Psychological Screening in the Australian Defence Force: An Historical and Contemporary Analysis of what Works

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Abstract

With a rapid and significant rise in psychological screening within the Australian Defence Force (ADF) over the past 20 years, ambiguity has developed between a psychological screen and a psychological assessment used for pre-employment and pre-deployment selection purposes. Additionally, confusion persists around what constitutes a mental health or psychology screen and when it should be used. To provide greater clarification, the origins and purpose of screening for selection for pre-employment and pre-deployment in the ADF and its current uses are explored in this article. A review of contemporary and historical literature examined the use of screening for military selection. It was concluded that screening for selection is useful when estimating traits such as intelligence in pre-employment selection and identifying current mental illness for pre-employment and pre-deployment selection. However, screening is not—and has never been—successful in identifying those who may be predisposed to developing mental distress in the future. The review, therefore, suggests a more nuanced approach to psychological screening for selection in the ADF. Recommendations are made to better understand and standardise the purpose of screening and to consider using different screening tools in a selection versus a mental health support context.

Keywords: psychological screen, selection, mental illness, mental distress, military

Introduction

The psychological selection of people into the ADF, and for deployment to warlike or peacekeeping activities once in the ADF, has been a topic of interest for decades. This is due to a need for the right people to be selected to ensure a successful mission and minimise the psychological harm to those deployed individuals. The military has historically used both psychological screening and psychological assessment processes for selection purposes, with advances in both processes often rapidly occurring during periods of conflict to meet the necessary expanding processing volume. These changes have incorporated the evolution of the psychological and psychiatric theories underpinning the selection processes, concurrently advancing the tools used in screening and assessment. Both processes have had varying levels of success. However, the use of psychological screens has multiple purposes and thus have tended to be used across several different purposes, often using the same screening tools, which can confuse the understanding of that purpose by those being screened. It has been some time since the ADF comprehensively reviewed its psychological screening program and its tools, with changes made incrementally in the last 10–15 years after an initial rapid expansion in response to multiple military commitments and concurrent government demands. As a result, there has been some blurring of both the intent and process of psychological screening in selection, which may have impacted screening's current overall 'fit for purpose' for the ADF.

In this article, the origins and purpose of screening for selection for pre-employment and pre-deployment in the ADF, as well as its current uses, are explored to better understand the possible uses and misuses of psychological screening in a military selection context and to provide future considerations for psychological screening in military selection. A blend of historical and contemporary approaches has been incorporated due to past military screening protocols and practices' strong influence on current practices within the ADF.

Method

A review of contemporary and historical literature, including journal articles, book chapters, and 'grey' literature that examined the use of screening for military selection, was conducted using the databases of Google Scholar, EBSCO, Ovid, ProQuest, ScienceDirect and Taylor & Francis. Terms used included 'psychological selection', 'armed force*', 'military personnel', 'military leader*', 'recruit*' and 'selection criteria'. Literature was selected for inclusion according to topic relevance (noting the focus on both historical and contemporary references), with a strong preference for empirical research, systematic reviews, and policy/procedural analysis. A secondary search was conducted within the reference lists of selected literature for material, particularly grey literature, not identified in the original search. Literature that focused only on screening for mental health issues in a military population, with no selection context, was not included as it was outside the scope of psychological screening for selection purposes.

The literature for psychological 'screening' and 'assessment' was found to be moderately confounded due to generally poor or missing definitions around what constituted a screen and an assessment for psychological selection purposes. Therefore, definitions were established to determine which literature would be considered within this review. The definitive definition for 'screening' is provided by the World Health Organization,[1] as '… the presumptive identification of unrecognised disease or defect by the application of tests, examinations or other procedures that can be applied rapidly'. The key point is that screening for indications of disease or similar in an otherwise well population is a quick process. Within psychology, screening is often conducted as a series of questions or via a standardised questionnaire or test and may be used for various functions.[2]

Screening is different to an 'assessment'. When used in psychology and mental health, an assessment evaluates an individual in a particular situation so that the information derived from the assessment can help make a decision or diagnosis.[3] An assessment may use some of the same questions and tools that a screen uses but generally goes into much more detail and is more multifaceted than a screen.[3] Both an assessment and a screen may be used for different purposes or contexts. Therefore, this purpose must be clearly articulated whenever a screening or assessment tool is used.[4] Characteristics of a psychological screen vs psychological assessment are outlined in Table 1.

The difference between the terms 'screening' and 'assessment' is important, as this dictates what tools can be used, the time taken to apply those tools and what the information could or should be used for. This has an impact on the relative understanding by those individuals, groups, and populations they are being used on, and potentially affect informed consent and stigma, both within selection contexts and within a mental health context.[4] The use of psychological assessment in a selection context is beyond the scope of this article, with our review limited to screening.

History of psychological screening for military – World War I

Much of Australia's early understanding of psychological screening comes from the British and the American systems used during World War I (WWI) and World War II (WWII). In both countries, screening was used to address a critical issue of people's capability in a large-scale conflict with a very short time frame and, therefore, was initially not evidence-based. The British traditionally approached their military as an extension of their social class system due to assumptions around hereditary being linked to good mental health and morality;[5] therefore, those of higher social standing were automatically assumed

Table 1: Characteristics of psychological screening and psychological assessment

Screening characteristics	Assessment characteristics
· Screening sorts out apparently well persons who probably have a disease from those who probably do not. · A screen is not intended to be diagnostic; however, it may be so if done rapidly. · Persons with positive or suspicious findings must be referred for assessment, diagnosis and necessary treatment. · May include verbal questions, physical examination and questionnaires.	· Administration and interpretation of psychological tests for the purposes of diagnosis and treatment. · Conducting structured and unstructured interviews. · Observations of interpersonal interactions. · Behavioural observations, including in natural settings. · May include neuropsychological assessment and/or behavioural assessment.

to be able to better cope with military demands. WWI challenged these assumptions, most notably because it swiftly became apparent that 'shell-shock' (now recognised as an early iteration of post-traumatic stress disorder [PTSD]) could affect both soldiers and officers.[5,6] The subsequent focus of the military was to understand the new war 'neuroses' as quickly as possible and find ways to treat them to get soldiers back to the front line. This was made ever more urgent with the increasing attrition rate and corresponding rush to replace recruits, which overwhelmed the medical officers in charge of their examinations.[7] Hence, due to other priorities, the pre-employment psychiatric screening of recruits was not approached systematically.

Similarly, in the United States of America (USA), screening was recommended to exclude those who were 'insane, feeble-minded, psychopathic and neuropathic'.[8] This screening only happened if the soldier came to the attention of their commander during training, resulting in a referral to a psychiatrist for pre-deployment screening or, if time was available, a psychiatric assessment. However, when this approach did not translate into lower psychiatric battle casualties, the USA began to attach psychiatrists to their induction centres to conduct pre-employment psychiatric screens rather than wait until they were in training. This did not significantly change the outcomes, as the screens were typically very brief, taking only a few minutes, due to the significant number of recruits that needed to be processed,[9] and lack of agreement on what screening criteria should be used for selection purposes.[10] This again points to the rapid expansion of screening due to the sheer volume of people taking priority over establishing consistent screening processes based on evidence and psychiatric theory, resulting in poor outcomes for the military, particularly around psychiatric casualties from the battlefield.

At about the same time, psychologists in the USA were considering how they could help with the war effort. Robert Yerkes, an American psychologist, was influenced by the prevailing contemporary social norms of equality, deciding that America could be more equitable and efficient if people could find their place in society based on their abilities, as determined by scientific testing.[11] He and his committee subsequently trialled and refined individual and group tools and procedures for the psychological screening of military recruits, aiming to identify recruits whose intelligence levels were insufficient for understanding military training.[12] The intelligence screening tools were used for mass pre-employment screening and later as part of assessments during training. The screens were also useful for identifying people suitable for officer training, senior non-commissioned officer selection, and specialised jobs,[12,13] contributing to his ideals of a meritocracy.[11] These screens successfully reduced military training failure rates,[14] and provided the foundation of many of the psychometric tests for intelligence and aptitude used by the military and the psychology profession today.

Australia did not use either mental health or intelligence screening for recruits during WWI. Instead, most of the soldiers who would be deemed psychologically unsuitable were identified by their commander during training prior to deployment overseas.[15] At the time, Australia still subscribed to a 'moral' (right vs wrong behaviour) concept of mental illness popular with the asylums in the previous century and closely linked to our convict history; thus, categories such as 'delinquent conduct' were included as psychiatric considerations.[16]

History of psychological screening for military – World War II

The sheer number of people being diagnosed with a type of war neurosis at the end of WWI set the scene for WWII, where there was an increase in interest in screening potential recruits for psychiatric vulnerabilities. WWII brought more nuance to the debate around the abilities of screening for pre-employment and pre-deployment, although its application continued to lack any standardisation. It was generally accepted that a recruit with *existing* psychiatric concerns could be detected through either their medical board (despite it lasting for only one to two minutes) or their conduct and behaviour during training. However, there was considerable debate about whether it was possible to *predict* who would break down in combat,[17] mainly as there was still doubt about what factors contributed to such breakdowns.[18] Thus, the factors used for psychiatric screening continued to lack evidence. An examination of some of the psychiatric questions and techniques used by both American and British psychiatrists during their examination of recruits reveals propensities in the approaches, which potentially screened out numerous otherwise suitable candidates for military service. For example, numerous psychiatrists ensured recruits were naked for their psychiatric examination, believing it gave clues into their personality and that they would be less likely to tell a lie.[19,20] During the psychiatric interview, the recruit would be marked down if they admitted to any topics in Table 2.

Table 2: Psychiatric interview topics*

The psychiatrist would mark down the recruit if they admitted to any of the following:
Stammering
Enuresis
Insomnia
Neurotic fears (such as the dark, loneliness, closed spaces)
Unsatisfactory record at work or school
Comparative lack of interest in sports
Fainting at the sight of blood
Visceral responses to such things as exams
Family background (including being from a 'broken home')
Temperament (whether they were sociable, obsessional, hysterical, psychopathic, depressed, anxious or narcissistic)

(Vernon and Parry, 1949: 151–2)
* Terms within the topics are those used during WWII

A closer look at some of the screening questions used by psychiatrists with recruits reveals a mix of traditional beliefs, such as the importance of hereditary factors in psychiatric predisposition to break down in combat and newer ideologies based on aptitude. This resulted in the psychiatric screening process being very subjective and heavily reliant on the interviewer's skill.[19] Therefore, to try and standardise the psychiatric interview, several attempts were made in the USA to create an effective neuropsychiatric screening tool[21,22] resulting in the Neuropsychiatric Screening Adjunct (NSA) to aid in the psychiatric interview.[23] Unfortunately, the tool was introduced too late in the war to have any real impact,[10] although incidentally, one of these psychiatric screens[21] was later adopted by the Australian Army Psychology Service for use on its recruits in the Korean War.

Use of the brief psychiatric screens that were being trialled in the USA at the time does not appear to have occurred in either Britain or Australia. Reasons for this varied; however, the countries appeared concerned about the lack of evidence for psychiatric screening and its predictive outcomes (as opposed to current mental disorders). One group of contemporary authors[(24)] argued that many screening outcomes could be related to educational achievement, suggesting socioeconomic factors rather than psychiatric factors and inadvertently supporting Yerkes' original intent for meritocracy. Another group concluded that the information gathered in a psychiatric interview for selection could be more reliably found and measured in psychometric testing,[25] providing evidence for the brief questionnaires being established by the USA, although too late for the WWII effort. Instead, both countries shifted towards an evolved screening process for intelligence and related training aptitudes established by Yerkes in WWI. These proved largely successful in reducing training failure rates[14,26] and were extended into psychological assessment procedures for selection into officer training and high-risk jobs.[14]

These historical studies all suggest that the screening for predisposition to psychiatric issues was not successful at either the pre-employment or pre-deployment stages and, in fact, rejected a vast number of people who probably would have provided adequate service at a time when the military was desperate for troops.[10,23] It also failed to recognise many of the issues we now know are equally important in retaining good mental health during and after deployment that are out of the individual's direct control but can be managed by the military itself, such as leadership, military training and unit culture.[27] Instead, these studies highlight the importance of looking for enduring traits unrelated to ideologies of morality or socioeconomic factors, such as intelligence and the importance of looking for current mental illness, where it impacted their ability to adapt to either training or even to society prior to joining the military. It also emphasises the importance of establishing an evidence base when rapid expansion of psychological selection is required in the military in order to not include or exclude people unnecessarily.

Contemporary approaches to psychological screening in the military

As a result of these findings, the unstandardised approach to psychiatric screening for military selection was largely abandoned after WWII. Screening for aptitude and significant current psychiatric disability continued as a result of their previous success, including through periods of conscription such as the Vietnam War, where recruits were observed during basic training and sent for psychiatric evaluation if they were unable to adapt.[28] However, despite a long history of failure, attempts also continued to identify soldiers and other workers who might face psychological difficulties in combat or high-stress situations in the future.

With the recognition of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) in 1980 and the rise of peacekeeping missions across the world in the 1990s, the focus on screening within the military shifted to align more with the WHO definition of screening—rather than using screens to try and identify *future* behaviour for pre-employment and pre-deployment, it instead started to be used for identifying those with a *current* mental health concern or illness. As a result, attention turned to developing a more contemporary understanding of the use of screening in a military context. Acknowledging the importance of the original WHO definition of screening,[1] Rona, Hyams and Wessely[29] outline six criteria for implementing screening for psychological morbidity in the military in Table 3.

Bliese, Wright and Hoge[30] expanded on these criteria further, arguing the importance of distinguishing between whether the screen is intended to find the *potential* of something vs the *actual* presence of something, whether it is intended to be given in a group or an individual context, and clearly defining the purpose of the screen. They also considered whether the symptoms being captured by screens infer a disorder is present (highlighting the importance of setting appropriate cut-offs on screening tools), whether the population understands the questions being asked (particularly if they are tired or worried about the outcome in a selection context), and the setting of where the screen questions are being asked. They stated that these processes can be used in both a selection and mental health context.

Within the ADF, psychological screening continues to be used in a pre-employment selection context that is largely consistent with how screening was used in WWII. Validated psychometric screens that provide a broad estimate of an individual's cognitive aptitude and current or previous mental illness are administered to all would-be recruits to determine the presence or absence of specific traits and to guide the allocation of recruits to specific roles.[31] The tools used for the screens for would-be recruits have evolved to reflect contemporary approaches to aptitude and mental illness. Similarly, recruits are monitored closely during their training and individually referred by their commander to a psychologist or psychiatrist for assessment if there are concerns about their ability to assimilate training or cope with the military environment.[31]

The ADF has also largely abandoned the concept of psychological screening in a pre-deployment context for potential vulnerability, instead restricting the mental health screening to detecting the current presence of mental illness as part of a broader pre-deployment health check. The current literature supports this approach including recent systematic reviews.[32] However, one systematic review[33] found emergency service workers with pre-existing mental illnesses or trauma were no more vulnerable than those without a comparable history to developing mental illness. Opie and others[32] suggested this may be due to specific procedures in place for the groups under consideration, such as different recruitment processes, training or types of stressors they are

Table 3: Criteria for implementing screening for psychological morbidity in the military

No.	Criteria
1.	Identified conditions should be important health problems.
2.	Screening tests should be clinically, socially and ethically acceptable.
3.	Screening tests should be simple, precise and validated.
4.	High-quality research evidence should demonstrate the effectiveness of screening in reducing psychiatric morbidity.
5.	Adequate staffing and facilities for all aspects of psychological screening programs are critical.
6.	Benefits of the screening program should outweigh the potential harm.

exposed to. The military context and its training processes are therefore crucial in determining the success or otherwise of psychological screening programs.

The approach to using psychological screening for targeted groups who are more likely to experience mental illness has resulted in the timing of the screens being shifted from per-deployment to end of deployment, or to those who have experienced a potentially traumatic event, to find individuals who may be experiencing symptoms of trauma-related concerns.[34] Early practices in Australia followed the Critical Incident Stress Management (CISM) model developed by Mitchell,[35] where psychologists would fly to the deployed location and conduct the CISM process just before troops returned home or directly after a potentially traumatic event. However, it did not involve questionnaires or other screening tools, and screening was conducted as part of a larger group with which many troops expressed dissatisfaction, feeling uncomfortable sharing their experiences in such a format.[36] In 2002, as the commitment to supporting East Timor in establishing independence became enduring and Australia rapidly became involved in several other global warlike and peacekeeping operations, screening shifted to the conduct of individual psychological screens using questionnaires. While some of the screening questionnaires have changed over time, they have tended to cover the identification of trauma exposure, PTSD symptoms, alcohol use and general psychological distress, and are validated either internal to the ADF or externally by international experts.[31] In recognition that psychosocial factors, social resources, and military leadership are important in developing longer-term psychological illness,[36,37] questionnaires covering stressors and organisational responses have also been utilised within some of these screens. This is an important development in how screening has evolved since the two World Wars, as it provides a standardised approach to screening and recognises the importance of context for the development of mental illness and mental distress. However, the screening process for end of deployment was also rapidly developed; it was used at least twice with virtually everybody leaving their deployed location regardless of their experience, and established low cut-off rates resulting in some people being referred for further assessment unnecessarily. It also was not applied to those who did not deploy, missing a significant part of the population that later research showed were more likely to experience mental illness than their deployed counterparts.[2] Subsequent processes ensured a more even and routine approach to screening for all ADF personnel; however, it highlights how rushing military psychological screening programs can result in either poor practice or missed groups.

The approach to screening has also expanded into use in a wide range of other contexts. Currently, many of the same mental health screens used in pre-deployment contexts are also used in sizeable organisational climate surveys. While this provides good information for commanders, it risks the individual confusing the survey with a screen used in a selection context, thus not answering truthfully for fear of career reprisals. It also runs a risk of 'screen fatigue', where individuals may refuse to answer the questions if asked the same ones repeatedly across different contexts.

Conclusions

Screening is an essential part of military selection for pre-employment and pre-deployment. Its attraction is evident, particularly given the volume of people the military needs to process at any given time. However, three key aspects come from analysing the history of psychological screening in a selection context. First, it is crucial to understand and standardise *what* you should be screening for and to take time to establish the evidence for its use. Screening for traits such as intelligence has demonstrated validity in predicting subsequent training success. Screening for current symptoms of psychiatric disorder also has some validity in predicting subsequent adjustment in a military environment. However, screening for the *potential* to develop future symptoms has been unsuccessful for over one hundred years and remains elusive. The military is better served by conducting targeted screens or assessments of those who have been identified as of concern rather than using an overly broad and mandated approach with its application to all military members. Psychological assessments for military selection are a valuable and logical expansion to the use of screening in a selection context, and a focus on how the two interact and complement one another in military selection is a potential area for future research and development.

Second, it is essential to establish when these screens should take place. The application of screening tools at the pre-employment stage is an accepted aspect of selection when processing significant numbers of people, particularly for sorting into groups for further training aptitude. Its use at the pre-deployment phase has limited validity beyond looking for current significant disorder or distress and depends heavily on the individual being honest and open when responding to the screen. Instead, psychological

screens are better placed after a deployment or potentially after significant events that may cause the development of mental illness, thus remaining consistent with the original WHO definition of a screen.

Thirdly, the validity and reliability of the psychometric screens used in military selection are paramount to their usefulness, allowing individuals to be assessed fairly and consistently across different times and environments. However, some consideration should be given to whether using the same screening questionnaires in a selection context inadvertently alters the honesty of individuals when they are provided with the same screen in a deployment context, as individuals may believe (rightly or falsely) that a mental health screen will contribute to a future selection decision, given its use in a past selection context. Different screens should be used in a selection vs a mental health support context to ally confusion and concerns.

In summary, the use of psychological screens in a military selection context has occurred since at least WWI and has evolved significantly. Psychological screening has utility with many candidates when estimating individual traits linked to likely training success in pre-employment selection. It can also be valuable in identifying current mental illness when considering selection for pre-deployment. The use of screening for the prediction of developing future mental illness, however, has never been successful and is unlikely to evolve to a point where it may be helpful in such scenarios in the near term, with a more targeted, nuanced and detailed psychological assessment being more appropriate in such circumstances. Incorporating any potential new uses of psychological screening requires the best understanding possible of its history and the screening contexts to be successful, otherwise history will potentially repeat itself with the rapid adoption of 'new screens' without reference to the evidence base to support it. Therefore, future research and endeavours in this field are best directed to using screens within a selection context for actual traits or concerns.

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