

Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study

Major Karl L Haas, RPN, RN, BN, MSSc(Counselling)

IN THE LATTER HALF of 1999 Australia had close to 6100 military personnel on overseas deployments. Currently, the Australian Defence Force (ADF) has about 25–30 personnel in Bougainville as unarmed peace monitors, and 1500 armed personnel in East Timor as part of the UN peace enforcement role. In the war against terrorism the ADF has hundreds of troops, with naval support ships, deployed in the Middle East. Smaller numbers are also employed as peace observers in such places as the Sinai (27), Kosovo (16), and Former Yugoslavia (10).¹

These overseas deployments have often involved a combination of personnel from the regular forces, reserves and civilian organisations.

The stress of peacekeeping

Stress is a normal part of human existence — a double-edged sword, which can help us mobilise and achieve, or physically and psychologically incapacitate us. War is the most dramatic concentration of deliberate physical and psychological trauma that societies can inflict upon each other. War psychologically scars almost all who participate in it and even those who observe it from afar.² The stress of war has the power to change individuals and entire communities forever.

Peacekeeping missions, which bring soldiers into war zones as non-combatants, present a wide variety of stresses that have short- and long-term effects on mental health. Frequently, peacekeepers witness large-scale devastation and atrocities.³ Soldiers are trained to win the day by the application of tactics and up to date weaponry, yet peacekeeping and humanitarian missions generally restrict tactical freedom and the use of force, exposing soldiers to stresses for which they are not prepared or trained. Various authors have described UN

Abstract

- ◆ **Objective:** To assess the levels of stress experienced by military health personnel on deployment.
- ◆ **Design and setting:** A structured questionnaire was posted to a non-random selection of serving members of the ADF recently returned from overseas duty in 1999 and 2002.
- ◆ **Participants:** Seven subjects in 1999 and 11 in 2002, comprising medical officers, nursing officers and medical assistants.
- ◆ **Main outcome measure:** Subjects' rating of stress levels compared with stress at home.
- ◆ **Results:** Respondents reported greater stress while deployed than at home, and had witnessed or seen their colleagues affected by highly stressful events. Respondents were more aware of the stress of subordinates and less aware of the stress of superiors. Most noted the need to talk about their stressful experiences, but, despite awareness of available counselling services, no respondents used professional counsellors. Psychologists were rated most trustworthy and helpful among potential counsellors, compared with others, such as chaplains and psychiatrists.
- ◆ **Conclusions:** Health professionals in the military are at risk of stress-induced mental health difficulties, are aware of these risks, but take little action to prevent or ameliorate long-term pathological responses to stresses experienced while deployed.

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personnel as exposed to a wider range of stressors than they would be in combat. Isolation, boredom, feelings of frustration, rage and helplessness due to strict UN rules of engagement, which only allow a soldier to shoot if under direct threat of loss of life or limb, all increase the stress of military personnel in a peacekeeping role.⁴⁻⁸

Australian military personnel on peacekeeping and similar non-combatant missions operate in some of the most difficult and inhospitable regions of the world and have been exposed to atrocities and violence in Somalia, Rwanda, Bougainville, Kosovo, East Timor and Afghanistan.

Since World War I there has been a plethora of research in relation to the enduring toll of combat on mental health. It is only in the last 15 years that our understanding of stress associated with military operations other than war has developed. Recent deployments by US forces indicate that the mental health and wellbeing of military personnel will vary

Major Haas is a Nursing Officer in the Army Reserve and currently posted as S02 Nursing at Regional Reserve Health Personnel-SA. He has been in the Reserves for 26 years. He has been on deployment to Bougainville and East Timor. His nursing specialty is mental health, and he works at Glenside Hospital as a Clinical Nurse Consultant specialising in rehabilitation and recovery. His interests are in combat stress reactions and psychological trauma relating to critical events.

Banfield Ward, Glenside Campus Mental Health Service, Royal Adelaide Hospital, Eastwood, SA.

Major Karl L Haas, RPN, RN, BN, MSSc(Counselling), Nursing Officer. Reprints will not be available from the author. Correspondence: Major Karl L Haas, Banfield Ward, Glenside Campus Mental Health Service, Royal Adelaide Hospital, PO Box 17, Eastwood, SA 5063. khaas@glenside.rah.sa.gov.au

greatly from one deployment to another. The mission to Somalia (Operation Restore Hope, 1993) was marked by unexpected combat casualties. The mission to Haiti (Operation Restore Democracy, 1994) saw unexpected self-inflicted casualties and suicides. In late 1995 the US committed 20 000 troops to Bosnia for Operation Joint Endeavor. During this operation there were 135 admissions to the combat restoration unit, from where 30 soldiers were evacuated to Germany due to maladaptive behaviour and suicidal and/or homicidal ideation.⁹

The United States military deployed 12 mental health personnel in Operation Restore Hope, 10 in Operation Restore Democracy and 38 in Operation Joint Endeavor. During Australia's involvement in Somalia there were no dedicated mental health support units. Nine hundred Australian soldiers served in Somalia, with at least 20% showing significant psychiatric morbidity 15 months after their return.⁵ Australia's involvement in Rwanda was to provide medical support to the 5500 strong UN force. Australian infantry and medical personnel witnessed the horrors of the Kibeho massacre.¹⁰ The reaction of Australian troops was one of frustration, helplessness, anger and hatred. It has been suggested that there could be a 3% incidence of post-traumatic stress disorder among the Australian contingent.¹¹ Findings from a study of these veterans are to be published soon and should give a more accurate picture of their mental health.

In this article I report the results of a pilot study of stress in Australian military health personnel. For the study I surveyed small groups of health personnel to discover whether they were under more stress while on overseas deployment than in Australia, and to ascertain their attitude towards mental health support services.

Methods

A 25-item questionnaire was sent with a covering letter and self-addressed return envelope to serving members of 3 Health Support Battalion who had completed an overseas deployment. The survey was voluntary and anonymous. The same questionnaire was used in the 1999 and 2002 survey.

Subjects

All subjects were reservists in the Royal Australian Army Medical Corps (RAAMC) or Royal Australian Army Nursing Corps (RAANC). Participants

were selected within 12 months of return to Australia. While it was known that the subjects had been deployed to the Gulf, Somalia, Rwanda, Bougainville and East Timor, no attempt was made to record the overseas mission of the respondents.

Results

Twelve surveys were sent in 1999 and seven health personnel responded. In 2002, 11 surveys were returned from 17 distributed.

All the participants in the 1999 survey indicated that they were under greater stress than they experienced in their normal work environment in Australia, and that they had witnessed or were aware of stressful events happening to others. In the 2002 survey, 6/11 said that they were under greater stress than usual, 7/11 that they had witnessed stressful events happening to others and 8/11 that they were aware of stressful events happening to others.

In regard to the stress of others, participants in both survey groups were most aware of the stress of subordinates, then peers, and least of all their superiors.

Over 70% of participants in both survey groups reported that their colleagues talked to them or another person about their experiences and feelings.

A series of questions asked participants who they talked to about distressing experiences that occurred on deployment (Box 2), which counselling services they found most trustworthy and helpful (Box 3), and whether counselling services should be available on deployment (Box 4).

I: Pilot study participants		
Survey group	1999 n = 7	2002 n = 11
Mission		
Peacekeeping	4	6
Humanitarian	1	3
Peace enforcement	2	2
Position		
Medical Officer	2	3
Nursing Officer	3	5
Medical Assistant	2	3
Deployment duration		
Four months or less	6	5
Six months or more	1	6
Time since last deployment		
Less than six months	6	3
Six to 12 months	0	8
More than five years	1	0

Discussion

In this pilot study, participants reported greater levels of stress while on deployment than they encountered in their normal work environment in Australia. Those on deployment not only witnessed and were involved in events that were distressing, but were also aware of others being distressed by such events. This result conforms with the findings of other reviews^{5,7-9} that soldiers on peacekeeping, observer, peace-enforcement and humanitarian missions face increased stresses. Part of this stress is associated with knowing that others within the group are stressed by events.^{2,12}

While one can "soldier on" with a "stiff upper lip", health personnel are no more immune to the stresses of peace-keeping missions than other soldiers.¹³⁻¹⁵

The importance of helping the helper deal with trauma and death within a military medical facility cannot be ignored.¹⁶

Dealing with stressors

Talking to one's peers helps one make some sense of traumatic events. When individuals realise that others (a process described as "defusing") share their feelings and thoughts of the traumatic event,² some of the immediate stress is dissipated. Of concern are the individuals who choose not to talk to anyone about their experiences. These individuals could be at a greater risk of developing longer-term mental health problems.

Reluctance to use services

More of the 2002 group were aware of the availability of counselling services than the 1999 group, but no survey participants actually used counselling services. Most of the 1999 group and half of the 2002 group indicated that they would not use counselling services to cope with stress, even if they were available. This is of concern, as the survey respondents were health personnel who should have had an understanding of the value of mental health interventions.

The reluctance to use mental health services may be attributable to a perception that using such services is an admission of inability to cope and meet the obligations of a soldier.¹⁷

Despite this reluctance, about 70% of participants felt that counselling services should be deployed. Anecdotal evidence suggests that health planners do not see mental health services as being a critical component when deploying troops overseas.

Preferred counsellors

In the pilot surveys, psychologists were rated the most trustworthy and helpful of six kinds of counsellors. Psychologists could enjoy higher acceptance due to the everyday use of the terms "psych" or "psychological support". Chaplains rated in second place as being trustworthy and third in relation to helping with stress. Psychiatrists rated in second place for helpfulness in dealing with stress, which could indicate recognition that psychiatrists could perform a useful role within a military environment. Psychiatric nurses, social workers and occupational therapists ranked lower. The respondents were all from medical and nursing corps within the army, which could account for some bias.

Delayed intervention increases morbidity

Returning from overseas deployment without any counselling or intervention by a mental health professional can sow the seeds of long term mental health problems in traumatised personnel. It has been suggested that immediate treatment of combat-induced stress will reduce the likelihood, or at least the severity, of post-traumatic stress disorder.¹⁷ Early intervention is effectively a preventive strategy.¹⁸ Interventions before or immediately after developing stress symptoms promote an adaptive response to trauma and prevent maladaptive responses that lead to long term mental health problems.

Starkey and Ashlock stated that, for military personnel who have experienced combat or other military-related trauma, the ideal time for treatment from a clinical standpoint is while the person is still on active duty.¹⁹

The philosophy of forward psychiatry, counselling and stress management is the most effective way of minimising long term problems.⁶

Commanders' responsibility

Commanders at all levels must be aware of and encourage soldiers to use available mental health services, thus minimising adverse effects on soldiers' mental health and wellbeing.^{4,6,18,20} The commander's role cannot be overemphasised; good leadership can make many stressors more bearable.¹⁷

Conclusion

This pilot study suggests that health personnel on overseas deployments experience greater stress than at home, and that most talk to others about their feelings associated with stressful events. Survey respondents did not use any counselling services while overseas, even when they knew that services were available. Health personnel should have a good understanding of the impact of mental distress on performance, yet they were reluctant to use such services.

What cannot be determined from this small study is why medical service personnel delay seeking mental health services, despite the possibility of increased psychiatric morbidity, with its associated costs and consequences for the individual and society. In a military context, reluctance to use mental health services could be owing to a lack of understanding, poor integration of men-

2: Who survey participants talked to about distressing experiences on deployment

	1999 n = 7	2002 n = 11
On deployment		
Talk to a peer	2	6
Write home	2	1
Phone home	1	2
Talk to chaplain	1	1
Counsel from psych	0	1
Other	1	1
Talk to no one	0	1
On return to Australia		
Talk to a friend	2	2
Spouse	3	2
Talk to no one	1	1
Stranger	1	1
Not applicable	0	4

tal health services with other health services, or poor accessibility, all of which will be the subject of future research. It may also be that stigmatisation and ridicule from other soldiers and possible consequences for one's military career, especially for officers, could be barriers to using mental health services.

Other military forces use a multidisciplinary approach and use the broader term "mental health services or support" rather than "psychological support", the term most common within the ADF. Currently, the ADF is reviewing its mental health strategy. This offers the opportunity for service development based on best practice, established by evidence-based research focused on the mental health and wellbeing of our service personnel.

Medical resources are readily available and accessible to soldiers on deployments. Soldiers are encouraged to use medical and first aid facilities to minimise any potential health problems to themselves and other unit members. Yet when it comes to mental health services, there is a reluctance by both individuals and planners to make such services integrated, accessible and non-stigmatising. Best practice indicates a multidisciplinary team approach for those who feel psychologically overwhelmed by events.

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3: Survey participants' ranking of the trustworthiness and helpfulness of counselling services

Professional group	Trustworthy ranking		Helpfulness ranking	
	1999 n = 7	2002 n = 11	1999 n = 7	2002 n = 11
Psychologist	1	2	1	1
Chaplain	2	1	3	3
Psychiatrist	3	4	2	2
Psychiatric nurse	4	3	4	4
Social worker	5	5	5	5
Occupational therapist	6	6	6	6

4: Survey participants' responses to questions on the availability of counselling services on deployment

Question	1999 n = 7	2002 n = 11
Were you aware that counselling services were available?	2	7
Did you use counselling services?	0	0
Do you think counselling services should be deployed?	5	8
Do you think you would use counselling services in future if they were deployed?	2	5

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