Joint Professional Military Education Psychological Health Training Manual

An Overview for Leaders

Summer 2012

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Feedback

Feedback is vital for improving the quality of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury education directorate training manuals. Instructor feedback (written or verbal) on the course and course materials is greatly appreciated. Completed feedback should be directed to:

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
Education Directorate
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Table of Contents

1 Introduction

This training manual is designed primarily for instructors, but may also be beneficial to course sponsors, training leads or other individuals responsible for measuring performance related to training and education. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) clinical training manuals are designed to enhance consistent delivery of training while also providing instructors the flexibility to tailor materials to the needs of the audience. DCoE professionals believe training is most effective when delivered by local instructors who can use examples relevant to the audience and reinforce education after the initial course is delivered. This manual does the following:

- Incorporates adult learning principles
- Equips instructors with tools to motivate learners to actively participate in the learning process
- Uses interchangeable modules, allowing instructors to customize the course based on audience needs
- Includes tools that allow instructors and organizations to assess the impact of instruction on learner knowledge and behavior

Defense Department Documents Supporting DCoE Instruction Manual Effort

This manual is one of a series DCoE developed in support of:

- National Defense Authorization Act (NDAA) 110-181, TITLE XVI Sec 1621(c)(6) and 1622(c)(6): Coordinate best practices for training mental health professionals with respect to psychological health, traumatic brain injury (TBI) and other mental health conditions
- Mental Health Task Force (MHTF) 5.1.3.1, 5.1.3.3 and 5.1.3.4: Develop and implement core curricula on psychological health and TBI for Defense Department health care providers and leaders
- Public Law (P.L.) 110-181 Sec. 1615(a) Uniform training standard among military departments for training and skills of medical and non-medical providers of care

2 Joint Professional Military Education Psychological Health Training

The Joint Professional Military Education (JPME) Psychological Health training was developed to educate leaders on the prevalence of psychological health conditions within the joint force and provide ways they can enhance Total Force Fitness (TFF). The training provides an overview of psychological disorders to include posttraumatic stress disorder (PTSD), depression and substance misuse, and includes information on co-morbidities. It also provides a list of additional resources that may provide information on the topics discussed.

This instructor manual is designed to help facilitators conduct this training within a one-hour timeframe. It contains speaker notes for each slide, frequently asked questions (FAQ) and a

glossary of key terms and acronyms. The JPME training is subdivided into six sections that can be taught independently.

It is also recommended that facilitators review the training objectives of each section with their audience after each section to ensure training objectives are met. The audience should be encouraged to take notes during the training session and reference fact sheets as necessary.

Finally, a list of resources is provided in the FAQ section that facilitators are encouraged to reference for additional information.

3 Slide Presentation

This section includes the PowerPoint presentation and accompanying instructor notes.

The slide presentation is made up of six sections that may be used individually or collectively based on need:

- Section I: Psychological Health - An Integral Component of Total Force Fitness
- Section II: Psychological Health Challenges Facing the Joint Force
- Section III: Confronting the Psychological Impact of Combat
- Section IV: Signs and Symptoms of Psychological Distress
- Section V: The Comorbidities of Psychological Disorders
- Section VI: Reducing Stigma Associated with Confronting Psychological Health Conditions

An Overview of Psychological Health – What Leaders Need to Know

Say:

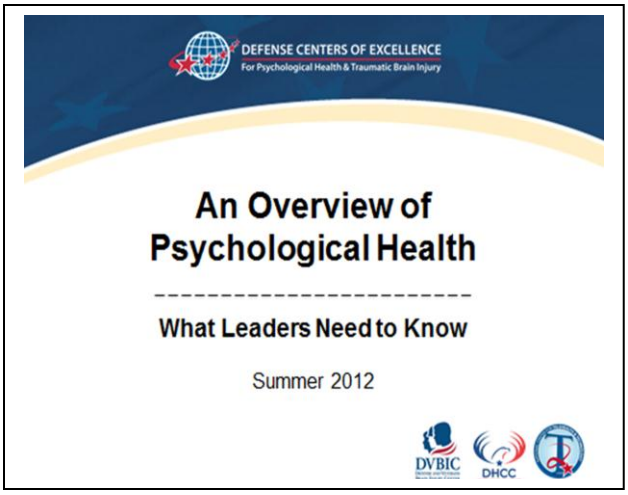
- No activities

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Topics Covered

Say:

This training presents the knowledge and skills combat leaders and line officers should possess on the range of psychological health conditions impacting deployed service members, such as PTSD. Engaged and educated leaders are empowered to enhance total fitness among service members.

This training is subdivided into six sections, which include:

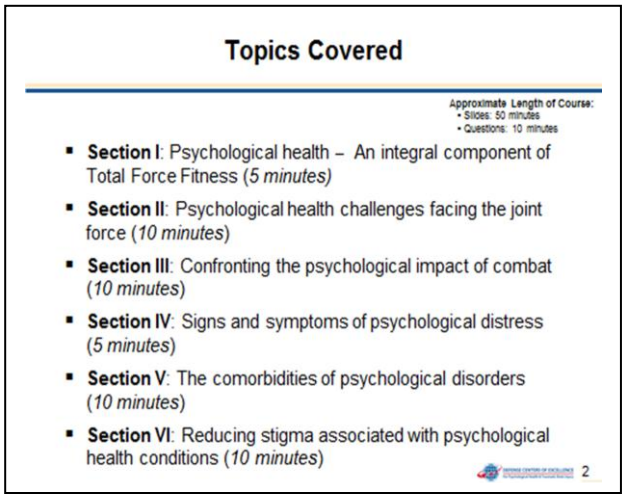
- Section I: Psychological health - an integral component of Total Force Fitness
- Section II: Psychological health challenges facing the joint force
- Section III: Confronting the psychological impacts of combat
- Section IV: Signs and symptoms of psychological distress
- Section V: The comorbidities of psychological disorders
- Section VI: Reducing stigma associated with psychological health conditions

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Objectives

Say:

By the end of this training, participants should be able to:

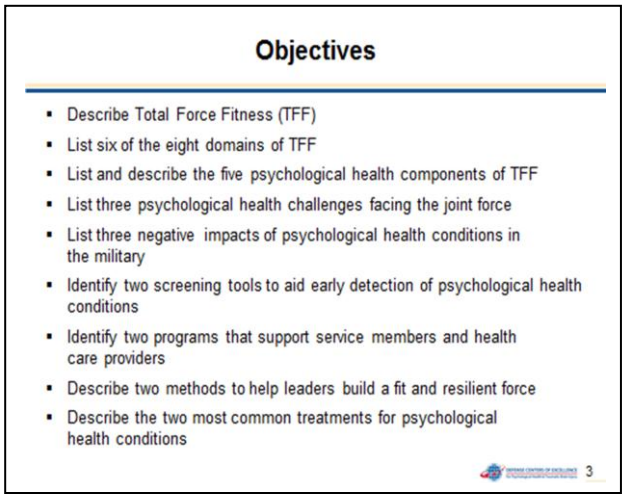
- Describe TFF
- List six of the eight domains of TFF
- List and describe the five components of the psychological health domain
- List three psychological health challenges facing the joint force
- List three negative impacts of psychological health conditions in the military
- Identify two screening tools to aid early detection of psychological health conditions
- Identify two programs that support service members and health care providers
- Describe two methods to help leaders build a fit and resilient force
- Describe the two most common treatments for psychological health conditions

Do:

- No activities

Additional Points (if any):

- None



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Objectives (cont'd)

Say:

Participants should also be able to:

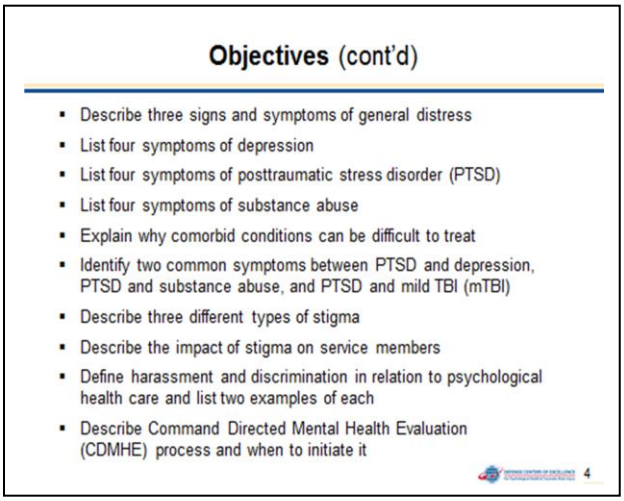
- Describe three signs and symptoms of general distress
- List four symptoms of depression
- List four symptoms of PTSD
- List four symptoms of substance abuse
- Explain why comorbid conditions can be difficult to treat
- Identify two common symptoms for each pair: PTSD/depression; PTSD/substance abuse; PTSD/mild TBI (mTBI)
- Describe three different types of stigma
- Describe the impact of stigma on service members
- Define harassment and discrimination in relation to psychological health care and list two examples of each
- Describe Command Directed Mental Health Evaluation (CDMHE) process and when to initiate it

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Psychological Health – An Integral Component of Total Force Fitness

Say:

Section one reviews the relationship between psychological health and Total Force Fitness.

Specific topics discussed include:

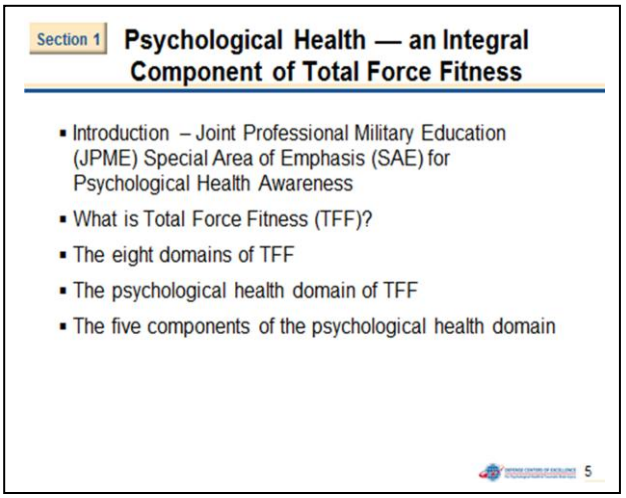
- What is TFF?
- What are the eight domains of TFF?
- The role of psychological health in TFF
- The five components of the psychological health domain

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Objectives – Section 1

Say:

At the end of this section of training, you should be able to:

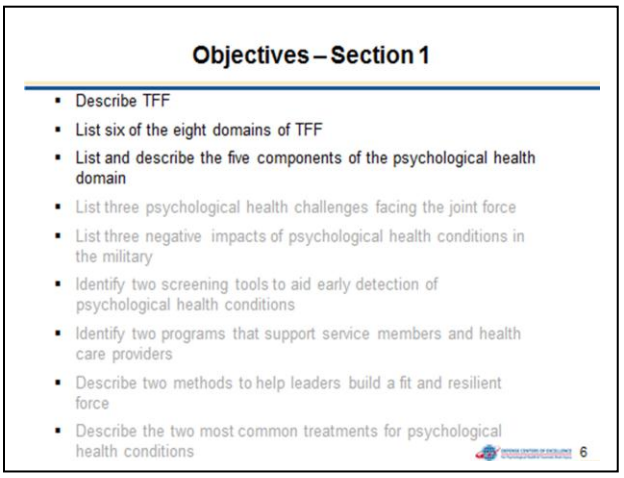
- Describe TFF
- List six of the eight domains of TFF
- List and describe the five components of the psychological health domain

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Introduction

Say:

Former chairman of the Joint Chiefs of Staff, Admiral Mike Mullen, identified psychological health awareness as a special area of emphasis for leaders across the joint force. Mullen has said that for service members to be fit, they must be healthy in mind and body, resilient and ready to complete their missions. He also stated that he believes that engaged and educated leaders may help to minimize the long-term impact of psychological health concerns upon the force, and improve the overall fitness of service members [1].

To meet this goal, Mullen listed six topic areas related to psychological health that should be included in Joint Professional Military Education. The six areas are:

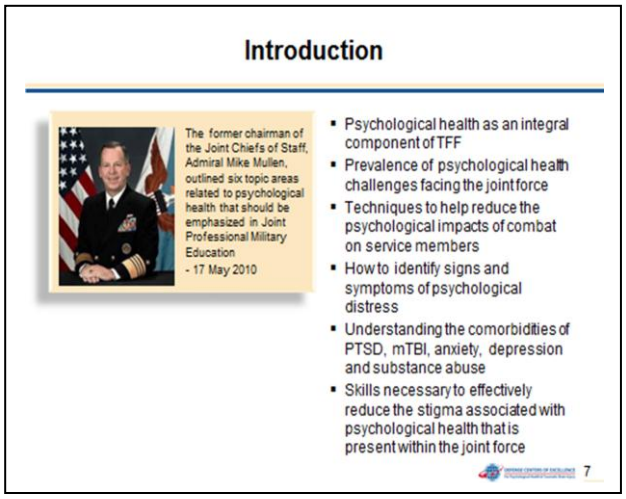
1. Psychological health and TFF
2. Prevalence of psychological health challenges facing the joint force
3. Ways to minimize the psychological impact of combat on service members
4. How to identify signs and symptoms of psychological distress
5. The comorbidities of PTSD, mTBI, anxiety, depression and substance abuse
6. Ways to reduce stigma associated with psychological health conditions

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

What is Total Force Fitness?

Say:

In a statement to attendees at the Total Fitness for the 21st Century conference, Mullen defined total fitness as “a state where mind and body are seen as one. The sum total of the many facets of individuals, their families, and the organizations to which they serve.”

Total Fitness is “a state in which the individual, family and organization can sustain optimal well-being and performance under all conditions.”

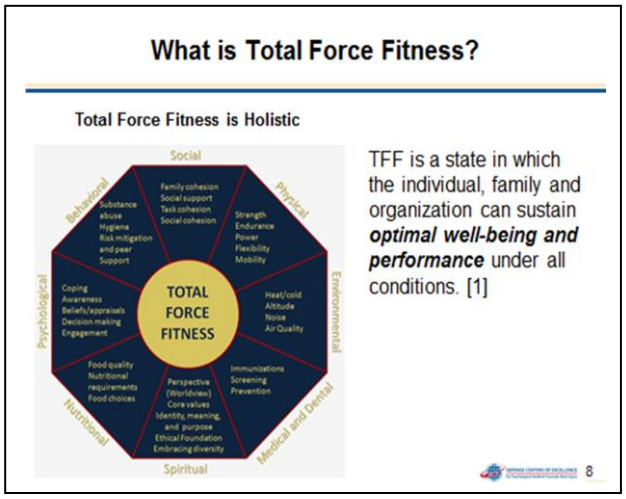
Total fitness includes eight interrelated elements: social fitness, physical fitness, environmental fitness, medical and dental fitness, spiritual fitness, nutritional fitness, psychological fitness, and behavioral fitness.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

The Eight Domains of Total Force Fitness

Say:

The eight domains of total fitness are subdivided into two categories: mind and body.

Total fitness domains relating to the body:

- Physical fitness – defined as accomplishing all aspects of the mission while remaining healthy/uninjured [2]
- Nutritional fitness – to provide and consume food in appropriate quantities, quality and proportions in order to preserve mission performance and protect against disease and/or injury [3]
- Medical/Dental fitness – maintaining mental and physical well-being [4]
- Environmental fitness – being able to perform mission-specific duties in every environment and endure the multiple stressors of deployment and war [4]

Total fitness domains relating to the mind:

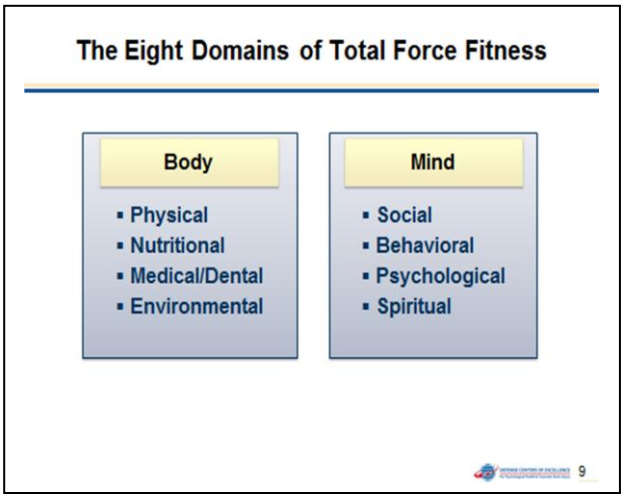
- Social fitness – to have healthy social networks in the unit, family and society that support optimal performance and well-being [5]
- Behavioral fitness – relationship between one's behavior and their positive or negative health outcomes [6]
- Psychological fitness – "the integration and optimization of mental, emotional, and behavioral abilities along with capacities to enhance performance and resilience" [7]
- Spiritual fitness – positive and helpful beliefs, practices and connecting expressions of human spirits [8]

Do:

- No activities

Additional Points (if any):

- None



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The Psychological Domain of Total Force Fitness

Say:

While the military has a long tradition of emphasizing physical fitness and medical fitness, other domains have not been specifically targeted for improvement. One very important domain is psychological fitness.

Psychological fitness has five components:

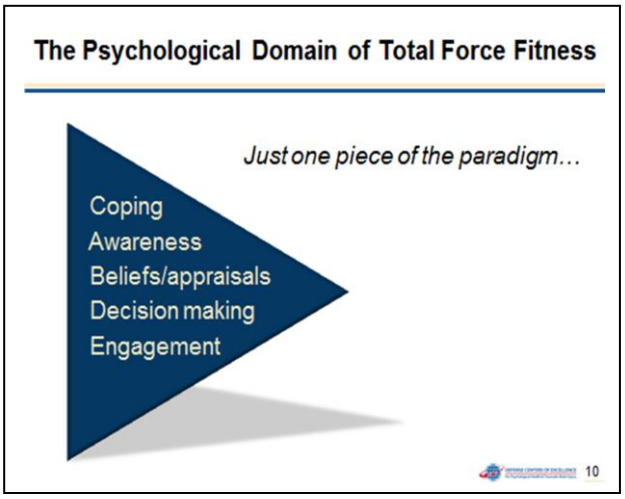
- Coping
- Awareness
- Beliefs/appraisals
- Decision making
- Engagement

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

The Five Components of Psychological Health

Say:

To be fit in all five areas of psychological fitness:

- Coping: The ability to cope with adversity and challenges
- Awareness: How you are doing mentally and emotionally
- Beliefs/appraisals: Being able to formulate and articulate values and beliefs and make accurate and often fast appraisals of situations
- Decision making: The ability to make sound decisions that not only affect yourself but those you lead
- Engagement: Being able to be engaged and attentive to the mission at hand

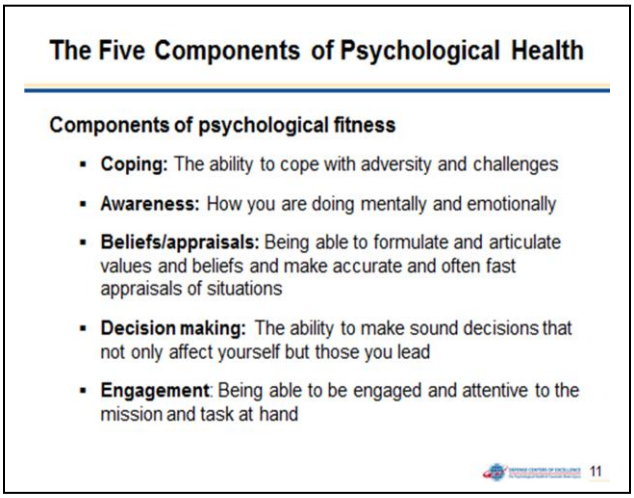
It's important to understand psychological health and how it relates to the joint force

Do:

- No activities

Additional Points (if any):

- None



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Psychological Health Challenges Facing the Joint Force

Say:

Section II discusses psychological health and TBI challenges facing the joint force. Knowledge of these challenges would empower leaders to enhance total force fitness.

First, we will give an overview of psychological health challenges in the joint force

Then, we will look at some of the key psychological health disorders in the Defense Department.

Specifically, we will review:

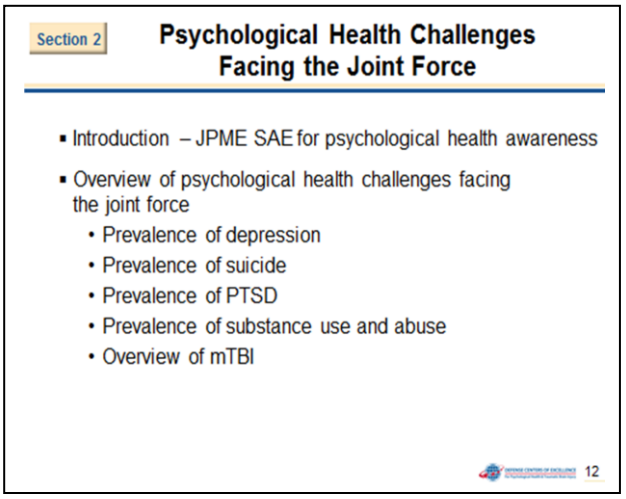
- Prevalence of depression
- Prevalence of suicide
- Prevalence of PTSD
- Prevalence of substance use and abuse
- The co-morbid physical injury, mTBI

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Objectives – Section 2

Say:

At the end of this section of training, you should be able to:

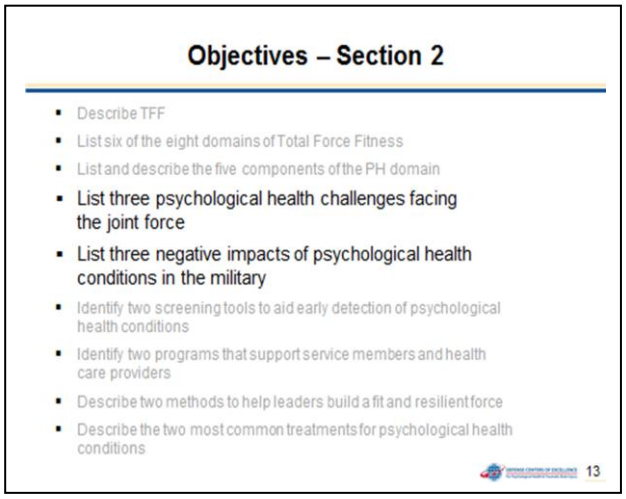
- List three psychological health challenges facing the joint force
- List three negative impacts of psychological health conditions in the military

Do:

- No activities

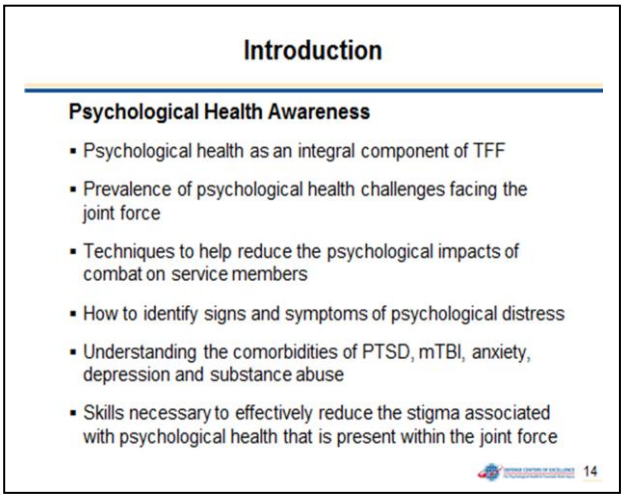
Additional Points (if any):

- None



Customizable Content (if any):

Introduction



Say:

**Note to instructor: Read this slide only if this section is your first lesson of the series. Skip slide if you are continuing from previous section.

Former chairman of the Joint Chiefs of Staff, Admiral Mike Mullen, identified psychological health awareness as a special area of emphasis for leaders across the joint force. Mullen has said that for service members to be fit, they must be healthy in mind and body, resilient and ready to complete their missions. He also stated his belief that engaged and educated leaders can help to minimize the long-term impact of psychological health concerns upon the force and improve the overall fitness of service members [1].

To meet this goal, Mullen listed six topic areas related to psychological health that should be included in Joint Professional Military Education. These six areas are:

1. Psychological health and TFF
2. Prevalence of psychological health challenges facing the joint force
3. Ways to minimize the psychological impacts of combat on service members
4. How to identify signs and symptoms of psychological distress
5. The comorbidities of PTSD, mTBI, anxiety, depression and substance abuse
6. Ways to reduce stigma associated with psychological health conditions

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Overview of Psychological Health Challenges Facing the Joint Force

Say:

As shown in this graph, psychological health disorders have increased dramatically across the joint force within the last several years. The rise in disorders is happening despite numerous programs and initiatives in place to reduce psychological health issues.

We are also losing personnel to medical board separations because of psychological health disorders, and are experiencing high rates of administrative separations for behavioral problems related to psychological health conditions and to suicide.

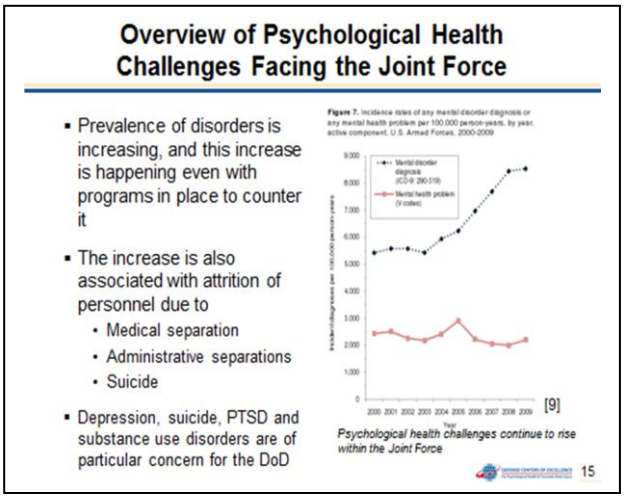
Depression, suicide, PTSD and substance use disorders are psychological health issues that are of particular concern to the Defense Department.

Do:

- No activities

Additional Points (if any):

- None



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Prevalence of Depression Within the Joint Force

Say:

Another prominent mental health disorder challenge facing the joint force is depression.

What is depression?

Depression is a clinical disorder that is often misunderstood. Clinical depression is far more than a period of being sad; it is a serious disorder that affects all aspects of a person's life. Because of the risk of suicide, depression can be life-threatening if not treated.

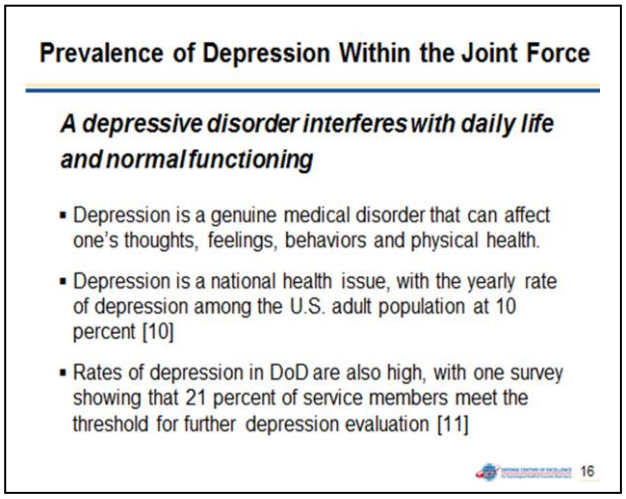
In 2008, up to 21 percent of service members met the threshold for additional depression evaluation during the Defense Department survey of health-related behaviors among active-duty personnel [12].

Do:

- No activities

Additional Points (if any):

- None



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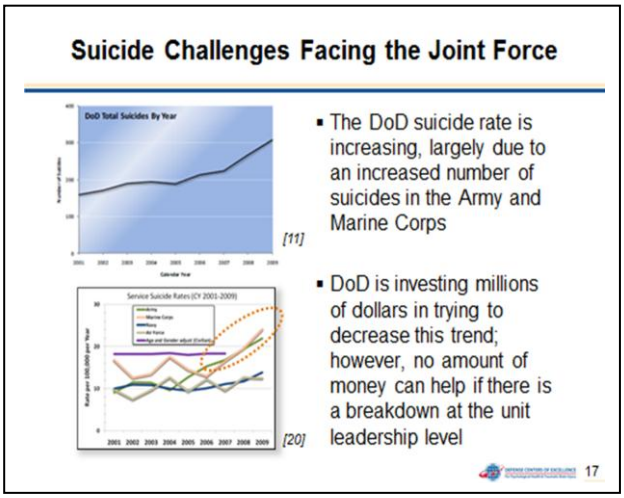
Suicide Challenges Facing the Joint Force



Say:

What is suicide?

Suicide occurs when a person intentionally inflicts bodily harm to himself/herself that results in loss of life [27].

The total number of suicides and the suicide rate have been increasing in the Defense Department since 2001 [12], with the highest rate in the Army and Marine Corps.

Suicide isn't only a military issue. In fact, the Defense Department has traditionally had a lower rate of suicide compared to the civilian population. In 2007, more than 34,000 civilians committed suicide, and approximately 8.3 million adults had serious thoughts of suicide in 2008 [14] [15].Because of several factors, including the stress of multiple deployments on the force, the Defense Department rate has increased and in 2007 the age-adjusted suicide rates of the Marine Corps and the Army exceeded the civilian population's rate.

Suicides continue to be a concern for the Defense Department and leaders must employ every effort in helping to prevent suicide within the force.

There are numerous resources that service members can reach out to if they need help. However, leaders must create an environment that encourages service members to seek help early, and be vigilant in identifying service members who may have psychological health concerns.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Prevalence of PTSD Within the Joint Force

Say:

Posttraumatic stress disorder is an anxiety disorder that may result from experiencing or witnessing a perceived life-threatening event -- combat, natural disaster, accident, etc.

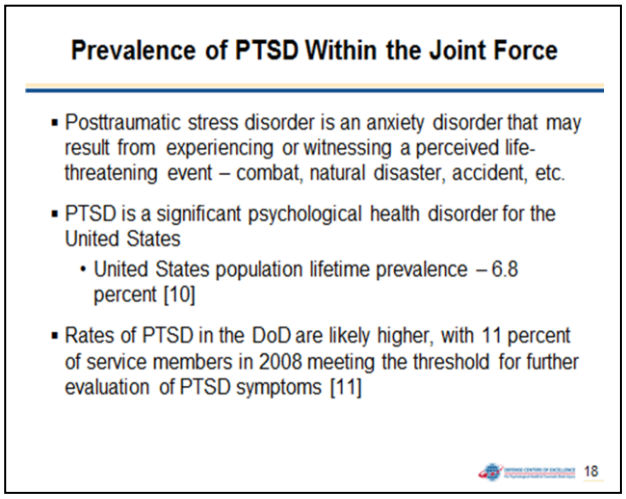
- PTSD is a significant psychological health disorder for the United States, with almost 7 percent of Americans having the disorder sometime during their lives
- Rates of PTSD in the Defense Department are likely higher, with one study in 2008 showing 11 percent of service members meeting the threshold for further evaluation of PTSD symptoms [12]

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Substance Use and Abuse Within the Joint Force

Say:

Alcohol abuse and drug abuse are significant problems for the Defense Department.

A 2008 Defense Department survey of self-reported, health-related behaviors showed that high numbers of personnel were engaging in heavy alcohol use across the joint force. The graph depicts a breakdown among the services: The Marine Corps had the highest rate at 28 percent; the Army Coast Guard and Navy rates were close to 20 percent; and the Air Force was the lowest at 14 percent.

Alcohol abuse results in tremendous costs to the department both financially and in lost productivity [13].

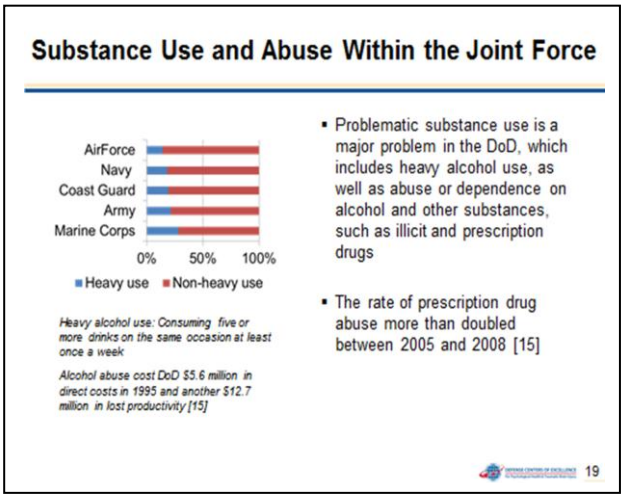
The use of illicit drugs and abuse of prescription drugs are also a problem for the joint force. Abuse of prescription drugs more than doubled between 2005 and 2008. Studies show that service members will use prescription drugs and/or alcohol to treat or suppress symptoms of psychological health conditions – this is referred to as "self-medication." While this may seem like a short-term remedy, it costs more to both service members and the department in the long run.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Military vs. Civilian

Say:

Compared to the civilian sector, the heavy use of alcohol and abuse of prescription drug use appears to be higher in the military. The Defense Department's drug deterrence program appears to encourage the military illicit drug use to remain at 2 percent; however, this may be an underreporting of actual illicit drug use.

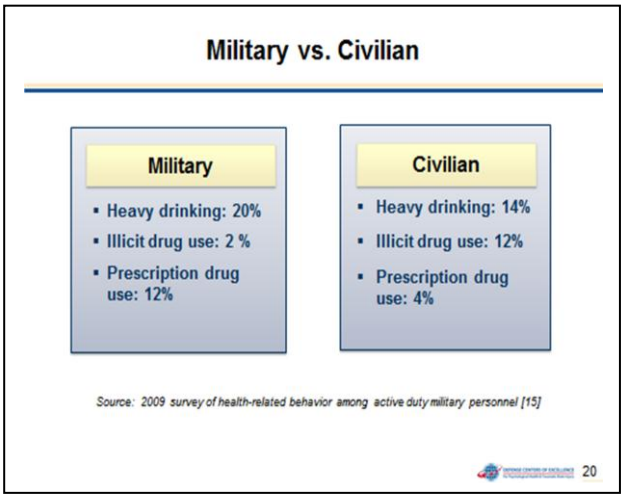
As leaders in the department, we have to work to decrease the rates of heavy alcohol use and prescription drug abuse, as such abuse thwarts TFF efforts and compromises overall mission capability.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

The Costs of Psychological Health Concerns

Say:

Psychological health concerns are very costly to service members and the Department. One very important cost is the loss of personnel by suicide. Additionally, service members are experiencing high stress at home (reflected by increased divorce rates and higher levels of spousal abuse), increased attrition from the military and higher numbers of referrals for Department of Veteran Affairs (VA) disability.

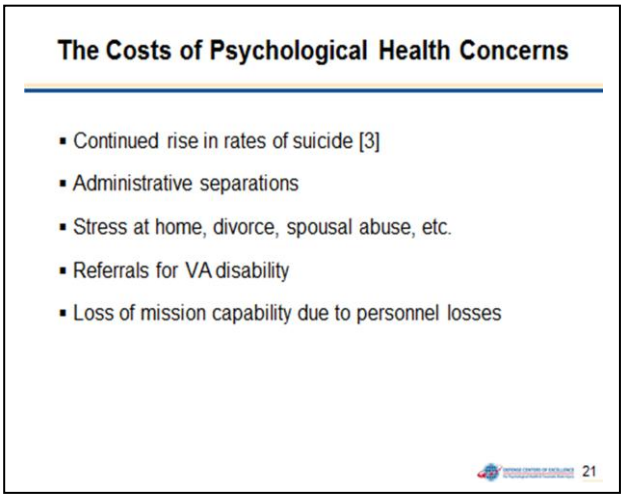
Besides the toll these issues take on the service members themselves, these factors also affect overall mission capability making the joint force less able to fulfill its roles.

Do:

- No activities

Additional Points (if any):

- None



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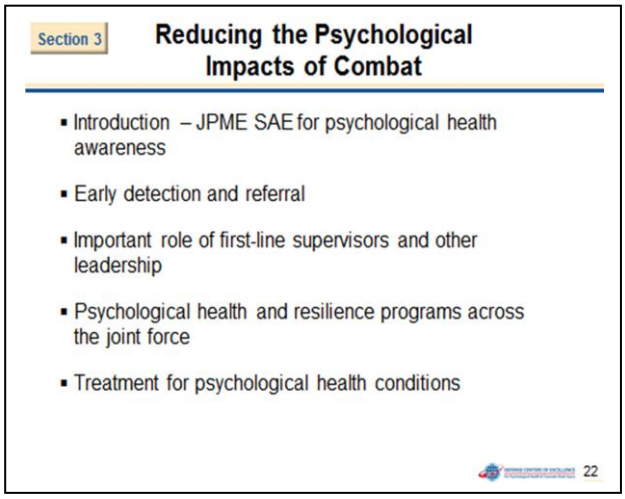
Reducing the Psychological Impacts of Combat



Say:

Almost a decade of high operational tempo has resulted in a stressed force. As good order and discipline in a garrison environment appears to have atrophied within some units, service members are more likely to engage in high-risk behavior. Policies, structures and programs may not always be adequate or be regularly used to meet the demands of a strained force.

Section III highlights the tools and programs that leaders have at their disposal and ways they can help minimize the psychological impacts of combat. Specifically, we will discuss:

- Early detection and referral of service members with psychological health concerns
- Leadership roles
- Psychological health and resilience programs across the joint force
- A strong emphasis on evidence-based treatments for psychological health issues

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Objectives – Section 3

Say:

At the end of this section, you should be able to:

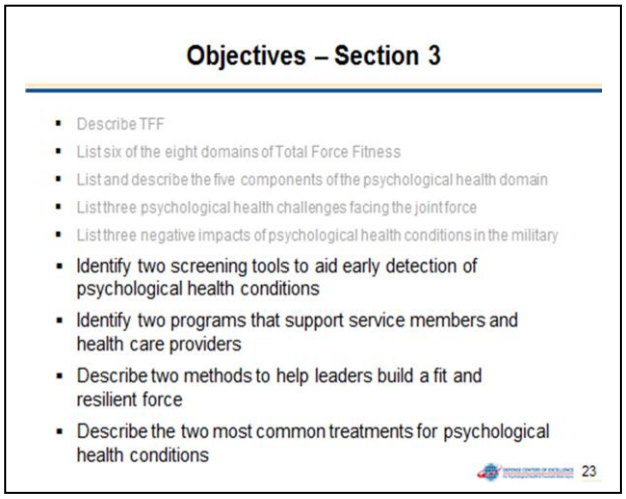
- Identify two screening tools to aid early detection of psychological health conditions
- Identify two programs that support service members and providers
- Describe two methods to help leaders build a fit and resilient force
- Describe the two most common treatments of psychological health conditions

Do:

- No activities

Additional Points (if any):

- None



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Introduction

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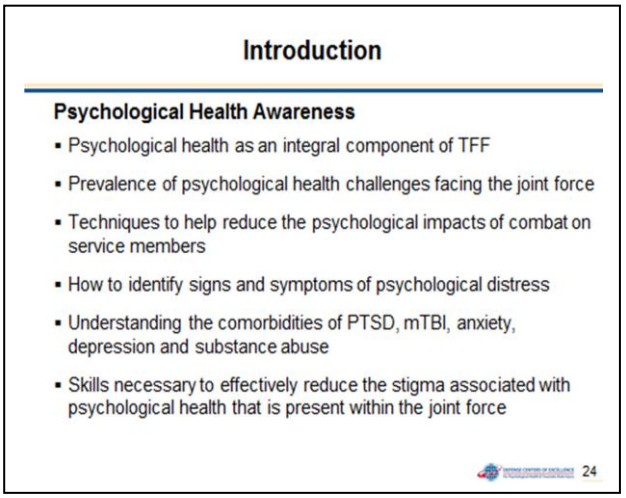
2. Prevalence of psychological health challenges facing the joint forces
3. Ways to minimize the psychological impacts of combat on service members
4. How to identify signs and symptoms of psychological distress
5. The comorbidities of PTSD, mTBI, anxiety, depression and substance abuse
6. Ways to reduce stigma associated with psychological health conditions present in the joint force

Do:

- No activities

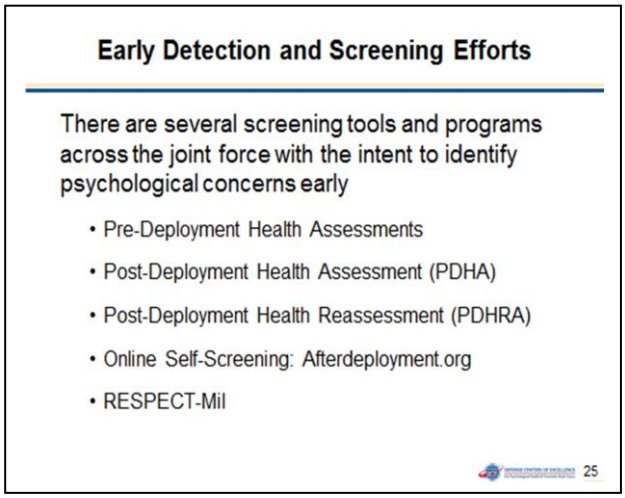
Additional Points (if any):

- None



Customizable Content (if any):

Early Detection and Screening Efforts



Say:

Research has shown that there are enormous benefits from early detection and treatment of behavioral health concerns. Early treatment can prevent conditions from getting worse or lasting longer than necessary, and may restore service members to a healthier state more quickly. Hence, the Defense Department has designed several screening programs to help identify service members with psychological health concerns.

Some of the most prominent include:

Defense Department policy requires all services to screen deploying service members for psychological health problems in four phases: two months prior to deployment; three to six months after deployment; seven to 12 months after deployment; and again 16 to 24 months after deployment.

- Pre-Deployment Health Assessments
- The Post-Deployment Health Assessment (PDHA) and Reassessment (PDHRA)
- Afterdeployment.org provides online screening tools that highlight symptoms consistent with mental health conditions. These tools do not provide a diagnosis, but give service members an indication of symptoms that may reflect a need for further assessment
- RESPECT-Mil is a treatment model designed by the Deployment Health Clinical Center (DHCC) to screen, assess and treat active duty service members with depression and/or PTSD

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Important Role of First-Line Supervisors and Other Leadership

Say:

Supportive leadership is important in helping to fight against the stigma of seeking help for psychological health concerns. Unfortunately, many supervisors and other leaders believe that conditions such as PTSD aren't real, and are hesitant to refer their members for care. This hesitation directly contributes to creating a barrier to care, causing service members to think that seeking help will have negative consequences. It's important for leadership to set the tone in encouraging service members to seek help without fear of being seen in a negative way.

Leadership must play an active role in early detection of potential behavioral health issues. By identifying potential issues early, leadership can prevent other problems from developing, including loss in productivity.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Psychological Health and Resilience Programs Across the Joint Force

Say:

The Defense Department has invested enormous resources to meet the psychological health care demands resulting from almost a decade of high-operational tempo. The department sponsors resources that leaders can use to enhance service members' health, such as:

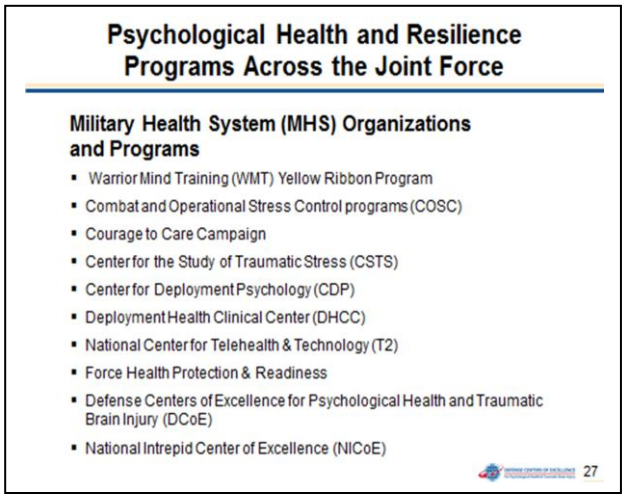
- Yellow Ribbon Program
- TRICARE Assistance Program
- Force Health Protection and Readiness
- National Intrepid Center of Excellence (NICoE)
- DCoE

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Psychological Health and Resilience Programs Across the Joint Force – Army

Say:

Army resilience training programs target providers as well as service members. Comprehensive Soldier Fitness (CSF) was initiated as a central element of wellness. Elements of the CSF program include:

- The Global Assessment Tool (GAT)
- Master Resilience Training (MRT)
- Comprehensive Resilience Modules (CRM)
- Institutional Training

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Resilience Programs Across the Joint Force – Navy and Marines

Say:

The Marine Corps Combat Operational Stress Control (COSC) program is dedicated to maintaining a ready fighting force and to protecting and restoring the health of Marines and their family members.

Navy Operational Stress Control (OSC) provides a comprehensive approach to prevent, identify and manage the adverse effects of operational stress and stress injuries on the health and readiness of sailors.

Family Overcoming Under Stress (FOCUS) is a family-focused program that addresses concerns regarding parental combat operational stress injuries and combat-related physical injuries. The program provides resilience training to military children and families.

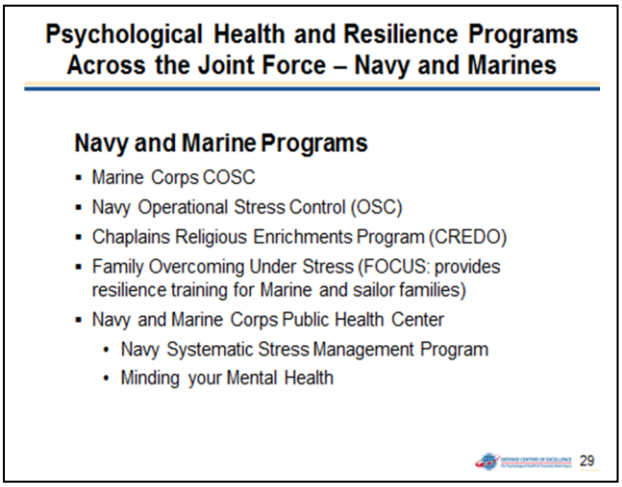
The Navy and Marine Corps Public Health Center is the proprietor of the Navy Systematic Stress Management Program and the Minding Your Mental Health program. Both programs are geared to address Sailors' and Marines' behavioral health concerns.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Resilience Programs Across the Joint Force – Air Force

Say:

In addition to promoting Defense Department-sponsored programs, the Air Force has initiated several new programs to address the psychological health concerns of Airmen. In 2010, the Air Force initiated Total Force Resilience, a program that addresses the root causes of suicides and teaches Airmen the skills they need to deal with psychological health concerns [27].

Other Air Force programs include:

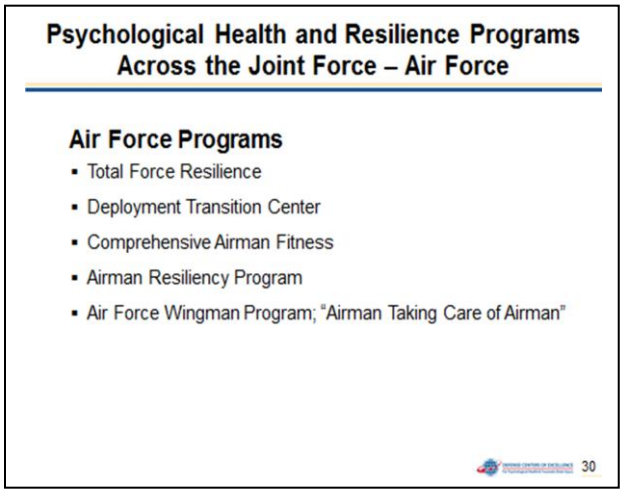
- Total Force Resilience
- Comprehensive Airman Fitness
- The Air Force Wingman Program

Do:

- No activities

Additional Points (if any):

- None



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How Leadership Can Help Build a Fit and Resilient Force

Say:

How can leaders help build a fit and resilient force? There is no magical answer, but research suggests four fundamental ways.

- Unit Cohesion – Research shows that unit cohesion can serve as a buffer against psychological health concerns such as PTSD, depressive symptoms and stress symptoms [28]. Service members are more likely to feel hopeful about their career and their future if they feel supported by their unit. By fostering unit cohesion, leaders can give service members a sense of belonging.
- Trust in Leadership – When service members have a sense of trust in their leadership, they are more likely to have a better outlook on life and adopt new strategies to successfully cope with challenges and adversities. In addition, service members are more likely to discuss family or financial challenges with leaders with whom they feel a sense of trust.
- Good Order and Discipline – Research shows that leadership can sway a service member's perception of and adaptation to stressful environments. Service members are likely to be influenced by the examples set by their leaders. For example, if leaders fail to enforce policies against DUIs, service members may be more likely to engage in alcohol abuse. Or, if service members believe their medical or personal privacy is not respected, they may be less likely to seek help for their personal problems.

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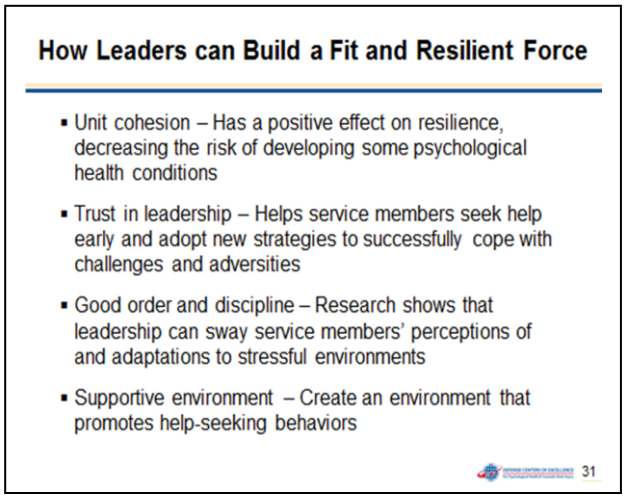

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- Supportive Environment– Leaders should seek to create an environment that promotes help-seeking behaviors. Many service members delay psychological health care for fear that it may impact their careers. Leaders must do more to foster help-seeking behaviors by discouraging discrimination and harassment surrounding psychological health issues, educating service members about the facts regarding psychological health care, and promoting healthy habits.

Do:

- No activities

Additional Points (if any):

- None

Treatment for Psychological Health Concerns

Say:

Several effective evidence-based treatments exist, all of which have been extensively tested and proven to work for depression, thoughts of suicide, PTSD and substance abuse.

The two general categories of treatment are:

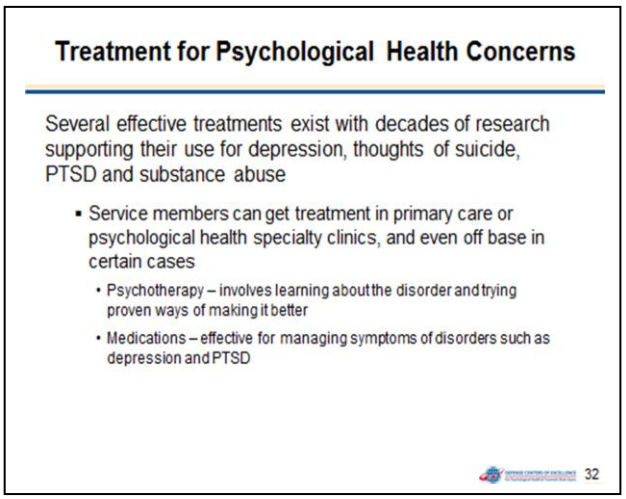
- Psychotherapy – which involves learning about the disorder and practicing proven ways of making it better
- Medications – which are effective for managing symptoms of depression and anxiety disorders like PTSD

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

How to Identify Service Members With Psychological Distress

Say:

To ensure Total Force Fitness, leaders must be able to recognize the signs and symptoms of psychological distress.

Section IV discusses the signs and symptoms of psychological distress, and also provides a basic overview of what a leader may see if a service member has one of these common psychological disorders:

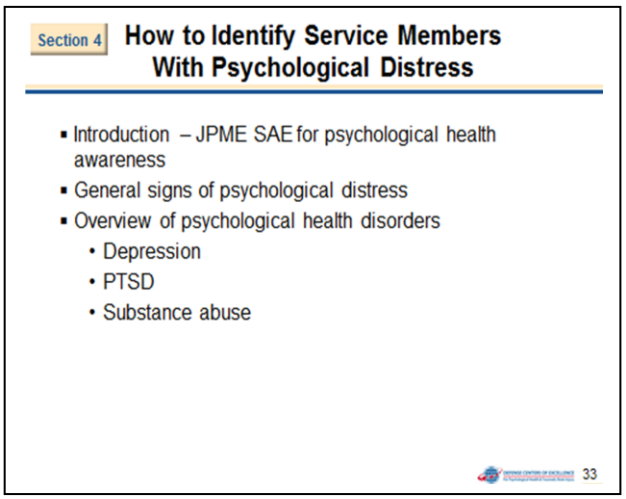
- Depression
- PTSD
- Substance abuse

Do:

- No activities

Additional Points (if any):

- None



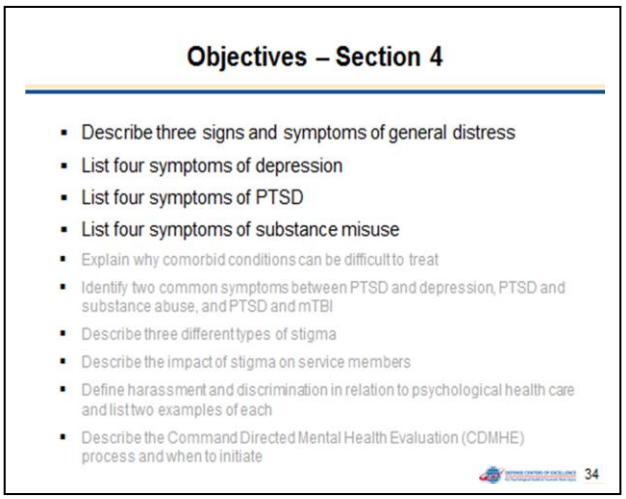
Customizable Content (if any):

Objectives – Section 4

Say:

At the end of this section, you should be able to:

- Describe three signs and symptoms of general distress
- List four symptoms of depression
- List four symptoms of PTSD
- List four symptoms of substance abuse



Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Introduction

Say:

**Note to instructor: Read this slide only if this section is your first lesson of the series. Skip slide if you are continuing from previous section.

Former chairman of the Joint Chiefs of Staff, Admiral Mike Mullen, identified psychological health awareness as a special area of emphasis for leaders across the joint force. Mullen said that for service members to be fit, they must be healthy in mind and body, resilient and ready to complete their missions. He also stated that engaged and educated leaders can help to minimize the long-term impact of psychological health concerns upon the force and improve the overall fitness of service members [1].

To meet this goal, Mullen listed six topic areas related to psychological health that should be included in Joint Professional Military Education. The six areas are:

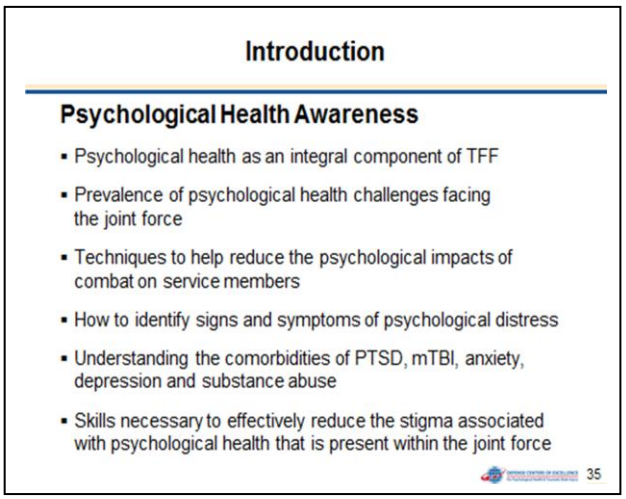
1. Psychological health and TFF
2. Prevalence of psychological health challenges facing the joint force
3. Ways to minimize the psychological impacts of combat on service members
4. How to identify signs and symptoms of psychological distress
5. The comorbidities of PTSD, mTBI, anxiety, depression and substance abuse
6. Reducing stigma associated with psychological health conditions

Do:

- No activities

Additional Points (if any):

- None



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General Signs of Distress

Say:

Any of these signs or symptoms can indicate some degree of psychological distress. Generally speaking, the more signs there are and the more they interfere with a person's performance, the more likely there is some sort of significant problem that needs to be addressed.

- Irritability or having a "short fuse," being frequently sarcastic or mean, or criticizing others for no reason
- Excessive worry or fearfulness, or fear and concern about dangers or potential problems that cannot be controlled, perhaps leading to increased fear and concern about others in the unit
- Difficulty falling asleep or staying asleep or lying awake for hours without sleep, even though tired, or waking up tired after only a few hours of sleep and being unable to fall back asleep
- Tardiness, or late for work with an unkempt appearance
- Feeling persistently "keyed up," an inability to relax, calm down or slow down even when there is sufficient time to do so
- Loss of interest or ability to feel pleasure in activities that used to be enjoyable
- Difficulty concentrating or sustaining mental focus
- Excessive and persistent feelings of guilt or hopelessness
- Avoidance of others; isolation from others
- Thoughts or impulses to harm oneself, peers or leaders

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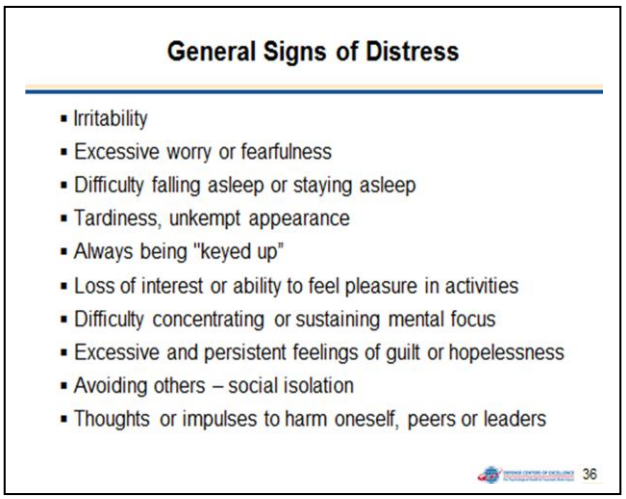


Customizable Content (if any):

A person can have one or more of these signs and not have a psychological health disorder, but you should note that many of these signs and symptoms of distress will be the only clue that your service member has a psychological disorder, as most people hide psychological problems from people at work. What you see as a leader is frequently the tip of the iceberg related to what is going on with the member.

Do:

- No activities

Additional Points (if any):

- None

What Leaders May See - Depression

Say:

When someone begins suddenly acting in an uncharacteristic manner, there are usually underlying problems that are causing the unexpected change in behavior.

Many service members will deny or hide their depression, and some may not even know they have depression, but they may just feel differently than they usually do.

The leader may see their subordinate making more mistakes, being late for work more frequently, and showing a poor attitude or irritability. All of these behaviors may be a result of the service member being depressed.

A service member who cannot concentrate and has difficulty remembering things will make more mistakes. If they are unable to sleep more than three to four hours a night, they will likely be irritable, and more likely to arrive late to work because of oversleeping.

If the person has no energy and feels tired all the time, it may seem like they have a bad attitude when tasked with assignments.

For someone who is hopeless about their future and even contemplating suicide, doing their best at work may be the last thing on their minds.

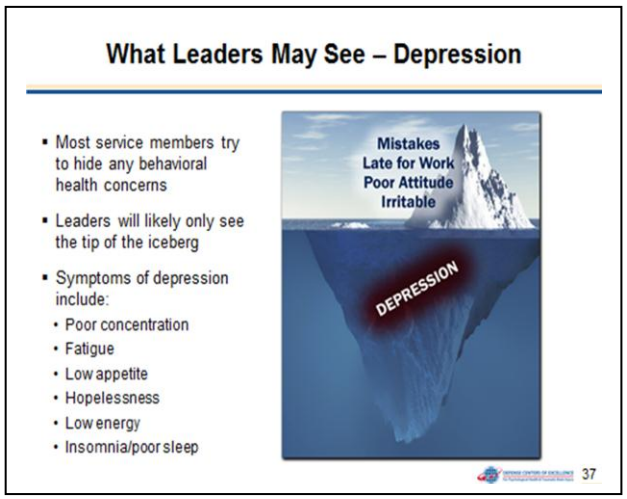
The challenge for leaders is to recognize these behaviors when they occur, and ask the member if they might be having other symptoms of depression. If the member's behavior is changing possibly as a result of depression, you need to encourage the person to seek help.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

What Leaders May See - PTSD

Say:

PTSD is prevalent among service members, especially following combat experiences. Because of stigma, many service members will not come forward, or simply may not recognize that what they are going through is a medical issue.

While service members may hide symptoms or be unaware of their PTSD, as a leader, you will likely be able to spot several changes in behaviors.

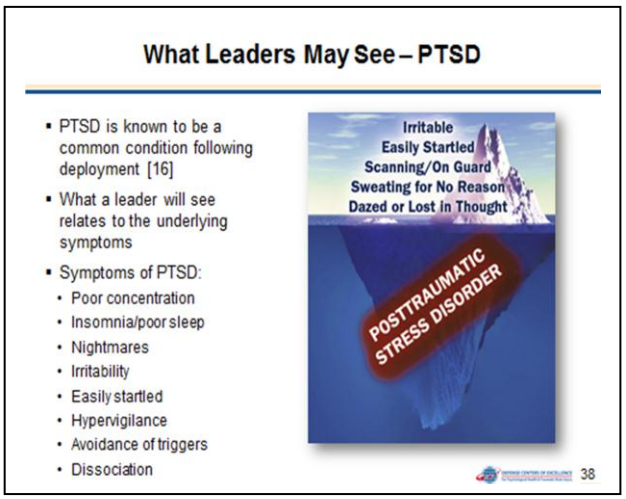
The symptoms of PTSD are listed here and explain a person's change in behavior.

- Someone with PTSD has difficulties concentrating (much like depression), and may have severe sleep problems, especially if they are having nightmares related to the trauma.
- They may be irritable, and even have bouts of intense rage in response to what seem like minor issues to others.
- They may be constantly on guard, scanning their environment, appearing tense and easily startled – this is called hypervigilance.
- They may avoid things that trigger unpleasant memories or emotions. Examples may be large crowds or discussions about combat experiences.
- They may "dissociate" look like they appear to be in a daze or look lost in thought.

Effective leaders are in touch with those they command. Therefore, leaders are in a better position to recognize changes in the behaviors of troubled personnel and may be more successful at encouraging them to seek the help they need.

Do:

- No activities



Customizable Content (if any):

Additional Points (if any):

- None

What Leaders May See – Substance Abuse

Say:

As we covered earlier, substance abuse (alcohol and other drugs) is a serious issue for the Defense Department.

Supervisors might observe a service member who is misusing substances arrive late for work (especially on Mondays), has an unkempt appearance or is often sick or injured.

Symptoms of substance abuse or dependence include:

- Failure to fulfill important roles or responsibilities, such as parenting tasks
- Illegal or harmful behavior, such as continued drinking after a DUI
- Continued use of substance despite harmful effects, such as continued alcohol use with severe liver damage
- Unsuccessful in efforts to stop using the substance
- Increased tolerance to substance effects, and needing more and more of the substance to get the same effect
- Physical withdrawal symptoms when the substance is removed (mild to severe), such as shaking or seizures after the removal of alcohol from a person who has been chronically abusing it

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Overlapping Symptoms in Psychological Disorders

Say:

Research shows that people who experience one disorder are more likely to have a second. Service members may become substance dependent as they rely on substances to manage other behavioral health concerns. Section five discusses the comorbidities of psychological disorders. Specifically, we will discuss:

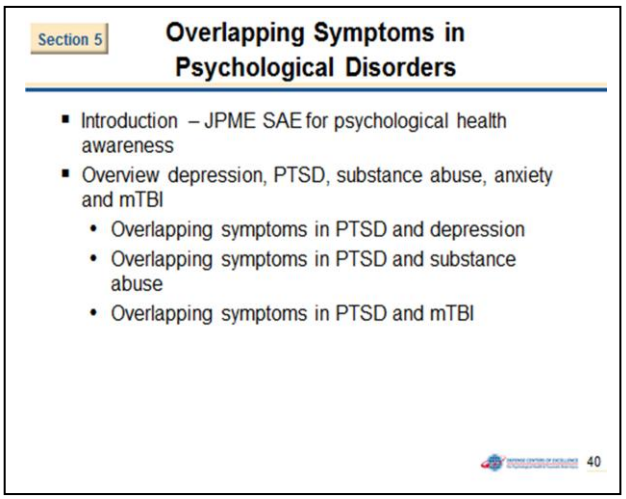
- The comorbidities of PTSD and depression
- The comorbidities of PTSD and substance abuse
- The comorbidities of PTSD and mTBI

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Objectives – Section 5

Say:

At the end of this section, you should be able to:

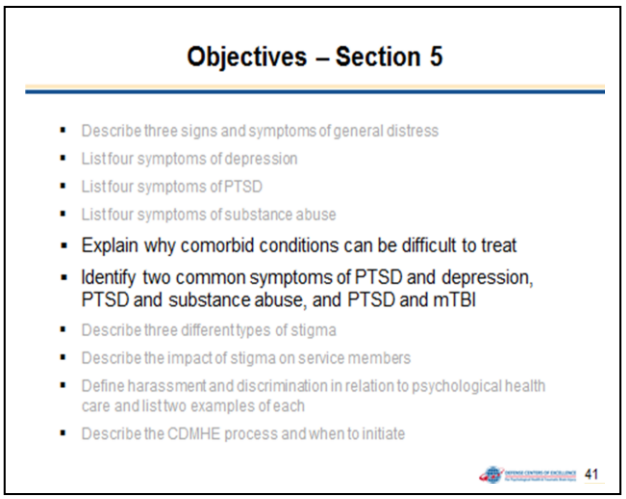
- Explain why comorbid conditions can be difficult to treat.
- Identify two common symptoms of PTSD and depression, PTSD and substance abuse, and PTSD and mTBI.

Do:

- No activities

Additional Points (if any):

- None



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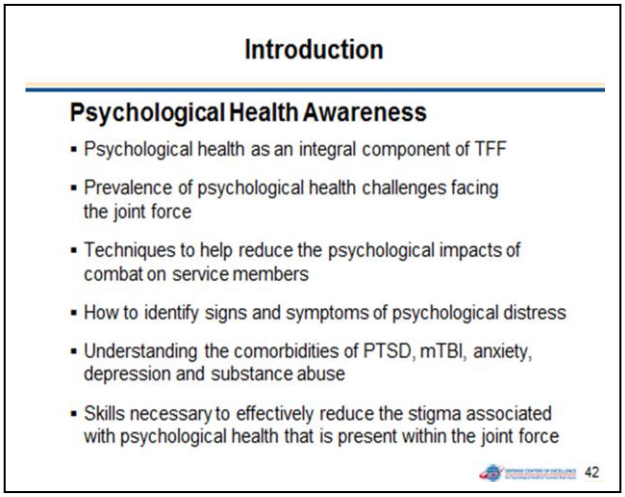
Introduction



Say:

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4. How to identify signs and symptoms of psychological distress
5. The comorbidities of PTSD, mTBI, anxiety, depression and substance abuse
6. Reducing stigma associated with psychological health conditions

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Overlapping Symptoms in Psychological Disorders

Say:

When someone has two or more disorders at the same time, their disorders are “comorbid.”

There are several psychological health disorders that often occur together, such as:

- PTSD and depression
- PTSD and substance abuse

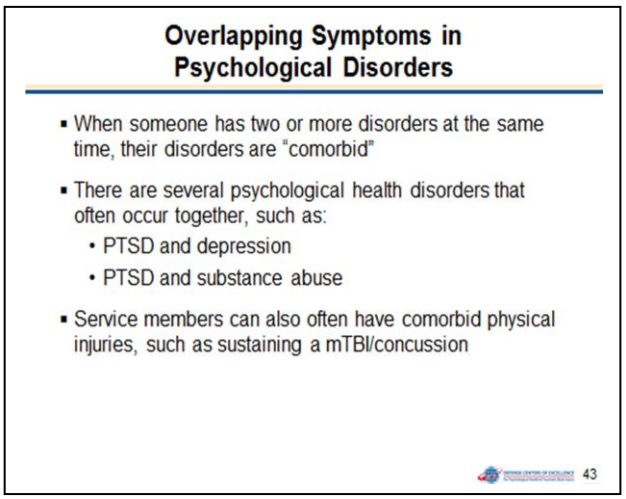
In addition to having more than one psychological health condition, service members may often have sustained mTBI.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Overlapping Symptoms in PTSD and Depression

Say:

Both PTSD and depression are fairly common disorders in the Defense Department and VA populations, and these two disorders have several symptoms in common. For instance, patients with both depression and PTSD may have insomnia and irritability.

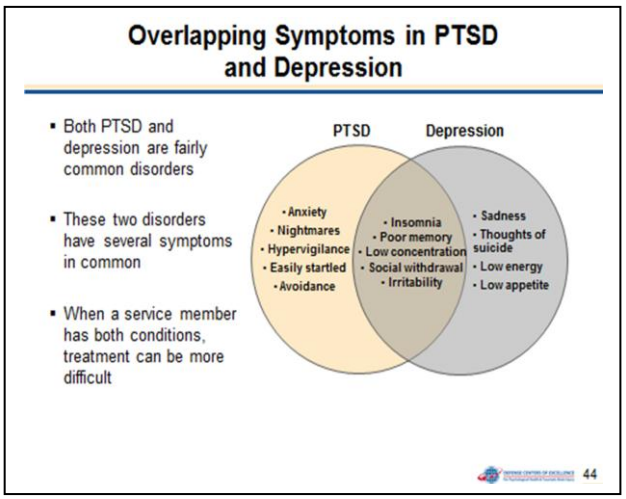
The important point to understand is that comorbid conditions are often more difficult to treat. For example, one of the best things a depressed person can do is to get out of the house and be around people. However, if they also have PTSD, they may avoid leaving the house because they want to avoid things that trigger memories of the trauma.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Overlapping Symptoms in PTSD and Substance Use Disorders

Say:

Both PTSD and substance use disorders (SUD) are fairly common disorders and they occur together fairly often.

Many times, service members with PTSD will use alcohol to self-medicate, hoping alcohol will provide short-term relief from some of the symptoms of PTSD.

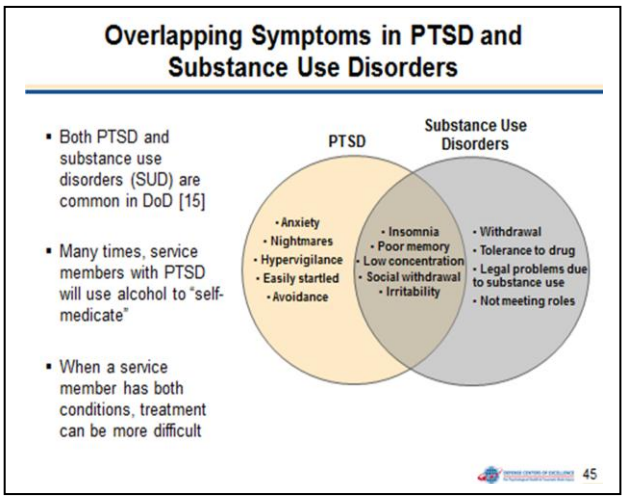
When a service member has both conditions, treatment can be more difficult – if someone is drinking heavily, the alcohol can have dangerous interactions with some medications used to treat PTSD. If the member gets a ticket for driving while under the influence or oversleeps because of substance misuse, they may add legal troubles to their worries.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Overlapping Symptoms in PTSD and mTBI

Say:

Many studies show that PTSD often co-occurs with mTBI following some combat trauma, such as an impact from an exploded improvised explosive device (IED) [21].

TBI is a traumatically-induced structural injury and/or physiological disruption of brain function as a result of an external force that causes an individual to lose consciousness, or have an alteration in consciousness or memory. The injury may result in physical, cognitive-behavioral and emotional symptoms. A TBI may be classified as mild, moderate or severe. The majority of TBIs that occur each year in the military and civilian communities are mTBIs, also known as concussions. Like all injuries, TBI is most appropriately and accurately diagnosed as soon as possible after the injury.

TBI is not a mental health condition. It is a physical injury. That being said, many symptoms that an individual may experience following a mTBI are similar to the symptoms in an individual who has PTSD, depression, chronic pain or substance use disorder (as illustrated in the diagram).

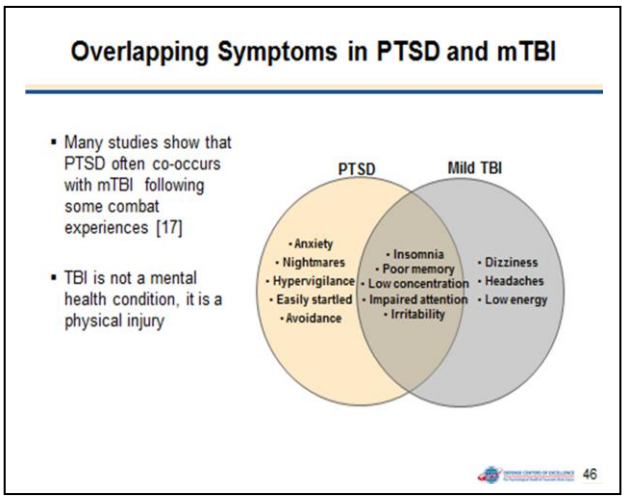
While many of the symptoms of each disorder overlap, each also has symptoms unique to the disorder. So, it is quite possible for an individual to have PTSD only, PTSD and a mTBI, or have sustained a mTBI and not have a co-occurring psychological health disorder.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Reducing Stigma Associated with Psychological Health Care

Say:

Some service members may be reluctant to seek care in part because of: 1) their fears of dealing with harassment and discrimination associated with psychological health care, or 2) because of the stigma surrounding psychological health care. Section VI offers examples of how leaders can reduce stigma associated with psychological health care. Specifically, we will discuss:

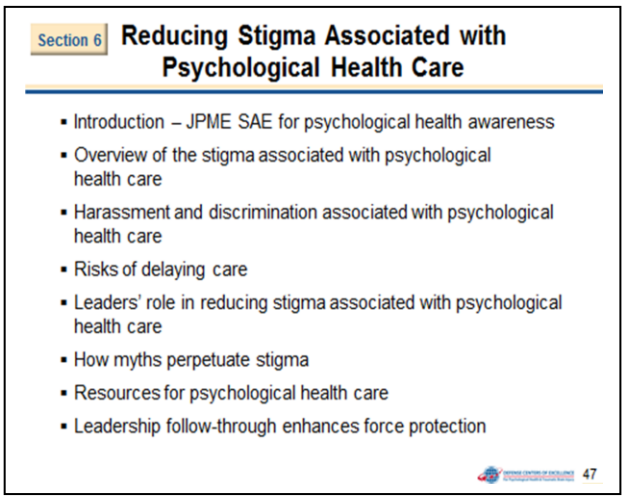
- Stigma associated with psychological health care
- Harassment and discrimination associated with psychological health care
- The risks of delaying care
- Leaders' role in reducing stigma associated with psychological health care and how myth perpetuates stigma
- Resources that leaders can use to help service members manage psychological health concerns

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Objectives – Section 6

Say:

By the end of this section, you should be able to:

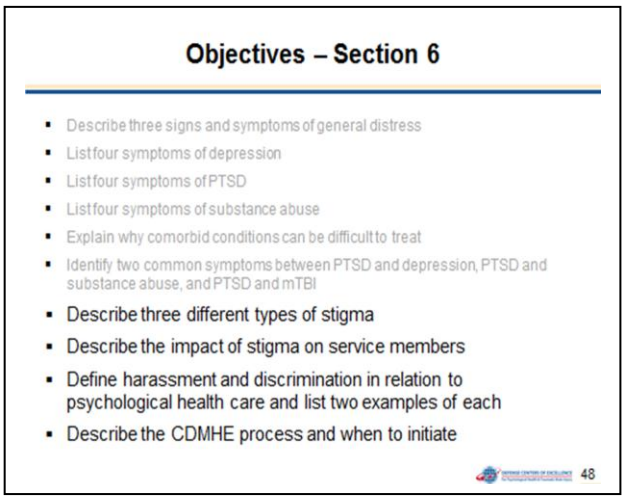
- Describe three different types of stigma
- Describe the impact of stigma amongst service members
- Define harassment and discrimination in relation to psychological health care and list two examples of each
- Describe the CDMHE process and when to initiate it

Do:

- No activities

Additional Points (if any):

- None



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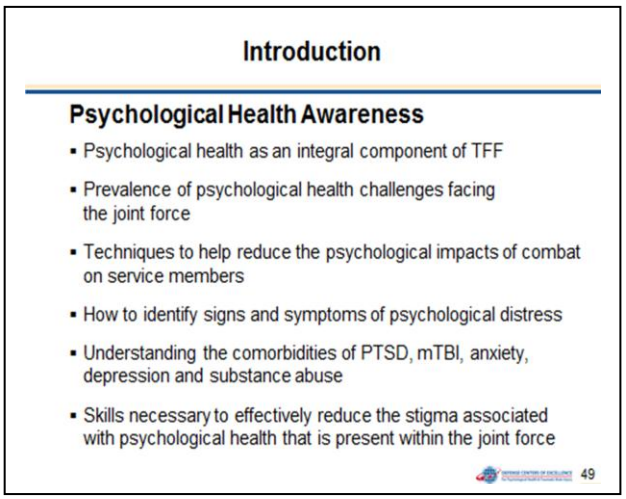
Introduction



Say:

**Note to instructor: Read this slide only if this section is your first lesson of the series. Skip slide if you are continuing from previous section.

The former chairman of the Joint Chiefs of Staff, Admiral Mike Mullen, identified psychological health awareness as a special area of emphasis for leaders across the joint force. Mullen has said that for service members to be fit, they must be healthy in mind and body, resilient and ready to complete their missions. He also stated that engaged and educated leaders can help to minimize the long-term impact of psychological health concerns upon the force, and improve the overall fitness of service members [1].

To meet this goal, Mullen listed six topic areas related to psychological health that should be included in Joint Professional Military Education. The six areas are:

1. Psychological health and TFF
2. Prevalence of psychological health challenges facing the joint force
3. Ways to minimize the psychological impacts of combat on service members
4. How to identify signs and symptoms of psychological distress
5. The comorbidities of PTSD, mTBI, anxiety, depression and substance abuse
6. Reducing stigma associated with psychological health conditions

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

What is Stigma?

Say:

What is stigma?
Stigma is defined as being “marked” or “branded.” Individuals who suffer from psychological health conditions are sometimes stigmatized because their peers or supervisors lack information about how common psychological health struggles are. Further, leaders may underestimate the ability of persons struggling with psychological health issues to continue to provide meaningful contributions to the mission. Potentially, these misconceptions may perpetuate negative stereotypes about psychological disorders. We know that ignorance about the benefits of seeking help for psychological concerns is a nationwide problem.

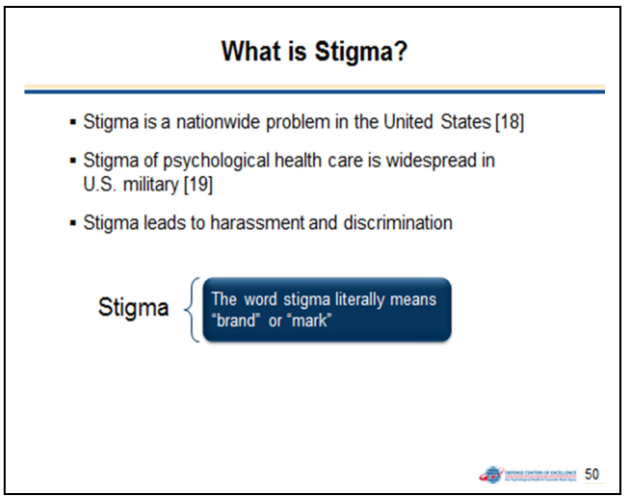
Stigma towards psychological health is also common throughout the military and often leads to harassment and discrimination. In a recent survey of service members, members stated they would avoid behavioral health care to escape being labeled as a person who cannot be relied on in a pinch, or worse, to avoid the label of one who uses or exaggerates an illness to malinger and avoid duty or deployment.

Do:

- No activities

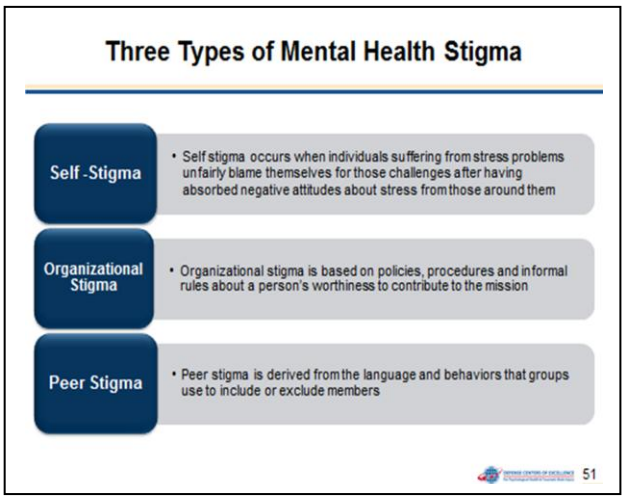
Additional Points (if any):

- None



Customizable Content (if any):

Three Types of Mental Health Stigma



Say:

There are three types of mental health stigma: self-stigma, organizational stigma and peer stigma.

- Self-stigma happens when someone unfairly blames themselves for their current problems/challenges after having absorbed negative attitudes from those around them.
- Organizational stigma is based on policies, procedures and informal rules about a person's worthiness to contribute to the mission.
- Peer stigma refers to the language and behaviors that groups use to include or exclude members.

All these forms of stigma are based on ignorance and can be defeated with knowledge, awareness and understanding. Teaching about how to reduce stigma is the responsibility of all military leaders.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Harassment and Discrimination When Seeking Care

Say:

Many service members have experienced harassment and discrimination because they decided to seek psychological health care. While many refer to this as part of "the stigma of mental health" it's actually no different from harassment or discrimination based on other differences, such as religion or race.

- Harassment is a behavior targeted at a group or individual, and the impact of that behavior results in creating an intimidating or hostile work environment for the targeted individual.
- Discrimination is behavior or policy of a group, individual or system that results in the recipient perceiving unfair treatment based on unique characteristics of the individual, typically race, religion, ethnicity, etc., but can also involve medical conditions.
- In a recent study, the Defense Department Suicide Task Force concluded that some leadership environments result in "discriminatory and humiliating treatment of service members" who seek help for psychological concerns. Such behavior affects morale, discipline and unit cohesion. Service members should support their buddies who do the right thing, and seek professional care if they have psychological concerns
- There is no place for harassment or discrimination in our military. We have zero tolerance policies on discrimination and harassment of any kind.

Do:

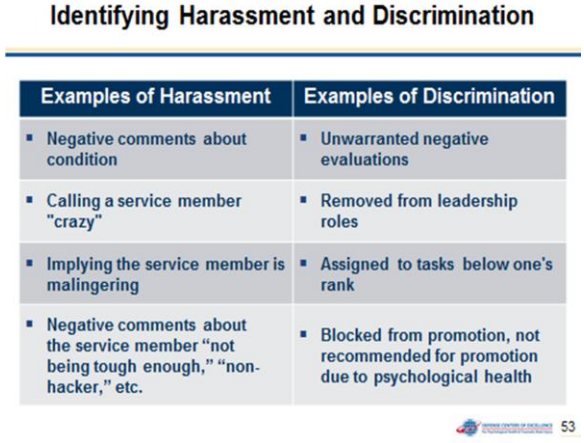
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Identifying Harassment and Discrimination



Say:

Some common examples of harassment and discrimination that a service member seeking psychological care may face are:

- Negative comments about a person's condition
- Calling a service member "crazy"
- Implying the service member is malingering
- Negative comments about the service member "not being tough enough" or "non-hacker," etc.

Examples of discrimination:

- Unwarranted negative evaluations based on psychological disorder
- Removed from leadership roles due to psychological disorder
- Assigned to task below one's rank due to psychological disorder
- Blocked from promotion, and not recommended for promotion because of psychological disorder

Each service member plays a critical role to eliminate stigma surrounding psychological care, by understanding that stigma can cause service members who need help to delay care, or never seek care at all.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Stigma Can Lead to a Delay in Care

Say:

Stigma is one of the biggest problems facing the military when it comes to preventing suicide and other negative events.

In a recent Defense Department Suicide Task Force report, service members claimed to despise the thought of going to a behavioral health clinic primarily because of the likelihood of harassment and discrimination. Myths and stereotypes about psychological health contribute to harassment and discrimination.

Stigma can lead to service members choosing to delay seeking help for their psychological concerns. For some service members, by the time they are convinced to finally come in for help, their careers and personal lives are already damaged.

Delay of care can worsen psychological health conditions, may make recovery more difficult, and increase the likelihood of adverse events and unsatisfactory outcomes.

Adverse events, such as a DUI or spousal abuse, can lead to loss of rank, money and social status. These and other losses make it more difficult for the member to recover from conditions such as depression or PTSD. It's much harder to focus on getting over depression or PTSD if the member is in the middle of a divorce or in legal trouble.

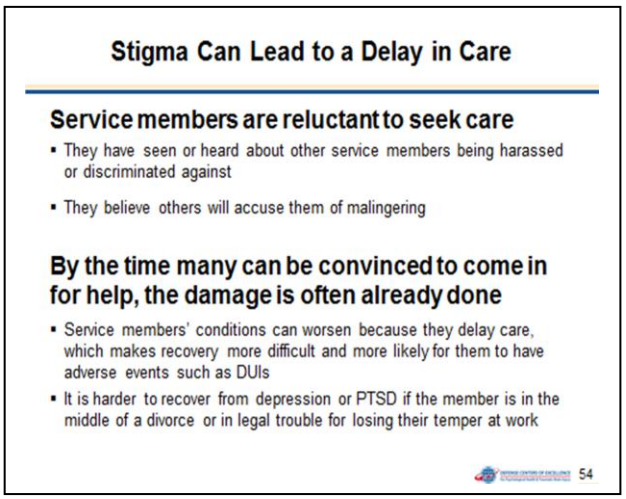
The delays and losses are preventable if we can eliminate the stigma of seeking care and dispel the myths and stereotypes surrounding psychological health.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

What Does NOT Constitute Discrimination?

Say:

While it is true that one should not be blocked from promotion for having PTSD or other behavioral health concerns, behaviors related to psychological disorders, such as DUIs or domestic violence can affect a service member's career.

Because many service members experiencing PTSD or other behavior health concerns do not seek care until after they have experienced one or more adverse events (DUI, domestic abuse, insubordination, etc.), many of these members are also blocked from promotion or lose leadership positions.

Unfortunately, the misconception is established that the service member is being punished or demoted because of psychological disorders, rather than because of the behaviors that led to the DUI or domestic violence incident. Not everyone with PTSD or alcohol abuse choose to treat their spouse violently or drive while drunk. Such stories may get passed around such as "Sgt. Jones saw psych and now he is not getting that platoon sergeant billet." Rumors may contribute to the belief that members who seek care don't get promoted ─ in many cases the damage was done BEFORE they decided to come in for care.

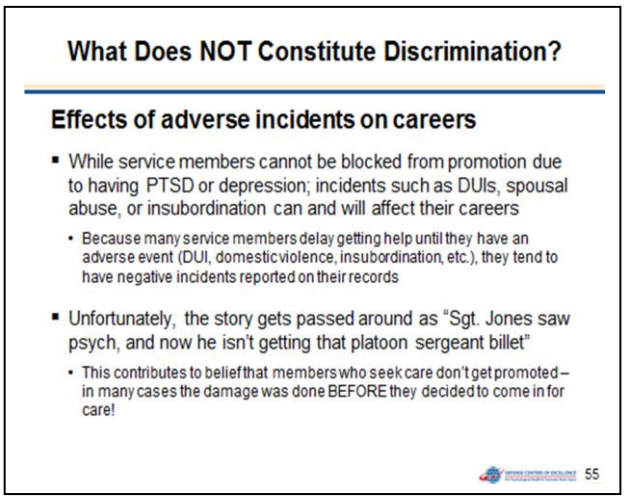
It is critical that service members get help early to decrease the odds of future adverse events related to their psychological disorder.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Knowing the Leader's Role in Reducing Stigma

Say:

As stated previously, leaders play a critical role in the task of reducing the stigma surrounding psychological health:

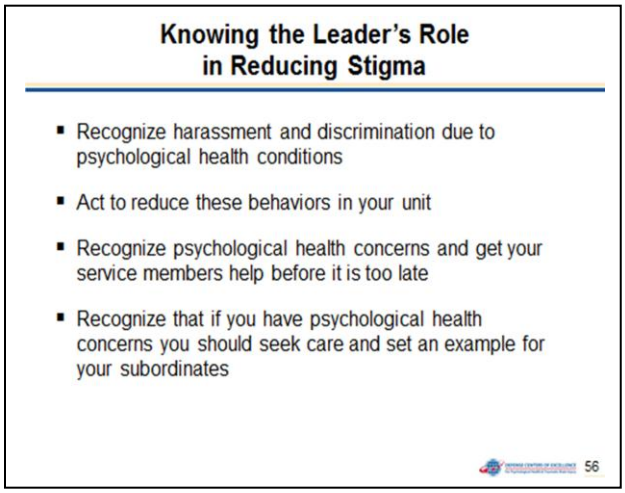
- The psychological health of your people is a critical piece of your unit's ability to meet its mission.
- It is important that you identify any form of harassment and/or discrimination in your unit and act to prevent these behaviors.
- Military leaders must create an environment where service members are willing and able to get help early for psychological health issues to prevent negative effects on their careers and lives.
- Leaders who have psychological health issues and don't seek care because of stigma are actually setting a poor example for their subordinates, one that discourages their subordinates from getting help.

Do:

- No activities

Additional Points (if any):

- None

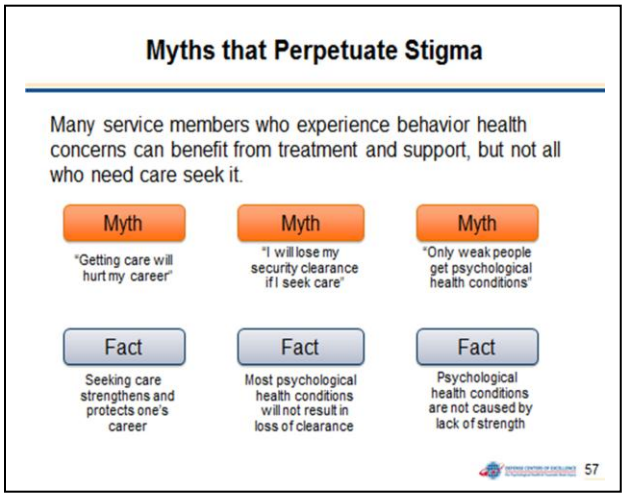


Customizable Content (if any):

Myths that Perpetuate Stigma

Say:

Many service members who experience behavior health concerns can benefit from treatment and support, but not all who need care seek it. Unfortunately, myths associated with psychological health care perpetuate stigma. It is critical for leaders to educate their service members on the facts surrounding psychological health and create an environment that fosters health-seeking behaviors.



Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Resources for Psychological Health

Say:

You can encourage service members to reach out for treatment information and resources.

These resources include several websites and off-base programs including face-to-face counseling in confidential settings.

Military chaplains are available to assist service members in distress and will often provide counseling services.

A service member with a psychological health issue can go to their primary care manager for screening for depression, substance abuse or PTSD without having to go first to the behavioral health clinic.

Treatment with specialists in behavioral health clinics is also available.

Remember that anytime someone is suicidal or homicidal, they should be escorted via an emergency commander-directed mental health evaluation to the behavioral health clinic during the day or to the nearest emergency room if the behavioral health clinic isn't open.

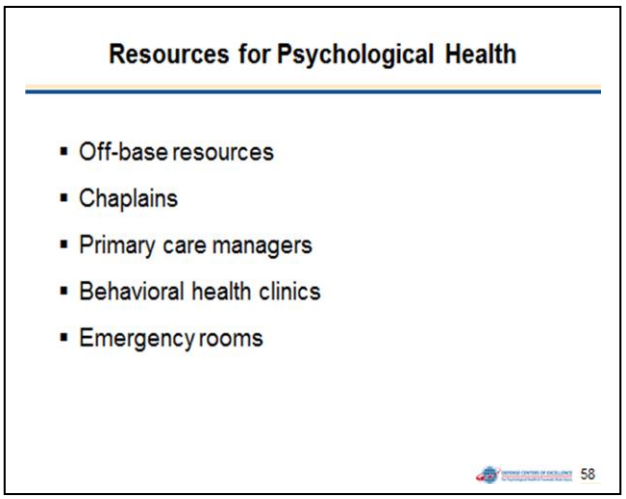
We will briefly cover some of these resources.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Knowing the Off-base Resources

Say:

These are some of the off-base resources services member can access to address psychological health concerns. Most of these resources provide 24-hour service over several mediums (phone, internet or face-to-face).

- The DCoE Outreach Center serves all services members, veterans and their families. The Outreach Center is available 24-hours and information is provided by phone, online chat or email.
- Afterdeployment.org serves all branches of the military along with their families and provides online information targeting PTSD, depression, anger, sleep, relationship concerns and other mental health challenges.
- The SuicideOutreach.org website supports all veterans, families and providers. It is a comprehensive resource where you will find access to hotlines, treatments, professional resources and other resources designed to link you to others.
- Military OneSource supports all eligible service members by providing access to consultants in person, online and by phone, as well as online resources for webinars and other resources.

Do:

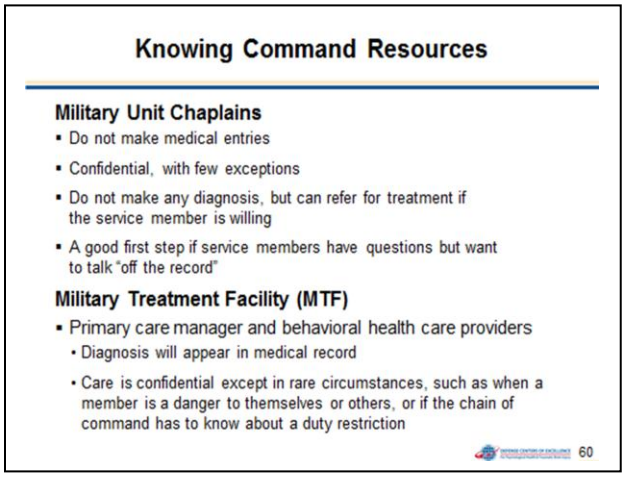
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Knowing Command Resources



Say:

Service members have the option to seek care at their local military treatment facility (MTF), or to talk to a chaplain.

The chaplain is a good "first-stop" if the service member just wants to talk and is unsure about wanting to get formal medical help. All conversations held with a chaplain are confidential, and no diagnosis is made. A chaplain can refer the service member to treatment if the member is willing to go.

MTFs provide world-class treatment to service members seeking help for psychological concerns. The service member is cared for by a primary care manager or a behavioral health care provider skilled in providing evidence-based treatments.

- Medical diagnosis is recorded in service member's medical records.
- Providers seek to keep all care confidential. However, because of legal and ethical requirements, a provider may have to violate confidentiality in rare cases like when a service member is a danger to themselves or others and needs to be hospitalized, admits to abusing a child or their spouse, or when the chain of command needs to know about a duty restriction — such as not being able to carry a weapon.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Command Directed Referrals for Mental Health Evaluations

Say:

Sometimes leaders are faced with a service member who has a psychological health concerns, but refuses to seek help. For this reason, leaders must be familiar with how to make a command-directed referral.

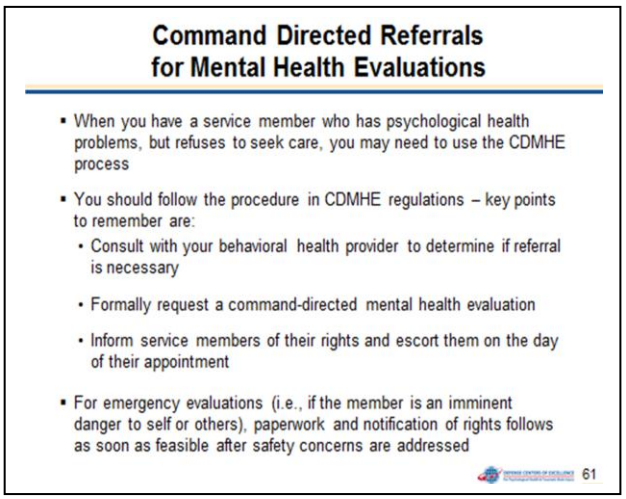
There are regulations that should be followed when making a referral ─ some of the main points to remember are:

- Commanders must discuss their concerns with a behavioral health provider to determine if referral is necessary. Not all issues can justify a command-directed referral. Only commanders on orders can make a commander directed referral, using the specific process outlined in DoDI 6490.1 and 6490.4.
- If the behavioral health provider recommends referral, commanders can then formally request a command-directed mental health evaluation and make an appointment for the service member.
- Commanders must directly inform service members of their rights in writing, and often escort is needed on the day of appointment.

Note that for emergency evaluations (i.e., if the member is an imminent danger to self or others), this process can be shortened in order to ensure a person's safety. The commander is still expected to discuss the situation with a mental health provider first. Then the service member should be escorted immediately to a behavioral health clinic or to the emergency room (depending on the advice of the provider). The required paperwork can be completed later. Defense Department Directive 6490.1 outlines the specific requirements of both routine and emergent referrals.

Do:

- No activities



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Additional Points (if any):

- None

References

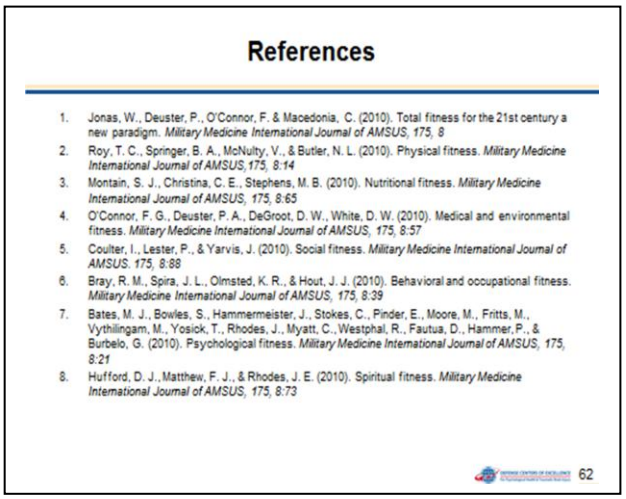
Say:
No slide notes

Do:

- No activities

Additional Points (if any):

- None



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References

Say:

No slide notes

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

References

Say:

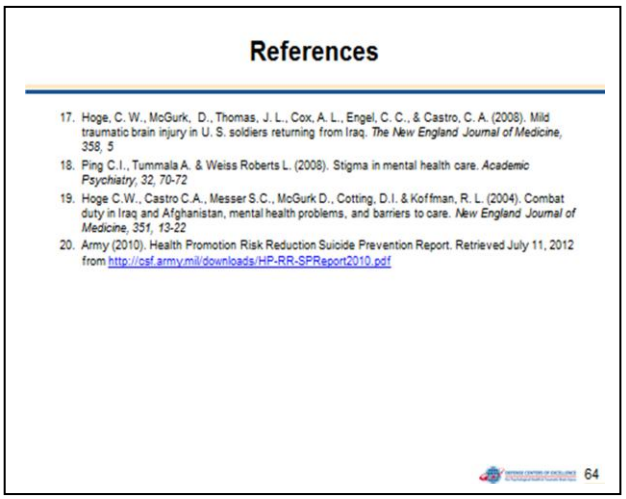
No slide notes

Do:

- No activities

Additional Points (if any):

- None



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End of slide presentation portion

Appendices

The following appendices are intended to provide the facilitator with:

APPENDIX A: EXPERIENTIAL EXERCISES

Utilization of experiential exercises (e.g., small group activities, simulation and role play) optimizes the potential impact of instruction. All materials and instruction necessary for successfully conducting these exercises is included in this section.

Screening for JPME Role Play: Instructor Overview

Before the role play begins:

- Discuss the following objectives with learners:
  - **Identify when unit members exhibit symptoms** consistent with psychological health conditions and/or mild TBI.
  - **Foster unit cohesion** by encouraging group connectivity/buddy care.
  - **Build or maintain trust** by sharing personal stories, demonstrating genuine care for unit members.
  - **Demonstrate good order and discipline** by enforcing a zero-tolerance policy related to discrimination and harassment.
  - **Cultivate a supporting environment** by educating service members about the facts surrounding psychological health, promoting healthy habits and encouraging service members who need medical care to seek help.
- Engage learners in discussion of why objectives are important.
- Ask learners to divide into groups of two:
  - One learner will serve as the line leader.
  - Other will serve as a subordinate member of the unit.
- Provide each group with the instructions specific to their "role"(four scenarios are provided within this manual).

During the role play:

- Move among groups and provide assistance as needed.
- Stop interactions after 10 minutes.

After the role play

- Ask one or more groups to de-brief and answer the following questions:
  - Which of the objectives were met?
  - What else could the leader have done to minimize potential for stigma?
  - Would these be difficult conversations to initiate in real life?
- Reinforce why these objectives are important, and encourage learners to strive to meet them.

Leader	Unit Member
• Review unit member history to determine his or her background and reason for the meeting. • Meet targeted learning objectives, as applicable: – **Identify when unit members exhibit symptoms** consistent with psychological health conditions and/or mTBI. – **Foster unit cohesion** by encouraging group connectivity/buddy care. – **Build or maintain trust** by sharing personal stories, demonstrating genuine care for unit members. – **Demonstrate good order and discipline** by enforcing a zero tolerance policy related to discrimination and harassment. – **Cultivate a supporting environment** by promoting healthy habits and encouraging service members who need medical care to seek help.	• Review unit member history and reason for the meeting. • Review information about unit member's concerns. • During discussion, consider which of the targeted learning objectives the leader has met.

Leader Role

Instructions: The participant acting in the leader role will be assigned to engage in a role play exercise with one member of his or her unit, either unit member A, B, C or D. The "leader" should prepare for the discussion by reading the history or background of the unit members coming to speak with him or her.

These scenarios are designed to provide two different perspectives. For scenarios involving unit members A, B and C, the leader should apply his or her own perspective to the discussion. The scenario involving unit member D is characterized as a leader-to-leader discussion. To ensure this scenario has divergent viewpoints, a "leader perspective" is specified for this scenario only. An overview of each scenario follows:

- **Scenario involving unit member A**: Unit member was arrested for driving under the influence; has had difficulty sleeping following recent deployment.
- **Scenario involving unit member B**: Unit member has been irritable and was in a recent physical altercation; behavior changed following recent motor vehicle accident.
- **Scenario involving unit member C**: New unit member has been harassing other members of the unit who have had frequent medical appointments.
- **Scenario involving unit member D**: This is the only scenario which takes place in theater. As unit member D is a non-commissioned officer, he or she is serving in a leadership capacity, although the "leader" role is the battalion commander. So that this role play involves two different perspectives, information is included on the "leader's" perspective. Unlike the previous scenarios, unit member D requested this meeting with the "leader."

After the exercise, the group will engage in discussion about their role play experience. Please be prepared to discuss any issues or key points you think are important based on the training provided today. Be honest about your attitudes towards psychological health and identify any challenges or obstacles that may still exist at the unit level. The goal of this exercise is to meet the following objectives, as applicable:

- **Identify when unit members exhibit symptoms** consistent with psychological health conditions and/or mTBI.
- **Foster unit cohesion** by encouraging group connectivity/buddy care.
- **Build or maintain trust** by sharing personal stories, demonstrating genuine care for unit members.
- **Demonstrate good order and discipline** by enforcing a zero-tolerance policy related to discrimination and harassment.
- **Cultivate a supporting environment** by promoting healthy habits, encouraging service members who need medical care to seek it.

Unit Member A History

- Service member A is a 22-year-old active-duty Marine who has recently returned with his unit from his first deployment. He is single and lives in the barracks. He is very outgoing and has many friends, both in the unit and in town. He has always been a top performer and has no record of any disciplinary issues. Recently, he has been routinely late for work, and has been found sleeping at work. During the weekend he was arrested for driving under the influence on base. You called him into your office to discuss this serious matter.

Unit Member B History

- Service member B is a 24-year-old Army E-4. He has had some difficulty with his work performance in the past, (he is slower to learn new tasks compared to others in his unit). He has long-standing diagnosis of a learning disorder, but has been otherwise healthy and fit. He has always been extremely motivated to stay in the military and has worked very hard to compensate for his learning challenges.
- He has not been deployed, but was recently involved in a serious motor vehicle accident; his car was broadsided by a drunk driver and a close friend was killed in the accident. He was not hospitalized following the accident, although he was given three days of convalescent leave by the medical provider.
- Since the accident, he has been very irritable at work and has gotten into several verbal altercations with co-workers about playing loud music. The most recent incident resulted in a physical fight, which was stopped immediately.
- You have asked him into your office to discuss his recent physical altercation.

Unit Member C History

- Service member C is a 20-year-old Army E-4 who completed a single combat deployment with another unit, where he was awarded a Purple Heart. He is single and currently lives in the barracks.
- He has recently joined the unit and knows few people, but people have overheard him calling co-workers “lazy” and “weak” because of frequent medical appointments.
- You have asked him into your office today to discuss his behaviors and the potential effects of his comments on unit morale and cohesion.

Unit Member D History

- Service member D is a 32-year-old Marine first sergeant, currently deployed at Forward Operating Base (FOB) Dela Ram, Afghanistan. He has completed four combat deployments and experienced heavy action, especially in Iraq in 2004. He has several documented concussions. Although he has recovered, he is often an advocate for his Marines on matters related to psychological health issues and concussion.
- The first sergeant has requested a meeting to discuss his concerns related to overall unit readiness and issues related to psychological health conditions and concussion. This discussion takes place in-theater.

Leader Perspective

As the leader, you are currently deployed with first sergeant D at FOB Dela Ram, Afghanistan, and are in charge of several artillery units. As the battalion commander, you are acutely aware of the high operational tempo and need for a fully staffed unit. As the operational tempo has increased, more and more of your unit members have been going to medical appointments for minor bumps and bruises that are typical in a day's work. You are concerned they are manipulating the system to get out of work. When they are away from the unit, the workload is heavier for the remaining unit members. You have asked several unit members to describe what happened and after talking to you they have cancelled their appointments. You take this as proof that you exposed their manipulation of the system.

Unit Member Role

Instructions: The participant acting as the unit member will be assigned the role of either unit member A, B, C or D. The participant serving in the unit member role should prepare for the discussion by reading your history or background and concerns. These scenarios are designed to provide two different perspectives. The scenario involving unit member D is characterized as a leader-to-leader discussion. To ensure this scenario has divergent viewpoints, a "leader perspective" is specified for this scenario only. An overview of each scenario follows:

- **Scenario involving unit member A**: Unit member was arrested for driving under the influence; has had difficulty sleeping following recent deployment.
- **Scenario involving unit member B**: Unit member has been irritable and was in a recent physical altercation; behavior changed following recent motor vehicle accident.
- **Scenario involving unit member C**: New unit member has been harassing other members of the unit who have had frequent medical appointments.
- **Scenario involving unit member D**: This is the only scenario which takes place in theater. As unit member D is a non-commissioned officer, he or she is serving in a leadership capacity, although the "leader" role is the battalion commander. So that this role play involves two different perspectives, information is included on the "leader's" perspective. Unlike the previous scenarios, unit member D requested this meeting with the "leader."

The leader should behave in ways that are consistent with the following objectives, as applicable:

- **Identify when unit members exhibit symptoms** consistent with psychological health conditions and/or mTBI.
- **Foster unit cohesion** by encouraging group connectivity/buddy care.
- **Build or maintain trust** by sharing personal stories, demonstrating genuine care for unit members.
- **Demonstrate good order and discipline** by enforcing a zero-tolerance policy related to discrimination and harassment.
- **Cultivate a supporting environment** by educating service members about the facts surrounding psychological health and TBI issues, promoting healthy habits, encouraging service members who need medical care to seek help.

After completing the exercise, the group will engage in discussion about your experience during the role play. Please be prepared to discuss any additional issues or key points you think are important based on the training provided today. Be honest about your attitudes toward psychological health conditions and identify any challenges or obstacles that may still exist at the unit level.

Unit Member A History

- You are a 22-year-old active-duty Marine who deployed once and recently returned with your unit. During your deployment your unit was under attack and your buddy was shot. While you attempted buddy care, his injuries were too devastating and he died.
- You are single and live in the barracks. You are very outgoing and have many friends, both in the unit and in town. You have always been a top performer and have no record of any disciplinary issues.
- Recently, you have been late for work several times and were found sleeping at work. You were arrested for driving under the influence during the weekend.

Unit Member A Concerns

- Your unit leader called you in today to discuss your arrest.
- Since returning from deployment you have had difficulty sleeping. Your energy drink intake has increased during the last several months and it seems to be the only way you can stay alert at work.
- You have had vivid nightmares and night terrors.
- Drinking alcohol helps you fall asleep and you are drinking more often and in greater amounts.
- You strongly deny any problems with your alcohol use. You think the arrest was a set up by the local police to target military personnel, as your blood alcohol level was just at the limit. You admit that the lack of sleep is taking a toll on your work performance.

Unit Member B History

- You are a 24-year-old Army E-4. You have had some difficulties with your work performance in the past (you are slower to learn new tasks compared to others in the unit). You have a long-standing diagnosis of a learning disorder, but have been otherwise healthy and fit.
- You are extremely motivated to stay in the military and have worked hard to compensate for your learning challenges.
- You have not been deployed, but you were recently involved in a serious motor vehicle accident; your car was broadsided by a drunk driver and a close friend was killed in the accident. You were not hospitalized following the accident, although you were given three days of convalescent leave from the medical provider.
- Since the accident, you have been irritable at work and have gotten into several verbal altercations with co-workers about playing loud music. The most recent incident resulted in a physical fight, which was stopped immediately.

Unit Member B Concerns

- Your unit leader called you in today to discuss the recent physical interaction with a co-worker.
- You feel significant grief over the death of your best friend in the car accident. Your sleep has been poor and you wake up feeling tired. It is difficult to fall asleep because of your frequent headaches. You have never had headaches before the accident.
- Loud music makes the headaches worse and you have also had much more trouble concentrating at work since the accident. You realize that you are more irritable and can't seem to ignore loud noises.
- Your girlfriend broke up with you because of the irritability.
- You are having trouble with memory lately.

Unit Member C History

- You are a single 20-year-old Army E-4 living in the barracks. You completed a single combat deployment with another unit and were awarded a Purple Heart. You recently joined a new unit and know few people. You miss the close friendships you had in your previous unit. You have called co-workers “lazy” and "weak" because they have frequent medical appointments.

Unit Member C Concerns

- Your unit leader called you in today to discuss issues related to your attitude and harassment towards your peers who may legitimately need medical attention to maintain readiness.
- You lost several of your good friends during the deployment and you still miss the closeness of your previous unit. You have found it difficult to make new friends and feel lonely and isolated.
- Because of the transfer, you have no support system and admit to feeling depressed and sad much of the time.
- You feel that some of your peers are faking illness in order to get special treatment. These individuals are frequently gone from the unit, and you feel that extra work is put on other unit members (including yourself) as a result of these frequent absences.
- You have had little-to-no experience working with someone with significant psychological health issues. You do not feel comfortable with these individuals, thinking that they may be “crazy”, “faking” or even dangerous. You are glad you don't have any issues from your deployment and think others should be tough like you.

Unit Member D History

- You are a 32-year-old Marine first sergeant currently deployed at FOB Dela Ram, Afghanistan. You have completed four combat deployments and have seen heavy action, especially while deployed to Iraq in 2004.
- You have sustained several concussions over the course of multiple deployments and while you have recovered, you also realize the importance of early treatment for both concussion and psychological health conditions.

Unit Member D Concerns

- You are seeing your unit leader today based on your request to discuss balancing the medical and psychological care needs of unit members in theater, while also making sure the unit can accomplish its mission.
- This particular leader has questioned the unit members about their medical appointments and minimized their injuries. This has discouraged the unit members from seeking medical care for what he considers "minor bumps and bruises." He repeatedly talks about the mission requirements and the need to have a fully staffed unit, as things will only get worse if they send people home for the little stuff.
- By discussing the importance of early identification and treatment of psychological health conditions and mTBI and helping him understand how these efforts contribute to mission readiness, you hope to change this leader’s willingness to recognize and support unit members seeking medical care for these issues in the future.

APPENDIX B: EVALUATION MATERIALS

All evaluation materials and relevant guidance for instructors to evaluate the course are included in this section.

Kirkpatrick Evaluation

In order to effectively measure the knowledge, skills and attitudes acquired through training or education, it may be appropriate to apply multiple evaluation techniques. Dr. Donald Kirkpatrick's training framework for evaluation is a straightforward means for measuring the impact of training-specific interventions on participant reaction, learning, behavior and outcomes. The table below highlights Kirkpatrick's Four Levels Evaluation Model and related data collection methods.

Kirkpatrick Level	Description	Data Collection Methods
Level 1 ***Reaction***	The degree to which participants react favorably to the training.	Course evaluation forms, verbal feedback, post-training surveys, increased participants through referrals.
Level 2 ***Learning***	To what degree participants acquire the intended knowledge, skills, attitudes, confidence and commitment based on their participation in a training event.	Pre- and post-training tests, performance-based skill evaluations, interviews or simulations.
Level 3 ***Behavior***	To what degree participants apply what they learned during training when they return to duty.	Observation and interviews of participants and their supervisors, chart reviews and self-assessments. Employing these methods throughout a period of time will measure the degree of change and sustainability.
Level 4 ***Results***	To what degree targeted outcomes occur as a result of the training event and subsequent reinforcement.	Observation, interviews and focus groups; cultural assessment; financial information; statistics.

Further information about education and training evaluation can be found at http://www.dcoe.health.mil/Training/TrainingDevelopmentToolkit.aspx for the Training Effectiveness Toolkit.

APPENDIX C: KEY TERMS

Term	Definition
Acute stress disorder (ASD)	A psychological health diagnosis that can occur after an individual has experienced trauma. This disorder must last more than two days, but less than one month after exposure to the trauma (may progress to PTSD if symptoms last more than one month). People with this disorder exhibit many of the same symptoms as PTSD.
Acute stress reaction (ASR)	Is not a formal diagnosis but is often used to refer to a range of short term conditions that develop in response to a traumatic event. Onset of at least some signs and symptoms may be simultaneous with the trauma itself or within minutes of the traumatic event, and may follow the trauma after an interval of hours or days. In most cases symptoms will disappear within days or even hours.
Anxiety Disorder	A psychological health condition characterized by persistent, excessive and irrational anxiety. There are several different anxiety disorders, which all have different patterns of symptoms. Some anxiety disorders are specific phobias, social anxiety disorder, generalized anxiety disorder (GAD), obsessive compulsive disorder (OCD), panic disorder and PTSD.
Behavioral Fitness	One of the eight domains of Total Force Fitness. It refers to the relationship between one's behavior and their positive or negative health outcomes. It includes substance abuse (drinking alcohol, tobacco use and illicit drug use) as well as other behaviors that reduce the risk for illness or injury, such as wearing safety equipment and maintaining good hygiene.
Cognitive Behavioral Therapy (CBT)	An approach to psychotherapy that teaches patients to modify both thinking and behavior. Patients learn to track their thinking and activities, and identify the consequences of those thoughts and activities such as in PTSD, depression or anxiety. Patients then learn techniques to change thinking that contributes to PTSD, depression/anxiety. For example, some techniques of CBT include education on CBT itself, goal-setting, identifying unhelpful thoughts and testing the accuracy of such thoughts. Changes in behavior often accompany changes in mood.
Combat Operational Stress Control (COSC)	A Marine Corps resilience program that is dedicated to maintaining a ready fighting force by protecting and restoring the health of Marines and their family members.
Combat and Operational Stress Reaction (COSR)	Reflects acute reactions to combat-related events and the cumulative stresses of military operations. COSR can present with a broad group of physical, mental and emotional symptoms and signs (e.g., depression, fatigue, anxiety, decreased concentration/memory, hyperarousal and others).
Command Directed Evaluation (CDE)	The process through which a commander directs a service member to undergo mental health evaluation because the service member has

	shown behavior that causes the commander to believe the service member may have a psychological disorder and further evaluation is warranted. There are CDE regulations that should be followed when making a referral. Some of the main points to remember are: • Commanders must discuss their concerns with a behavioral health provider first to determine if referral is necessary as not all issues justify a CDE. • If the behavioral health provider recommends referral, commanders can then formally request a command-directed mental health evaluation and make an appointment for the service member. • Commanders must directly inform service members in writing of their rights and often need to escort them on the day of appointment. • Only the unit commander can direct a service member to undergo a mental health evaluation.
Co-morbid or Co-occurring disorders	Mental health or medical conditions that occur at the same time.
Comprehensive Soldier Fitness (CSF)	U.S. Army resilience-building program designed to give warfighters, families and communities the skills to adapt to life's challenges. The training program was built on decades of scientific study on performance and readiness.
Concussion	The term is interchangeable with mTBI (see mTBI) and refers to a hit, blow or jolt to the head that briefly causes a loss or alteration of consciousness. Some symptoms of a concussion are: headaches, dizziness, balance difficulties, blurred vision and irritability, temporary gaps in memory, sleep problems and attention and concentration problems.
Chaplain Religious Enrichment Program (CREDO)	A program of retreats enabling military members and their families to develop personal and spiritual resources in order to be more successful at meeting the unique challenges of military life.
Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury (DCoE)	DCoE is a Defense Department organization that assesses, validates, oversees and facilitates prevention, resilience, identification, treatment, outreach, rehabilitation and reintegration programs for psychological health and traumatic brain injury to ensure the Defense Department meets the needs of the nation’s military communities, warriors and families.
Depression	Depression is a term that refers to a feeling of sadness, but can also be used to refer to several clinical disorders. When sadness lasts for more than a few days and interferes with daily life, normal functioning, and relationships with others, it may be a disorder. There are several types of depressive disorders, including major depressive disorder, dysthymia and others.
Discrimination	The unequal treatment of individuals or groups based on arbitrary characteristics such as, but not limited to, race, sex, ethnicity, cultural background, religion, sexual orientation or medical illness. For example,

	it can include prejudicial treatment of service members who seek psychological health care (or because of any of the above characteristics). Examples of discrimination include: • Unwarranted negative evaluations as a result of psychological disorder. • Removal from leadership roles as a result of psychological disorder. • Assignment to tasks below one's rank as a result of psychological disorder, • Blocked from promotion, and not recommended for promotion due to psychological disorder (or other characteristic).
Dysthymic Disorder (Dysthymia)	Is a psychological health disorder specifically a type of depression. According to the DSM-IV-TR, the essential feature of dysthymic disorder is a chronically depressed mood that occurs for most of the day, more days than not, for at least two years.
Emotional Fitness	One of the three components of psychological fitness. It refers to the way people feel about themselves, others and their environment and is reflected in behaviors such as displays of optimism and perseverance.
Environment Fitness	One of the eight domains of total fitness. It refers to the ability to perform mission-specific duties in every environment and endure the multiple stressors of deployment and war.
Families OverComing Under Stress (FOCUS)	A resilience program that provides training for military children and families to address concerns regarding parental combat operational stress injuries and combat-related physical injuries.
Global Assessment Tool (GAT)	Web-based survey instrument used to assess the dimensions of emotional, social, spiritual and family fitness. The tool is not meant to provide a diagnosis, but does provide an opportunity to track one's self-development and growth over time across the four dimensions of emotional, social, spiritual and family fitness.
Harassment:	To disturb persistently; torment; pester; persecute. It is often because of a person's particular characteristic or membership in a particular group (see discrimination). For example, harassment can be behavior intended to disturb or upset service members who seek psychological health care, and results in a hostile and intimidating work environment.
Heavy Alcohol Use	Consuming five or more drinks on the same occasion at least once a week according to the Defense Department Survey of Health Related Behaviors Among Active Duty Military Personnel (2009).
Hypervigilance	Refers to someone being constantly tense and on guard for a perceived threat.
Illicit Drug	Refers to drugs that are not sanctioned by law; unlawful (example: marijuana, cocaine, etc.).
Improvised Explosive Device (IED)	Homemade or "improvised" bomb that is frequently the cause of mTBI or concussive injuries in combat (please see mTBI or concussion).
Joint Force	Refers to the combined forces of the U.S. Military; Army, Navy, Marine Corps, Air Force and Coast Guard.

Joint Professional Military Education (JPME)	A form of professional military education that provides a multi-service approach to topics that affect the joint forces. The curriculum focus is on how the unified commanders, Joint Staff and Defense Department use the instruments of national power to develop and carry out national military strategy, develop joint operational expertise and perspectives, and hone joint war fighting skills.
Major Depressive Disorder	Is a psychological health disorder characterized by depressed mood or loss of interest in pleasurable activities and other symptoms such as weight gain/loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue/loss of energy, feelings of worthlessness/inappropriate guilt, diminished cognitive function and recurrent thoughts of death or suicide for a period of at least two weeks.
Medical Fitness	One of the eight domains of total fitness. It refers to the ability to maintain mental and physical well-being.
Mental Fitness	One of the three components of psychological fitness. It refers to the way people think and process information. When one is mentally fit they may be seen as being self-confident and flexible in how they think.
Mild Traumatic Brain Injury (mTBI)	Another term for concussion.
Navy Operational Stress Control (OSC)	Navy program that provides a comprehensive approach to prevent, identify and manage the adverse effects of operational stress, and stress injuries on the health and readiness of sailors.
The Navy and Marine Corps Public Health Center	Proprietor of the Navy Systematic Stress Management Program and the Minding Your Mental Health programs. Both programs are geared toward addressing behavioral health concerns of Sailors and Marines.
National Intrepid Center of Excellence (NICoE)	Proprietor of the Navy Systematic Stress Management Program and the Minding Your Mental Health programs. Both programs are geared toward addressing behavioral health concerns of Sailors and Marines.
Nutritional Fitness	One of the eight domains of total fitness. It refers to the ability to provide and consume food in appropriate quantities, qualities and proportions in order to preserve mission performance and protect against diseases and injuries.
Off-Base Resources	Psychological health resources that are normally located off the base or post. Some service members find it easier to reach out and use non-military resources for fear that others will know they have psychological health issues. Some of these resources are: • The DCoE Outreach Center • Afterdeployment.org • The TRICARE Assistance Program • The SuicideOutreach.org website • MilitaryOneSource
Organizational Stigma	Stigma that is based on policies, procedures and informal rules about worthiness to contribute to the mission.
Peer Stigma	Stigma that is derived from the language and behaviors that groups use to include or exclude members.

Physical Fitness	One of the eight domains of total fitness. It refers to the ability to accomplish all aspects of the mission while remaining healthy and uninjured.
Post-Deployment Health Assessment (PDHA)	All service members complete the Post-Deployment Health Assessment (PDHA) upon returning from deployment with a health care provider. This assessment identifies service members who may be having persistent symptoms from their deployment.
Post-Deployment Reassessment (PDHRA)	The Post-Deployment Health Reassessment (PDHRA) is performed 90 days after the PDHA with a health care provider. This reassessment identifies service members who may be having persistent symptoms from their deployment.
Posttraumatic Stress Disorder (PTSD)	An anxiety disorder that can develop after exposure to a traumatic event. Symptoms include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and increased arousal, all of which occur for more than one month and cause significant distress or impairment in social, occupational or other important areas of functioning.
Psychological Distress	The result of external (see psychosocial stressors) and internal stressors, both real and perceived. Psychological distress can produce a number of signs that others can identify. Some common signs of psychological distress include: • Irritability • Excessive worry or fearfulness • Difficulty falling asleep or staying asleep • Late for work, unkempt appearance • Always "keyed up” • Loss of interest or ability to feel pleasure in activities • Difficulty concentrating or sustaining mental focus • Excessive and persistent feelings of guilt or hopelessness • Avoiding others; social isolation • Thoughts or impulses to harm oneself or peers or leader
Psychological Fitness	One of eight domains of total fitness. It refers to the integration and optimization of mental, emotional and behavioral abilities along with capacities to enhance performance and resilience. These components (as defined in this section) include: • Mental Fitness • Emotional Fitness • Behavioral Fitness
Psychological Health (PH)	The term psychological health is used in this training as a synonym for behavioral health, mental health and psychiatric health.
Psychotherapy	The treatment of psychological and emotional disorders using techniques designed to provide symptom relief and behavior change with the goal of improved social and occupational functioning.

Psychosocial Stressors	Stressors that are related to one's primary support system, social environment, educational, occupational, housing or economic situation. Can also include problems related to access of health care services, problems with the legal system and other psychosocial problems.
Resilience	The ability to bounce back or quickly recover from difficult conditions. It is the ability to maintain or return to previous levels of well-being and functioning in response to tough circumstances. For example "resilient" individuals are less affected by negative events than a non-resilient individual.
Self-Medication	Refers to the use of over-the-counter drugs, prescription drugs, illicit drugs, alcohol and or other controlled substances to address medical or psychological concerns.
Self-Stigma	When a person blames themself after having absorbed negative attitudes from others about challenges the person faces in life such as mental health/medical diagnoses or disabilities.
Social Fitness	One of the eight domains of total fitness. It refers to the ability to have healthy social networks in the unit, family and society that support optimal performance and well-being.
Spiritual Fitness	One of the eight domains of total fitness. It refers to the ability to have positive and helpful beliefs, practices and connecting expressions related to the human spirit.
Stigma	Stigma is defined as being "marked" or "branded." When applied to individuals who suffer from psychological health problems, it refers to being looked down upon because others may not understand the how common psychological health struggles are, or because others may believe myths and misconceptions regarding psychological health.
Substance Abuse	Is a psychological health disorder characterized by a pattern of substance use that results in recurrent and significant adverse consequences for the person abusing the substance?
Substance Dependence	Substance dependence is related to substance abuse. However, dependence also includes additional symptoms, which may include tolerance, withdrawal and compulsive use, and reflects the person is further down the path of addiction.
Suicide	To voluntarily self-inflict bodily harm that results in death.
Total Force Fitness (TFF)	A state where mind and body are seen as one -- the sum total of individuals, their families and their affiliated organizations. According to Adm. Michael Mullen it is: "A state in which the individual, family and organization can sustain optimal well-being and performance under all conditions." Total fitness includes eight inter-related elements (which are defined in this section): • Social fitness • Physical fitness • Environmental fitness • Medical fitness • Spiritual fitness • Nutritional fitness • Psychological fitness

	• Behavioral fitness
Traumatic Brain Injury (TBI)	A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force. The injury is indicated by the onset or worsening of at least one of the following factors immediately after the event: • Any period of loss or a decreased level of consciousness • Any loss of memory of events immediately before or after the injury • Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.) • Neurological deficits (i.e., weakness, loss of balance, change in vision, numbness, etc.) • Intracranial lesion
TRICARE	The Defense Department health care program for eligible uniformed service members and their families.
TRICARE Assistance Program (TRIAP)	Allows eligible TRICARE beneficiaries to use a computer, webcam and associated software to speak directly to a licensed counselor via the Internet at any time of the day or night. They can log onto the system an unlimited number of times to receive counseling services including assessments, short-term sessions or referral to more specialized or comprehensive care if necessary.
National Center for Telehealth and Technology (T2)	National Center for Telehealth and Technology is a Defense Department agency that researches, develops, evaluates, and deploys new and existing technologies for psychological health and traumatic brain injury across the department.

APPENDIX D: ACRONYMS

Acronyms used in the course are provided below.

Term	Definition
COSC	Combat Operational Stress Control
CDE	Command Directed Evaluation
CRM	Comprehensive Resilience Module
CSF	Comprehensive Soldier Fitness
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DoD	Department of Defense
DHCC	Deployment Health Clinical Center
DUI	Driving Under the Influence
ED	Education Directorate
FOCUS	Family OverComing Under Stress
FAQ	Frequently Asked Questions
GAT	Global Assessment Tool
JPME	Joint Professional Military Education
MRT	Master Resilience Training
MHTF	Mental Health Task Force
mTBI	Mild Traumatic Brain Injury
NDAA	National Defense Authorization Act
NICoE	National Intrepid Center of Excellence

OSC	Operational Stress Control
PDHA	Post Deployment Health Assessment
PDHRA	Post Deployment Health Re-Assessment
PTS	Posttraumatic Stress
PTSD	Posttraumatic Stress Disorder
P.L.	Public Law
SMART	Specific, Measurable, Achievable, Realistic, Time-bound
SUD	Substance Use Disorder
TFF	Total Force Fitness
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs

APPENDIX E: ICONS

This section includes icons and their descriptions that will be used throughout the instructor's module to highlight key learning points or link to additional learning materials (e.g., video vignette, role play scenario). Example icons and their corresponding actions are shown below.

Icon	Corresponding Action
	Activity
	Customizable Content
	Discussion
	eLearning Exercise
	Experiential Exercise
	Instructor Note
	Interactive Exercise
	Key Points
	Kit

	Materials
	Mneumonics
	Play Video
	Recommended Reading
	Simulation and Feedback
	Time
	Video Time
	Web
	Worksheets

APPENDIX F: FREQUENTLY ASKED QUESTIONS (FAQS)

Q: ***Will everyone in my unit experience psychological concerns after a deployment?***

A: No, people react to stressors from deployment and trauma experiences differently. Therefore, not everyone will experience psychological concerns after a deployment. However, everyone should be screened for psychological concerns and encouraged to report concerns if symptoms appear later.

Q: ***How can leaders help build a fit and resilient force?***

A: Leaders can help build a fit and resilient force by using existing tools with an adjusted focus that decreases stigma and increases fitness by:

- Unit Cohesion – Service members are more likely to feel hopeful about their career and their future if they feel supported by their unit. By fostering unit cohesion, leaders can give service members a sense of belonging.
- Trust in Leadership – When service members have a sense of trust in their leadership, they are more likely to have a better outlook on life and adopt new strategies to successfully cope with challenges and adversities.
- Good Order and Discipline – Research shows that leadership sways service members' perception of and adaption to stressful environments.
- Supportive Environment – Leaders should seek to create an environment that promotes help seeking behavior by discouraging discrimination and harassment surrounding psychological health issues, educating service members about the facts regarding psychological health care, and promoting healthy habits.

Q: ***How can leaders identify service members with psychological distress and or psychological health concerns?***

A: Leaders can be most helpful in identifying service members with psychological health concerns by:

- Being knowledgeable of common symptoms associated with these disorders.
- Being willing to take appropriate actions when a service member is suspected of having psychological health concerns.
- Provide in-service training on psychological health issues at the unit level.

Q: ***How can commanders help minimize the impact of combat on service member?***

A: Three prominent ways commanders can help minimize the impact of combat on service members include:

- **Screening** before/after deployment and at regular intervals with:
  - Pre-deployment Health Assessments
  - The Post-deployment Health Assessment (PDHA) and Reassessments

  - Military Pathways and Afterdeployment.org provide online screening tools that highlight symptoms consistent with mental health conditions. These tools do not provide a diagnosis, but give service members an indication of their current mental state. These tools are useful to service members who want to complete a screening in a completely confidential setting.

- **Educating** service members about the reality of psychological health, and the need to seek care early if a service member has a problem.

- **Using** materials and techniques from the various resilience programs that are sponsored by the Defense Department (Comprehensive Soldier Fitness, Naval Center for Combat Operational Stress Control, etc.).

Q: ***What is the role of a commander in ensuring Total Force Fitness?***

A: Commanders can help foster Total Force Fitness within their own units by establishing local policies and programs that promote:

- **Physical fitness**
- **Nutritional fitness**
- **Medical fitness**
- **Environmental fitness**
- **Social fitness**
- **Behavioral fitness**
- **Psychological fitness**
- **Spiritual fitness**

Q: ***How can leaders help dispel the myths surrounding psychological health?***

A: The most important thing a leader can do to dispel the myths about psychological health is to become better informed regarding the realities about psychological health conditions and seeking care. Besides becoming more educated, you can also:

- Provide education to your service members on psychological health topics
- Make sure that service members in your unit do not face harassment or discrimination when they decide to come forward to get care.

Q: ***What kinds of psychological health resources are available to leaders and their service members with psychological health concerns?***

A: There are a wide range of resources available to service members experiencing psychological health concerns, which can be grouped broadly as:

- Command Resources- Such as one's unit chaplain, the local military treatment facility, which will have primary care providers and possibly behavioral health specialists

- Off base Resources- These include Military One Source, Afterdeployment.org, the outreach center of the DoD/VA Suicide Outreach Center and others. (please see table below)

Q: Where can I find additional resources for myself and my service members?

A: The following organizations may provide additional information on PTSD, depression, suicide, mTBI, TBI and/or substance misuse:

Organizations	Contact Information
After Deployment	(866) 966-1020 *http://afterdeployment.org/*
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)	(800) 510-7897 *http://www.dcoe.health.mil/*
Defense and Veterans Brain Injury Center (DVBIC)	(800) 870-9244 *http://www.dvbic.org/Service-Members---Veterans.aspx*
Military One Source	(800) 342-9647 *http://www.militaryonesource.com/MOS.aspx*
DoD/VA Suicide Outreach	(800) 273 8255 (TALK), Veterans, Service Members and Family Members: **Press 1** *http://www.suicideoutreach.org/*
National Suicide Prevention Lifeline	(800) 273-8255 (TALK) *http://www.suicidepreventionlifeline.org/*
The National Institute of Mental Health	(866) 615-6464 *http://www.nimh.nih.gov/health/topics/depression/index.shtml*

For information useful to clinicians and other health care providers	*Clinical Support tools (CSTs) from clinical practice guidelines such as CPG toolkit cards, brochures or handbooks are available at https://www.gmo.amedd.army.mil/pguide.htm and click on CPG Shopping Cart*

APPENDIX G: SOURCES

Much of the material in this document is adapted from the following sources listed below. The use of their material is taken verbatim from each site as it applies to each specific term. For questions regarding a specific term please visit the links below.

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