
Operational Mental Health: A User’s guide for medical staff

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Background

United Kingdom’s Armed Forces undertake a wide variety of tasks which include war fighting, peacekeeping, security maintenance and disaster relief to name but a few. It is hard to think of any military duties, including training exercises, in which there is not a significant risk of exposure to substantial levels of stress. Furthermore the high operational tempo over recent years, when taken in conjunction with the ever decreasing numbers of military personnel available to perform the seemingly ever increasing number of tasks further increases the likelihood that service men and women will be subject to psychological pressure. The aim of this paper is to examine the ways that military medical services can assist the chain of command in preparing personnel for operational duties, supporting them whilst they carry out such duties and in bringing them home. The principles described in this paper apply equally to full time and reserve personnel, although one must remember that many reservists do not enjoy the same regular and beneficial access to peer support as regulars.

History

During the First World War the link between war and poor mental health has was established. In the Second World War the British Army recognised the need to employ subject matter experts (SME) to assist them in keeping the fighting force in a good state of psychological health. Both psychiatrists and psychologists were recruited into the Royal Army Medical Corps (RAMC) where they experimented with novel treatments, (1) drawing on ideas from psychoanalysis and social psychology. Indeed once the War ended many of the mental health professionals who had served their country went on to make use of their military experiences in their work as a civilian. The work of psychiatrists, who had served in the military, including Wilfred Bion, Michael Foulkes and Maxwell Jones, was very influential in the way that the (2) National Health Service and the private sector structured their clinical services (3).

Preparing Troops for Operations

Military personnel come from a wide variety of socioeconomic and educational backgrounds. Taking into account the wide variety of experiences is essential when considering what sort of preparation is required and likely to be effective. Proper preparation of service personnel coupled with effective early treatment and return to duty, is a force multiplier (4).

There are numerous factors which are important in terms of effectively preparing deploying personnel, some of which are considered below.

Training

The process of recruitment and initial training is designed, in part, to weed out those individuals who are unlikely to be robust enough to serve usefully in an operational environment. However there are many elements which determine how psychologically hardy, and therefore operationally effective an individual is, and training is one of them. There is no doubt that rigorous, regular and realistic training is the best psychological preparation. Medical staff should do all they can to ensure
that personnel are able to partake in as much of the operationally directed training that their unit is engaged in. Although it may seem kind or caring to allow individuals who are anxious about particular aspect of rigorous exercises to be excused on the basis of their anxiety, this should not be done lightly as they may have missed out on a valuable opportunity to undertake a task, with the appropriate guidance, which they previously did not think they were able to. It is important, therefore, that medical staff do as much as possible to ensure that service personnel face their fears, and overcome them through supervised training experiences, rather than avoid the feared situation only to find that they cannot perform effectively in an operational environment.

Psychoeducation

There is clear evidence (5, 6, 7) to support all activity which fosters a culture of Mental Health awareness by involving all within the military community. An educated fighting force that understands the imperative of avoiding unnecessary medicalisation and stigmatisation is more likely to maintain its psychological fitness and hence its operational capability. Psychoeducation is a term to describe the necessary elements of any preparatory mental health briefing.

Ideally this should be delivered by mental health personnel who are due to deploy with the assembled battlegroup. This allows all personnel to identify who their specialist mental health support will be in theatre, helping to overcome the stigma of having to identify the specialist when in theatre. However if such personnel are not available then any confident and informed person can deliver the brief. There are three essential elements to a preparatory psychoeducational brief:

1. Normalisation of anticipatory battle anxiety and of post incident distress. The presenter should aim to demystify the normal human reactions to stressful circumstances and explain how personnel might distinguish problematic from non problematic reactions (the main distinguishing feature being not the nature of the reaction but instead whether the soldier can function effectively).

2. Identification of simple self help strategies to deal with the effects of stress. This should include distraction, talking with colleagues, taking exercise, getting sufficient sleep, eating regularly and limiting exposure to unnecessary stressors (such as not volunteering for the extra guard duty when in fact catching up on well needed sleep was possible). The emphasis should be to explain that operational effectiveness is more like a marathon (requiring self pacing) than a sprint.

3. Explanation of the availability of possible sources of support. This should include explaining the role of the medical staff, padres, chain of command and welfare staff. Some units, such as the Grenadier Guards, may have specially trained peer support practitioners who have been trained in Trauma Risk Management or TRiM, a model of traumatic stress management pioneered by the Royal Marines (8, 9).

Other matters

Although not primarily a medical responsibility it is useful for medical staff to know something about morale and unit cohesion as they are key factors in determining the
mental health of troops on the battlefield, not least because they may have to lead their own staff into battle. Grinker and Spiegel (1945) suggested four main elements to morale namely faith in the leadership, faith in the common purpose, having an adequate balance of work and rest and faith in each other (10). At times all, bar the last, may be lacking especially in operational environments. It is well known that faith in each other is a key element which determines how personnel will perform in difficult conditions and medical staff should encourage deploying units to do all they can to foster a mutually supportive environment before they deploy.

Another important issue in determining how people will perform in an operational environment is the service person’s view on how their family will cope when they are away. General Normal Schwarzkopf (1992), Commander of coalition forces during the 1991 Gulf War is quoted as saying “You can train your men as much as you want, but what do you think will happen if there is a war and these boys run around with the thought that nobody cares for their family? No way will they fight as effectively, of course that I can assure you” (11). Thus it follows that a well functioning family welfare service will assist military personnel to adopt the required operationally effective frame of mind.

Finally it is worth considering how apparently routine medical matters may take on disproportionate importance in the minds of those due to shortly deploy to an operational area. Whilst wondering how one’s back or knees will hold up at the next fitness test, such concerns may impair effective functioning in areas where the afflicted person perceives their injury to possibly affect their personal safety or indeed the safety of colleagues. Thus when a medical professional considers that a medical complaint will not prevent deployment, they should be forceful in passing their opinion onto patients, to reassure them that they will be able to carry out all that the mission requires them to.

Supporting Personnel in theatre

The principles of forward psychiatry remain the cornerstone upon which the mental health of the British Armed Forces is maintained and managed in an operational environment. Forward psychiatry refers to the principles of Proximity, Immediacy, Expectancy and Simplicity. These have been extant since World War I (WWI) and claims have been made that when used properly up to 80% of personnel who present with operationally related mental health disorders can be returned to effective duty. Jones and Wessely (2003) have argued that such figures are over estimates (12). The US military use a modern version of forward psychiatry called combat stress control, which utilises the same principles. Thus, in the absence of any other proven model of in theatre mental health provision, the UK military still uses the PIES principles in the varied casualty treatment regimes in force.

Proximity

The principle of proximity refers to the treatment of personnel somewhere near the front line. In WWI this was “within the sounds of the guns” although clearly with asymmetrical warfare and a rapidly moving battlefield being the norm in modern combat operations, it is often difficult to know where the front line is. However
keeping personnel who are suffering with the symptoms of acute stress with their colleagues (section, platoon or company) is a good concept.

This means that medical staff should ensure that provision is made for useful tasking of stressed personnel that does not involve removal from their immediate unit. This maximizes the chance that a person will be able to return to operational effectiveness within a short period of time. The aim of any management is to keep someone working in an operationally significant but rehabilitative position. This might be, for example, helping the company sergeant major with an administrative task or assisting in re-supply of ammunition. It is important that the unit personnel who supervise stressed individuals do their utmost not to unduly stigmatise them. In some cases it may be necessary to remove the firing pin from a stressed person’s personal weapon (this is less stigmatising than removing the weapon completely) but this should not be done without careful consideration of the tactical situation or without the agreement of the command.

**Immediacy**

This simply means that when someone appears to be suffering it is a good idea to do something about it sooner rather than later. This does not mean that the possibly affected individual should be removed from the source of stress unless they cannot function, but instead it may be worthwhile making sure that that person is the next one to get a substantial rest or to go for food. Depending on the operational imperative, a variety of simple stress relieving strategies can be put into place, however the immediacy principle merely suggests if someone thinks a unit member is suffering with a stress-related problem then it’s worth doing something about it sooner rather than later.

**Expectancy**

This is probably the most important principle of managing battlefield stress. It is vital to install a sense of confidence in those who are feeling the effects of excessive pressure that their feelings are normal, controllable and time limited. If you can suggest that the affected individual will be strong in stress and will continue to fulfil their functional role, this increases the likelihood that they will be able to do so. If medical staff do the opposite and suggest that it is unlikely that the individual will be able to function, suggesting instead it is likely that they will need to be evacuated or separated from their unit this may become a self fulfilling prophecy. Do not look for victims else you will find them. Therefore to maximise the chances for a successful outcome, affected personnel should be told, with confidence, that they will be able to continue to support their colleagues and the operational objectives.

Remember that dealing with stressed individuals is best done by avoiding labelling them as patients. They are soldiers who are having normal reactions and they will be back to their normal self soon.

**Simplicity**

This principle embodies the scientific literature that suggests that when personnel are feeling under pressure, they do not require specialised mental health interventions as
the first intervention. Instead simple strategies such as encouraging rest, protection from the worst of the battle, protecting them from the media and talking to their colleagues are likely to be effective. The US military use the phrase “3 hot’s and a cot” (meaning three hot meals and a good night’s sleep) to describe what they see as the most effective battlefield stress reduction technique. The battlefield is no place for counsellors and good man management is the most effective intervention to reduce stress levels.

**Operational Mental Health provision**

The allocation of mental health personnel to the order of battle is the responsibility of Permanent Joint Headquarters (PJHQ). They will assess the size of the force that is due to deploy and estimate the psychological risks that the mission is likely to pose to deployed forces. This risk assessment process involves numerous factors including the nature of the threat (e.g. is there likely to be a chemical or biological weapon threat which will increase the psychological risks) and the experience of having deployed forces to the same or similar theatres of operation. Although it is difficult to generalise this equates to one psychiatrist and three to five psychiatric nurses being deployed to support a Brigade. Once an operation becomes stabilised it is possible to provide military mental health care with embedded Community Psychiatric Nurses (CPNs) with regular supervisory visits from a consultant psychiatrist (13).

Psychiatric personnel’s primary responsibility is to keep the fighting force healthy and effective. This means they will expect to liaise with the chain of command and unit medical staff as regularly as possible. Where there is no possibility of keeping an affected individual with their unit they will endeavour to rehabilitate evacuated personnel rapidly in theatre rather than returning them to the UK. This means that units should be ready to receive previously affected personnel back. This will mean that medical staff will need to manage the command’s expectation that when personnel are evacuated for a stress-related problem they will not return. Return to unit (RTU) should be regarded as the norm rather than the exception for most stress related problems that originate in theatre. The majority of those cases seen during Op Telic 1 were RTU’d (13). Clearly though, there will be some cases where RTU is just not feasible and mental health professionals in theatre will be able to advise medical staff about such individuals.

**Homecoming and the post operational period**

There are numerous anecdotes about the homecoming of the troops after the Falklands conflict. Most suggest that the Royal Marines, who returned on the troopship Canberra, settled quietly into their lives having worked out their battle residue whilst at sea. On the other hand, it is suggested that Paratroopers, who flew home, did not have the opportunity to unwind from their previously necessary combat focused mindset. As a result it is said that they caused havoc in the towns where they lived or were based. However there is no conclusive evidence to back up such claims.

The current practice is for each brigade to consider what is necessary for its personnel. This section will attempt to explore some of the potential approaches that may be considered and point out possible roles for medical staff.
**Homecoming briefs**

A psychoeducational brief, FMed 1021, for personnel who are due to leave theatre is usual practice and was mandatory for troops who returned home after the 2003 War in Iraq (Operation TELIC). This usually covers much the same as the pre-deployment brief, emphasizing that some personnel may experience unusual and intense reactions to what they have experienced in theatre and that in most cases this will settle with time. Providing advice on the nature of the normal reactions to stress, effective self help techniques and sources of available support is routine. It is also worth providing troops with leaflets which restate the points bought out in the brief and which may be given to their families when they return.

Homecoming briefs also tend to cover the process of re-uniting with loved ones and friends. Letting personnel know that families may not have missed them whilst they are away or may not be necessarily as joyful as the returning troops would like is customary. Many soldiers, especially those who have not deployed before expect their partners to have cold champagne on ice to celebrate and do not realise that those who have remained at home may instead be looking forward to being able to leave the kids with the service person and take the first opportunity they have had in ages to go out and have fun with their friends. Thus homecoming briefs are about stress education but also about managing expectation.

**Decompression**

Although there is no conclusive evidence to support it, there is an accepted dictum that flying straight from an area of conflict to spending many weeks of post operational tour leave (POTL) at home is not good practice. Whilst it is also nonsensical to overly delay homecoming a happy medium is achievable. The only contemporary trial of decompression was carried out in Canadian forces after deploying to Afghanistan in 2002. Instead of flying straight home they were instead sent to Guam for a week long period of intense stress education including anger management, suicide awareness and a busy daily work routine. They did not find any conclusive benefits and many personnel complained about the two hour long lectures, physical exercise sessions that began at 6am and being kept away from their loved ones back in Canada.

Although the need for decompression is a command responsibility there is evidence to suggest that most service personnel prefer to talk to peers who have been on the same deployment and their family about their operational experience (14). Having an opportunity to talk about their deployment experiences, in a low stress environment, should provide the most therapeutic environment for those who have just returned from operations to process their experiences. Social support that is perceived as being supportive has also been shown to be beneficial (15). This is likely to be available from friends and family. However during the POTL period all personnel should know where they can gain support should they require it. This is likely to be from the chain of command, medical services, chaplains, welfare services or mental health professional depending on which resources are available locally.
The debriefing controversy

Until 2000 it was standard practice for stress debriefings to be carried out for military personnel who had been involved in traumatic events, which clearly may have included those experienced on operations. However there has been a myriad of evidence which has shown that routine single session psychological debriefing is not only ineffective but may in fact be harmful (16,17). In 2000 the then Surgeon General issued a policy stating that routine psychological debriefing was to cease. Such guidance is in accordance with the recently issued National Institute for Clinical Excellence’s (NICE) guidance on the management of Post Traumatic Stress Disorder (PTSD) (18). It is worth pointing out at this point that PTSD is an uncommon outcome after traumatic events or operational deployments. For instance after the 1991 Gulf War less than 3% of deployed troops suffered with PTSD. Other forms of mental disorder including depression, adjustment disorders and substance misuse disorders are far more common (19) although the majority of troops who deploy do not suffer with any mental health disorder.

However, although it is clear that not all personnel will require any form of psychological intervention, some will inevitably develop psychological problems as a result of their operational service. It is worth all medical staff adopting a high index of suspicion also called “watchful waiting” in their approach to personnel who have returned from operations. Most people who will develop problems are likely to show signs within the first few months of having returned home, although recent data from the USA suggests that in US troops the prevalence of operationally associated mental health disorders continues to rise for the year following deployment. As yet there is no conclusive evidence to suggest this is true for UK forces but keeping a watchful wait and ensuring the chain of command do the same is likely to be good practice. It is likely that immediate line managers and peers are in the best position to spot personnel who have stress related problems that do not resolve. Welfare services may also pick up operationally related psychological problems which many manifest as relationship problems. Additionally unit discipline staff should be aware that behavioural disturbance that is out of keeping with an individual’s previous disciplinary record may be a sign that a service person is suffering with a mental health problem.

Trauma Risk Management (TRIM)

Within the Royal Marines and some Army units, including the Grenadier Guards, there are a number of non medical personnel who have been trained in the identification of and simple management of traumatic stress related disorders. These TRiM practitioners may be able to assist both the command and medical personnel in maintaining vigilance after troops return home. Furthermore gaining assistance from TRiM practitioners may be seen as less stigmatising by personnel who have concerns that asking for help for stress-related problems from medical or psychiatric staff will adversely affect their career.

Conclusions
This paper has aimed to give medical staff an insight into the important issues related to operational mental health. It should be remembered that keeping a military unit psychologically healthy is an effective force multiplier. The provision of good mental health is primarily a chain of command responsibility but there will be numerous times when the command will look to medical staff to advise them on this matter. Most people who suffer with stress in relation to operational deployments will not go on to develop formal mental health disorders and there are numerous ways that medical staff can intervene at an early stage to prevent stress related problems progressing further. As with other areas of medical practice, when considering operational stress the maxim that prevention is better than cure holds true.

References


4. Joint Warfare Publication 4-03, Paragraph 311.

5. Joint Warfare Publication 4-03, Paragraph 313.


