Mental health consequences for U.S. military and Department of Defense (DoD) civilian personnel and intelligence professionals, particularly for those who have experienced decades of significant overseas deployment responsibilities, is a topic of serious concern. In 2014, the decision to honor a fallen U.S. Central Intelligence Agency (CIA) officer who died by suicide in Afghanistan with a star on the Agency’s Memorial Wall brought particular attention to the mental health needs of the U.S. Intelligence Community (IC).1 Although the pace of deployments, especially in support of stressful counterterrorism missions, has slowed markedly, the mental health needs of IC professionals have increased rather than diminished. Technology today brings potentially traumatic events more rapidly and vividly to U.S. intelligence professionals, whether they are in the United States or abroad.
IC leaders might not always appreciate the complex ways that trauma can affect the IC workforce, which plays a critical and unique role in our national security system. Members of the IC workforce

- collect and protect our nation’s secrets, a function that often requires them to put boundaries between their personal and professional lives
- often are an audience to violent and difficult problems, but with little autonomy to decide how to address events because of their professional obligation to remain policy advisers rather than policymakers
- frequently work under strenuous conditions, such as long hours, shift work, work without pay—or even work that deploys them to a warzone.

Their accomplishments and successes might go unrecognized, and the IC’s reputation might be unfairly tarnished by the public. IC professionals are bound by law and oath to secrecy. Such responsibility puts them at heightened risk of experiencing trauma, either directly or indirectly, and limits their recourse in managing such trauma.

The Diagnostic and Statistical Manual of Mental Disorders defines trauma as “actual or threatened death, serious injury, or sexual violence.” There are various types of possible trauma exposure. In addition to direct personal trauma exposure or personally witnessing trauma to others, there also exists “repeated or extreme exposure to adverse details” of a traumatic event. This latter category of exposure, sometimes termed secondary traumatic stress or vicarious traumatization, can affect IC professionals (or similar professions, such as journalists or activists) who are exposed to trauma in their work lives.

In the course of their work, IC analysts can be exposed to content that includes traumatic audio, images, and video. IC collectors can be exposed to similar content and might work in precarious or potentially unsafe environments or with unsavory collaborators to gather the information necessary to understand adversaries. IC support professionals can experience the same types of exposure but might not be recognized as readily as an affected population, given that the exposure is secondary to their main professional functions. Traumatic exposure can be associated with intrusive symptoms (e.g., nightmares, unwanted or upsetting thoughts), avoidance, negative thoughts or feelings, or physiological arousal and reactivity; such symptoms have potential implications for IC professionals’ mental health and their readiness to support their assigned missions.

This Perspective explores the potential for U.S. intelligence professionals to experience trauma-related stress as a consequence of their jobs, and the effects of such stress and trauma on the IC as a whole. We introduce a conceptual model, which was refined in light of literature and interviews with current mid- to senior-level IC managers and

### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CIA</td>
<td>Central Intelligence Agency</td>
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<tr>
<td>DIA</td>
<td>Defense Intelligence Agency</td>
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<tr>
<td>DoD</td>
<td>Department of Defense</td>
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<tr>
<td>FBI</td>
<td>Federal Bureau of Investigation</td>
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<tr>
<td>EAP</td>
<td>employee assistance program</td>
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<tr>
<td>IC</td>
<td>U.S. Intelligence Community</td>
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<tr>
<td>PTSD</td>
<td>posttraumatic stress disorder</td>
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a focus group composed of former IC employees who discussed the risks of trauma for IC professionals, resources to responses, barriers to care, effects on the IC, and how the IC could better support its workforce. The methodology and limitations of the study are described in detail in the box on the next page.

A Conceptual Model for Reactions to Stress and Trauma in the IC Workplace

To explore and elucidate this topic, a multidisciplinary RAND research team drew upon RAND’s extensive previous work on the mental health of U.S. military and federal employees and reviewed existing literature on trauma and empathy-based stress, particularly among the IC or similar fields. Using the literature most relevant to the IC context in addition to two relevant conceptual models, the team drafted a conceptual model for trauma in the IC.

In this model (see Figure 1), traumatic events combine with the operational characteristics in which they occur to create the stressors experienced, building upon a model on the psychology of counterterrorism operations. How each individual experiences the stress is affected by mitigating and risk factors at the organizational and personal levels. Examples of personal factors include prior trauma exposure and level and types of social support. Organizational factors, such as the level of organizational support, can also affect outcomes. All of these factors culminate in a variety of cognitive, affective, and behavioral outcomes, which are detailed in the reviewed literature, much of which overlaps in descriptions of symptom expressions. Interventions could be useful in alleviating such problems or even in promoting positive post-trauma growth.

Terminology to Define Different Trauma Types

The mental health field has long focused on assessing the effects of traumatic events on the individuals who experience them, either directly or indirectly. Past research has focused on work, specifically, as a source of exposure to trauma, with special considerations about not only the effects on individuals but also the effects on work, retention, and mission. This established body of literature provides IC professionals with a way to describe their experiences, as well as a way that others can better understand it, and allows the IC to draw upon lessons from studies that focus on professionals in similar fields (e.g., military personnel, police officers, first responders).

Drawing on our review of the literature, we consider three types of stressors:

- **Direct trauma** consists of “actual or threatened death, serious injury, or sexual violence.” Exposures can be of various types: experiencing direct personal exposures, personally witnessing trauma to others, learning that a family member or close friend was exposed to trauma, or experiencing “repeated or extreme exposure to aversive details of a traumatic event.”
- **Secondary trauma** can be exposure that involves hearing about traumatic events through work or the experience of supporting individuals who survive trauma. The concept of secondary trauma was
Methodology and Limitations

For this exploratory research, our research team relied on a review of existing RAND research and academic literature, interviews with IC professionals at the middle- and senior-management levels, and a focus group of RAND experts who are former mid-level analysts and mid- to senior-level IC managers. The literature we consulted focused on trauma- and empathy-based stress on civilian professional populations, particularly among the IC or similar fields, such as law enforcement professionals, first responders, and professionals in social work fields, along with military IC professionals. Using the literature most relevant to the IC context, along with two relevant conceptual models that relate to trauma and its effects, our research team devised a draft conceptual model for trauma in the IC. After the research team adjusted the conceptual model to reflect the IC’s unique nature, we presented the revised model to the current and former IC personnel in the interviews and the focus group, respectively. According to their varied professional experiences, interviewees and focus group participants recommended additions and deletions to the model. We discussed the potential updates and also referred back to the relevant research literature when choosing which revisions to implement.

For the not-for-attribution interviews, we identified subjects via professional contacts from the research team. Moreover, we used a snowball sampling method to gather recommendations for additional interviews from the interviewees. Our interview pool was relatively small, consisting of nine IC professionals at the mid- to senior-management level; the focus group comprised eight former IC professionals. Although our interviewees and the focus group participants include individuals with experience at the Office of the Director of National Intelligence, Central Intelligence Agency, Federal Bureau of Investigation (FBI), and other relevant organizations, many participants had spent much or all of their careers at the Defense Intelligence Agency (DIA). Hence, limitations of this work are that the interviews and single focus group included relatively small sample sizes and our interviews were not representative of the breadth or depth of the IC. To address this limitation, future research could focus on interviewing a representative sample of personnel from across all 18 intelligence agencies. In addition to questions relating to the conceptual model, the interviewees and focus group participants provided information regarding potential job categories and tasks that could lead to trauma exposure, individual and organizational variables that could influence trauma responses, mental health services the IC offers employees, and constraints that could prevent personnel from accessing the support they might need. Because of the small number of interviewees, our research team also conducted an informal thematic analysis to identify key trends and quotes to include in the Perspective.

Another limitation relates to the nature of this publication as an unclassified Perspective. Some potential interviewees declined to participate as a result of the unclassified status; they did not want to discuss their work and its mental health effects outside of secured environments. As discussed in the Perspective, the need-to-know culture associated with security clearances likely limits the willingness or ability of employees to raise concerns about the traumatic effects of their work.

The RAND National Security Research Division’s standardized human subjects research screening methods, developed in collaboration with RAND’s Institutional Review Board, deemed that this does not constitute human-subjects research. Nonetheless, all interviews are attributed anonymously throughout this report in compliance with the U.S. Federal Policy for the Protection of Human Subjects (also known as the Common Rule). Furthermore, human subject protections (HSP) protocols have been used in this Perspective in accordance with the appropriate statutes and DoD regulations that govern HSP. The views of the interviewees, which HSP rendered anonymously, are solely their own and do not represent the official policy or position of DoD, IC agencies, or the U.S. government.
FIGURE 1
Conceptual Model for Reactions to Stress and Trauma in the IC Workplace

<table>
<thead>
<tr>
<th>Traumatic Events</th>
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<tr>
<td>• Direct trauma exposure</td>
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<tr>
<td>• Secondary trauma exposure</td>
</tr>
<tr>
<td>• Potentially morally injurious events</td>
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Exposure to trauma can be direct or indirect.

<table>
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<tr>
<th>Operational Characteristics</th>
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<tbody>
<tr>
<td>• Environment</td>
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<tr>
<td>• Duration</td>
</tr>
<tr>
<td>• Supervision, personnel</td>
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<tr>
<td>• Task</td>
</tr>
<tr>
<td>• Level of danger</td>
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<tr>
<td>• Communication</td>
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Operational characteristics—or specific characteristics of the work or workplace—can affect the way individuals react to trauma exposure.

<table>
<thead>
<tr>
<th>Mitigating and Risk Factors</th>
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</thead>
<tbody>
<tr>
<td>• Individual differences</td>
</tr>
<tr>
<td>• Organizational environment</td>
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Trauma exposure itself does not guarantee a given outcome. A variety of individual and organizational mitigating and risk factors influence the exposure’s outcome.

<table>
<thead>
<tr>
<th>Interventions</th>
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<tr>
<td>• Individual or workplace</td>
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<tr>
<td>• Formal or informal</td>
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Interventions can support those who experienced trauma exposure.

<table>
<thead>
<tr>
<th>Cognitive, Affective, and Behavioral Outcomes</th>
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<tbody>
<tr>
<td><strong>Positive</strong></td>
</tr>
<tr>
<td>• Posttraumatic growth</td>
</tr>
<tr>
<td>• Compassion satisfaction</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
</tr>
<tr>
<td>• PTSD</td>
</tr>
<tr>
<td>• Secondary traumatic stress</td>
</tr>
<tr>
<td>• Moral injury</td>
</tr>
<tr>
<td>• Compassion fatigue</td>
</tr>
<tr>
<td>• Depression</td>
</tr>
<tr>
<td>• Burnout</td>
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<tr>
<td>• Substance abuse</td>
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<tr>
<td>• Fatigue</td>
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The types of trauma exposure and occupational features of the workplace can lead to both positive and negative mental health outcomes.


NOTES: PTSD = posttraumatic stress disorder. Interventions rarely occur, so they do not merit direct placement and connection within the model’s flow. However, because they can occur, they have a place within the conceptual model.
established as a way to fill a need to describe the effects of trauma exposure on professionals such as mental health practitioners, educators, journalists, researchers, human rights activists, police, and health care workers.\footnote{8}

- Potentially morally injurious events are situations involving “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.”\footnote{9}

Note that a single event could meet all three of these definitions because of overlapping definitions across the categories.

**IC Personnel’s Risk for All Three Types of Trauma**

IC personnel are at risk of experiencing a variety of traumas, depending on their work environment and professional focus. Figure 2 illustrates which categories of personnel within the IC could be at the highest risk for each type of exposure. Personnel in certain positions that are, by their nature, in the field (e.g., case officers and defense attachés) are at risk of both direct and secondary trauma because they often operate in hostile environments and could run sources operating at personal risk. Staff members who deploy to provide forward intelligence support to combat operations (generally CIA and DIA all-source analysts and collectors) are at risk of direct trauma from the wartime effort around them and of secondary trauma from their involvement in supporting and observing kinetic military action. The quick turnarounds, short nature, and general ad hoc approaches taken to these deployments increases the likelihood that these needs could go unrecognized and unaddressed—particularly because analysts often leave their home office or organization and deploy individually to augment a fusion center or task force.\footnote{10}

IC professionals also can work in environments where they are continuously exposed to reports and stories about systematic violence. This is particularly true for IC members whose work focuses on counterterrorism, counternarcotics, wartime conflict, instances of genocide and ethnic cleansing, countries with prolific sexualized violence, weapons of mass destruction, prisoners of war or missing in action cases, refugees, and document or technical exploitation.\footnote{11} Although the IC has a long history of working with material in textual formats (recognizing the National Security Agency’s specific work with audio material and the National Geospatial-Intelligence Agency’s specific work with still images), IC analysts are increasingly likely to engage with visual violent material—for example, when analyzing videos al-Qa’ida posted of beheadings or reviewing gory images recovered from a laptop during a military operation. Moreover, because of military operations, gruesome and traumatic material often is easily accessible and can even be shared via email, which means that, at times, such material is presented to professionals who are not prepared to view such material.\footnote{12} Those individuals working on such topics are at increased risk of suffering stress reactions from their prolonged exposure to such graphic and affecting content.

The existing literature on trauma exposure among IC professionals has primarily been conducted in the context of the U.S. Air Force, with special focus on drone-operator teams.\footnote{13} These professionals tend to be deployed in garrison, usually piloting unmanned aircraft remotely from
within the United States, and their work involves stress in the form of long hours of high vigilance, accompanied by exposure to high-definition combat imagery and occasional involvement in combat. A 2018 study queried personnel engaged in remote combat and graphic media exploitation operations via focus groups and surveys. The study found that certain types of experiences, such as witnessing U.S. military or civilian casualties or atrocities committed by the enemy, heightened personnel’s risk for posttraumatic stress and moral injury. This also highlights the risk to IC professionals, stressing the importance of understanding how these risks translate beyond this narrow type of intelligence work to the broader IC.

A less appreciated and understood type of trauma is potentially morally injurious events, for which all IC members are at risk. IC professionals adhere to a codified set of professional ethics, including seeking and speaking the truth, conducting themselves in a lawful manner that respects privacy and civil liberties, and being responsible stewards of the public trust, which includes protecting intelligence sources and methods and being accountable to institutions and the people of the United States. Yet politicians supported by the IC might not adhere to these same ethics; they might leak intelligence, compromising sources and methods, or knowingly speak falsehoods. IC members can also betray this code of conduct—for example, through espionage, as was the case of Edward Snowden’s
IC professionals could feel complicit in policy decisions even though they often lack the agency to determine policy outcomes.

theft and unauthorized disclosure of intelligence documents. Exposure of programs that have overstepped their authorities or other intelligence efforts and are called into question publicly may also put IC members at risk of moral injury. Compartmentalization is the concept that IC members are only aware of topics about which they have a demonstrated need for such knowledge; IC members are often not authorized to know what their colleagues are doing, but they need to have confidence that behavior is ethical. Wrongdoing that reflects that some parts of the IC are not adhering to its stated code of ethics raises questions about whether IC institutions can be trusted or about whether an IC professional is unknowingly a participant in a corrupt or unconstitutional system.

IC professionals could also be at risk of traumatic stress reactions from watching atrocities that they perhaps anticipated but, from their perspective, a policymaker did not take action to avoid or prevent. For example, an IC professional might be aware of a pending genocide or mass violent event abroad, but they must defer to policymakers’ decisions on whether to act and whether such an action is in the U.S. national interest. IC professionals are not simply bystanders of these types of actions: They play a critical role in the policymaking process and, therefore, could feel complicit in these decisions even though they often lack the agency to determine policy outcomes. IC professionals can suffer similar injuries from intelligence failures or as a result of intelligence gaps. A study of intelligence counter-terrorism professionals found that those professionals who were responsible for research, analysis, and communication felt a sense of guilt and blame when they missed something important.

Outcomes of Trauma—Both Negative and Positive

Existing literature can help us understand specific mental health outcomes from trauma exposure and how those can affect professionals’ well-being, as well as an organization’s mission at large. Importantly, the literature reveals that such effects are not universally negative: A variety of both negative and positive outcomes are well documented.

Perhaps the most well-known category of negative outcomes includes PTSD and other mental health disorders. Recounting this literature is beyond the scope of this review, but the box on the next page provides a brief description of symptoms that meet diagnostic criteria for PTSD. In addition to the effects on individual employees’ well-being, an organization that employs many employees suffering from PTSD or other negative outcomes is affected as well. Effects can include high staff turnover, reduced
productivity, and reduced total workdays (although further research is still needed).

Other negative outcomes are also possible, such as depression and unhealthy substance use, although estimates of the outcomes’ prevalence vary widely across studies.\(^{26}\) Moreover, unhealthy substance use and depression often overlap.\(^{27}\) Some interviewees anecdotally noted the prevalence of a happy-hour culture throughout their respective communities, noting that alcohol is often seen as an acceptable coping mechanism, whereas other substances are unlikely to be used because of prohibitions and the risk of losing a security clearance or job.\(^{28}\)

**Secondary traumatic stress** presents similarly to the symptoms of PTSD. Its symptoms, which include intrusive symptoms, avoidance, negative thoughts and feelings, and arousal, are usually considered in terms of severity rather than being used to determine a diagnosis or condition.\(^{29}\) For individuals who support trauma survivors, including police, health care workers, and therapists, secondary traumatic stress is also sometimes called compassion fatigue.\(^{30}\) One of our interviewees shared a story about a contractor analyst who slept under his desk one night as a result of stress from his account. This analyst lived alone and, therefore, lacked support mechanisms external to the office. Eventually, his company did provide mental health services, once the issue was identified.\(^{31}\) Another former analyst who was pregnant recounted how she began premature labor as a result of stressful and traumatic work; she also mentioned witnessing colleagues having heart attacks and experiencing anxiety from the stress.\(^{32}\)

There are a variety of negative outcomes associated with moral injury, including psychological, physical, social, and spiritual changes.\(^{33}\) Interviewees noted multiple instances of intelligence professionals encountering moral dilemmas throughout their careers, often surrounding the effects that intelligence or military operations can have on human sources or innocent civilians. One former military and civilian analyst and manager said, “I have seen people become very disturbed about those types of discussions, up to and including tears in a meeting, if we do something that might really hurt innocent people.”\(^{34}\) Others noted that policymakers not respecting IC judgments and the workforce or not preparing for events the IC warned about, such as war crimes or invasions, can lead to similarly morally injurious feelings and reactions.\(^{35}\) A large study of U.S. veterans who served in Iraq or Afghanistan showed

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**Posttraumatic Stress Disorder**

Following exposure to a traumatic event, PTSD diagnosis requires the following four criteria, which must persist for at least one month following the trauma exposure:

- at least one intrusion symptom (e.g., distressing memories, dreams, or distress in reaction to trauma reminders)
- at least one avoidance symptom (e.g., avoiding thoughts, feelings, or reminders of the event)
- at least two “negative alterations in cognitions and mood” (e.g., exaggerated negative beliefs, decreased interest in important activities, feeling detached from others)
- at least two “alterations in arousal and reactivity” (e.g., irritability, difficulty sleeping, and concentration problems).

increased rates of mental disorders and suicidal ideation among veterans exposed to potentially morally injurious events. The researchers note that it is still unclear how unique, and distinct from PTSD, these issues are and whether specific treatments are warranted to address them; further research is certainly warranted to determine differences between PTSD and moral injury.

Professional burnout is another potential negative consequence of work-related trauma exposure, although it is related more to general work stress (e.g., unfair treatment, unmanageable workload, lack of role clarity, unreasonable time pressure, poor communication) than to trauma content per se. Burnout does not involve the specific symptoms of PTSD but rather general feelings of hopelessness and being ineffectual at work that gradually lead to a state of emotional exhaustion and can lead an employee to leave their job. Moreover, our interviewees noted the impact that burnout is having on the IC workforce, exacerbating professional exposure to secondary trauma. In some instances, when employees advocate for themselves, requesting less stressful positions, managers have responded with, “Nope, you’re too valuable to us; we can’t move you.”

Notably, the scientific literature has also explored potential positive outcomes associated with trauma exposure: posttraumatic growth and compassion satisfaction.

The first positive outcome, posttraumatic growth, is defined as transformative positive change that can result from highly challenging life crises, including enhanced perceptions of self, relationship to others, and philosophy of life. This is seen as a dimension that is independent of posttraumatic stress, and PTSD symptoms are seen as a prerequisite for this type of growth. Psychological growth is associated with such outcomes as improved well-being; positive physiological changes; and positive work-related outcomes, including a sense of accomplishment, meaningfulness of work, and positive leadership behaviors. In one study, counterterrorism professionals identified the importance of their work despite the negatives of being “haunted” by experiences or feeling distant from their past selves, from others, or from the future. For leaders and policymakers, the positives centered on being a director of useful action. For counterterrorism field professionals, positives included the accomplishment of passing a test of courage, admiration and affection for colleagues, and a sense of victory when successful.

Another positive outcome is compassion satisfaction, defined as the pleasure that one derives from being able to do work effectively. In many studies, it is included alongside measures of negative outcomes to assess the factors related to maintaining compassion in the face of workplace trauma exposure.

Operational Characteristics of an Environment That Can Increase Trauma Risks

Operational and organizational characteristics—or specific characteristics of the work or workplace—can affect the ways in which individuals react to traumatic content. Substantial literature shows that operational characteristics of work environments where personnel are assigned have an impact on subsequent mental health outcomes for military service members, helper professionals, and personnel responsible for internet content monitoring. Recognition
of the dangers of such environments exists within the IC, but the same understanding of operational impacts might not extend to the headquarters environment. Many of the current and former IC professionals with whom we spoke provided examples of situations in which resources were not provided to support them or other employees in processing graphic material and traumatic events. For example, two professionals shared personal reflections regarding the impact of viewing hours of video and images related to hostage cases and the lack of institutional training or support. One stated that they compartmentalized the impact to such a degree that they forgot the impact on new analysts until they saw one “crying at their desk as they processed the humanity of the hostage.” Upon further reflection, the interviewee realized that the IC discusses work in terms of mission, as if analysts were disconnected from their empathy and feelings during business hours. This tendency reflects a cultural acceptance of “but the job is the job” and a failure to address the impact on employees.

In our review of studies focused on deployment of military personnel, we found certain aspects of deployment experiences were salient in terms of mental health outcomes. Studies on deployment of military personnel have shown consistent evidence that PTSD symptoms are higher among those injured while deployed, and the single biggest predictor is exposure to combat. The literature that is most germane for the IC similarly highlights the importance of operational factors in informing mental health experiences: It is not simply the exposure to potentially traumatic events but compounding occupational stress that can make individuals more susceptible to experiencing trauma. Although one might assume that direct combat exposure would be the factor that most directly affects mental health, studies suggest that the constant stressors related to work—such as long hours, shift work, short-staffing, and poor leadership—can be more frequent detrimental sources.

In terms of organizational variables, literature on deployed military personnel has focused specifically on mental health outcomes but also on the ways that perceived unit support and unit leadership, the prevalence of non–combat-related stressors during deployment, and
sustained presence in dangerous locations affect mental health outcomes. Negative work environments within the IC, such as poor management that fails to focus on employee well-being, can exacerbate the risk to employees. A few interviewees underscored that consistently toxic office environments, such as those where racism or sexism explicitly or passively exists, can be damaging to resilience. One interviewee noted concerns about the emotional and professional impacts on people of color when colleagues make derogatory comments about adversaries who share the same skin tone as IC employees. A paper published in 2020 focuses on how organizational factors influenced IC security breaches, highlighting that one notable case was influenced by “a work environment marred by bullying, physical violence, vandalism, retaliation, and negligent management” within one section of the CIA. A study focused on Internet Crimes Against Children Task Force personnel showed that low organizational support was related to mental health outcomes.

IC organizations that have more of a military culture, such as DIA, were seen by interviewees as being at greater risk of these types of problems, both because of the potential for military leaders to expect civilians to have the same temperament as service members and because of the more-frequent turnover for military leadership than for civilian leadership. These IC organizations can inherit some of the negative aspects of the military’s culture, such as dismissal of misgivings or reticence, or a “Suck it up, Buttercup” attitude, without being balanced by some of the positive elements of the military, such as chaplains, which are not available to the IC civilian workforce.

Conversely, IC managers can provide a positive environment by recognizing the value of mental well-being and lowering barriers to seeking care when it is needed, something interviewees consistently highlighted as necessary. One manager noted, “You can have institutional structures, but 90 percent of management is local and having presence.” The manager further noted the criticality of leadership honestly engaging with their employees to acknowledge and gauge stress levels: “Having a team where people can be honest is important, but you also have to have someone who can say, ‘I get this, you’re under stress, let’s do something.’”

Poor Understanding of the Risks of Trauma Exposure

Despite IC professionals being at risk of experiencing traumatic or potentially injurious events through their professional responsibilities, these risks are poorly or not generally understood, which reduces the effectiveness of mitigating risk factors and interventions. In contrast, the potential for staff to experience direct trauma from a deployment or a colleague’s suicide is generally recognized. Supervisors receive training on employee assistance program (EAP) resources and how to engage services for employees, but these services are generally viewed as supporting direct trauma experiences, according to interviewees and focus group participants. This is not to say that IC professionals receive sufficient support for trauma. IC professionals returning from deployment, for example, are typically required to meet with a psychologist even though this interaction is often superficial. Multiple interviewees noted that pre- and post-deployment sessions were short, limiting opportunities to build trust with psychologists, and psychologists’ security clearance statuses were
unclear. However, EAP services were viewed favorably among interviewees and were well advertised, especially to supervisors who could recommend them to staff. We do not have data on how frequently these services are used or how effectively they are received, but we spoke to individuals who had positive anecdotal experiences or observations. EAPs have the benefit of being able to provide support for staff in a classified environment and to serve as a networking mechanism in cases that exceed its capacity. A couple of the IC supervisors with whom we spoke mentioned that they brought in EAP staff to brief their organizations during periods of increased stress. That said, EAP programs were generally seen as services for individuals who experienced direct trauma and stress. It is not clear whether they are also seen as a recourse for those experiencing secondary traumatic stress, and their aptitude to deal with issues of other types of empathy-based stress is also unclear.

Secondary traumatic stress is not an issue that IC supervisors and managers are necessarily trained and equipped to understand. Individuals suffering from secondary traumatic stress may also fail to recognize the effects of this stress, or they may lack the vocabulary needed to describe their feelings so as to effectively seek care. One interviewee noted that it is quite possible that most employees do not think that there can be mental health issues in the community, particularly among analysts: “I sit at a desk all day long. I write reports. How can I think I’m having a traumatic experience from just reading?”

Mitigating and Risk Factors Can Help Predict the Potential for Trauma and Reduce Its Likelihood

An individual’s likelihood of experiencing a particular outcome is not predetermined by the experience of trauma exposure; rather, studies indicate that outcomes are influenced by a variety of mitigating and risk factors. Just as the operational characteristics of an environment can affect the risk of trauma, there are also individual risk factors.

Despite the existence of a large body of research directed toward understanding who recovers and who develops lasting mental health problems following exposure to trauma, there are some limitations to this work. These studies tend to examine the factors for a particular type of exposure (e.g., family violence, trauma experienced by refugees, trauma experienced by firefighters), and most do not control for different predictors simultaneously but rather examine univariate relationships.
The types of predictors span the periods before, during, and after trauma exposure and are thus often grouped into three categories: pre-trauma characteristics (e.g., past history of trauma exposure), peri-traumatic factors (e.g., severity), and post-trauma factors (e.g., social support, additional life stress). PTSD studies of the general population show that the most-consistent pre-trauma predictors are personal and family psychiatric history and history of child abuse.\(^6^6\) Although demographics tend to be inconsistent predictors of PTSD, the risk for PTSD appears to be higher among women and for individuals with lower socioeconomic status.\(^6^7\) Despite the fact that gender is confounded with the type of trauma exposure in many cases (e.g., women are more likely to experience sexual assault, men are more likely to experience accidental injuries), women appear to be at higher risk even within trauma type.\(^6^8\) Combat exposure is the primary risk factor for mental disorders among service members.\(^6^9\)

The literature on secondary traumatic stress is smaller and tends to include not military service members but spouses and health care providers.\(^7^0\) A systematic review of 31 studies of first responders identified several risk factors—including age; gender; exposure; emotional exhaustion; and posttraumatic factors, such as social support and substance use—to predict secondary traumatic stress, although levels of secondary traumatic stress were low overall.\(^7^1\) Even with the end of combat operations in Afghanistan and Iraq, it is important for the IC to consider the risk of combat exposure in relation to secondary traumatic stress. Many of our interviewees and focus group participants provided personal examples of friends being killed or injured in suicide bombing attacks or even colleagues being killed in non–work-related circumstances.\(^7^2\) One former official who was based in an embassy relayed the impact of having to identify human remains, spending hours to determine whether the body was that of an American to provide proper notifications.\(^7^3\) Moreover, the constant exposures to mass graves, counterterrorism strikes, videos of hostages, and media exploitation were consistently highlighted as reoccurring traumatic incidents for IC professionals.\(^7^4\)

It is important to recognize that trauma is not experienced equally: There are various factors that affect an individual’s resilience to trauma. Literature that addresses protective factors or resilience to trauma includes social support,\(^7^5\) as well as the concept of hardiness, defined as a personality construct that involves a strong sense of commitment, belief that one is in control, and the perception of difficulties as challenges rather than threats.\(^7^6\) Resilience is often expected of IC professionals, and it is often perceived as staff become accustomed to the job and experienced at coping with difficult situations without expressing emotion or acknowledging the mental impact. Seasoned professionals may be so resilient to the stressful demands of their professions that they may fail to recognize the needs of new and junior staff, but they also may fail to recognize when they have reached the limits of their own emotional capacity.

IC leaders may fail to appreciate how building mental buffers against trauma-related stress—particularly buffers that reduce the practice of empathy among IC professionals—can open professionals to cognitive biases. Empathy may be seen as a weakness that makes someone emotional and, therefore, not rational or analytic. One senior manager relayed to us that other managers told her she was not “tough enough” as an office chief.\(^7^7\) She
IC leaders may fail to appreciate how building mental buffers against trauma-related stress—particularly buffers that reduce the practice of empathy among IC professionals—can open professionals to cognitive biases.

added, “In our business, it’s hard for people to see that you can be tough and vulnerable at the same time. I think those skills of being available and listening are as important as anything else. Because we deal with life and death, people think that if you’re vulnerable you can’t make tough decisions.”78 According to interviewees, empathy should instead be seen as a professional asset; it is what allows IC professionals to understand adversaries and targets of collection.79 Focus group participants noted that a lack of empathy can open individuals up to biases that impair objective analysis, particularly a tendency to see the U.S. side as good or right and adversaries as wrong or evil, especially after these individuals spend significant time focusing on a country that, for example, consistently commits atrocities.80 Over time, this bias can cloud individuals’ self-perceptions and assessments of targets and the ways that individuals present this information to policymakers, which then can affect the policies that are designed and implemented. Moreover, the compassion fatigue aspect of secondary traumatic stress can increase biases and decrease objectivity among analysts. One former IC professional noted, “If you can never recognize and acknowledge when something good happens, and it’s all bad, that’s a problem. It impacts the mission.”81

Barriers for IC Employees Seeking Care

Our interviews exposed concerns about the lack of a culture of mental wellness in the IC. There may need to be a systematic effort to address these problems and make deeper cultural changes. The needs for physical wellness are recognized—for example, many agencies authorize staff to spend a few hours per week exercising while on the clock or provide a gym in the facility—but the same philosophy is not applied to mental wellness. While our conversations highlighted the increased advertisement of EAP services throughout the IC, interviewees also noted some limitations of these services. Foremost was that EAPs offer only a handful of sessions for employees, as they are not meant to be a formal treatment. Moreover, a direct-referral service to external mental health care, particularly one that
Stigma is a well-recognized hindrance to seeking mental health care, but there are some unique constraints for IC personnel.

takes insurance coverage and geographic constraints into account, does not exist. With a significant portion of IC employees living in the greater Washington, D.C., area, financial concerns and commuting times are factors that can limit access. One interviewee expressed the belief that senior IC management viewed EAPs as an “easy button” and the primary mental health resource for staff, recommending the service without a clear understanding of the expanse of mental health issues facing employees. A current manager expressed similar concerns about the limited knowledge of the varied impacts of trauma on the workforce and the seemingly singular agency-provided resource, noting that this could lead to increased employee distrust of managers and services, such as EAPs, that are offered by IC agencies. Another current manager emphasized that “mental health services [are] partly [an interpersonal] chemistry issue; you need to feel safe.”

Occupational trauma exposure opens up the possibility of workplace prevention for all employees and early intervention for those who have been exposed to trauma. Researchers recommend a proactive approach to addressing the mental health impacts of workplace trauma exposure, and a recent scoping review concluded that “[early] interventions [for] emergency responders [work best] when these are tailored to the needs of the population, are supported by the host organization, and harness existing social cohesion and peer support processes within a team or unit.” Intelligence organizations could also look at other models of support, such as those used by the Army and the FBI. For individuals who develop PTSD that is impairing their daily lives, mental health treatments are available.

Stigma is a well-recognized hindrance to seeking mental health care, but there are some unique constraints for IC personnel. IC employees may be concerned that seeking help will negatively affect their security clearances and threaten their ability to maintain their positions; this issue is reflected in military culture as well. Although the Standard Form (SF) 86, which is required for national security positions, states that mental health is important and that seeking mental health treatment is encouraged, it also states that “there may be times when such a [mental health] condition can affect a person’s eligibility for a security clearance.” The SF-86 was modified in 2016 to ask questions about only mental health conditions that have required hospitalization or ordered treatment or that related to a diagnosis of psychotic disorder, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder or another mental health condition that substantially adversely affects judgment, reliability, or trustworthiness. These changes amounted to a rec-
ognition that the SF-86’s previous broad question about whether an applicant had consulted with or been counseled by a mental health practitioner for any reason was a deterrent to individuals seeking mental health treatment, even though clearances were reportedly rarely denied because of mental health counseling. Some individuals have wondered whether questions about mental health should be removed entirely given that it rarely leads to security clearance denial or revocation, and, for those cases in which it would, there would be other indications of risk. With the ongoing shift to the Continuous Evaluation Program for the security clearance process, an opportunity exists to proactively include reviews and discussions with mental health professionals to screen current IC employees’ exposure to trauma and resiliency to it, according to one of our interviewees.

The need for secrecy also limits IC professionals’ ability to employ some mechanisms for coping with stress and trauma. Principally, IC employees generally cannot discuss their work with their loved ones, so they are unable to share concerns and experiences freely with family and friends. Because of the requirement that individuals have a demonstrated need to know in order to access classified information, IC members might not be able to discuss stressors or experiences even with cleared colleagues, further isolating these employees. In the words of one current IC manager, “We’re trained not to talk about anything. You don’t talk about your work, and, if you do, you don’t talk about the problems. First, last, and everything is security focused.” Our conversations revealed concerns over “happy hour culture” and perceived high levels of alcohol consumption as the “acceptable” way to manage work-related stressors and traumas throughout the IC.

Fears over violating need to know or accusations of sharing classified information with uncleared personnel may also make an IC professional reliant on EAP services, which could provide support in a classified setting. EAPs, however, may be seen as a last resort, seen as punishment for the employee, or referred when performance has already been adversely affected. Concerns regarding mental health confidentiality within the military led to the development of confidential avenues for nonmedical counseling for issues that do not meet the criteria for a formal psychiatric diagnosis; similar models may prove useful for the IC. One current manager affirmed this concern with her own predeployment experiences relating to a long-standing anxiety diagnosis: “I had to meet a psychologist; they asked me some personal questions that I felt were a violation of what they needed to know to clear me.”

IC professionals may also be concerned about how they will be perceived by their coworkers if it becomes known that they are seeking support for trauma. Some of our focus group participants noted how peer pressure influenced personnel not wanting to be identified as someone who cannot “cope with the gruesomeness” of some jobs. This may also have a gender dimension—for example, men may be concerned that they need to be seen as “tough,” whereas women may not want to be seen as “emotional,” an idea agreed upon by current and former personnel. One female manager stated that, as a result of stressors related to the coronavirus disease 2019 pandemic, she was having more “open and honest conversations” with her female colleagues about difficulties, but not with her male counterparts. The gender divide can also directly relate to whether an individual is seen as competent for the job, given that so much of the credibility of an IC professional is
Much of the credibility of an IC professional is contingent on their judgment and mental fitness. If someone is perceived as overwrought or irrational, their work may be unfairly discredited by those around them. Because women are more likely to experience negative responses to trauma, this concern is not unfounded.

The Way Forward

Through our literature review, initial interviews with current IC professionals, and the focus group with former IC professionals, we learned that exposure to trauma and the multiple ways that such exposure manifests are a concern within the IC. Moreover, the IC has only a limited understanding of the symptoms of various types of trauma and the strict parameters that surround discussions about trauma and mental health within the IC, and it would benefit from a concerted effort to consider these issues by learning more about the community’s needs. As one current manager stated, “If they [the IC] are not going to talk about it proactively on the inside, they’re not going to talk about it outside. What’s prompted the discussion in the military is violence—suicides and radicalization—and the IC hasn’t had [such violence].”

Many of our conversations with IC members highlighted how addressing mental health issues within the IC is a reactive endeavor, as opposed to a proactive one, and burdens the individual with identifying their issue with limited education and support. One former employee noted how the current process reflects a broader theme in American culture in which institutions treat mental health as the responsibility of the individual instead of providing systemic supports that recognize an employee as a “whole person.” Moreover, a few of the middle managers with whom we spoke provided recommendations related to seeking mental health care or building resiliency skills based on their own experiences or crowdsourcing from their friends across the IC. One went so far as to say, “The IC doesn’t talk about why you should take care of mental health, [only] what needs to be reported.” These practices further stigmatize seeking mental health care and degrade individual and institutional efforts to build a culture of mental wellness. Our conceptual model provided a guide for our conversations but also, more critically, a common language and understanding of how trauma affects individuals and organizations. Future research could identify the most-effective methods for communication with the IC workforce, especially from senior leaders, about protecting mental health and emotional well-being.

Our interviews showed that the changes in reporting requirements probably have not reduced the stigma associated with employees seeking treatment. Agencies, through their security and EAP representatives, could provide details and examples of what behaviors and activities would affect an employee’s clearance or ability to hold
a certain job; for supervisors, more regular and extensive training on trauma exposure, intervention methods, and available resources appear to be gaps that could be easily remedied. Moreover, by frequently initiating discussions about their own mental health and the actions they have taken to address any concerns, senior leaders could aid in the effort to improve the IC’s culture in relation to mental health and trauma exposure. One former military analyst and manager described an instance that occurred while he was based at an embassy, in which the ambassador required all employees to meet with a psychiatrist after a traumatic event.

A proactive approach to addressing the mental health effects of workplace trauma exposure is recommended in the literature. A review of posttraumatic growth at work concluded that two factors could enable growth: occupational support (e.g., building organizational culture and establishing processes to support employees exposed to trauma) and attentive companionship (e.g., creating conditions that foster trust and safety, designing formal roles for attentive companionship). Further research into designing and implementing effective processes and resources that could be provided by the IC for the workforce could consider methods to foster posttraumatic growth following trauma exposure.

IC leaders recognize that human capital is one of the IC’s most critical resources. In her confirmation hearing, Director of National Intelligence Avril Haines highlighted the workforce’s having “unparalleled dedication and expertise” in its “indispensable role in protecting the country from the most dangerous threats.” However, as the national security community shifts focus from Iraq and Afghanistan, IC personnel will continue to be exposed to traumatic events, such as the spring 2022 Russian invasion of Ukraine and the resulting destruction, including potential war crimes. The human and fiscal costs to individual IC employees and the community as a whole will continue. Research shows that the cost of caring for war veterans peaks 30 to 40 years following a conflict; although health care options for military veterans are different from those offered to current and retired U.S. government civilian employees, this analysis of long-term health needs identifies only one area of potential long-term impact on IC personnel. The need for the IC to support its employees who are exposed to trauma through their work is not simply an ethical obligation to provide for employees’ well-being:

As the national security community shifts focus from Iraq and Afghanistan, IC personnel will continue to be exposed to traumatic events, such as the spring 2022 Russian invasion of Ukraine and the resulting destruction.
Failure to meet this need could negatively affect the quality of work and the retention of qualified personnel within the IC. The IC would benefit from a concerted effort to consider these issues by learning more about the community’s needs, identifying best practices, and initiating programs to meet the workforce needs.

Notes


3 Professional burnout and employee turnover are potential consequences of emotional exhaustion associated with secondary trauma exposure. Among IC professionals, there might also be concerns about barriers to care or coping mechanisms (e.g., unhealthy substance use or risky behaviors) that make analysts more vulnerable to error or recruitment by foreign intelligence services.


10 Our conversations focused on analysts and collectors; however, one discussion mentioned IC support staff being exposed to traumatic events through their work of logistics, communications, administrative support, construction, reconstruction, and life support activities (including mortuary affairs), often in remote and dangerous regions. Future research could consider the breadth of occupations (beyond only analysts and collectors) that could be exposed to traumatic events.

11 Although exploitation of physical documents and textual, visual, and audio data found on computers and cell phones rose to prominence as a result of counterterrorism raids, the capability and its usage existed for centuries prior. Those personnel conducting the review, summary, and triage of such material were often exposed to extreme violence (including beheadings or torture), violent pornography, and extreme descriptions of violence.

12 Interview with IC official, April 29, 2021.

13 These teams include pilots, sensor operators, military intelligence coordinators, imagery analysts, and intelligence exploitation operators.


15 Researchers interviewed imagery analysts from the Distributed Common Ground System (DCGS). The interviewees displayed increased risk for posttraumatic stress if they witnessed a civilian death (Wayne Chappelle et al., “Emotional Reactions of Distributed Common Ground System Imagery Analysts Exposed to Remote Combat Operations,” Psychological Trauma: Theory, Research, Practice, and Policy, March 12, 2020). DCGS is the intelligence, surveillance, and reconnaissance collection, processing, and analysis system for the U.S. Air Force. Information collected from the larger unmanned aerial systems and fixed-wing airborne intel platforms (including live feed, imagery, and signals intel-
Although there is substantial literature on PTSD, insights into PTSD prevalence tend to be notably limited. Many studies are cross-sectional, conducted only on treatment-seeking individuals or on a convenience sample, who might not be representative of all of those who are affected. Studies can also fail to control for combat exposure, which is the strongest predictor of negative outcomes. Estimates of service member PTSD rates therefore vary widely across studies, ranging from 0 to 48 percent in non-treatment-seeking samples and 2 to 68 percent in treatment-seeking samples (Rajeev Ramchand et al., “Prevalence of, Risk Factors for, and Consequences of Posttraumatic Stress Disorder and Other Mental Health Problems in Military Populations Deployed to Iraq and Afghanistan,” Current Psychiatry Reports, Vol. 17, 2015).

For instance, the review of studies about deployment to Iraq and Afghanistan reveals that prevalence of clinical depression ranged from 4 to 45 percent and prevalence of substance use disorder ranged from 4 to 66 percent. As with PTSD, the estimates of prevalence were higher in studies whose samples comprised treatment-seeking individuals (Ramchand et al., 2015).


Bryant, 2019.

A 2008 RAND study (Tanielian and Jaycox, eds.) estimates point prevalence at 14 percent each for both PTSD and depression, with 9 percent of individuals qualifying for both diagnoses and 5 percent qualifying for each of the conditions alone, for a total of 18.5 percent with either condition.

There is a substantial literature on the epidemiology, diagnosis, and prevalence of PTSD among service members. For an early and influential example, see Terri Tanielian and Lisa H. Jaycox, eds., Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008.
Blair E. Wisco et al., “Moral Injury in U.S. Combat Veterans: Results from the National Health and Resilience in Veterans Study,” *Depression and Anxiety*, Vol. 34, 2017. Other studies have focused on police officers, refugees, and professionals and parents involved in child protective services (see Griffin et al., 2019).

A 2018 review focused on studies regarding occupational exposure to potentially morally injurious events and their relationship to PTSD, depression, suicidality, and anxiety. Not surprisingly, the studies found significant correlations between potentially morally injurious events and the mental health and well-being outcomes across studies, which mostly focused on military occupations. However, most of the studies did not control for other traumatic experiences, life stress, or other contextual factors that could also be relevant to mental health (see Victoria Williamson, Sharon A. M. Stevelink, and Neil Greenberg, “Occupational Moral Injury and Mental Health: Systematic Review and Meta-Analysis,” *British Journal of Psychiatry*, Vol. 212, No. 6, 2018).


Stamm, 2009.


Focus group of former IC officials, June 23, 2021; interview with IC official, April 23, 2021.

Interview with IC official, April 14, 2021; interview with IC official, April 23, 2021.

Ramchand et al., 2015.

A 2017 review of drone-operator teams identifies the most-frequent sources of occupational stress as operational factors, such as long hours, low unit manning, and shift work, rather than combat-related factors, such as participating in a strike or observing its aftermath (Cherie Armour and Jana Ross, “The Health and Well-Being of Military Drone Operators and Intelligence Analysts: A Systematic Review,” *Military Psychology*, Vol. 29, No. 2, 2017).


A study that focused on U.S. Air Force remote warriors—a mix of pilots and intelligence and cyberwarfare operators—and occurrences of severe psychological distress or suicide highlighted occupational factors, such as job dissatisfaction (e.g., low responsibility or opportunities for career advancement) and other life problems (e.g., alcohol abuse)


55 Interview with IC official, April 29, 2021.


57 Brady, 2017.

58 Interview with IC official, May 21, 2021; focus group of former IC officials, June 23, 2021.

59 Interview with IC official, May 21, 2021.

60 Focus group of former IC officials, June 23, 2021; interview with IC official, April 14, 2021; interview with IC official, April 23, 2021; interview with IC official, April 29, 2021; interview with IC official, May 21, 2021.

61 Interview with IC official, April 23, 2021; interview with IC official, April 14, 2021; focus group of former IC officials, June 23, 2021.

62 Interview with IC official, April 14, 2021; interview with IC official, April 23, 2021.

63 Interview with IC official, April 29, 2021; interview with IC official, May 21, 2021.

64 A 2009 paper reviewed EAPs within the IC. Similar to findings from our interviews, the research found that EAPs are an “integral component” to IC human resources, leadership support, and personnel reliability (Paul R. Clavelle, “Consulting to the Intelligence Community: An Employee Assistance Program Model,” *Consulting Psychology Journal: Practice and Research*, Vol. 61, No. 1, 2009). The FBI’s EAP includes crisis intervention and chaplain- and peer-support programs. It evolved from a program that began in the early 1980s to address the unique stressors that undercover FBI agents faced. The FBI’s support evolved to adjust to the organization’s culture, needs, and priorities, as well as to manage expectations, avoid mission creep, and define roles and responsibilities. The FBI’s EAP could be a model for other IC agencies’ EAPs (Meredith Krause, “History and Evolution of the FBI’s Undercover Safeguard Program,” *Consulting Psychology Journal: Practice and Research*, Vol. 61, No. 1, 2009).

65 Interview with IC official, April 23, 2021.


67 Bryant, 2019. In a large study of UK police officers and staff, the risk of PTSD, anxiety, and depression among those who experienced a traumatic event in the prior six months was higher for women, those not in a relationship, staff (i.e., employees of the police department who were not police officers), and those who engaged in heavy drinking (Sharon A. M. Stevelink et al., “Probable PTSD, Depression and Anxiety in 40,299 UK Police Officers and Staff: Prevalence, Risk Factors and Associations with Blood Pressure,” *PLoS ONE*, Vol. 15, No. 11, 2020). A separate study showed that junior enlisted personnel and some health care and combat specialists are more vulnerable to PTSD and depression than officers (Ramchand et al., 2015).


69 Ramchand et al., 2015. The studies we considered use different scales to define the term combat exposure. One commonly used scale includes 11 nonoverlapping items that were empirically derived from a longer list of 24 items that is often used by DoD. Some items are specific to direct trauma (e.g., smelling decomposing bodies, being injured, engaging in hand-to-hand combat), whereas others would also be applicable to other types of exposure (e.g., having a friend who was
seriously wounded or killed, being responsible for the death of a civilian). However, the scales usually count different types of exposures for the total score, meaning that people in rear support positions or in remote drone operations will always score lower than people deployed to a combat zone.


72 Interview with IC official, May 21, 2021; focus group of former IC officials, June 23, 2021.

73 Focus group of former IC officials, June 23, 2021.

74 Interview with IC official, April 14, 2021; interview with IC official, April 23, 2021; interview with IC official, April 29, 2021; interview with IC official, May 21, 2021; focus group of former IC officials, June 23, 2021.


77 Interview with IC official, May 21, 2021.

78 Interview with IC official, May 21, 2021.

79 Focus group of former IC officials, June 23, 2021.

80 Focus group of former IC officials, June 23, 2021.

81 Focus group of former IC officials, June 23, 2021.

82 Interview with IC official, April 29, 2021; interview with IC official, April 14, 2021.

83 Interview with IC official, April 23, 2021.

84 Interview with IC official, April 29, 2021.

85 Interview with IC official, April 23, 2021.


89 Bryant, 2019; Tanielian and Jaycox, 2008.
A 2009 study on EAPs in the IC found that stigma around EAP help-seeking, as well as concerns about maintaining a security clearance, are barriers. Since the study’s publication, some of the recommendations for reducing employee resistance have been implemented, such as “unequivocal” management support, including statements about confidentiality and a broad array of wellness activities that help EAPs collaborate with managers and employees and acclimate to the culture of the organization. Because of the parameters of the study, we do not know whether other recommendations have been implemented (Clavelle, 2009). For more information about stigma-related barriers in seeking mental health treatment that are present in the military, see S. J. Coleman et al., “Stigma-Related Barriers and Facilitators to Help Seeking for Mental Health Issues in the Armed Forces: A Systematic Review and Thematic Synthesis of Qualitative Literature,” *Psychological Medicine,* Vol. 47, No. 11, 2017.


Interview with IC official, April 14, 2021.

Interview with IC official, April 14, 2021.

Interview with IC official, April 14, 2021; interview with IC official, April 29, 2021.

Interview with IC official, May 21, 2021; interview with IC official, April 29, 2021.


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Interview with IC official, April 23, 2021; focus group of former IC officials, June 23, 2021; interview with IC official, May 21, 2021.

Interview with IC official, April 23, 2021.

Interview with IC official, April 14, 2021.

Focus group of former IC officials, June 23, 2021.

Interview with IC official, April 14, 2021; interview with IC official, April 23, 2021.

Interview with IC official, April 14, 2021.

Interview with IC official, April 14, 2021; interview with IC official, April 23, 2021; interview with IC official, April 23, 2021.

Interview with IC official, April 14, 2021.

Interview with IC official, April 14, 2021; interview with IC official, April 23, 2021; interview with IC official, May 21, 2021.

One interviewee commented that a departing senior executive, in his retirement email, implored employees to attend to their mental health. The interviewee noted frustration in their anecdotal discussions with colleagues that this senior leader did not discuss mental health previously and did not provide an opportunity to engage with the workforce about the issue at the agency (RAND interview with IC official, April 23, 2021).

Focus group of former IC officials, June 23, 2021.

Molnar et al., 2017; Ludick and Figley, 2017; Richins et al., 2020.


References


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About This Perspective

The mental health of U.S. military and Department of Defense civilian personnel and intelligence professionals, particularly after decades of significant overseas deployment responsibilities, is a topic of concern. Although the pace of deployments, especially in support of stressful counterterrorism missions, has slowed markedly, the mental health needs of intelligence professionals is evolving rather than diminishing. The 20 years following the September 11, 2001, terrorist attacks have illustrated that intelligence support occurs both in forward locations and throughout the United States, with technology ensuring that traumatic events and information can be shared globally and in nearly real time. That said, U.S. Intelligence Community (IC) leaders might not always appreciate the complex ways that trauma can affect the intelligence workforce. Intelligence professionals play a critical and unique role in the U.S. national security system, and these responsibilities put those professionals at risk of experiencing trauma, either directly or indirectly, and limit their recourse in managing such trauma. This Perspective explores the potential for U.S. intelligence professionals to experience trauma-related stress reactions because of their jobs, as well as the effects of any such stress and trauma on the IC.

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