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PSYCHOPROPHYLAXIS OF STRESS CONDITIONS ARISING IN MILITARY SERVICE

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Annotatsiya: Maqolada harbiy xizmat jarayonida yuzaga keladigan stress holatlarining psixoprofilaktikasi masalasi xalqaro dalillarga asoslangan tibbiyot va harbiy psixologiya yutuqlari nuqtayi nazaridan tahlil qilinadi. Tadqiqotning dolzarbligi shundaki, jangovar va operatsion stress harbiy xizmatchilar orasida depressiya, xavotir buzilishlari va travmadan keyingi stress buzilishining keng tarqalishiga olib keladi, bu esa jangovar shaylik, intizom va shaxsiy tarkib salomatligiga bevosita ta'sir ko'rsatadi. Maqolaning maqsadi yetakchi xalqaro tadqiqot markazlari, randomizatsiyalangan nazoratli sinovlar, Cochrane sharhlari va meta-tahlillar natijalarini tizimli umumlashtirib, psixoprofilaktika choralarining samaradorligini baholash va ularni yagona bosqichli modelga keltirishdan iborat. Tahlil natijasida stressga emlash treningi, rezilientlikni rivojlantirish dasturlari, mindfulness asosidagi mashg'ulotlar, qo'mondonlik va jamoa birligini mustahkamlash, PIE tamoyillari asosidagi frontal yordam hamda tengdoshlar tomonidan amalga oshiriladigan travma xavfini boshqarish tizimi eng ishonchli yondashuvlar ekani aniqlandi. Shu bilan birga, bir martalik majburiy psixologik debrifing travmadan keyingi buzilishlarning oldini olmasligi va zararli bo'lishi mumkinligi ko'rsatildi. Xulosada harbiy psixoprofilaktikani xizmatga qabul qilishdan xizmatdan keyingi davrgacha davom etadigan uzluksiz, ko'p darajali tizim sifatida tashkil etish taklif etiladi.

Annotation: The article examines the psychoprophylaxis of stress conditions arising in military service through the lens of evidence-based medicine and contemporary military psychology. Combat and operational stress is associated with a substantial burden of depression, anxiety disorders and post-traumatic stress disorder among service members, with direct consequences for combat readiness, discipline and force health. The aim of the study is to synthesize findings from leading international research programmes, including randomized controlled trials, Cochrane reviews and meta-analyses, in order to evaluate the effectiveness of preventive interventions and to integrate them into a coherent phase-based model. The analysis demonstrates that stress inoculation training, structured resilience training, mindfulness-based mental fitness training, leadership and unit cohesion, forward intervention guided by the principles of proximity, immediacy and expectancy, and peer-delivered trauma risk management constitute the most defensible components of a preventive system. Conversely, single-session compulsory psychological debriefing has not been shown to prevent post-traumatic disorders and may be harmful. The article concludes that military psychoprophylaxis should be organized as a continuous,

multilevel system extending from recruitment through deployment to reintegration, with routine outcome evaluation built into every stage.

Kalit so'zlar: psixoprofilaktika, jangovar stress, operatsion stress, harbiy xizmatchilar, rezilientlik, stressga emlash treningi, travmadan keyingi stress buzilishi, psixologik debrifing, qo'mondonlik, jamoa birligi, travma xavfini boshqarish

Key words: psychoprophylaxis, combat stress, operational stress, service members, resilience, stress inoculation training, post-traumatic stress disorder, psychological debriefing, leadership, unit cohesion, trauma risk management

INTRODUCTION

In military service, exposure to extreme stressors such as threat to life, sleep deprivation, separation from family and the loss of comrades is not an accident but a foreseeable feature of the role. The task is therefore to anticipate, limit and prevent its adverse consequences. This is the domain of psychoprophylaxis, understood as an organized system of psychological, medical, educational and command measures directed at preserving the mental health and functional capacity of personnel before, during and after exposure to stressful conditions of service.

The scale of the problem became evident in the large epidemiological studies conducted after the wars in Iraq and Afghanistan. In a landmark study published in the New England Journal of Medicine, Hoge and colleagues found that between 15.6 and 17.1 per cent of United States soldiers and Marines surveyed after deployment to Iraq met screening criteria for major depression, generalized anxiety or post-traumatic stress disorder, compared with 9.3 per cent before deployment, and that only a minority of those who screened positive had sought professional help, largely because of perceived stigma and organizational barriers [1]. A cohort study of the United Kingdom armed forces published in The Lancet reported a prevalence of probable post-traumatic stress disorder of 4.0 per cent, of common mental disorders of 19.7 per cent and of alcohol misuse of 13.0 per cent, with risk concentrated among reservists and personnel in combat roles [2]. The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) further demonstrated that approximately one in four non-deployed United States soldiers met criteria for a current mental disorder and that the majority of these disorders had their onset before enlistment [3]. These data show that military stress pathology is neither rare nor confined to the battlefield: it originates partly in pre-existing vulnerability, is amplified by operational exposure and is perpetuated by barriers to care.

The theoretical foundation for prevention lies in the transactional model of stress formulated by Lazarus and Folkman, according to which the psychological outcome of a stressor depends not only on its objective intensity but on the individual's cognitive appraisal of threat and of available coping resources [4]. If appraisal and coping can be shaped, then the trajectory from exposure to disorder can be modified. Bonanno's work on human resilience added a second essential insight: the most common response to potentially traumatic events is not chronic dysfunction but a stable trajectory of healthy functioning, which means that prevention should aim to strengthen and protect natural resilience rather than to medicalize normal stress reactions [5].

Despite the extensive literature, preventive practice in many armed forces remains fragmented. Interventions are often introduced on the basis of intuitive appeal rather than evidence, and some widely used procedures have later proven ineffective or even harmful. The purpose of the present article is therefore to synthesize the most authoritative evidence on the psychoprophylaxis of military stress, drawing exclusively on peer-reviewed work by leading specialists in the field, and to organize this evidence into a phase-based model suitable for implementation in military units. The central research question is which preventive measures have demonstrated effectiveness at each stage of the service cycle, and which commonly used measures should be abandoned or reformed in light of current evidence.

LITERATURE REVIEW AND METHODS

The scientific understanding of military stress has developed along several complementary lines. The first concerns risk factors. In a meta-analysis of fourteen risk factors for post-traumatic stress disorder across military and civilian samples, Brewin, Andrews and Valentine showed that pre-trauma factors such as psychiatric history and childhood adversity exerted relatively weak and inconsistent effects, whereas factors operating during and after the trauma, particularly trauma severity, lack of social support and subsequent life stress, had the strongest associations with the disorder [6]. This finding has a direct preventive implication: the post-exposure social environment, which is largely under organizational control, matters more than many fixed individual characteristics. Bryant's systematic review of acute stress disorder added that early symptom profiles are poor predictors of later post-traumatic stress disorder, because many people who develop chronic disorder do not initially meet acute criteria while many with acute reactions recover spontaneously [7]. Prevention cannot therefore rely solely on the early identification of individuals with intense initial reactions.

The second line of research concerns protective factors at the individual and group levels. Bartone's work on psychological hardiness, defined as a combination of commitment, control and challenge, demonstrated that hardiness moderates the effects of operational stress on health, and that leaders can foster hardiness in their units by the way they interpret and give meaning to stressful experiences [8]. Jones and colleagues, studying British troops in Afghanistan, showed that perceived quality of leadership, unit cohesion and morale were independently associated with lower rates of post-traumatic stress symptoms and common mental disorders, even after accounting for combat exposure [9]. These studies establish the unit, and not merely the individual, as a legitimate target of psychoprophylaxis.

The third line of research concerns structured preventive training. Meichenbaum's stress inoculation training proposes three phases: conceptualization, in which trainees learn how stress operates; skill acquisition and rehearsal, in which they practise coping techniques such as arousal control and cognitive restructuring; and application, in which skills are applied under gradually increasing, realistic stress [10]. In a meta-analysis of 37 studies, Saunders, Driskell, Johnston and Salas found that stress inoculation training significantly reduced performance anxiety and state anxiety and improved performance under stress [11]. Building on positive psychology, the United States Army launched the Comprehensive Soldier Fitness programme, which addresses emotional,

social, family, spiritual and physical dimensions of fitness [12], and its central component, Master Resilience Training, prepares non-commissioned officers to teach resilience skills derived from the Penn Resiliency Program to their own soldiers [13]. More recently, mindfulness-based mind fitness training has been tested with military personnel. In a controlled study with Marines preparing for deployment, Johnson and colleagues found that such training improved heart rate and breathing recovery after intense combat simulation and altered neural responses in brain regions associated with interoception and emotion regulation [14], while Jha and colleagues demonstrated that mindfulness training protected military cohorts against the deterioration of sustained attention during high-demand pre-deployment periods [15].

The fourth line of research concerns early intervention after exposure. The principles of proximity, immediacy and expectancy, often referred to as PIE, have roots in the First World War and were evaluated systematically by Solomon and Benbenishty among Israeli soldiers in the 1982 Lebanon War, where each principle was associated with a higher rate of return to unit and a lower rate of subsequent post-traumatic stress disorder [16]. Jones and Wessely's historical analysis, however, cautioned that the effectiveness of forward psychiatry was more modest and context-dependent than commonly believed [17]. In the broader field of disaster and trauma response, Hobfoll and an international panel of experts identified five empirically supported principles of immediate and mid-term intervention: promoting a sense of safety, calming, self- and community efficacy, connectedness and hope [18]. In sharp contrast, the Cochrane review by Rose, Bisson, Churchill and Wessely concluded that single-session individual psychological debriefing does not prevent post-traumatic stress disorder and that at least one trial suggested an increased risk of the disorder among debriefed individuals at follow-up [19]. In response, military organizations developed alternative models. Adler and colleagues tested Battlemind debriefing and Battlemind training in a large trial in which platoons of soldiers returning from Iraq were randomized to intervention conditions, finding small but meaningful benefits, particularly for soldiers with high combat exposure [20]. The United Kingdom armed forces adopted Trauma Risk Management, a peer-delivered system in which trained non-medical personnel assess colleagues after traumatic events and facilitate referral when needed [21]. A cluster randomized controlled trial in Royal Navy ships showed that this system did not harm participants and was acceptable to personnel, although it did not produce significant changes in measured psychological health over the trial period [22].

The fifth line comprises systematic syntheses. Reviews by Mulligan and colleagues and by Hourani and colleagues concluded that psycho-educational and stress control interventions are widespread and acceptable but rigorously evaluated only rarely, with skills-based approaches appearing most promising [23; 24]. Vanhove and colleagues, in a meta-analysis of resilience-building programmes in occupational settings including the military, found small overall effects that were stronger for programmes delivered one-to-one and for those targeting at-risk individuals, and that tended to diminish over time [25]. Joyce and colleagues, in a meta-analysis published in BMJ Open, found that resilience training improves resilience and that programmes combining cognitive-behavioural and mindfulness elements appear particularly effective [26]. Finally, Nash and Watson's review of the joint guideline of the United States Department of Veterans Affairs and

Department of Defense established the policy framework for managing acute stress and preventing post-traumatic stress disorder in military health systems [27].

Methodologically, the present study is a theoretical and analytical review. Sources were selected according to explicit criteria of authority: publication in peer-reviewed journals of high standing, such as the New England Journal of Medicine, The Lancet, JAMA Psychiatry, the American Journal of Psychiatry, American Psychologist and the Cochrane Database of Systematic Reviews; authorship by researchers holding doctoral degrees in psychology or medicine and affiliated with recognized military or academic research centres; and preference for randomized controlled trials, systematic reviews and meta-analyses over single observational studies. Bibliographic data for all journal sources were verified through the Crossref registry. The study employed methods of analysis and synthesis, comparative evaluation of interventions according to their level of evidence, classification of measures by level of prevention (primary, secondary and tertiary) and by phase of the service cycle, and a systemic approach to integrating the findings into a coherent model of psychoprophylaxis.

DISCUSSION

The reviewed evidence permits a reconsideration of what psychoprophylaxis in the military should mean in practice. Traditionally, prevention has been understood as the transmission of information: lectures on stress, leaflets on warning signs and briefings before deployment. The systematic reviews by Mulligan and colleagues and by Hourani and colleagues indicate that information alone rarely changes outcomes [23; 24]. Effective prevention appears to require the acquisition of skills under conditions that resemble real service demands. This is the core logic of stress inoculation training, whose meta-analytic support derives precisely from the combination of education, deliberate practice and graduated exposure [10; 11]. From the perspective of the transactional model, such training modifies both primary appraisal, by making threatening situations more familiar and predictable, and secondary appraisal, by increasing the perceived adequacy of coping resources [4]. The practical implication is that psychoprophylaxis must be integrated into combat training rather than added as a separate theoretical module.

Comprehensive Soldier Fitness illustrates both the promise and the limits of large-scale resilience programmes. Its train-the-trainer model, in which non-commissioned officers teach resilience as a professional skill, helps counter the stigma identified by Hoge and colleagues [1; 12; 13]. Yet meta-analytic evidence shows that such effects are small and decay over time [25], so booster sessions, integration into routine unit life and targeting of higher-risk subgroups are needed to sustain them.

Mindfulness-based mind fitness training trains attentional control and non-reactive awareness rather than cognitive restructuring. The available trials suggest that it may protect both stress recovery and operational performance [14; 15], a dual benefit that helps justify training time, but samples have been small and long-term clinical outcomes remain to be established.

The most consequential lesson of the literature concerns psychological debriefing. For several decades, single-session debriefing was widely applied after critical incidents on the assumption that early emotional processing of traumatic experience prevents later disorder. The Cochrane review

demonstrated that this assumption was unfounded and that compulsory debriefing may increase risk in some individuals [19]. Bonanno's work offers a plausible explanation: since most people follow a resilient trajectory, a procedure that requires everyone to re-experience and verbalize trauma immediately may interfere with natural recovery processes [5]. The response of military researchers was instructive. Rather than abandoning early intervention, they redesigned it. Battlemind debriefing reframed post-deployment reactions as adaptive combat skills that need to be recalibrated for home life, rather than as symptoms, and was delivered to intact units rather than to isolated individuals [20]. Trauma Risk Management replaced universal debriefing with watchful waiting, peer assessment and selective referral [21; 22]. Both approaches are consistent with the five principles identified by Hobfoll and colleagues [18] and with the observation by Bryant that early symptoms alone do not reliably identify those who will develop chronic disorder [7]. The lesson for psychoprophylaxis is that early support should be practical, social and needs-based, and that formal psychological treatment should be reserved for those with persistent or worsening symptoms.

Because lack of social support is among the strongest risk factors for post-traumatic stress disorder [6], and leadership quality and cohesion are associated with lower morbidity [8; 9], the commander is in effect the principal agent of psychoprophylaxis. A leader who gives meaning to difficult events, maintains predictable routines and normalizes help-seeking creates the conditions in which natural resilience operates; psychoprophylaxis should therefore be embedded in leadership education at all levels of command.

The principles of proximity, immediacy and expectancy retain practical value for managing acute combat and operational stress reactions [16], although return-to-duty rates may overstate their long-term effectiveness [17]; they should therefore never delay referral of individuals with severe or persistent symptoms. Finally, the evidence base has limitations: most high-quality studies come from the United States, the United Kingdom and Israel, outcomes are often self-reported and short-term, and a definitive Cochrane synthesis of pre-deployment programmes is still in progress [28]. Any national programme of psychoprophylaxis should therefore include its own systematic evaluation.

RESULTS

The analysis yielded several principal results. First, it established that stress-related mental disorders in military populations are common, that a substantial part of them has pre-service origins, and that their consequences are aggravated by stigma and barriers to care [1; 2; 3]. Psychoprophylaxis must therefore begin at the stage of recruitment and initial training and continue throughout the service cycle, rather than being confined to the period immediately surrounding combat deployment.

Second, the evidence was organized into a phase-based model of military psychoprophylaxis comprising four stages: pre-service and initial training, pre-deployment, deployment, and post-deployment and reintegration. Each stage has its own set of preventive measures, while leadership, unit cohesion, stigma reduction and outcome evaluation operate across all stages. The model and the strength of the supporting evidence are summarized in Table 1 and Figure 1.

Table 1. Phase-based model of psychoprophylaxis of military stress and the strength of supporting evidence

Phase of service	Main preventive measures	Key evidence	Strength of evidence
Pre-service and initial training	Screening for vulnerability, psychoeducation, basic resilience skills	[3; 12; 13; 23]	Moderate for skills, limited for psychoeducation alone
Pre-deployment	Stress inoculation training, resilience training, mindfulness training, cohesion building	[8; 9; 11; 14; 15; 25; 26]	Moderate (meta-analyses and controlled trials)
Deployment	PIE principles, psychological first aid, leader and peer monitoring	[16; 17; 18; 27]	Moderate, partly observational
Post-deployment and reintegration	Battlemind-type transition training, TRiM, screening and referral	[19; 20; 21; 22]	Moderate (randomized trials); single-session debriefing not recommended

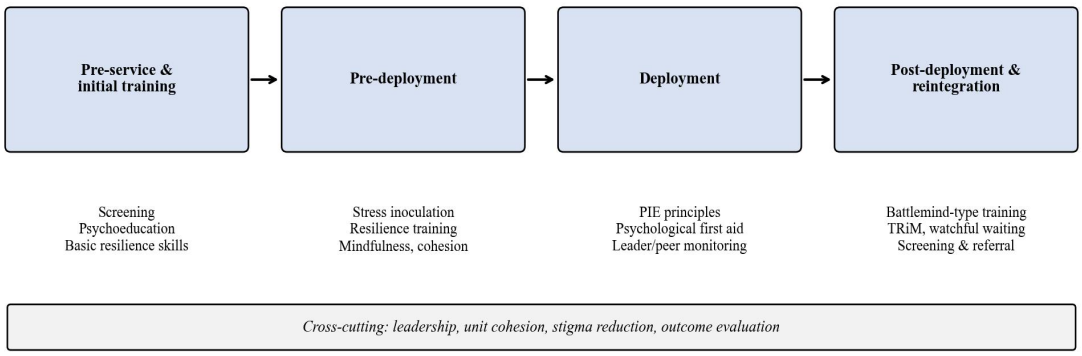


Figure 1. Phase-based model of psychoprophylaxis of stress in military service

Third, the analysis distinguished between measures that are supported by evidence and those that are not. Stress inoculation training, structured resilience training with periodic reinforcement, mindfulness-based mind fitness training, leadership and cohesion building, and peer-based watchful waiting with selective referral are supported by randomized trials, controlled studies or meta-analyses [9; 11; 14; 20; 22; 25; 26]. Single-session compulsory psychological debriefing is not

supported and should be removed from routine practice [19]. Psychoeducation alone, without skill practice, is acceptable to personnel but has limited evidence of effectiveness [23; 24].

Fourth, the analysis identified the unit commander as the central agent of psychoprophylaxis. Social support, leadership quality and cohesion emerged as among the most powerful modifiable factors affecting mental health outcomes [6; 8; 9]. This result shifts the emphasis of prevention from specialist-delivered interventions toward the education of leaders and the design of unit routines.

Fifth, the analysis showed that preventive effects are generally modest in size and tend to decay over time [25]. It follows that effective psychoprophylaxis is not a single intervention but a continuous system in which several moderately effective measures are combined, reinforced and adapted to the risk profile of different groups of personnel.

CONCLUSION

Psychoprophylaxis of stress conditions in military service is a scientifically grounded and practically necessary component of force health protection. The international evidence reviewed in this article demonstrates that stress-related disorders are widespread among service members, that their origins extend beyond the battlefield, and that their impact is magnified by stigma and delayed help-seeking. At the same time, the evidence shows that their burden can be reduced through a coherent system of preventive measures.

The most defensible elements of such a system are skills-based preparation through stress inoculation and resilience training, mindfulness-based mental fitness training, strong leadership and unit cohesion, forward management of acute stress reactions guided by the principles of proximity, immediacy and expectancy, psychological first aid, and peer-delivered trauma risk management with selective referral to specialist care. The experience with single-session psychological debriefing provides an important warning that well-intentioned interventions can be ineffective or harmful, and that every preventive measure must be subjected to empirical evaluation.

On this basis, it is recommended that military psychoprophylaxis be organized as a continuous, multilevel process extending from recruitment to reintegration; that psychological preparation be integrated into combat training rather than delivered as isolated lectures; that commanders at all levels be trained as the primary agents of prevention; that compulsory single-session debriefing be replaced by watchful waiting, peer support and needs-based referral; and that national programmes include systematic monitoring of outcomes adapted to their own cultural and organizational context. Implemented in this way, psychoprophylaxis becomes not an auxiliary medical service but an integral part of the combat readiness of the armed forces.

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