

EDUCATING U.S. ARMY RESERVE
SOLDIERS ON RESILIENCY

by

Charlene Ann Lewis-Richardson

A professional paper submitted in partial fulfillment
of the requirements for the degree

of

Master

of

Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 2012

©COPYRIGHT

by

Charlene Ann Lewis-Richardson

2012

All Rights Reserved

APPROVAL

of a professional paper submitted by

Charlene Ann Lewis-Richardson

This professional paper has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citation, bibliographic style, and consistency and is ready for submission to The Graduate School.

Dr. Kathleen Schachman

Approved for the College of Nursing

Dr. Helen Melland

Approved for The Graduate School

Dr. Carl A. Fox

STATEMENT OF PERMISSION TO USE

In presenting this professional paper in partial fulfillment of the requirements for a master's degree at Montana State University, I agree that the Library shall make it available to borrowers under rules of the Library.

If I have indicated my intention to copyright this thesis by including a copyright notice page, copying is allowable only for scholarly purposes, consistent with "fair use" as prescribed in the U.S. Copyright Law. Requests for permission for extended quotation from or reproduction of this thesis in whole or in parts may be granted only by the copyright holder.

Charlene Ann Lewis-Richardson

April 2012

ACKNOWLEDGEMENTS

I would like to express appreciation for my husband Shawn. His continual support and encouragement assisted me in completing my project. His “never give up” attitude and constant support helped me through to the end. My daughters Megan and Brittnee were there to help me laugh and see that “this too shall pass.” I want to thank my granddaughter Madison for her kisses and hugs and unconditional love that assisted me in moving forward when some days it was questionable. I want to thank my parents and siblings for their never ending support. My siblings Michele and Jim were there along the way to offer humor that allowed me to see that I could finish my project. My parents always stated hard work and determination pays off. Their instillation of a strong work ethic and never give up attitude has assisted me to complete my masters program and become the first one in my family to complete a graduate degree.

Lastly, I would like to acknowledge the dedication and special attributes of my committee chair Kathleen Schachman, PhD, RN, committee members Deanna Babb, MSN, APRN, FNP-BC and Helen Williams, MSN, RN. They each made significant contributions to my success of this project by providing endless amounts of time, feedback and encouragement.

TABLE OF CONTENTS

1. BACKGROUND AND SIGNIFICANCE.....	1
Purpose of the Project.....	4
Objectives of the Project	5
Theoretical Framework	
The Health Promotion Model by Nola J. Pender	5
Principles of Adult Education	6
Learning Styles.....	8
2. LITERATURE REVIEW	10
Current Training Programs on Resiliency in the U.S. Army Reserve	11
Is Resiliency Training Effective in Preventing or Reducing PTSD?	13
PTSD Care and Treatment Available to Reserve Soldiers Currently in the United States and the State of Montana.....	18
3. METHODOLOGY	23
Project Design.....	23
Target Population	23
Setting.....	25
Pre-Test-Assessment	25
Development of Presentation.....	28
Content	29
Delivery of the Educational Program.....	30
Evaluation of the Educational Program.....	31
Resources.....	32
Institutional Review Board Approval.....	33
4. PROJECT OUTCOME.....	35
Demographic Characteristics	35
Evaluation of the Educational Program.....	36
5. REFLECTIONS	39
Lessons Learned.....	39

TABLE OF CONTENTS - CONTINUED

REFERENCES 42

APPENDICES 46

 APPENDIX A: PTSD Knowledge Test..... 47

 APPENDIX B: Awareness And Resiliency Training..... 50

 APPENDIX C: Resiliency Pyramid..... 61

 APPENDIX D: Teaching Plan..... 63

 APPENDIX E: Soldier Evaluation Form of PTSD..... 66

LIST OF FIGURES

Figure	Page
1. 4225th Soldiers with PTSD.	24
2. PTSD Knowledge Test – Handed out and Completed.....	27
3. Results of PTSD Knowledge Test.	27
4. Rank Structure of Attendees.	35
5. Breakdown of Responses to Post-Evaluation Form.....	37

ABSTRACT

Resiliency is defined as a set of processes that enable good outcomes in spite of serious threats. It is the ability to persist in the face of challenges and to bounce back from adversity. US Army Reserve soldiers need to be trained on resiliency to provide them with tools to cope with stress and deal with adverse events. PTSD has increased by 40% since the beginning of the Global War on Terrorism. Resiliency training will be a proactive step to assist in minimizing the occurrence of PTSD.

The purpose of this professional project was to present an educational program to US Army Reserve soldiers in Montana. Education includes the definition of PTSD, the risk factors for PTSD and practical hands-on exercises for developing resiliency skills.

The project consisted of a 11-question knowledge pre-test regarding PTSD, a 45-minute educational presentation on resiliency and a 5-question post-presentation questionnaire disbursed to the 75 US Army Reserve soldier participants. It occurred at Fort Harrison in Helena, MT. The educational intervention was based on Nola Pender's Health Promotion Model and grounded in principles of adult learning.

The results of the project revealed the soldiers strongly agreed that the objectives of resiliency training and education were helpful. The soldiers felt they could take the information presented in the educational project and utilize it in their US Army Reserve life and their civilian careers and family relationships. The U.S. Army exists to protect this country. Our soldiers, family members, and Army civilians have never failed to answer our nation's call during a time of need. The Army needs to recognize they need to do more to prepare the forces for the psychological demands that come with fighting a protracted, decades-long conflict. Resiliency training will do that!

CHAPTER 1

BACKGROUND AND SIGNIFICANCE

More than 1.8 million American service members have deployed to Iraq or Afghanistan in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) since the beginning of the Global War on Terrorism in October 2001 (Litz, 2009). Over 37 percent have deployed at least twice. According to the Department of Veteran Affairs in June 2010, there were 171,423 war veterans who were diagnosed with Post-Traumatic Stress Disorder (PTSD) who had been deployed to Iraq or Afghanistan in support of OIF or OEF. Christopher Frueh, MD, clinical psychologist and Department of Veteran Affairs clinical researcher reported from 1999 to 2004 the number of veterans receiving VA disability payments for PTSD increased to 79 percent (from 120,265 to 215, 871), where as those soldiers receiving disability payments for other disabilities increased only 12.2 percent. The Department of Veteran Affairs distributes up to \$4.3 billion annually toward PTSD disability payments. Our nation is being impacted fiscally and emotionally and psychologically by PTSD.

In September of 2009, Stanford University published a study (<http://www.stanford.edu/group/knowledgebase>), a Dynamic Model for PTSD Among U.S. Troops in Operation Iraqi Freedom, by Michael P. Atkinson of the Naval Postgraduate School and Adam Guetz of Stanford University, and Lawrence M. Wein of Stanford Graduate School of Business. This study revealed an estimated 35 percent prevalence rate of PTSD among Iraq and Afghanistan war veterans. This percentage is

staggering and is continuing to escalate. As Operation Iraqi Freedom draws down but Operation Enduring Freedom in Afghanistan continues and as more troops deploy several times the rate of PTSD continues to climb.

PTSD can be debilitating, not only does it impact the soldier but their families and many aspects of daily living. PTSD is a disorder that has significant complexity.

According to the *DSM-IV-TR* (Diagnosed Statistical Manual) the definition of PTSD is: a complex disorder in which the affected person's memory, emotional response, intellectual process, and nervous system have all been disrupted by one or more traumatic experience. PTSD is summarized as a "normal reaction to an abnormal event." The *DSM-IV-TR* classifies PTSD as an anxiety disorder (<http://www.mindsordres.com/Ob-Ps/Post-traumatic-stress-disorder.html>). There are 6 criteria the *DSM-IV-TR* Manual for Mental Health Disorders has specified for the identification of PTSD. These are: a stressor, an intrusive recollection of the stressor, feeling avoidant or numbing, having hyper-arousal, the duration of the symptoms and the signs and symptoms having functional significance on the soldier's activities of daily living.

There are specific risk factors identified in the *DSM-IV-TR* that predispose soldiers to PTSD. These are female gender, experiencing intense or long-lasting trauma, having experienced trauma earlier in life, lacking a good support system of family and friends, having a first degree relative with mental health problems, including PTSD, having a first-degree relative with depression and having been abused or neglected as a child. The risk factors for PTSD are prevalent in over 10% of soldiers in the U.S. military, both active duty forces and National Guard and Reserve forces (Litz, 2009).

With so many soldiers having risk factors for PTSD there is a large percentage of soldiers return from Iraq or Afghanistan with signs and symptoms of PTSD. According to a recent report from the National Center for PTSD (<http://www.ptsd.va.gov/professional/newsletters/research-quarterly/V20N1.pdf>) over 35 percent of Active duty soldiers returning from Iraq and Afghanistan have signs and symptoms of PTSD. It was also noted in this report that as much as 40 percent of National Guard and Reserve soldiers have signs and symptoms of PTSD.

The Department of Defense (DOD) has been proactive in seeking solutions to reduce the incidence of PTSD. The DOD and the Veterans Administration has dedicated unprecedented attention and resources to address PTSD in recent years, and evidence suggests that these policies and strategies have had a positive impact. However, work still needs to be done. In 2007, the Department of Defense Task Force on Mental Health concluded that despite the progressive recognition of the burden of mental illnesses, such as PTSD, and the development of many new and promising programs for its prevention and treatment, current efforts are inadequate to ensure the psychological health of our fighting forces. Repeated deployments of mental health providers to support troops have in inadequacies for providing mental health services to current military members. New strategies to effectively provide services to members of the Reserve Components are necessary to see a decline in PTSD. Insufficient attention has been paid to the vital task of prevention (National Council on Disability, 2004).

PTSD can be debilitating, but the effects can be mitigated by early intervention and prompt effective treatment. Although medical and scientific research on how to

prevent, screen for, and treat PTSD is incomplete there have been steps made for prevention.

Proactive training instead of reactive training is essential to see a decline in PTSD. Emphasis must be placed on minimizing combat stress reactions, and preventing normal stress reactions from developing into PTSD when they do occur. The DOD has been proactive in seeking solutions to reduce the incidence of PTSD; many of these interventions are focused on resiliency.

Resiliency is defined as a set of processes that enables good outcomes in spite of serious threats (Masten, 2001). In other words, resiliency is the ability to persist in the face of challenges and to bounce back from adversity. There are a number of evidence based protective factors that contribute to resiliency: optimism, effective problem solving, faith, sense of meaning, self efficacy, flexibility, impulse control, empathy, close relationships and spirituality (Masters & Reed, 2002). Soldiers need to be trained to develop these evidence based protection factors. Resiliency training will address these factors and educate soldiers and provide soldiers with tools to cope with stress and adversity. The intention of this program is to develop resiliency skills in our troops and provide practical exercises for them to instill effective problem solving skills in hopes of decreasing the occurrences of PTSD in soldiers after they are exposed to adverse events.

Purpose of the Project

The purpose of this professional project was to present an educational program to United States Army Reserve soldiers in Montana to provide to them the tools they would

need to develop strategies for developing resiliency when exposed to adverse situations or stressful events. Education includes definition of PTSD, the risk factors for PTSD and practical hands-on exercises for developing resiliency skills.

Objectives of the Project

Two broad goals for the educational program were:

1. Increase the soldier's knowledge of the *DSM-IV-TR* definition of PTSD and educate regarding risk factors and symptoms of PTSD.
2. Increase soldier's awareness of resiliency training and develop skills for resiliency. Incorporate a practical exercise into the educational program to help solidify the awareness of resiliency and appropriate problem solving.

Theoretical Framework

The Health Promotion Model by Nola J. Pender

The health promotion model (HPM) proposed by Nola J. Pender (1982; revised, 1996) was designed to be a “complementary counterpart to models of health protection.” It defines health as a positive dynamic state not merely the absence of disease. Providing education to Montana soldiers regarding resiliency training and building necessary skills parallels Nola J. Penders Health Promotion Model. Educating soldiers on the importance of resiliency skills will help them understand that their mental health is just as important as their physical health.

The health promotion model notes that each person has unique personal characteristics and experiences that affect subsequent actions. The set of variables for

behavioral specific knowledge and affect have important motivational significance. Health promotion behaviors should result in improved health, enhanced functional ability and better quality of life at all stages of development

(http://nursingplanet.com/health_promotion_model.html). Resiliency skills training results in improved health and decreased mental anguish when faced with adversity. Soldiers who have appropriate resiliency skills education and training will be able to promote their health by seeing decreased emotional turmoil and PTSD.

Health promoting behavior is the desired behavioral outcome and is the end point in the Health Promotion Model. Health promoting behavior of the Health Promotion Model is the highest component of the resiliency pyramid. Real-time resiliency is shutting down counter-productive thinking to enable great concentration and focus on the task at hand. Being able to provide training and education to soldiers so they are able to achieve health promoting behavior and real time resiliency is the ultimate goal.

Principles of Adult Education

Knowledge of the principles of adult education is important to ensure the participants are educated appropriately. Development of resiliency training program was based on principles of adult education. All adults learn in different styles. Malcolm Knowles (1980) defined adult education,

In its broadest sense, the term describes a process—the process of adults learning. In this sense it encompasses practically all experiences of mature men and women by which they acquire new knowledge, understanding, skills, attitudes, interests, or values (p. 25).

During his research, Knowles (1980) developed six concepts, which are the theoretical framework supporting adult learning principles:

1. *Autonomous and self-directed*: Developmentally a mature person sheds dependency and moves toward developing and becoming independent and self-directed.
2. *Life experience and knowledge*: With age comes experience, as a person develops throughout life they acquire various experiences that become the foundation for self-directed learning.
3. *Readiness to learn*: Individuals have a willingness to learn when they experience an occasion for necessitating increased knowledge. Impetus to master new information and eagerness to learn are significant aspects in achieving learning by adults.
4. *Problem focused*: Adults are motivated to learn new knowledge, which will help them problem solve a current or future experience, or acquire skills that they actually are facing in the moment.
5. *Motivation*: Adult learners demonstrate internal motivation, which initiates desire to learn and apply their new knowledge to real life situations.
6. *Knowing*: It is beneficial for the adult learner to understand the importance of learning and what they can gain by learning new information.

Most adults participate in an educational program due to the necessity of gaining knowledge in a specific area affecting their current life situation. A fundamental reason

why adults may participate in learning opportunities is to institute change in their level of knowledge, skills, behavior, and attitude.

Learning Styles

Many adult learners have adopted a learning style distinguished by specific preference patterns. An assessment of learners' style is a major step in the process of educational planning. Many learning styles are used when synthesizing information. LeCroy (2009) and Russell (2006) report that three primary learning styles may be used: visual, auditory, and psychomotor methods. Some adult learners use a combination of these styles, further influencing an adult's ability to learn. The visual learner prefers to visualize pictures, graphs, images to help comprehend the information, as compared to detailed explanations. The visual learner prefers written instruction, visual illustration, or reading notes (Russell, 2006). The auditory learner favors listening to the information that is presented. The adult learner would rather listen to someone discuss and orally present instructional content, and would prefer auditory instruction rather than reading the information. Adult learners who prefer this style can remember verbal instruction and accept oral presentations. The psychomotor learner desires to perform a task or skill that is being taught. They prefer the "hands on" type of instruction and the need to demonstrate newly acquired skills (Russell, 2006). Adult learners are self-directed, have a wealth of experience, and are motivated and ready to learn. Adult learners usually come to an educational session with preconceived ideas, thoughts, and concerns about the topic. Adult learners are problem-centered and want to expand their knowledge about

practical information that pertains to them (LeCroy, 2009). Effective facilitators and educators take into account preferred learning styles and adult learning principles when planning and presenting educational programs.

CHAPTER 2

LITERATURE REVIEW

The aim of the literature review was to identify and access research reports which pertain to the current definition of PTSD, review of risk factors of PTSD, identify resiliency training education and research and review the current successful care and treatment of PTSD our soldiers are receiving in our nation and the state of Montana. Three databases were utilized; they were PILOTS (Published International Literature on Traumatic Stress), CINAHL and PschInfo. Search terms used to elicit information were PTSD definition, resiliency, and risk factors for PTSD, statistics pertaining to current PTSD diagnosis, care and treatment of PTSD soldiers, health promotion model and adult learning, adult education and PTSD support centers. Articles were reviewed from nursing and psychological journals. Additional PTSD information was gathered from the Department of Veteran Affairs National Center for PTSD website. It is quite possible that the subject terms used in this literature review did not capture some publications that could be pertinent to this project. However, of the articles obtained, review of the reference lists provided further articles that pertain to this literature review. Peer reviewed and primary research studies were selected. The literature review will focus on what has already been done for resiliency training programs in the U.S. Army Reserve, is resiliency training effective in preventing or reducing PTSD and PTSD care and treatment available to Reserve soldiers currently in our nation and state.

Current Training Programs on Resiliency
in the U.S. Army Reserve

The United States Army has a Comprehensive Soldier Fitness program for their Active duty force soldiers. It is a program that is an integrated and proactive approach to developing psychological resiliency in our soldiers, in their family members, and in the Army's civilian workforce. It was developed out of recognition that the current American soldier has rotated between combat and home for more than nine years, incurring cumulative levels of stress that are impacting their performance, their readiness and in many cases their personal relationships. The importance of a resiliency program is due to the fact that our soldiers are operating in an era of persistent conflict. Persistent conflict is defined as protracted confrontation among state, non-state, and individual actors who are increasingly willing to use violence to accomplish their political and ideological objectives (Casey, 2011). While the top officers of the Army cannot determine when this era of persistent conflict is going to end, they do know that American servicemen and women will continue to be in harm's way defending our way of life. It is the responsibility of the senior Army leadership, to ensure soldiers, their family members, and Army civilians are prepared, both physically and psychologically to continue to serve and/or support those in combat for years.

The Army is leveraging the science of psychology in order to improve the force's resiliency. The active duty Army soldiers are being exposed to prevention strategies when exposed to adverse or stressful events and enhancement strategies on how to finesse their psychological strengths that are already present in some of the soldiers.

The Comprehensive Soldier Fitness (CSF) program is a “strength-based” resiliency program that shows promise for soldiers and it is a support network so soldiers can “be” better before deploying to combat so they will not have to “get” better after they return (Casey, 2011). The CSF program is structured into three blocks. The first block is training and education initiatives associated with taking a holistic approach to developing psychological resiliency within five dimensions: physical, social, emotional, spiritual, and family. Second, the program looks at several teaching strategies, in the classroom and via the Web, in order to reach the entire Army community while catering to a variety of learning styles. Third, in its recognition that the developmental needs of an 18-year-old are significantly different from those of a 40-year-old colonel, CSF is not a “one size fits all” program but rather one that adapts to each individual’s psychological resiliency level.

The program consists of four components: The first is an online self-assessment to identify resiliency strengths. This is called the Global Assessment Tool or GAT. It has already been taken by 900,000 soldiers. The second component consists of online self-help modules tailored to the results of the assessment. The third component, the training of master resiliency trainers, is designed to be conducted down to the unit level of Active duty forces. This is a great program that unfortunately Montana Army Reserve soldiers are not exposed to.

Army Reserve soldiers have not had exposure at the unit level to resiliency training. The Global Assessment Tool (GAT) is available to soldiers but soldiers are fearful of ramifications if they answer the GAT honestly. It has been noted that 34

percent of soldiers returning from deployments in Afghanistan or Iraq feel they will be treated differently if they seek out behavioral health care (Casey, 2011), 40 percent believed that their leaders would blame them for the problem and over 50 percent believe that they would be seen as weak. Facing statistics like these, the Army Reserves must ensure that efforts to become psychologically stronger are not thwarted by a culture adverse to even the word *psychological*. These percentages are evidence that the need for resiliency training prior to deployments or exposure to adverse or stressful events is imperative to the strength of our fighting reserve forces.

Is Resiliency Training Effective in Preventing or Reducing PTSD?

Since the beginning of the Global War on Terrorism in October 2001 the rising numbers of suicide among our military service members and veterans is at an all time high (Elmore, 2010). Data suggests that the Army suicide rate is now higher than that among the general U.S. population.

The war in Iraq and Afghanistan has exposed our soldiers to daily urban fighting, suicide bombers, and guerilla tactics of insurgents who blend into the general public. This creates an extra layer of stress on our soldiers that takes its toll. “One very potent predictor of later mental health problems is the sense of constant, perceived threat of attack,” which is particularly acute, states Lynda King, PhD at the National Center for PTSD and the Massachusetts Veterans Epidemiology Research and Information Center. Soldiers are exposed to constant stress and adverse events. They are reluctant to seek care and are fearful of pursuing mental health care in fear of being “labeled.” The U.S.

Army Reserve needs an effective stigma-reducing program that provides early interventions before exposure to adverse or stressful events. This is resiliency.

Does resiliency training actually work? This question has occurred frequently throughout the U.S. Army as the numbers of soldiers diagnosed with PTSD continues to rise from the recent conflicts in Iraq and Afghanistan. Brigadier General Rhonda Cornum is a formidable champion of resilience and optimism in the face of adversity. In February of 1991, when she was a flight surgeon during Operation Desert Shield in the Persian Gulf War, Brig. Gen. Cornum survived a harrowing week which included a fiery helicopter crash, bullet wounds, two broken arms, enemy capture, and an abusive assault. She was one of three who survived the ordeal: five others did not. She recounts, “I just approached that particular little stressful week as any other event. Events happen: you make every effort for events like that not to happen, but when they do, you just deal with it” (Langille, 2011). Brigadier General Rhonda Cornum is an MD, urological surgeon and has a PhD in nutrition and biochemistry from Cornell University. She has seen through the years in commanding soldiers that not everyone approaches adversity with resiliency and optimism.

The Us Army’s Chief of Staff, General George W. Casey, Jr. wrote in a special issue of *American Psychologist*, the flagship journal of the APA, that developing psychological resilience should gain a standing in the Army equivalent to that of the calisthenics that start each soldier’s day (Stix, 2011). Many people think they have grown through tragedy – except the research shows they seldom do. That is where resiliency training and education comes into play. If these people/soldiers’ had been

educated on resiliency prior to exposure to adverse or stressful events would they be able to “deal with it” as Brig General Cornum states and “move on?”

Resiliency has been researched thoroughly by Dr. Martin E.P Seligman and Dr. Karen Reivich, psychology experts at the University of Pennsylvania. The Pennsylvania Resiliency Project has demonstrated to be successful in improving performance and preventing negative outcomes. This evidence based practice by the University of Pennsylvania has provided enough research for the U.S. Army to utilize its components and launch Comprehensive Soldier Fitness.

The Penn Resiliency Program (PRP) is evidence based practice fostered by the University of Pennsylvania Positive Psychology Center, with project initiatives carried out by other universities, including Swarthmore College and West Chester University. This group-based program initially was developed to prevent the initial onset of and decrease the exacerbation of depression in young elementary and middle school-aged children. By incorporating specific coping and problem solving skills, this intervention attempted to study two main facets of research: the efficacy of the program implemented by school staff and the decrease in severity of depressive symptoms at onset, and a generalized decrease in the level of symptoms displayed over a specific length of time.

The PRP is a secondary prevention strategy that identifies disease or illness in its earliest stages and prevents further progression, such as PTSD. The subjects of this study were categorized according to the severity of the symptoms they present. The main focus of the initiative was to curb the extent to which symptoms occur in the children and decrease the severity of symptom onset. In the present study, PRP was compared to

another initiative, the Penn Enhancement Program (PEP) and a no-intervention control (CON); all three groups completed the same weekly assignments. It was hypothesized that the PRP would decrease depression symptoms when compared to the PEP and the control groups. Beginning in 1997, this randomized controlled study was implemented in three suburban, metropolitan schools in the U.S with each producing mixed results. There were a total of 697 students, stratified by gender and grade level, entering the intervention phase. These children cleared an initial survey and screening, Children's Depression Inventory (CDI), for baseline measures of the severity of depression disorders. A CDI score greater than or equal to 13 signified mild to severe depression, and these students were excluded from the study. PRP progresses by teaching students various cognitive-behavioral and problem-solving related skills, and how to apply these to situations they face. The sessions were conducted once a week (90 minutes) for twelve weeks with weekly assignments. School teachers, counselors, and graduate students who were not directly affiliated with the research team led these group discussions.

The Penn Resiliency Program (PRP) provided guidance to adolescents to understand, relate, and interpret everyday events to cope with depression. This randomized controlled, evidence-based study allowed for comparisons to a control (CON) and an alternative program, Penn Enhancement Program (PEP), which focuses more on discussing the stress factors related to adolescent depression. The initial means of CDI scores for schools A, B, and C were 7.03, 9.51, and 8.71 respectively with a total of 697 participants. Since schools A and B presented similar results, the researchers combined A and B's data to compare to school C.

Though the statistical results did not show a significant level of reduction in depression, the absolute decrease of depressive symptoms in participants from A and B highlighted PRP's positive benefits. During this study, the data from A and B revealed prevention of elevated depressive symptoms relative to CON ($p < 0.01$). The Penn Resiliency Program, is more promising in keeping adolescents mentally healthy than no program at all.

With this evidence based practice General George W. Casey, Jr. of the U.S. Army felt the PRP had proven itself through repeated replications and that it was effective to educate and assist soldiers when faced with adversity or stressful events. General George Case states, "We at the U.S. Army are satisfied with the research from the PRP and are ready to bet it will prevent depression, anxiety and PTSD. This is not an academic exercise. This is war. I want resiliency training to be rolled out to the whole Army!" (Stix, 2011).

The resiliency program focuses on training involving techniques such as mental reframing used by cognitive-behavior psychologist to get patients to review thoughts in a more positive light (Stix, 2011). Evaluations of the programs through at least 21 controlled studies in 2,400 children ages eight to 15 showed success in preventing depression an anxiety. Now the U.S. Army is jumping on board and is offering to their Active duty forces and their families what is being labeled, "the largest deliberate psychological intervention" ever attempted. The \$125 million five year program already has 800,000 soldiers working with an online "global assessment tool" and taking courses to enhance "fitness" in various aspects of emotional resilience. U.S. Army Reserve

soldiers have access to the GAT but the courses to enhance “fitness” in various aspects of emotional resiliency are not available to Reserve soldiers. U.S. Army Reserve soldiers have faced numerous deployments since the beginning of the Global War on Terrorism in 2001. U.S. Army Reserve soldiers need education and training on resiliency just as our active duty forces receive. Reserve soldiers need to have access to resiliency training and be aware of local resources for their mental health care and treatment after returning from deployments.

PTSD Care and Treatment Available
to Reserve Soldiers Currently in the
United States and the State of Montana

Studies to date suggest that 10-18% of combat troops serving in OEF/OIF have probable PTSD following deployment, and the prevalence does not diminish over time (Litz, 2009). Consistent with a wealth of prior research, there is a strong association between the cumulative burdens of combat and operational stressors and probable PTSD. Of note, National Guard and Reservists soldiers may be especially at risk over time due to the challenges faced with integrating back into society and civilian careers vs. the Active duty forces.

The earliest OEF/OIF studies were cross-sectional in design. Hoge et al. (2004) conducted anonymous assessments of multiple convenience samples of Army and Marine Corps combat troops one week prior to deployment and approximately four months post-deployment. Using the PTSD Checklist (PCL), Hoge et al. (2004) estimated the prevalence of probable PTSD to be 9% at pre-deployment, with post-deployment rates of

12% and 18% for OEF and OIF troops respectively. Schell and Marshall (2008) conducted a random-digit telephone survey of formerly deployed OEF/ OIF active-duty and reserve/guard personnel from all service branches (>60% had deployed 18-36 months prior) at a convenience sample of sites across the country. Using the PCL, the probable PTSD prevalence was 14%. Deployment length and degree of combat exposure were associated with probable PTSD risk (the rate for participants with no exposure was 1.5%), but time since last deployment was not. Longitudinal studies began appearing later than cross-sectional studies. Milliken et al. (2007) compared Army screening surveillance data for a large convenience sample collected in the month before redeployment with screening data collected 4-10 months post-deployment. Probable PTSD prevalence for active-duty soldiers increased from 11.8% to 16.7%, and for Reservists and National Guard members from 12.7% to 24.5%. Higher probable PTSD prevalence among Reserve/Guard members has been found in other U.S. service branches (Schell & Marshall, 2008; Smith, Ryan, et al., 2008), and among United Kingdom (UK) troops (Browne et al., 2007; Hotopf et al., 2006), and is particularly noteworthy because approximately 40% of U.S. OEF/OIF troops are Guard or Reserve. Bliese et al. (2007) screened a smaller convenience cohort of redeployed soldiers within 7 days of redeployment and again 120 days later, using the PCL. The rates of probable PTSD climbed from 3% to 8% between the two assessments. Smith, Ryan, et al. (2008) reported findings for more than 50,000 service members from all branches in the *Millennium Cohort Study* who were assessed at enrollment and 3 years later, nearly 12,000 of whom were deployed to OIF/OEF for the first time after the baseline assess-

ment. They found probable PTSD incidence (new onset) rates of 8.7% among deployed service members who reported combat exposure.

These statistics are staggering. Evidence based research shows that Reserve soldiers are at an increased risk for PTSD. Reserve soldiers need to have access to mental health care not only nationally but statewide. U.S. Army Reserve soldiers need to be able to access mental health and medical care related to their PTSD diagnosis.

The Department of Veteran Affairs has clinics throughout the state of Montana. These clinics are located in Helena at Fort Harrison, outpatient clinics in Hamilton, Havre and Plentywood and Community based outpatient clinics in Anaconda, Billings, Bozeman, Cut Bank, Glasgow, Glendive, Great Falls, Kalispell, Lewiston, Libby, Miles City and Missoula.

Soldiers need to meet criteria to be eligible for VA healthcare. This criterion is: if you served in the active military, naval or air service and are separated under any condition other than dishonorable, you may qualify for VA health care benefits. If the soldier served on active duty in a theater of combat operations after November 11, 1998, they may be eligible for an extended period of free VA health care benefits.

If the soldier has not been on active duty and does not meet the criteria for the Department of Veteran Affairs health care they are eligible to utilize Military One Source (<http://www.militaryonesource.mil>). This Department of Defense program establishes a “one stop” place to go for soldiers whenever they or their family members need assistance with any kind of problem. Military Once Source is available 24 hours a day, seven days a week, 365 days a year. It is a great augmentation to the family service

currently available on military installations. It is readily available to National Guard and Army Reserve soldiers via an 800 number. The services include everything from common, everyday difficulties that might face a family to life's most complicated situations.

When a soldier calls Military One Source for help, the person answering the phone has at least a master's degree in social work or a degree in counseling service. The person is trained specifically to deal with military issues -- issues that complicate military life. So they're very sensitive to what the soldier asks. The voice on the other end doesn't make judgments about situations. They are there to listen to what the soldier has to say, evaluate it, and give you the beginnings of an answer or actually the answer to your question.

Military One Source runs the gamut of situations: from needing a plumber in the middle of the night to fix a broken pipe, to needing veterinary service for a sick dog. It also handles things like helping families new to an area find childcare, or information about the school system, summer jobs – whatever is needed.

They also have a very detailed counseling service available to all soldiers. The soldier has the option to see a counselor in person or they can also participate in group counseling sessions via “Tele-health.”

Soldiers shouldn't be afraid or embarrassed to seek help from Military One Source. Soldiers are still apprehensive to ask for help. Military One Source tries to convince people that the person at the other end of the phone isn't going to be judgmental about their situation.

Word of mouth is the best way to get the word out about Military One Source within a unit. Soldiers need to be educated that asking for help isn't a sign of weakness; it's it is a sign of smartness

(<http://usmilitary.about.com/od/familydomestic/a/onesource.htm>).

CHAPTER 3

METHODOLOGY

Project Design

The purpose of this project was to develop an educational program in resiliency training for US Army Reserve soldiers. The desired outcome was to increase awareness and education of resiliency in men and women at risk for Post-Traumatic Stress Disorder (PTSD). The program was based on a comprehensive literature review and input gathered from a PTSD knowledge test provided to 145 US Army Reserve soldiers at the 4225th US Army Hospital in Helena, MT.

US Army Reserve soldiers have minimal exposure to the US Army Comprehensive Soldier Fitness Program (CSF). The CSF is a preventive program that seeks to enhance psychological resiliency among all members of the Army community, which include soldiers, family members, and Department of the Army civilians (Casey, 2011). It is not a medical treatment program but CSF helps those service members who are psychologically healthy face life's adversities – including combat and prolonged separation from loved ones – by providing evidence-based training (Casey, 2011).

Target Population

The target population was US Army Reserve soldiers who are currently attending monthly Battle Training Assemblies at Fort Harrison in Helena, MT with the 4225th US Army Hospital. The US Army Reserve soldiers vary in terms of time in service as a

Reserve soldier. Approximately 1/3 of the soldiers have been in a US Army Reserve status for 6 month or less, another 1/3 for 1 to 10 years and the remaining 1/3 from 10 years to 30 years in service.

The target population consisted of approximately 145 US Army Reserve soldiers who have been deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom and soldiers who had not been deployed, or new recruits. There is an equal mix between the soldiers who have not been deployed and new recruits. Approximately 1/4 of the soldiers had been deployed more than once and the remaining 3/4 had not been deployed. Unfortunately the 4225th USAH has had a number of soldiers impacted by PTSD. Of the 145 soldiers within the unit, approximately 25 soldiers have been diagnosed with PTSD, as shown in Figure 1.

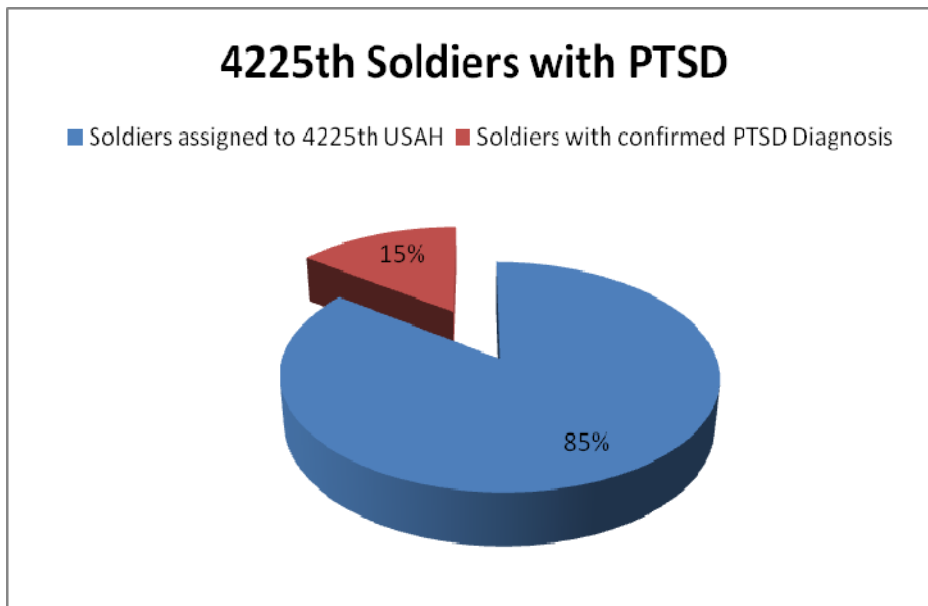


Figure 1. 4225th Soldiers with PTSD.

There could be more, but soldiers are not required to disclose to their leadership if they have been diagnosed or treated for PTSD. These US Army Reserve soldiers were chosen as the target population due to their exposure to combat and also that as a Reserve unit these soldiers are not deployed as a unit and are “cross-leveled” into other units. The 4225th USAH is considered a “back fill” unit. This means soldiers can be chosen individually to deploy with a unit and have had no prior interaction with this unit or the soldiers within the unit before deployment. This is a stressful event and when combined with going to a combat zone with unfamiliar soldiers, increases the need for resiliency education and awareness.

Setting

The setting for the educational program was Ft. Harrison in Helena, MT. The National Guard/Army Reserve post has a large facility located on Ft Harrison. Helena, MT is centrally located for the 4225th US Army Hospital soldiers and is their required monthly meeting facility for their Battle Training Assemblies.

The presentation was in an auditorium with a large screen. The lighting was at a level to ensure the participants were able to see the visual aids effectively. The temperature was set appropriately for learning and the participants were able to participate efficiently.

Pre-Test-Assessment

Content for the educational presentation was based on a comprehensive literature review, knowledge pre-test regarding PTSD and the author’s experience as a US Army

Reserve Company Commander. The author met with US Army Reserve leaders from the 4225th US Army Hospital to get an overview of where the key leaders felt the soldier's needs were regarding PTSD education and resiliency awareness. The key leaders included the Battalion Commander and the Executive Officer, both at the rank of "Major" who have been in the 4225th USAH over 10 years.

The author conducted a formal assessment of the knowledge of PTSD of US Army Reserve soldiers in the 4225th US Army Hospital prior to planning and developing the one hour educational presentation. The knowledge pre-test was developed by the author and evaluated by her committee chair Dr. Kathleen Schachman and the leadership of the 4225th US Army Hospital. The evaluators felt the pre-test was appropriate and were anxious to review the results of it to determine the educational needs of the US Army Reserve soldier in the 4225th US Army Hospital. The author researched prior PTSD knowledge tests and developed an 11 question multiple choice test to gauge the level of knowledge the soldiers had regarding PTSD (Appendix A).

The 4225th US Army Hospital has 145 soldiers assigned to the unit manning roster. There are soldiers who are not there consistently every month and other soldiers who perform their Battle Training Assembly in other locations. In November 2011 there were 75 PTSD Knowledge Pre-Test questionnaires handed out, 30 questionnaires were returned (40% response). The results of the PTSD Knowledge Test questionnaires were as follows in Figure 2:

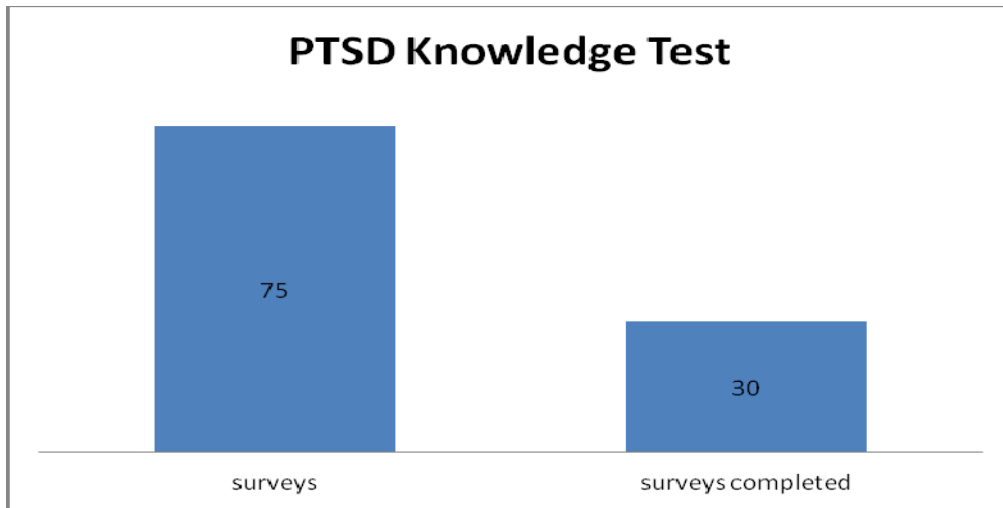


Figure 2. PTSD Knowledge Test – Handed out and Completed.

Findings from the PTSD knowledge pre-test revealed that the soldiers of the 4225th US Army Hospital had good baseline knowledge of PTSD with all of the soldiers (n=30) responding correctly to the 11 questions, as seen in Figure 3 below:

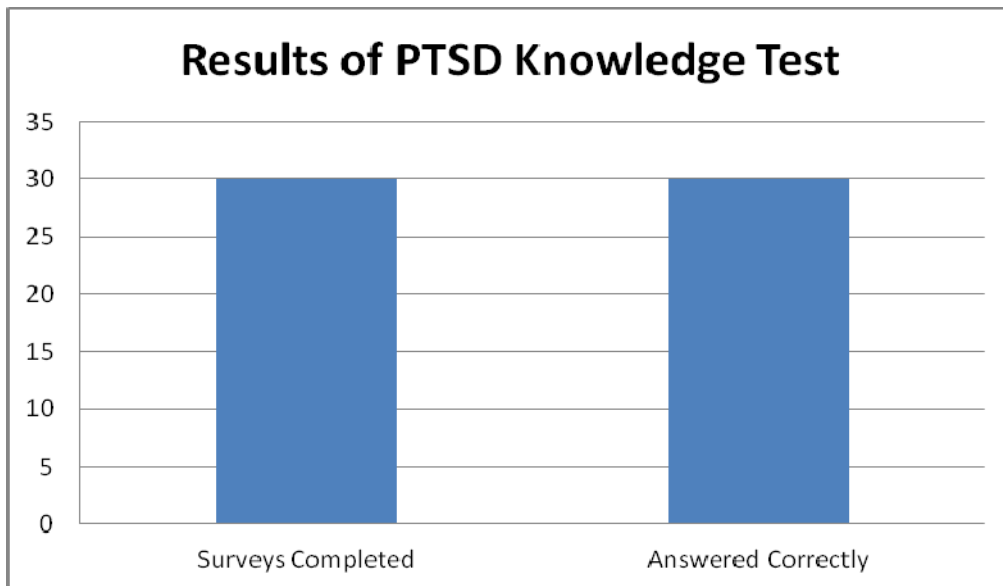


Figure 3. Results of PTSD Knowledge Test.

The leadership reviewed the results of the questionnaire and suggested that although there was good baseline knowledge of PTSD, the need is there for awareness and education on how to avoid or diminish PTSD through resiliency. This comes with resiliency education and awareness. The commander of the 4225th USAH requested an educational program on resiliency training to educate their soldiers on concepts of self-growth and positive psychology and how to effectively deal with exposure to adverse or stressful events, whether it be in the military or civilian life.

The 4225th USAH leadership felt that resiliency-building skills would be a great educational presentation and one that could be utilized effectively by the soldiers. The Battalion Commander and the Executive Officer felt there should be a brief overview of the appropriate, *DSM-IVTR* PTSD definition and PTSD risk factors and the majority of the educational presentation be focused on resiliency training, a practical exercise regarding the Activation, Thought and Consequences model (ATC) and community resources available to the US Army Reserve soldiers.

Development of Presentation

Content

The author selected evidence-based content suitable for US Army Reserve soldiers from the comprehensive literature review, the National Center for PTSD and the resiliency workbook developed by Dr. Karen Reivich from the University of Pennsylvania (Reivich, 2009).

A teaching plan (Appendix D) was developed, based upon 5 learning objectives. Teaching strategies were identified for each objective, along with evaluation criteria to determine if each objective was met. The purpose of the educational program was to provide the soldier with awareness of Resiliency and go through a practical hands-on exercise regarding the Activating, Thought and Consequences (ATC) sequence of resiliency.

The goal was to establish awareness of resiliency so soldiers of the 4225th USAH when faced with adversity or stressful events are able to refer to the handouts and information to assist them. The objectives of the education presentation were included in the Power Point Presentation (Appendix B). The educational project consisted of a Power Point presentation that highlighted the learning objectives. Following the 1 hour educational presentation the soldier will be able to:

- List the criteria for PTSD diagnosis and risk factors for PTSD.
- Identify 3 resiliency skills for exposure to adversity or stressful events
- Identification of the 3 components of the ATC principle
- Identification of the components of the Resiliency pyramid
- Provide resources for PTSD support for US Army Reserve Soldiers

Information for the presentation was obtained from the Comprehensive Soldier Fitness Handbook and Resiliency Training workbook for US Army active duty soldiers.

Content Outline

The content outline for the educational presentation included review of an updated and current definition of PTSD and the criteria for the diagnosis and risk factors

for PTSD. The author reviewed the definition from the Diagnostic Statistical Manual-IV-TR 2011 and discussed the six factors that need to be present for an appropriate diagnosis of PTSD and the 8 risk factors that pre-dispose soldiers to PTSD. The resiliency skills were reviewed in relation to the Resiliency pyramid. This content was presented in a Power Point model with visual aids and auditory instruction. The soldiers were given a hand-out of the resiliency pyramid (Appendix C).

Delivery of the Educational Program

Once assembled in the auditorium, a 30-minute Power Point presentation was delivered. Soldiers were given handouts that corresponded to the Power Point slide of the Resiliency Pyramid and pencils in case they wanted to make notes on the handout. At the completion of the Power Point presentation, a practical exercise was completed relating to the “ATC” principles and the presentation concluded with a 15-minute question/answer session.

An activating event, the “A” component was described to the soldiers. They were told that a fictional tactical non-commissioned officer, yelled at them after they placed their weapon on the ground to perform a detainee search at the training lane. The soldiers were then asked what their thoughts were when the non-commissioned officer yelled at them and what they said to themselves in the heat of the moment. This is the “T” component when the non-commissioned officer was shouting at them. They were instructed to write down these thoughts. The soldiers were then asked to reflect and share their “ER” or emotions and reaction to their thoughts, which is the “C” component of the ATC principle, the Consequences. The author then asked them to identify what the

thinking traps were of their thoughts. The soldiers were asked to determine if the thoughts were negative and if so, why?

The process of avoiding thinking traps was presented along with how to avoid jumping to conclusions. The group then discussed strategies to slow down their thinking traps. They reviewed examining their thoughts to support their conclusions and if the soldiers expressed themselves clearly. If there was confusion the author and the soldiers discussed where they should have provided more information or spoke up to receive clarification of the issue from the non-commissioned officer.

Following the hands-on practical exercise a question answer period ensued. During this time, participants shared their experiences about PTSD or resiliency. At the conclusion of the education presentation, participants were instructed to complete and return the evaluation form without placing their name on the form. There was opportunity for individuals to meet with the present after the educational presentation to answer personal questions or issues regarding PTSD or resiliency training.

Evaluation of the Educational Program

At the completion of the educational program the participants were given a 5-question evaluation form of the PTSD and Resiliency presentation. The anonymous form was submitted to a drop box by the soldiers after the presentation. The evaluation was broken down with columns where the soldier was to mark strongly agree, agree, disagree and strongly disagree in response to five questions regarding the presentation (Appendix E). The first question asked if the information that was provided was important and useful to them as a soldier and civilian. The second question asked if the presentation

provided helpful information and practical resources. Question three asked if the soldiers understood how to implement the Resiliency pyramid. The fourth question asked if the presentation enabled the soldier to be more effective as a soldier. The final question asked if the soldiers would recommend this presentation to other soldiers and their families.

Resources

Adult learners effectively learn in three ways, visually, auditory and psychomotor. LeCroy (2009) and Russell (2006) identified adult learning styles and how most adults learn and retain information with visual aids, such as graphs and power point slides and also through auditory instruction and psychomotor learning, such as hands on exercises. Adults who can hear the information being presented and visualize the information retain it longer and learn the information more efficiently. The visual and auditory approach was utilized in that soldiers are familiar with this style of teaching and able to receive the information appropriately.

The application of Malcolm Knowles (1980) self-directed learning principle was used to garner individual participants' questions about PTSD or resiliency and to foster dialogue. In its broadest meaning, ['self-directed learning'](#) describes, according to **Malcolm Knowles (1975: 18)** a process:

in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes.

The soldiers of the 4225th USAH utilized the self-directed learning principle by writing down notes throughout the presentation and inquiring about additional

information regarding PTSD resiliency. Their initiative to go beyond the Power Point presentation allowed for a thoughtful period of discussion and reflection.

Nola J. Pender, PhD, RN, FAAN nursing theorist who developed the health promotion model designed the model to be a “complementary counterpart to models of health protection” (http://nursingplanet.com/health_promotion_model.html). The educational presentation regarding resiliency was developed to raise awareness of the importance of instilling positive psychology to assist soldiers through stressful or adverse events. By utilizing Nola J. Penders health promotion model the educational presentation was able to mirror health protection principles of resiliency and promote positive health decisions.

The practical exercise regarding the ATC principle is an excellent example of health protection. Each soldier has unique personal characteristics and experiences that affect subsequent actions (http://nursingplanet.com/health_promotion_model.html) such as the scenario that was presented regarding SFC Smith and the hand on practical exercise. The ATC principle is a great example of the health promotion model.

Institutional Review Board Approval

The Institutional Review Board for the Protection of Human Subjects at Montana State University did not review this project. In that this was research conducted in an established or commonly accepted educational setting involving normal educational practices approval from the IRB was not obtained (<http://www2.montana.edu/irb/applic.html>) the educational program was exempt from IRB approval.

The knowledge test regarding PTSD and the evaluation form were voluntarily submitted and received. There was no coercion for participating or reward for being present for the educational presentation. Soldiers were given the knowledge test and evaluation form and told they could voluntarily return them to a drop box that the author could review. There were no ramifications if the forms were not submitted.

CHAPTER 4

PROJECT OUTCOME

Demographic Characteristics

The educational presentation was attended by 75 soldiers from the 4225th USAH. The soldier's attendance was voluntary and not a mandatory training event. The 75 personnel included 55 enlisted soldiers. Of the 55 enlisted soldiers 25 were Non-Commissioned Officers and 30 were ranks of Privates thru Specialists. As seen in Table 4; twenty of the participants were Officers, of the 20, ten were of the rank of Lieutenants through Captains and ten were of the rank of Major through Colonel.

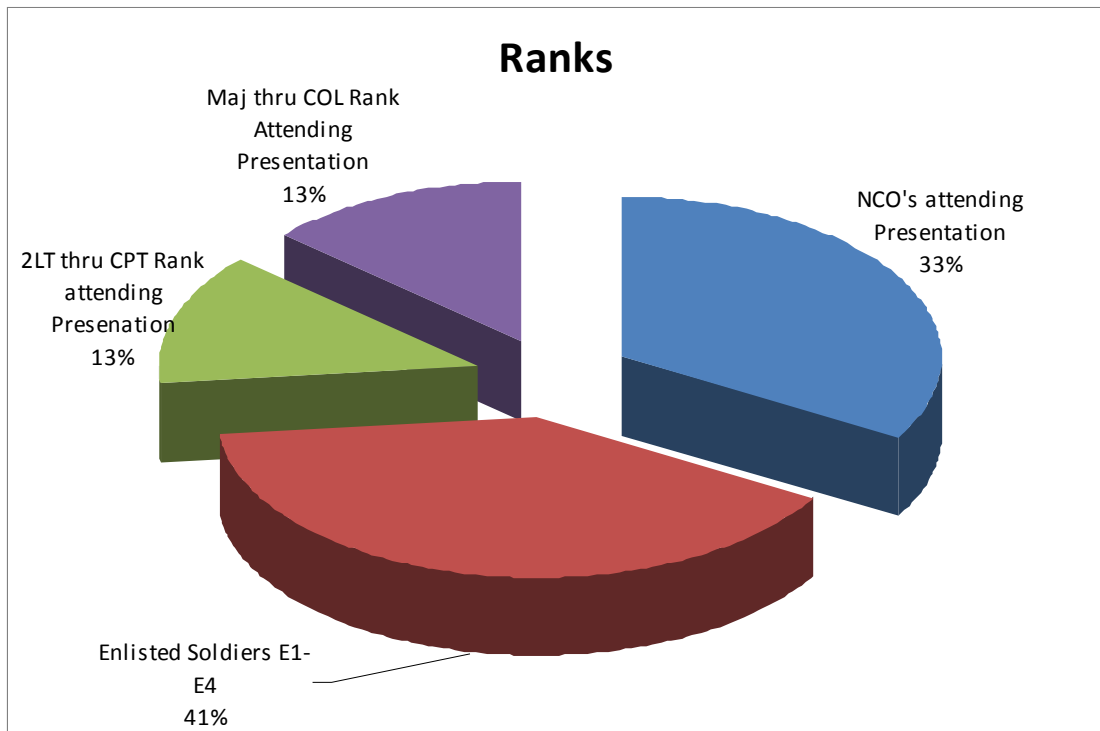


Figure 4. Rank Structure of Attendees.

The vast majority of participants resided in Montana with 60% from the western part of the state. There were 5 soldiers who drove from the Seattle, Washington area to attend monthly Battle Training Assembly with the 4225th US Army Hospital.

The soldiers were equally distributed between those who had been deployed to Iraq or Afghanistan and soldiers who had been deployed stateside in support of the Global War on Terrorism. There were 39 soldiers who had gone to Iraq or Afghanistan and the remaining 36 soldiers had been mobilized in support of the Global War on Terrorism and had mobilizations occur in the United States, such as Ft. Lewis Washington, Ft. Leavenworth Kansas and Fort Sam Houston in San Antonio, TX.

Evaluation of the Educational Program

The educational presentation was evaluated by the soldiers using a five question evaluation form (Appendix E). The results of the evaluation regarding PTSD and Resiliency education program are as follows:

Question 1. *The information that was provided was important and useful to me as a soldier and civilian.* 70 soldiers strongly agreed the information that was provided was important and useful to them as a soldier and civilian, 5 soldiers agree.

Question 2. *The presentation provided helpful information and practical resources.* 55 soldiers answered they strongly agreed with question two and 20 agreed.

Question 3. *I understand how to implement the “Resiliency Pyramid.”* 35 soldiers responded they strongly agreed, 25 agreed and 15 disagreed.

Question 4. *The presentation enables me to be more effective as a soldier.* 70 soldiers responded with strongly agreeing and 5 agreed.

Question 5. *I would recommend this presentation to other soldiers and their families.* 70 soldiers strongly agreed and 5 soldiers agreed.

Breakdown of responses to post-evaluation form, Figure 5:

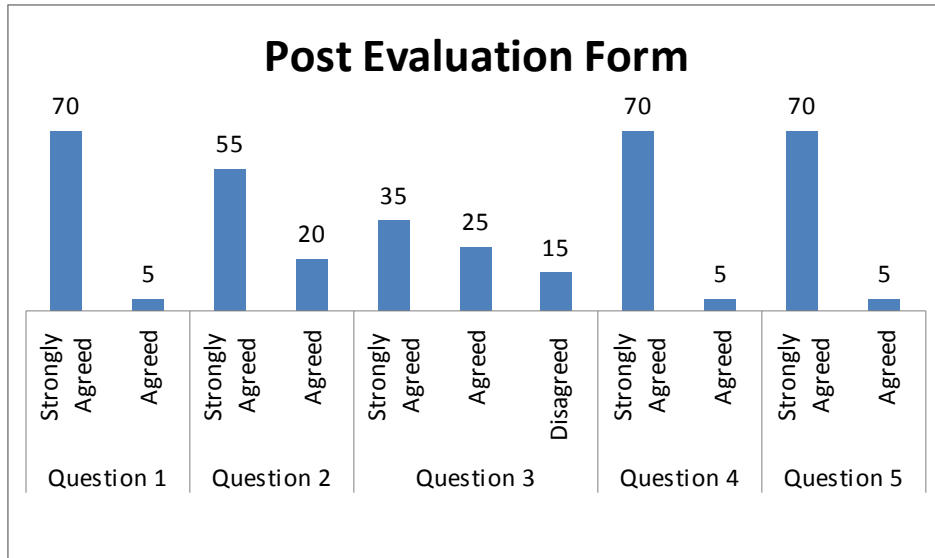


Figure 5. Breakdown of Responses to Post-Evaluation Form.

Following the soldier's evaluation form discussion ensued regarding resiliency education. A soldier inquired about additional training regarding resiliency. The soldiers were very interested in learning more about resiliency and how to apply it to their everyday life as soldiers and civilians. The author was able to provide references to the National PTSD site and the Comprehensive Soldier Fitness website for the soldiers. The author also discussed communicating with the 4225th USAH leadership to incorporate additional resiliency training into their yearly training calendars.

It is important for nurses to use teaching and learning principles when developing educational program objectives.

The five teaching objectives for the educational program were to:

- List the criteria for PTSD diagnosis and risk factors for PTSD.
- Identify 3 resiliency skills for exposure to adversity or stressful events
- Identification of the 3 components of the ATC principle
- Identification of the components of the Resiliency pyramid
- Resources for PTSD support for US Army Reserve Soldiers

Overall the soldiers felt the presentation was helpful and strongly agreed that the objectives identified in the educational program were helpful for them for initial resiliency training and awareness. The soldiers of the 4225th USAH felt the information presented was presented in an organized format and at an interpretable level for the soldiers.

CHAPTER 5

REFLECTIONS

Lessons Learned

The one hour educational presentation offered general information about PTSD and Resiliency awareness and training. Topics discussed during the education presentation were: criteria for PTSD, diagnosis and risk factors for PTSD, resiliency skills for exposure to adversity or stressful events, identification of the 3 components of the ATC principle, identification of the components of the Resiliency pyramid and resources for PTSD support for US Army Reserve soldiers. The author noted that the educational presentation was not an appropriate venue for addressing the various personal impact participants were presently dealing with regarding PTSD or in regards to someone they knew with PTSD. The critical lesson learned by the author was that all 75 participants have been affected by PTSD, either themselves or someone they knew.

The second key lesson learned was each objective should have been evaluated to ensure the objectives were met and achieved. In retrospect each objective should have been identified and a test given to measure the achievement of each objective. The objectives were covered but a knowledge test of these objectives was not give after the educational presentation.

The third lesson learned by the author was that the education presentation covered some information but not in a thorough manner as the soldiers needed. For example, the author addressed the Resiliency pyramid and a handout was provided of this pyramid.

There should have been more time spent on the components of the Resiliency pyramid and how these components can be applied to everyday life as a soldier or a civilian.

In reviewing back over Nola J. Pender, PhD, RN, FAAN nursing theorist who developed the health promotion model design instilling positive psychology in soldiers to assist them thru stressful or adverse events mirrors her theory. The goal of the presentation was to instill health protection principles of resiliency and promote positive health decisions. To ensure this was accomplished the author should have focused the post-presentation evaluation on the achievement of the learning objectives. The author focused on the presentation itself vs. the achievement of the learning objectives.

The pre-test would have been more consistent if it was conducted on the same group of soldiers who attended the presentation, There were soldiers who completed the pre-test and were not present for the presentation. This inconsistency did not help achieve continuity of information from who received the actual presentation as to who completed the PTSD Knowledge test.

Resiliency is an important component of preparing soldiers for battle. Developing psychologically resilient soldiers, family members and Army civilians is an important component of changing the Army culture – from a culture in which behavioral health was once stigmatized to a culture in which psychological fitness is recognized as every bit as important as physical fitness (Casey, 2011). The U.S. Army is focused on bringing Resiliency training to their troops. Unfortunately US Army Reserve soldiers are the last to essential training such as this and the importance of having a consistent Resiliency training program is important to the success of our soldiers. The Army exists to protect

this country. Our soldiers, family members, and Army civilians have never failed to answer our nation's call during a time of need. The Army needs to recognize they need to do more to prepare the forces for the psychological demands that come with fighting a protracted, decades-long conflict. Resiliency training will do that – to better prepare our Army community to help protect America in a complex and uncertain future!

REFERENCES

- Atkinson, Michael P., Guetz, Adam, Wein, Lawrence. A Dynamic Model for PTSD Among U.S. Troops in Operation Iraqi Freedom. *Management Science*, 2009; 55. 1454-1468.
- Bliese, P.D., Wright, K.M., Adler, A.B., Thomas, J.L., & Hoge, C.W. (2007). Timing of Post Combat Mental Health Assessments. *Psychological Services*, 4, 141-148.
- Browne, T., Hull, L., L., Horn, O., Jones, M., Murphy, D., Fear, N.T., et al. (2007) Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *British Journal of Psychiatry*, 190, 484-489.
- Casey, George W. Jr., *Comprehensive Soldier Fitness: A Vision for Psychological Resilience in the U.S. Army*. *American Psychologist*. Vol. 66, No. 1; January 2011, 1-3.
- Elmore, Diane L., Van Dyk, Kathleen M. Warrior Suicides: APA testifies on the most effective ways to prevent an escalation problem. *American Psychological Association*. May 2010, vol. 41, No. 5, 20-25.
- Encyclopedia of Mental Health Disorders (2012). Definition of Post Traumatic Stress Disorder. Retrieved from <http://www.minddisorders.com/Ob-Ps/Post-traumatic-stress-disorder.html>.
- Frueh, Christopher, Grubaugh, Anouk, Elhai, Jon, Buckley, Todd. US Department of Veterans Affairs Disability Policies for Posttraumatic Stress Disorder: Administrative Trends and Implications for Treatment, Rehabilitation, and Research. *American Journal of Public Health*. Vol 97, December 2007, no. 12, 2143-2145.
- Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13-22.
- Hotopf, M. Hull, L., Fear, N.T., Browne, T., Horn, O., Iversen, A., et al. (2006). The health of UK military personnel who deployed to the 2003 Iraq War; A cohort study. *Lancet*, 367, 1731-1741.
- Knowles, M.S. (1980). *The modern practice of adult education from pedagogy to andragogy*. Englewood Cliffs: Prentice Hall Cambridge.
- Langille, Jane (2011). *Army's Comprehensive Soldier Fitness Program Builds Resiliency*. Retrieved from <http://www.healthymagination.com/blog/army>.

- LeCroy, C. (2009). Incontinence patient education: Strategies to enhance the teachable moment. *Urologic Nursing*, 29(3), 155-156, 176.
- Litz, Brett T., Schlenger William, E. PTSD in Service Members and New Veterans of the Iraq and Afghanistan Wars: A bibliography and critique. *PTSD Research Quarterly*. Vol 20, no. 1, Winter 2009, 1-3.
- Masten A.S., & Reed, M.G.J. (2001). Resilience processes in development. *American Psychologist*, 56, 227-238.
- Masten, A.S. & Reed, M.G. J. (2002). Resilience in development. In C.R. Snyder & S.J. Lopez (Eds.), *Handbook of positive psychology* (pp. 74-88). New York, NY: Oxford University Press.
- Military One Source (2009). Health and Relationships. Retrieved from <http://www.militaryonesource.mil>.
- Military One Source (2009). Domestic Violence, PTSD. Retrieved from <http://usmilitary.about.com/od/familydomestic/a/oncesource.htm>
- Milliken, C.S., Auchterlonie, J.L., & Hoge, C.W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. *Journal of the American Medical Association*, 298, 2141-2148.
- National Center for Post Traumatic Stress Disorder (2011). What is PTSD? Retrieved from <http://www.ptsd.va.gov/professional/newsletters/ptsd-rq.asp>.
- National Council on Disability (2009). Invisible Wounds: Serving Service Member and Veterans with PTSD and TBI. Retrieved from <http://www.tbiwashington.org/professionals/documents/veterans.doc>
- Nursing Theories (2012). Nursing Theories: The Health Promotion Model. Retrieved from http://nursingplanet.com/health_promotion_model.html.
- Reivich, Karen J. Resilience Training. *Comprehensive Soldier Fitness*. Copyright 2009. 1-50.
- Reivich, Karen J., Seligman, Martin, E.P., McBride, Sharon. Master Resilience Training in the U.S. Army. *American Psychologist*, jan 2011, vol. 66, No. 1, 25-34.
- Russell, S.S. (2006). An overview of adult-learning process. *Urologic Nursing*, 26(5), 349-352, 370.

Schell, T. L., & Marshall, G. N. (2008). Survey of individuals previously deployed for OEF/OIF. In T. Tanielian and L.H. Jaycox (Eds.), *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Center for Military Health Policy Research, 87-115.

Seligman, Martin E. P., Schulman, Peter, Tryon, Alyssa M., Group Prevention of Depression and Anxiety Symptoms. Retrieved from <http://www.ppc.sas.upenn.edu/depprevseligman2007.pdf>

Smith, T. C., Ryan, M.A.K., Wingard, D.L., Slymen, D.J., Sallis, J.F., Kritz-Silverstein, D., et al. (2008). New onset and persistent symptoms of post-traumatic stress disorder self reported after deployment and combat exposures: Prospective population based US military cohort study. *British Medical Journal*, 336, 366-371.

Stix, Gary. Basic Resilience Training. February 15, 2011. Retrieved from <http://www.scientificamerican.com/article>.

APPENDICES

APPENDIX A

PTSD KNOWLEDGE TEST

PTSD Knowledge Test

Please write the **letter** of the correct answer on the line provided.

- _____ 1. PTSD stands for _____.
- a. Posttraumatic Stress Injury
 - b. Post-Trauma Systems Design
 - c. Posttraumatic Stress Disorder
 - d. Post-Time Stress Display
- _____ 2. Which of the following events can cause the development of PTSD?
- a. A natural disaster
 - b. Child sexual or physical abuse
 - c. Combat or military exposure
 - d. All of the above
- _____ 3. Which of the following is **not** a symptom typical of PTSD?
- a. Numbing
 - b. Forgetting about the event
 - c. Avoidance
 - d. Depression
- _____ 4. PTSD can cause symptoms in the following areas
- a. Physical
 - b. Emotional
 - c. Substance Abuse
 - d. All of the above
- _____ 5. Which of the following can happen when someone takes too much responsibility for a traumatic event?
- a. Self-blame
 - b. Guilt
 - c. Shame
 - d. All of the above
- _____ 6. Which of the following is **not** an example of re-experiencing the traumatic event?
- a. Flashbacks
 - b. Nightmares
 - c. Watching a war-themed movie
 - d. Feelings of intense distress
- _____ 7. Which of the following is an example of problems people with PTSD may have?
- a. Drinking or drug problems
 - b. Relationship problems including divorce and violence
 - c. Suicidal thoughts
 - d. All of the above

_____ 8. Who can develop PTSD?

- a. Men
- b. Women
- c. Children
- d. Men and Women
- e. Anyone

_____ 9. Which of the following is an example of who people should **not** talk to for help if they experience symptoms of PTSD?

- a. Friends and family members
- b. Counselors
- c. Children
- d. Doctors

_____ 10. People suffering from PTSD should expect treatment to _____.

- a. immediately cure the PTSD-related symptoms
- b. stop all memories of the traumatic event
- c. last only a couple days
- d. none of the above

11. Please provide what services you are aware of that assist U.S. Army Reserve soldiers and their families if they need assistance with PTSD.

APPENDIX B

AWARENESS AND RESILIENCY TRAINING

PTSD AWARENESS AND RESILIENCY TRAINING

Char Richardson, BSN, RN
Montana State University
Family Nurse Practitioner Graduate
Student



Learning Objectives

- Identify criteria for PTSD diagnosis
- Identify 3 resiliency skills for exposure to adversity or a challenge
- Name 3 components of the ATC principle
- Identify the components of the resiliency pyramid
- Identify resources for PTSD Support

Overview

- Diagnostic criteria
- PTSD Data
- Review of risk factors
- Resiliency
 - Activating Event
 - Thoughts
 - Consequences
- Resiliency Pyramid
 - ATC
 - Avoid Thinking Traps
 - Detect Icebergs
 - Energy Management
 - Problem Solving
 - Put it in Perspective
 - Real-time Resiliency Support Groups/Resources

Diagnostic Criteria

- PTSD: The Diagnostic & Statistical Manual for Mental Health Disorders Identifies 6 criteria for the identification of PTSD. They are:
 - Criteria A: Stressor
 - Criteria B: Intrusive Recollection
 - Criteria C: Avoidant/Numbing
 - Criteria D: Hyper-arousal
 - Criteria E: Duration
 - Criteria F: Functional Significance

Recent Dept of VA Trends regarding PTSD

- From 1999 to 2004, the number of veterans receiving disability payments for PTSD increased 79.5% (from 120,265 to 215,871), whereas those receiving payments for other disabilities increased on 12.2%
- From 1999 to 2004, total PTSD disability payments rose 148.8% to \$4.3 billion annually (Frueh, pg. 2143)

Risk Factors for PTSD

- Being female
- Experiencing intense or long-lasting trauma
- Having experienced other trauma earlier in life
- Having other mental health problems, such as anxiety or depression
- Lacking a good support system of family and friends
- Having first-degree relatives with mental health problems, including PTSD
- Having first-degree relatives with depression
- Having been abused or neglected as a child

RESILIENCY

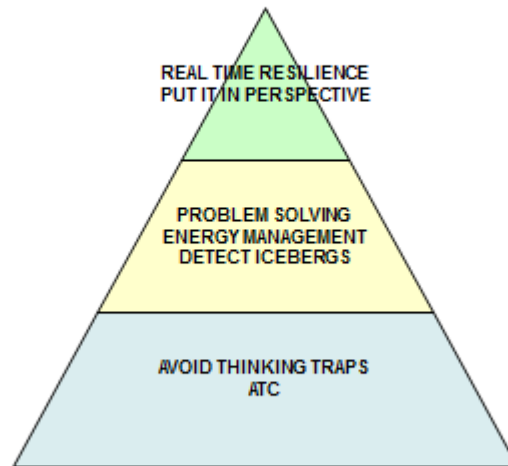
Definition:

The ability to grow and thrive in
the face of challenges and bounce
back from adversity

(Reivich, 2009)




RESILIENCY PYRAMID



ATC PRINCIPLE

- **Activating Event**
 - A trigger; a challenge, adversity or positive event
- **Thoughts**
 - Your interpretations of the Activating Event; what you say to yourself
- **Consequences: ER**
 - E: Emotions
 - R: Reactions – in order to understand your reactions to a situation

AVOID THINKING TRAPS

- Identify and Correct 
 - Counterproductive patterns in thinking through the use of Critical Questions
- **CRITICAL QUESTIONS**
- **Jumping to Conclusions: Slow Down:**
 - What is the evidence?
- **Mind Reading: Speak Up:**
 - Did I express myself? Did I ask for information?

Critical Questions continued:

- Me, Me, Me: Look outward: How did others and/or circumstances contribute?
- Them, Them, Them: Look inward: How did I contribute?
- Always, Always, Always: Grab control: What's changeable? What can I control?
- Everything, Everything, Everything: Look at behavior: What is the behavior that explains the situation?



DETECT ICEBERGS



- Identify deep beliefs and core values that fuel out-of-proportion emotion and evaluate the accuracy and usefulness of these beliefs.
- Use the “What” questions in any order to help identify the Iceberg Belief:
 - what is the most upsetting part of that for me?
 - what does that mean to me, what is the worst part for me?
 - Assuming that is true, what about that is so upsetting to me?

ENERGY MANAGEMENT

- Regulate emotion and energy levels to enable critical thinking and optimal performance
 - Identify the worst, best and most likely outcomes of a situation in that order and develop a plan for dealing with the most likely outcomes.



Problem Solving

- Accurately identify what caused the problem and identify solution strategies

FIGHT the confirmation Bias: Distance yourself from your thought, ask fair questions, consult with others, and prove your thoughts false.



Put It In Perspective

- Stop catastrophic thinking, reduce anxiety, and improve problem solving by identifying the Worst, Best, and the Most Likely outcomes of a situation
- Develop a plan for dealing with the most likely outcomes

Real-Time Resilience

- Shut down counterproductive thinking to enable greater concentration and focus on the task at hand
1. Fight Back against counterproductive thoughts by using sentence starters:
 - That's not completely true because
 - A more optimistic way of seeing this is
 - The most likely implication is...and I can...



Army Reserve Support

- Army One Source:
-<http://www.myarmyonesource.com>

Excellent site with links to resources for Army Reserve soldiers and their families



Veterans Affairs Resources

- The Department of Veterans Affairs has resources available to soldiers who have mobilized/deployed.
-<http://www.ptsd.va.gov/professional/web-resources/military-resources.asp>

This site has resources and web pages available for soldiers to access regarding PTSD.

QUESTIONS?????

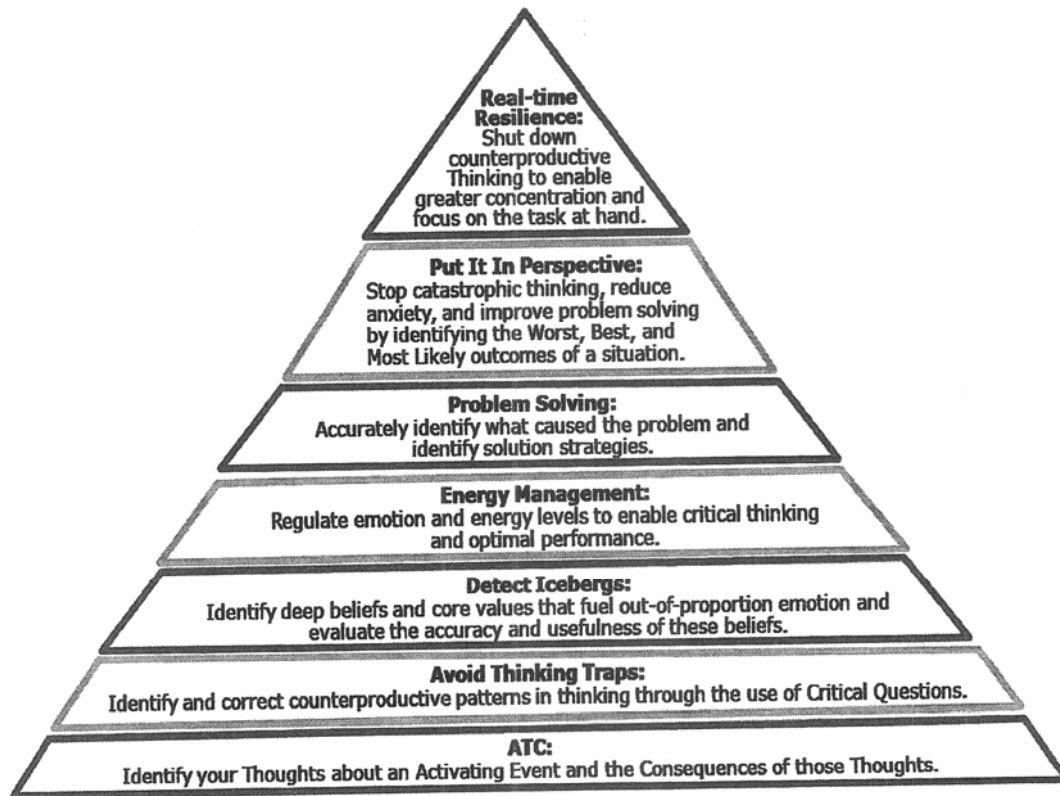
References:

- Frueh, Christopher, Grubaugh, Anouk, Elhai, Jon, Buckley, Todd. US Department of Veterans Affairs Disability Policies for Posttraumatic Stress Disorder: Administrative Trends and Implications For Treatment, Rehabilitation, and Research. *American Journal of Public Health*. Vol 97, December 2007, no. 12, pgs. 2143-2145.
- Reivich, Karen. Resilience Training. *Comprehensive Soldier Fitness*. Copyright 2009. pgs. 1-50.

APPENDIX C

RESILIENCY PYRAMID

Resilience Skills Overview



APPENDIX D

TEACHING PLAN

TEACHING PLAN

PURPOSE:

To provide US Army Reserve soldiers with education and awareness regarding resiliency skills and training.

GOAL:

The soldier will identify of criteria needed for a PTSD diagnosis, identify three resiliency skills, name the three components of the ATC principle, identify components of the resiliency pyramid and identify resources for PTSD support.

OBJECTIVES:

Following a 45-minute teaching session the soldier will:

1. Identify criteria for a PTSD diagnosis
2. Identify three resiliency skills
3. Name three components of the ATC principles
4. Identify components of the resiliency pyramid
5. Identify resources for PTDS support

Conclusions and Discussion

CONTENT OUTLINE:

1. Soldier will need to be able to identify 6 criteria for PTSD diagnosis as per the DSM-IV-TR Manual for Mental Health disorders.
2. Soldier will identify 3 resiliency skills for exposure to adversity or stressful events
3. Identify the three components of the ATC principle
4. Identify the components of the resiliency pyramid
5. Provide resource for PTSD support for US Army Reserve Soldiers

METHOD OF INSTRUCTION

1. The first objective will be addressed with visual and auditory learning approaches. Power point will be utilized and verbal instruction.
2. The second objective will be addressed through visual and auditory learning approaches.
3. The 3 components of the ATC principle are addressed through a hands-on practical exercise the soldiers will perform.
4. The resiliency pyramid components will be addressed with a visual handout and auditory instruction.
5. The resources for PTSD will be presented with auditory instruction and visual handouts.

TIME ALLOTTED:

1. First objective is covered in 5 minutes.
2. Second objective is covered in 10 minutes.
3. Third objective is covered in 15 minutes
4. Fourth objective is covered in 10 minutes.
5. Fifth objective is covered in 5 minutes.

The presentation was 45 minutes.

RESOURCES:

1. Objective 1 the resources utilized were the mental health encyclopedia for the appropriate DSM-IV-TR definition.
2. The Comprehensive Soldier Fitness from the Active Duty US Army was utilized. Dr. Karen Reivich, copy right 2009.
3. Resources for the third objective were utilized from the CSF workbook by Dr. Karen Reivich.
4. The resources for the resiliency pyramid also came from the CSF workbook.
5. The resources for the resources available to our soldiers were web sites regarding Military One Source.

METHOD OF EVALUATION:

1. Discussion and verbalization from soldiers of criteria for PTSD diagnosis.
2. Discussion and verbalization regarding 3 resiliency skills.
3. Observation of return demonstration
4. Observation of return demonstration and verbalization of components of pyramid.
5. Discussion and question answer session regarding resources.

References:

Bastable, Susan B., Third Edition, Nurse as Educator; Principles of Teaching and Learning for Nursing Practice. Retrieved from:
http://books.google.com/books?id=iGzFiIbKh4gC&pg=PA409&source=gbv_selected_pages&cad=3#v=onepage&q&f=false.

APPENDIX E

SOLDIER EVALUATION FORM OF PTSD

SOLDIER EVALUATION FORM OF PTSD/RESILIENCY EDUCATION

Strongly Agree Agree Disagree Strongly Disagree

1. The information that was provided was important and useful to me as a soldier and civilian.

2. The presentation provided helpful information and practical resources.

3. I understand how to implement the "Resiliency Pyramid."

4. The presentation enables me to be more effective as a soldier.

5. I would recommend this presentation to other soldiers and their families.