Peer responses to perceived stress in the Royal Navy

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Introduction

The psychological impact of warfare was recognized in Ancient Greece [1] and has been an incontrovertible issue since World War One [2]. Medical and lay attitudes to distressed military personnel have varied and have often viewed service personnel as weak or somehow deficient should they be unable to withstand the horrors of war [2,3]. However, it is currently accepted that exposure to potentially traumatic events can result in short- and long-term psychological distress [4]. By virtue of their role, the Armed Forces are at significant risk of suffering occupationally related distress. As they can never prevent exposing personnel to traumatic stressors, military commanders need to find effective ways of managing them [4].

The Ministry of Defence (MoD), as with all organizations, has a legal duty of care towards its employees. The issue was closely examined in the 2002 Post-Traumatic Stress Disorder trial [5]. The case was found in favour of the MoD; however, the MoD accepted that Post-Traumatic Stress reactions were an ongoing organizational issue. Within the Royal Navy (RN), a peer-led traumatic stress management strategy known as Trauma Risk Management (TRiM) has been developed. TRiM encourages peer support, education and monitoring of individuals exposed to potentially traumatic events [4,6].

TRiM aims to engender cultural change towards an environment not only better equipped to deal with the psychological aftermath of traumatic events but also able to highlight those requiring further support [4]. An ongoing randomized controlled trial (RCT) of TRiM is assessing any changes in culture, occupational health
functionality and psychological morbidity, after implementing the system.

Within both civilian and military settings, Deliberate Self-Harm (DSH) is an important issue. According to the National Institute of Clinical Excellence (NICE) ~160,000 DSH cases present to Accident and Emergency (A&E) departments annually [7,8]; the lifetime prevalence of DSH is 5% [9]. NICE state that physical and psychological management must be immediate and long term if psychological morbidity is suspected [10]. DSH in operational environments is especially problematic for leaders. Operational effectiveness, group morale and cohesion must be maintained, while providing for the individual’s needs in an often unsympathetic environment [11]. A 2005 DSH audit in one RN psychiatric clinic found that, similar to the civilian population, younger personnel and females were especially at risk [12,13,8].

Although translating civilian statistics to military personnel requires caution, 25% of the general population who DSH will repeat the act [8,13]. Also within civilian settings irrespective of the severity of attempt (the degree of injury or self-harm should not be used as an indicator of intent [7]), those who DSH are at 50–100 times greater risk of subsequent suicide [14]. DSH is strongly associated with a number of psychiatric conditions and a prior psychiatric history is a notable civilian and military risk factor [3,8]. The majority of DSH cases seen in A&E departments meet criteria for at least one psychiatric diagnosis [15]; two-thirds as suffer from clinical depression and one-half from a personality disorder [11]. Therefore, DSH may herald other latent psychiatric conditions which are incompatible with continued military service.

Both suicide and DSH are sensitive issues [16,17] and the protection of the psychological well-being of service personnel is as much a public relations issue as an occupational necessity. The very act of highlighting DSH as a problem which requires ‘special’ solutions may generate an issue from an act that would otherwise be easily manageable within a closed institution such as the services. Although research statistics vary, it has been suggested that the lifetime prevalence of suicidal or DSH ideation may be 15–25% [18] [19] and may affect 5% of the population annually [16,20]. While Kuo et al. [21], in their 13-year prospective follow-up, conclude that ideation is an important antecedent to a suicidal act (relative risk of 6.09), it is evident that the majority of those with self-harming thoughts do not self-harm. How those in authority decide the point that self-harming thoughts in themselves justify employability restrictions is unclear and likely to vary depending on the nature of occupation.

Cultural issues play an important role in moderating stress responses, both at an organizational and individual level. The UK military encourages individuals to adopt a resilient ‘stiff upper lip’ when faced with stressful circumstances, traumatic or otherwise [22]. As there are considerable difficulties in measuring culture using quantitative methodologies, this study, part of the TRiM RCT, used semi-structured interviews with vignette questions about hypothetical scenarios. The qualitative analysis did not aim to provide statistically valid estimates of opinion or belief and the study’s value lies in gaining a broader understanding of important issues [23].

The study aimed to examine attitudes, perceptions and cultural beliefs within the RN towards mental illness before TRiM implementation. The study also investigated how RN personnel might manage distressed peers if they threatened DSH.

Methods

The TRiM RCT was designed to involve 12 warships. After baseline assessment, half the warships were scheduled to receive TRiM training with effects assessed after 12–18 months as most RN personnel spend between 2 and 5 years with one ship. Ethical approval was obtained from the MoD (Navy) Personnel Research Ethics Committee. Stratified sampling was used to ensure that the ranks of those interviewed were proportional to the range of ranks within any particular vessel. Informed consent was gained from all participants; no personnel refused to be interviewed.

As part of the TRiM trial, baseline measurements 30–35 one-to-one structured interviews per vessel were conducted. Rank selection was proportionally representative from Officers, Senior Ratings (SRs) and Junior Ratings (JRs). Non-officers enter the service as JRs and it takes a minimum of 5 years to become SRs. Promotion is usually dependent on competitive selection.

The results concern responses to a vignette, presented during one-to-one interviews with one of five researchers (V.L., N.G., Paul Cawkill, S.W., Glynne Parsons). This focused upon how interviewees might respond to perceived stress in a peer and consisted of five questions (presented below).

All interviewers were well acquainted with the RN and naval jargon to facilitate rapport with interviewees. Voice recording was not used in order to increase interview compliance; interviewers transcribed all responses. Qualitative analysis was undertaken by generating categories derived inductively from the interview contents [8]. This gave rise to ~15 to 20 loosely grouped sub-categories. Decisions about the generated categories and whether answers were positive or negative resulted from team discussion, one of who was a military psychiatrist. Negative comments were ones thought not likely to reduce distress levels or appeared ignorant of the potential risk of harm to distressed individuals. The analysis was completed by refining themes by repeatedly indexing responses into the following broader categories:

a) If you noticed one of your colleagues (of a similar rank/rate) appearing vacant and not performing at work what, if anything, would you do?
Positive response
Negative response

b) If things appeared to be getting worse and whatever you had tried above was not working and the person was getting worse, what would you do then?
- Refer on
- Self manage
- Nothing

c) What would you expect the outcome to be from a. and b. above?
- Advice given
- Respite from work given
- N/A

d) If the person told you that they had thought about harming themselves, what would you do then?
- Stop them
- Refer to Medical staff
- Refer to Management staff
- Negative response

e) If they saw a doctor or psychiatric professional because of their self-harming thoughts what effect do you think that it would have on their long-term career?
- Negative impact
- No impact
- Positive impact
- Don’t know

Results

The group comprised of 142 individuals aged between 18 and 48 years old. This represented 38% of the total number of interviews randomly selected from 11 warships. Respondents had been with their current unit between 12 days and 84 months.

There were only a few negative or unhelpful responses to the first vignette question concerning interviewees’ possible actions after noticing a colleague appearing vacant and not performing at work. Between 96 and 98% of all ranks gave positive responses.

Responses to the second question concerning respondents possible actions if things appeared to be deteriorating were divided into those service personnel who felt well placed to continue managing the problem themselves (20%, n = 28) and those reporting that they would ask for help from or pass the situation onto a senior (79%, n = 112). Differences in responses by rank are shown in Table 1.

When the responses were considered by rank, senior ranks, Officers (42%) and SRs (23%) were more likely to try and manage the problem themselves. The results from the third question which enquired about possible outcomes from interviewees’ first two answers indicated generally positive outcomes; no respondents indicated that the distressed individual would be reprimanded. The majority were of the opinion that their peer would receive advice from the consulted senior (71%, n = 101) (see Table 2).

Table 1. Responses, by rank, to Q. 2 concerning a colleague’s emotional state which appeared to be getting worse

<table>
<thead>
<tr>
<th>Rank</th>
<th>Refer on</th>
<th>Self manage</th>
<th>Do nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers</td>
<td>58% (n = 14)</td>
<td>42% (n = 10)</td>
<td>0</td>
</tr>
<tr>
<td>SRs</td>
<td>77% (n = 37)</td>
<td>23% (n = 11)</td>
<td>0</td>
</tr>
<tr>
<td>JRs</td>
<td>84% (n = 59)</td>
<td>13% (n = 9)</td>
<td>3% (n = 2)</td>
</tr>
</tbody>
</table>

Table 2. Responses, by rank, to Q. 3 concerning the likely outcome of the help given to a distressed colleague

<table>
<thead>
<tr>
<th>Rank</th>
<th>Give advice</th>
<th>Allow respite</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers</td>
<td>50% (n = 12)</td>
<td>42% (n = 10)</td>
<td>8% (n = 2)</td>
</tr>
<tr>
<td>SRs</td>
<td>77% (n = 37)</td>
<td>17% (n = 8)</td>
<td>6% (n = 3)</td>
</tr>
<tr>
<td>JRs</td>
<td>74% (n = 52)</td>
<td>23% (n = 16)</td>
<td>3% (n = 2)</td>
</tr>
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</table>

The remainder suggested that distressed peers would be given some form of respite from work or duties (24%, n = 34). Officers tended to favour their distressed peers receiving respite (50%) while non-officers thought advice would be more appropriate (75%, n = 89).

The responses to the question concerning possible actions following being told that a peer had thought about harming themselves were divided between those who assumed the DSH act was imminent and those who thought it was likely. Thus, several answers followed the notion ‘stop them, then go and get help’; such responses were recorded into both the ‘Stop’ and ‘Medical/Management’ categories. This section gave rise to 182 comments in total.

The majority (95%, n = 173) of comments were positive. Officers (36%) were more likely to refer to senior managers (often the Commanding Officer or the Executive officer the second in command) than SRs (17%) or JRs (27%). Only a small number of negative comments were reported, most by JRs (7%) (see Table 3).

The final question about the potential career implications of asking for help with self-harming thoughts provided the most divided response. Though a significant number were unsure of the consequences (14%, n = 20) and few proposed positive outcomes (3%, n = 4), the majority were split between ‘no impact’ (41%, n = 58) and a ‘negative impact’ (43%, n = 61) upon their peer’s career. Examining the answers by rank revealed that JRs were substantially more likely to suggest negative outcome (56%) than either Officers (29%, n = 7) or SRs (29%, n = 14) (see Table 4).

Examples of qualitative comments for each question can be found in Table 5.

Discussion

The results show the majority of respondents reported they would respond positively and appropriately towards
distressed peers. Most interviewees would appropriately refer the more serious cases to senior officers or medical personnel; however, such positive action was not universal. Less than half of those interviewed thought that receiving support in relation to thoughts of self-harm would be detrimental to an individual’s long-term career.

Table 3. Responses, by rank, to Q. 4 concerning actions that might be taken if a peer reported that they had thought of self-harming

<table>
<thead>
<tr>
<th>Rank</th>
<th>Stop them</th>
<th>Medical referral</th>
<th>Management referral</th>
<th>Negative action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers</td>
<td>21% (n = 7)</td>
<td>40% (n = 13)</td>
<td>36% (n = 12)</td>
<td>3% (n = 1)</td>
</tr>
<tr>
<td>SRs</td>
<td>19% (n = 11)</td>
<td>60% (n = 35)</td>
<td>17% (n = 10)</td>
<td>3% (n = 2)</td>
</tr>
<tr>
<td>JRs</td>
<td>18% (n = 16)</td>
<td>48% (n = 44)</td>
<td>27% (n = 25)</td>
<td>7% (n = 6)</td>
</tr>
</tbody>
</table>

Table 4. Responses, by rank, to Q. 5 concerning the possible career impact of seeking professional help for thoughts of self-harm

<table>
<thead>
<tr>
<th>Rank</th>
<th>Unsure</th>
<th>Positive impact</th>
<th>No effect</th>
<th>Negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers</td>
<td>13% (n = 3)</td>
<td>4% (n = 1)</td>
<td>54% (n = 13)</td>
<td>29% (n = 7)</td>
</tr>
<tr>
<td>SRs</td>
<td>15% (n = 7)</td>
<td>6% (n = 3)</td>
<td>50% (n = 24)</td>
<td>29% (n = 14)</td>
</tr>
<tr>
<td>JRs</td>
<td>14% (n = 10)</td>
<td>0</td>
<td>30% (n = 21)</td>
<td>56% (n = 39)</td>
</tr>
</tbody>
</table>

Table 5. Qualitative examples of comments expressed by respondents

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
<th>Comment examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you noticed one of your colleagues (of a similar rank/rate) appearing vacant and not performing at work what, if anything, would you do?</td>
<td>Positive</td>
<td>Approach them, have a chat, find out their problems I would have a word with EWO (executive warrant officer—most experienced SR onboard)</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>Not my responsibility I would tell him to sort himself out, you know get on with it</td>
</tr>
<tr>
<td>2. If things appeared to be getting worse and whatever you had tried above was not working and the person was getting worse, what would you do then?</td>
<td>Refer</td>
<td>I would inform MO (Medical Officer, a fully trained registered doctor) Would mention it to boss/Divisional Officer (line manager)</td>
</tr>
<tr>
<td></td>
<td>Self manage</td>
<td>Go and see peers, on the quiet, looking after each other Take a bit of work off them</td>
</tr>
<tr>
<td></td>
<td>Do nothing</td>
<td>I would probably distance myself from them</td>
</tr>
<tr>
<td>3. What would you expect the outcome to be from the questions above?</td>
<td>Advice</td>
<td>Give good advice MO (Medical Officer) would have a chat with them, offer support</td>
</tr>
<tr>
<td>4. If the person told you that they had thought about harming themselves, what would you do then?</td>
<td>Respite</td>
<td>Get time off or reduce workload</td>
</tr>
<tr>
<td></td>
<td>Stop them</td>
<td>I would try and talk them out of it</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>Inform Medical Officer</td>
</tr>
<tr>
<td></td>
<td>Management</td>
<td>Inform the Military police Go and get OOD (officer of the day—duty officer)</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>Laugh it off and tell them not to be so stupid Might avoid the subject</td>
</tr>
<tr>
<td>5. If they saw a doctor or psychiatric professional because of their self-harming thoughts what effect do you think that it would have on their long-term career?</td>
<td>Negative</td>
<td>I don’t think they would ever return to frontline service People would stay away from them and not include them in anything</td>
</tr>
<tr>
<td></td>
<td>No impact</td>
<td>Nothing. Everything would be done medical in confidence therefore they would get better</td>
</tr>
<tr>
<td></td>
<td>Positive</td>
<td>I would hope that… better able to deal with stress as they would have been taught how to cope with things and do things better</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>It may depend upon how much it has affected them psychologically and if there are any consequences in terms of performance</td>
</tr>
</tbody>
</table>
Qualitative methods, while allowing for an endless range of responses, may be subject to the Hawthorne Effect; that is to say that overly positive responses may have been given in order that respondents appeared acceptable to the interviewer. Also interviews cannot distinguish between the possible reactions towards likeable peers rather than peers who are disliked. Qualitative methodology does not allow for valid statistical comparisons between groups in the same way that quantitative studies would do as a result of methodology and sample size. Therefore, although rank groupings are proportionally correct, it was not possible to be certain that differences found between ranks groups were statistically valid.

Finding that the majority of individuals would signpost appropriately distressed peers reflects the finding of Greenberg et al. [22] that 98% of UK peacekeepers spoke informally about operational stress to friends or peers. This is perhaps not surprising as peers are well placed to provide emotional and functional support to distressed colleagues whose usual coping mechanisms are overwhelmed. Peer support has been shown to be of substantial benefit to those subject to the effects of excessive pressure [24].

Faced with a persistently distressed peer, the majority of junior personnel favoured referring the problem to someone senior. This is particularly relevant as previous studies have shown that within UK military junior ranks are especially vulnerable to developing mental health problems [25]. Our finding differs from those of Cawkill et al. [26] who argued that not only were military individuals reluctant to self-disclose but also Armed Forces personnel felt little support was available from peers or commanders. This maybe because Cawkill's study examined the expectations of distressed individuals, who are more pessimistic about the support that would be available for them; Hoge et al. [27] have shown that an important barrier to the receipt of care is the fear of being stigmatized, particularly among those who are unwell.

Many respondents reported that those referred would generally receive either appropriate advice or respite from duties. Our finding that non-officers favoured advice while officers favoured respite most probably arose from differences in service experience, training and authority as much as attitudes. Most respondents did not indicate that receiving help would have any immediate career implications.

Like the RN, resilient organizations may view stress negatively with sufferers being labelled as weak [28] or unsuitable for responsibility [10]. Stigmatization may also occur [15]. Our findings though suggest that distressed employees should not fear seeking help from those around them as it likely they will receive appropriate care.

When a peer mentioned that they may harm themselves swift action was again the predominant response. Our results showed that, irrespective of rank, those aware of potential DSH favoured referring the issue to more appropriate sources of support, usually managers or medical staff [7].

The Armed Forces are not alone in requiring robust individuals to perform in exceptionally difficult circumstances. The emergency services, the diplomatic service and many media organizations share similar needs. Research suggests that employees in such organizations are at risk of psychological problems while deployed [29,30]. Our findings are therefore likely to be of relevance to such organizations, especially so where personnel cannot readily access UK style healthcare and instead rely on peers and managers for support.

The Health & Safety Executive recognize that the availability of workplace support and the nature of workplace relationships are important factors which must be managed to minimize stress at work. Our results would suggest that interventions aimed at ensuring that more junior staff members know what to do about distress in others may be especially useful. Local, and therefore more accessible, support may also decrease the stigma of asking for assistance from medical or mental health providers which is a considerable barrier to care for many. Inevitably, a small proportion of distressed employees will require professional help; however, this study indicates that peers are willing to refer on such cases. The notion of mess camaraderie has always been strong within the RN ensuring that ships were ready to wage war and our results suggest that comradeship may be just as useful for battling psychological difficulties.

### Key points

- Most RN personnel would deal with distressed colleagues in an appropriate and positive manner and did not report stigmatizing beliefs concerning mental health issues.
- Junior personnel were less positive about the impact on an individual's career should help be requested because someone was intending to harm themselves.
- Peer-led support may be an acceptable and effective way of initial management of distressed employees especially in organizations that favour resilience.

### Conflicts of interest

None declared.

### References

1. Marlowe D. Psychological and Psychosocial Consequences of Combat and Deployment: with Special Emphasis on the Gulf

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