# AFTER RETURNING FROM MILITARY DEPLOYMENT TO HOTSPOTS OF IRAQ AND AFGHANISTAN – THE ESTONIAN EXPERIENCE

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***This article*** *has been produced in close cooperation with a key person of the Psychological Service (PSY.S.) of the Estonian Defence Forces (EDF) Ltn. Merle Tihaste and with special advisory remarks from Capt. Lauri Abel and Major Kersti Lea representing the Estonian MoD.*

*The first author's position, as a reserve officer, has enabled him to observe and analyze this particular topic from 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 Afghanistan.

At first glance the amount of Estonian military contingency in Iraq and Afghanistan is not big. But in a more detailed look one discovers that Estonia's human participation in Afghanistan 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 comparison with the United Kingdom which has 1 soldier per 8000 and the United States – 15.000.

90% of our contingency are Combat Units. They operate in the hottest spots, patrolling on the streets of Baghdad and operating in Helmand Province. They have no restrictive limitations of military activity (national caveat). They operate out of base, on the streets of Baghdad, every day and in Helmand Province they do not return to base sometimes for several weeks.

The severity of military engagement is characterized by certain lessons-learned as well the losses; 2+2 combatants – dead, 15+20 – injured, which gives reason to expect that the rate of mental health problems 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 had various mental symptoms which had

further developed into posttraumatic stress disorders (PTSD). Which in turn make the combatants incapable of acting 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 substantially increased rates of suicide.

**In contrast** to the international experience in the Estonian Defence Forces we do not have cases of diagnosed PTSD and deployment related suicides among our combatants during and after returning from deployment to Iraq.

**Is this a true picture** of the Estonian combatants` mental health state after returning from deployment or do we miss some facts? Are our soldiers really better selected among candidates for deployment in comparison to other NATO countries? Are they possibly better prepared to resist extreme conditions, better guided through the dramatic scenes of the war theatre and brought back home „in time”? Is their social re-adaptation matched to the conditions and circumstances back home better than in other NATO countries? Are we using better methods to prepare, monitor and support our deployed soldiers? Or are these results just an erroneous illusion caused by the fact that we are not seeing the true picture?

**The PSY. S. of EDF** was officially founded in 1993 but in 2008 is still manned by only 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; Research & Science, Education and Training and Counseling & Consulting.

Although located in different units all psychologists contribute to monitoring the mental health status of our combatants before, during and after deployment.

**In the Pre-Deployment phase** they prepare deploying personnel through psycho-educational training for better adaptation to the operational environment and to manage the related stressors. In Leadership Training they debrief combatants in the case of critical incident, communication and problem-solving techniques and unit moral.

In Unit Training they talk about individual differences in the adapting process, the role of family and close relationships, stress, burn-out symptoms and how to cope with them.

**In the Deployment phase** they perform support of most significant others, distance attendance to identify psychological disorders and misbehaviors. Consulting in case of conflict situations in unit or problems at home. The leaders and soldiers are guaranteed with psychological support in case they need it.

**In the Post-Deployment phase** they screen emotional stability, physical health and the process of psychosocial re-adaptation. On returning from deployment (in the airport) a clinical screening test (EST-Questionnaire) is administered to assess potential psychiatric deviation together with a medical check.

1 month after homecoming an individual interview with psychologist takes place together with the filling of the PTSD-Questionnaire.

6 months after homecoming a 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 at what objective factors have contributed to creation of this positive result.

All deployed soldiers are chosen from an active service contingency. No conscripts are deployed. Recruiting 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 a vacation follows. It is not unexpectedly cut. No prolongation of the rotation period to 12 or to 15 months happens. In the case of multiple rotations (2–6) the decision to go was seemingly easier because the experience acquired earlier 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. As well a though guy syndrome („Big boys don't cry") is deep rooted in the Estonian way of thinking.

**While psychologists 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" as well as having no systematic mental health monitoring during deployment. We miss the deployment related health research, troops health assessment system, epidemiological research or exhaustive post-deployment health screening. What we have is uncoordinated (non-systematic) activities to cover every single case that pops up, a chaotically documented history of events and soldiers with apparently hidden problems that have not been solved.

**Do our psychologists monitor our combatants' mental symptoms continuously enough?**

As stated we have no clinical psychologist stationed in Iraq or Afghanistan to detect early 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, as well as after 7 months period after returning from deployment.

No legal basis exists in the EDF to order a soldier to undergo Medical Checks or interviews after deployment. It means that our soldiers participate in follow up studies only based on their good will. Also, no one compensates the soldier for the traveling costs to regular Medical Checks. This diminishes our opportunity to get a true picture about a soldier's general health after deployment as well as to identify and react to negative changes.

## Conclusions

1. The Psychological Service of the EDF has made a successful attempt to perform the monitoring of the 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 the EDF seem to consider the Psychologist's Statement as not decisive, not advisory and not a priority (in the Military Decision Making Process). Although nobody disagrees with the conceptual idea, there is no initiative to structure the activities of psychological or psychiatric support for deployed Estonian soldiers in an effective manner.
3. Taking into account the high presence of the Estonian contingency in the military hotspots of Iraq and Afghanistan - the Psychological Service of

the EDF with only 3 chaotically located persons – is dramatically unmanned and unstructured.

4. As acknowledging of mental health problems in connection to acute or chronic combat stress is undervalued by higher authorities in the EDF – a shortage exists in diagnosing, treating and rehabilitating.
5. According to private interviews with our soldiers, an urgent need exists to legally adopt a comprehensive system of Social Guarantees and Family Support Programs. Its absence is becoming an existential reason for our deployed soldiers to loose their further motivation in participating in following rotations.