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Military Training: Does It predispose service personnel to Negative Mental Health Issues?

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Abstract

At initial (basic) training recruits from all services and most nations are subject to an intense environment where they are physically and mentally challenged throughout their waking day. Their civilian experiences and identity are systematically remodeled to fit the requirements of the nation's services. Most recruits are able to cope with this extreme environment, albeit with some impact on their mental wellbeing, whereas those unable to cope either physically or emotionally are discharged from the Military through medical or administrative procedures. The recruit training environment is characterized by being totally controlled by another person (instructor) where they must succeed (perform) and conform to the service requirements or suffer formal and informal punishments. It is contended that this form of totally controlled environment impacts on the recruit's mental wellbeing. Its effects either manifest immediately at a significant level, necessitating discharge, or occur at a lower level enabling service personnel to remain effective whilst staying in the Military; in some cases, not manifesting until they face the rigours of operational service. Operational service, be it war-like or peacekeeping, is an extremely stressful environment that can trigger latent mental health challenges or create new challenges, including but not limited to, depression, anxiety and post-traumatic stress disorder.

Negative mental health resulting from Military service can led to self-isolation and marital discord resulting in some instances to homelessness or at worst suicide. It is incumbent on the Military to investigate the manner in which recruit training is conducted, and to determine if changes could reduce the predisposition to negative mental health consequences, both from recruit training and subsequent military service.

Introduction

During initial training, recruits are exposed to intense environmental demands on a continuous basis for several months. The recruit is isolated from family and peer support, negating their civilian status and diminishing self-esteem. The recruit's actions are closely supervised and their behaviour being highly controlled, with little or no opportunity for individuality. Initial training in the Military, be it recruit or officer cadet training, is designed to break down existing behaviours and personality in order to rebuild the individual - civilians are resocialized under relative isolation to become soldiers [1] - regardless of the service or the nation. The recruit is required to conform to a set of norms, which emphasizes dominance, violence, toughness, overt heterosexual desire, and risk taking [2].

The environmental context of recruit training is predominantly that of a 'total institution' [3]; the characteristics of which are:

(a) that all aspects of life occur in the same place under the same authority,

(b) that each phase of daily functioning is carried out in the immediate company of others, with everyone treated alike and required to do the same thing,

(c) that activities are tightly scheduled, and the scheduling is imposed by institutional authorities, and

(d) that all activities are part of an overall plan to fulfill the aims of the institution.

Most recruits enter the Military with some expectations of the intensity of the training and some degree of apprehension, which becomes invariably magnified by both routine and specific occurrences in the training environment. The training process thus consists of intense training, linked with heavy doses of reward and punishment (sometimes for no obvious reason) applied to shape the desired behavior and conform to the structure of the system [4].

The process of transforming civilians into service personnel has been described by military historian Gwynne Dyer [5] as a form of conditioning in which inductees are encouraged to *partially submerge their individuality for the good of their unit*. She argues that this conditioning is essential for military functioning in combat situations which necessitates people under stressful conditions to perform actions which are absent in civilian life.

The environmental stressors of initial basic training are common across nations, services and genders, however it is the way in which they are applied that differs. This application is often different between regular and reserve basic training, whereas regular service personnel remain within the tightly controlled system and undergo further specialist training while reservists head back to their civilian environment after basic training [6].

Yet,

Basic training is basically brainwash; All the classical methods of brainwash (breaking, assimilation, instillation, and reaffirming) are present and brainwash can really cause you PTSD and/ or psychological trauma. It is actually intended to cause psychological trauma. The purpose of the recruit training is to shatter your civilian mind, break it, and instill a new military mind instead [7].

Brainwashing creates *pseudo-psychopaths* who will follow orders instinctively and who can kill another human being when necessary [7]; demanding adherence to a different set of values than civilian life.

This rebuilding into the required military image can have negative emotional consequences for the individual [8]. Where a recruit fails to conform to the requirement or fails to achieve the required training standard, they will receive additional training to correct their faults, which is seen by the recruits as a form of punishment, known in the Australian Army as the Defaulters Parade. For those having difficulty meeting these additional requirements, the training demands continue to increase leading to additional training which compounds an already highly stressful situation [9].

An example of a defaulter's parade is the demand to undertake military drill in full battle order, a tactic used with both officers in training and recruits. An often-used tactic in both recruit and officer training is group punishment for the failure of a single member, resulting in all members of the section/squad/ serving the same punishment as the defaulter. As a consequence, the defaulter can lose the trust of the group resulting in punishment being dealt out by section/squad members to 'assist the defaulter to conform and perform' .

Basic Military training is uniquely stressful for recruits, most of whom are beginning the transition to adulthood. In a study of USAF military trainees many new service personnel struggled with the physically and psychologically taxing environment of recruit training, which cause them social and emotional distress and may have put them at risk for the development of adverse psychological health outcomes [10]. Despite pre-enlistment medical screening, mental health-related problems are consistently listed as a significant cause of attrition during Basic Military training in the US armed service, with depression and anxiety in particular having been identified as main causes [11].

Larson et al. contend that psychological problems such as depression, personality disorder, and excessive anxiety are a major cause of first-term enlisted attrition in the U.S. Navy, wherein at least 7% of recruits (more than 3,000 individuals per year) are discharged for psychological reasons, making this the most common source of recruit separation. They consider this to be a low estimate of actual psychological attrition as many others separate through administrative categories [12]. However, not all of those who develop mental health issues during their training separate from the Military, with many continuing training and have a successful career.

Further, the lack of emotional control during Military training can predispose some recruits to psychological difficulties later in life, whether still in the Military or upon discharge [13]. Bonner [14] posits that the level of regimentation and loss of personal freedom during training can predispose military personnel to depression, post-traumatic stress disorder and generalized anxiety disorder when they encounter adverse situations and environments in the future. Recruits who have experienced negative mental health issues in previous civilian life become susceptible to further mental health issues when exposed to the rigours of military training, often resulting in separation from the service [10].

One of the concerns surrounding mental health issues is the stigma that is attached to it by a large number of service personnel [15]. Because of the mental health stigma, service personnel may not report mental health concerns for fear of being branded a malingerer, being ostracized by one's peers or a fear of being separated from the Military because of their negative mental health issue [16]. This is less of a problem when in initial or specialized training as the instructional staff and/or

attendant psychologists are available to identify and support service personnel with mental health issues. The problem occurs once training has been completed and the individual is posted to a unit where the stigma is more prevalent, and rumours abound about the consequences of reporting a mental health issue [17]. This issue will be discussed later in the paper once the consequences of operational service are introduced.

Locus of Control

One cognitive construct that has been associated with depression and anxiety in basic military training is Locus of Control (LOC) [18]. LOC relates to a person's perception as to whether training outcomes (e.g., rewards or punishments) are based on their own behaviour (internal LOC) or whether the outcomes are based on chance or someone else's behaviour (external LOC). Multiple researchers have found a relationship between LOC and depression, such that higher levels of external LOC are associated with depression and that generally a high internal LOC is a strong bulwark against negative mental health [19].

The Military generally attracts individuals with strong self-esteem [20], however, those who transition straight from school, never having experienced independence, never having had much experience tend to enter recruit training lacking developed social skills [21]. They are more likely to develop an external LOC and may end up with impacted mental health even if they are able to graduate [22].

Not all recruits/officer cadets manage to change the enforced external LOC to a more positive and self-actualizing internal LOC by the time they graduate, and many carry that external LOC throughout their Military career and into civilian life post military service. When these individual leaves the Military, they can have difficulty reengaging with civilian life, leading to emotional isolation, loneliness which can eventually lead to depression.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder has been widely researched in the Military, particularly in relation to exposure to war-like combat operations. It was recognized as an outcome of combat exposure as melancholia following the American Civil War, as shell shock following the First World War, combat related stress following the Second World and since Vietnam as post-traumatic stress disorder [23]. The primary aspect for a diagnosis of PTSD is that the individual has been exposed to a traumatic event in which the individual experienced was confronted by events involving death or serious injury or witnessed a threat to the physical wellbeing of self or others [24]. PTSD refers to the long-term aftermath of the trauma but differs from Acute Stress Disorder (ASD) which refers to the initial traumatic symptoms that occur immediately after the trauma [25]. ASD can transition into PTSD if the symptoms are not dealt with appropriately or if the service person remains in the combat environment and is unable to be treated in a timely manner. The nature of modern military operations, either combat, or peacemaking expose the serviceman/woman regularly to potentially traumatic events [26].

The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) characterizes PTSD as [DSM IV 24]:

A. Exposure to actual or threatened death, serious injury, or sexual violence.

B. Presence of intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred.

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred.

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred.

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

Treatments depend upon the nature of trauma experienced, the symptoms being experienced, and the skill set, training, and philosophical regime of the treating professional. In general, three types of treatments are available - psychological, pharmacological and exercise, mindfulness and self-help. The main psychological treatments for PTSD include cognitive behavioural therapy (CBT) and eye movement desensitization and reprocessing (EMDR), brief psychodynamic psychotherapy, hypnotherapy and stress management. Alternative treatments including imagery rehearsal, interpersonal therapy, supportive counselling, person-centered therapy and emotion freedom techniques [24].

The Psychological Impacts of Operational Service

When service personnel are deployed into military operations abroad, they face an increased risk of physical harm to themselves, their comrades, civilians and enemies with a consequent increased risk to their mental health

compared to their non-deployed counterparts [27]. In modern conflicts, military personnel are deployed to theaters in which insurgents use guerilla tactics where the face of an insurgent is often unclear from the general population; such tactics include improvised explosive devices and suicide missions [28]. These tactics may lead to severe mental stress, the often hidden, but real psychological cost of combat operations [29].

The majority of military personnel who return from operational deployment will readjust successfully to civilian life or continued military service. However, the intensity and uncertainty of modern combat and the exposure to other deployment stressors mean that some will return with differing impacts on their mental health (psychological trauma), potentially impacting their reintegration into society.

Military personnel will often face a combination of stressors within combat and war settings that are unique. These may instigate responses, such as PTSD, guilt, family and partner difficulties, as well as nightmares and flashbacks [30].

Australian Gulf War veterans were at greater risk of developing post-Gulf War anxiety disorders including post-traumatic stress disorder, affective disorders and substance use disorders compared with non-deployed military personnel of the era [30]. The occurrence of these disorders remained elevated even a decade after deployment.

Male and female US service members deployed into Iraq and Afghanistan and involved in combat were at an increased risk for depression compared with those who were non-deployed. Thus, it is combat exposure not the theatre deployment that is a risk factor for new-onset depression among US service members [27]. Similarly, Pietrzak et al. [26,31] in reviewing longitudinal studies on mental health outcomes in military personnel returning from operational service identified combat exposure per se rather than mere deployment to have a negative impact on mental health in general.

The changing trajectory of mental health problems after deployment or between deployments has been confirmed by other military studies. These studies support findings that mental health problems and needs change in time and may increase with the accumulation of stressful events in post-deployment life [27].

The impact of combat deployment on PTSD has been extensively studied, but the impact of combat exposure on anxiety and depression is less well known [27,30,32]. In a study on US Marines deployed to Iraq and Afghanistan, Booth-Kewley et. al. [32] identified five factors that were significant in the development of depression: deployment-related stressors, combat exposure, attitudes toward leadership, mild traumatic brain injury symptoms, and marital status. They noted that deployment related stressors had a stronger association with both anxiety and depression than combat exposure; this would suggest that modifying deployment related stressors may impact the prevalence of anxiety and depression post-deployment. Interestingly reserve forces have been found to have worse health outcomes in comparison with regular forces post operational service [26].

The Impact of Peace Keeping Operations on Mental Health and Wellbeing

The main objectives of United Nations (U.N.) peacekeeping missions are to prevent hostility, restore stability, and keep the peace in areas of conflict, which involves monitoring the activities on the target population, providing or supporting the provision of humanitarian and medical support and the provision of protection to non-combatants [31]. Peacekeeping can be a complex operation, changing in a short period of time from a low threat focus, such as the provision of humanitarian aid to that with a high threat focus of population protection, exposing peacekeepers to a range of potential deployment stressors, potentially including combat, that may impact their mental health [34].

The majority of studies into soldier mental health post operational deployment have concentrated on combat operations rather than peace keeping operations causing Forbes et. al. to lament that the mental health outcomes of military personnel deployed on peacekeeping missions have been relatively neglected in the military mental health literature [35].

A 2013 study on the impact of peacekeeping on long term mental health, which examined the mental health status of veterans 10 – 15 years after deployment, found that veterans on peacekeeping missions experienced mental health illness comparable to those of the Vietnam war era, putting peacekeeping operations on a similar footing to combat operations in regard to negative mental health consequences. The study identified that some 60% of veterans were coping well post separation, whereas 20% showed moderate levels of mental health impairment and the remaining 20% identified with more severe mental health issues [36].

In general, most Service personnel returning from Peace Keeping Operations do well in the months after deployment, however, for those returning soldiers who do encounter post deployment difficulties four factors were found to have an impact on mental health and PTSD [37]:

1) level of exposure to traumatic events during deployment,

2) number of deployments,

3) pre-deployment personality traits or disorder, and

4) post-deployment stressors.

Swedish peacekeepers who were deployed to Bosnia, a low intensity conflict, and who experienced traumatic experiences

during the deployment, as well as stressful life events post-deployment, reported the poorest mental health compared to those that did not have traumatic exposure during deployment. Post-deployment stressors had the greatest impact on poor mental health after one year. It would seem that traumatic operational experiences predisposed peacekeepers to poor mental health from post deployment stressors [38].

A recent study showed that Australian peacekeepers who served between 1989 and 2002 had *significantly higher 12-month prevalence of PTSD (16.8%), major depressive episode (7%), generalized anxiety disorder (4.7%), alcohol misuse (12%), alcohol dependence (11.3%) and suicidal ideation (10.7%)* compared to the civilian population [39]. Forbes et. al. identified that the presence of these psychiatric disorders was most closely related with exposure to potentially traumatic events and concluded that peacekeeping veterans should be treated equally to combat veterans with respect to military mental health initiatives [40].

In a study of New Zealand peacekeepers deployed to Bosnia, MacDonald et al. [41] found that levels of PTSD and depression increased during deployment in comparison to control groups who were deployed to other overseas missions or who remained in New Zealand. She contended that these increases were specific to the highly stressful Bosnian deployment rather than overseas deployment per se and that the six-month period post deployment was also a highly stressful period in reacclimating to normal civilian life. Their conclusion was that support should be tailored to the length and nature of the deployment and the type of stressor experienced.

Mental Health Stigma

Mental health stigma is not solely a problem of the military, rather it covers most sectors of the population with men in particular being averse to discussing their mental health issues [40]. Yet, mental health stigma is a continuing issue within the nations' militaries [41]. As such a need exists to identify the concerns of public stigma and personal beliefs of mental illness and mental health treatment in order to address the potential barriers to treatment in military and veteran populations [44].

Stigma is considered to be a belief relating to *an attribute that is deeply discrediting*, that reduces the individual or group, *from a whole and usual person to a tainted, discounted one* [43]. Stigma occurs when groups with *power stereotype hold prejudice or discriminate against a group* or individual *that has been labeled as separate or different* [43].

Across all nations studied, approximately 60% of military personnel who experience mental health problems do not seek help, however many of them could benefit from seeking professional support. One of the most frequently reported barriers to help-seeking for mental health problems in the military is concerns about stigma [45]. Some service personnel actively avoided mental health support because of concerns of an impact on future career prospects, whilst others that evidenced high presence of stigma still sought assistance from mental health services or evidenced intention to do so in the future [46]. Dickstein et al. [47] found that the two most identified stigma concerns related to concern about their leadership's perceptions and subsequent harm to their career and their peers' perceptions of them being weak.

There is a need to overcome the stigma barrier both for those with a diagnosable mental illness and also for those with an occupational impairment that occurs as a result of sub-threshold conditions that are still having an impact on the organization [48]. As well as having a mental health stigma there are many service personnel within the nations' services who do not realise that they have a disorder for which help is available; they may acknowledge symptoms but do not recognize that they need treatment [49]. Similarly, whilst acknowledging symptoms, some service personnel prefer to manage the condition on their own.

There are few actual barriers to care within the military, as there are abundant specialists to treat a variety of mental health disorders both within the military and available to the military. The barriers that exist to accessing mental health care relate to individual and collective ignorance and poor leadership [46]. Most of the attention has been focused on attitudinal barriers to care, that is stigma and recent attempts have been made to consider mental illnesses as injuries (particularly when operationally related) [50].

Further, Mark Zamorski [50] laments that mental health providers tend to target stigma as the only barrier to care, failing to consider discrimination, erosion of social support, and the creation of an additional impost on those already trying to cope with mental illness. The Canadian military have attempted to reduce the stigmatization of mental health issues by using the term Operational Stress Injury (OSI) to describe psychological illnesses resulting from traumatic events experience by soldiers during an operational deployment. Along with Veterans Affairs Canada the military have established Operational Trauma and Stress Support Centres across Canada to facilitate early diagnosis and treatment of members and veterans suffering from OSIs. Whilst it manages to identify and treat many veterans it takes some a long time to present for care and they consider that shame, isolation and the institutional stigmatizing of mental illness as the reasons that prevent veterans from seeking help [51].

Discussion

The environmental intensity of recruit training can cause mental health issues in recruits, regardless of service, nationality and gender. A strong correlation exists between external locus of control (LOC) and adverse mental health

outcomes in initial (basic) training necessitating some recruits to separate from military service. Whilst most recruits will transition to an internal LOC as they advance through their training curriculum, whereas others will retain an external LOC with adverse mental health outcomes and have difficulty adjusting to their chosen military career.

Given the known stressors of operational deployment, those service personnel who complete their basic training with some lingering adverse mental health issues would be anticipated to be more susceptible to the rigours of deployment, and ultimately develop major mental health issues such as Major Depressive Disorder, Generalized Anxiety Disorder and or PTSD.

Most service personnel who develop adverse mental health issues post operational deployment, either separated voluntarily or separated administratively, return to civilian life in a compromised state [52]. Although there are nations offering programs for the treatment of service personnel with adverse mental health situations, not all separating personnel are able or wish to avail themselves of these services [53]. For those service personnel who do not receive appropriate treatment for their mental health condition, the outcomes can be alcohol abuse, domestic violence, relationship breakdown, isolation and eventual homelessness [54]. Whilst there has been a greater acceptance of returned service personnel by the community at large, those with untreated poor mental health are at risk of social exclusion, which further exacerbates mental health problems leading to social isolation, depression and unfortunately many are unable to cope with the situation and commit suicide [55].

Conclusions

The genesis of this article relates to the personal experience of a 21-year veteran Military Psychologist with the Australian Army, with much of that time spent in recruit selection and psychological counselling of recruits. Whilst some of the statements contained within the paper may not have a peer reviewed background, the experience gained by the author in selecting and counselling of recruits, deployment into an operational war zone as an occupational psychologist and the counselling of psychologically challenged veterans affords the author views a degree of authenticity, that can not necessarily be gained from a research background.

Operational service be it combat related or non combat deployment (e.g., peacekeeping or administrative support) has caused mental health issues within a high percentage of service personnel worldwide, that are either recognised and receive treatment or may go unrecognized due stigma, ignorance or self-treatment and separate from the service and end in up the general community with a mental health disorder. More is needed to be undertaken whilst the service person is still in the military to identify and treat those with mental health issues, regardless of cause and not discharge personnel suffering from a recognizable mental illness/injury.

As negative mental health issues may not surface until years after the service person separates from the service, this places a responsibility of the military and or ex-serviceman/woman's supporting organizations to ensure that they facilitate the follow-up of discharging personnel to identify and where possible rectify the negative mental health outcomes acquired throughout their service career.

It has been demonstrated that rigours of recruit training predispose service personnel to negative mental health issues. As such, it is incumbent upon the military organizations of nations to undertake research to determine how to better structure recruit/basic training in such a manner that the requirements of the various services are met (performance and conformance) without negatively impacting the recruit's mental wellbeing.

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