After returning from military deployment to hotspots of Iraq and Afganistan – Estonian experince

Capt. (R) Tiit Meren MD PhD - „ Civilian Surgeons-in-Deployment“, Reserve Officers´ Association of Estonia.
Ltn. Merle Tihaste MSc, - Applied Research Center, Estonian National Defence Collegue

This article *has been produced in close cooperation with a key person of the Psychologic Service (PSY.S.) of Estonian Defence Forces (EDF) Ltn. Merle Tihaste and with special advisory remarks from Capt. Lauri Abel and Major Kersti Lea representing Estonian MoD. The first author´s position, as a reserve officer, has enabled him to observe and analyse this particular topic on a more independent (neutral) standpoint and to draw conclusions that are, indeed, a subject for further discussion.*

Since 2004 Estonian troops have participated as coalition-partners in military stabilization operations in Iraq and as ISAF combat units in Afganistan.
At first glance the amount of Estonian military contingency in Iraq and Afganistan is not big. But in more detailed look one discovers that Estonia´s human participation in Afganistan per capita of national population is even bigger than from certain other NATO countries; we have deployed 1 soldier per 5800 of our national population. In comparisson United Kingdom has 1 soldier per 8000 and the United States – 15.000 .
90% of our contingency are Combat Unites. They operate in the hottest spots, patrolling on the streets of Bagdad and operating in Helmand Province.They have no restrictive limitations of military activity (national caveat). They operate out of Base on the streets of Bagdad every day and in Helmand Province they are not returning to Base sometimes several weeks.
The severity of military engagement is characterized by certain Leassons-learned and aswell the losses; 2+2 warriors - dead, 15+20 – injured, which gives reason to expect that the rate of mental health promblems in our soldiers could be substantial .

International experience on combat stress and associated mental symptoms:
US,Canadian and UK military psychologists report that at least 10-20% of deployed soldiers have various mental symptoms which had further developed into posttraumatic stress disorders (PTSD). Which in turn make the warriors not capable to act in the war theatre, not deployable in the next round of rotation and not acceptable to their families when they return back home. Repeat „combat tours“, according to US sources, increase the presence of acute combat stress to 50% (!) in their contingencies and substancially increased rates of suicide.

In contrast to international experience the Psychological Service of Estonian Defence Force reports preliminary results with absence (!) of PTSD and suicides in our warriors during and after returning from deployment to Iraq and Afganistan.

Is this a true picture of the Estonian warrior`s mental health state after returning from deployment or do we miss some facts? Are our soldiers really better selected among candidates to deployment in comparisson to other Nato countries? Are they possibly better prepared to resist extreme conditions , better guided through the dramatic sceens of war theatre and brought back home „in time“? Is their social readaptation to match to conditions and circumstances back at home better than in other Nato countries?
Do our military psychologists use standard international methods to prepare, monitor and support our deployed soldiers? Are the periods monitored enough to draw decicive conclusions?

The PSY. S. of EDF was officially founded in 1993 but in 2007 is still manned only by 3 psychologists. Their ambition is to win recognition in the eyes and minds of our defence leaders and to establish a task oriented central structure and the post of Head of Psychological Service of EDF together with a corresponding chain of command.Under his/her supervision 3 departments should be established; Reserarch & Science, Education and Training and Councelling & Consulting.
Meanwhile these 3 psychologists are monitoring mental health status of our warriors before, during and after deployment.
In pre-deployment phase they prepare deploying personel through psycho-educational training to better adaption to the operational environment and to manage the related stressors. In Leadership Training they debrief warriors in the case of critical incident, comunication and problem-solving techniques and unite moral.
In Unit Training they talk about individual differences in the adapting process, the role of family and close relationship, stress, Burn-out symptoms and how to cope with it.
In Deployment phase they perform support of most significant others, distance attendance to identify psychological disorders and misbehaviors. Consulting in case of conflight situations in unit or problems in homefront. The leaders and soldiers are guaranteed with psychological support in case they need it.
In Post-Deployment phase they screen emotional stability, physical health and the process of psychosocial re-adaptation. At returning from deployment (in the airport) clinical screening test (EST-Questionnaire) to assess potential psychiatric deviation is administered together with medical check.
1 month after homecoming an individual interview with psychologist takes place together with filling the PTSD-Questionnaire.
6 months after homecoming follow-up contact takes place.

To answer the question do we have a true picture of our soldier´s mental health status – let us look first what factors have contributed to creation of this positive result.
All deployed soldiers are choosen from active service contingency. No conscripts are deployed. Recruting doesn´t happen in supermarkets or university campuses among failed students. No specially appetizing bonuses are offered. Joining deployment rests purely on the free will of our soldier.
The terms offered by the deployment contract are probably rather liberal; rotation lasts only 6 months and vacation follows. It is not unexpectedly cut. No prolongation of rotation period to 12 or to 15 months happens. In case of multiple rotations (2-6) the decision to go was seemingly easy because the acquaired earlier experince had motivated our soldiers to continue with their job.

What factors may have created a false picture? According to psychologist´s interviews „Fear to talk“ is one of the leading problems.
In the war theatre some of our soldiers are afraid to ask for help for mental symptoms ... because they fear it endangers their future career. Some of them simply prefer not to talk at all about their past memories. It may have happened that with their mental symptoms that had somatized they go and complain only to their civilian GP´s and on condition, that no backflow of information to military medicine doctors happens. Aswell a though guy syndrome („Big boys don´t cry“) is deep routed in Estonian way of thinking.

While psychologist have the results of their interviews, military leaders of EDF have their fixed opinions that often don´t go side by side with the psychologists´view.

The latter state that unfortunately we don´t have a clinical psychologist „in the Base“. We miss the deployment related health research, troops health assessment system, epidemiological research or exhaustive post-deployment health screening. What we have is incoordinated (non-systematic) activities to cover every single case that pops up, chaotically documented history of events and soldiers with apparently hidden problems that have not been solved.

Do our psychologists monitor our warriors´mental symptoms continuosly enough?
As stated we have no clinical psychologist stationed in Iraq or Afganistan to detect early (starting) mental symptoms of a problem that might grow big and be difficult to recognize and treat afterwards. „Blind periods“in monitoring mental status exists between 1.-6. months, aswell starting from 7. months after returning from deployment.
No legal basis exists in EDF to order a soldier to Medical Checks or interviews after deployment. No one compensates to the soldier the travelling costs to regular Medical Checks.

Conclusions:
1. The Psychological Service of EDF has made a successful attempt to perform monitoring of mental health status of deployed soldiers and has presented the results from their provisional studies and interviews to the defence community of Estonia.

2. The higher authorities of EDF seem to consider Psychologist´s Statement not decisive, not advisory and not a priority (in the Military Decision Making Process). And thus they deny the need to increase military psychological or psychiatric support to deployed Estonian soldiers.

3. Taking into account the high presence of Estonian contingency in military hotspots of Iraq and Afganistan - the Psychological Service of EDF with only 3 persons - is dramatically unmanned and understructured.

4. As acknowledging of mental health problems in connection to acute or chronic combat stress is undervalued by higher authorities in EDF – a shortage in diagnosing, treating and rehabilitating exists.

5.According to private interviews with our soldiers, an urging need exists to legally adopt a comprehensive system of Social Guarantees and Family Support Programms. Its absence is becoming an existential reason for our deployed soldiers to loose their further motivation in participating in next rotations.