



**UNIVERSITY OF ZAMBIA AND ZIMBABWE OPEN UNIVERSITY
POSTGRADUATE PROGRAMMES**

**ROLE OF COUNSELLING IN REDUCING
OPERATIONAL STRESS IN SOLDIERS IN KABWE,
ZAMBIA**

**BY
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ZIMBABWE OPEN UNIVERSITY IN FULLFILMENT OF THE REQUIREMENTS
FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN COUNSELLING**

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DEDICATION

This study is dedicated to my God, myself, my family; future scholars, friends and to the development of Zambia.

DECLARATION

I wish to declare that this is my original work and where other people's ideas have been used, they have duly been acknowledged.

Sign.....

Date

CERTIFICATE OF APPROVAL

This dissertation by Cosmas Chiimbwe is approved as fulfillment of the requirements for award of degree of Master of Science in Counselling of the University of Zambia in association of Zimbabwe Open University.

Examiner..... Date.....

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ABSTRACT

This study examined the causes of operational stress in soldiers, adverse effects, and assessed the role of counselling in reducing operational stress in soldiers in Kabwe, Zambia. Stress and stressors are an inherent part of warfare because of the violence, the physical conditions, and duration of operations. Stress represents “the mobilization” of the body and mind to counteract stressors. The causes of stress will always be there as long as soldiers are deployed in an environment which is a breeding ground, for example during operations in battle front and prolonged operation and other factors. Early identification of stressors and adverse effects can minimize the negative effects of combat and operational stress (COS). Adverse refers to physical, mental, and emotional manifestations; loss of personnel due to combat ineffectiveness. The study therefore, was aimed at finding ways of reducing stress. With the following objectives: to determine the causes; determine the adverse effect of operational stress and assess the role of counselling in reducing operational stress in soldiers at Chindwin and Kohima barracks, the study revealed that counseling is one of the measures which can minimize the high levels of operational stress in soldiers deployed and after, if incorporated in the training programmes by utilizing the services of the professional chaplains and medical personnel. A descriptive survey was used in conducting the research. Collection of data was done by interviewing a sample population of 50 participants and by use of questionnaires. Qualitative method was employed to collect data. Qualitative research emphasizes understanding of verbal narratives. The method was used because participants were met at once hence it saved on time. The participants asserted that counseling can play a vital role through the services of military chaplain counselors and mental health professionals in Operational Stress control for prevention, identification, counseling therapy and treatment. Through questionnaires and interviews it was established that those who were counseled received help than those who did not. In this case pro counseling must be extended even when the soldiers are out of stressful field in order to prevent unusual behavior such as extremely drug/alcohol abuse, indulge in sexuality, malingering, absenteeism without official leave, marital problems, financial indiscipline just to mention a few.

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ABBREVIATIONS AND ACRONYMS

PTSD	Post Traumatic Stress Disorder
COSR	Combat and Operational Stress Reaction
UCMJ	Uniformed Code of Military Justice
OEF	Operation in Enduring Freedom
OIF	Operation in Iraq Freedom
IEDS	Improvised Explosives Devices
UN	United Nations
PDHRA	Post Development Health Reassessment Association
PDHA	Post Development Health Association

CHAPTER ONE INTRODUCTION

1.0 Overview

The chapter presents the study background, problem statement, purpose of the study, study objectives, research questions, significance of the study, and delimitation of the study and definitions of terms used in the study.

1.2 Background to the study

In today's battlefield, everyone is a soldier. Whether serving in the infantry, providing healthcare, or providing logistical support, all military personnel face the threat of attack from a dedicated enemy force of stress. Routine existence in a combat zone places all service members at risk for exposure to a range of significant stressors. In peacetime as well as war, the effects of combat and operational stress are experienced by all soldiers in every type of military operation, including combat-like conditions present throughout the entire spectrum of military operations.

The acknowledgement of the negative psychological impact of war on soldiers can be traced back to early cultural mythology. However, it wasn't until the late 17th century that an attempt was made to apply a diagnostic label to a breakdown on the battlefield - *nostalgia*. Originally called the "Swiss disease" due to its manifestation in Swiss villagers who were involuntarily placed in rouge armies, it eventually was acknowledged as a universal problem (Jones, 1995).

In 1871, a former Army psychiatrist during the US Civil War, Da Costa wrote about a cardiac condition known as "Irritable Heart". Also referred to as cardiac neurosis, neuro-circulatory asthenia, nervous heart, and eventually soldier's heart, the syndrome was characterized by shortness of breath, sweating, nausea and diarrhea, dull aching of the chest, and a persistent tachycardia during mild levels of exertion. The soldiers also struggled with the reminders of combat (Wooley, 2002). Although Arthur Bowen Richards Myers in 1870 originally described the syndrome one year prior in his book, *on the etiology and prevalence of diseases of the heart among soldiers*, Da Costa reported detailed cases of soldiers suffering from this ailment while fighting in the American Civil War. An interesting note about Da Costa's accounts is that the symptom presentations he details are very similar to what the psychological and psychiatric communities today call anxiety and more specifically panic.

Another interesting point is that Da Costa as noticed by Binneveld (1998), many of the soldiers improved just by removing them from the forward lines and allowing them to rest. Although these accounts are not the first documented cases of combat stress and its treatment in soldiers, they are most likely the first with a sufficient level of description that allows us to make a comparison to our current nomenclature and knowledge about treatment. Further he said, combat stress control Shell Shock, a term “shell shock” was a product of the First World War. It was used to describe the psychological trauma that men suffered as a result of the intense combat prevalent throughout the European theater. Originally, men were believed to be suffering from the direct physical effects of shell blasts or poisoning due to the odd and unfamiliar symptom presentation. Stokes, (2005), pointed out that, over time, most cases were found not to have been close to exploding artillery, and were diagnosed as “war neurosis”. Some of the more common symptoms of this phenomenon were agitation, fatigue, increased startle response, loss of concentration, and mood liability. Conversion reactions with localized loss of sensory or motor function that resembled neurological damage were also common.

Gilbert (1994) and Binneveld (1998), alluded that many of the fighters would flee the battle-site due to an overwhelming sense of fear and panic or become paralyzed and incapable of movement. Consequently, many of these warriors were labeled as cowards or “malingerers.”

Jones (1995), a British psychiatrist during World War I studying the phenomenon of shell shock, presented a paper at the Royal School of Medicine in 1917 which was then published one year later in the journal *Lancet* and described a type of neurosis suffered by soldiers that he attributed to a form of repression. He argued that soldiers under intense stress would attempt to mentally withdraw from the adverse stimuli of war. River’s explanation of the psychological mechanisms seen in these soldiers is similar to what most behavioral health professionals today would call dissociation. However, what made River’s work so important was that he was able to describe several cases in which there was successful amelioration of symptoms.

As the World War II successor to shell shock, battle fatigue became a popular term in military medicine that is still used in many of the discussions of combat stress today. Battle fatigue is considered to be caused by one (or usually a combination) of four contributing factors: sudden exposure, cumulative exposure, physical stressors, and home front issues (US Department of the Army, 1994a).US Department of the Army, (1994b), concluded that, its symptoms are similar to

shell shock and soldier's heart in that the individual may experience fatigue, anxiety, loss of concentration and motivation, depression, memory loss, and disturbances in physical functioning. During World War II, treatment for battle fatigue focused on returning the soldier to the front in order to keep fighting and keep the unit strong. Initially thought to be cruel and counterproductive, service members were found to be able to reintegrate back into their units and continue as productive warriors. This is consistent with what was found in the Russo-Japanese War, World War I, Korea, Vietnam, the Israeli, Lebanon, incursion, and many others. Historical accounts suggest that it was the new replacement who is most likely to fail catastrophically and not the experienced soldier (Stokes, 2005). Post-Traumatic Stress Disorder (PTSD) is one of the most well known and publicized mental health disorders in the world. It is characterized by an exposure to a traumatic event with symptoms from three different clusters: intrusive Combat Stress Control thoughts/recollections, avoidant/numbing symptoms, and hyper-arousal (American Psychiatric Association, 2000). The disorder gained its widespread recognition as a result of the Vietnam War. After thousands of returning veterans lined the halls of VA hospitals, scientists began to take a closer look at this complex disorder (Dicks, 1990). American Psychiatric Association, 1987), as an official diagnosis. Consequently, numerous research projects were undertaken to learn more about this disorder and how best to treat those affected by it. To date, most of the major studies related to post traumatic stress disorder (PTSD) are with Vietnam veterans. One of the more influential of these studies was conducted in 1983 by the National Vietnam Veterans Readjustment Study which was mandated by the U.S. Congress. The aim of the study was to determine the prevalence of PTSD in returning veterans as well as identify any readjustment/reintegration problems that they faced. The investigators found that approximately 30% of males and 26% of females who participated in the Vietnam War had PTSD at some point during their lives. They also found that there was a higher incidence in minority populations (Kalka, 1990).

The reactions of troops to stressful events in combat and combat operations, for the most part, have stayed the same over the past several centuries. What has not stayed the same is how they are classified and understood. This is not a trivial difference. In order to develop preventative measures for warding off combat and operational stress reactions and to implement tested and effective treatment strategies, a thorough understanding of the process of combat-operational

stress is crucial. As a result of this Combat Stress Control understanding, the military has been able to develop successful programs in “combating” combat-operational stress.

Ben-Shalom (2015) revealed that military operations in the last decades entail far more diverse challenges than those described in the psychological and psychiatric literature developed following world war two. Often these challenges are described as operational stress, Two significant components in this composite of challenges are injury and death from hostile enemy actions with the negative affect derived from prolonged boredom, lack of action and monotony, Yet such an exhausting routine can suddenly and without control be interrupted by an enemy attack. Typical situations are sudden attacks on military posts, skirmishes during patrols, mortar fire attacks and explosion. Marlowe (2001) said, stress and stressors are an inherent part of warfare because of the violence, the physical conditions, and duration of operations that make up the nature of war. It has been studied and documented that some stresses are good for an individual because they improve performance. Stress represents “the mobilization of the body and mind to counteract stressors.” Stress as an inherent part of life and can be positive or negative. A stressor is any event or situation that requires an unusual change in the way a person responds. It is often unfamiliar or creates conflict among motives within a person.

There are two types of common stressors: among the soldiers mental and physical. A physical stressor has a direct impact on the body and includes both environmental and physiological conditions. A mental stressor is one in which information impacts the brain with no physical. Maladaptive Stress Reaction occurs when a person reaches their breaking point. Maladaptive Stress Reaction includes combat and operational stress reaction (COSR) and misconduct stress behaviors. COSR is applied to any stress reaction in a military environment. They are only transient reactions to the traumatic stress of combat and cumulative stresses of military operations. They can impact an individual both physically and mentally. Misconduct Stress Behaviors range from minor breaches of unit orders or regulations to serious violations of the Uniformed Code of Military Justice (UCMJ) and the Law of Land Warfare. Examples include substance abuse, brutal violence, recklessness, desertion, malingering, and fraternization. Other negative reactions include physical fatigue, mental fatigue, and battle fatigue. Physical fatigue is weariness and/or decreased performance capability due to hard or prolonged worked/effort, muscle tiredness, aerobic fatigue, and sleep deprivation. Physical illness and intense emotions

can produce fatigue. Mental fatigue is impaired performance due to continued mental effort on a specific task. Emotions, such as boredom or uncertainty, also produce mental fatigue. Battle fatigue/combat stress reaction is produced by both physical and mental tasks.

Turabian, Kate (2007), also observed that, the adverse refers to physical, mental, and emotional manifestations; loss of personnel due to combat ineffectiveness; misconduct stress behavior; and other short- and long-term conditions produced by combat stress. These adverse effects are known as maladaptive stress reactions. Military communities or Soldiers are often faced with myriads of emotional pain due stress arising operational and multiple deployments and general effects of being in the combat zone. In Zambia Army like in any other conversional military organization; the health physical, emotional and mental fitness of a soldier are the pillars for a healthy military establishment as these help to keep the morale high of the men and woman in uniform. However, the question of significance is to investigate if adequate counseling is being provided to soldiers in mitigating and minimizing the adverse effects operational stress. However, there is still a knowledge gap in Zambia because no study has been done to critically examine the adverse effects of Operational Stress in soldiers Therefore, if no study such a study is done, on the role of counseling in reducing Operational Stress in soldiers in Zambia Army will remain as a problem of significance. This is what this study tries to establish

US Department of the Army (2006), revealed that, these operations range from training, all phases of deployment, peacekeeping, humanitarian missions, stability and reconstruction, and government support missions, to missions that may include weapons of mass destruction or chemical, biological, radiological, nuclear, and explosive weapons. It is important to understand that combat and operational experiences affect all soldiers and reflect all activities soldiers are exposed to throughout the length of their military service, whether a complete career or single enlistment. Service members continually face the potential for deployment and combat, long and strenuous training missions, and separations from families.

Further analyses, operational stressors are as follows; prolonged exposure to extreme geographical environments such as desert heat or arctic cold, reduced quality of life and communication resources over extended period of time, prolonged separation from significant support systems such as family, exposure to significant injuries over multiple missions such as witnessing the death of several unit members over the course of many combat missions. Stress

has both physical and behavioral effects. Stress may increase disease rates by disrupting hygiene and protective measures, as well as impairing the body's immune defenses. Stress may progress to behavioral health disorders, including suicidal or homicidal behaviors. Some stressors contribute to misconduct that requires disciplinary action and may take a soldier from duty for legal action and incarceration. Stress can also result in battle and non battle injuries through inattention, clumsiness, and reckless behavior, including equipment loss and friendly fire incidents. Excessive stress in combat contributes to lapses in operational and tactical judgment and to missed opportunities that could increase the numbers of soldiers injured over time. Although many stressors in combat situations result from deliberate enemy actions aimed at killing, wounding, or demoralizing US soldiers and US allies, other stressors are due to the natural environment, such as intense heat or cold, humidity, or poor air quality. Still others result from leaders' own calculated or miscalculated choices (for example, decisions about unit strength, maneuvers, the time of an attack, and plans for medical and logistical support). Sound leadership works to keep operational stressors within tolerable limits and prepares troops mentally and physically to endure them. In some cases, however, excessive stress can affect the decision making and judgment of both leader and soldiers, resulting in missed opportunities, or worse, in high casualties or failure to complete the mission. Finally, some of the most potent stressors are interpersonal in nature and can be due to conflict in the unit or on the home front. Extreme reactions to such stressors may involve harm to self (as in the case of a soldier who becomes suicidal on discovering his wife wants a divorce) or to others (as in the case of a soldier who impulsively fires a weapon at the unit noncommissioned officer out of rage over perceived unfairness). US Department of the Army (2006) assert that, these stressors must be identified and when possible, corrected or controlled. The stressors are categorized as follows mental, physical and emotional Stressors.

A mental stressor is one in which the brain receives information about a given threat or demand, but this information results only in indirect physical impact on the body. Instead, its primary effect is to place demands on and evoke reactions from the perceptual, cognitive, or emotional systems of the brain (e.g., information overload, perceived lack of control, or grief-producing losses).The two types of mental stressors are cognitive and emotional. Mental stressors associated with cognitive, information (too much or too little), sensory overload or deprivation, ambiguity, uncertainty, unpredictability, time pressure or waiting, difficult decision (rules of

engagement). Mental stress may cause four emotional conditions in soldier: some examples of emotional conditions: can attributed to ,being in a new unit, isolated, lonely, fear and anxiety-producing threats (of death, injury, failure, or loss), grief-producing losses (bereavement), resentment, anger, and rage-producing frustration and guilt, inactivity, producing boredom, conflicting/divided motives and loyalties, spiritual confrontation or temptation causing loss of faith, interpersonal conflict (unity, buddy), home-front worries, homesickness, loss of privacy, victimization/harassment, and the exposure to combat/dead bodies, having been killed. Mental stressors can lead to adaptive or maladaptive stress behaviors that decrease or increase the exposure to physical stressors.

A physical stressor has a direct, potentially harmful effect on the body. These stressors may be external environmental conditions (such as temperature) or the internal physiologic demands required by or placed upon the human body (such as the need for hydration or an immune response to a viral infection). The examples of the two types of physical stressors (environmental and physiologic) Also, physical stressors cause mental stressors when they result in discomfort, distraction, and threat of harm, as well as when they directly impair brain functions. Physical Stressors associated with environmental are heat, cold, wetness, dust, vibration, noise, blast, noxious odors (fumes, poisons, chemicals) directed-energy weapons/devices, ionizing radiation, infectious agents, physical work, poor visibility (bright lights, darkness, haze), difficult or arduous terrain, and high altitude. Physiologic stressors also included, sleep deprivation, dehydration, malnutrition, poor hygiene, muscular and aerobic fatigue, overuse or underuse of muscles, impaired immune system, illness or injury, sexual frustration, substance use (smoking, caffeine, and alcohol), obesity, and poor physical condition.

The soldiers in Zambia are no exception except that they are comparatively in an ideal stress breeding environment due to frequent and large number of uncertainties/ changes vis-à-vis civilian counterparts with similar service conditions (Mukesh Batra 2010). In view of the challenges which are associated with operational stress the study sought to examine the role of counseling in reducing operational stress in Soldiers in Kabwe District of Zambia.

1.3. Statement of the Problem

Soldiers on operation and those that return from Military operation suffer physical and mental health problems as a result of exposure to stressful environment (Bartone 2006). What was not known was how counselling can play a role to mitigate the adverse effects of operational stress in soldiers, the study therefore, sought to investigate the role of counseling in reducing the adverse effects of operational stress in the Soldiers at Chindwin and Kohima Barracks in Kabwe District of Zambia.

1.4 Purpose of the Study

The purpose of the study was to establish the role of counseling in mitigating operational stress in soldiers in Kabwe of Zambia.

1.5 Objectives of the Study

The following are objectives that guided the study:

- 1 To seek to understand the causes of Operational Stress in soldiers at Chindwin and Kohima Barracks.
- 2 To examine the adverse effects of Operational Stress in soldiers at Chindwin and Kohima Barracks.
- 3 Assessed the role of counseling in reducing Operational Stress in soldiers in, Kabwe, Zambia`s Chindwin and Kohima Barracks.

1.6 Research Questions

The following questions guided the study:

- 1 What are the causes of Operational stress in soldiers at Chindwin and Kohima Barracks?
- 2 What are the adverse effects of Operational Stress in soldiers at Chindwin and Kohima?
- 3 What is the role of Counseling in reducing Operational Stress in soldiers at Chindwin and Kohima?

1.7 Significance of the Study

Through the study it is hoped that the findings may help the command to understand the causes of Operational stress in Soldier. In addition it was also hoped that the adverse effects of operational stress in Soldiers may also be identified. It was further hoped that the role of counselling in addressing operational stress may be understood.

1.8 Delimitations of the Study

The study focused on Chindwin and Kohima barracks. The areas were chosen because they were effective for data collection, since most of the soldiers had undergone trainings and operations both at locally and abroad which resulted in high levels of stress.

1.9 Limitations of the Study

The study faced a number of limitations such as limited secondary data regarding counselling of soldiers on operational. The other limitation was that enough data was not collected because the target group was a military oriented; hence information was restricted to the researcher. As a result caution must be exercised if these findings are going to be generalized to other Barracks.

1.10 Definition of Terms used in the Study

The following terms were defined operationally to enhance understanding: -

Operational stress: is intense and unrelenting stress experienced in a theatre of operations or on exercises, common to all participants. Examples: build-up of daily frustrations, conflict with a colleague, long separation from family and friends, family difficulties, long hours and heightened work pace, adjustment to living in a community setting, change in culture, climate, diet, etc.(Valcartier Health Centre,2010).

Stress: is defined as a nonspecific response of the body to a stimulus or event (Stressors). Under a general model of the stress response, when an individual experiences a stressor, the stressor would lead to a physiological response, one that can be measured by several indicators, such as elevated heart rate. In related literature, the term “stress” is used to refer to this physiological response (Selye, 1956).

Counselling: can also mean a relationship between a concerned person and a person with a need. This relationship is usually person-to-person, although sometimes it may involve more than two people. It is designed to help people to understand and clarify their views, and learn how to reach their self-determined goals through meaningful, well-informed choices, and through the resolution of emotional or interpersonal problems.

1.11 Summary

The chapter was presentation of the study background, and problem statement, on the soldiers who suffer physical and mental health problems as a result of exposure to stressful environment on return from Military operation. The study also explored on the role of what counseling plays to mitigate the adverse effects of operational stress in soldiers. This chapter further looked at purpose of the study, study objectives, research questions, significance of the study, and delimitation of the study and definitions of terms used in the study.

CHAPTER TWO LITERATURE REVIEW

2.0 Overview

This Chapter presents relevant literature reviewed which is related to the role of counseling in mitigating adverse effects of military operational stress in Soldiers. The literature covers several related topics which include the background to the operation stress, the nature of stressors in military operations, effects of operational stress in soldiers, and how stress was addressed in the military operation Worldwide. In addition, present the role of counselling in addressing stress in military operations Worldwide, the role of chaplains in counseling and it ends with a summary in which the knowledge gap is brought into for this study to fill.

2.1 Background to the operational stress and need for counselling

Unlike a physical wound produced by a bullet or artillery round, combat stress does not necessarily produce any visible wounds on its victim. Yet, the impact of combat stress can be just as devastating as wounds produced by munitions. Combat stress has received many labels since the First World War. These labels include “shell shock, war neurosis, psychoneurosis, combat fatigue, combat reaction, stress reaction, battle stress reaction, battlefield fatigue, and battlefield stress.” All these labels were an attempt to characterize and comprehend what happens to an individual on the battlefield when stress enters the negative realm and begins to adversely impact a soldier’s performance. These manifestations are known as combat stress reactions. It is important to note that names matter. Shell shock, the name given to psychological casualties as a result of the artillery barrages on the trenches during World War I, was considered an acceptable or soldierly term for its victims because there was a direct correlation between the physical condition and the blast/concussive over-pressure. Conversely, the terms war neurosis and psychoneurosis carried an inherently negative connotation because they implied by their name that a mental illness or disorder existed. The victims, their fellow soldiers, and society did not consider these terms acceptable or soldierly and therefore it produced a negative effect within individuals and units. The types of operations, sustained or continuous, the duration, duration of exposure to high levels of stress, and sleep levels played an important role in soldiers’ reaction to COS (Larry, 1980)

World War I marked the beginning of the study of combat stress by civilian and military medical professionals alike. This war started out as a war of movement during which few combat stress casualties were observed. As the war changed to trench warfare an unexplainable phenomenon began to significantly impact the combat effectiveness of soldiers. World War I demonstrated the earliest attempts to understand the effects of combat stress on individuals. The first official term to define the physical and psychological effects of war was created in order to explain the new phenomenon. The term shell shock was used initially because it characterized the state and condition of soldiers “after intensive shelling.....with no neurological reason” to explain the change. Shell shock produced numerous casualties which forced the military to seek an explanation. Dr. Rivers, a Royal Army Medical Corps Officer, stated that his dilemma was “how to convince a romantic officer corps that shell shock reflected the reaction of normal men to abnormal circumstances, rather than lack of character.” This statement reflects the beginnings of the negative stigma that became attached to individuals who became combat stress casualties.

In 1916, the term war neurosis replaced shell shocked as the number of combat stress casualties continued due to different combat conditions. The old term, shell shock, was now inadequate because it did not account for the new enigma that continued to cause adverse combat stress reactions without a direct cause. This name change also had negative a impact of the perception of both soldiers that suffered from war neurosis and members of the soldier’s unit.(Marlowe., 2001)

He further said, there were high levels of intensity with little to no opportunity to rest and refit, the high number of stress casualties limited units’ ability to accomplish their mission. British and French medical personnel experimented through trial and error to determine how to mitigate losses in manpower due to combat stress. “When the United States committed forces to the war, American psychiatrists confirmed and used the treatment procedures developed by the British and French.”¹⁷ The end result was military medical personnel were able to utilize civilian medical knowledge as it developed a foundation of knowledge on combat stress reaction in individuals. As World War I neared its conclusion, there was better treatment for combat stress casualties and a better return to duty rate. These were made possible because of collaboration between civilian and military medical personnel and proper diagnosis. However, misunderstanding and the negative stigma remained among non-medical personnel. This misunderstanding was displayed by the execution of “well over three hundred [soldiers] for

desertion and cowardice” by the British at the conclusion of the war when in actuality these individuals were combat stress casualties.

World War I marked the beginning of the military’s attempt to identify and counter the destructive effects of combat stress. Society frowned on men expressing what they perceived to be fear or cowardice. “World War I taught us that each war interacts with the beliefs of the wider popular culture and medical and psychological knowledge and beliefs of the time.” During the interwar years civilian psychologists and theorists had a profound impact on the military’s rationale for dealing with combat stress and soldiers. This period witnessed “the development and spread of the concepts and assumptions of depth psychology” by civilian psychologists and psychiatrists.²⁰ Eugenics was one of the dominating theories of the interwar years. This theory advanced the notions that “the possibility of improving the qualities of the human species....especially by means such as discouraging reproduction by persons having genetic defects or presumed to have inheritable undesirable traits (negative eugenics) or encouraging reproduction by persons presumed to have inheritable desirable traits (positive eugenics).” Simply stated, the military came to believe that individuals susceptible to combat stress could be identified through screening and excluded from military service. The majority of individuals considered to fit into this criterion were blacks, Jews, and southern Europeans. This period marked a regression in the military’s attempt to understand and deal with combat stress. The emerging mindset was individuals most likely to become stress casualties could be excluded from military service, thereby reducing the costs to the military and the loss of combat effective soldiers during combat. “The [US] military and the nation went into World War II believing almost implicitly that soldier selection [screening] would be the solution to [eliminating] all military health problems.” Over one and a half million men were rejected and excluded from joining the military for emotional, mental, or educational deficiencies. “Between 1942 and 1945 over 500,000 more [soldiers] were separated from the Army on psychiatric or behavioral grounds.” The screening program’s effectiveness was tested early in the war. Many U.S. service members that fought at Guadalcanal became combat stress casualties. Likewise, U.S. forces that fought in North Africa witnessed a high combat stress casualty rate. The pre-selection process to exclude weak and susceptible individuals was seemingly a failure. The military was again in a reactive posture.

The term combat exhaustion became the newest label for combat stress during World War II. It replaced the terms war neurosis and psychoneurosis because negative connotations were associated with the terms. This change in terminology made it easier for the medical corps to provide treatment. Again, the initial loss of service members as combat stress casualties significantly impacted the ability of units to accomplish the mission which necessitated the need to diagnose and treat soldiers suffering from combat exhaustion. In a medical study conducted by a General Board it concluded that “combat exhaustion was one of the major causes of non-effectiveness among combat troops” and “combat exhaustion ispreventable and emphasis should be placed on prevention rather than on treatment.” It was recommended by this board “that the term combat exhaustion, forward of the Army’s rear boundaries be continued” because this was an effective means of treating and returning to duty combat troops that suffered from exhaustion. World War II witnessed both unsuccessful attempts and successful strides within the military, especially the medical corps, in dealing with and minimizing the effects of combat exhaustion on service members. In the General Board report it was recommended that “all echelons of the medical service must be combat exhaustion conscious” and “young, general duty, medical corps officers should be given special training in practical neuropsychiatry with special emphasis on combat exhaustion and neuropsychiatry reaction in war.” Several effective methods were identified by the medical corps for the prevention of combat exhaustion. They included “the application of good leadership, the maintenance of unit spirit and spirit de corps, periodic relief of front-line troops for rest and rehabilitation, rotation of individuals from combat units to assignments in rear areas, indoctrination and training of replacements and their assimilation into the unit prior to entry into combat, the maintenance of a high state of discipline, and screening for the purpose of eliminating those individuals with mental and physical defects.”

Eli Ginzberg. (1959), pointed out that the U.S. military was ultimately successful in treating combat stress casualties. But, it had to re-learn the lessons of World War I because of the failure of the screening process. The North African Campaign, the assault landings on the beaches, and the Marines amphibious assaults in the Pacific all produced many combat exhaustion casualties. World War II featured battles that exposed soldiers to high levels of stress for extended periods of time with little to no opportunity to rest. An American psychiatrist, Thomas Salmon, was sent to the theater of operations to evaluate the situation and make recommendations on how to

prevent combat stress casualties. His observations formed the foundation of preventive measures that should be taken to prevent the loss of combat fighting forces due to combat stress. The adjustment he recommended was the allocation of a psychiatrist to all U.S. divisions. The changes once made allowed the military to assume a proactive posture in dealing with the impact of combat stress on soldiers. However, at the conclusion of World War II, the focus of training and education to understand and treat combat stress remained on the military's medical corps.

The Korean War again found the Army in a reactive posture. Initially, combat stress casualties were high (250 per thousand per year). The Army sent COL Glass to Korea to establish forward psychiatric care. He instituted the three-echelon system of care to treat combat stress casualties. The first echelon was the division psychiatrist, second echelon theater-level hospitals, and the third echelon Japan- or U.S. based hospitals. Dr. Glass created mobile mental health units which helped reinforce the division psychiatrist during periods of heavy fighting. Combat stress casualties rate decreased and return to duty rates (RTD) increased. The high level of stress produced by intense fighting and heightened reactions was not as prevalent. Combat tours were shorter in duration which meant service members could return to some sense of normalcy quicker. The Korean War, like previous wars found the military reactive in its attempt to minimize the effects of combat stress on combat effectiveness. It took work by military medical professionals to change the tide. This war witnessed the change in the organization of care for stress casualties. Once the changes were instituted the Army reached a positive posture, and the focus shifted to prevention.

The Vietnam War was very different from the previous wars because of the low proportion of combat stress casualties produced during the war. However, a massive number of combat stress casualties came years later. The term PTSD was introduced because of this war. Vietnam broke from past patterns of combat stress casualty production. The combat stress casualties were at their lowest for the years with the most intense fighting. This conflict also provides an excellent example of the importance of having a preventive program that starts prior to deployment and continues through to post-deployment. The Vietnam Conflict fell into three very distinct phases, each was marked by differing perceptions of the war, its nature, its legitimacy, and the way combat was executed. This war also intersected with the drug epidemic that was prevalent in U.S. society at the time. The first phase spanned from the advisory phase to the insurgency fight.

It extended from the 1950s through mid-1965. The second phase spanned from mid-1965 to the Tet Offensive and was a combination of counter-insurgency and conventional fighting. Phase three spanned from the defeat of the insurgency after Tet to the final withdrawal of U.S. service members. Conventional warfare characterized the fighting during this phase. The change in phases is important because it required a mindset change in Soldiers as to the execution of combat. The Vietnam War did not have the traditional fronts and clearly delineated battlefield geometry because soldiers operated in a jungle environment where the enemy was all around. This ambiguity increased the stress of soldiers operating in this environment because of the fluidity of the battlefield. Hard fighting by soldiers was typically followed by periods of rest and decompression. "Air superiority, brevity of contacts with the enemy, rapid medical evacuation for all casualties, and twelve month tours combined to reduce the stress, fear and fatigue levels compared to other wars. The Vietnam War demonstrated the importance between perception and reality. The media's portrayal of the war produced a belief in the minds of our population that the U.S. was losing the war. However, soldiers were left confused by how Americans could say we lost the war, when they never lost a battle. Tactical victories by our military did not translate into strategic success for our country. Service members returning from this war had no outlet to release the pent up frustrations that had gathered because of the country's perception of their performance and presence in Vietnam.

The re-deployment home was a source of stress for soldiers who typically re-deployed from the conflict alone or in small groups. They did not return home to hangars filled with family members, friends, and fellow soldiers. Because of the public perception of the war these soldiers were not viewed as war time heroes and welcomed home. They were often insulted and disrespected because the war was viewed as wrong. The end result was service members became long-term combat stress casualties. More than any previous conflict this war highlighted the importance of using a three-phased approach: Pre-combat training and education, combat decompression, and post-deployment care.

The Gulf War was a conundrum. The one hundred hour war which witnessed the defeat of Saddam Hussein's military forces at the hands of a U.S. led coalition was spectacular. However, the number of long-term combat stress casualties produced makes it a mystery. This conflict featured our air superiority and limited direct contact between coalition and enemy forces. Our

weapons systems gave us the ability to engage and destroy enemy forces at long distances. In order to understand why the casualties were so high this conflict has to be viewed through its two operations: Desert Shield and Desert Storm.

Desert Shield/Storm encompassed pre deployment to pre-command of major combat operations. The deployment to the Middle East was a consistent stressor on many service members. Service members experienced stresses for several reasons. First, there were several false starts. Soldiers were alerted to deploy and said their goodbyes to family and friends only to find out the departure was postponed. Second, there was ambiguity because soldiers did not know how long the deployment would last. During the pre hostilities soldiers also experienced stress related to concerns about family and friends. A soldiers' ability to call home on a frequent and consistent basis was limited. The delivery of mail was extremely slow. These factors produced stress because the soldier did not know what was happening back home. This conflict marked the first time that the majority, sixty percent, of the deploying force was married (Larry, 1980)

Finally, soldiers did not know when the ground war would commence or how long it would last. Therefore, the stresses produced by the deployment outweighed the stresses of combat for many of the service members. The living conditions and lack of recreation was a stress producer. Soldiers were isolated from the host nation populace and they had no place to go or escape for quiet time. Soldiers and leaders shared living space which led to a perception of constant observation and evaluation. The public perception and support for Soldiers was positive. Yet, doubts about continued service became another source of stress. Many service members did not know if they would continue to serve in the military because of the down-sizing of the force. This created stress because of employment and financial uncertainty. This historical look at the military and the ways it has addressed combat stress demonstrates the evolution of terms, the incorporation of medical personnel at the lowest levels, and the creation of stress control teams in an attempt to minimize the negative effects. More importantly, it demonstrates the reactive nature the military has had at the beginning of each war or conflict. It took significant measures to stem the impact of combat stress and change the posture of the military into an active and positive position. Each war had different conditions, societal differences, technological differences, and medical differences. Irrespective of these differences, the posture of the military throughout has been reactive and it has usually taken drastic measures to curve the impact of combat stress. As one looks at these historical examples a few things stand out. First, the

duration of wars has typically decreased, Vietnam being the exception. Direct U.S. involvement in World War II lasted from 1941-1945, the Korean War: 1950- 1953 (armistice signed, the war is not officially over), Vietnam War: 1963-1973, Gulf War: 1990-1991. The length of wars and conflicts has changed because of the change in our society's tolerance for war. This can be attributed to several factors that include technological advances, medical advances, change in the will of the people, ability to mobilize for warfare, and societal values to name a few. Secondly, warfare has become increasingly distant. World War I was marked by trench warfare, World War II was marked by a mobile battlefield, the Vietnam War was marked by close air support and helicopters, and the Gulf War was marked by weapons systems that could travel over long distance to engage the enemy. Warfare is not as personal in many instances on today's battlefield. Thirdly, the focus of combat stress has resided primarily with the civilian and military medical arenas, as well as, the academic world as opposed to those mostly affected by these stresses; the soldiers, airmen, sailors, and marines. From World War I through the Gulf War the focus has been on how the military medical profession can do a better job identifying, understanding, and treating those that suffer from combat stress in order to return them to duty. We see the work of civilian psychiatry in forming the basis of knowledge in WWI, the use of divisional psychiatric teams during WW II, the creation of tiered treatment levels, and the creation of combat stress teams deployed to lower echelon units during Desert Shield/Storm. Finally, this historical analysis demonstrates the lack of education for service members and leaders about combat stress prior to the execution of combat operations, the importance of mitigation during war, and treatment post-deployment.

In Zambia, soldiers who participated in combat or who were deployed to military operations in support of combat were always been affected by these experiences. Persistent reactions to combat and operational stress are clearly identifiable in the literature of antiquity (Shay, 1994, 2003), and military surgeons have described characteristic stress reactions at least since the 18th century (Jones, 1995). The specific reactions experienced by warriors have changed, somewhat, from generation to generation and war to war (Jones, 1995), but a lot has not changed over time. Terror is still terror. Grief is still grief. Courage, honor, and self-sacrifice are the most venerable of reactions to stress that still play the role they always have in military operations. Deployment can be a complex and sometimes overwhelming process for military service members and their families. The stress associated with extended separations, increased workloads, shifting

demands, and unstable deployment schedules can be difficult to manage under any circumstances. In addition many of the service members are deployed to combat zones where their lives are threatened, and the situation is primed for the development of significant emotional problems for military personnel and their families. First proposed by Logan (1987) and refined by others (Pincus et al., 1999; Pincus et al., 2001) is divided into four distinct phases including: Pre-Deployment (from notification to departure), deployment (the period from departure to return), reunion (often termed redeployment in the military) and post- Deployment. The pre-deployment phase consists of the “ramping up” period preceding actual deployment of military personnel. During this phase, service members are often occupied with training for the upcoming mission and preparing equipment for deployment. The deployment phase covers the period when the service member is away from his or her family, often working in a dangerous and stressful environment. During the reunion phase, both the service member and family prepare for his or her return home. During post-deployment, the service member returns home and is reunited with his or her family and community. In the past, this phase was seen as the terminal phase of the deployment cycle; however, contemporary military operations.

In Zambia Army like in any other conversional military organization; the health physical, emotional and mental fitness of a soldier are the pillars for a healthy military establishment. Therefore, if no study is done, on the role of counseling in reducing Operational Stress in soldiers then the levels of stress will remain as a problem of significance.

While the stress of repeated deployments alone can contribute to significant behavioral health and relationship problems, it is clear that the unique stressors associated with military combat exposure are primary risk factors for psychological impairment among military personnel. Hosek et al. (2006) documented the psychological stressors related to combat exposure and length of deployment. These authors reported that 11% to 18% of personnel exposed to military deployment Services. Combat experience symptoms of increased stress reactions and mental disorders compared to only about 9% of those without combat experience. Hosek et al., (2006) also found that as the duration of the deployment tour increased, so did the rate of adverse stress reactions. (Adler and Castro, 2001) also said, this is consistent with previous research showing that posttraumatic stress disorder (PTSD) symptoms are more prevalent among personnel deployed for longer than four months. Research on PTSD arising from either civilian or combat

trauma consistently shows that the severity of trauma exposure is directly related to the persistence and extent of posttraumatic symptoms.

Many Zambian soldiers have been involved in demobilization, on United Nations peace keeping operations and have encountered this kind of stress. Given the risks associated with the stress of deployment and exposure to combat, it is not surprising that military service members and their families may be suffering significant mental health problems in the wake of current military operations.

2.2 Nature of stressors in military operations

Primary causes of stress in Military Operations are mostly isolation, ambiguity, powerlessness, boredom, and danger of injury or death and workload.

2.2.1 Isolation

Soldiers deployed to remote locations, far away from home, separated from their families, frequently without good tools or methods for communicating. They find themselves in a strange land and culture, often surrounded by coworkers who are new to them, as the deployed unit was specially configured for a particular mission. They feel isolated and alone. Ambiguity Often in modern military operations, the mission and rules of engagement are unclear, there are multiple missions that are in conflict, or the mission changes over time. The role and purpose of the soldier may be similarly unclear. Confusion and mystery in the command structure adds to this uncertainty (who is in charge of what?). Lack of understanding of host nation language and cultural practices, and how these impact on deployed forces, further adds to the uncertainty (which norms and practices are acceptable in the host culture, and which are not?). This uncertainty can also pertain to other national contingents in a multinational coalition force.

2.2.2 Powerlessness

Security and operational concerns (e.g., “force protection”) often lead to movement restrictions; for example, soldiers were not allowed to leave their base camp. Soldiers may also be unable to interact with the local populace, and are prevented from doing the things they are used to doing (e.g., running or jogging for exercise, displaying their home country’s flag), and may also face a

variety of restrictions on dress and behavior. They have few choices. Movement and communication restrictions also prevent soldiers from learning about local culture and language, and resources that might be available locally, adding to their sense of powerlessness. They may also observe soldiers from other branches or national contingents operating with different rules and privileges in the same environment, but have no explanation for these different standards. Soldiers may see local people in need of help—wounded, ill, hungry, or despairing but be unable to give assistance due to movement and contact rules and regulations.

2.2.3 Boredom

Modern military missions frequently involve long periods of “staying in place,” often without significant work to do. As the weeks and months tick by, soldiers start can leaders influence hardiness? Others have noted the significance of a sense of powerlessness in peacekeeping operations. For example, Weisaeth and Sund (1982) found that in Norwegian soldiers serving in Lebanon under the United Nations peacekeeping mission, the feeling of being powerless to act or intervene was a main contributor to post-traumatic stress symptoms to get bored. To some degree, this can be countered by providing more entertainment and sports activities for soldiers. However, the real problem of boredom seems to result from lack of meaningful work or constructive activities in which to engage. Daily tasks often take on a repetitive dullness, with a sense that nothing important is being accomplished.

2.2.4 Danger

This dimension encompasses the real physical dangers and threats that are often present in the deployed environment, threats that can result in injury or death. Things like bullets, mines, bombs, or other hazards in the deployed setting are included here, as well as the risk of accidents, disease, and exposure to toxic substances. In current U.S. and coalition operations in Iraq and Afghanistan, this includes many hidden dangers such as suicide bombers, snipers, and improvised explosive devices (IEDs). This source of stress can be direct, representing threats to oneself, or indirect, representing threats to one’s comrades. Exposure to severely injured or dead people, and the psychological stress this can entail, is also considered under this stress dimension.

2.2.5 Work load

This factor represents the increasing frequency, length, and rapid pace of deployments that many military units are encountering. Also, most deployments are characterized by a 24-hr, 7-day-a-week work schedule in which soldiers are always on duty, with no time off. Work-related sleep deprivation is often a related feature. Training and operation activities in the period leading up to a deployment also usually entail a heavy workload and extremely long days. The same is generally true for military units returning home from a deployment, who must work overtime to assure that all vehicles and equipment are properly cleaned, maintained, and accounted for. It is important to remember that although these major dimensions of stress on modern military operations are discussed as six distinct factors, in practice they overlap and interact in multiple ways (Bartone, 2001; Bartone et al., 1998). The next question is what tools, strategies, or coping mechanisms can be applied to increase resiliency or resistance to these stressors, both at the individual and unit levels. Some authors have suggested that unit cohesion is a powerful influence on unit resiliency under stress (Ingraham & Manning, 1981; Paton, 1997), and that leadership can also play an important role

2.3 Effects of Operational Stress in Soldiers

Nash (2016), states that, the most common stress reactions include Mild stress reaction may be signaled by changes in behavior and discernible only by the individual Soldier or by close comrades. Without self-report, it can be difficult to observe stress-related changes. The unit leader and medical personnel depend on information from the Soldier or his comrades for early recognition of COSR to provide prompt and appropriate help. Severe stress reactions may prevent the individual from performing his duties or create a concern for personal safety or the safety of others. The reactions do not necessarily mean that the person must be relieved from duty, but warrant immediate evaluation and help by leadership. If not provided support, Soldiers may become COSR casualties.

Mostly they became casualties of fatigue resulting into slow reaction time, difficulty sorting out priorities, difficulty starting routine tasks, excessive concern with seemingly minor issues, indecision and difficulty focusing attention as evidenced by a tendency to do familiar tasks and preoccupation with familiar details. These reactions may reach a point where the person becomes very passive or wanders aimlessly. The inability to relax because of prolonged muscular tension

wastes energy and leads to fatigue and exhaustion.. Muscles must relax periodically to enable free blood flow, waste product flushing, and nutrient replenishment. Other signs that a soldier might experience are digestive and urinary systems, nausea (*butterflies in the stomach*) is a common stress feeling, and vomiting may occur as a result of an extreme experience like that of a firefight, shelling, or in anticipation of danger, appetite loss may result as a reaction to stress. It becomes a significant problem if rapid weight loss occurs or the person who does not eat a sufficiently balanced diet to keep his muscles and brain supplied for sustained operations

Others suffer from acute abdominal pain (*knotted stomach*, heartburn) may occur during combat, persistent and severe abdominal pain is a disruptive reaction and may indicate a medical condition, and frequent urination may occur, especially at night. During extremely dangerous moments, the inability to control bowel and/or bladder functions (incontinence) may occur. Incontinence is embarrassing, but it is not abnormal under these circumstances. Sometimes a Soldier who has experienced intense battle conditions cannot fall asleep even when the situation permits or when he does fall asleep, he frequently wakes up and has difficulty getting back to sleep and during this time the soldier experience terror dreams, battle dreams, and nightmares of other kinds cause difficulty in staying asleep. Sleep disturbances in the form of dreams are part of the coping process. This process of working through combat experiences is a means of increasing the level of tolerance of combat stress. The individual may have battle-related nightmares or dreams that a close relative (such as a spouse or parent) or another person important in his life has been killed in the battle. As time passes, the nightmares tend to occur with less intensity and less frequency. In some cases, a Soldier, even when awake, may experience the memory of the stressful incident as if it were recurring (called a *flashback*). This is usually triggered by a smell, sound, or sight, and is not harmful as long as the Soldier realizes it is only a memory and does not react inappropriately or feel overwhelmed. However, if it happens frequently or is very distressing, help should be sought from the chaplain or medical person However, on the other hand excessive sleep is also a sign of substance abuse or depression. (Persistent insomnia is a more common indicator of possible depression.)

Furthermore, Kirkland, Bartone, & Marlowe, (1993) alluded that this can cause, visual and hearing problems and partial paralysis. Stress-related blindness, deafness, loss of other sensations, and partial paralysis are not true physical injuries, but physical symptoms that

unconsciously enable the individual to escape or avoid a seemingly intolerably stressful situation. These symptoms can quickly improve with reassurance and encouragement from comrades, unit medical personnel, or physician. If they persist, the physician must examine the Soldier to be sure there is not a physical cause; for example, laser hazards (such as laser range finders) can cause temporary or partial blindness and nearby explosions can cause ear damage. Individuals with these physical conditions are unaware of the causative relationship with their inability to cope with stress. These cases are genuinely concerned with their physical symptoms and want to get better. They are willing to discuss them and do not mind being examined. This is contrary to malingerers faking a physical illness, who are often reluctant to talk, or who overdramatize their disability and refuse an examination. Hearing problems include the inability to hear orders and/or nearby conversations or complete deafness occurs. If these reactions do not recover quickly with immediate reassurance, care must be taken in moving the casualty to medical treatment facility (MTF) for an evaluation to avoid making a possible nerve or spinal cord injury worse.

Nash (2016), To the extremely he said, hyperalert, this refers to being distracted by any external stimuli that might signal danger and overreacting to things that are, in fact, safe. The hyperalert Soldier is not truly in tune with his environment, but is on a hair trigger. A Soldier who is on hyperalert is likely to overreact and consequences can range from firing at an innocent noise to designating an innocent target as hostile, or misinterpreting reassuring information as threats, and reacting without adequate critical thinking. If not handled earlier it enters into startle reactions, this is part of an increased sensitivity to minor external stimuli (on-guard reactions).leaping, jumping, cringing, and jerking, or other forms of involuntary self-protective motor responses to sudden noises are noted.

Anxiety, fear of death, pain, and injury causes anxiety reactions. After witnessing the loss of a comrade in combat, a Soldier may lose self-confidence and feel overly vulnerable or incapable. or death of a buddy leads to serious loss of emotional support and feelings of survivor guilt are common.

Depression is a general state of low mood and a loss of interest or pleasure in activities that were once enjoyed. Life becomes flat and grey, and nothing seems fun, exciting, or enjoyable anymore. These depressed states can be very intense, leading to a total withdrawal from others and a state of numbness, or they can be lower in intensity– just feeling "down in the dumps."

They may last for as little as a few hours or as long as months or even years. In more severe cases, the person may believe that life is no longer worth living. Around 50% of people with chronic PTSD also have significant problems with depression (Nash 2016), Depression is often associated with guilt. People with PTSD often report strong feelings of guilt, shame, and remorse. This may be about the fact that they survived while others did not; it may be about what they had to do to survive; it may be related to things they did about which they now feel ashamed. The nature of war is such that there are often no acceptable or "good" options: all options are bad (for example, kill or be killed). Sometimes the guilt results from trying to apply civilian, or peacetime, standards to a combat situation. If we judge our actions then by our standards now, we may end up feeling guilty and ashamed. For some Veterans, those feelings can be very damaging and can get in the way of recovery.

Depression can also lead into abuse of the most common problem drug and alcohol. Illicit, drugs such as marijuana or prescription medications. Drug and alcohol abuse impairs the person's ability to function effectively and to relate to other people. It can cause great difficulties in areas such as relationships, work, finances, and can cause violent behaviour. If the Soldier is in a depressed mood, he may be observed to exhibit very little body movement and to have an almost expressionless mask-like face. The Soldier may present disheveled in appearance, with reduced personal hygiene, and with little military bearing. Substance abuse: □ Some Soldiers may attempt to use substances such as alcohol or drugs as a means of escaping combat and operational stress. The use of substances in a combat area makes some Soldiers less capable of functioning on the job. These Soldiers are less able to adapt to the tremendous demands placed on them in combat.

Loss of adaptability, the common reactions include uncontrolled emotional outbursts such as crying, yelling, or laughing, some Soldiers may become withdrawn, silent, and try to isolate themselves. Uncontrolled reactions can appear singly or in combination with a number of other symptoms. In this state, the individual may become restless, unable to keep still, and move aimlessly about. For example, the person may appear dazed and may wander around aimlessly. He may appear confused and disoriented and exhibit either a complete or partial memory loss. Soldiers exhibiting this behavior should be removed from duties until the cause for this behavior can be determined because such soldiers may compromise their own safety in a desperate

attempt to escape the danger that has overwhelmed them. They may compromise the safety of others if panic is not quelled early, it can easily spread to others. (Kirkland, Bartone, & Marlowe, 1993).

2.4 How the stress was addressed in Military operational stress Worldwide

According to Nash (2006), ascertains that, it is a responsibility of Military leaders for Combat/Operational Stress Control of United States of America Army to make sure that there is prevention, identification, and treatment of adverse stress reactions seen, on the surface, like health care functions that should be the primary responsibility of medical personnel. However, medical personnel can never assume primary responsibility for combat/operational stress control because stress is not an unintentional by-product of military training and operations, but an integral characteristic of both realistic training and operations. Military commanders intentionally impose stress on their troops during training to familiarize them with the essential nature of combat and to make them more capable and resilient to the challenges they will later face during actual operations, and commanders lead their troops through sometimes extreme stress on their way to victory on the battlefield. The fundamental tools for prevention selection, training, leadership, and unit camaraderie and esprit de corps all lie in the hands of military leaders at all levels. Early identification of adverse stress reactions depends largely on the awareness and attitudes promoted in a military unit by its commander. And effective management of adverse stress reactions, once identified, is best delivered by military leaders at the lowest possible level. Therefore, military commanders bear primary responsibility for combat/operational stress control in their units, and their subordinate military leaders, at all levels, are responsible for continuously implementing their commanders' combat/operational stress control policies and procedures. This has always been the case in military forces, since long before the term "stress" was first used to describe the response of warriors to military operations the spectrum of war stressors.

According to the research conducted, it was reviewed that soldiers react differently to stress in line with their personalities. Personality can affect an individual response to stress in several ways. Individuals who express higher levels of anxiety, classified as high reactivity, have been shown to exhibit more pronounced physical responses (in terms of heart rate) to stressors (Pearson and Thackray, 1970). Pearson and Thackray (1970) examined this relationship using a

color identification test known as the Press Test. In the experiment, the subjects were divided into low- and high-anxiety groups based on previous testing. The two groups took the test the first time, for the purposes of this report, type 1 moderators are moderators that intervene in the stressor-stress response relationship, reducing the physiological response of the individual to the stressor. Type 2 moderators intervene in the stress performance relationship and can reduce the negative effects of stress on performance.-external stressors. Before the second trial, the individuals were told that if their score fell from the first trial, they would receive a shock. The researchers measured heart rate change and score change for the two groups. The low-anxiety group exhibited a mean heart rate change of beats per minute and an increase in score of 3.54 (out of 15 maximum). The high-anxiety group, however, had a much larger increase in heart rate, beats per minute, and a much smaller increase in score, 0.7 points. These findings support the argument that low-anxiety individuals are better able to deal with the physiological effects of external stressors and are more likely to experience a performance improvement from the introduction of certain stressors, in this case the threat of an electric shock. However, it is interesting to note that even the high-anxiety group had an increase in score between the two trials, suggesting the relevance of the inverted-U-shaped stress performance relationship. Caplan and Jones (1975) shows that individuals with Type A personalities also exhibit more significant stress responses than those with Type B personalities when confronted with identical stressors. The researchers created a stressful situation involving time pressure and increased workload and measured the reported stress levels of Type A and B personalities.

From the two personalities mentioned above the experiment shows that can be self regulating, the low-anxiety group exhibited less threat of stress and the high-anxiety much larger increase in heart rate, beats per minute more stressful a person experience. However, uncertainty or lack of control can be a negative moderator, one that increases the negative effects of stress on performance. According to Leitch (2003), uncertainty can increase the negative effects of stress on performance in several key ways. First, the presence of uncertainty requires that the individual spend additional time thinking about the appropriate response and even preparing for a range of possible outcomes. This can lead to a delay in action and even additional physiological response to stress as the body is forced to “stand-by.” Furthermore, uncertainty can lead to disaster or worst-case scenario thinking that can distract the individual from the task at

hand. Therefore, from the research results it has become clear that a soldier can regulate the levels of stress in a stressful environment.

Another possible way of reducing negative levels of stress is training. Training as a way to reduce the effects of stress is one of the most studied moderators and also a highly effective one. In addition, it is a moderator that can be developed, altered, and controlled fairly easily as compared with many of the moderators listed previously. First, it is important to note that training can serve as either a type 1 or type 2 moderators that is, it can intervene either before (immediately following the stressor) or after the individual stress response occurs. Most research on the moderating effects of training focuses on a particular type of training stress exposure training in which the individual is repeatedly exposed to a certain stressor and asked to perform a target task under that stressor. Considering stress as a type 1 moderator, Driskell and Johnston (1998) propose that use of stress exposure training for example, subjecting an individual to extreme heat or lighting can gradually lessen the individual's relationship in several ways. First, stress exposure training allows individuals to practice performing complex tasks while being confronted with an external stressor. This can lead to task master and can allow individuals to build strategies to maintain performance under stress. In addition, stress exposure training can reduce some of the uncertainty involved in stressful situations by allowing individuals to form more accurate expectations about the effects that stressors and stress will have on their bodies and performance. Through training, individuals may also learn how to manage uncertainty and maintain high levels of performance despite its presence: There are many studies that offer empirical evidence for the positive impact of training programs on reducing the physiological and performance effects of stress.

Deikis (1982) looks at the effects of relaxation training on the performance of an underwater task among three groups of scuba diving students. Hardy persons have a high sense of life and work commitment, a greater feeling of control, and are more open to change and challenges in life. They tend to interpret stressful and painful experiences as a normal aspect of existence, part of life that is overall interesting and worthwhile.

In Zambian situation, and like any other Country in the World training is number one moderator in reducing operational stress and for enhancing Esprit de corps (team work) and high moral among soldiers. The training prior to deployment has proved to be effective, any single training

has been very beneficial, to the soldiers because it is conducted according to the task to be accomplished and the expected environment in the operational area. It is through training that individual soldier begin to study situation in the deployment area and prepare psychologically, physically and spiritually

Furthermore, this result suggests that military leaders can rely on training to reduce the performance decrement of the more anxious personnel and those who appear particularly affected by the existence of stressors. The authors also highlight several characteristics of the training itself that may contribute to the effectiveness of the training. For example, they note that the effect of training on performance is greater when the training includes some kind of behavioral practice, when the size of the training group is small (no more than nine people), and when the training occurs in a field or naturalistic setting. These results indicate that effectively structured and administered training can moderate the effects of stress on performance both for physical tasks and for more mental or analytical ones. Training acts as a moderator for both groups and individuals and is directly relevant and applicable to the military case. Prior exposure to deployment-like situations and challenges reduces uncertainty and improves performance in deployment situations (Segal, Furukawa, and Lindh, 1990). For policy makers, the importance of training as a moderator is increased by the fact that it can be directly controlled and targeted to reduce the negative performance effects of specific stressors. Military planners use the information provided in this report to maximize the moderating effects of training for military personnel. However, research is still lacking into how adaptive capability can be incorporated into training exercises as well as on the nature of the group cohesion-performance relationship. These types of studies could help planners make even better use of training as a moderator. It is worth noting that new military interventions to prevent PTSD and combat stress reaction already make use of many of the moderators like group cohesion and self-efficacy.

The leaders might increase hardy cognitions, attitudes, and behaviors within their organizations during highly stressful operations. This potential for leaders to boost hardiness as a pathway to resiliency in groups under stress merits further active investigation. Military operations across the entire range of conflict expose military personnel (and increasingly, contract workers) to a multitude of stressors. These stressors can lead to a variety of negative health consequences, both physical and mental. For example, Hoge et al. (2004) recently reported that up to 17% of U.S.

veterans of the Iraq conflict reported symptoms of major depression, anxiety, or posttraumatic stress disorder (PTSD). Bonanno (2004) however, pointed that, it is often neglected in studies of this kind is that most exposed individuals appear to respond with remarkable resiliency to stress, and this includes very severe or traumatic stress.

Ritchie, et al (2006).noted that, most survivors of the September 11, 2001, attack on the Pentagon appear to have adjusted extremely well to this acutely stressful event, with no formal mental health intervention other than practical support provided in the aftermath. (Similarly, as pointed out by Wessely (2005), the vast majority of Londoners responded to the July 2005 terrorist strikes on the London public transit system not with psychopathology, but with resilience. One examination of historical events during World War II also shows the same pattern of broad public resilience, rather than breakdown in the face of the Nazi German bombings of London that killed 40,000 people (Jones, et al 2004).

What accounts for such resiliency? If the factors or pathways that lead to human resiliency under stress were better understood, perhaps some of these resiliency factors could be developed or amplified in those who are initially low in resilience, and more vulnerable to stress. Such an approach now seems even more important, given the generally recognized failure of post disaster psychological interventions such as critical incident stress debriefing (Mitchell & Everly, 2000). This article focuses attention on personality hardiness, one of several potential “pathways to resilience” posited by Bonanno (2004). Based on both theoretical and empirical grounds, he argued, that leaders in military units may well be able to foster increases in the kinds of cognitions and behaviors that typify the high-hardy person’s response to stressful circumstances.

It is useful to begin by describing the nature of the stressors encountered by troops in modern military operations. Following this, the hardiness construct is explained in some detail, including both theoretical background and some empirical findings showing that hardiness serves to buffer or moderate the ill effects of stress. Suggest that the primary underlying mechanism in the hardiness–resiliency process involves how stressful experiences get interpreted or made sense of in the context of one’s entire life experience. Several theoretical positions support the view that leaders may influence this process in work groups such as military units. High-hardy leaders may facilitate positive coping with stress by shaping the shared understandings of stressful events and experiences within the group in a positive and constructive direction. Personality dimension of

hardiness, and suggest how leaders might utilize this construct to increase individual and group resiliency under stress.

The US Department of the Army.(2006). Combat and Operational Stress Control Field Manual emphasizes on Battlemind to prepare a soldier for battle or war anticipated. The term “Battlemind” represents the US Army psychological resiliency building program. The term describes a soldier’s resiliency skills or inner strength to face fear and adversity during combat with courage. Battlemind training enhances the psychological readiness of every soldier for a stronger and more resilient force. It targets successful individual and organizational recognition of traumatic brain injury, PTSD, suicide risk, and other predictable stressors from military operations to mitigate the effect on mission and readiness. There are four main objectives of Battlemind training for soldiers and their families: (1) mental preparation for the rigors of combat and military deployments, (2) successful transition back home, (3) effective assistance for Battlemind buddies” during the transition home, and (4) preparation for the likelihood of deploying again. Battlemind meets these objectives by applying a three-pillar systematic approach: (1) life cycle, (2) deployment cycle, and (3) soldier support. Life-cycle training is the long-term institutional initiative to help soldiers and leaders reduce existing behavioral health barriers. It facilitates organizational growth by targeting stigma and institutional barriers through cohesion and progressive leader development training during critical points in a soldier’s military career. Deployment-cycle training targets each phase of deployment and builds upon techniques learned during life-cycle training. Combat skills and the battle mindset are what the soldier utilizes to sustain and survive in high-stress operational environments. Battlemind skills help soldiers survive; however, those same skills must be adapted as soldiers transition from a combat or operational mission back to garrison and home environments. Although each soldier makes individual adjustments, the key to a successful transition home is to adapt combat skills so they are just as effective at home as they were in combat.

Battlemind training brings in the aspect of Cohesion and Morale. Cohesion, or the bonds among soldiers, has traditionally been posited as the primary motivation for soldiers in combat. High cohesion and morale enhance adaptive stress reactions in soldiers and organizations and are the best predictors of resiliency within a unit or organization. Units with high cohesion tend to experience a lower rate of COSR than those with low cohesion and morale. Esprit de corps can transcend the problems of race and prejudice. The upkeep of morale and cohesion in combat is

recognized as a vital element in the production of combat power in tactical units.¹³ Supportive leadership, regardless of whether a soldier has been to combat or not, is related to how well soldiers fare, both at a personal level (personal morale) and at a unit level (unit morale, cohesion, and combat readiness). This is good news for the military, because leaders can be trained to be more supportive and increase the chances of soldiers having higher personal morale, higher unit morale, better unit cohesion, and higher perceptions of combat readiness.¹⁹ In fact, if unit leaders do nothing more under COSC programs integrated in their organization than focus on unit cohesion and morale, they will have met what is known in the US Army as the “80% solution.”

The Soldier’s restoration involves the 1- to 3-day management of soldiers with COSR or behavioral disorders, normally near a medical treatment facility in close proximity to the unit. This approach uses the “Rs”: for Reassurance of formality, Rest (respite from combat or break from the work), Replenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep), Restore confidence with purposeful activities and contact with the soldier’s unit, Return to duty and reunite the soldier with the unit. *Behavioral Health Treatment* Patients with identified behavioral disorders receive ongoing evaluation, treatment, and follow-up. This functional area implies a therapist–patient relationship, clinical documentation, and adherence to clinical standards of care. Soldier’s reconditioning is an intensive program of work therapy, military activities, physical training, and psychotherapy (. US Department of the Army2006)

2.5 Role of Counselling in Addressing Operations Stress in Military Worldwide

Counseling is one of the missing links of among military personnel. Majority of all who go through crisis rarely go through counseling hence the kind of problems that many encounter when under emotional stress persist. Counseling is also one of the tools that help the soldiers to know where to find help when faced with challenge (Goerz & Goerz 2004). Counseling provides training and help to spot unrealistic expectation and immaturity in the individual. Pastoral counseling also helps the individual soldiers to identify and clarify effects of emotional stress (Goerz & Goerz 2004:). Military officers and Soldiers do not come to the chaplain to discuss ‘religion’ but life: they come for a wedding arrangement, marital counsel, funeral arrangement, memorial service and other services (Rennick 2011: Todd 2013) highlight the need for faith and society to re-engage with such vital moral questions. Military chaplains continue to operate

within the dynamic tension between faith communities, the armed services and society, offering a distinct moral presence and contribution. Rennick (2011) state that “the chaplain are moralists, thinkers, peacemakers, peacekeepers, performers of rites, soul builders, rebuilders, companion of the brave, necessary friend but they are not soldiers (Rennick 2011).

The chaplaincy Corps provides many intervention methods through counseling. According to the Zambia Army Chaplaincy Corps Manual (2012) Counseling constitutes a major dimension of the Chaplain’s caring ministry. The Chaplain has a responsibility to keep abreast with the latest developments in the field of professional counseling. (Zambia Army Chaplaincy Manual 2012) Pastoral counselling (*cura animarum*, ‘*cure of the soul*’), is a classical expression for pastoral work, designating the special process of caring for human life because God created it and all people. (Van Dyk 2005; Loul 1998). .In fact the experiences of chaplains in the second world war popularised the use of pastoral counselling in treating soldier with psychological disorders.(Berkley 1994) People in the military community belong to God and they too must receive pastoral care and counselling. Pastoral counselling does not only aim at faith development in the counselee, but does also facilitate the improvement of the counselee’s “capacity and ability to cope with and manage life problems in order to enable [him or her] live a more personally satisfying life” (Van Dyk 2005). Religious Support for Combat and Operational Stress Control

The US Army Chaplain Corps is an invaluable asset in ongoing Combat and Operational Stress Control (COSC) support operations. Soldiers often approach chaplains first to obtain resources to address identified Combat and Operational Stress Reactions (COSRs). Soldiers’ inner resources are generally rooted in religious and spiritual values. In combat, soldiers often show increased interest in religious beliefs. When religious and spiritual values are challenged by the chaos of combat, soldiers may lose connection with the inner resources that previously sustained them. The unit ministry team is the primary resource available to soldiers experiencing such dilemmas, providing assistance as they seek to refocus their spiritual values. The ministry team provides preventive, immediate, and restorative spiritual and emotional support to soldiers experiencing COSR. Chaplain counselor assist members with the types of issues above when in a cultural transition, it is important that soldiers explore and understand their own cultural values, beliefs, and worldviews prior to the operation. In doing so, they can become aware of their own

perspectives and learn to see the differences between their own interactions and motivations in comparison to those of foreign locals. Understanding that culture is not a set of unalterable (or stereotypical) categories, but rather complex webs of relations that are continuously changing and evolving, may help military members to step aside from any tendency to generalize isolated behavior of some individuals to all foreign groups. Exploring how they can shift themselves from being the center (i.e., comparing all they see through the filter of their own culture) will help them hold preconceived concepts about foreign people more tentatively, create different meanings and perceptions, or accept different perspectives as they become more fully informed about the cultural networks to which they are charged (i.e., cultural flexibility). It may also help members to offer education on how to work more effectively with interpreters, especially by understanding how the interpreter is culturally situated and the influence of this on the process of translation. These higher level skills and abilities will help members to gain more understanding and accept a not knowing, versus should-know stance while evaluating a situation.

Furthering intercultural adjustment, members and their military groups participate in Gudykunst (1998) psycho educational training model, which focuses on the concepts of uncertainty, anxiety, and mindfulness. Gudykunst recommends sessions in which participants explore cultural differences through culturally-based exercises; understand how anxiety and uncertainty influence adaptation to new cultures; learn and practice methods to successfully manage anxiety in new cultural environments (e.g., exposing soldiers to a variety of anxiety-reduction techniques and practicing those that work best); and learn and practice methods to successfully manage uncertainty so that participants might better predict both group and individual behaviors in a new culture. Assistance in understanding individualist and collectivist behaviors in conflict resolution would also be helpful to increase effectiveness in conflicts between groups, as well as in adjustment to cultural differences (Ting-Toomey 1994).

In every military operation, personnel are subject to highly stressful and dangerous situations where injury and death are possible. Mental health assistance is necessary for debilitating stress responses during and after operations. Interventions during an operation may include the opportunity to debrief traumatic experiences (e.g., Critical Incident Stress Management, see Mitchell 2004); recognize and act on operational stress reactions that may become overwhelming, either with self-help strategies (e.g., diaphragmatic breathing, relaxation techniques), or with peer support, or sessions with a professional helper(s) (i.e., psychologist or

counselor) to talk about other general concerns that cause stress (e.g., worries related to family members back home) if available on site (e.g., Combat Stress Control Unit, see Bacon and Staudenmeier 2003; Reyes and Hicklin 2005). It is military like even Zambian set up and World in general to conduct debrief after a major military operation in order to look at demerit and merit during an exercise as way of offering counselling to the soldiers for the purpose of adjusting and reunite with the family.

When military personnel return home after an operation, there is often difficulty with readjustment and operational stress injuries (see DeVries 1996; Scaer 2001; Smith 2002). In recognition of this struggle, the United States army, for example, requires military members to remain in an intermediary base for a number of days before going home. This allows members an opportunity to rest, debrief, and obtain information about available support in their communities. Additionally, military members may have a peer support system that employs non-professional peer helpers (e.g., Operational Stress Injury Social Support [OSISS] in Canada). These types of peer support groups offer the opportunity for members to stay connected, as leaving the intensity of their alliance can cause depression, loneliness, and isolation while at home during leave or between operations.

In the context of an occupational culture, family support is seen as an aid in reducing the impact of highly stressful work and mitigating post-trauma responses (Goff et al. 2006; Regehr 2005). However, job stress can lessen the quality of marital interactions and cause partners to feel more negatively toward the relationship (Larson and Almeida 1999); especially when those occupations involve risks for trauma and family members are supporting and coping with traumatized members. In this regard, counselors need to include an assessment of the level of family and relationship functioning (e.g., negative changes in relationships, level of anger or violence, withdrawal of interest or time with family) and address these issues with the primary client, spouse and/or family members as an adjunct to post-trauma intervention (Management of Posttraumatic Stress Working Group 2004).

Family interventions could include education about posttraumatic stress (nature of symptoms, coping strategies, recovery expectations), communication skills training, parent education, or referrals to specialists such as substance abuse counselors or occupational therapists for chronic pain management.

According to Chaumba and Bride (2010), military women experience three main types of trauma: combat trauma, military sexual abuse trauma, and environmentally-induced trauma (e.g., infectious diseases, extreme living conditions, heat). Further, women are at increased risk of developing posttraumatic stress disorder and are less likely to be diagnosed or treated for trauma beyond combat experience. With this awareness, counselors need to fully explore the extent of the trauma experiences women may present, offer advocacy in their pursuit of justice (e.g., rape perpetrated by male members), address specific issues related to sexual assault (e.g., suicidality, safety, relationship disruptions), and assist women in gaining gender-sensitive health care services, as a large majority of women (up to 87%) do not access veterans' services.

Finally, for counselors without military service experience, two actions must be recommended. First, taking the time to learn as much as possible about the operations with which the clients were involved; secondary wounding can take place from a therapist's lack of knowledge, recognition, and respect for the risks of military service. Second, taking the position of an outsider seeking to understand a soldier's experience is more helpful than a stance that sends a message of expertise about the military context without an insider perspective. As with all counseling, therapists are essentially limited by their own cultural constraints and beliefs.

Counseling is important because all soldiers meet difficulties and crisis stage in the stages of life and during operational deployments. Sometimes people in a crisis come for help awfully late and sometimes after the problem have already shattered into pieces the concern individuals. However many times those who seek pastoral¹ help on time on time in many cases return to wholeness and healthy. (Berkley 1994) From mere observation it is easy to conclude that counseling among the Soldiers and Officer is not a common feature or can be said it is missing.. This is one challenge which bleeds trouble in most military personnel.

2.6 Role of Chaplains in Counselling

The chaplain is one person in a larger team, and this team ultimate concern is to fulfill the military mission objective. Anything that detracts men and women in uniform from training and completion of the mission is of great interest to the commanders. Therefore Commanding Officers expect the chaplains to handle and resolve such devastation which may arise from

operational stress and other life problems. (Berkley 1994). Generally chaplains are expected to be proactive in order to maintain the morale of all men and women in uniform. A basic motivation for such action is the chaplain's personal understanding of ministry with armed personnel, arising from operational deployment. (Berkley 1994)

Chaplains have come from a centuries-old tradition of pastoral care. Historically, and throughout the first centuries of American colonial and national history, pastors of various denominations lived or sometimes "circuit rode" between tiny, agrarian communities, leading worship, caring for the sick, and often burying the dead. With college and frequently seminary degrees, these clergymen were often the most highly educated and widely experienced in their communities, and were called on to perform many helping tasks, sometimes even including medical care, for their isolated charges. "Pastoral care" developed a very wide range of activities during this period. Following this historic pattern, today's clergy often see the role of pastoral counselling as part of their scriptural injunction to take oversight of the flock by caring for one another's burdens chaplains do their trade well when they follow recognized principles of spiritual leadership regarding the care of another's soul, personal concern, faith in the value and meaning of life, and hope. These values are typically shared by most counseling modalities pastoral or not. Although chaplains collectively represent many faiths, each individually comes from one particular faith group. Each chaplain is endorsed by a specific denomination, but the task is to minister to every soldier in the command. Consequently, chaplains have diverse responsibilities besides conducting the rituals, rites, and sacraments (referred to above) and public worship services (their most common responsibility), chaplains also provide pastoral care and counseling. It is in the pastoral relationship that the work of chaplains overlaps most closely with military psychiatry. As a result, military mental health workers commonly find that they are partnered with chaplains in areas such as resiliency in preparation for combat, stress control in combat, suicide prevention, wounded soldier recovery, soldier reintegration, trauma recovery, family issues, and care for the caregiver (Waynick (2006).

Confidentiality is one unique aspect of the chaplain-penitent relationship is the nature and extent of confidentiality. In order to best partner with chaplains, mental health providers must become comfortable with this unique aspect of the chaplain soldier family-member relationship. Chaplains are partners with other military helping personnel in the overall psychological well-

being of soldiers, because they are typically assigned at battalion level, who often handles the day-to-day bulk of basic issues faced by soldiers. This often consists of straight forward “problem solving” related to professional issues, relationships, life choices, and spirituality. Chaplains provide proximity, immediacy, and expectancy in their basic counselling services, they have the ability to work with soldiers within the unit and meet their needs quickly.

Because chaplains are an integral part of their units, they are often familiar with the home situations of the soldiers. Chaplains can provide a “reach-back” capability to soldiers, contacting other chaplains who are collocated with family members. Thus the deployed chaplain often bridges the gap on issues caused by family separations. As such they do pastoral counseling, which includes serving as first responders to crisis events as well as making good and timely referrals to mental health and other agencies for the well-being of the soldiers (Waynick 2006).

A prime example of chaplains partnering with mental health personnel is occurring during critical incidents in both Iraq and Afghanistan. Chaplains trained in crisis processing often perform critical incident stress ministry shortly after the event. Mental health providers also play this role for chaplains. Both professions speak a similar language and have similar goals in ensuring the well-being of soldiers. For many deployed chaplains and mental health professionals, the personal relationships they share and the supportive interactions they sustain in the midst of the struggle have become a keystone of their ability to stay healthy and effective through the trials of long deployments (Waynick, 2006).

2.7 Summary

The researcher summarised the Chapter that literature reviewed has provided context and understanding of what operational stress is, its causes in various countries, its adverse effects and how it was mitigated. However, none of these studies brought out the role of counselling in mitigating adverse effects of stress in Soldiers at Chindwin and Kohima Barracks in Kabwe District. This situation created a knowledge gap that necessitated this study.

CHAPTER THREE RESEARCH METHODOLOGY

3.0 Overview

The Chapter presents the methodology followed in the study, research design, population sample size, sampling procedure, Instrument for data collection, procedure for data collection, data analysis and ethical considerations.

3.1 Research Methodology

Research methodology is a philosophical assumption or paradigm the researcher employs. In this study, a qualitative methodology was used. Research methods refer to the methods the researcher uses in performing research operation. This chapter discusses the research design, study population, study sample, sampling techniques, data collection instruments, data collection procedure, data analysis instruments and procedure.

3.2 Research Design

A research design can be thought of as the structure of research. It is regarded as an arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance with the research purpose” (Kombo and Tromp 2006).The study employed a descriptive survey research design because it sought to collect both qualitative and qualitative data from participants.

3.3 Study Population

The term population refers to the entire group of persons or elements that have at least one thing in common” (Kombo and Tromp, 2006).The study population is the part of the population which represents the characteristics of the population and suits with the researcher’s purpose (Petra Christian University, 2010).The study population was all the commissioned and non Commissioned Officers at Chindwin and Kohima Barracks. The population was chosen because it is more often involved in operations, home and abroad respectively and in addition Kohima being a training School.

3.4 Study Sample Size

The study sample was fifty (50) soldiers at Chidwin and Kohima Barracks of whom twenty five (25) were female and the other twenty five (25) were male.

3.5 Sampling techniques

The study employed purposive sampling in coming up with a sample size for the purpose of establishing the role of counseling in reducing operational stress among soldiers in Kabwe Zambia. Purposive sampling was used to select the participants from the lists of soldiers who had served both in international and local operations in the Unit.

3.6 Data Collection Instruments

The instruments employed in data collection were semi structured questionnaires and semi structured interview guide which were also given to the respondents and informants for purposes of collecting qualitative data. The questions contained in these data collection instruments were both open-ended and closed-ended questions. Such a design was made possible for the collection of qualitative data.

Questionnaires were used because larger amount of data was collected from a large number of people within the shortest possible time and the other justification is that they are a cheaper way of collecting data. The semi structured interview guidelines were used to collect primary data which is one's true views and fresh original information.

3.7 Data collection procedure

After getting a letter of an introduction from the Institute of Distance Education (IDE), and the researcher presented it to the Brigade Commander 2 Infantry Brigade Headquarters and Commandant. The researcher got permission in writing from them.

The instruments employed in data collection were semi structured questionnaires and in depth interviews (in form of interview guide) given to the respondents and informants respectively. The semi-structured questionnaires were administered to the participants while the in depth interview guide were also designed and presented to management. The questions contained in

these data collection instruments were both open-ended and closed-ended questions. Such a design was made possible for the collection of qualitative data.

Questionnaires and interviews were used to collect data from the respondents in the community. This therefore allowed the researcher to collect accurate information and to stimulate new ideas.

3.8 Data Analysis

Since the study was descriptive in nature the researcher utilized a qualitative research approach in analyzing the data. This approach helped the researcher to interpret the behaviors of the participants. The analysis was based on evidence and the recurrent themes that emerged in the data collected from questionnaires, and interviews.

The first step was for the researcher to familiarize himself with the data collected; the aim of this first step was for researcher to get to the grip with the information in detail in order make sense of the raw data collected.

This qualitative data analysis involved breaking up data into emerging themes, in line with the research questions in order to establish the patterns and relationship (Mouton 2001). In order to present the data accurately, succinctly and honestly it was coded, organized, quantified and analyzed. To begin the final data analysis all the material from interviews and questionnaires that spoke to one theme or concept were categorized together, compared, and variations and connection between themes coming out from the Data were analysed and grouped (Rakotsoane & Rakotsoane 2006). The data was reduced to manageable level and recorded in bullet form under each major theme. The researcher checked for similarities and differences between responses from different respondents (Senior Officers, and soldiers), and then record the data accordingly (Smith 2008).

The data was carefully edited, systematically classified and tabulated, scientifically analysed and interpreted rationally (Sidhu 2006). The Collected data was related to present situation obtaining and the research process resulted into conclusion and recommendation in chapter five and six of this research (Smith 2008).

3.9 Ethical Consideration

During this study the researcher avoided plagiarism by properly acknowledging and referencing all sources through in-texting, citations and bibliography. During the process of gathering information the researcher fully explained to the participants the nature of the study and read through the letter of intent and explained the questions to all respondents. Permission was requested from the Zambia Army and other institution for use of Zambia Army military materials and facilities during the research process. The right to privacy and the protection of vulnerability of respondents was respected at all times during and after the research. The respondents and participants were all kept as anonymous. This study followed strictly the rules laid down by University of Zambia in writing of a dissertation.

3.10 Summary

This chapter was a discussion on the methodology which was used during the study. This chapter elaborated on the methodology which was used during the study. The research methods employed included the research design, target population, study sample, sampling procedures, data collection instruments and data collection procedures. It used both quantitative and qualitative methods to analyze the data

CHAPTER-FOUR PRESENTATION OF FINDINGS

4.0 Overview

This fourth chapter of the study is aimed at bringing out the key findings that were of major concern in the study and critical analysis was done on each aspect ranging from the demographic data to the specific research questions and objectives that were done. The chapter analyzes demographic data, general data and specific research data respectively on gender of participants, marital, education of participants. Furthermore the study is a presentation on the causes of operational stress, adverse effects of operational stress and, role of counselling in mitigating effects of stress and summary of chapter. The research findings were categorized and presented under the study questions which were as follows;

1. What are the causes of Operational stress in soldiers at Chindwin and Kohima Barracks?
2. What are the adverse effects of Operational Stress in soldiers at Chindwin and Kohima?
3. What is the role of Counseling in reducing Operational Stress in soldiers at Chindwin and Kohima?

4.1 Causes of Operational Stress in Soldiers

The causes of stress from the Soldiers were another key property that would not be a minus in the undertaking of this study as its impact was so very much influential to the soldiers. The responses were given in form of qualitative nature and they were compiled together and are as follows; fifty (50) participants showed that the main causes of stress included the following, eleven (11) said prolonged stay than planned in the operation area (OPS) which resulted into home sick, monotony, sleepless nights, Ten (10) said that the environment was another factor contributing to stress. This refers to hostile situation, difference in weather condition, language barrier and cultural imbalance, six (06) indicated that poor management on the part of the leaders (lack proper equipment, not clear or uncertainty about the mission, no rest and recreation facilities, and erratic supply of food, water, and sanitation), four (04) respondents showed that lack of motivation factors also influenced high levels of stress (uncertainty about the payment, delayed or missing promotions) and eight (08) respondents said family problems back home also contributed to stress among soldiers (sickness, marital problem, and financial problem).

Further, four (04) out of fifty (50) respondents said that poor training during pre-deployment resulted into lack of team work especially when the troops are drawn from different Units, fitness and endurance . Furthermore, they said that there is poor relationship if training among soldiers is poorly done especially if soldiers are drawn from different units hence it takes time for them to open and share the experiences among themselves, five (05) alluded to the fact that troops facing disciplinary cases were more stressful because they did not know the results of their disciplinary actions to taken be against them, eight (08) female respondents stated that, they were affected by stress because they missed their families because they were closer to their families especially children than the male fox. Even in care provision to the family, female counter parts provide more care and support than males hence being more emotionally attached families which they indent to miss and ultimately fall into stress.

4.2 Adverse Effects of Operational Stress in Soldiers

The adverse effects of stress stated by the participants (Soldiers) were another key property that would not be ignored in the undertaking of this study as its impact was so influential to the outcome of findings of the study. Marlowe. (2001), pointed out that, adverse refers to physical, mental, and emotional manifestations; loss of personnel due to combat ineffectiveness; misconduct stress behavior; and other short- and long-term conditions produced by combat stress. These adverse effects are known as maladaptive stress reactions. The following were some of the responses out of 50 participants on adverse effects of operational stress. Three (03) participants indicated that low self esteem affects the performance; six (06) participants indicated that stress dampens morale which leads to loneliness, three (03) participants indicated that affects mental and physical aspect, and eight (08) participants indicated that stress leads to suicidal attempts and two cases were reported. Then two (02) participants indicated unusual behaviors (alcohol and drug abuse and sexually active) sand three (03) participants indicated that stress causes isolation.

According to senior officers when it came to adverse effects of operational stress, that “troops deployed feel isolated and alone. Further, they brought out another causative to isolation among soldiers; poor training due to limited time flame given to train troops together during pre-deployment. They said, given enough time to train the troops together; troops are glued together,

get to know each other well and create their peer groups to share their experiences especially when the troops are drawn from different units”.

On the other hand another senior officer cited two cases of Sudan and Angola as examples. In the Sudan`s case he recounted that: “ soldiers were more stressful than in Angola `s mission because pre deployment training period was short due to the emergency deployment of troops in that Country and troops were drawn from different Units and they had not acquainted themselves to each other fully. Two serious cases were brought to light during the interviews; involving a male none commissioned officer and female commissioned officer. He said a non-commissioned officer suddenly became mute for number of months due to environmental factor until he was evacuated to level 3 Clinic and later evacuated to Zambia, but on his way to Zambia at Nairobi Airport the environment became friendly and started talking. By the time he reached the Kenneth Kaunda Airport it was clear that he fully recovered and refused to be taken to the hospital as a patient but, opted to reunite with his family members who met him at the Airport. On the other hand, a female commissioned officer under a stressful circumstance due a storm, she abandoned her troops.

In reference to Angola mission one of the senior officers said there were less serious cases of stress were reported because troops were able to train together for long time and the results were that; troop understood the mission task ahead of them very well and rules of engagement were clear them, to void mission ambiguity, environment expected, political situation, duration, culture, basic language (greeting), at the same time soldiers were physically fit and a formidable team was constituted.

During the study three (03) participants indicated that stress caused emotional tantrums, three (03) other participants indicated that stress caused resentment towards work and environment and one (01) participant indicated that stress caused Muteness. Three Participants indicated that stress caused Boredom. Another participant narrated that staying in place,” often without significant work to do, as the weeks and months keep on going, soldiers develop the significance of sense of boredom in peacekeeping operations. For example, to some degree, this can be countered by providing more entertainment and sports activities for soldiers. However, the real problem of boredom seems to result from lack of meaningful work or constructive activities in which to engage. Daily tasks often take on a repetitive dullness, with a sense that nothing

important is being accomplished. Four (04) participants indicated that stress caused lack of sleep while six (06) participants indicated that operational stress results into home sicknesses. Eight (08) participants indicated that stress caused loss of focus on work/performance due to resentment to work place. In an exclusive interview, two senior commissioned officers (commanders) shared same sentiments and disclosed that soldiers find themselves in a strange land and culture, often surrounded by co-workers who are new to each other as result it becomes a challenge to share common experiences, especially when the deployed unit was assembled from different units for a particular mission. Furthermore, the senior officers pointed out that, training must be vigorous to any assignment of this magnitude to minimize operational stress in hostility conditions. Vigorous training results into fitness and endurance of the soldiers to overcome any stressful atmosphere.

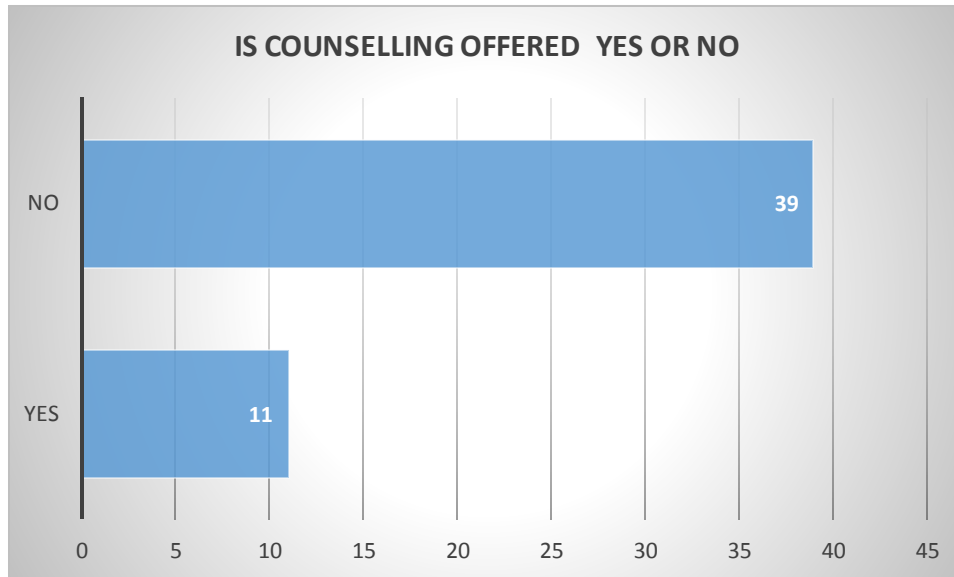
The US Department of the Army, (1994b), indicated that, its symptoms of deployment stress are similar to shell shock and soldier's heart in that the individual may experience fatigue, anxiety, loss of concentration and motivation, depression, memory loss, and disturbances in physical functioning. During World War II, treatment for battle fatigue focused on returning the soldier to the front in order to keep fighting and keep the unit strong. Initially thought to be cruel and counterproductive, service members were found to be able to reintegrate back into their units and continue as productive warriors.

The findings informed the study that causes of stress for the soldiers would come from various sources. Therefore, the study realized that what was vital were the measures put in place to manage stress from the superiors, not only in the army but also in any work setting.

4.3 Role of Counselling in Mitigating Effects of Operational Stress in Soldiers in, Kabwe, Zambia.

The Soldiers were asked whether they received any form of counselling that was intended to reduce any form of stress that they went through. Having asked them, the responses were given as shown in figure below figure 3;

Figure One: Whether Conselling was offered to Soldiers?



The options were provided in regard to the question that was asked and the respondents were granted a choice of either saying YES or NO. The number of study participants that said yes they had received counselling in one way or the other was on a lower side as they were only 11 out of the total population of 50. The number of people that said they had not received any type of counselling in any way were on a higher side been 39 out of the 50 study participants. The study revealed that 11 out of 50 participants had received counseling and benefited and 39 out of 50 never received counseling services. The responses were given as shown below:

During the interviews one senior commissioned officer talked of importance of the role of counselling in mitigating adverse effects of stress. The senior officer, had this to say for the future deployment both United Nations (UN) assignments and local operations; recommended that soldiers must be told how much money they are expected to earn as allowances in the mission and after, and be counselled during pre deployment, on how to spend the money in order to lessen over expecting, spending and anxiety which have had potential to breed operational stress in soldiers when their expectation is not meant.

4.4 Summary

The chapter has analyzed demographic data, general and specific research data respectively on gender, marital, education of participants, Causes of Operational Stress in Soldiers, adverse effects of Operational Stress in soldiers and role of counselling in mitigating effects of operational stress in soldiers in, Kabwe, Zambia.

As regards to the role of counseling, it was found that counseling plays a big role in addressing operational stress in soldiers such as coping up with stress, identification of stressful behavior and prevention of stress in soldiers.

The findings of the study also indicated that lack adequate training, prolong operational deployment, separation from the family, ambiguity of mission, poor leadership, lack of equipment, and environment caused operational stress in soldiers at Chindwin and Kohima Barracks Kabwe. The study further revealed that as a result of operational stress in soldiers, the following adverse effects were identified, low self esteem, poor performance. , dampen morale, loneliness, mental and physical stress disorders, suicidal attempts alcohol and drug abuse and sexually abuse and isolation.

CHAPTER-FIVE DISCUSSION OF FINDINGS

5.0 Overview

The chapter discusses the finding in relation to study objectives. The study objectives were as follows;

1. To seek to understand the causes of Operational Stress in soldiers at Chindwin and Kohima Barracks.
2. To examine the adverse effects of Operational Stress in soldiers at Chindwin and Kohima Barracks.
3. To Assess the role of counseling in reducing Operational Stress in soldiers in, Kabwe, Zambia`s Chindwin and Kohima Barracks.

5.1 Causes of Operational Stress in soldiers at Chindwin and Kohima Barracks -

First, the research study provides insight into the types of stressors faced by military personnel on various types of deployments, and how these stressors affect individual functioning and performance. Some of the most significant stressors associated with both types of deployments are uncertainty, long work hours, risk of death or disease, boredom, and separation from family.

Bell, Bartone, Schumm, &Gade, (1997), in support asserted that, more frequent deployments also involve more family separations, a recognized stressor for soldiers and one obvious way to reduce the stress associated with military operations is to lessen the frequency and duration of deployments. According to Turabian & Kate (2007), enemy forces and the perceived threat created stress. Iraq's military was the fourth largest in the world. Its weapons and equipment were.....thought to be comparable to U.S. weapons and equipment. Iraq was known to possess chemical weapons and Saddam Hussein had previously used these weapons against Iran. All these factors produced stress on service members. Combat stress teams were deployed to the brigade/battalion level and treatment was swift and effective (Turabian, Kate 2007).

Turabian, Kate (2007) echoed same sentiment that, during the pre hostilities soldiers also experienced stress related to concerns about family and friends. A soldiers' ability to call home

on a frequent and consistent basis was limited. The delivery of mail was extremely slow. These factors produced stress because the soldier did not know what was happening back home.

The researcher agrees with the findings because in reality most Military personnel are faced with emotional stress, which arises from a number of factors such as marital and separation arising from operational deployments. Most Military Personnel who are married get stressed because of missing their families a lot especially that in most cases the soldiers are given very little or no time at all to communicate with their families.

Further, the study concluded that the participants from Chindwin Barracks were more vulnerable to stressors as they were subjected to stressful environment as a fighting Battalion during their international and local operation. Stressors such as long deployments, separation from their families, deployed to remote locations far away from home coupled with no recreation facilities, while the counterparts from Kohima are not because most of the times were in Barracks to train others and are managers of stress during training.

5.2 Adverse Effects of Operational Stress.

The study showed that stress adversely affected performance of soldiers. The study responses, from participants highlight that, when an individual experiences a stressor, the stressor lead him or her to a physiological response, one characterized by elevated heart rate, and lack of sleep..

To the contrary the study showed that others participants, mostly male and single soldiers their performance in high stress breeding areas improved by the presence of enough stimulation to keep them vigilant and alert, but not enough to divert or absorb their energy and focus.

Participants from Chindwin experienced more cases of operational stress than their counterparts from Kohima because they were more often in operations areas than trainer of trainers from Kohima whose duty is to train soldiers in military courses and more skilled in the area of overcoming stress. The research showed that though soldiers from Chindwin and Kohima Barracks experienced stress in a stressful environment and suffered physical and mental health challenges following exposure to stress, many others show remarkable resilience, remaining healthy despite high stress levels. If the factors that account for resilience can be clearly identified and understood, perhaps resilience can be enhanced even for those most vulnerable to stress.

Therefore, the researcher, ascertain that, often deployment a soldier is subjected more he or she is exposed to stressors and stressors vary from other and the stress levels differ from one person and the other depending on how the body responds to the stressors.

5.3 Role of Counselling in Mitigating Adverse Effects of Stress

The study reveals 11 out of 50 participants received counseling and 29 never received counseling services.

The nature of the responses that were recorded prompted the researcher to deduce that indeed there was need for more counselling in the Army and to the Soldiers in particular. The frequency of soldiers that had had no access to counselling was on the higher side and this showed the researcher that there was a lot of counselling that was supposed to be done if and only if Stress levels in soldiers was to be reduced.

The study revealed that all the participants indicated that counselling could play a vital role in reducing operational stress among soldiers as indicated in figure 3 above. The larger number of participants indicated that they needed counseling to be done to them but they had no access to the services hence they needed more support from the higher authority to put it into effect.

On the other hand the smaller number that had undergone counselling services did show that the service had benefited them in many ways such that they have a way out now on how best they can manage stress among themselves.

The research also showed that those that had undergone counseling services from Chindwin and Kohima Barracks benefited from the services in the following ways, they were no longer lonely had shown high levels of interactions, also moral was high and high performance levels among them increased.

The study showed that money aspect can be a source of operational stress to soldiers if they are not told how much money they are expected to earn as allowances in the mission and after. In view of this, counselling has the role to play in mitigating adverse effects of stress during pre deployment, on how to spend the money in order to lessen over expecting, spending and anxiety which have had potential to breed operational stress in soldiers when their expectations are not meant. So far the researcher was able to deduce that no formal counselling was conducted on money matters before deployment during pre deployment training on how much is expected in the mission and after the deployment yet is one of the source of operational stress especially UN

operations .Therefore, if properly counseled, will enable the soldiers to plan and prepare a budget within their means to avoid over spending both in mission area and back home, because if not handled properly this had had potential to generate into stressful atmosphere resulting into bad behavior such as alcohol and drug abuse and sexually active which can lead to poor performance, and heavy debts in deployment area and back home.

The researcher was able to conclude that all interviewed senior commissioned officers shared the same sentiments from Kohima that soldiers by nature of their duty will find themselves in a stressful environment when need be, therefore, they strengthened on the following: -

Robust pre deployment training is cardinal to enhance stress management in soldiers to match with expected condition in the anticipated mission ahead, and at the same time troops will be physically fit and endured to meet any environment in this World. Therefore, the researcher affirms to their views which were also supported by Kobasa, (1979), who asserted that, hardy persons have a high sense of life and work commitment, a greater feeling of control, and is more open to change and challenges in life. They tend to interpret stressful and painful experiences as a normal aspect of existence, part of life that is overall interesting and worthwhile. In order to mitigate stress levels among soldiers the respondents proposed the following the following measures which included;; need for good leadership in order to promote team work and moral among soldiers., allowed to interact among soldiers and civilians during sports activities and, recreation times and formulation of formidable stress management teams of counselors to manage operational stress

5.4 Summary

The chapter was discussing on the finding in relation to study objectives which were to seek to understand the causes of operational stress in soldiers, examine the adverse effects of operational stress and to assess the role of counseling in reducing operational stress in soldiers in, Kabwe, Zambia`s Chindwin and Kohima Barracks.

CHAPTER SIX CONCLUSIONS AND RECOMMENDATIONS

6.0 Overview

This chapter drew conclusions and recommendations of the study on causes, the adverse effects of operational stress and the role of counselling in reducing operational stress in soldiers in, Kabwe, Zambia.

6.1 Conclusion

The study concludes that all the participants indicated that counselling could play a vital role in reducing operational stress among soldiers as indicated in figure 3 above. The larger number of participants indicated that they needed counseling to be done to them but they had no access to the services hence they needed more support from the higher authority to put it into effect. On the other hand the smaller number that had undergone counseling services did show that the service had benefited them in many ways such that they have a way out now on how best they can manage stress among themselves. The research also showed that those that had undergone counseling services benefited from the services in the following ways, they were no longer lonely, had shown high levels of interactions, also moral and high performance levels among them. The following were found to be causes of operational stress among soldiers: prolonged stay at operational site than planned, the environment , poor management, lack of motivation factors, family problems back home, poor training during pre-deployment (team work), and facing of disciplinary cases.

Meanwhile, adverse effects of operational stress included: low self esteem, loss of focus on work/performance, dampens morale , affects mental and physical aspect, leads to suicidal attempts, unusual behavior, isolation, emotional tantrums resentment to work environment, muteness, boredom, lack of sleep and home sickness.

On other hand the study reveals the positive results from some of the participants who alluded that they were able to perform well in high stressful environment. This was also supported by the literature on the relationship between stress and performance that is most relevant to the military context.

The main observation to be drawn from this literature review is that although stressors will almost certainly have a physiological effect on individual service members (such as increasing heart rate) and will likely have at least some negative effect on their performance of complex tasks, the application of moderators, including training, counseling and provision of additional information, can help individuals to adapt successfully to challenging stressors and maintain high levels of performance. Furthermore, as discussed previously, moderate levels of stress can actually contribute to heightened vigilance and improved performance on certain tasks.

Systematic program, which incorporates counselling education, training, and phased prevention if properly integrated, will allow the military to minimize the negative effects of combat and operational stress. The training conducted by the military tends to be effective because it is tough, realistic, and replicates stressful environments. Military commanders intentionally impose stress on their troops during training to familiarize them with the essential nature of combat and to make them more capable and resilient to the challenges they will later face during actual operations, and commanders lead their troops through sometimes extreme stress on their way to victory on the battlefield.

Further, the fundamental tools for prevention of stress is to ensure that training of services providers is intensified in stress management who includes, chaplains, medical personnel and commanders at all levels in order to enhance professionalism and esprit de corps among military leaders at all levels.

6.2 Recommendations

These recommendations will require a fundamental change in how our military addresses combat and operation stress (COS) if we expect them to take root and change our posture towards prevention on the basis of the study findings. The researcher was prompted to make the following recommendations as stated below: -

- 1 The Army High Command in charge of training may consider integrating counselling in training programs during pre-deployment, in deployment and post deployment.

- 2 Formal counselling if possible must be conducted on money matters before deployment during pre deployment training on how much is expected in the mission and after the deployment in order to avoid over spending which might cause stress in soldiers.
- 3 The Corp of Chaplaincy and Medical should take pivotal role in ensuring that counselling is an ongoing service among soldier.

Future Research Proposal

In future a research may be on how young soldiers respond to operational stress during deployment as compared to older soldiers

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APPENDICES

APPENDIX ONE 1 INTRODUCTION LETTER TO THE RESPONDENTS

Dear participants,

I am a post graduate student at the University of Zambia pursuing a Master of Science in counselling degree and currently undertaking a research on the role of counseling in reducing operational stress among soldiers in Zambia.

You are part of the purposive selected sample from the total staff population for this institution and I am requesting for your assistance by completing this questionnaire truthfully and honestly. Please be assured that the information you are to give will be treated with utmost confidentiality because the research is purely academic. For this reason you are not to write your name or any other information to display your identity on this questionnaire.

Cosmas Chiimbwe

Student

APPENDIX 2 RESEARCH QUESTIONNAIRE

SECTION A: PERSONAL INFORMATION

Tick the brackets of your response

1. Answer the following questions:
 - a. How old are you?
 - (1) (18_25 years),
 - (2) (25_45 years),
 - (3) (45 and above)
 - b. What is your sex?
 - (1) Male.....[]
 - (2) Female... []
 - c. Marital Status
 - (1) Single.....[]
 - (2) Married....[]
 - (3) Widowed..[]
 - (4) Divorced. []
 - (5) Separated []
2. What level of education did you reach?
 - a. Grade nine and below.....[]
 - b. Grade ten and above..... []

c. First degree and above... []

3. When did you join the Zambia Army as a soldier? (Mark)

a. 2 years ago.....[]

b. 4 years ago.....[]

c. Or more..... []

4. Have you taken part in any Operation Programs that take place in the Zambia Army both abroad and local?

a. Yes..... []

b. No..... []

5. What do you understand by Operational Stress?

.....
.....

6. Do Soldiers and Officers experience Operational Stress during deployment? (Mark)

a. Yes

b. No

7. Did you experience any Operational Stress?

a. Yes.....

b. No.....

8. If the answer is Yes, what were the courses of Operational Stress and your experience?

Please explain

.....
.....

9. During your deployment, did you witness someone who had experienced Operational Stress?

a. Yes

b. No

10. If the answer is Yes,

a. How many cases of Operational Stress were reported during the deployment?

.....
.....

b. What was his or her experience? Explain

.....
.....

c. What kind of services or help were/ was provided?

.....
.....

SECTION B:

1. Are there counseling services offered to reduce Operational Stress during pre-deployment?

a) Yes.....

b) No.....

2. If the answer is Yes, how do you describe the role of counselling in reducing Operational Stress among soldiers? And if the answer is NO answer question five (05)

a) Very poor..... []

b) Poor..... []

c) Very good..... []

d) Good..... []

3. If your answer is very poor or poor what are your recommendations?

.....
.....

4. If your answer is good or very good explain why you say so

.....
.....

5. If your answer in question one (01) is NO what do you think should be done to reduce Operational Stress?

.....
.....

6. Do you think counseling plays an effective role in reducing Operation Stress among soldiers in Zambia Army?

a) Yes..... []

b) No..... []

7. If the answer is yes, explain how

.....
.....

8. If your answer is No, state the reasons why?

.....
.....

9. What do you think should be done to ensure that there is no Operational Stress in soldiers in Zambia Army?

.....
.....
10. In your own opinion, what do you think should be done to ensure the effectiveness in counseling to prevent Operational Stress in soldiers by the Command?

.....
.....
11. Does Operational Stress has a negative impact on soldiers and their performance?

a. Yes..... b. No.....

12. If Yes, how? Please explain

.....
.....
13. What are the causes of Operational Stress among the soldiers? Give five (05) causes

.....
.....
14. What are the possible measures to address Operational stress in soldiers? Give three (03)

.....
.....
15. What has the military done in the past concerning Operational Stress and was it successful?

.....
.....
16. What does the current military doctrine say about Operational stress?

17. How effective is the current counseling doctrine Operation Stress?

.....
.....

18. How has the counseling doctrine been implemented in the past?

.....
.....

19. What can be done to ensure better and complete treatment for Operational Stress in future?

.....
.....

20. If you experienced problems to do with Operational Stress during operation programs, what measures were put in place to overcome your stress?

.....
.....

21. How do you describe operational Stress in soldiers in your Unit?

a) Low..... []

b) Medium..... []

c) High..... []

**APPENDIX 3- SEMI STRUCTURED INTERVIEWS GUIDE FOR SENIOR
COMMISSIONED OFFICERS**

1. During your deployment, did you witness someone who had experienced Operational Stress?
2. How many cases of Operational Stress were reported during the deployment?
3. Are there counseling services offered to reduce Operational Stress during pre-deployment?
4. What are the causes of Operational Stress among the soldiers? Give five (05) causes
5. What has the military done in the past concerning Operational Stress and was it successful? What are the possible measures to address Operational stress in soldiers? Give three (03)
6. What can be done to ensure better and complete treatment for Operational Stress in future?
7. In your own opinion, what do you think should be done to ensure the effectiveness in counseling to prevent operational stress in soldiers by the Command?
8. Does Operational Stress have a negative impact on soldiers and their performance?
9. Do you think counseling plays an effective role in reducing Operation Stress in soldiers in Zambia Army?