

The Challenges and Psychological Impact of Delivering Nursing Care within a War Zone

Abstract

Background. Between 2001 and 2014, British military nurses served in Afghanistan caring for both Service personnel and local nationals of all ages. However, there have been few research studies assessing the psychological impact of delivering nursing care in a War Zone hospital.

Purpose. To explore the challenges and psychological stressors facing military nurses in undertaking their operational role.

Method. A Constructivist Grounded Theory was utilised. Semi-structured interviews were conducted with 18 British Armed Forces nurses at Camp Bastion Hospital, Afghanistan, in June – July 2013.

Discussion. Military nurses faced prolonged periods of caring for seriously injured poly trauma casualties of all ages, and there were associated distressing psychological effects and prolonged periods of adjustment on returning home. Caring for children was a particular concern. The factors that caused stress, both on deployment and returning home, along with measures to address these issues such as time for rest and exercise, can change rapidly in response to the dynamic flux in clinical intensity common within the deployable environment.

Conclusion. Clinical training, a good command structure, the requirement for rest, recuperation, exercise and diet were important in reducing psychological stress within a War Zone. No formal debriefing model was advocated for clinical staff who appear to want to discuss traumatic incidents as a group and this may have contributed to stigma and nurses' feeling isolated. On returning home, military nurses reported being disconnected from the civilian wards and departments. The study raised the question of who cares for the carers, as participants reported a perception that others felt that they should be able to cope without any emotional issues. It is envisioned that the results are transferable internationally to nurses from other Armed forces and will raise awareness with civilian colleagues.

Keywords: Military Nursing / British Army / Defence Nursing / Qualitative Research / Grounded Theory / Afghanistan / Psychological Stressors / Futility

INTRODUCTION

Military nurses traditionally face extraordinary challenges whilst undertaking their duties, and their relationship with the military patients is a special bond (Hay, 1953). When providing direct care for wounded Service personnel and managing the healthcare environment, military nurses are confronted with challenging ethical dilemmas.

Afghanistan conflict

The Afghanistan conflict (2001-2004) resulted in the deployment of an International Security Assistance Force (ISAF)¹ comprising of British, USA and other allied troops. The medical obligation included caring for ISAF troops, the Afghan National Security Forces (ANSF)² formed of Afghan Armed Forces and police, local nationals of all ages including paediatrics and captured persons (CPers) (Simpson et al, 2014). Communication with local nationals was predominately through an interpreter.

The hub of secondary healthcare delivery was Camp Bastion Hospital with a work-force consisting of multi-national British, USA and Danish clinical staff. Healthcare provision in many areas was commendable (Care Quality Commission, 2012; Stockinger, 2012), resulting in lives saved where patients would previously have died (Hodgetts, 2012). Coalition patients were repatriated via casualty evacuation, often within 72 hours, whilst the local population were reassigned into an Afghan healthcare service outside of the military's authority.

Military nursing education and clinical development

In peacetime, British military nurses undertake clinical assignments in civilian healthcare facilities with the aim of guaranteeing that they have the mandatory competencies to provide high quality and safe care within the nurse's particular field of practice. These placements are aligned to academic programmes. All medical personnel undertake collective training

¹ International Security Assistance Force (ISAF). British, USA and other allied troops.

² Afghan National Security Forces (ANSF). Afghan armed forces and police.

immediately before disembarking within a 2-week course including macro-simulation (Gaba, 2007).

Ongoing challenges are that within the peacetime settings, military nurses have limited contact with paediatrics and are not regularly subjected to War Zone levels of trauma. The military clinical setting raises important ethical issues including a perception of futility, for example fearing that local national patients may die when transferred into the local healthcare service (Sokol, 2011). The accompanying moral distress may result in nurses leaving the profession and burnout (Fry et al, 2002).

Psychological Support

Potential recruits to the British Armed forces are screened for psychiatric problems during the preliminary selection procedures. Successful candidates receive military psycho-educational training on an annual basis, and this is enhanced during the force generation process when preparing for an operational deployment involving sending troops to a War / conflict zone. The aim is to advise Service-personnel of mental health (MH) problems, provide information to maintain mental wellbeing and reduce stigma. This, combined with early diagnosis of MH problems ensures that troops arrive in conflict zones with prominent levels of physical and mental strength, the 'healthy warrior' (Larson et al, 2008; Wilson et al, 2009).

The most common stressors leading to MH problems on deployment relate to relationship and family problems, and occupational difficulties (Finnegan et al, 2014a). For clinical personnel, there are additional factors connected to treating high numbers of severe poly-trauma casualties that may result in compassion fatigue (Boyle, 2011). These casualties include children, a vicarious trauma which has a direct bearing on mental well-being. (McGarry, 2013). Clinical personnel may have to complete their duties irrespective of risks to their own safety, and may defer processing the associated psychological issues until they return home, when post operational MH complications may appear (Batham et al, 2012).

Critical Incident Stress Debriefing (Mitchell, 1983) was previously utilised to help troops psychologically address their involvement in traumatic events but this intervention was withdrawn due to concerns regarding effectiveness (NICE, 2005). Subsequently, when MH problems materialise on deployments, there are peer support programmes such as Traumatic Risk Management (TRiM) (Jones et al, 2003) and military MH nurses are present if required.

Operational MH support is based on community care with a focus on risk management, risk assessment and patient maintenance, and personnel who require a MH intervention are evacuated home (Finnegan et al, 2014b).

The UK has additional arrangements in place, such as the Suicide Vulnerability Risk Management policy to protect vulnerable personnel (Fertout et al, 2011). Returning from Afghanistan, UK troops completed a compulsory 36 hours decompression period providing rest and recuperation and promoting a positive adjustment to life outside a War Zone. The objective was to normalize their psychological and behavioural responses, although quantifiable MH benefits were unclear (Hacker –Hughes, 2008). A Post Operational Stress Management (POSM)³ policy should have ensured that all staff were interviewed and appropriate support offered if required. In addition, on returning home, troops were entitled to a period of post operational tour leave (POTL), which is a sanctioned period of annual leave / holiday.

Transition theories would suggest that an adjustment period of up to one year would be expected on returning from an operational tour (Anderson et al, 2012). Yet MH stigma may have a negative influence on help-seeking behaviour, and troops with MH problems may perceive / be socially isolated. This can lead to reluctance in admitting they have a problem, sensing that an admission of psychological distress signifies a personal weakness (Batham et al, 2012).

How these challenges were tackled, and the knowledge elucidated from nursing in War Zones can positively inspire nursing on an international scale. However, whilst the quality and quantity of international military nursing research is improving (Kasper & Kelley, 2014; Currie & Chipps, 2015), there have been limited studies evaluating the psychological impact of nursing on operations (Elliott, 2014), and this paper presents findings from the only UK qualitative nursing research completed on deployment.

AIM

³ Post Operational Stress Management (POSM). UK policy outlining the support provided for personnel on return from operational deployments.

The aim of the study was to explore the challenges and psychological stressors facing military nurses in undertaking their operational role.

THEORY

Evidence was obtained from deployed military nurses in order to gain a novel insight into the psychological stressors and challenges encountered during an operational tour. A constructivist grounded theory was chosen (Silverman, 2013, Charmaz, 2014) to explain the contributors' outlook. Grounded theory analysis and qualitative coding was employed to form the evolving theoretical framework. (Charmaz, 2014), From the outset, initial then focussed line by line coding acknowledged words and phrases that highlighted the psychological stressors and challenges experienced during an operational tour. This process helped shape the emerging categories that were used consistently. The recognition of fit and relevance assisted the examination of emerging themes; empowered by theoretical sampling that was strategic, specific and systematic (Silverman, 2013). This provided the insight into why something happened, and used this evolving knowledge to predict the psychological stressors and challenges faced by military nurses on deployment. The co-relation between these categories as an emerging theory become noticeable through axial coding that reconstructed the information that had been previously splintered during initial coding, thereby providing lucidity to the developing theory. Data was then inspected as a blind theoretical sampling exercise to determine comparators and disparities. The findings are therefore built on multiple rather than stand-alone attestations.

Constructivist theory designates that the factors influencing an individual's perception are swayed by the environment, media, political views, local contexts and cultures (Silverman, 2013). This evaluation indicates that War Zone qualitative research should be undertaken on deployment. In the limited number of British qualitative studies, sample groups ranged between 12 and 19 personnel (Crawford et al, 2009; Batham et al, 2012; Kiernan et al, 2013; Finnegan et al 2014a).

METHOD

The research was completed in Camp Bastion Hospital, Afghanistan during June and July 2013. Semi-structured interviews were conducted with 18 military nurses drawn from a convenience sample of 59 based in the Hospital. Senior nurses from each department were invited to volunteer, as it was predicted that they would offer the furthestmost insightful testimony due to their experience and appointment. The interview schedule was built following advice from clinical, military, lay personnel, members of the research team and a pilot study. The lead author, who is an experienced British Army nurse and researcher, deployed to Afghanistan to collect data. This author had extensive experience of completing consultations with this participant group; including knowledge of the clinical and military nuances of language. Respondents were informed of the study before the author arrived in Afghanistan, and then given 48 hours to either accept or reject the proposal to join this voluntary research. This was considered important as a measure to ensure that contributors did not feel coerced into participation. Interviews were digitally recorded, with the intent to interview each respondent once due to geographical limitations, length of the author's time in Bastion Hospital and restrictions regarding further access to Afghanistan.

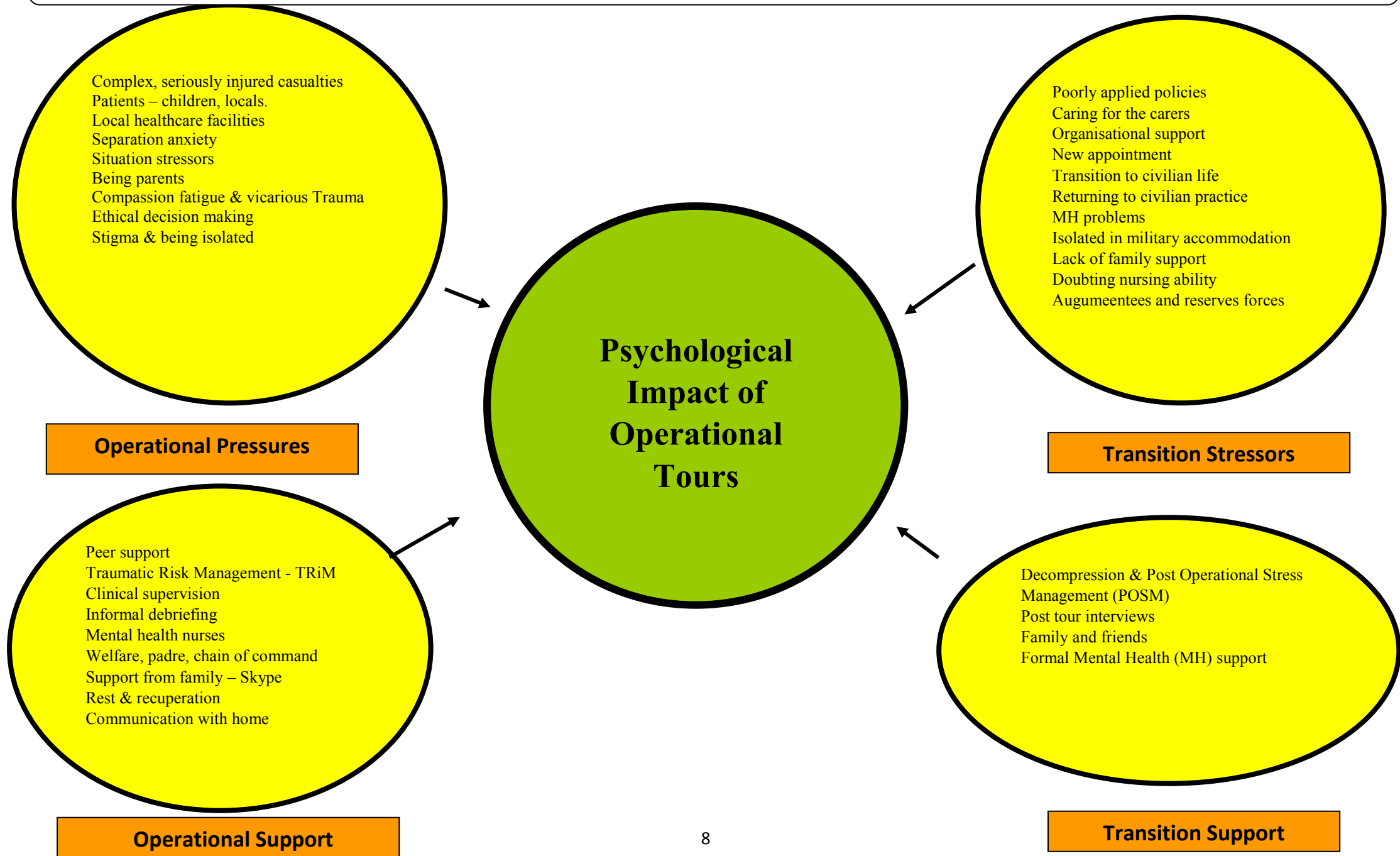
PROCEDURES

Interviews lasted between 17 and 70 minutes with a mean of 50 minutes and a SD of 12. The first author transcribed the interviews soon after the consultation, and additionally completed field notes highlighting the stressors that applied to certain activities, events, and forums. There was early and constant comparison of the interview data which aided the reframing of the interviews and subsequent analysis. Interviews continued until the emerging categories were "saturated" (Charmaz, 2014), achieved when the information no longer produced original theoretical insight (Silverman, 2013).

Grounded Theory analysis was conducted (Charmaz, 2014), and qualitative coding utilised to determine and define what was happening and to shape the emergent theoretical framework. This resulted in a model detailed the psychological impact of an operational tour and indicated areas for improvement. Whilst respondents commented on their experiences, the discussion section below is built on multiple rather than stand-alone attestations. Demographic data analysis was performed using SPSS Version 22.

FINDINGS

The qualitative coding informed by memo writing, constant comparison of the data, and supervision resulted in the indication of 33 categories. The findings are presented in a model comprising of four major clusters: operational stressors; operational support; transition stressors, and transition support. These theoretical groupings are responsive to the dynamic mediums of manpower, experience, clinical activity, and length of tour. Furthermore, by ethical issues and futility. This model is presented diagrammatically at Figure 1 with the intent of portraying the relationships between categories to ensure accuracy and clarity.



As an evolving theory, the model will require additional examination. Demographic detail is in Table 1, and whilst there is no intention to extract quantitative inference from the small number of results, the content does provide detail to inform similar studies.

Sample Group Demographics		
Gender	Male	56% (N=10)
	Female	44% (N=8)
Age	Range	29 to 50 years old
	Mean	39 Years old
Rank	Officers	72% (N=13)
	Others Ranks	28% (N=5)
Service	Royal Navy	6% (N=1)
	Army	72% (N=13)
	RAF	22% (N=4)
Marital Status	Married	72% (N=13)
	Single	17% (N=3)
	Separated	6% (N=1)
	Divorced	6% (N=1)
Parents	Yes	68% (N=12)
Length of Time as Qualified Nurse	Mean	14 years
	Median	11 Years
	SD	7 years
Length of time in UK Ministry of Defence (MOD)	Mean	11 Years
	SD	5 years
Operational Experience	Previous Deployment	95% (N=17)
	2 or more deployments	84% (N=15)
	4 or more	56% (N=15)
	6 or more	33% (N=6)
	Range	0 to 9 Deployments
Location of Previous Experience	Afghanistan	84% (N=15)

	Iraq	73% (N=13)
Table 1		

The following discussion was determined by respondents' beliefs, and the narrative is reinforced by pertinent quotes utilised to illuminate the theme. The results are UK focussed, but British nurses deployed equally with USA colleagues and evidence indicates that lessons learnt from War Zone nursing have both military and civilian international implications. The study was approved by the UK Ministry of Defence Research Ethics Committee, and complies with direction detailed in the Data Protection Act (1998) and Health Education Authority (2014). Informed consent was obtained, and the results are presented with the intent of ensuring the anonymity of respondents who are referred to as AA, BB etc.

Operational Stressors

Long periods away from home result in predicable stressors such as missing friends / family or local issues such as personality clashes. These factors are acutely exacerbated when the nurses are employed in a hospital receiving extraordinarily high numbers of complex poly trauma seriously injured casualties including insurgents. Respondents were conscious that this environment had a direct bearing on their mental wellbeing, especially those serving in a conflict area for the first time. In the preparatory phase, effort is made to ensure that deploying personal are emotionally robust through a combination of clinical exposure, education and simulation training. However, respondents stated that this still did not fully prepare nurses for the first seriously injured operational casualty. Nurses ruminated on how they would cope with similar injuries such as losing a limb.

“so it made me think, what if I lost my arm? What would I do? What sport would I do? I started going into that process. I'd have to do something.” (PP)

Issues such as caring for terminally ill patients was emotionally difficult. Nurses were aware that the local healthcare infrastructure was under-developed; and they have a responsibility to ensure that medical resources were available for injured ISAF troops and not all utilised for the civilian population.

For many, operational deployments presented the first exposure to critically ill children which was cited as being extremely challenging. Clinical demands were different with children becoming unstable much more rapidly. These issues were intensified when the nurse was also a parent:

“In ITU it was a culture shock and seeing the state of the injuries. It did play on me, especially children, as we had a lot then. One in particular still plays on my mind, a little child dying; fragmentation wounds all over, parents were somewhere else. And he was dying in front of me, and crying my eyes out because it reflects back on your own children.” (NN)

In addition to age, the nationality of the casualty could heighten emotional reactions. Working closely with USA multi-national colleagues, participants noticed the extra impact of caring for badly injured casualties from the same armed forces. Within this environment, participants described both compassion and physical fatigue as a result of the sheer weight of casualties and length of tour. Respondents reported feelings of guilt, concerned that they were not providing their best care, and even doubting their skills and competency. Psychological support for senior ranks / Officers was less obvious due to the military hierarchical system. This group refrained from discussing emotionally distressing events; not wanting to appear weak to junior staff, which in cases resulted in them being isolated.

“I’m the only Major on my shift. Do you understand? Therefore I have to be very guarded about what I say and how much I offload because if I start to go wobble it’s not good is it? You need to be seen to be rising above that for your juniors because there is no way that I want to be seen by the juniors to be weak.” (EE)

There were ethical implications when caring for captured personnel. In accordance with the Geneva Convention (1949), Camp Bastion clinical staff routinely treated CPers, often for several weeks. Often nurse / patient bonds developed irrespective that the patient may have

attributed to injuries sustained by other patients. In this environment; some nurses identified that they would prefer to give precedence of care to ISAF troops.

“You see people change when you have the same nationality looking after the same nationality, and I am just as bad. I have more empathy for my British counterparts than I do my Afghan patients. You can call me awful, I don’t know, but I am aware of it and I try me level hardest to be as non-prejudiced and to be as good as I can with every aspect.” (GG)

With strong nursing leadership, mentoring, and self-awareness, the findings implied that the nurses treated all patients as a vulnerable, resulting in care and compassion irrespective of background, beliefs or affiliations.

Operational Support

The UK provide formal psychological and psychiatric support through Field Mental Health Teams. In addition, interventions were available to address the potentially negative psychological implications of serving within this operational environment. A healthy mind starts with the importance of a good diet, exercise, and the need for rest and recuperation. Communication with family and friends via social media as Skype was seen as positive; especially for parents. Peer support from colleagues was valued, and information regarding their patient’s ongoing progress / deterioration was identified as being important, although this was not always available.

“You spend time getting to know the patient and they go back into the NHS, and you don’t know how they get on. On my last tour I treated a patient and about a year later he was on the television, so for us that really mattered. To see him from how he was with us, and the rehab he had had was fantastic. It’s closing the loop, and that is a really good thing” (CC)

The military chain of command was influential in tackling psychosocial stressors, and it was regularly stressed the importance of knowing the troops, which was enhanced when nurses deployed with friends from their home base. In high pressure situations respondents kept the padre informed of the increased tempo so he was aware when his help may be required. Following certain stressful incidents such as caring for terminally ill children, senior hospital staff were aware of the emotional impact, however structured critical incident stress debriefing was discouraged as it may cause harm (NICE, 2005). Respondents however

maintained staff meetings to embrace discussion on all aspects of clinical care with attendees afforded the opportunity to discuss personal feelings. In addition, clinical supervision sessions designed to provide a structured format for learning were modified to deal with sensitive issues and address psychological trauma.

“Clinical supervision... time when a patient, and we had put so much work into them, passed away. And talking about why we decided to withdraw treatment. My forum is open to views, opinions, and drops the rank structure as a time for reflection. Any issues can be brought up, and then talk about it and address it.” (NN)

Transition Stressors

Some respondents reported that the tour had not had a negative emotional impact, and the intimacy of Bastion could be protecting, and it was observed that the problems occur on returning home. However, the majority reported that post operational tour support did not prepare them for re-integration back into civilian life, and there was a period of adjustment and mood changes. This can range from general irritability to a significant MH problem, and be the primary motivator for personnel leaving the British Armed Forces Defence Medical Services.

“I went back into the unit, asked if I was OK, “yeah, I’m fine”; and it wasn’t until my POTL {Post Operational Tour Leave} that I was just a bit of a mess really. Just very emotional, if anybody asked me how I was I would just cry, and that is how my stress manifested in me being ridiculously emotional. But, I went back to work after my 4 weeks off. I went back clinically that it really hit me, and I was a complete wreck when I went back onto the unit. So at that point I went sick and I had about 6 weeks of being at home, trying to just gather my thoughts.” MM

Participant recognised that colleagues needed support on returning home from tour, particularly those back from their first deployment, to assist in the adjustment from high intensity to normal duties. Respondents felt it was important that on return from operations, that nurses worked alongside colleagues with shared experiences. However, the interviews indicated that there was a lack of support and loss of military ethos whilst potentially being isolated; in particular those detached from military barracks and housing, for example nurses living in rented civilian accommodation.

“In Birmingham I live in a flat in the city centre and my neighbours don’t have a clue what I do.” DD

This could be compromised even further when nurses were posted (that is appointed to a new job in a different unit) and therefore separated from colleagues who would otherwise be monitoring their wellbeing. The new role can in itself be a stressful period for both the military nurse and in cases their spouse and family. There were reports of “*post tour blues*”, and returning to a civilian health service that did not understand the associated pressures of an operational tour, with duties now seen as mundane, leading to frustration.

“You go back to the NHS and there is a feeling that no one can understand what you have done. It’s returning back to the mundane, and people get post tour fatigue syndrome. You have come from this high, where you are very much part of a much stronger tightly knit team, and then you go back to a different ward, and you are working with nurses that don’t understand what you have just been through. And that can be really frustrating.” (FF)

Others felt the long term impact may not be acknowledged for quite a period of time. Some felt it was inevitable:

“The kind of analogy for me is that if you have been drinking heavily for a number of weeks, you are going to have consequences. A hangover, physical consequences. If you are exposed to high levels of stress and emotions for a period of weeks then you are going to have consequences. You are going to have a kind of emotional hangover from that. I think everyone will to an extent”. OO

One of the identified stressors was returning to a Firm Base (local peacetime setting) clinical unit, and potentially caring for service-personnel evacuated from Afghanistan. When the clinical hierarchy were perceived as unsupportive, (as the impact of the enduring nature of the Afghanistan and Iraq conflicts resulted in seniors desensitizing) and not receptive, then the combined effect can have a disturbing impact as individuals beginning to doubt their ability as nurses. These issues were particularly acute for individual augmentees (personnel who deployed alone to support the main formation in order to fill a specific manning shortfall) and reservists.

Transition Support

Post tour support can be variable; ranging from good to poor where the minimum provision was offered. The military has arrangements to provide psychological support such as decompression and POSM which were reported as being inconsistently applied. Some felt that decompression was excellent whilst others reported significant reservations and certain cohorts such as individual augmentees missed out altogether. POSM might not be completed, resulting in nurses feeling isolated. When completed, post tour interviews were viewed as a mandated exercise rather than focussing on ensuring that nurses were mentally well and adjusted.

“I think there is an element of box ticking. I’ve been guilty of it myself as a line manager. I’m not sure I’m the right person. I know my stuff, and should be able to say you’re not the same person who left here, but I would argue that anyone who has served here wouldn’t be the same person that left. It will change you; because you are seeing things that no-one should have to see.” JJ

On returning home, some nurses return to a unit that may not have colleagues from their deployment. There were reports of a disengagement with the military chain of command; of being interviewed by untrained personnel who did not know the recipient and may not understand the implications or the nurse’s role. Therefore, respondents perceived that POSM would be enhanced if there was a follow up briefing, as they had to deal with operationally attributable stressors without support. In addition, it is important that nurses receive formal recognition on returning to the UK. This can be enhanced by giving personnel the chance to inform others of their experiences, which was seen as a means of improving self-worth and energising others for the challenges ahead.

There was also an assumption that medical personnel should be knowledgeable regarding emotional reactions to traumatic events. This belief existed in both the medical services and the wider defence community, and a belief that medical personnel and nurses can treat themselves.

“Certainly the recurring theme is that they expect medics to look after themselves. Why are you getting distressed by this? You are a medic. You’re used to it. Get over it. You see a guy with his hand blow off, but you’re a medic. I’ve certainly seen the aftermath of that in the UK, I found this really distressing and nobody would help me.” (AA).

DISCUSSION

This paper provides insight into the psychological stressors associated with nursing in a War Zone, and the utilisation of policies and procedures that are intended to minimise any negative emotional impact. The unique aspect of this qualitative research is that it is the first of its kind, with interviews conducted on deployment in Afghanistan, with the intent to provide an original insight that may not have been achieved through alternative methods. Whilst the settings are extraordinary for the majority of the international nursing workforce, it is anticipated certain aspects will strike resonance, especially those nurses in other Armed Forces or involved in humanitarian employment.

Military nurses face prolonged periods of caring for complex seriously injured casualties of all ages, and it is within this demanding environment that they hone their nursing skills. The psychological stressors are predictable, with measures in place to help, yet nurses still described distressing effects and prolonged periods of adjustment on returning home. Caring for children, in particular when the nurse was also a parent, was a specific concern and lack of routine clinical exposure to these types of injuries was offered as a reason for these anxieties.

The authors suggest that within nursing specialties there is a personal continuum for most nurses regarding the scope of practice in which they wish to work, and others areas that they would decline. Therefore nurses will generally migrate to areas where they feel comfortable, for example MH nurses working in adult community services may not tolerate working in paediatric burns, and vice versa. It is therefore foreseeable that some will struggle emotionally when faced with patients from another speciality or discipline. Yet military nurses are not offered this luxury, and have to face whatever comes their way. The recent deployment of British military nurses to Sierra Leone to help in the humanitarian crisis caused by the Ebola Virus Disease outbreak providing a vivid example. Workforce planning and preparation should identify potential shortfalls, and support nurses to achieve the necessary clinical experience and competencies.

The factors that cause stress, both on deployment and returning home, along with the measures to address these issues are presented in Figure 1. The situational stressors associated with a deployment can change rapidly in response to the metamorphosis and

dynamic flux in intensity common within War Zones. The research highlights concepts and interventions that when correctly applied are well received, such as training, working under a good command structure, the requirement for rest, recuperation, exercise and diet. Being able to communicate easily and regularly with home was valued. Yet, no formal debriefing model is provided for clinical staff who appear to want to discuss traumatic incidents as a group, and thereby compensate through mediums such as clinical supervision. The lack of structure may be a reason why stigma may be present, and certain personnel felt isolated and inhibited from revealing their concerns.

Formal support on returning home appears to be inconsistently applied. The majority of respondents recognised periods of adjustment and changes in mood yet the one off post tour interviews, sometimes provided by a relative stranger failed to capture these problems or promote appropriate help-seeking behaviour. On returning to work, nurses reported feeling disconnected from the civilian wards and departments, and valued working alongside colleagues with shared experiences from the recent deployment. However, being transferred to another unit interfered with this requirement, and led to additional stressors at a particularly vulnerable time. Similar issues were noted in reservists and individual augmentees. The question of who cares for the carers, and the nurses' perception that others felt that they should be able to cope automatically, without any emotional issues, is an area that should be addressed. Nurses need their carers too.

The findings can enlighten military nursing in a number of ways. Clinical placements in the peacetime setting should incorporate a wide diversity of clinical exposure including paediatrics. In war / conflict zones a structure for discussing traumatic events may help resolve underlying distress, reduce stigma and promote help seeking behaviour. On returning from deployment, POSM should be a progressive process, with interviews given at various time points and not just a one off discussion. Particular support should be given at the re-entry to the civilian work environment, and recognition that clinical training does not offer protection from emotional distress.

CONCLUSION

Whilst nursing and military qualitative studies have improved over recent years, this remains an under-researched area. The few British military studies have provided an original insight

into the challenges faced on deployment, with results that have shaped policy, procedures, education and clinical practice. Whilst the emerging model presented in this paper will need further testing and development, it is intended that the results will be transferable internationally to nurses from other Armed forces. This will also raise awareness with civilian colleagues into the potential stressors, thereby helping the transition of military nurses retuning home.

LIMITATIONS

The Camp Bastion environment provide a number of challenges. The lead researcher as a senior British Army nurse meant that personnel may not disclose their true opinions. However, participants understood the research question and there appeared to be no issues regarding their attestations. Restrictions on access to Afghanistan meant that the data could only be collected once. The views were from the British military nurses, and whilst they worked alongside international colleagues (predominately USA), the opinions expressed may not be transferable.

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