Crisis responders in Sri Lanka: Exploring impact and treatment considerations through the perspectives of mental health professionals

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\textbf{Abstract.} Purpose – South Asian mental health professionals were invited to identify influences on mental health symptom severity among responders during crisis events in Sri Lanka. Further consideration was given to the treatment that could be applied to improve the mental wellbeing of such individuals. Methodology – Twenty-nine mental health professionals (14 civilian and 15 military based) completed a semi-structured interview that incorporated a guided discussion on the mental health experiences observed in crisis responders. Key findings – Thematic Analysis was conducted, yielding two categories. The first understanding from mental health professionals of the impact of trauma that crisis responders in Sri Lanka can experience providing 10 themes capturing the diversity of impact on mental health and social structures. The second category was effective intervention for crisis mental health responders and yielded two main themes. A number of subthemes underpinned each theme across the two categories. Originality – The current study is one of the first to explore mental health symptomology and treatment considerations for crisis responders in a South Asian sample, through the perspective of mental health responders.

\textbf{Keywords.} Mental health; Trauma recovery; Crisis responders; Disaster management; Military; Sri Lanka

\textbf{Introduction}

Crisis situations occur world-wide, affecting individuals independent of their personal demographics and characteristics. The World Health Organization (WHO; 2011) describe a crisis event as experiencing and/or witnessing either personally or on a mass scale, an unanticipated or gradually developing conflict or natural disaster, including disease breakouts, and violence/abuse. It is the frontline crisis responders that then deal directly with the management of such crisis events who may therefore present with an amplified risk of a

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psychological trauma response to such events. Psychological trauma can be triggered from perceived or actual threat of emotional and/or physical harm (van der Kolk, 2014). An individual can develop varied symptoms of psychological distress, including a range of mental health symptomology such as anxiety and fear-based symptoms (e.g. Bisson et al., 2015).

In Sri Lanka, frontline crisis responders predominantly include the military as they undertake several roles, including disaster relief, disease breakouts (e.g. COVID-19) as well as responding to policing matters. These frontline responders can present with a heightened risk of mental health difficulties due to their prolonged and/or continued exposure to crisis events, arguably leading to a heightened risk of a trauma response and subsequent greater need for professional mental health support compared to those not-deployed (Chapman et al, 2014). Similarly, emergency healthcare workers frequently exposed to workplace stressors, including loss of life and traumatised clients, can experience long-term emotional reactions, including self-blame, anxiety, frustration, depression, and feelings of helplessness (Gillespie et al., 2013), all of which fit within the expected components of psychological trauma. Overall, public health crises can further increase pressures likely to be placed on these frontline crisis responders, exacerbating these stressors and amplifying susceptibility to psychological trauma (Muller et al., 2020).

However, exposure to these crisis events may not always result in mental health pathology. Some crisis responders may perceive crisis situations as a challenge to overcome and, as a result, not manifest post-crisis difficulties (Dulmus, 2003; Brencher & Wilkenfeld, 2022). Further, the development of a trauma response after exposure to a highly stressful event can be influenced by the individual’s ability to cope with adversity (e.g. Reisenzein, 2019; Sherin & Nemeroff, 2022). Yet, other factors can further influence recovery, such as disconnection from their families and community, as well as self-stigma in seeking professional help (e.g., Adams et al. 2021). This can be further compounded when a need for professional support is not driven independently. For instance, Becker (2009) emphasised the benefits of crisis responders seeking professional support by their own initiative, therefore having autonomy over their treatment choices.

Of further consideration is the culture of the organisation, and the challenges this can create in allowing a crisis responder access to support for mental health (Beckley et al, 2023). This can be especially important when organisations, such as the police, military or alike, are highly structured and procedural, with cultural nuances as to how such support is arranged. Whilst there is little research on the Sri Lankan Military, a comparison group would be law enforcement. This is particularly helpful since law enforcement is a main role of the Sri Lankan Military. Law enforcement culture can potentially lead to the view that officers are more able to cope with intense, repeated stressors from critical events as a result of their employment (e.g. Wright et al, 2006), albeit more contemporaneous research recognises the issue of cumulative stress/PTSD (Beckley et al, 2023). Of course, perception of ability to cope can be very different to the reality. Dowling et al (2006), for example, reported that over two thirds of 9/11 responding officers (68%) reported at least one disaster-related stress symptom up to 15 to 27 months post the event, with at least 20% progressing to significant difficulties that required further support. In addition, there can be concerns by some law enforcement officers about how confidentiality is maintained, and which can provoke fear of threat to their job security (Dowling et al., 2006), thereby leading to a reluctance to seek treatment/support to try and offset the progression of mental health symptoms.

Emerging mental health difficulties in crisis responders appears a particularly valuable and yet under-researched area to consider. There has been a tendency to view mental health
symptoms as present or absent, failing to account for the dynamic element of symptom expression, including the progression of symptoms across time and/or developing resolution. Factors that may influence this in those responding to crisis events can be the prior challenges the individual may bring to an event(s), such as challenges in adaptive coping mechanisms, social support and secure attachments, with other factors more event specific and including repeated exposure to life-threatening danger, pre-existing negative life events, and/or individual factors such as personality and negative temperament (e.g., Barr & Corral Rodríguez, 2023; Blakey et al., 2022; Presseau et al., 2019). Importantly, what is required from such mental health risk is the need to protect and buffer against such risk, as well as manage and reduce symptomology, if it begins to emerge. It is here that the importance of access to intervention and treatment becomes paramount.

One of the most popular intervention approaches has been the ‘Crisis Debriefing Model’, aiming to mitigate immediate stress reactions by talking through the event, which can include reviewing graphic details. There are concerns around the efficacy of this approach, as research suggests that it does not reduce stress but instead could exacerbate the severity of trauma symptoms. However, there remains some evidence that supports the efficacy of its components to social support and psychoeducation (Regehr, 2001). However, other approaches present with clearer efficacy in trauma symptom reduction. Miles et al. (2023), for example, reported that service personnel diagnosed with PTSD reported a reduction in several symptoms after receiving Cognitive Processing Therapy (CPT), although not in relation to hyperarousal. However, short-term treatment is seemingly more popular as service receivers report a disinterest in long-term treatment approaches, along with budget restrictions that place limitations on what can be accessed (Lewis & Roberts, 2001).

What current research lacks is an understanding of mental health difficulties in crisis responders in Sri Lanka and consequently a consideration of intervention/treatment approaches that are not based on the experiences of crisis responders from Western countries. In addition, the most commonly assessed crisis situation has been combat exposure when uniformed forces have been deployed to foreign countries. The impact of other crisis situations such as natural disasters and crisis situations in their home country (e.g., pandemics such as COVID-19) are scarcely considered. Most studies have also predominantly considered only self-report psychometric questionnaires and not included qualitative interviews and/or information from treating professionals (De Silva et al., 2022).

Consequently, this paper aims to address these gaps by qualitatively assessing the experiences of Sri Lankan mental health professionals regarding the factors that influence crisis event mental health symptomology in crisis responders and considerations for the delivery of mental health interventions for such responders.

Method

Drawing on a qualitative approach to research, this study adopted the interview method in order to examine influences on mental health symptom severity among responders during crisis events in Sri Lanka. While further consideration was given to treatment that can improve the mental wellbeing of such individuals.

Participants

Twenty-nine mental health professionals took part, comprising fourteen civilian registered mental health professionals (i.e., psychologists and counsellors: response rate: 77%) and 15 from the Sri Lankan Ministry of Defence, specifically the army and navy (response rate: 83%). The mean age of the civilian mental health professional sample was 35.6 years ($SD = 5.79$),
with the majority female. The mean age of the military mental health professional sample was 36.3 years (SD = 6.93), with the majority male. Each participant (P1, P2, etc.) was assigned a code to support anonymity with the letter ‘M’ referring to military based and letter ‘C’ referring to civilian mental health professional sample.

**Measures**

In addition to gathering demographic information (age, gender) and information on personal exposure to crisis situations, all completed a semi-structured interview developed to obtain views on the various factors thought to influence mental health symptomology following exposure to a crisis event, including views associated with treatment delivery. The interview asked professionals explicitly about risk and protective factors that aggravated/alleviated post-crisis mental health difficulties, factors that encouraged/prevented support-seeking behaviour and strengths, and challenges in treatment/intervention delivery. Participants reflected on their own experiences as crisis responders, if relevant, but through the lens of being a mental health provider.

**Procedure**

All civilian participants, with the exception of one, engaged in a single interview at their workplace. The exception was interviewed via video call due to them residing outside of Sri Lanka at the time of data collection. The average interview length for the civilian sample was 36 minutes (SD = 18.45). Military based participants engaged via video call due to restrictions imposed by the COVID-19 pandemic at the time of their interviews. The average interview length was 75 minutes (SD = 26.75). Ethical approval was granted by the University of Central Lancashire, with approval also obtained from the Sri Lankan Ministry of Defence.

**Data analysis**

Interviews were manually transcribed and explored using Thematic Analysis (Braun & Clarke, 2006). All transcripts were analysed by the lead researcher. A second researcher analysed every even numbered participant (50% of the same), thus allowing for consensus to be determined. This was achieved, with 80 to 95% of the codes reaching agreement, which is within the recommended threshold (e.g., McAlister et al., 2017).

**Results**

The following results centre on two categories that emerged from the Thematic Analysis. These categories are: a) Mental health professionals’ perceptions of factors influencing mental health symptomology in crisis responders in Sri Lanka and b) Mental health professionals’ perceptions for delivering effective interventions for crisis responders. Each category yielded a number of themes and sub-themes as present below.

**a) Mental health professionals’ perceptions of factors influencing mental health symptomology in crisis responders in Sri Lanka: Resulting themes**

Within category 1, the Thematic Analysis generated three themes falling into 10 sub-themes. The three themes underpinning the results are: (i) Amplified risk, (ii) Buffered against risk and (iii) Variable impact which reflect the factors influencing mental health symptomology in crisis responders in various ways, as follows:
Theme 1 - Amplified risk: Loss of purpose

The ending of a critical event of war in the country was observed to have left crisis responders feeling purposeless, demotivated, and uninterested in other duties considered more routine (e.g. agriculture and construction work). This was then considered as having a detrimental impact on mental health due to reduced self-worth:

“Most of them [service personnel] joined the army for the war, “but now the war is over, so what do I do now?” is a common question that they have. They spent the majority of their lives with a weapon, honoring the tasks and responsibilities in the military, and that’s all they have.” (C, P12).

This then further linked to boredom through this loss of purpose:

“The environment that they [service personnel] operate in, it's a very confined space and after the war especially, there’s a lot of boredom because they are just laying around most of the time now, except for some people who might be doing different things, so that boredom plays a huge role in their emotional health and functioning as well” (C, P1).

Theme 2 - Amplified risk: Lacking insight into mental health symptomology

Some crisis responders would find it difficult to seek help for emerging mental health difficulties due to a lack of insight in respect of symptomology, and where attitudinal barriers may further prevent the development of such insight. For instance, it was reflected that some crisis responders have low insight, and do not seek psychological services due to concerns of side effects of medication, stigma of mental health, and a lack of interest or knowledge:

“The effectiveness of awareness programmes is low because they [service personnel] participate in these programmes for the sake of it, simply because they have been nominated by their superior as programmes require a certain number of people to attend. Only a few people will understand the message and try to apply it to their lives.” (C, P6)

Lack of knowledge of mental health creating barriers could further be observed by engagement in other practices when trying to understand their symptoms, such as:

“There has been a lot of instances where soldiers reveal that up until the workshop, they were under the impression that they or wives were under some kind of black magic spell and had spent a lot of money on superstitious practices. After they have exhausted all of their other options like going to religious places and superstitious practices, then they come for therapy after they are fed up.” (C, P14)

This overall lack of insight was noted by crisis responders further only seeking support for symptoms once it was at risk of affecting their economic status, such as risking unemployment, or creating family difficulties:
The majority of them seek help when they have family issues or if they start having problems at work. It’s very unlikely that they would seek help just because they are personally feeling frustrated.” (M, P15)

**Theme 3 - Amplified risk: Need to assert capability and hardiness**

There was a need for crisis responders to assert themselves as capable and able, most notably within military personnel. For instance, those working as military personnel would report a need to maintain an image of being capable and resilient, which included not presenting with mental health difficulties:

“Seeking psychological help or having psychological illness is labelled as a sign of weakness. It does not fit with the military role. “We [service personnel] are heroes. We have no drawbacks. We are unharmed.” That male ego, hero perspective sometimes it is a protective factor but on other times, it prevents them from asking for help.” (C, P4)

**Theme 4 - Amplified risk: Disconnection from family support and social connection**

Due to the nature of their work duties, crisis responders were often noted as disconnected from their community and families. This was felt to elevate their mental health difficulties:

“The most important thing to them is their families. All of them [service personnel] were away from their families [during the war]. Sometimes their leave comes like 60-70 days later. This affected their emotional and psychological well-being a lot. The wife’s support is very important. There are many wives who complain that their husbands don’t get leave on time and don’t get a lot of free time to talk with them.” (C, P10)

This was further observed when COVID-19 then restricted their abilities to gain family support and connectedness, including at times of personal distress, further exacerbating mental health symptomology:

“Some crisis responders couldn’t even attend funerals of their own parents because of COVID restrictions. This could be a turning point in their lives; losing their closest family, their roles models. These factors affect their psyche more than the risk of being exposed to crisis situations.” (M, P9)

**Theme 5 - Amplified risk: Recent critical events triggering unresolved traumas**

Exposure to various crisis events as part of their work role could at times, and for some, trigger incidents of unresolved traumas in their past. This could relate to an unresolved trauma response from engaging in past critical events, as well as other personal losses:

“When I hear about similar incidents, I have flashbacks about some of the crisis events that I was exposed to. I remember dead bodies and how those were carried. Then I feel really restless. It’s really difficult for me. I can feel my heartbeat rising. With COVID, I am having flashbacks and feelings of restlessness more often. When I see facial expressions of crisis responders, it takes me back to when they were responding to the Meethotamulla rescue mission. I often remember war stories that soldiers tell me, so the
slightest thing startles me. Another time I get flashbacks is when I see distressing footage from news and social media. I get irritated and sweat a lot. I get easily startled by even small noises. It doesn’t last for long, but it happens often. The future feels uncertain, especially with COVID. So many people call our hotline. It is so many people that I feel sick now when I hear the phone rings.” (M, P5)

Theme 6 - Buffer against risk: Importance of reliable and continuing peer support

Peer support emerged as an essential and healthy coping mechanism for crisis responders, and in helping to buffer against any mental health challenges (“They are surviving because of this bond”; M, P5). It was also noted that peer relationships could be timebound and restricted due to workplace conditions. As such, it was not always a long-term or reliable support system, yet it was positive when present. For example:

“When it comes to peers, these friendships are only there during duty hours. I mean that they don’t get to form long lasting friendships because you only stay for one year in a camp, and then you are transferred again.” (M, P11)

Theme 7 - Buffer against risk: Sense of meaning

Reduction in risk of mental health difficulties appeared linked to a sense of meaning and understanding in the work they were doing as crisis responders, and when dealing with crisis events. For example:

“Compared to the western part of the world, the prevalence [of PTSD] is low for some reason. We have to accept that. My interpretation for that is because we had a meaning for our war. They [service personnel] knew clearly what they were fighting for……here, soldiers have the sense of obligation to protect their nation and family. Sri Lankan soldiers could clearly see the consequences of their fighting, so the guilt is comparatively low.” (C, P6)

Theme 8 - Variable impact: Changeable impact of religion as a coping mechanism

This theme offered a mixed presentation in regard to the value that religion could offer, with some crisis responders presenting the view that engaging in religious practice did not protect against mental health difficulties, nor did it promote a health recovery:

“We used to seek counselling assistance from the temple, but in today’s society, religious beliefs themselves can be triggering. For example, the Easter Attack which was religiously motivated. We don’t get the same relief as we used to from religion.” (M, P8)

However, some crisis responders did regard religion as offering some coping assistance in managing the distress arising from trauma:
“Something I’ve noted about soldiers who fought in the frontline is that they have become really religious now. It’s their coping mechanism. They try to accept what happened by convincing themselves that it [the war] was “meant to happen”.” (M, P5)

Theme 9 - Variable impact: Variable response from the community as a benefit or difficulty

The response from the community towards Sri Lankan military personnel was considered of significance and would suggest some potential for a buffering response against their trauma when social appreciation from the community was observed:

“The public attitude about the military is very positive. They see them as heroes. Even when they [service personnel] have gone through terrible experiences and lost their limbs, they are proud about it. Even when life is tough for them, it [social acceptance] gets them going. It is a very strong motivator for them.” (C, P4)

However, if this positive response from the community changes due to the crisis event, and where the response from the community was less favourable, this could then impact negatively on the social appreciation, and ultimately mental health:

“Acceptance from society and how they are portrayed by the media matters to them a lot. This was very present during the war. Not that it’s not there now, but that recognition and respect are less now. With the Easter attack and the pandemic, recognition increased, but now it is low again. They [crisis responders] go through a lot, so when they come out of it, this acceptance is what makes it worth it for them. When it is not there, the value that they give for themselves also changes.” (M, P2)

Theme 10 - Variable impact: Variable support from senior management in mental health recovery

There were variable observations where senior management would encourage and support the crisis responder in seeking psychological support for trauma symptomology, versus others who would not. There were instances where some senior management would be more dismissive of the need for such support. Overall, this theme noted the variable response from management in the support of mental health recovery:

“High-ranking officers with a good level of education have a good understanding of our services and would refer their subordinates to us. They know the importance of psychological support. But those who came into their senior positions from infantry units have a more militarised mindset which only focuses on discipline. They think psychological support is useless.” (M, P13).

There were further instances where some senior management would not only discourage junior officers, but also instill stigma about seeking psychological support:
“Superiors are one of the main reasons for them [service personnel] to not seek help. Most of these seniors have the attitude that people who seek psychological services are “psychos”. So, most of the soldiers are scared to go for counselling sessions. They are worried that they will be called, “crazy”. These seniors sometimes explicitly tell their juniors, “Don’t go for counselling. It’s not good for you. You are just trying to be a baby by going to a counsellor”. (C, P10)

b) Mental health professionals’ perceptions for delivering effective interventions for crisis responders: Resulting themes

Two main themes emerged from within category b, with each theme comprising subthemes. These were noted as follows:

Theme 1: Attributes of service providers in therapeutic support

The individual characteristics and engagement of mental health professionals was felt to contribute to strengths and challenges in the recovery process of crisis responders who were presenting with mental health symptomology as a result of their work. This theme had two sub-themes: approachability, care and empathic concern of mental health professionals, and need for continuous professional development:

Subtheme 1- Approachability, care, and empathic concern of Mental Health Professionals. The personal attributes of mental health professionals such as their approachability, their ability to relate to crisis responders, effective communication skills, and ethical practices were key considerations for effective engagement in intervention. Barriers toward such effectiveness presented where the professionals were inconsiderate to the individual’s distress, held negative attitudes, beliefs and actions that dismissed the crisis responders’ traumatic experiences. For example:

“People who work as counsellors in forces have to be more approachable and not have this whole thing going on where they take on the role of an officer than a counsellor. They [service personnel] don’t feel like going because sometimes the counsellor would be someone who’s also been to the war so they might look at the person as, “Oh, I’ve also gone through this so what are you complaining about?” or “it’s all in your head. I have gone through this, and I’ve lost so many people, so why are you complaining?”, which I know that some counsellors have told their clients. This leaves them [service personnel] feeling very invalidated and most probably not go back again for help.” (C, P1)
could be further compounded by a lack of military mental health professionals engaging with the wider civilian mental health community. One of the civilian mental health professionals, for example, noted the importance of learning from the experiences of crisis responders and their treating mental health professional in the military, to better understand the unique nature of exposure protracted crisis situations:

“I don’t think we need to go for any more courses or training, but if we get exposure from different settings, foreign or local, that’s good. I have a basic degree and that has been sufficient for me to work both inside the military and outside civilian settings. I have not had the opportunity yet to use my education of four years, so it makes me wonder why I have to study more. I’m not saying that we should stop learning, but it doesn’t make sense to say that the quality of my services entirely depends on my formal education. It’s good if we get the opportunity, but it shouldn’t be a deciding factor of my capabilities.” (M, P2)

There were further observations in the limitations of predominantly English material:

“The language barrier is also there because most of the readings and worksheets are in English. Some counsellors may not be able to read, comprehend, and deliver from English to Sinhala. Sometimes [they] may not even have the interest to read because it is not a language that they are familiar with. It’s a major limitation to deliver up-to-date interventions.” (C, P12)

**Theme 2: Aspects of service delivery**

The influence of factors that are external (out of their control) to service providers and crisis responders was noted as an overall theme, split in to four subthemes of accessibility to services, quality of service provision, limited availability of resources and challenging workplace conditions. These focused on the military experience and were as follows:

**Subtheme 1 - Accessibility to services.** It was noted that crisis responders were often undiagnosed and/or untreated for their mental health difficulties due to a reduced access to mental health services in the military. This could be impeded by factors such as stigma and hierarchy:

“There is a certain amount of politics involved, when it comes to rank, status, and family background, so it is difficult for some military personnel to get help, but for some, it is easily accessible.” (C, P8)

However, some professionals reported that accessibility had improved as a response to COVID:

“I wore PPE kits and spoke to COVID patients when they needed psychological help. It was a big deal for them during a time that they were distanced and isolated from others. We established a 24-hour service for them which they found really helpful.” (M, P10)

The lack of agency to decline services was viewed as a positive factor by some of the professionals:
“When you have been referred to go for counselling, they [service personnel] don’t have the choice like in the private sector. They are given a date and then on the day, they are sent from the camp to the hospital with a note. After your appointment, the hospital gives you back that note to handover to the camp office, with the next visit date. Wherever you are in the country, you will somehow be sent for your appointment on that day. They are sent even if they like it or not.” (C, P12)

**Subtheme 2 - Quality of service provision.** There were several negative factors that were felt to reduce the quality of services provided to crisis responders. This related to a lack of culture-specific knowledge on trauma and psychological measures adapted to the Sri Lankan context, differing standards in providing evidence based, person-centred and trauma-informed therapeutic interventions, as well as highly militarised therapeutic settings:

“Assessing trauma for military personnel is different. There are different scales. Most of the European psychological interventions are focused on one-time trauma, but military personnel go through multiple traumas. Addressing this trauma and delivery of psychological interventions are not that easy.” (C, P5)

“We [mental health professionals] are not part of recruitment, but it should be made essential because we will be able to identify individuals who are struggling; sign of self-harm and check their background details for any risk factors like parents who have committed suicide. Individuals like this get easily depressed during military training, so it’s important to recognise them early. Because we get priority in situations like this, some people in senior administration don’t like to have us involved.” (M, P12)

In contrast, some professionals stated that certain components of militarised settings could enhance psychological support:

“There are good things about the system as well. For example, every officer selected for foreign missions must talk to a counselling officer before their departure. We discuss family concerns, risk of sexually transmitted infections, and coping strategies before they leave for foreign missions.” (M, P4)

**Subtheme 3 - Limited availability of resources.** There were a range of challenges through resource availability that could impact on the interventions offered and a willingness for individuals to then engage in these. For example, a lack of qualified practitioners, a lack of comprehensive and regular research, a lack of systematised follow-up procedure, physical resources (e.g., transport, stationery, building facilities), and restricted access to external resource personnel. It was further noted that this then exacerbated during the pandemic:

“With the pandemic, we realised that we lack a lot of resources. We didn’t have the technology to offer services remotely. If we have a system like that, we can even continue it after the pandemic. We can talk to someone in Jaffna from Colombo, so they don’t have to travel 10 hours for one session. It takes about three days. One day to travel, one day for the session, and then another day to travel back. It’s just not a good use of time and resources. Just because of how difficult it is, they [crisis responders] may be reluctant to seek help then.” (M, P2)
A lack of availability was further observed by employing professionals with limited experience in working with the client group, and not employing enough suitably qualified clinicians:

“We [psychologists] join the army after completing our first degree. If I take myself as an example, by the time I joined the army after completing my bachelor’s, I didn’t have enough clinical experience to treat a client. I learned it on the job. Before the first batch of psychologists were hired, the army didn’t have an understanding about a psychology degree, so they had hired persons with philosophy degrees, and this is concerning because we have to question if they provide a quality service to our clients.” (M, P5)

“There are not enough counsellors and psychologists to support the strength of the army. There have been times that I am sick of my job…tired of having to continuously support so many soldiers. Sometimes I think to myself, “What the hell am I doing! What am I trying to achieve by doing all this?” (M, P5)

Subtheme 4 - Challenging workplace conditions. There were various challenges that were focused on the military workplace that was felt to hinder the success of interventions. This included a lack of privacy and confidentiality due to hierarchy in the military setting, mixed role expectations on military mental health professionals, a primary focus on psychiatric drugs over psychological support, an appraisal process that discriminates against crisis responders who seek psychological services, and dismissive attitudes of senior management toward mental health professionals. For example:

“We have a 24/7 hotline, and they can call us anytime, but to meet us in person, they have to go through a lengthy and complicated process. The whole platoon will get to know if someone wants to see a counsellor because the soldier has to talk to so many people to get permission. In the army system, soldiers cannot just come to see us, even if they are willing to. They have to come through their managers. Otherwise, there will be consequences.” (M, P13)

“Since therapists were not part of the active battlefield, some senior officers try to disregard the capacity of psychologists by saying things like, “what do you know about these people [service personnel]? We know best how to handle them”. They [officers] are under the impression that therapists also should have the same experiences to understand trauma related difficulties. The attitude towards psychological services is still very negative. When I tried to introduce new psychological measures, they rejected it saying, “we had a war for 30 years. We never assessed people for recruitment while we did the war, so we don’t need it now.” (C, P6)

Discussion
By considering the perspectives of mental health professionals supporting crisis responders in Sri Lanka, the research was able to capture several factors that could influence the emergence and maintenance of mental health symptoms in crisis responders. These included factors that could amplify risk, those that could potentially buffer against it and those that were more variable in impact. The analysis also demonstrated several components that impacted on the effectiveness of intervention being offered to crisis responders that were struggling with their
mental health symptomology. This included the skill and accessibility of the mental health professional providing the support, alongside workplace conditions.

A notable overall finding of the current research was the diversity of mental health responding as captured by the influence of pre-existing individual factors, need to account for cultural aspects in terms of the social responding and workplace culture, and the role of disclosure in seeking treatment. The range of responses needed to address mental health was reflected in previous research by Jones et al (2021). The role of disclosure in seeking treatment included a sense of maintaining autonomy over treatment decisions, perhaps as a reflection of being exposed to crisis situations over which autonomy could not be achieved. The importance of accounting for the individual in the response became clearly evidenced at this point, which has implications for more manualised approaches to supporting crisis responders. Put simply, the suffering of trauma remains an individual experience even when the crisis event is a shared one. Thus, expecting diversity in responding as opposed to uniformity is a key message that emerges from these findings and should therefore drive individualised therapeutic responding.

Several themes appear particularly pertinent and echo further the importance of the individual in a crisis situation. Themes linked to a loss of purpose in role, a sense of meaning becomes lost, with a lack of fulfilment in more routine activities, linking to low self-worth. Overall, this would suggest that engagement in critical incidents presented as a defining feature of a sense of self. Once an individual was no longer exposed to such events, there was a fragmenting of identity leading to mental health symptomology. Subsequent difficulties in acknowledging and discussing such symptomology (i.e. an extension of disclosure) due to a need to present as capable, hardy and able to those around them was perpetuated further by the positive role model they felt they had to maintain to others and which was reinforced within the community. Thus, a public fragmentation of self into a more depreciating and less able version of themselves was arguably contributing to a reduction in mental health. The issue of fragmentation of oneself has been captured in previous work that explores high risk situations (Williams et al, 2021). Acknowledging vulnerability through allowing expressions of poor mental health was simply more difficult and arguably placed additional emotional burdens on crisis responders.

However, acknowledgement was further impacted by a lack of insight into mental health difficulties and how these could present, alongside the cumulative impact of unresolved trauma events. The level of support from the community and loved ones would further influence the amplification of such mental health symptomology risk, with reduced access to supportive others, such as family members who could offer emotional support, appearing to exacerbate symptomology. This is consistent with Adams et al (2021) who argue that factors such as disconnection from families and community, as well as self-stigma in seeking professional help can all impede recovery. This disconnection from family and lack of social connection due to their role would therefore create challenges in the mental health recovery. For instance, it was noted that there was value in the support they received from their peers, but due to their role requiring placement in differing locations after periods of time, there was a disruption to this positive line of support, and where it would appear valuable when present but not maintained across time.

Positive support could further arise from senior management, and where there was clear evidence of support in assisting the crisis responder in reducing their mental health recovery. Yet this could be mixed and seemingly dependent on the senior manager and their beliefs in respect of mental health. Mental health recovery could certainly be hindered by dismissive attitudes regarding the value of psychological support by some senior personnel, a finding
reflected in research of law enforcement and their mental health (Bell et al, 2022; Beckley et al, 2023). This appeared especially pertinent in the military, where hierarchy and discipline was key and respect ascribed to more senior personnel. Thus, dismissive attitudes by those of a higher rank could arguably carry greater influence in terms of allowing for disclosure of mental health challenges and supporting positive attitudes to managing the emergence of such symptoms.

This clearly could impact on the quality of intervention on offer to support the mental health recovery of crisis responders. Interventions quality in terms of provision appeared mixed and dependent on the expertise and training of the mental health professional, their workload commitments, and support for such interventions at a senior level. This points to the experiencing of mental health symptoms by crisis responders and the treatment of the same as one that is directed from senior staff downwards, and thus not by those who necessarily have experienced direct exposure to the crisis. Rather it would appear that the therapeutic responding at an organisational level and the permitting of mental health disclosure is arguably driven by the more detached spectator (i.e., senior management) than those with either lived experience (i.e., the crisis responder) or those professionally sharing the lived experience (i.e., mental health professionals).

Connected to this, the therapeutic approach of the mental health professional presented as paramount. Limitations in the success of intervention could be driven by a counsellor presenting as less approachable and appreciative of the crisis responder’s distress. This could arguably be a result of them aligning more to the detached spectator position as opposed to acting through the lens of a professional who had also shared the lived experience (i.e., a mental health professional who had lived experience of crisis responding). The expertise and knowledge further linked to this, where some mental health professionals lacked sufficient knowledge in the area of trauma intervention (acknowledged by some but not all) and where some mental health professionals held the seemingly naïve view that their ‘basic training’ would necessarily equip them to engage in such complex intervention. However, a need for enhanced and/or continuous professional development was acknowledged as a need in order to provide effective interventions to the crisis responder experiencing mental health symptomology, a theme that has emerged in recent research exploring mental health and first responders (Anderson et al, 2020; Crane et al, 2022; Lavoie et al, 2022).

The study presented in this paper also noted that challenges in intervention accessibility for the crisis responder was impacted by the workplace provision of such services, where there was limited availability, and which in part appeared linked to a stigma that it was less important. This could also include the addition of substantial barriers that a crisis responder was expected to overcome in order to secure the support. Such barriers could include a lack of agency, where crisis responders needing support were directed to attend psychological support. This then accumulated with a lack of appreciation of cultural modifications that may be required to enable successful trauma intervention, as well as a lack of privacy that they are engaging in psychological support that requires a level of confidentiality. A lack of agency would fit with the work of Becker (2009) where the benefits of crisis responders seeking professional support by their own initiative are emphasised. As noted earlier, autonomy is important and any explicit or implicit coercion to engage in therapy is counterintuitive to effective therapeutic working and serves only to remove agency from an individual who may already be experiencing a fragmentation to their sense of self. Furthermore, a lack of confidentiality would be detrimental and would fit with the concerns raised by Dowling et al (2006).

Further challenges were also observed through resources restrictions, such as a lack of suitably qualified mental health professionals to meet demand, as well as limited technology
options to offer support, leading to the crisis responder having to (at times) spend considerable time in order to arrive for face to face support, where online options could be considered. Thus, several barriers to offering successful interventions were noted, both at an individual crisis responder level as well as at a wider organisation level. In highlighting this, the research demonstrated both the diversity in mental health responding but also the diversity of issues to account for to develop effective organisational responding in a manner that will support crisis responders.

Strengths and limitations of the current research
The current research is one of the first to specifically consider crisis responders in a South Asian sample, and to qualitatively assess lived experiences and professional views of civilian and military mental health professionals regarding factors in trauma recovery and considerations for effective mental health intervention for crisis responders in the military. The current research offered only an introduction of understanding in this area and did not assess the impact of other factors, such as severe physical injuries and/or disabilities on symptom severity and treatment progress, as well as post exposure to trauma-inducing events. Moreover, it was an initial study to determine mental health impact from exposure to crisis events in the course of employment duties. Therefore, future research should assess this in more detail, with a larger cohort of crisis responders, and potentially split the groups more directly from those in the military versus those not. Regardless, a strength of the study represents the diversity in sampling of mental health professionals and the qualitative approach. Such an approach offers a clear richness of information that can explore the diversity of views and experiences in more detail than by adopting a standardised quantitative approach.

Conclusion
Findings from this study illustrate the importance of considering psychological trauma in crisis responders, and the factors that may hinder a true reflection of distress. This study illustrates that there several factors restricting engagement in discussion of distress and in seeking support. For instance, crisis responders lack of insight into the emergence of mental health symptomology, a need to assert a sense of resilience in order to meet the expectations of their role, alongside variable support for them to engage in intervention to manage any presenting difficulties, all present as factors to account for. Yet also, and of particular importance, is the sense of identity that a crisis responder can gain from their role, and the sense of loss of self and identity if this is no longer present for them. The importance of accounting for this and placing the individual at the forefront of the professional response presents as key. The latter will require increased organisational support at a senior level and one that avoids a ‘detached spectator’ approach that fails to appreciate the lived experience of crisis responders or to account for the unique cultural, religious, and/or political differences that may arise in a culture that need to be accounted for both in understanding trauma and in determining individual-centred interventions.

References


systematic narrative review of the international literature. Health Policy, 125(3), 375-384.


