

Psychological Support Pre-During and Post-Deployment

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ABSTRACT

From the early nineties until now over 35.000 servicemen were send abroad for their term. The Division of Ambulant Psychotherapy of the Royal Netherlands Land Army developed a comprehensive set of measures. A policy to secure maximum deployability and minimise the (long)lasting effects of stressful encounters during these operations. In this paper ten steps are presented which comprises this policy for psychological support pre- during and post deployment. One step of this policy, the after care questionnaire, will be presented in more detail.

Introduction

The psychological effects of war and peacekeeping upon soldiers are very well known. They comprise all problems from maladaptation after return, up to and including fullblown post traumatic stress disorders.

The Netherlands, although being a small country, has a large history of involvement in (UN) peacekeeping operations. It started with a peacekeeping operation in Albania in 1913, through Korea 1950, to Lebanon 1979-1985. In this last operation, UNIFIL, 8000 men and women from the Royal Netherlands Land Army (RNLA) served, of whom 9 were killed.

Some figures: Operations started in 1991 in Saudi Arabia and Iraq (with the Gulf war and later Provide Comfort), then Cambodia, Haiti, Angola, operations in 15 countries in all. From the RNLA about 20.000 served in the former Yugoslavia. At the moment about 1200 men and women serve in Bosnia, 650 in Afghanistan and about 200 in 10 other UN/NATO or EC-missions.

All together about 35.000 men and women, regular as well as –until 1996- conscript soldiers, were and are involved, since Lebanon until now.

Neither the UN, NATO nor the WEU have a doctrine or clear policy on psychological support before, during and after operations. Each participating country has it own responsibility in this matter.

The RNLA developed a comprehensive policy to secure maximum deployability and minimise the (long)lasting effects of stressful encounters during operations. This policy focuses upon the armed forces, before, during, and after missions of soldiers during peacekeeping operations, starting with initial psychological selection, up to and including veteran care, and thus set the stage in which all aspects of welfare during peace keeping operations fit very well. In more detail some results are given from the structural questionnaire surveys as an essential part of this policy.

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Two final remarks. There is no UN policy, nor a policy in NATO or WEU concerning psychological support. It is a national responsibility, and the remainder of this paper is based on the policy of the Royal Netherlands Land Army and the Royal Marechaussee (or military police). The two other forces of the Netherlands; the Air Force and the Navy (including the Marines) implemented a similar policy, that differs in detail depending for example on the nature of the mission and their own health care system.

Secondly: Not only the NATO, the WEU, or the UN, but also the so called Non Governmental Organisations, like the Red Cross or Medicin sans Frontieres consider people in need, their responsibility. Apart from those two important organisations, the World Health Organisation knows over 450 non-governmental bodies with their own policies regarding psychological support.

Contributions of military psychology to UN-operations, principles.

A lot is learned from literature and personal contacts with colleagues from other countries; for example the experience of colleagues in Israel, the United States, especially after Vietnam, and Norway (the UNIFIL-study).

But of course there are our own experiences, with for example the veterans from the political conflicts in the former Dutch Indies 50 years ago, but still a current topic. Then Korea, and later Lebanon (1979-1985) where we had over 8000 men. After that operation three major studies into the problems of these UNIFIL-veterans (1980, 1987, 1989) were conducted. To give only one of the research results: in 1987 about 10 percent of our Lebanon-veterans still suffered from problems related to their mission: from maladaptation to PTSD. In those days however, hardly support was given by behavioural scientists or psychotherapists, mainly because there were only a few of them at that moment, and psychological support was not so well accepted as it is nowadays.

Research and the experiences of therapists have shown that soldiers who have problems coping with their experiences resulting from a mission, frequently withdraw from social contacts, feel themselves misunderstood and often deny that they have any psychological problem. These symptoms mean that military personnel with psychological problems will very difficult get in touch with a social worker or a therapist, on their own initiative.

Based upon four guidelines the Division of Ambulant Psychotherapy of the RNLA has developed a comprehensive set of measures to break down barriers between soldier and therapist in order to make professional help approachable for the soldier in need. All this is done, not to stigmatize the soldier in having psychological problems, but to offer help as soon is possible for the soldier in need and his homefront. These guidelines follow 'normal' military principles; like good leadership, group cohesion, and so on. These four guidelines are:

stable individuals,

homefront care,

stress as a normal reaction,

and the Salmon principles.

Policy of the Royal Netherlands Land Army on psychological support by operations abroad.

This policy comprises 10 ‘steps’:

step 1: initial or intake selection for regular soldiers:

by means of among other things personality tests and an interview, aimed at the deployability abroad and psychological fitness, we assess psychological stability and try to filter out the high risk groups.

step 2: education and counselling on stress and social support, preferably by the psychologist who will accompany the unit as a field psychologist when the unit is sent abroad. In this process of counselling we also incorporate the homefront. The education consists of training and lessons on stress and especially for key personnel training in debriefing techniques, to apply after calamities have happened and the field psychologist is, for example due to large distances, not available immediately.

step 3: Support by a field clinical psychologist in the area of operations.

Each unit of battalion size has a so called social coordinating committee, already in the barracks in Holland. This committee comprises the unit medical doctor, the chaplain, the welfare officer, the personnel officer (S1), and when the unit is assigned abroad, a field clinical psychologist. The latter has three tasks: he is an advisor to the commander; he supports the key personnel; and he acts as a counsellor or therapists when necessary.

step 4: Family support or homefront care.

The RNLA facilitates the establishment of and guides the so called ‘homefront committees’. They comprise partners or parents of soldiers deployed in UN operations, and help each other in difficult times, in meetings and through so called telephone circles.

Of course a sitcen – a situation centre at the Army Headquarters – is available on a 24 hour basis for the family that needs information on the whereabouts of their relatives. Although the RNLA takes initiatives and facilitates with financial help, personnel and so on, it is, and will stay, the responsibility of the partners and parents if they themselves will join the committee of the unit the soldier belongs to.

step 5: Psychological debriefing.

Of course, after each serious incident, the clinical psychologist or the key functionary in the unit will conduct a debriefing. Moreover, a psychological debriefing takes place before the personnel return home after their duty abroad. This is normally done in the area of operations and in the units, but if necessary, with personnel deployed individually as UN monitors for example, debriefing will be done immediately after return to the Netherlands as well.

Eventually, when a clinical psychologist is needed, but is not available in the area of operations (for example because the unit was too small to assign one to) a psychologist or a team will be flown into the area.

During these debriefing meetings written material is handed out on possible delayed effects and how to act if problems arise.

step 6: Reintegration meetings.

8 weeks after returning to the Netherlands the soldiers are invited to take part in a reintegration meeting guided by the social service of the army. This is done in units preferably, but here too individual personnel, again the UN monitors for example, can join these meetings as well. During these meetings the soldiers discuss their adaptation to normal life, in work and family, the so called reintegration process, and the problems they are confronted with. Together they try to find solutions.

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step 7: In an active, personal approach, personnel who have been deployed are sent an 'aftercare questionnaire', approximately 9 months following their return. The home front of the servicemen or women also receives a questionnaire. In more detail this step in psychological support will be discussed later on.

step 8: Veteran Care.

Four basic principles guide the policy of the RNLA concerning veterans from operations abroad:

1. veteran care is the responsibility of the army, even though the veterans are no longer part of that army.
2. there should be an active approach, an outreach to the veterans, to survey possible problems and to offer help.
3. the help offered by the army is as accessible as possible. That is, there are no barriers. A veteran in need of support can approach his own psychotherapist, the officer-clinical psychologist who he served with during his duty, even if the veteran has left the army already.
4. there is a good collaboration between the military mental health services, the veterans organisations, and the specialised civilian mental health centres. The Veteran Institute has a central coordinating role in these activities.

Important to mention is the fact that in the Netherlands a veteran is a serviceman who left the army and has been abroad for his term. Other papers on this symposium will give more detailed information about the activities of the veterans care.

step 9: All lessons learned are collected by a special office of the chief of army staff. This relates not only to the experiences in our branch, but also in operations, logistics and so on. Behavioural scientists help to structure the way the information is compiled, and to analyse the data and draw conclusions.

step 10: Last, but not at least, there is the systematic evaluation of all steps mentioned above.

Aftercare questionnaire

As mentioned earlier, research and the experiences of therapists identified soldiers with problems resulting from experiences of a mission. Withdrawal from social contacts, misunderstanding and denial that they have any problem led to psychological problems in which the soldier will not get in touch with a therapist, on their own initiative.

This is why it is necessary for each individual serviceman or woman to be contacted, to determine whether they are encountering problems as a result of their assignment, and to offer them help if they need it.

Against this background, personnel who have been deployed are sent an 'aftercare questionnaire', approximately 9 months following their return. The home front of the servicemen or women also receives a questionnaire. The main purpose of these questionnaires is to offer (after)care to (former) servicemen and women, and their home front. This psychological care will be offered by the Division of Ambulant Psychotherapy.

This active, personal approach is also called **outreach**. Outreach can prevent military personnel having to battle with problems for years, before they finally seek help. It is our experience that the likelihood of successful treatment is greatly enhanced if the symptoms are spotted in time.

This questionnaire includes items regarding to the stressors military personnel experience during their term; a PTSD-survey concerning intrusion, avoidance and hyperarousal experiences; items about mental and physical changes since the mission and adjustments to life at work and at home in the Netherlands; two SCL-90 dimensions; and so on.

In the mid-nineties the Division of Ambulant Psychotherapy has started with this active approach. On this moment almost 30.000 questionnaires has been send out to all servicemen and their home front, started with Provide Comfort in Iraq in the early nineties until now. Table 1 gives some interesting results about this retrospective surveys.

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Table 1: Comparison between different periods¹⁻².

	Period 1991 - 1996	Period 1996 – 1998	Period 1998 –1999	Period 1999-2000
Surveys returned	N=5035	N=2158	N=1517	N=2029
Response	46%	42%	38%	36%
Most reported serious events:				
- Witnessing human suffering	74.4%	50.9%	44.0%	57,5%
- Shootings (not aimed at the soldier)	79.2%	38.6%	25.6%	38,9%
- Witnessing death/wounded locals	51.8%	22.2%	13.8%	26,9%
- Rejection by local people	47.3%	28.5%	28.4%	25,4%
- Personal danger	43.7%	18.7%	15.2%	16,5%
Readjustment problems:				
- Partial PTSD	20.4%	14.7%	14.0%	16,1%
- Full blown PTSD	4.3%	2.6%	2.0%	2,6%
- Sleep disturbances (SCL-90)	15.6%	12.6%	11.9%	12,2%
- Somatic disturbances (SCL-90)	12.4%	9.8%	7.6%	10,5%
Care:				
- Contacted by telephone	27.0%	16.0%	14.6%	14,0%
- Accepted help	8.0%	3.5%	2.3%	3,1%
- Already treated	2.0%	2.3%	2.1%	2,5%
- Already treated elsewhere	1.2%	1.6%	1.8%	2,5%

Period 1991- 1996: Provide Comfort - ICFY - UNPROFOR - (DI t/m III) - UNTAC - UNAVEM - WEU - etc.

Period 1996- 1998: IFOR2 - SFOR1-2 - MAPE - etc.

Period 1998- 1999: SFOR 3-4-5 - MAPE - UNIPTF - UNFICYP - etc.

Period 1999- 2000: SFOR 6-7 -KFOR1-2 - MAPE - UNIPTF - UNFICYP - etc.

There are high incidences of reported events and readjustment problems for the period 1991-1996. It is the period in which we had to deal with the war in Yugoslavia (e.g. Srebrenica) and Rwanda.. 4.3% of the respondents were diagnosed as having PTSD and for 27% of the respondents there was an indication for problems due to their term abroad.

Reasons for inviting someone for care were:

- reported stressful encounters during operations,
- reported fysical or mental changes,
- welfare or complaints of the partner,
- the respondent asked for an interview with a therapist.

The second and third period gives a decrease in reported serious events, readjustment problems and care. It is the last period 1999-2000 which give rise to all above. A further decline is curved upward, mostly due to the experiences of the Kosovo-conflict.

Over the years we can see a slight decline in response. This is troublesome. In 1999 a non response survey³ indicated, fortunately, that the main reason for not responding was mostly due to not having problems. Nevertheless, non response is a pity and for the future we must be creative in our efforts how to deal with this negative development.

It became clear from several aftercare studies that military personnel experiencing psychological problems as a result of a mission can indeed be traced by means of the questionnaire and the majority of respondents considered this active approach to be a positive development.

In 1998 a study was conducted by TNO, the Netherlands⁴, concerning the physical complaints from servicemen situated in Lukavac in the mid-nineties. From this study it was recommended that every soldier must be monitored psychological as well physical.

Right on this moment efforts are made between physicians and psychologists in sending out an combined questionnaire for signalling medical and psychological problems by servicemen after their return from an operation⁵.

Some concluding remarks

An overview of a policy including ten separate steps in which therapists can contribute to peace keeping operations has been presented. This policy, adopted by the RNLA, seems to be effective. There is a decrease in problems, and those psychological problems can be treated at an earlier stage and thus resolved easier, quicker and thoroughly. Above that there is a greater acceptance of the contribution of psychologists in the army. The fact that soldiers too have emotions and can have emotional problems that can be discussed and treated is now a fact of life in the army.

For a better monitoring of the servicemen, efforts are made between physicians and therapists, in sending out a combined questionnaire for detecting medical and psychological problems in an early stage. Future is promising for a better health care system for the servicemen of the Royal Netherlands Land Army.

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SYMPOSIA DISCUSSION - PAPER 27

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Discussor's Name: Surg.Capt Hoejenbos (NL)

Question:

Are there any NATO-guidelines about procedures in the psychosocial field?

Author's Reply:

Not that I know of. If there are guidelines I would be very interested.

