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ORIGINAL RESEARCH

Journal of
COMMUNITY SAFETY & WELL-BEING

Military first responders in Sri Lanka: Post-crisis psychosocial challenges and treatment recommendations by mental health professionals

Raneesha De Silva*, Jane L. Ireland[†,‡], Philip Birch[¶], Carol A. Ireland[†,‡], Michael Lewis[†,‡], Methma Atapattu[§,‖]

ABSTRACT

This research explored perspectives of civilian and military-based mental health professionals regarding mental health challenges, influencing factors, and treatment considerations for military first responders in Sri Lanka, after they have been exposed to crisis events. Twenty-nine mental health professionals from Sri Lanka (14 civilian and 15 military-based) engaged in a semi-structured interview to share their experiences and recommendations in treating military first responders from Sri Lanka army and navy. The thematic analysis yielded two main categories of data: (1) factors influencing the impact of exposure to crisis events and (2) factors influencing effective interventions for first responders in the Sri Lanka military. These two categories were further analysed as themes and subthemes, based on factors which amplify, buffer against, and/or have a variable impact on trauma symptomatology and factors external to military first responders, which could impact their recovery efficiency. This study is one of the first to explore mental health challenges and treatment considerations for military first responders in South Asia, through the perspective of civilian and military-based mental health professionals.

Key Words Mental health; trauma recovery; crisis responders; disaster management; military; Sri Lanka.

INTRODUCTION

Crisis situations occur worldwide, affecting individuals independent of their personal demographics and characteristics. The World Health Organization (WHO, 2011) describes a crisis event as experiencing and/or witnessing, either personally or on a mass scale, an unanticipated or gradually developing conflict or natural disaster, including disease breakouts, and violence/abuse. It is the frontline crisis responders (e.g., law enforcement agencies, paramedics, and fire fighters) who directly manage such crisis events, and therefore may present with an amplified risk of a psychological trauma response to such events. Psychological trauma can be triggered from perceived or actual threat of emotional and/or physical harm (van der Kolk, 2014). An individual can develop varied symptoms of psychological distress, including a range of mental health symptomatology such as anxiety and fear-based symptoms (e.g., Bisson et al., 2015).

In Sri Lanka, frontline crisis responders predominantly include the military as they undertake several roles, in addition to protection against violence and terrorism (e.g., multiple and continuous armed conflicts in modern history from 1971 until 2009 since the independence in 1948, the Easter Attack bombing in 2019). The Sri Lankan military personnel are the first responders for rescue and relief missions during natural disasters (e.g., monsoon flooding, droughts, landslides), disease breakouts (e.g., COVID-19), and other policing matters (e.g., managing public protests during the economic crisis in 2022). These military frontline responders can present with a heightened risk to develop and/or exacerbate mental health difficulties due to their prolonged and/or continued exposure to aforesaid crisis events, arguably leading to a heightened risk of a trauma response and subsequent greater need for professional mental health support, compared to those who are not deployed as crisis responders (Chapman et al., 2014). Overall, public health crises can further increase pressures

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likely to be placed on frontline crisis responders, exacerbating these stressors and amplifying their susceptibility to psychological trauma (Muller et al., 2020).

However, exposure to these crisis events may not always result in mental health pathology. Some crisis responders may perceive crisis situations as a challenge to overcome, and hence, the perceived stress may lead to post-traumatic growth (i.e., resilience) and not manifest as post-crisis difficulties (Dulmus & Hilarski, 2003). Furthermore, the development of a trauma response after exposure to a highly stressful event can be minimised by an individual's ability to cope with adversity as the perception of crisis situations and traumatising events depend on personal characteristics, the type of crisis situation, previous exposure to crisis situation, and one's cultural values (e.g., Reisenzein, 2019; Sherin & Nemeroff, 2022). Yet, some factors can negatively influence recovery, such as disconnection from their families and community and self-stigma in seeking professional help (Adams et al., 2021). This can be further compounded when a need for professional support is not driven independently. For instance, Becker et al. (2009) emphasised the benefits of crisis responders seeking professional support by their own initiative, therefore having autonomy over their treatment choices, and short-term treatment is seemingly more popular as service receivers report a disinterest in long-term treatment approaches, along with budget restrictions imposing limitations on sustainability and accessibility (Lewis & Roberts, 2001) of services.

Of further consideration is the culture of an organisation and challenges imposed by its context, which can restrict crisis responders accessing support for mental health difficulties (e.g. Kellner et al, 2019). This can be especially detrimental when organisations, such as the police, military, or alike, are highly structured and procedural, with cultural nuances as to how such support is arranged. Whilst there is little research on military crisis responders in Sri Lanka, a comparison group would be law enforcement agencies. This is particularly helpful since law enforcement is a role of the Sri Lankan military as well. Research has evidenced how law enforcement culture can result in the stigmatisation of officers in both recognising mental health and accessing support services (Velazquez & Hernandez, 2019), yet contemporaneous research recognises the issue of police officer mental health, in particular cumulative stress/post-traumatic stress disorder (PTSD) amongst officers (see Beckley et al., 2023). There can, however, be concerns amongst law enforcement officers regarding their confidentiality when accessing mental health services, which can provoke fear of threat to their job security and thereby leading to a reluctance to seek treatment/support for mental health difficulties (Yerk, 2024).

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

Existing literature is based on English-speaking, middle-aged, Caucasian, male crisis responders from Western countries, and the most commonly assessed crisis situation is combat exposure, where military personnel have been deployed to foreign countries. The impact of crisis situations in responding to combat exposure in one's home country and exposure to multiple protracted crisis situations are scarcely assessed. Majority of these research studies had predominantly used only self-reported psychometric questionnaires and not employed a qualitative approach (De Silva et al., 2022). What current research lacks is an understanding of influencing factors that impact mental health difficulties of military crisis responders and consequently, an understanding of intrinsic and external factors that influence the effectiveness of intervention/treatment approaches that are based on expert views and experiences of mental health professionals treating crisis responders from non-Western countries.

Therefore, this paper aims to address these gaps by qualitatively assessing expert views and experiences of Sri Lankan civilian and military-based mental health professionals regarding factors that impact mental health (of military crisis responders), after exposure to crisis events, and considerations to enhance effectiveness of treatment/interventions for military crisis responders in Sri Lanka.

METHODS

Drawing on a qualitative approach to research, this study adopted the interview method to examine influences on mental health well-being among military first responders (after exposure to crisis events) in Sri Lanka, and influencing factors for treatment/intervention effectiveness to improve their mental well-being.

Procedure

Ethical approval was granted by the University of Central Lancashire (UK), with additional approval obtained from the Ministry of Defence in Sri Lanka. All participants consented to engage.

All civilian practitioners engaged through an in-person interview at their respective workplaces, and military-based practitioners were interviewed via video call due to restrictions imposed by the COVID-19 pandemic at the time of their interviews. After ensuring privacy and assuring confidentiality, all interviews were audio recorded with participant consent, and concluded within one meeting, without requiring multiple days to complete the interview.

Participants

Twenty-nine mental health professionals (i.e., psychologists and counsellors), comprising 14 civilian (registered with the Sri Lanka Psychological Association and/or Sri Lanka National Association of Counsellors; response rate: 77%) and 15 from the Sri Lanka army and navy (response rate: 83%) were interviewed regarding their experiences in treat-

ing military crisis responders. Only certified mental health professionals were recruited in line with the study eligibility criteria, which limited participation from the military-based sample. Consequently, the number of civilian mental health professionals recruited was limited as well to quantitatively complement the number of military-based professionals. Civilian mental health professionals may not have the opportunity to continuously provide services to military crisis responders, and military-based psychologists and/or counsellors are commissioned officers, who proactively and continuously work with crisis responders in the military. Military-based mental health professionals also reflected on their own experiences as crisis responders, if relevant, but through the lens of a mental health service provider. Each participant (P1, P2, etc.) was assigned a code to support anonymity, with the letter "M" referring to military-based and the letter "C" referring to civilian mental health professionals.

Measures

In addition to gathering demographic data (i.e., age, gender, level of qualification and experience, the number of service years) and information on personal exposure to crisis situations, all engaged with a semi-structured interview developed to obtain practitioners views on factors thought to influence mental health and recovery of military crisis responders, after exposure to crisis events. The interview asked professionals explicitly about risk and protective factors that aggravated/alleviated post-crisis mental health difficulties, factors that encouraged/prevented support-seeking behaviour, and strengths and challenges in treatment/intervention delivery.

Data Analysis

Interviews were manually transcribed and explored using thematic analysis (Braun & Clarke, 2006). Five main themes emerged, which were tabulated under two categories and further analysed into 16 subthemes. The number of participants who contributed to these subthemes is reported as a split percentage of civilian ("C") and military-based ("M") samples.

All transcripts were analysed by the lead researcher, and a second researcher analysed every even-numbered participant (50% of the same), thus allowing for consensus to be determined. This was achieved, with 80–95% of the codes reaching agreement, which is within the recommended threshold (e.g., McAlister et al., 2017).

RESULTS

The youngest civilian mental health professional was 26 years and the oldest was 47 years (mean (M) = 35.64, standard deviation (SD) = 5.79). The highest number of practice years was 17, whilst the lowest was three years (M = 9.28, SD = 4.37). Most of the practitioners were females (71%) with a postgraduate qualification (93%) and lived in the Western province (71%). The youngest military-based participant was 28 years and the oldest was 54 years (M = 36.33, SD = 6.93). The highest number of practice years (in the military) was 12, whilst the lowest was one year (M = 3.80, SD = 2.88). The majority of the sample was males from the navy (66%) with a postgraduate qualification (73%) and lived in the Western province (53%). The average interview length was 36 minutes (SD = 18.45) for civilian practitioners and 75 minutes (SD = 26.75) for military-based practitioners.

Two primary categories emerged from the thematic analysis: (1) factors influencing mental health symptomatology of and (2) factors influencing effective interventions for military first responders from Sri Lanka army and navy. Each category yielded main themes and subthemes.

Primary Category 1: Mental Health Professionals' Perceptions of Factors Influencing Mental Health Symptomatology in Military First Responders in Sri Lanka

Within the first category, influencing factors were collated as (1) amplified risks (i.e., factors that could increase the severity of symptomatology), (2) buffers against risk (i.e., factors that could decrease the severity of symptomatology), and (3) factors with variable impact (i.e., factors that could either increase or decrease the severity of symptomatology). These three themes are composed by subthemes presenting said factors.

Theme 1: Factors with amplified risks

Subtheme 1: Loss of Purpose (C: 50%; M: 100%) The ending of a three-decade-long war in the country was observed to have left military crisis responders feeling purposeless, demotivated, and uninterested in other duties considered more routine (e.g., agriculture and construction work). This was then considered to have a detrimental impact on mental health due to reduced self-worth:

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

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

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

Subtheme 2: Lacking Insight into Mental Health Symptomatology (C: 86%; M: 100%) Some military crisis responders would find it difficult to seek help for emerging mental health difficulties due to lack of insight, and attitudinal barriers may further prevent development of such insight. For instance, it was reflected that some military crisis responders have low insight and do not seek psychological services due to concerns of side effects of medication, stigma against mental health difficulties, and lack of interest or knowledge:

> The effectiveness of awareness programmes is low because they [crisis responders] participate in these programmes for the sake of it, simply because they have been nominated by their superior as programmes require a certain number of people to attend. Only a few people

> will understand the message and try to apply it to their lives. (C, P6)

Owing to the lack of knowledge on mental health, barriers were created, which could further be observed by engagement in other practices when trying to understand their symptoms:

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

This overall lack of insight was further noted when it became apparent that military crisis responders seek professional mental health support, only when their economic status and/or personal relationships are at risk:

> The majority of them seek help when they have family issues or if they start having problems at work. It's very unlikely that they would seek help just because they are personally feeling frustrated. (M, P15)

Subtheme 3: Need to Assert Capability and Hardiness (C: 36%; M: 60%) Military crisis responders attempt to portray a persona to assert themselves as "capable" and "resilient" due to community perception of military persons as "heroes":

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

Subtheme 4: Disconnection from Family Support and Social Relations (C: 60%; M: 93%) Due to the nature of their work duties, military crisis responders are often disconnected from their families and communities, which elevate their mental health difficulties:

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

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

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

Subtheme 5: Recent Critical Events Triggering Unresolved Traumas (C: 86%; M: 73%) Exposure to various and continuous crisis events as part of their work role, as well as other personal losses could at times trigger unresolved traumas. This could relate to an unresolved trauma response from engaging in past critical events:

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

Theme 2: Factors buffering against risk

Subtheme 1: Importance of Reliable and Continuing Peer Support (C: 14%; M: 47%) Peer support emerged as an essential and healthy coping mechanism for military crisis responders to buffer against mental health challenges ("They are surviving because of this bond"; M, P5). It was also noted that peer relationships could be time bound and restricted due to workplace conditions. As such, it was not always a long-term or reliable support system, yet it was positive when present:

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

Subtheme 2: Sense of Meaning (C: 50%; M: 100%) Reduction in risk of developing and exacerbation of mental health difficulties appeared to be linked with a sense of meaning and understanding in their role as military crisis responders:

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

Theme 3: Factors with a variable impact

Subtheme 1: Religion as a Coping Mechanism (C: 0%; M: 87%) This theme offered a mixed presentation in regard to the relief that religion could offer, to elevate mental health difficulties:

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

In contrast, some mental health professionals regarded religion as a coping strategy for military first responders to manage distress arising from exposure to crisis situations:

> Something I've noted about soldiers who fought in the frontline [of the war] is that they have become really religious now. It's their coping mechanism. They try to accept what happened by convincing themselves that it [the war] was "*meant to happen*". (M, P5)

Subtheme 2: Response from the Community (C: 28%; M: 87%) The response from the community towards Sri Lankan military personnel was considered positively significant and therefore, suggests some potential for a buffering impact against mental health difficulties due to social appreciation:

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

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

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

Subtheme 3: Support from Senior Management (C: 71%; M: 87%) Mental health professionals noted that military senior management would sometimes encourage and support crisis responders to seek professional support for mental health difficulties, but sometimes could be dismissive of the need for such support:

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

There were further instances where some senior military leadership would not only discourage junior officers but also instill stigma about seeking psychological support:

> Superiors are one of the main reasons for them [crisis responders] to not seek help. Most of these seniors have the attitude that people who seek psychological services are "*psychos*". So, most of the soldiers are scared to go for counselling sessions. They are worried that they will be called "*crazy*". These seniors sometimes explicitly tell their juniors, "*Don't go for counselling. It's not good for you. You are just trying to be a baby by going to a counsellor*". (C, P10)

Primary Category 2: Mental Health Professionals' Perceptions of Factors Influencing Effective Interventions for Military First Responders in Sri Lanka

Two main themes emerged from category 2, which outlined internal and external factors to mental health professionals, which may impact the effectiveness of treatment/interventions. Subthemes were formulated to present a breakdown of said internal and external factors.

Theme 1: Attributes of service providers in therapeutic support

Individual characteristics and nature of engagement by mental health professionals were recognised as significant factors to influence the recovery process of military first responders presenting mental health difficulties as a result of exposure to crisis events. This theme is composed of two subthemes as well.

Subtheme 1: Approachability, Care, and Empathic Concern by Mental Health Professionals (C: 43%; M: 60%) Personal attributes of mental health professionals, such as their approachability, their ability to relate to military crisis responders, impactful communication skills, and ethical practices were stated as key considerations for effective engagement in intervention. Barriers towards such effectiveness were noted as professionals who were inconsiderate of an individual's distress and held negative attitudes, beliefs, and actions that dismissed military crisis responders' traumatic experiences:

> People who work as counsellors in forces have to be more approachable and not take on the role of an officer than a counsellor. They [crisis responders] don't feel like seeking support because sometimes the counsellor would be someone who's also been to the war so they might look at the person as, "*Oh, I've also gone through this so what are you complaining about?*" or "*It's all in your head. I have gone through this, and I've lost so many people, so why are you complaining?*", which I know that some counsellors have told their clients. This leaves them [crisis responders] feeling very invalidated and most probably not return for help. (C, P1)

Subtheme 2: Need for Continuous Professional Development (C: 36%; M: 67%) A need for continuous development for mental health professionals was noted as an important factor in effective interventions. It was noted that due to lack of appropriate and sufficient opportunities to develop and/or use existing knowledge through professional courses and peer interactions, which is further compounded by a lack of qualified military mental health professionals, barriers were imposed for continuous professional development. However, a military mental health professional disagreed with the perspective of other professionals by stating that the lack of opportunity to utilise existing knowledge and skills is more concerning than the need for continuous professional development:

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

Adding to the importance of field and peer learning, a civilian mental health professional emphasised the importance of learning from experiences of military crisis responders and their treating military-based mental health professionals to better understand the impact of exposure to protracted crisis situations. The lack of contextualised and culturally appropriate trauma literature and psychometric assessments was also noted as a significant limitation for continuous professional development:

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

Theme 2: Aspects of service delivery

The influence of factors that are external (out of their control) to mental health professionals and military crisis responders was noted as an overall theme and split into the following four subthemes.

Subtheme 1: Accessibility to Services (C: 93%; M: 100%) There is a high possibility for crisis responders to be undiagnosed and/or untreated for their mental health difficulties due to reduced access to mental health services in the military. This is further impeded by factors such as stigma and hierarchical structure in the military:

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

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

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

The lack of agency to decline services was viewed as a positive factor by some of the professionals:

> When you have been referred to go for counselling, they [crisis responders] don't have the choice like in the private sector. They are given a date and then on the day, they are sent from the camp to the hospital with a note. After your appointment, the hospital gives you back that note to handover to the camp office, with the next visit date. Wherever you are in the country, you will somehow be sent for your appointment on that day. They are sent even if they like it or not. (C, P12)

Subtheme 2: Quality of Service Provision (C: 64%; M: 100%) Several negative factors were recognised to have reduced the quality of mental health services provided to military crisis responders. In addition to the highly militarised therapeutic settings, this relates to the lack of culture-specific knowledge on trauma and psychological measures adapted to the Sri Lankan context and differing standards in providing evidence based, person-centred, and trauma-informed therapeutic interventions through a multidisciplinary team:

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

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

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

> There are good things about the system as well. For example, every officer selected for foreign missions must talk to a counselling officer before their departure. We

> discuss family concerns, risk of sexually transmitted infections, and coping strategies before they leave for foreign missions. (M, P4)

Subtheme 3: Limited Availability of Resources (C: 86%; M: 100%) The quality of interventions and the willingness to seek professional support could be impacted due to lack of resources. For example, lack of qualified practitioners with limited experience, comprehensive and regular research, systematised follow-up procedure, physical resources (e.g., transport, stationery, building facilities), and restricted access to external resource personnel. Professionals emphasised that the situation further exacerbated during the pandemic:

> With the pandemic, we realised that we lack a lot of resources. We didn't have the technology to offer services remotely. If we have a system like that, we can even continue it after the pandemic. We can talk to someone in Jaffna from Colombo, so they don't have to travel 10 hours for one session. It takes about three days. One day to travel, one day for the session, and then another day to travel back. It's just not a good use of time and resources. Just because of how difficult it is, they [crisis responders] may be reluctant to seek help then." (M, P2)

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

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

Subtheme 4: Challenging Workplace Conditions (C: 57%; M: 100%) Lack of privacy and confidentiality due to hierarchy in the military setting, mixed role expectations on military mental health professionals, a primary focus on psychiatric drugs over psychological support, an appraisal process that discriminates against crisis responders who seek psychological services, and dismissive attitudes of senior management towards mental health professionals were noted to hinder effectiveness of interventions:

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

> Since therapists were not part of active battlefields, some senior officers tend to be dismissive about the capacity of psychologists by saying things like, "*what do you know about these people [military crisis responders]? We know best how to handle them*". They [officers] are under the impression that therapists should also undergo the same experiences to know what it's like. The attitude towards psychological services is still very negative. When I tried to introduce new psychological measures, they [military leadership] rejected by saying, "*We had a war for 30 years. We never assessed people for recruitment while we had the war, so we don't need it now.*" (C, P6)

DISCUSSION

By considering the perspective of mental health professionals who support military crisis responders in Sri Lanka, this research was able to capture several factors that could influence the emergence and maintenance of mental health symptoms in military first responders, after exposure to crisis situations. These included factors that could amplify risk, those that could potentially buffer against it, and those that have a more variable impact. The analysis also identified several factors that could potentially impact effectiveness of interventions/treatments offered to military crisis responders in Sri Lanka. Subthemes emphasised on the importance of competence and accessibility of mental health professionals, alongside workplace conditions. In contrast to the majority of current literature which has assessed Caucasian, male, crisis responders from Western countries, who were exposed to combat in foreign countries (De Silva et al., 2022), the current research focused on non-Caucasian crisis responders from armed forces, who were deployed within their home country as first responders. Civilian participants mostly included female professionals whilst military-based participants mostly included male professionals, which is representative of gender distribution in mental health services and the military in Sri Lanka. The two samples were not distinctly different in their other demographic variables. Independent of participants' gender and context they work in (civilian or military-based), professionals expressed balanced views, providing supportive statements for different hypotheses under the same themes.

Findings from this present research support existing literature that being disconnected from their families and community, negative experiences in the past including continuous exposure to crisis situations, self-stigma in seeking professional help, restricted access to mental health services due to toxic organisational values, the type of crisis situation, and one's cultural values amplify mental health difficulties for crisis responders (Barr & Corral Rodríguez, 2023; Beckley et al., 2023; Blakey et al., 2022; Miles et al., 2023; Presseau et al., 2019; Reisenzein, 2019; Sherin & Nemeroff, 2022). The current study adds to the existing literature that this amplified risk further exacerbated during the COVID-19 pandemic due to isolation, yet a considerable number of crisis responders from the Sri Lanka military sought professional support

during the pandemic due to fear of losing their jobs, and/or because of the negative impact on their families. Lack of free will to approach and/or engage with mental health services was viewed by some of the military-based professionals as a positive aspect of the military setting to ensure treatment compliance, opposing the recommendation by Becker et al. (2009) that seeking professional support on one's own initiative and being actively involved in the treatment process improves recovery.

A novel finding from the present research is that though military personnel in Sri Lanka generally report a very strong sense of pride and receive a positive response from the community, it had diluted since the end of the decades-long war in 2009. Engaging in non-defence work (e.g., agriculture and construction) has negatively affected their motivation and social image of being viewed as "masculine and resilient". Though the nature of their work changed as crisis responders due to the pandemic, it in turn negatively impacted themselves and their families due to high infection rates reported from the military. Another novel finding from the current research is the role of religion and/or superstitious faith in trauma recovery. Military-based professionals shared mixed views regarding benefits and the frequency of engagement in religious and/or superstitious practices as a coping mechanism by military crisis responders. The present research emphasised that peer support and assistance from the government and/or military leadership are of utmost importance for recovery, which increased during the COVID-19 response; though resources were minimal and some experts lacked familiarity in using technology, it was positively viewed by military-based professionals as a way forward.

The importance of qualified and experienced practitioners and opportunity for their continuous professional development were other themes that strongly emerged during this research, which had not become apparent through previous research.

According to Lewis and Roberts (2001), short-term treatment is preferred by service recipients, and it has become the way forward also due to reduced budget allocations. The current research is not able to support or challenge these findings as 'treatment preference' did not explicitly emerge as a theme, but frequent transfers of both mental health professionals and crisis responders were noted to hinder recovery progress. Similar to Lewis and Roberts (2001), the present research findings emphasise on the importance of using standardised assessments with strong psychometrics. Unique to the current research, the importance of culture-specific trauma knowledge and the use of culture-sensitive psychometric assessments were emphasised by professionals.

Implications for Practice and Policy

Findings from the present research will improve insight of both civilian and/or military-based mental health professionals, military leadership, and the Sri Lankan government to consider anticipatory actions to prevent, mitigate, and/or respond to risks of development and/or exacerbation of mental health difficulties of military first responders, after exposure to crisis situations. This insight will also be helpful for practitioners and policymakers alike to revise/develop and implement evidence-based, trauma-informed, culturally appropriate, and context-responsive interventions/treatment pathways and organisational policies through a multidisciplinary team for the wider community of crisis responders beyond the Sri Lankan military.

Strengths and Limitations of the Current Research

The current research is one of the first to specifically consider military crisis responders in a South Asian sample; and to qualitatively assess lived experiences and professional views of civilian and military-based mental health professionals regarding influencing factors in trauma recovery and effective mental health intervention for crisis responders in the military. The current research offered only an introduction of understanding in this area and did not assess the impact of other factors, such as severe physical injuries and/or disabilities, suicide ideations and/or attempts, and criminal convictions/dishonourable discharges of military crisis responders. Therefore, future research should assess this in more detail, with a larger cohort of mental health professionals and military crisis responders themselves, allowing the possibility to generalise findings and to conduct advanced statistical analyses to complement qualitative findings. However, the pathway to become a registered mental health professional is not regulated in Sri Lanka and hence, it may be difficult to recruit a large number of suitable practitioners.

The Sri Lanka Defence Ministry did not grant permission to share interview data due to concerns regarding sensitivity of information, which impacts the study's validity and reproducibility. Regardless, a strength of this study is the diverse sampling of mental health professionals and the use of a qualitative approach, as such an approach offers a richer exploration of expert views and field experiences, providing more detailed insights than a standardised quantitative approach.

CONCLUSIONS

The present research consolidates existing literature and presents new findings regarding a military crisis responder sample in South Asia through experiences of mental health professionals. The authors believe that new findings presented through this research further improve current understandings in trauma literature and provide a snapshot view from the Global South, in the aftermath of exposure to protracted, continuous, and multiple crisis situations, including the COVID-19 pandemic.

The findings from this study illustrate the importance of considering psychological trauma in crisis responders and factors that may hinder a true reflection of distress. This study illustrates that there are several factors restricting engagement in discussion of distress and in seeking support. For instance, crisis responders' self-stigma, a need to assert a sense of resilience in order to meet expectations of their protector role, and variable support for them to engage in treatment/intervention to manage mental health difficulties. Of particular importance is the sense of identity that a crisis responder can gain from their role and the sense of loss of self and identity if this is no longer present for them. The importance of accounting for this and placing the individual at the forefront of the professional response is paramount. The latter will require increased organisational support at a senior level and one that avoids a 'detached spectator'

approach, which fails to appreciate lived experiences of crisis responders or account for unique cultural, religious, and/or political differences that may arise in a context needing improved understanding in trauma to determine person-centred treatment/interventions.

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CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Sri Lanka Defence Ministry did not grant permission for data to be shared publicly. Consequently, supporting data is not available.

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