

A Study Into Commanders' Understanding Of, And Attitudes To, Stress And Stress-Related Problems

P Cawkill

ABSTRACT Objectives

To undertake a tri-Service questionnaire survey to examine the commanders' understanding of, and attitudes to, stress and stress-related problems.

Methods

A questionnaire was designed to elicit information on: Personal experience of stress and stress-related problems; Stress education; Pre-deployments briefings; and Post-incident stress debriefing. A total of 9,020 questionnaires were distributed between the three Services based on their proportional manning contribution to the Armed Forces as a whole. The population sampled ranged in rank from Corporal/Leading Rate up to, and including, Colonel/Captain RN/Group Captain (ranks below Leading Rate/Corporal were excluded because of their lack of command experience). The overall response rate was 55.8%. The study was carried out between September and December 2001 (i.e. pre-OP TELIC).

Results

Chronic work-based stressors were seen as most stressful when compared with family and health stressors. Most respondents accepted that stress and stress-related problems exist, but were reluctant to disclose their own stress-related problems or seek help for fear that it might be detrimental both personally and professionally. There was found to be little support from peers or commanders. Little stress training was provided during recruit training, there were gaps in pre-deployment briefings and little in the way of post-deployment stress support.

Conclusions

Some of the more negative findings could have implications in terms of seeking help for stress-related problems at an early stage, which is counter-productive to the military's genuine attempts to foster the psychological welfare of its employees. Some concerns could be alleviated by better and more timely stress education, preferably early

on in a commander's career, so that positive attitudes to stress and stress-related problems can be formed and any negative attitudes changed, thereby bringing about a change in organisational culture in relation to stress. Some of the study's concerns were addressed by the Operational Health Strategic Surveillance Committee which advised on operational health aspects of OP TELIC.

Introduction

The Armed Forces, by the very nature of their role, involves Service personnel being exposed to multiple, interacting and occasionally prolonged stressful events. The stressors associated with combat and peacekeeping operations are numerous and varied and in the case of mobilisation include: being uprooted from one's normal role and environment; uncertainty about the duration and nature of the operation; a hostile and uncomfortable environment; a threat to personal safety; and the potential for witnessing atrocities and undertaking body handling duties. The effects of war on combat-exposed soldiers has been reported and extensively described since the first World War (1, 2, 3, 4, 5).

However, whilst many operational stressors are unique to the Armed Forces (although there may be some slight similarities with the civilian Police Force (6)), there are also chronic social and occupational stressors affecting military personnel which are less obvious and more insidious. Of the number of recent small scale studies undertaken into UK military stress, certain recurring non-operational themes tend to emerge. For example, lack of training; inadequate decision-making; family separation and communication problems, poor management, boredom, heavy workload, and housing problems, etc (7, 8, 9).

Much of the work on stress in the Armed Forces to-date has tended to mainly identify the different types of stressors and their effects on individuals. Very little research has been carried out into the attitudes of military personnel on stress and stress-related problems. For instance, a recent literature review of traumatic stress carried out by the Institute of Psychiatry on behalf of the MoD included military attitudes to stress/PTSD (10) cited only three papers. The most relevant British research found that, whilst

Mr P Cawkill
BSc (Hons), MSc,
SRN, RMN, Dip.
Couns., C.Psychol.
Senior Psychologist
Human Sciences
Defence Science and
Technology Laboratory
(Dstl),
Farnborough,
Hants. GU14 0LX.
(Dstl is an agency of the
MoD)

E-mail: pecawkill@dstl.gov.uk

there was general acknowledgement that stress and related problems exist, many (particularly senior officers) still believed that those who experienced stress are weak (9). Other studies have indicated that: stress and stress-related problems are related to lack of moral fibre and a reluctance of the military to acknowledge the concept of prolonged stress (11); there is a perceived lack of trust in the operational capabilities of someone suffering from traumatic stress by his/her colleagues (12), there is the stigma attached to stress and mental illness (13, 14).

Attitudes to stress are very important because the way stress affects military personnel (be it acute or chronic), is not only dependent on personal characteristics and past experience, but also on how the situation is managed by the commander (commander being defined in this article as including all ranks from Corporal/Leading Hand to Colonel/Captain RN/Group Captain). An essential part of this man-management is the attitude of the commander in relation to stress. Traditionally, the culture of the military has been one of intolerance to matters psychological, which in turn could have a negative effect on a commander's attitude to stress and stress-related problems, and their subsequent management of such factors.

The aim of this study therefore, was to undertake a tri-Service questionnaire survey to examine the commanders' understanding of, and attitudes to, stress and stress-related problems¹. (Stress and stress-related problems are defined² in the Information Box shown in Figure 1).

Stress and stress-related problems defined

Wherever there is a psychological stressor, there is the potential for a stress reaction. The stressor may be chronic and occur over a long period of time, e.g. lack of manpower, or it might be acute and traumatic, e.g. combat or peacekeeping operations. For the purposes of this study, stress was defined as:

"The reaction people have when the demands on them are excessive and result in a negative effect on their ability to function in work and social situations".

One of the consequences of excessive pressures is that it can lead to stress-related problems, which for the purposes of this study includes: worry/anxiety, insomnia, problems concentrating and coping, irritability, relationship problems, tiredness, fatigue, etc. It is acknowledged that people can suffer from one or a combination of such factors.

Fig 1. Information Box.

Methods

The questionnaire was designed by the author in conjunction with the Professor of Tri-Service Defence Psychiatry, Royal Defence Medical College, with some

assistance from QinetiQ Centre for Human Sciences, and the occupational psychology departments of the RN/RM and the RAF. Due to time constraints it was not possible to undertake a large pilot trial though the draft questionnaire was scrutinised by several uniformed personnel attached to Dstl, and also the occupational psychologists from the Royal Navy and RAF.

The questionnaire was divided into the following sections and question areas:

- Face sheet – Containing information on the purpose of the survey, confidentiality, statement relating to voluntary participation, assistance, and where to return the questionnaire.
- Definitions – Relating to commander, stress, and stress-related problems.
- Section A – Background details (i.e. age, sex, marital status, rank, length of service, operational tours).
- Section B – Personal experience of stress and stress-related problems (e.g. cause of personal stress (i.e. work, family, health pressures), who approached for help and advice, effects of seeking help, support from colleagues and commander).
- Section C – Stress Education (e.g. awareness of stress, type of military stress education/presentations received, who taught stress courses, effect of education on current attitudes to stress, perceived role of the commander in relation to stress).
- Section D – Pre-deployments briefings (e.g. if received, who presented, how long, effect on current understanding, appropriateness of information, use of handouts).
- Section E – Post-incident stress debriefing (if received, helpfulness of debriefing, perception of current levels of psychological support).
- Section F – General comments (space was provided for respondents to give additional comments if desired).

An example of one of the questions included in the questionnaire is shown in Figure 2 below:

I believe that in seeking in-Service support: (Tick one box only).	
I would be perceived as weak by my Commanders	<input type="checkbox"/> 1
It would adversely affect my promotion prospects	<input type="checkbox"/> 2
I would be less likely to be given roles/tasks of responsibility	<input type="checkbox"/> 3
I would not be trusted by my peers when faced with stressful situations (e.g. combat)	<input type="checkbox"/> 4
There would be no adverse effect(s) on my career	<input type="checkbox"/> 5

Fig 2. Question example.

¹ This article represents a synopsis of work funded by the Human Sciences Domain of the UK Ministry of Defence Scientific Research Programme [15].

² Definition as proposed by the then Tri-Service Professor of Defence Psychiatry, Royal Defence Medical College, MoD.

A total of 9,020 questionnaires were distributed amongst the three Services based on their proportional manning contribution to the Armed Forces as a whole. The population sampled ranged in rank from Corporal/Leading Rate up to, and including, Colonel/Captain RN/Group Captain (ranks below Corporal/Leading Rate were excluded because of their lack of command experience). Due to the small number of serving females and the likelihood of a potential small number of returns, females were oversampled. Respondents were not required to provide their name or contact details in the hope that anonymity would encourage a greater response rate. A covering letter was supplied, and a business reply facility was arranged so that each questionnaire was accompanied by a stamped addressed return envelope. All questionnaires were despatched in September 2001 with a standard six-week turnaround period. 200 questionnaires were returned to sender incomplete. The overall response rate was 55.8% (N=4,921).

Results

The findings are sub-divided into the following sections³:

1. Sample characteristics

The majority of respondents (60%) were in the age range 31-40 years. In terms of gender, 78% were males and 22% were females. Given that the total percentage of females in the Armed Forces (Corporal and above) at 1 April 2001 was 15%, females as a whole can be seen to be well represented in this study. Similar proportions were reflected in the officer/other rank split with 75% male officers and 25% female officers, and 78% male other ranks and 22% female other ranks. All ranks sampled across the three Services were represented. The majority (56%) had served between 10 to 20 years. Deployment experience included Northern Ireland, Bosnia, Kosovo, The Falklands, and The Gulf.

2. Personal experience of stress during Service career

Nearly 50% of respondents (N=2,293) admitted to having occasionally suffered from stress (RN/RM 49%, Army 45%, RAF 48%). Similar figures were obtained when

comparing officers against other ranks, and males against females. Fewer than 10% often suffered from stress.

From a choice of work, family or health pressures, nearly 50% of respondents (N=2,198) selected work pressures as the single most contributing factor to their having experienced stress. Officers were more likely than other ranks to state work pressures as a cause. Heavy workload was particularly defined as the single main work pressure with 30% of responses.

Having experienced stress-related problems, respondents were asked to indicate, from a list of military personnel, one or more people they approached for help. A large number (N=1,943) selected the category 'no-one' (RN/RM 37%, Army 40%, RAF 40%). When respondents did approach someone else for help and advice it was generally a friend within the unit. Male respondents were almost twice as likely as female respondents to state that they did not approach anyone for help and advice. When asked whom they would approach now (from a list including social support outside of the military), a large number (N=2,765) stated that they would talk to their partner first (RN/RM 56%, Army 54%, RAF 59%).

Respondents were asked to rate a number of stress-related statements on a 5 point scale ranging from 1 (Strongly agree) to 5 (Strongly disagree). In summary, all three Services:

- disagreed that people who experience stress-related problems are weak;
- neither agreed nor disagreed that the Armed Forces are placing too much emphasis on stress;
- agreed that it is acceptable to suffer from stress-related problems in combat, Operations Other than War, and regular duties;
- neither agreed nor disagreed that there is enough support for stress-related problems in the Armed Forces;
- agreed that seeking in-Service support (e.g. from a Medical Officer) would adversely affect their career;
- agreed that seeking in-Service support through their chain of command would adversely affect their career;
- neither agreed nor disagreed that they would trust any in-Service support to be confidential.

A further question sought to elaborate on the perceived consequences of seeking in-Service support for stress-related problems. Approximately 85% of respondents (N=4,021) thought there would be some detrimental effect to themselves. Many respondents (N=1,580) stated that the major consequence would be that they would be less likely to be given roles/tasks of responsibility (RN/RM 34%, Army 31%, RAF 34%). This was followed by being perceived as weak by the commander, then adverse effects to promotion prospects, and lastly, by not being trusted by peers when

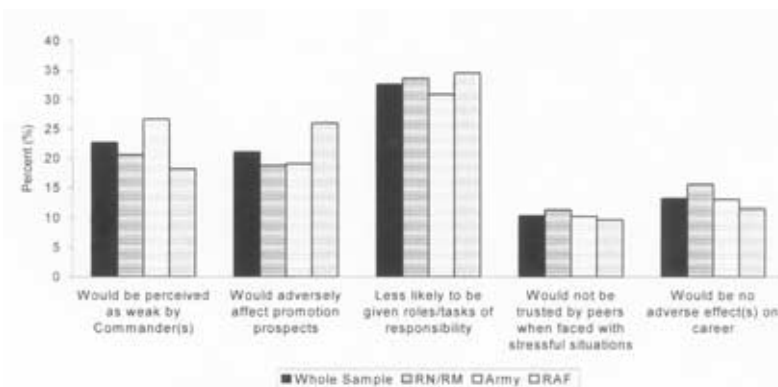


Fig 3. Effects of seeking in-Service support.

³ It should be noted that percentages have been rounded up/down to the nearest whole number.

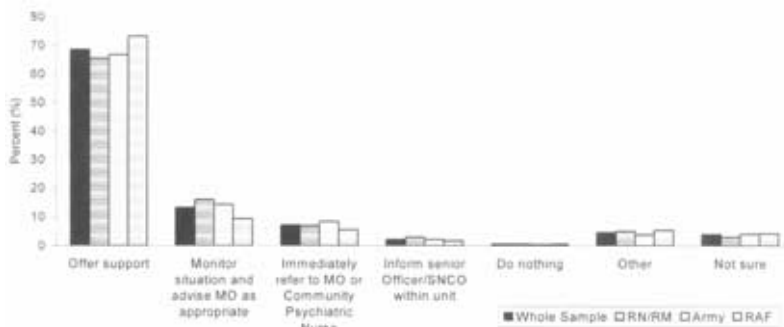


Fig 4. Main role of the commander in dealing with stress.

faced with stressful situations (e.g. combat) (see Figure 3). Officers were more concerned than other ranks about being perceived as weak by their commanders whilst other ranks were more concerned than officers about the adverse effects on their promotion.

Respondents were asked to indicate how supportive their immediate commander had been following their experience of stress-related problems. All three Services stated that the immediate commander offered some token of support and understanding (RN/RM 12%, Army 9%, RAF 11%). The findings showed a rather ambivalent response as to the support and understanding received from the commander.

3. Stress education

Respondents were asked to indicate how they had become aware of stress and stress-related problems and were provided with a list of categories from which they could tick as many that applied. The largest number of responses (N=2,750) was for 'through personal experience of stress' (RN/RM 57%, Army 54%, RAF 58%). This was closely followed by responses for 'witnessing the reactions of others to stress', then 'through the media (e.g. newspapers, radio, television)'. Most of these sources tend to be subjective, and in the case of the media, are often related to the end effects of stress such as PTSD and are invariably put across to the public in sensationalist terms frequently highlighting the legal and financial aspects, which gives a rather distorted view. Fewer respondents (28%) claimed to have learnt about stress by more objective means, e.g. stress training/awareness programmes.

For those respondents who claimed to have received formal in-Service training (N=1,499) there was a variable response across the three Services in terms of when they actually received their stress training. There was a consistently low figure across the three Services for receiving stress training during basic training (RN/RM 4%, Army 3% RAF 3%).

Half of those respondents receiving in-Service training claimed that the teaching sessions had slightly increased their understanding, the largest percentage of 55% being for the RN/RM (N=749).

Approximately 25% stated that the teaching session(s) had greatly increased their understanding of stress.

Overall, for those receiving in-Service training, the sessions appeared to have had a positive influence on respondents' attitudes, with approximately 40% stating that there had been a fairly positive influence in their accepting that stress and stress-related problems exist. A very small minority of respondents claimed there had been a negative influence.

Approximately 68% of respondents (N=3,352) stated that the main role of the commander should be to offer support in relation to dealing with stress and adverse stress-related reactions (e.g. opportunity to talk, open-door policy). The next main role stated was that of monitoring the situation and advising the Medical Officer as appropriate. On the whole, respondents appeared to think that the commander should first deal with the situation in-house and not just refer on. Less than 0.7% thought they should do nothing (see Figure 4).

4. Pre-deployment briefings

Pre-deployment briefings serve to inform, and in the case of stress briefings personnel are informed as to what is normal and to be expected, and also more importantly, what is abnormal and when and who they should approach for help. This 'normalisation' process helps the person come to terms and cope with their own individual reaction, and thereby increase their understanding and maintain a positive attitude. It also places a certain amount of responsibility on the individual to proactively seek help when appropriate.

Only 64% (N=3,144) of respondents claimed to have received a pre-deployment briefing (the response to this question being dependent to a certain extent on whether or not the respondent had been deployed). A low proportion of these respondents (i.e. 24%, N=787) stated that there had been a stress presentation included as part of any pre-deployment briefing they may have received (RN/RM 15%, Army 33%, RAF 10%). Just over 50% of the Army respondents (N=340) who stated that they had received a stress presentation indicated that it had increased their understanding.

Having received the stress presentation, just over 50% (N=499) stated that there had been no change in the way they dealt with colleagues (RN/RM 55%, Army 55%, RAF 55%), whilst approximately 45% of respondents (N=408) stated that there had been a more positive approach. A very small minority of respondents stated that there had been a more negative approach (0.3%).

Approximately 70% of respondents (N=695) who answered this question stated that they had not received any form of

handout (e.g. information leaflet) following their pre-deployment stress briefing. For those respondents who had since gone on to experience a stress-related incident (N=258), the majority stated that they did not have the handout available (RN/RM 54%, Army 72%, RAF 73%). Less than 13% of respondents (N=33) had read the handout, found it useful and followed its advice. Pre-deployment stress presentation handouts are seen as a useful aide memoire because information imparted at the time of the briefing may not be retained, particularly if there are several presentations.

5. *Post-incident stress debriefing/intervention*

Of the 2,206 respondents who answered this question 90% had not received a debriefing/intervention following a stressful incident (RN/RM 91%, Army 87%, RAF 93%). (Following a directive from the then Surgeon General's Department it is now no longer standard practice for serving personnel to receive a Critical Incident Stress Debriefing (CISD). This decision was based partly on the evidence of the Cochrane Review which indicated that one-off psychological interventions showed no benefit (16).) For those who did receive a stress debriefing/intervention approximately 33% (N=110) found them quite helpful. More than half of the sample of 2,094 indicated that they thought the support was inadequate (RN/RM 60%, Army 53%, RAF 62%). Officers were more likely than other ranks to have a positive view of the support available.

Discussion

The findings present a unique opinion of stress and stress-related problems across the Armed Forces, as stress studies in the past have generally only considered single Service perspectives. The survey considered both acute and chronic stress. One of the main findings of the study was that approximately half of the survey population had some personal experience of suffering from occupational stress (e.g. heavy workload and poor decision-making). Yet whilst the prevailing view was that it is acceptable to suffer from stress, many individuals would not necessarily trust others to hold the same view and feared that disclosure might affect their reputation/character (e.g. being perceived as weak, not being trusted by peers) or career development (e.g. not being given tasks/roles, promotion prospects). There were also concerns over confidentiality. Added to this, for many military personnel the one person they would approach first for help and advice would be their partner, thereby effectively keeping the issue away from the work situation. This could have major implications in terms of seeking help for stress-related problems at an early stage. Such a negative attitude is hardly conducive to the military's genuine current

attempts to foster the psychological welfare of its employees.

In support of the Armed Forces, a number of pre-deployment briefings relating to stress and post traumatic stress disorder are in place along with the associated handouts (and have been for a number of years). Stress education is also provided. As such, a certain amount of onus is placed on the individual to take responsibility for their own welfare and proactively seek help when appropriate. Uniformed mental health workers such as psychiatrists and community psychiatric nurses, along with civilian clinical psychologists also provide an admirable clinical service despite dwindling numbers. Indeed, the recent ruling in the Class Action brought by 2,000 British Service personnel against the UK MoD relating to negligence with regard to post-incident psychological support, found in favour of the MoD on the majority of charges. Added to this, the Royal Marines (RMs) are currently pioneering the CINC Fleet Trauma Risk Management (TRIM) Programme. TRIM has evolved out of the RM Stress Trauma Project and has been functional for six years. It is based on the principles of education, risk assessment and mentoring. The programme is peer group delivered by non-mental health worker practitioners ranging in rank from Corporal to Colonel and from all branches of the Naval Service, who have undertaken specific trauma training (17). In addition, the Operational Health Strategic Surveillance Committee was established in January 2003 to advise on operational health aspects of OP TELIC. In accordance with extant policy the Defence Consultant Advisor in Psychiatry prepared specific pre- and post-deployment briefings and post-deployment handouts. Families were also taken into consideration with the distribution of the 'Coming Home' brief.

Overall, the findings of the study indicate that the macho military culture still prevails and stress and stress-related problems are still viewed negatively. The Armed Forces as a whole need to be seen as more accepting of stress and stress-related problems, so that when personnel are adversely affected by stress they are more likely to seek help and be open about their difficulties without fear of prejudice or perceived negative effects on their career. This cultural shift can be brought about by more and better stress education, preferably early on in a Service person's career so that positive attitudes can be formed and negative attitudes changed. This should have the knock on effect of shaping the attitudes of tomorrow's commanders which in turn, will help bring about a shift in organisational culture in relation to stress.

References

1. Kardiner A. The Traumatic Neurosis of War. Psychosomatic Medicine Monograph II-III. New

- York: Paul B. Hoeber 1941.
2. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar CR, Weiss DS. Trauma and the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study. New York: Brunner/Mazel 1990.
 3. O'Brien L, Hughes SJ. Symptoms of post traumatic stress disorder in Falklands veterans five years after the conflict. *British Journal of Psychiatry* 1991; **159**: 135-141.
 4. Solomon Z. Combat Stress Reaction: The Enduring Toll of War. New York: Plenum Press 1993.
 5. Deahl MP, Gilham AB, Thomas J, Searl MM, Srinivasan M. Psychological sequelae following Gulf War: factors associated with subsequent morbidity and the effectiveness of psychological debriefing. *British Journal of Psychiatry* 1994; **165**: 60-5.
 6. Alexander DA, Walker LG, Innes G, Irving BL. Police Stress at Work. London: Police Foundation 1993.
 7. Breakwell GM, Spacie K. Command stress: A study into stressors encountered by commanders on Operation GRAPPLE. Note for the record, 6/95. June 1995. MoD Report.
 8. Breakwell GM, Spacie K. Sleep, stress and decision-making: Report of a study into OP GRANBY. Note for the record, 10/94. October 1994. MoD Report.
 9. Harvey JS. Stress: Attitudes and experiences of British Army personnel. DRA Report N0. DRA/LS3/CR96103/1.0, October 1996. Defence Research Agency, Farnborough, Hants.
 10. Anson M, Yule W. Literature Review of Post Traumatic Stress Disorder (PTSD). King's College, University of London, Institute of Psychiatry 1999.
 11. Scurfield RM. Posttraumatic stress disorder in Vietnam Veterans. In J.P. Wilson & B. Raphael (Eds.) *International Handbook of Traumatic Stress*, Chapter 23, pp 285-295. New York: Plenum Press 1993.
 12. Schneider RJ, Luscomb RL. Battle stress reaction and the United States Army. *Military Medicine*, Vol. 149(2), 66-69, February 1984.
 13. Nunnally J. *Popular Conceptions of Mental Health: Their Development and Change*. New York: Holt, Rinehart and Winston, Inc 1961.
 14. Porter TL, Johnson WB. Psychiatric stigma in the military. *Military Medicine* 1994; **159**: 602-605.
 15. Cawkill P. A Study into Commanders' Understanding and Attitudes to Stress and Stress-related Problems. Dstl Technical Report No. DSTL/CR02664. 2002. Dstl Farnborough.
 16. Rose S, Bisson J, Wessely S. Psychological debriefing for preventing post traumatic disorder (PTSD) (Cochrane Review). *The Cochrane Library*, Issue 3, 2003. Oxford: Update Software Ltd.
 17. Jones N, Roberts P. *Combat Stress Trauma Management and Risk Assessment. A Guide for RMC Combat Stress Trauma Practitioners (4th Edit.)* 1998. HQRN 1562. MoD.