

# Editorials

Continuing editorial comments by LTC Craig A. Myatt and Dr. Douglas C. Johnson on “Psychological Resilience and Postdeployment Social Support Protect Against Traumatic Stress and Depressive Symptoms in Soldiers Returning from Operations Enduring Freedom and Iraqi Freedom,” *Depression and Anxiety* (Pietrzak, et al., 2009a) and “Psychosocial Buffers of Traumatic Stress, Depressive Symptoms, and Psychosocial Difficulties in Veterans of Operations Enduring Freedom and Iraqi Freedom: The Role of Resilience, Unit Support, and Postdeployment Social Support,” *Journal of Affective Disorders* (Pietrzak, et al., 2009b).

Ongoing discussion on resilience leads to the following question: “What factors differentiate individuals who respond well to chronic exposure and high-intensity stressors from those who are unable to adapt?” The concept of psychological resilience has received significant attention in recent years from the medical research community as well as military training and operational commands. To be sure, extant research indicates that resilience is a complex, dynamic, and multi-dimensional factor that is difficult to define comprehensively and challenging to measure.

To date, resilience research has focused on outcomes. Namely, who bounces back from stress and who does not. Special Operations Forces (SOF) have an exemplary record of applied resilience outcome research, as their missions are predicated on the ability to identify individuals (i.e. assessment and selection) who adaptively respond to high-intensity stressors. However, resilience outcome research does little to explicate processes of resilience, the “how” and “why” individuals adapt differently. In other words, how do resilient people think, how do they behave, how do they interact with their environment, and how do they regulate emotions?

As resilience research evolves, efforts are beginning to focus more on processes and associated factors. Promising examples of this are two recent articles focusing on unit cohesion and post-deployment social support as protective factors against potentially deleterious effects of combat stress (Pietrzak et al., 2009a, 2009b). Data for these articles were collected cross-sectionally in active-duty combat personnel (N = 272) who served in Operations Enduring Freedom and Iraqi Freedom (OEF/OIF).

Pietrzak et al. (2009a, 2009b) hypothesized that OEF/OIF veterans with PTSD would score lower on measures of resilience and social support than veterans without PTSD. The authors also hypothesized that unit cohesion and social support would protect against depression. They used the PTSD Checklist – Military Version (PCL-M) to measure symptoms of combat stress and the Connor-Davidson Resilience Scale (CD-RISC) to measure psychological resilience in a battery of self-report assessments that also

examined combat experiences, depressive symptoms, unit support, and postdeployment social support. The researchers established a cut-off score on the PCL-M to identify veterans with PTSD. Among participants, those in the PTSD group scored lower on the CD-RISC (less resilience) than those in the no-PTSD group. In addition, regression analysis suggested that scores measuring psychological resilience on the CD-RISC and post deployment social support were negatively associated with PTSD and depressive symptoms.

Measures of unit cohesion and post-deployment support were taken from the Deployment Risk and Resilience Inventory (DRRI; King, King, and Vogt, 2003). Assessment of unit cohesion included questions such as, “My unit was like family to me,” “Most people in my unit were trustworthy,” and “I could go to most people in my unit for help when I had a personal problem.” Post-Deployment support was assessed with questions that included, “My supervisor understands when I need time off to take care of personal matters,” “When I am unable to attend to daily chores, there is someone who will help me with these tasks,” and “Among my friends or relatives, there is someone I go to when I need good advice.”

As mentioned in previous editorial comments, the authors fully addressed the limitations in their study, one of which involved the cross-sectional nature of the study. The cross-sectional study provided a snap-shot of the behavioral health of OEF/OIF veterans. They addressed that limitation by emphasizing the need for longitudinal studies that examine the role of resilience and support factors over time. Pietrzak et al. (2009a, 2009b) convincingly conclude that resilience and social support may buffer against symptoms of traumatic stress (e.g. PTSD, depression) by a host of mechanisms. Those mechanisms may include: decreased hypothalamic-pituitary-adrenal axis reactivity; decreased stress related physiological arousal; decreased fear-related appraisals and cognitions; improved emotional regulation; and enhanced self-efficacy and control. Several of those mechanisms suggest the importance of future research and applications to adopt a biopsychosocial framework.

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