

**ANNEX A**

**WRAIR REPORT OF SOLDIER HEALTH AND WELL-BEING ASSESSMENT**

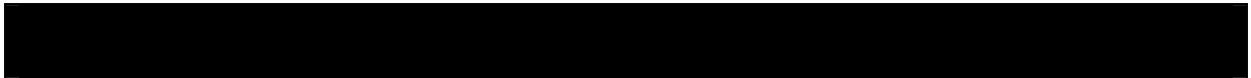
**Operation Iraqi Freedom (OIF)  
Mental Health Advisory Team (MHAT)**

**16 December 2003**

**Chartered by:  
U.S. Army Surgeon General**

***This is an annex to the OIF MHAT Report addressing the health and well-being of Soldiers deployed to OIF, including Kuwait and Iraq. The findings were obtained via the Soldier Health and Well-being Survey and focus group interviews conducted with junior enlisted Soldiers and NCOs at the company level.***

This report is redacted to remove unit identifications, unit locations, and personal identity information in accordance with Army Regulation 25-55, *Department of the Army Freedom of Information Act Program*, and Army Regulation 340-21, *The Army Privacy Program*. Redacted information appears throughout this report blacked out, such as below.



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## **ANNEX A to OIF MHAT REPORT**

### **INTRODUCTION**

The objective of the OIF Soldier Study is to assess the health and well-being of OIF Soldiers deployed to Kuwait and Iraq. To accomplish this goal, a standardized survey instrument was administered to approximately 750 Soldiers stationed at various base camps throughout Kuwait and Iraq. In addition, the survey was supplemented by conducting focus group interviews with junior enlisted Soldiers and NCOs. Findings and recommendations are presented first, followed by figures, summary of methods and procedures of survey administration, and summary of focus groups. Preliminary findings from this study were provided to the CJTF-7 and CFLCC leadership.

### **FINDINGS**

#### ***1. OIF Soldiers report experiencing multiple operational stressors.***

OIF Soldiers reported experiencing multiple combat and operational stressors. The most often reported combat stressors included seeing dead bodies or human remains, being attacked or ambushed, and knowing someone who was seriously injured or killed. The most frequently reported deployment stressors included uncertain re-deployment date, long deployment length, separation and communication with family, and lack of personal privacy. These operational stressors were significantly correlated with low morale, low cohesion, and mental health problems.

#### ***2. Significant prevalence of mental health concerns/ unmet mental health care needs exist.***

This assessment shows that a significant proportion of Soldiers deployed to OIF are experiencing mental health concerns, and that there is an important unmet need for mental health / counseling services.

#### **Distress levels and interest in receiving help.**

Seventy-seven (77%) percent of OIF Soldiers reported currently experiencing no, or a mild, stress, emotional or family problem. Sixteen (16%) of OIF Soldiers reported currently experiencing a moderate and 7% reported currently experiencing a severe stress, emotional, or family problem. Overall, 15% of Soldiers reported interest in receiving help.

#### **Mental health status**

Seventeen (17%) percent of Soldiers screened positive for traumatic stress, depression or anxiety and reported impairment in social or occupational functioning. This compares with a rate of approximately 11% for Soldiers from XVIII ABN Corps who just returned

from Afghanistan (OEF). Most of this difference was attributable to OIF Soldiers screening significantly higher on the traumatic stress scale (15% OIF vs. 7% post-OEF). Overall, junior-ranking Soldiers reported higher rates of mental health problems than senior-ranking Soldiers. Active component Soldiers had higher rates of mental health problems than reserve component Soldiers. This latter finding is consistent with the higher suicide rate of OIF active duty Soldiers compared to reserve component Soldiers.

### **Use of Behavioral Health Services**

*Of the Soldiers who screened positive for depression, anxiety, or traumatic stress, only 27% reported receiving any help at any time during the deployment from a mental health professional, general medical doctor, chaplain. Of the Soldiers who reported interest in receiving help, only 32% received some form of help.*

#### **3. Soldier morale and unit cohesion was low.**

In comparison to other units studied in garrison or peacekeeping operations, OIF Soldiers reported low or very low personal and unit morale. Fifty-two percent (52%) of Soldiers reported low or very low personal morale and 72% reported low or very low unit morale. Unit cohesion was also lower than comparison units either preparing to deploy to OIF or who just recently returned from OEF.

#### **4. Barriers/obstacles impede Soldiers from obtaining mental health assistance.**

Soldiers most in need of mental health care were twice as likely as other Soldiers to report concerns about accessing services. Among Soldiers who screened positive for depression, anxiety, or traumatic stress, 26% reported that it would be too difficult to get to the location of behavioral health services. Other barriers reported among those who screened positive included difficulty getting time off from work to get help (43%), not knowing where to go for help (24%), or mental health services not being available (24%). Perceived stigma to care was also an important concern for OIF soldiers; Soldiers reported that they may be seen as weak (59%), that they would be treated differently by unit leadership (58%), that the unit would have less confidence in them (49%), or that their leaders would blame them for the problem (46%).

#### **5. Perceived inequities in personnel and deployment policies adversely affected morale and cohesion.**

Focus group interviews with junior enlisted Soldiers and NCOs indicated that there are many disparities in housing, access to email and phones, and MWR facilities between base camps and different units. Also there were concerns from Soldiers that changes in unit leadership during the deployment were adversely affecting morale and cohesion. For the reserve component Soldiers in OIF, the twelve months “boots on ground” policy was seen as unfair.

## **6. Marital / family separation was a concern for OIF Soldiers.**

Being separated from family was reported as a major stressor by Soldiers (57% reported high/very high trouble or concern). Despite being separated from their spouses and high operational stressors, OIF Soldiers who were married reported high marital satisfaction; 78-80% reported that they had a good and stable marriage. However, 11% of married Soldiers reported currently planning to separate or divorce. Many focus groups expressed concerns that rear detachment staff and FRG groups were not able to adequately support families. In the survey, 55% of married Soldiers reported not being satisfied with the rear-detachment support; 54% were not satisfied with the Family Readiness Group (FRG) support. Data from the prior surveys and focus groups of spouses of Soldiers deployed to OIF and OEF identified similar concerns about the ability of rear detachment and FRG groups to adequately support families.

## **7. Beneficial effects of training Soldiers in handling stresses of deployment.**

Less than half of respondents reported receiving sufficient training in suicide prevention or handling the stresses of deployment. However, a very important finding was that Soldiers who reported that they received training in suicide prevention or maintaining psychological well-being were significantly more likely to endorse that they felt comfortable receiving counseling from a chaplain or mental health professional, to endorse that they knew how to obtain mental health care while in theatre, and that they had personally assisted another Soldier with a mental health problem.

## **RECOMMENDATIONS**

### **1. Execute an aggressive behavioral health outreach program.**

A high percentage of Soldiers reported interest in receiving mental health support and/or screened positive for a mental health problem. However, data suggests that significant barriers are preventing Soldiers from receiving help, such as transportation constraints, knowing where to get help, mental health services not being perceived as available, and stigma.

Behavioral health care providers can reduce and/or eliminate many of these barriers by physically going to the Soldiers who need and/or want help. Since the data indicated that both chaplains and mental health professionals were accessed at a similarly low rate, both groups need to develop and execute an aggressive forward-deployed behavioral health outreach program. Establishing a predictable, regular, and visible presence at the company/battalion level is essential.

### **2. Review existing Soldier deployment policies pertaining to quality of life services in theatre, deployment cycle, and officer rotations.**

Soldiers are extremely sensitive to inequities in access to services and support, particularly in a deployed environment. For example, Soldiers based at remote or austere sites might have limited or no access to services such as email, phones, PX, dining facilities compared to Soldiers located or living at more mature base camps. When Soldiers from remote locations get the opportunity to visit other locations, they

often are not permitted to use facilities operated by other units. Policies need to be established to assure that Soldiers based at remote/austere sites have priority access to services/facilities when visiting these more mature base camps.

Officer rotation and deployment length policies need to be carefully reviewed to ensure stabilization of leadership positions for the duration of the deployment cycle (pre, mid, and post deployment).

### **3. *Train Soldiers in meeting the demands of deployment/combat related stressors.***

The data suggest that training Soldiers in suicide awareness and in dealing with the stresses of deployment have many potential benefits. Standardized training materials need to be developed that teaches these skills to Soldiers and leaders.

### **4. *Implement a peer-mentoring program.***

Soldiers reported that they were much more willing to turn to a member of their unit for support than a chaplain or mental health professional. This suggests that developing a human resource risk management program utilizing mid-grade NCOs within each company could facilitate the early identification and intervention of behavioral health issues at the company level. Consideration should be given to developing a program to train one or two NCOs per company who could serve as the commander's advisor/trainer for issues such as suicide prevention and coping with the stressors of deployment and military life. This peer-mentor would also serve as the liaison between the unit, chaplain, and mental health and installation support, and would assist in stress education and suicide awareness training. Most importantly, this peer mentor will serve as an advocate for those Soldiers least likely to seek help for a behavioral health problem due to stigma and other barriers (see Appendix 1).

### **5. *Provide BH services for Soldier and family members at the BN/BDE level to enhance services, facilitate access, and improve command/FRG support.***

The majority of Soldiers and family members in distress do not receive needed behavioral healthcare. In addition, there were many concerns about the ability of rear detachment and FRG groups to adequately support families, a finding also identified in surveys conducted among spouses of Soldiers deployed to OIF/ OEF. The data suggest the Army needs to establish permanent social work support at the brigade / battalion level to provide counseling for families. During deployments, the unit assigned social worker / behavioral health professionals should work with the rear detachment and FRGs to provide individual and family services.

## **RESEARCH NEEDS**

### **1. *Conduct a follow-up assessment of OIF Soldiers in theatre.***

The findings presented in this report are based on a cross-sectional sample, and therefore *causal* statements about the impact of the combat and deployment stressors on the health and well-being of Soldiers cannot be made. A follow-up assessment of

OIF Soldiers in Iraq and Kuwait should be considered in order to better establish causal relationships between the combat and operational stressors and the health and well-being outcomes. This follow-up assessment should be conducted by a small WRAIR Soldier Dimension Research Team just prior to Soldiers returning to home station.

**2. *Develop and field a behavioral health needs assessment and unit climate tool for the operational environment.***

In order to accurately and systemically determine the behavioral health needs of deployed Soldiers and insure that those needs are being met, a standardized behavioral health needs assessment instrument needs to be developed and fielded. This tool should include an assessment of levels of stress, mental health status, unit climate, level of training in behavioral health issues, and an assessment of access and acceptability of counseling services. The commander, chaplains, and mental health professionals would utilize the findings from this behavioral health assessment to target specific issues for action, including behavioral health prevention and early intervention.

**3. *Identify the scientifically valid key leadership behaviors that facilitate Soldier morale, cohesion, and unit performance in a hostile environment.***

Leadership at the local level is critical for maintaining high Soldier moral, unit cohesion and unit performance. Identifying and training those specific leader behaviors that have been associated with optimal Soldier and unit performance needs to be a top priority for future research efforts and leader development.

**4. *Determine the effectiveness of Critical Incident Stress Debriefing (CISD).***

Given that a significant number of Soldiers screened positive on the post-traumatic stress disorder (PTSD) scale, it is imperative that the U.S. Army determine the most efficacious early intervention strategy for attenuating or preventing the onset of PTSD. Presently the critical incident stress-debriefing (CISD) model is the most widely used methodology applied to groups exposed to traumatic events, although its effectiveness has not been demonstrated. The Walter Reed Army Institute of Research (WRAIR) already has a scientifically approved research protocol to assess the effectiveness of CISD in ameliorating the adverse mental health effects of Soldiers exposed to combat. Immediately execute the WRAIR debriefing study to identify the best early intervention methodology for use with Soldiers exposed to combat

## **PRESENTATION OF DATA THAT SUPPORTS THE FINDINGS**

### ***Survey Methods and Procedures***

The OIF Soldier health and well-being survey was conducted for the MHAT under an approved protocol of the Walter Reed Army Institute of Research (PI: [REDACTED]). The survey is part of a larger effort involving pre- and post- deployment surveys of Soldiers from XVIII ABN Corps, USASOC, and Marine Expeditionary Forces. The survey was designed as a rapid assessment of the health and well-being of the Soldiers deployed in OIF. Details of the survey instrument are included in Appendix 2.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (CJTF-7) operational theaters and administered surveys and conducted focus groups between 27 August and 30 September 2003.

In CJTF-7, combat line companies from brigade combat teams (BCT) were targeted for assessment. An effort was made to include BCTs located in different geographical regions within particular zones. In CFLCC, the survey targeted units that were thought to have high operational stress including transporters and MPs. In both CJTF-7 and CFLCC, combat support hospitals (CSH) were also included. Companies were selected by the operational units, and samples of approximately 25 Soldiers were drawn at the company level, based on mission availability (see Table 1 for unit and locations). Participants were briefed on the purpose of the MHAT's mission, the anonymity of the questionnaire, and the fact that participation was voluntary. The surveys were conducted anonymously. Signed informed consent was obtained from all participants prior to survey administration per the WRAIR protocol. More than 99% of Soldiers briefed agreed to complete the survey.

### ***Quality Control of Data***

Data from the surveys were entered into Microsoft Access. A complete quality assurance check was conducted on random selection of 5% of surveys (n = 41). All 285 fields from these 41 records were directly compared between the electronic and paper surveys (n=11,685 comparisons). 22 errors were found for an error rate of 0.18%. Errors were randomly distributed throughout the fields.

### ***Comparison Populations***

Data from two other anonymous data collections conducted under the same WRAIR protocol are included in this report for comparison with the OIF data collection. These data collections, conducted between January and March 2003, involved 2530 Soldiers from XVIII ABN Corps surveyed approximately three months after returning from a six month deployment to Afghanistan and 2072 Soldiers surveyed just prior to deployment to Iraq (the unit remains in Iraq now).

## Study Sample

Participants were 756 U.S. Army Soldiers from different units serving in Operation Iraqi Freedom (See Tables 1-3). Most of the participants were male (86%). The rank distribution was as follows: junior enlisted Soldiers 58%, NCOs 35%, and officers 7%. This distribution was very similar to the rank distribution for the comparison populations. Two-thirds (67%) were Caucasian, 17% were African-American, and 9% were Hispanic. Participants tended to be young (50% were younger than 25), with an average of six (6) years (median 4 years) in the military. 72% were active component and 28% were reserve component with an average of 22 months in their current unit. Participants had been deployed nearly 6 months (average 176 days) in the past year, and were based in Iraq (77%) or Kuwait (23%). Forty-seven percent (47%) of the sample was married, and 46% had one or more children.

Table 1: Units Surveyed

CJTF-7				
1 <sup>st</sup> AD	4 <sup>th</sup> ID	101 <sup>st</sup> AA	3 <sup>rd</sup> ACR	Med Bde
CFLCC				
Trans Group	MED Bde	Separate Units		

Table 2: Types of Units Surveyed

Unit Type	# of Surveys
Combat	423
Medical	125
Transportation	72
Engineers	50
Military Police	35
Civil Affairs	27
Signal	12
Other/ Not Listed	12
<b>Total</b>	<b>756</b>

Table 3: Survey Locations

Location	# of Surveys	Location	# of Surveys
Iraq	75	Iraq	41
Kuwait	64	Iraq	26
Iraq	55	Iraq	25
Kuwait	52	Iraq	25
Iraq	51	Iraq	24
Iraq	50	Iraq	24
Iraq	50	Iraq	24
Iraq	45	Iraq	20
Kuwait	44	Kuwait	14
Iraq	42	Kuwait	5
		<b>Total</b>	<b>756</b>

### Sample Size

Based on the size of the U.S. Army reserve and active component populations in OIF, a sample size of 750 is more than adequate to detect most conditions that occur at a predicted prevalence of 5-10% (for example the prevalence of screening positive for depression or PTSD). For example, 202 is the minimum number of completed surveys necessary to detect a condition with a prevalence of 5% (range no more than 2-8%) at the 95% confidence level. The 750 surveys therefore provides sufficient numbers to look at important subgroups within the population, for example active vs. reserve component Soldiers, as there were over 200 of each sampled. For female Soldiers, the 100 completed surveys was sufficient to detect a condition with a prevalence of 7% (range no more than 2-12%) at the 95% confidence level. The study focused primarily on enlisted and NCO Soldiers by design.

### **DATA FINDING #1: OIF Soldiers report experiencing multiple operational stressors.**

#### **Combat Stressors**

Most OIF Soldiers reported experiencing combat stressors. The most often reported combat stressors include seeing destroyed homes and villages (78%), seeing dead bodies or human remains (67%), having hostile reactions from civilians (65%), receiving small arms fire (63%), being attacked or ambushed (61%), and knowing someone who was seriously injured or killed (59%). Less frequent but important combat experiences included engaging in a firefight (37%), being directly responsible for death of enemy combatant (19%), engaging in hand-to-hand combat (11%), being wounded/ injured (10%). Other reported combat/deployment-related experiences included encountering grateful civilians (85%) and demonstrating success in training (80%).

51% of Soldiers reported that they had been in serious danger of being injured or killed on at least several occasions during the deployment. The average number of days deployed in a forward in a hostile sector was 100 days.

There were significant differences in the combat exposures between reserve and active component Soldiers. For example 48% of active component Soldiers reported engaging in a firefight compared with only 10% of reserve component Soldiers. Sixty-one percent of AC Soldiers reported being in serious danger of being injured or killed several times during the deployment vs. only 28% of RC Soldiers.

Combat stressors were statistically correlated with mental health problems. For example, being attacked or ambushed was associated with screening positive for depression, anxiety, or post-traumatic stress ( $p < .001$ ). Duration in a hostile area and engaging in a firefight was associated with screening positive for depression, anxiety, or post-traumatic stress ( $p < .05$ ,  $p < .001$  respectively). Duration in a hostile sector was associated with increased cohesion ( $p < .05$ ).

### **Non-combat deployment stressors**

The most frequently reported non-combat stressors include uncertain re-deployment date (87% high/very high trouble or concern), long deployment length (71% high/very high trouble or concern), lack of privacy or personal space (55% high/very high trouble or concern), boring or repetitive work (54% high/very high trouble or concern). Respondents reported being deployed an average of 176 days in the past year.

Uncertain redeployment date was significantly associated with decreased unit and personal morale, cohesion, and screening positive for depression, anxiety, or post-traumatic stress. Longer deployment length (measured by days deployed in the past year) was significantly associated with decreased personal and unit morale, and cohesion ( $p < .05$  for all), but not with screening positive for depression, anxiety, or Post-traumatic stress.

### ***DATA FINDING #2: Significant prevalence of mental health concerns/ unmet mental health care needs.***

#### **Distress levels and interest in receiving help**

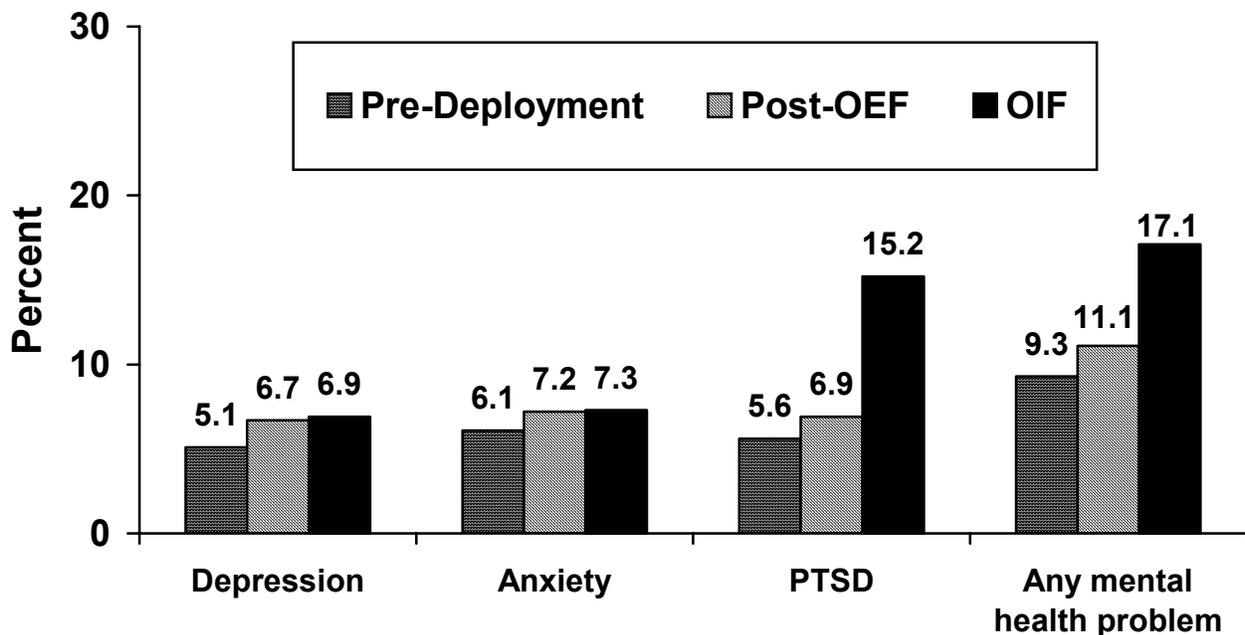
Sixteen percent of OIF Soldiers reported currently experiencing a moderate stress, emotional, alcohol, or family problem (17% of Junior Enlisted, 15% of NCOs, and 10% of officers; 18% of AC, 11% of RC). Seven percent of OIF Soldiers reported currently experiencing a severe stress, emotional, alcohol, or family problem (8% of Junior Enlisted, 6% of NCOs, and no officers; 7% of AC, 6% of RC). Many OIF Soldiers are interested in receiving help for a stress, emotional, alcohol, or family problem. Fifteen percent of OIF Soldiers are currently interested in receiving help (16% of Junior Enlisted, 15% of NCOs, and 10% of officers; 16% of AC, 13% of RC). This compares with a rate of 8-10% of Soldiers surveyed in garrison post-OEF or pre-OIF.

## Mental health status

Using standardized clinical screening instruments, 17% of OIF Soldiers screened positive for post-traumatic stress, depression, or anxiety (Figure 1), and reported impairment in occupational or social functioning (19% of Junior Enlisted, 16% of NCOs, and 7% of officers; 19% of AC, 13% of RC). Seven percent of Soldiers screened positive for depression (8% of Jr. Enlisted, 6% of NCOs, and 2% of officers; 8% of AC, 5% of RC). Seven percent of Soldiers screened positive for anxiety (9% of Jr. Enlisted, 6% of NCOs, and 2% of officers; 8% of AC, 6% of RC). Fifteen percent of Soldiers screened positive for post-traumatic stress (17% of Jr. Enlisted, 15% of NCOs, and 7% of officers; 16% of AC, 12% of RC).

Comparative data was also available from surveys conducted among XVIII ABN Corps Soldiers who were either preparing to deploy to OIF (“Pre-Deployment”) or had just returned from Afghanistan (“Post-OEF”). Overall, 9% of the pre-deployment and 11% of the post-OEF Soldiers screened positive for depression, anxiety, or post-traumatic stress (Figure 1). The difference between the OIF and post-OEF rates of mental health problems was almost entirely due to the increased prevalence of post-traumatic stress in OIF Soldiers.

**Figure 1. Mental Health Status.** Percent of OIF Soldiers who screened positive on the depression, anxiety, or traumatic stress scales (and who reported a functional impairment) compared to Soldiers from the XVIII ABN Corps prior to deployment to OIF (pre-deployment) or post-Operation Enduring Freedom



(post-OEF).

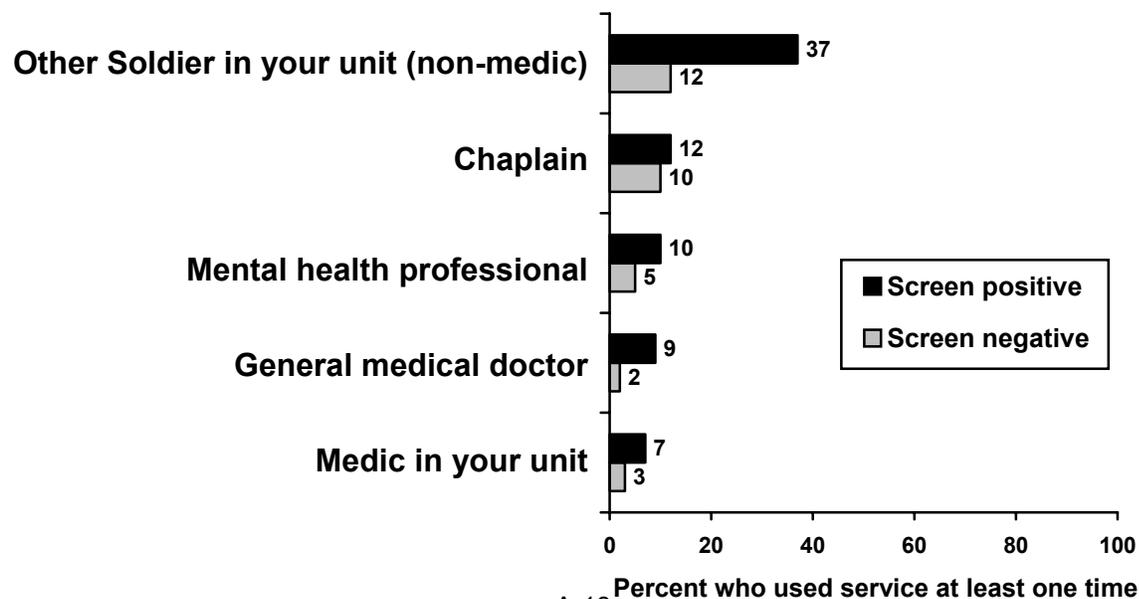
Screening positive for depression, anxiety, or post-traumatic stress was significantly associated with lower personal and unit morale, and low cohesion.

A single screening question for suicidal ideation in the past month (“thoughts that you would be better off dead or of hurting yourself in some way”) was endorsed by 17% of Soldiers. This compared with a rate of 12% of Soldiers surveyed prior to deployment to Iraq ( $p < .01$ ). It is important to note that this is a broad screening question and cannot be used to predict suicide risk without other clinical information (such as the questions included on the entire depression screen, information on suicide intent and planning, as well as other risk factors). Nevertheless, the increase noted between pre-OIF and OIF Soldiers is of concern, especially in the context of several completed suicides during the same period.

### Use of mental health services

Of the Soldiers who screened positive for depression, anxiety, traumatic-traumatic stress, only 27% reported receiving help at any time during the deployment from a mental health professional, general medical doctor, or chaplain. This is very similar to the rate of accessing health care among Soldiers in garrison post OEF or pre-OIF. Of the Soldiers who reported interest in receiving help, only 32% reported receiving help during the deployment. Soldiers reported turning to other Soldiers for support much more often than they accessed care from mental health professionals or chaplains (Figure 2). Chaplains were accessed at a similar rate as mental health professionals. There were differences in reported mental health care use during the deployment based on whether Soldiers met screening criteria for a mental health problem (depression, anxiety, traumatic-traumatic stress). Overall, of Soldiers who endorsed the question about thoughts of dying or self-harm, less than one-third (28%) reported receiving help from a chaplain, a mental health professional or general medical doctor.

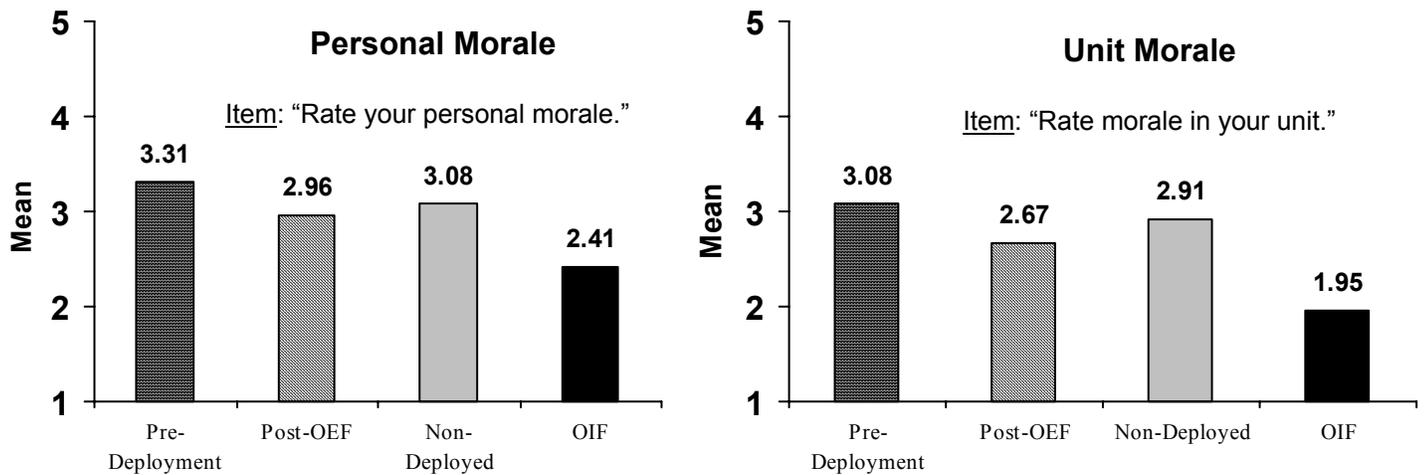
**Figure 2. Mental Health Care Use.** Percent of OIF Soldiers who reported at least one time using a Soldier in the unit, the chaplain, a mental health professional, a general medical doctor or the medic for a mental health problem as a function of whether they screened positive or negative on either the depression, anxiety or post-traumatic stress scale.



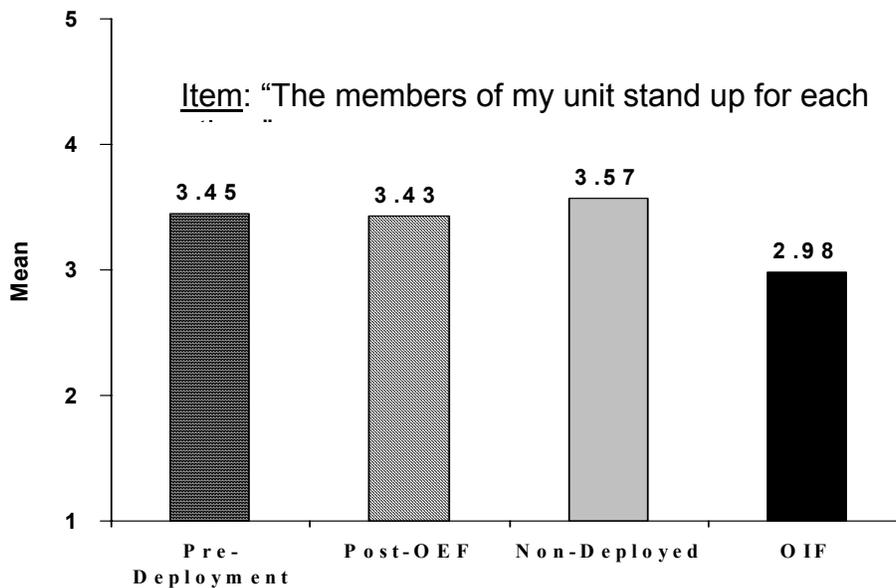
**DATA FINDING #3: Low Soldier morale and unit cohesion.**

In comparison to other units studied in garrison pre- or post-deployment, the morale and cohesion of OIF Soldiers were low (Figures 3 and 4). Fifty-two percent of OIF Soldiers report low or very low personal morale, and 72% report low or very low unit morale.

**Figure 3. Personal and Unit Morale.** Mean personal and unit morale scores of OIF Soldiers compared to Soldiers from the XVIII ABN Corps in garrison (non-deployed), post-Operation Enduring Freedom (post-OEF), and prior to deployment to OIF (pre-deployment).



**Figure 4. Unit Cohesion.** Mean unit cohesion scores of OIF Soldiers compared to Soldiers from the XVIII ABN Corps in garrison (non-deployed), post-Operation Enduring Freedom (post-OEF), and prior to deployment to OIF (pre-deployment).



Personal morale differed by rank (percent reporting low or very low morale: 57% junior enlisted, 49% NCOs, 25% officers;  $p < .001$ ).

Unit morale and cohesion both were significantly lower for reserve component (RC) Soldiers compared with active component (AC) Soldiers (low/very low morale 79% RC vs. 69% AC,  $p = .034$ ; mean cohesion 2.77 RC vs. 3.06 AC,  $p < .001$ ).

Soldiers who reported better access to communication home (phone, mail, email) also reported significantly higher unit and personal morale ( $p < .005$  for both), and cohesion ( $p = .019$ ).

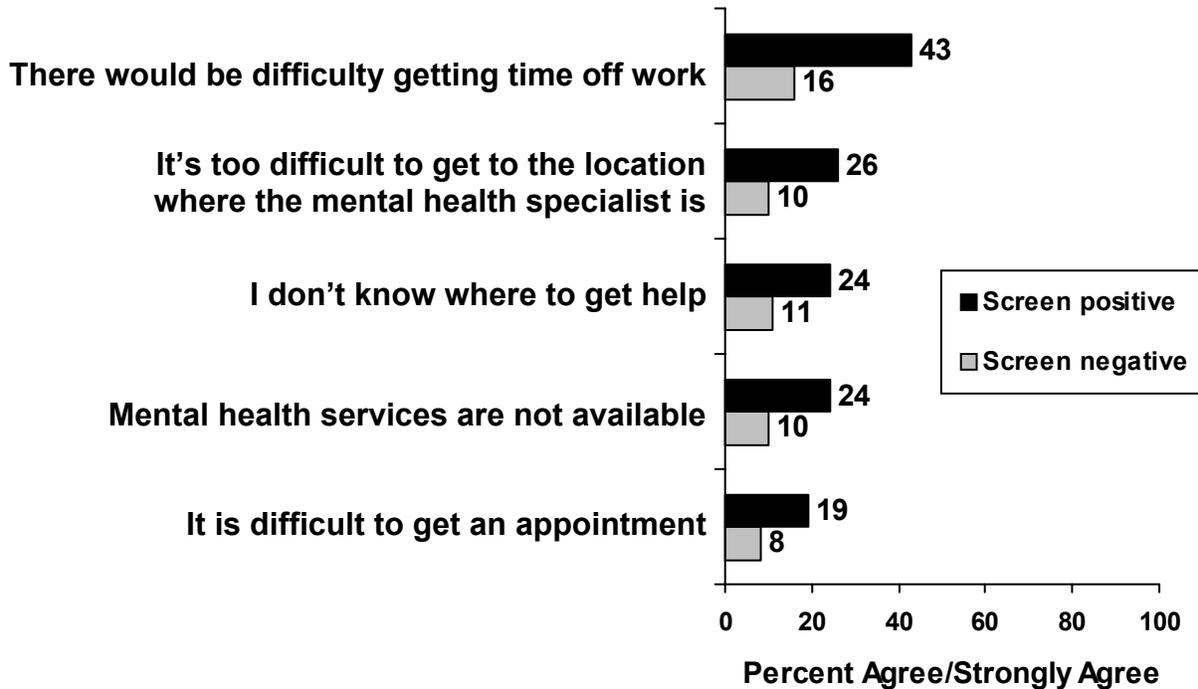
The more positive the perceptions of officer and NCO leadership, the higher the reported personal and unit morale and cohesion.

Regarding retention, 53% of Soldiers indicated an intention to leave the military at the end of their current obligation. This is 10% higher than Soldiers from XVIII ABN Corps surveyed just prior to deployment to Iraq. Both personal and unit morale were significantly related to Soldiers intentions to remain in the military ( $p < .001$  and  $p < .004$ , respectively). The higher the perception of unit cohesion reported by Soldiers, the higher their intention to remain in the military ( $p < .001$ ).

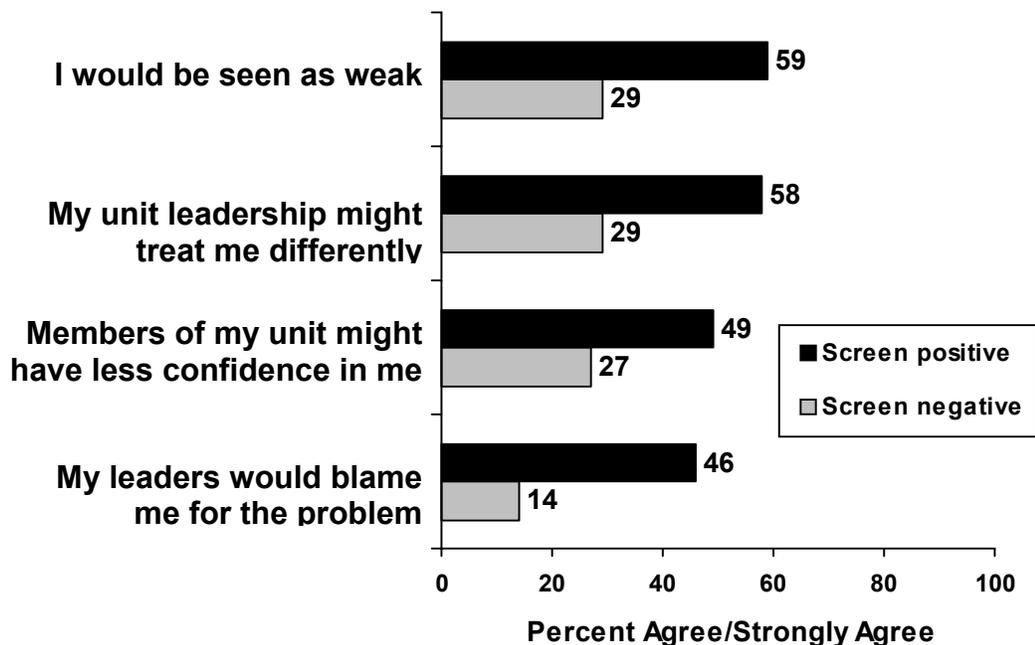
***DATA FINDING #4: Barriers/obstacles impede Soldiers from obtaining mental health assistance.***

Soldiers most in need of mental health care were twice as likely as other Soldiers to report concerns about accessing services (Figures 5 and 6). Among Soldiers who screened positive for depression, anxiety, traumatic-traumatic stress, 26% reported that it would be too difficult to get to the location of behavioral health services. Other barriers reported among those who screened positive included difficulty getting time off from work (43%), not knowing where to go for help (24%), or mental health services not being available (24%). Perceived stigma to care among those who screened positive was also an important concern particularly that they may be seen as weak (59%), that they would be treated differently by unit leadership (58%), that the unit would have less confidence in them (49%), or that their leaders would blame them for the problem (46%). Perceived stigma was similar for all ranks.

**Figure 5. Mental Health Care Barriers.** Percent of OIF Soldiers who agreed or strongly agreed with statements concerning mental health care barriers that would affect their decision to receive mental health counseling while deployed as a function of whether they screened positive or negative on either the depression, anxiety or post-traumatic stress scale.



**Figure 6. Mental Health Care Stigma.** Percent of OIF Soldiers who agreed or strongly agreed with mental health care stigma statements that would affect their decision to receive mental health counseling while deployed as a function of whether they screened positive or negative on either the depression, anxiety or post-traumatic stress scale.

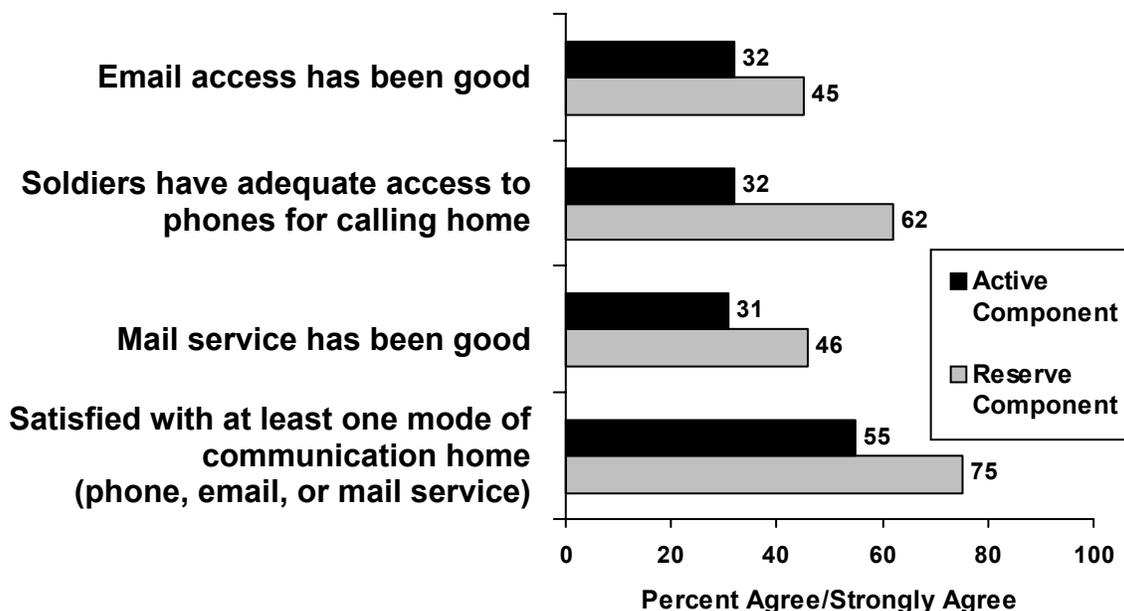


**DATA FINDING #5: Perceived inequities in personnel and deployment policies adversely affected morale and cohesion.**

Focus group interviews with junior enlisted Soldiers and NCOs indicated that Soldiers perceive that there are many disparities in housing, access to email and phones, and MWR facilities between base camps and different units. Also there were concerns that changes in unit leadership during the deployment were adversely affecting morale and cohesion. Specifically, enlisted Soldiers reported that the deployment was adversely impacting their career progression while officers were allowed to PCS for career advancement. For the reserve component Soldiers in OIF, the twelve months “boots on ground” policy was seen as unfair because the time in the mobilization phase was not included in the 12-month activation period.

Data from the survey supported the focus group interviews. Relatively few Soldiers reported satisfaction with phones, mail or email as an effective means for communicating home (Figure 7). There was a large disparity between AC and RC Soldiers in satisfaction with communications, with RC Soldiers having much higher satisfaction (RC, 75%; AC, 55%)( $p < .001$ ) (Figure 7). This may be a function of location, as many RC Soldiers are located in Kuwait, which was a more developed theater of operation than Iraq. Satisfaction with at least one method of communicating home was significantly associated with higher unit and personal morale, higher cohesion, better perceptions of NCO and officer leadership, higher retention intentions, and lower rates of screening positive for depression, anxiety, or PTSD ( $p < .02$  for all).

**Figure 7. Communication by Component.** Percent of OIF Soldiers who agreed or strongly agreed that they had adequate email, phones, or email for communication home as a function of component.



**DATA FINDING #6. Marital / family separation was a concern for OIF Soldiers.**

Soldiers reported being separated from family as a major stressor (57% reported high/very high trouble or concern). Despite being separated from their spouses, OIF Soldiers who were married reported high marital satisfaction; 78-80% reported that they had a good and stable marriage. However, 11% of married Soldiers reported currently planning to separate or divorce. 55% of married Soldiers reported not being satisfied with the rear-detachment support of their families; 54% were not satisfied with the Family Readiness Group (FRG) support. Marital satisfaction did not differ significantly by rank (junior enlisted vs. NCO vs. officer/warrant officer), nor did marital satisfaction differ by service component (AC vs. RC).

**DATA FINDING #7. Beneficial effects of training Soldiers in handling the stressors of deployment.**

Only 29% of Soldiers agreed that they had received adequate training in handling the stresses of deployment and/or combat. Forty-five (45%) indicated that training for identifying Soldiers at risk for suicide was sufficient. However 60% reported confidence in their ability to identify Soldiers at risk for suicide, and 67% reported confidence in their ability to identify Soldiers with depression symptoms. Forty-eight (48%) of Soldiers indicated that they had received suicide prevention training since arriving in theatre, and 24% indicated that they had attended training to improve and/or maintain their psychological well-being since arriving in theatre.

A very important finding was that Soldiers who reported that they received training in suicide prevention or maintaining psychological well-being were significantly more likely to endorse that they felt comfortable receiving counseling from a chaplain or mental health professional ( $p < .001$ ), to endorse that they knew how to obtain mental health care while in theatre ( $p < .001$ ), and that they had personally assisted another Soldier with a mental health problem ( $p < .01$ ).

**DISCUSSION**

This survey focused on Soldiers from line companies, both reserve and active component, and is most representative of junior enlisted and NCO Soldiers. One limitation is that the survey did not utilize a random sampling design of all OIF Soldiers, which would have been logistically much more difficult to conduct in the operational setting. However, every effort was made to obtain a representative sample at the company level from line units throughout the OIF Theater of operations. Thus, these findings may not generalize to Soldiers at battalion, brigade, and division levels.

The most important findings included (a) low overall morale and cohesion and (b) the relatively high rates of mental health concerns. These findings need to be interpreted in the context of the operational tempo and combat stressors experienced by OIF Soldiers,

as well as what is known about the prevalence of mental health concerns in the general population.

Lower morale and cohesion were associated with higher rates of mental health concerns. However, there were some important distinctions noted between reserve and active component Soldiers. While cohesion and morale were higher among active component Soldiers than reserve component Soldiers, rates of mental health concerns were higher among active component Soldiers. This inverse relationship is likely related to the much higher rate of combat experiences and less favorable living conditions among active component units located in Iraq compared with reserve component units located mostly in Kuwait.

Regarding mental health concerns, rates of screening positive for depression and anxiety were almost identical to rates reported among Soldiers in garrison after returning from OEF or prior to deploying to OIF (~7%). These screening rates provide a broad estimate of the population that may be at risk for depression or anxiety, and can be used for planning purposes regarding allocation of behavioral health resources in theater. They are comparable to rates previously reported in civilian and military populations (Kessler, 2000; Hoge, 2002).

OIF Soldiers had much higher rates of screening positive on the post-traumatic stress scale than Soldiers in garrison (15% vs. 7%). This is related to the high rate of combat experiences among OIF Soldiers, particularly among active component Soldiers. Multiple studies have confirmed the link between combat and lifetime risk of post-traumatic stress (Pierson, 2001, 2002). It is important to keep in mind that the post-traumatic stress checklist used in this survey is a screening instrument, and it is impossible to distinguish between acute stress reactions and PTSD with this scale. Since combat experiences are ongoing, it is likely that many of the Soldiers are experiencing acute stress reactions. Further data collections over time are necessary to determine the proportion of Soldiers that may go on to develop more chronic PTSD symptoms.

Sixteen percent (16%) of OIF Soldiers surveyed reported interest in receiving help for a stress, emotional or family problem. This compares with a rate of 8-10% among Soldiers in the comparative pre-OIF, post-OEF garrison samples. Although Soldiers express a strong interest in receiving help, the high rates of perceived stigma and other barriers to care likely prevent them from obtaining help. Concerns about stigma and barriers to care are greatest among those Soldiers most in need of services (those who screening positive for depression, anxiety, traumatic-traumatic stress). Concerns about stigma are not specific to the operational environment, as similar rates of concerns have been observed in garrison surveys (Hoge, et. al., 2003; Britt, 2000). However, this survey documented that the OIF operational environment presents some unique physical barriers to receiving care, particularly involving problems with transportation to locations where mental health professionals are located.

While it may be difficult to moderate the inherent stressors of combat, data from this survey identified several things that may improve morale and well-being of OIF Soldiers (Thomas, Castro, 2003). This includes reducing the barriers to receiving behavioral health support in the forward environment, establishing predictable deployment schedules, reducing perceived inequities in quality of life services, and enhancing the training of Soldiers to meet the demands and stressors of deployment.

## **APPENDIX 1 (Peer-Mentoring Program) to ANNEX A to OIF MHAT REPORT**

**SUBJECT:** Soldier Peer Mentoring Care & Support (PMCS) Program.

**1. PURPOSE:** To review the importance of an early risk management and peer support program.

**2. RECOMMENDATION:** The proposed PMCS program is the earliest and first line of defense for the distressed Soldier. Soldier PMCS is a Commander's risk management program and can best be conceptualized as the behavioral health equivalent of the Combat Lifesaver or Combat Medic programs. PMCS provides Commanders and leaders with unit-based critical early identification, mitigation and referral of Soldiers with family, operational and combat stress issues as part the Commanders Risk Management program.

### **3. BACKGROUND:**

a. Since the Gulf War of 1990-91, the OP/PERSTEMPO for Soldiers has steadily increased, while the numbers of Soldiers to fulfill these missions has decreased. As a result Soldiers and their families are experiencing increasing levels of stress that continue to be manifested in ways that can often be destructive for the Soldier and his/her family and the Army community. Recent clustering of suicide/homicides at Ft. Bragg, and more recently, the clustering of OIF suicides in July 2003 are tragic examples.

b. Current mitigation and identification support systems such as Chain of Command, NCO leadership, Chaplains, Behavioral Health, and family support system do an excellent job given their inherent limitations, but have not optimally reduced levels of incidents. The recent Mental Health Advisory Team (MHAT) findings from the Soldier Health and Well-Being Survey indicate that Soldiers who screened positive for mental health problems will talk with other solders about their problem at a rate three times greater than they will with chaplains and behavioral health professionals. Additionally, Behavioral Health as a self-referral system is often perceived as "career ending" or "shameful" (letting down the individual Soldier or the Soldier's peers). FM 22-100 and FM 22-101 address leadership principles of counseling, coaching, and mentoring, but 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.

c. Our allies have also experienced similar family, operational, and combat concerns. In 1996, at the direction of the Commandant, the British Royal Marines developed and instituted a peer-driven risk management and support system. The program 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 same. All British military forces are projected to adapt and implement by end of 2003.

**4. CONCEPT OF OPERATION:** Capitalize on the proven success of “train the trainer” programs and train an initial cadre of Army Behavioral Health Providers (BHP) to train other Army BHP and Soldiers already trained in the Army ASIST program. Supplement learning activities for trained Soldiers through the use of a self directed interactive CD.

**5. SUMMARY:** The Soldier PMCS program is designed as a “Soldier driven”, early portal of entry for identification, mediation, and referral for family, operational, and combat-related behavioral health & stress issues. PMCS can be fielded rapidly as a self paced, self learning module supplemented by training provided by US Army Behavioral Health Officers (Train the Trainer). Ideally Commanders can further leverage the PMCS Soldier’s training by matching those Soldiers who have already received ASIST training.

## **APPENDIX 2 (Summary of Soldier Health and Well-Being Survey) to ANNEX A to OIF MHAT REPORT**

The Soldier survey is a specially adapted version of a questionnaire being used by the Walter Reed Army Institute of Research (WRAIR) to assess the ongoing effects of OPTEMPO, combat exposure, and mental and physical health variables on Soldiers and marines, as well as family members. Data from other samples collected previously by the WRAIR are utilized as comparison data in this report.

The findings from scales and items contained within the survey presented in this report include:

### ***Morale and unit cohesion***

Participants were asked to rate both their personal morale and the morale in their unit on a five-point scale from “very low” to “very high.” Unit cohesion was measured as an average of participants’ agreement or disagreement to three questions: “The members of my unit are cooperative with each other,” “The members of my unit know that they can depend on each other,” and “The members of my unit stand up for each other.” (Castro, 2000)

### ***Officer and NCO leadership***

Participants rated a series of four questions on a five-point scale (“Never” to “Always”) for both their NCOs and officers in their unit. Questions included: “In your unit, how often do NCOs [officers] tell Soldiers when they have done a good job,” “In your unit, how often do NCOs [officers] embarrass Soldiers in front of other Soldiers,” “In your unit, how often do NCOs [officers] try to look good to higher-ups by assigning extra missions or details to Soldiers,” and “In your unit, how often do NCOs [officers] exhibit clear thinking and reasonable action under stress?” The average of these four questions formed a composite scale score for NCO leadership and officer leadership respectively. (Castro 2000)

### ***Stigma and barriers to behavioral health care***

Stigma and barriers to receiving mental health care were assessed by asking each participant to agree or disagree (on a five-point scale) with a series of 17 questions. Physical barrier questions included, “I don’t know where to get help,” “It is difficult to get an appointment”, “It’s too difficult to get to the location where the mental health specialist is.” Stigma questions included “I don’t trust mental health professionals,” “My leadership would treat me differently,” “My leaders would blame me for the problem,” and “I would be seen as weak.” (Hoge, 2003; Britt 2000)

### ***Marital satisfaction and family support***

A number of factors were examined about marriages and how families were supported at home station.

*Marital Satisfaction* – Measured by the average response to four questions (“I have a good marriage,” “My relationship with my spouse is very stable,” “My relationship with my spouse makes me happy,” and “I really feel like a part of a team with my spouse.”). In addition, participants were asked whether or not they (or their spouses) intended to separate or divorce.

*Family Support During Deployment* – Participants were asked to rate their satisfaction of their unit rear detachment’s support of their families, and their satisfaction with their unit family readiness group’s (FRG) support of their families.

### ***Combat and deployment stressors***

Combat and deployment stressors were examined using two scales.

*Combat Exposure* – The frequency of combat exposure to various combat events were examined, and participants were asked to rate the number of times they felt they were in serious danger of being injured or killed (four-point scale). Example questions include, “Being attacked or ambushed,” “Receiving small arms fire,” “Seeing dead bodies or human remains,” “Clearing/searching homes or buildings,” “Being responsible for the death of an enemy combatant”.

*Deployment Stressors* – Participants also rated their concern about various other stressors along a five-point scale. Deployment stressors included, “Being separated from family,” “Uncertain redeployment date,” “Duration of deployment,” “Lack of privacy,” and “Boring and repetitive work.”

### ***Mental health status***

Participants were asked a number of questions about their current mental health functioning in the areas of depression, generalized anxiety, and post-traumatic stress (post-traumatic stress ). In order to score positive for one of these three areas, the participant had to endorse several items on each scale according to established clinical guidelines at “More than half the days” (depression/ anxiety scales), or “Moderate” level (traumatic stress scale) AND mark that the problem caused functional impairment. The functional impairment question for depression and anxiety was based on a single question asking the respondent to rate how difficult the symptoms had made it to do his/her work or get along with other people. “Very difficult” or “extremely difficult” was scored positive. The functioning question for post-traumatic stress was based on questions that asked if the symptoms had affected their work. This established a conservative estimate of those at high risk for a possible mental disorder. (Spitzer, 1999; Blanchard, 1996)

### ***Retention***

Participants were asked to describe their current career intentions along a six-point scale from “definitely stay in until retirement” to “definitely leave upon completion of [one’s] current obligation.”

***Quality of life***

Quality of life was examined through the answers (on a five-point scale) participants gave to a number of questions. These questions included “difficulties communicating back home (e.g. phone calls, email, mail),” and “lack of privacy or personal space.”

***Training***

Soldiers were asked if they agreed on a 5-point scale from strongly disagree to strongly agree if training in suicide prevention was adequate, if training for identifying Soldiers at risk for suicide was sufficient, and if training in handling the stresses of deployment was adequate. Soldiers were also asked their confidence in their ability to identify Soldiers with depressive symptoms, at risk for suicide, and whether they had attended training in suicide prevention or stress education.

## **APPENDIX 3 (Summary of Focus Group Interviews and Procedures) to ANNEX A to OIF MHAT REPORT**

### **INTRODUCTION**

Thirty-four small group interviews with junior enlisted (N = 17 groups) and NCOs (N = 17 groups) from CFLIC (Kuwait) and CJTF7 (Iraq) were conducted to obtain Soldiers' perspectives on the operational/combat stressors they encountered, their quality of life, leadership, deployment length, morale, access to health care, and family support.

### **APPROACH**

#### **Focus Groups**

All interviews were conducted by at least two MHAT team members. Thirty-four groups were conducted at sixteen different locations throughout the Kuwait and Iraq area of operations with the following group composition: combat, combat support, combat service support, and medical.

#### **Themes/Questions**

Prior to all interviews, key themes and specific questions that every MHAT interview team would attempt to address were determined. All groups were asked the same questions. Below are the specific themes and questions for all focus groups.

Themes: Length of deployment, key events experienced by unit/individual. Mission evaluation, morale of individual/unit, access to health care, access to command, leadership, family well-being, and quality of life. Interview questions included: (1) how long have you been deployed (i.e., in country)? How long do you think Soldiers should be deployed to Iraq? (2) What missions or operations have you conducted since arriving in country? Do you think that you have been successful? What was the impact on the unit? (3) What has been the most positive aspect of this deployment? What has worked well? The most negative? What has been the most stressful aspect of the deployment? (4) How would you rate the morale in your company? High, medium, low? (5) How would you evaluate the health and well-being of the company? Physical health? Mental health? (6) How has leadership been? NCOs? Officers? (7) What about leadership at the battalion level and above? How has it been? (8) How is your family doing during the deployment? Is the Family Readiness Group and rear detachment doing a good job? (9) Have you been able to take R & R? How do Soldiers unwind while deployed? How often do Soldiers in your unit "get a break?"

#### **Procedures**

All interviews began with members of the MHAT interview team introducing themselves and describing the purpose and objective of the interview. Confidentiality and anonymity

were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the group members were recorded. All interviews lasted approximately 60 minutes.

## **RESULTS**

### **Junior Enlisted Soldiers from Combat Units Stationed in Iraq**

The junior enlisted Soldiers from Combat Arms units consisted of 62 Soldiers representing a wide and varied range of combat MOS's. Fourteen separate combat arms companies were surveyed throughout the CJTF-7 AO. Twenty-two Soldiers were married and forty Soldiers were single. Length of deployment for all Soldiers ranged from five months to eight months. All but three of the 62 Soldiers felt that six months was the longest a deployment should last, though roughly half of the Soldiers agreed they could do a year tour if the de-mobilization/redeployment date was firm and known in advance. "Give me a count down, not a count up." "Six months should be the limit. After that time, you start thinking more of home than on the mission." Key events for the groups centered primarily on combat experiences. Other key events included a friendly fire incident, change of command, changing de-mobilization dates, and the uncertainty of returning home. All group members moved several times within the theater of operations. All groups reported doing patrol missions and other details. Most group members felt they have been successful in accomplishing the tasks given to them. Some groups expressed concern that their raids had become less productive, netting fewer bad guys and weapons as time went on. The groups varied on their reports of positive and negative aspects of the deployment. Four of the groups commented on the positive aspects of "combat pay and tax breaks". Several members of the groups felt positive about the reception they received from Iraqi citizens shortly after Saddam was removed from power. Some group members felt the cohesion formed in the unit was positive. Many group members listed separation from family and unknown rotation dates as negative aspects of the deployment. Nearly half of the groups reported "improvised explosive devices" (IED) as a negative aspect of the deployment. Other group comments on negative aspects included a friendly fire incident and the assignment of mundane "make work" tasks. Morale was listed as low by nearly three fourths of the groups. None of the groups rated morale higher than "medium" or a "4-6" on a 10 point scale. Some key factors identified for low morale were, "You see other units in charge of us and they are living better than we are." "It's not equitable in theater." Some groups cited the rotation of some Soldiers due to ETS as "morale busters" for the unit. "If we're losing manpower and this mission is so important, then why are they leaving (ETS Soldiers)?" All groups reported generally good physical health. Several groups reported some mental health issues, i.e.; increased agitation, depression, or family problems. Groups were evenly divided on quality of NCO and officer leadership. Some groups reported their leaders as poor, only interested in furthering their own careers, and, some groups reporting their leaders as doing good and looking out for Soldiers. Nearly 75% of the groups reported that their Battalion level command leadership as poor. The primary complaint was "a lack of concern for us" and the initiation of "garrison style" policies and duties. All the groups reported that access to physical health care was generally good

with some problems related to distance and time required for travel. One group cited a problem that once they got to sick call they were told they needed to come back for an appointment time. Over half of the groups reported no awareness or contact with mental health services. Other group members indicated their commands would not be supportive of using mental health, "We can't go to anyone because our command won't let us have time off and they're too macho. My platoon sergeant would call me a(expletive)!" Over half of the groups reported the Family Readiness Groups as "broke or doing poorly". One group stated their FRG was doing a good job but had gotten "a lot of bad information" relative to the unit's re-deployment and other events. "They planned a homecoming bash for us...we didn't show up." All groups reported living conditions were acceptable, primarily because of the improvement over what they previously were living in. Time off and R & R experiences varied for each group. Many group members felt they would not be able to benefit from the R & R program because of manpower constraints and because the selection criteria to go on R & R rewarded those who re-enlisted at the expense of the rest of the Soldiers. Several Soldiers who went on R & R were not complimentary of the experience, "It sucked!" "Too many regulations. Nobody wants to go now." One group member reported that Soldiers were being charged for bottled drinking water at his R & R location. Ability to communicate back home with family members varied from group to group. Some groups were limited to a few short minutes of email or phone calls every few weeks, while other groups had opportunities for both on a weekly basis. Additional comments for some groups centered on the stressful nature of IEDs and the risks involved in the mission.

### **Junior Enlisted Soldiers from Combat Service and Combat Service Support Units Stationed in Iraq**

The junior enlisted Soldiers from Combat Support/Combat Service Support organizations consisted of 28 Soldiers ranging in rank from Private First Class to Specialist. The group consisted of 14 males and 14 females. Ten Soldiers were married and eighteen were single. There were four separate focus groups conducted at separate geographical locations. All Soldiers had been in theater for 6-7 months. All of the group members felt the length of deployment should be six months but could be longer if there was a mid-term break. Key events included a riot in the enemy prisoner of war (EPW) prison and handling human remains. All Soldiers felt their role in the mission was successful. Positive aspects included the early appreciation of Iraqi citizens and the self-confidence that they gained as individual Soldiers. Negative aspects included changes in mission role and rules of engagement. All but one Soldier listed their morale as low or very low (1 on a scale of 1-10). All group members identified their mental health as low and on the decline. Soldiers were fairly evenly divided in their assessment of the quality of leadership for their NCOs and company grade officers, ranging from poor to good. Those responding with poor listed their leadership as unapproachable and instituting "garrison type duties" in a combat environment. Battalion level leadership was described as "non supportive" and "never seen". Access to medical care was rated as adequate, however, access to mental health care was rated as either "not available" or "uncertain" by several groups. One group indicated seeing mental health professionals would adversely impact their career. Members of

one group indicated the FRG was difficult to relate to and that “they didn’t trust them.” Quality of life issues (i.e., living quarters, time off, etc) were okay or adequate for one group while the other group was currently living in tents without air conditioning and limited time to relax. Some reported that when they were given time off, if they laid in their bunks, “someone would come along and give us duty because we weren’t doing anything”. Some group members stated concerns about the R & R trips being given “to warriors not supporters.” All groups had email and phones available on a limited basis. Additional comments made by the groups included: a need to clarify current mission, truthful communication from command, a firm return date, and commanders and senior NCOs acting more responsively to Soldiers needs and concerns. “They may not be able to solve our problem, but they could at least listen and tell us up front the truth like adults.”

### **NCOs from Combat Units Stationed in Iraq**

Eight separate all-male groups consisting of 49 NCOs ranging in rank from E5 to E9 were held at various base camps throughout the Iraq AO. Thirty-two Soldiers were married; two divorced, and 14 were single. Length of group time deployed varied between 6-7 months for all groups. The groups were evenly divided on suggested length of time. Half felt 6 months was plenty. The other half felt a year was acceptable if there was still a mission. Soldiers who endorsed a year stay felt a year or two-year break between deployments was also needed. Some Soldiers indicated they had been deployed 20 out of 24 months. Some group members also felt Korea should be counted as a deployment. Key events for the groups included combat experiences, particularly IED exposure on the roads, ‘no warning orders or operations orders’ until 4 months into the war, and the allowance of officers to rotate out of theater to continue their career advancement. Most members felt they had been successful in their assigned mission and felt good about the job they had done. “We have been successful; we are dragging them down one by one.” As time goes on however, many NCOs felt they had inherited a mission for which they had not been trained or should be doing, “We are not trained to be part of the Peace Corps, we are Soldiers.” “We send confusing messages to the Soldiers. We came here to kill people. Now that we are not doing that they should send us home. Now we are told to smile and be nice to them.... and then we find weapons in the floor of their home.” The groups listed unit cohesion, relying on training, and relationships developed as positive aspects of the deployment. Groups also listed uncertain rotation date and changing statements about rotation as negative aspects. “The false return dates are very hard on morale; ...Soldiers are not believing what the command has to say about anything.” Group members also listed “Soldiers bitching about broke things” and the NCOs not having the resources to fix the complaints of Soldiers. All but two groups listed their morale as low, “We are showing high (morale on the outside for the sake of our Soldiers), but we are actually low (on the inside)” All of the NCOs in the group indicated that many NCOs are ‘putting on’ a high morale act in an effort to prevent discouraging their Soldiers. Low morale was attributed to several factors: (1) field grade officers and Generals “living like kings” while they (regular troops) lived in conditions less agreeable, (2) increased down time leading to more time to think about their circumstances, and (3) poor mail services. One group indicated they only

started receiving mail three weeks prior to the interviews in September (a period of approximately 5 months). All group members stated that the physical health of their units was good, a few indicated problems getting dental appointments. Over half of the groups indicated their unit was experiencing signs of stress, fatigue, and anger. Soldiers either indicated they would not seek mental health help (they would rather use their own internal resources) or could not gain access to mental health services. Groups were evenly divided on leadership issues: some groups felt they had strong leadership at all levels and other groups felt their leadership was “broke”, “Command and control has been(expletive).” Of major concern to many group members is the change of officer staff during the deployment. The overall opinion is that the changing of officers is disruptive and is a significant contributor to the low morale issue. Most groups felt access to health care, both physical and mental health, was good. Only one group indicated that their unit would “make fun of them” for using mental health. Nearly all group members indicated their families were doing poor to fair with the primary frustrations centered on the one-year deployment and the changes in rotation dates. Many felt that FRGs were not adequately meeting Soldiers family needs. A few Soldiers indicated that early in the deployment there was contact with FRG, but as time went on, the contact died off. Over half the group members were angry and frustrated with their rear detachments. They felt “rear d” Soldiers were living the easy life and failing to fulfill the duties they were given to support the main body of Soldiers in Iraq. Housing was adequate and continually improving for all group members. Time to relax and access to MWR/R & R varied among group members with most feeling it was adequate. Group members located near the Coalition Provisional Authority (CPA) work areas were very concerned about the disparity in life style and access to amenities. “The NCOs were very upset to see E-2s walking around with cell phones, being able to call home anytime they want, while ‘the guys getting shot at don’t have anything. It’s a slap in the face.” All groups had access to email, phones and regular mail on varying degrees of regularity. Some groups encountered restricted access to phones from higher headquarters units who told Soldiers that the phone use was only for HHQ staff. Additional group comments included; “...Soldiers who get legitimate Red Cross messages aren’t allowed to go home, but officers who need to go to school can.”. One NCO was upset when General ██████ retired, “How can you let the Commanding General retire when we are at war?” Many group members were concerned with being part of the fight and now being asked to help change the hearts and minds of Iraqis. “The 82d was part of the invading force, and now they want us to be nice to people we were trying to kill. It screws with our heads.”

### **NCOS from Combat Support/Combat Service Support Units Stationed in Iraq**

Five separate groups totally twenty-nine Soldiers participated in the focus groups. Twenty-five of the Soldiers were male and eighteen Soldiers identified themselves being married. Rank ranged from E-5 to E-6. Most group members had been in country for a period of six months. All members felt six months was the ideal maximum time for a tour like Iraq. Some stated they could go longer (9 months to a year) but only if the return dates were firm and known in advance so their families could plan. Group members listed key events as “combat injuries” particularly IEDs. Several group members also

listed change of command by their leaders, "Its as if they brought us here and left us." However, one group with similar circumstances told of their high regard for their commander in spite of his having to leave and go back to CONUS. What separated this group of Soldiers from all other groups reporting their commander leaving was the open knowledge that the Commander did everything he could to "stay with his Soldiers" but in the end was forced to leave by 'higher ups'. All groups reported their missions as successful. Missions varied widely amongst the types of support groups. No group reported feeling that they were no longer doing a useless mission, this differs from CA NCOs. Most Soldiers reported the change in unit cohesion as a positive thing and the confidence in themselves that this deployment generated. On the negative side Soldiers were concerned with the inequities between officers and enlisted ( ability to attend schools, rotations) and the lack of telephones. "The Army didn't bring enough phones and the Air Force has gotten tired of us using theirs." Morale for all groups ranged from very low to medium. Those indicating low morale attributed long work hours, uncertainty of rotation dates and the introduction of "garrison type duties and attitudes" into the theater. Physical health among all group members was reported as good though many reported feeling fatigued and overworked. (one grouped worked 18-hour days, 7 days a week). Mental health generally was considered to be low to medium with many reporting to be depressed or stressed. Leadership varied among group members, with some indicating NCOs as doing a good job and others indicating they did poorly. Officers were likewise rated. Most complaints made were with leadership at the battalion and above levels. The major complaints centered on officers being allowed to continue advancing their careers while everyone else was on hold. Soldiers from the groups reported access to health care as good. Some reported they would not use mental health care because of the stigma attached to it. Group members varied on how their families were doing and how they felt the FRG was meeting their family's needs. Some indicated their families were doing very poorly and that FRG was "broke" while others indicated the problem for FRGs was in getting good information to give to families. Quality of life issues varied among groups. Most felt their housing situation was continuing to improve and that currently it was not too bad. Time off for many was meaningless because there was either a limited amount of things to do or they simply did not have time off. R & R and MWR trips varied but most felt they would not be able to take advantage of it because of duties and policies. Communication for many was marginally adequate. Some complained about the high cost of phones to call home. Some stated they had paid as much as \$2.00 a minute to call. Additional comments again focused on the disparity between officers and enlisted with regards to being allowed to continue education and career advancement. Many NCOs expressed concern about not being properly trained or equipped for the change in mission roles they are now performing. Some NCOs stated "More manpower is needed for these types of missions. We are exhausted and have nothing to look forward to but another rotation over here. There are no incentives to stay (in the Army) ... They'll offer someone off the street money to come in and all we'll be offered is another rotation away from our families."

### **NCOs from Medical Units Stationed in Iraq**

This group consisted of nine members ranging in rank from E5 to E6. Seven members were male and two female. Eight of the members were married. The group had been in theater for 6 months and all felt 6 months was the ideal maximum time for this type of deployment. Key events are listed as daily mortar attacks and SCUD attacks early in the war. They felt their mission of providing patient care in a hostile environment had been successful. Uncertainty related to rotation dates was the only negative aspect listed. Morale was low for all members; they felt they were beginning to “unravel mentally”. Rating of leadership quality for NCO and Officers varied among group members. Battalion level leadership was rated as very poor. The FRG initially was “horrible” but is getting better. The FRG has been misreporting some information. Quality of life issues are good with adequate opportunities for communication with families. Additional comments were, “ a lack of people with TOE/ field experience. TDA Soldiers don’t know what’s going on.” “Some leadership positions have been given to reservists and they don’t understand how things work.”

### **Junior Enlisted Soldiers from Combat Support/Combat Service Support Units Stationed in Kuwait**

The junior enlisted Soldiers from Combat Support/Combat Service Support organizations in Kuwait consisted of 4 Soldiers ranging in rank from private first class to specialist. One was married, three were single. There was one female and three males. This group has been deployed for nine months at time of interview. Collectively they felt 6 months, including time spent in MOAB, was sufficient time for a deployment. This group listed the initial de-mobilization/redeployment order cancellation and subsequent cancellations of de-mobilization/redeployment dates as a key factor. The only positive aspect they could identify for the deployment was the level of trust they developed with each other. Everything else was listed as a negative experience with particular negative focus on leadership. Morale was listed as low to medium. This group reported that NCO leadership seemed to “have given up “ on leading. They reported officers as “the worse of all leaders” and that the officers would not accompany them on missions into Iraq. This group also reported that BN level NCO leadership was allowed to take leave while other Soldiers were not. There were no complaints or issues raised with access to medical or behavioral health care. The group viewed the Family Readiness Group as inactive. Quality of life issues, i.e.; housing/personal space, MWR opportunities, and sufficient time to relax were not issues for the group, however, all of the group would have preferred more personal living space. The group had adequate means and access to communication with home. Additional comments by the group were concerns about stop loss impacting RC/NG ability to ETS while not impacting AC Soldiers, and, concerns that officers were given opportunity to take leave or time off to spend time with service member spouses in theater while enlisted Soldiers with similar circumstances were not afforded the opportunity to see their spouses.

### **Junior Enlisted Soldiers from Medical Units Stationed in Kuwait**

The junior enlisted for medical organizations in Kuwait consisted of four Soldiers ranging in rank from private first class to specialist. One was married and three were single. There were two females and two males. This group has been deployed for seven months, they did not respond to how long the length of deployment should be. The key event for this group was change of command. They viewed the change of command as positive, "more supportive, more information on what's going on". This group did not change geographical locations during OIF. Members of this group did not identify comments related to their mission. The group listed morale as "always low" in spite of their statements that having "hot showers, good food, time to focus on promotions and the availability of R & R trips" was available to them. The group endorsed good physical and mental health and reported that access to care was not an issue. The group was divided on quality of NCO leadership. Some group members felt NCOs as a whole did a good job, while other group members felt NCOs "whined and acted out." The group had similar comments for officer leadership. There was concern over double standards between the enlisted and officers. Junior enlisted Soldiers were reprimanded for uniform violations while officers uniform violations were not addressed by command. Battalion level leadership was new and the group felt that the new commander and SGM showed genuine interest in quality of life and other important issues. The group gave low marks to the Family Support Group, indicating that it was "inactive". Quality of life issues such as housing, food, time off, MWR were not issues. Communication to family and friends back home was sufficient but had been better before. The unit was recently forced to make cutbacks in the number of phones available for staff to use.

### **NCOs from Combat Support/Combat Service Support Units Stationed in Kuwait**

There were five NCOs ranging in rank from SGT to SSG. One was single, four were married. All group members were male. The group has been deployed for nine months including mobilization. The group felt one year for all phases was an adequate deployment length. This group listed two key events: (1) extension of deployment beyond one year. (2) Unit tasking to four different battalions. Each of these four different battalions was reported by the group to have rotated back to CONUS. The group members were based out of Kuwait but traveled extensively into Iraq. The group took pride in the accomplishment of their mission. They reported, "feeling honored" to transport the 3d ID out of theater. They now felt that they were doing "make work" missions. The most positive aspect of OIF for this group was the opportunity to "make more money" (through combat pay incentives). The most negative aspect was "leadership constantly lying to Soldiers." While access to health care was good, the group reported that Soldiers in their organization were discouraged from seeking health care and that those Soldiers receiving profiles were verbally "degraded", given bad details, and the medical profile challenged by leadership. "The unit discounts the 'doctors' orders." The group commented that NCO leadership "sucks." "Some NCOs do a good job but "many do not give a damn." One group member stated that his platoon leader had made such a negative impact on him that he was planning on leaving the Army after 15 years of service. The group commented that the officers would "go with the flow and avoid issues". There was no discussion on battalion leadership or family

support groups. Quality of life issues were not a problem. Access to communication was good. Additional comments were: "The government hanged us (NG and Reserve)," "Many reservists will lose their businesses back home," "We're hauling things now that could be handling more efficiently and economically by another means of transport."

### **NCOs from Medical Units Stationed in Kuwait**

There were nine NCOs from two medical units (one active, one reservist) interviewed in separate focus groups. Their rank ranged from SGT to SFC. There were four females and five males. Five Soldiers were married. All NCOs were either from the 91 series MOS or were Soldiers assigned as support to the medical unit. Both focus groups had been deployed for six months. The group was evenly divided between six months and one year on length of deployment. Key events for the group were listed as either change of command or the "rumor of fraternization" within the organization. The change of command was viewed as highly positive. Neither group changed geographical locations during OIF. Primary mission for both groups has been medical care of coalition service members and US. Both groups viewed their performance as rewarding and successful. The group stated a positive aspect of the deployment was "good training." Negative aspects of the deployment were listed as: "false hope and promises on return dates," separation from family, lack of privacy, and "difficulty in making decisions to make things happen." The group reported morale as low. One group reported morale as high within work units/sections, but low as an organization because of company level policies/actions. Both groups reported physical health as good while one group reported mental health as poor. Access to care was good but the group reporting poor mental health voiced concern over seeking mental health services. This group was reluctant to seek care from members of their own organization. The AC group felt NCO/Officer leaders were "professional" and did "admirable" jobs. The RC group felt discounted and unsupported as NCOs and that some officers encouraged Soldiers to jump the chain of command and come directly to the officer. Battalion command issues were not addressed in either group. Both groups, AC/RC had negative comments on their FRGs. The groups reported that family members were not being contacted and kept informed. Quality of life was not an issue for either group. Soldiers felt they had comfortable living arrangements, adequate time to relax and adequate time for organized R & R functions. Communication with family members was also an issue. The group stated TRICARE was an issue for their family. Soldiers whose dependents relocated geographically had difficulty using TRICARE because they were registered in a different TRICARE region.

#### **APPENDIX 4 (References) to ANNEX A to OIF MHAT REPORT**

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