problems like low mood, motivation and poor sleep.

Summary

These are my personal views and reflections from a hugely rewarding experience. They are not opinions or recommendations of the MOD or any other institution I am associated with. I realise that there may be various logistical reasons why my recommendations cannot be carried out; however I do hope that some will be able to be put into place. If nothing else I gained a massive amount from my travelling fellowship and it has already had a positive impact on my own clinical work. I hope to continue to pass on what I have learnt from the fellowship for many years to come. A special thank you goes to the Winston Churchill Memorial Trust for providing me with this fantastic opportunity and everyone who helped me before and during my visit.

References

1. Kinzie, J.D., & Goetz, R.R. (1996). A Century of Group Therapy. Group therapy was used a lot in the treatment facilities in the US alongside individual exposure work for PTSD. They provided peer support and a psycho-educational aspect to individual treatment plans. It is doubtful whether any UK DCMH receives enough PTSD referrals to run a trauma recovery group but some DCMHs do run groups of other kinds. For example, DCMH Portsmouth run structured closed groups for anxiety and anger management. They also run an open and unstructured support group. There is a lack of evidence for the effectiveness of the latter type of group. What the Trauma Recovery Groups in the US demonstrated to me is that you can have effective open but structured group therapy which can be based around a fixed weekly programme incorporating evidence based approaches.

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References


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