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An Introduction to the Special Issue on the MHAT-IV

Charles R. Figley

This special issue focuses on an extraordinary report of an extraordinary study. The report, "the Mental Health Advisory Team (MHAT) IV," was released on November 17, 2006, to the Office of the U.S. Army Surgeon General. The study was requested a year earlier. Although it took more than a half a year to be released, it survived considerable scrutiny and challenges from a wide sector. The concerns in some sectors, especially those outside the U.S. Army, were mainly that the report would be viewed as (a) too controversial, (b) calling into question the current policies that require extended and frequent deployments, (c) too obviously linked to deployment with a large array of negative consequences, and (d) causing a public outcry about the toll of the current wars in which American forces were engaged in terms of the troubling mental health consequences for these war fighters and their families now and perhaps for the rest of their lives. But the team, headed by two behavioral psychologists, Carl Castro, PhD, a U.S. army colonel, and Dennis McGurk, PhD, a U.S. army major, answered every concern and prevailed with the argument that it is better for everyone to know the truth in their research findings to better understand the costs of waging war under the current circumstances. The full report has been available since May 2007 at http://www.armymedicine.army.mil/news/mhat/mhat_iv/MHAT_IV_Report_17NOV06.pdf.

The goals of the MHAT-IV (i.e., the report) were to (a) assess soldier and marine mental health and well-being, (b) examine the delivery of behavioral health care in Operation Iraqi Freedom, and (c) provide recommendations for sustaining and improving troop behavioral health to command, that is, the Office of the U.S. Army Surgeon General. The report assessed the mental health of the deployed force from August 28 through October 3, 2006. The results are based on the data from anonymous soldier (N = 1,320) and marine (N = 447) surveys as well as on behavioral health, primary care, and unit ministry team surveys. The report also includes the results of specific focus group interviews with soldiers and marines, as well as interviews and focus groups with army and navy behavioral health personnel. Various secondary sources in addition to the research team's personal observations are also part of the report.

Three articles are published in this special issue that come directly from the report and are, therefore, public domain as is the report itself. They represent the three major elements of the report: (a) the intensity of combat and other stressors of those serving "down range," (b) battlefield ethics, and (c) the results of efforts to prevent suicides there. These articles are followed in the second part of the special issue by five commentaries from experts with knowledge about immediate and long-term psychosocial consequences for war fighters.

The first commentary is written by the leading combat psychiatrist within the U.S. Navy, Robert Koffman, MD, MPH. He served in Iraq when data for the report were being collected and assisted the data collection team. Judith Lyons, PhD, and Karen Grantz, PsyD, are clinical psychologists with different Veteran Affairs Medical Centers (Jackson, Mississippi and Louisville, Kentucky, respectively) and are responsible for the mental health treatment of combatants once they leave active military service. Paula Chapman was formerly with the Florida National Guard and currently serves as a Veteran Affairs researcher and statistician. The final commentary is written by Patrick Donahue, a U.S. army colonel who led soldiers into battle and knows the value of the report to battalion commanders like himself.

The final part of the special issue is written by those who are intimately familiar with the report. Elspeth Cameron Ritchie, MD, MPH, is a U.S. army

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colonel and one of the senior psychiatrists within the U.S. Army and Consultant to the U.S. Army Surgeon General for Behavioral Health. She focuses on the recommendations of this and earlier MHAT reports. The final article in the special issue, written by the authors of the report, Castro and McGurk, is both a commentary and a set of reactions to the other articles.

Before turning to the special issue, however, it is important for the reader to appreciate the central findings of this important report. (1) The level of combat is the main determinant of soldiers and marines screening positive for a mental health problem. (2) For soldiers, deployment length and family separations were the top noncombat (deployment) issues. Notably, the marines had fewer noncombat deployment concerns due to shorter deployment lengths. (3) Although taking in-theatre rest and relaxation was found to be an important factor in enhancing behavioral health, only 5% of soldiers reported they were authorized and took any rest and relaxation. (4) Soldiers and marines reported general resentment about the creation and enforcement of garrison-like rules in a combat environment. (5) Soldier morale was lower than marine morale, which can also be attributed to deployment length. (6) Overall, soldiers had higher rates of mental health problems than marines. However, when matched for deployment length and deployment history, soldiers' mental health rates were similar to those of marines'. (7) Multiple war deployers (those who were serving on their second, third, or subsequent deployment) reported higher acute stress than those deployed to war for the first time. (8) Deployment length was related to higher rates of mental health problems and marital problems. (9) As a way of demonstrating the importance of training and supervision, the report notes that good noncommissioned officer leadership was the key to sustaining soldier and marine mental health and well-being. (10) Marital concerns were higher than in previous surveys among Operation Iraqi Freedom troops, and like other concerns, they were related to deployment length. (11) As with previous MHAT reports, this one also found suicide rates were 28% higher compared with average army rates for those not deployed (16.1 vs. 11.6 soldier suicides per year per 100,000, respectively). (12) It is not surprising that current suicide prevention training is not effective in reducing suicides down range because they were not designed for a combat/deployed environment. (13) Regarding battlefield ethics, approximately 10% of soldiers and marines report mistreating noncombatants. That is, these combatants reported engaging in at least one act of hitting or kicking a noncombatant when not necessary or damaging or destroying Iraqi property when not necessary. (14) Soldiers who have high levels of anger, experienced high levels of combat, or screened positive for a mental health problem were nearly twice as likely to mistreat noncombatants as those who had low levels of anger or combat or screened negative for a mental health problem. (15) Noncombat (Transition Team) soldiers had lower rates of mental health problems compared with combat (Brigade Combat Team) soldiers due in part to unmet behavioral health care needs. (16) Behavioral health providers require additional Combat and Operational Stress Control training prior to deploying to Iraq and very few attended the Army Medical Department Center & School Combat and Operational Stress Control course. (17) Unfortunately, there is no standardized joint reporting system for monitoring mental health status and suicide surveillance of service members in a combat/deployed environment.

Readers of this journal and in particular members of the Green Cross Academy of Traumatology are well aware of the immediate and long-term behavioral health consequences of highly stressful events. They are aware of reports here and in other trauma-informed journals of how early evidence-based interventions are critical in avoiding stress injuries and subsequent long-term mental health problems. These problems include, but are not limited to, posttraumatic stress disorder, depression, substance abuse, family violence, and suicide. The extraordinary contributions of the MHAT-IV and other contributions in this special issue will enable readers and others to more effectively understand and help our brave combatants and their families return to civilian or garrison lives with excellent prospects for resilience and posttraumatic growth.

What has set these most recent wars apart from the Vietnam War is the enduring appreciation and respect for the men and women in uniform who, despite their personal misgivings, answer the call to serve their country in war. We as a nation and as mental health professionals owe them and their family the very best help possible for as long as it is needed. The journal's Editorial Board and I trust that this special issue contributes to that goal.

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