THE METAL HEALTH BENEFITS OF SERVING WITHIN THE BRITISH ARMY

Introduction

The mental health (MH) of soldiers remains extremely newsworthy, and is regularly featured in high profile media forums that focus on post traumatic stress disorder (PTSD) (Wheeler, 2011, Panorama, 2011, Silent Witness, 2011), often resulting in a perception within the public eye that military MH (MMH) problems are caused by the awfulness of war, and that soldiers evacuated from hostilities are returned with combat stress related disorders. These perceptions reflect the focus of MMH research. Added to the potential negative MH implications of operational tours, is that stress is a ubiquitous occurrence for soldiers, encapsulated within a lifestyle of constant change and demands, and often associated with long periods of time spent away from family and friends (Busuttil, 2010).

Mental well being cannot be found in isolation, and MH is not just an absence of mental illness, but people getting the best from their lives (Conrad & White, 2010). MH within the Army is predominately concerned with young men's issues, and with the challenges faced in this demanding world, there is a requirement to provide men with the tools to help them manage their emotions (White & Conrad, 2010). The Army "family" can provide support to help soldiers to deal with many of life's challenges, and the sense of being part of a bonded team, living in a close community, can be very rewarding (Goffman, 1963). Many people enlist to access these positive elements of army life, and make a conscientious decision to join an organisation where they get to learn trades, become employable, get to do things that are adventurous, see places they would never otherwise get to such as Cyprus and Belize (British Army, 2011). For University graduates, funding is available to support them through their studies and then a very attractive salary, working environment and career pathway (GradFutures, 2011).

Stressors Faced Within The Army

The army also recognises that any significant alteration in a soldier's lifestyle or new demands may influence their ability to function, and there are numerous biopsychosocial life events that place extra demands, and may induce the onset of MH disorders (Finnegan et al, 2010a; Finnegan et al, 2010b). Common everyday stressors leading to MH problems such as: social isolation, lack of a confidant or social support (Kaplan et al, 1987); relationship problems (Finnegan et al, 2010a); poverty (Belle, 1990), alcohol abuse (Fear et al, 2010) and poor physical health (Kukull et al, 1986) would be expected to be reflected within the military population but is often not referenced in media reports. There are also stressors unique to the macho military workforce (Finnegan, 1997) such as: psychological adjustment to operationally linked traumatic events (Scott & Stradling, 1992); serving in operational areas (Black et al, 2004), whilst the pressures on a military family are well recognised (Dandeker et al, 2008; Norton-Taylor, 2008).

Those who enlist from dysfunctional families (Patterson, 2002) or have a history of childhood abuse (Bagley & Ramsey, 1986); may join the Army as a means of escaping (Busuttil, 2010).

They then face significant lifestyle changes, including separation from family and friends, restriction of freedom and privileges, and physical conditioning. For new recruits, the main stressors are adapting to the military environment, and changes in personal circumstances such as new relationships or family demands (Deu et al, 2004). This often resulted in personnel wishing to leave the Armed Forces, while facing extended periods of notice to leave and they may self harm; sometimes due to their distress or to manipulate their circumstances (Crawford et al, 2009). It should however be noted that there are MOD policies that should ensure that personnel who are vulnerable to MH problems, and who make an error of judgement in joining the Army, can subsequently leave. These measures include that all recruits undertake an assessment that aims to match them to a number of suitable career options. Then they undergo an entrance medical examination, and those with a previous history of MH problems are either excluded of deferred. Soldiers then have the option to leave during basic training.

It is also recognised that the pace of military operations and the number of tours place a strain on families (Britt & Dawson, 2005; Tarn, 2006). Wessely (2005) has predicted that overstretch and the increasing number of deployments, with the adverse affect on family life and well-being, will be a more significant cause of MH problems than conventional psychiatric disorders including PTSD. However, few studies have focussed on the benefits of serving within the British Army, and the occupational, environmental, welfare and medical support that can be found within this close knit community.

Common Military Mental Health Problems

It is important to acknowledge that all soldiers, depending on the level of stressors they face has a breaking point (Wessely, 2005), however, serious mental illness is rare in the British military, where the majority of service personnel do not experience MH problems, and of the approximate 1600 who leave the Services each year on medical grounds, only 150 were for MH reasons (Busuttil, 2010). The most common MH disorders affecting UK armed forces are depression, alcohol misuse, adjustment and anxiety disorders (Turner et al, 2005; Finnegan et al, 2007, Iversen & Greenberg, 2009), and these conditions are the main MH factors in reducing the fighting capability of the British Armed forces. To date, research from recent conflicts have not indicated a significant increase in operationally linked problems within the British armed forces, although within the media "*there has certainly been an epidemic of stories about PTSD*" (Wessely, 2005), and rates of PTSD have remained relatively low (Finnegan et al, 2007; Jones et al, 2008; Iversen & Greenberg, 2009; Iversen et al, 2009, Fear et al, 2010). US studies have indicated that operational tours since the commencement of Gulf War 1 (1991) have had a negative MH impact on troops (Black et al, 2004) although UK research has produced different outcomes, and often concluded that well motivated British troops, fighting in low intensity conflicts, were not negatively affected in large numbers with combat stress reactions (Hacker-Hughes et al, 2005) and troops generally do well; and "*There are those for whom active service remains the best thing that ever happened to them"* (Wessely, 2005).

Studies have also indicated that involvement in hostile exchanges with enemy forces were not the major reason for operational evacuations. Turner et al's (2005) Iraq War II (2003) study

indicated that 69% of MH evacuees were non combatants, and the reason for evacuation was attributed to environmental, separation and inter-personnel difficulties. More recent studies have shown that operational referrals were notable for the few PTSD cases and the majority of patients were diagnosed as adjustment disorders, mood disorders and cases where it was not possible to assign a diagnostic category due to the medicalisation of normal reactions to difficult circumstances (Jones et al, 2008). There does not appear to be an epidemic of psychological disorders once troops recover from operations; with few reports of MH problems that were directly attributed to a deployment (Jones et al, 2008).

Defence Mental Health Services

The Ministry of Defence invests a significant amount of time, effort and money in aiming to provide an effective occupational MH service that is accessible, readily available and within a culture that tackles stigma and positively acknowledges a duty of care (Finnegan et al, 2007). The Defence Medical Services (DMS) focus on meeting the operational imperative of producing a capable workforce, able to undertake their military duties without physical or mental problems. This is achieved by maximising the psychological support offered to Service personnel through the provision of immediate MH support with the expectation that they will return to duty. Numerous Performance Indicators (PIs) have been instigated to demonstrate that the DMS provides a measurable effective service; such as monitoring whether urgent MH referrals were assessed within 1 working day, routine referrals within 20 working days and that a hospital beds was identified within 4 hours. These PIs have been achieved in 95% of occasions, and indicated an exceptional standard of service provision, reflected in a satisfaction survey where 93% of soldiers rated their MH services highly (Finnegan & Finnegan, 2007). These figures suggest that the care offered is at least as good, if not better, than the NHS. There are also specific policies and measures in place to address problematic issues such as alcohol abuse. For those nearing the end of the career, there is resettlement training, and MH support available for late onset MH problems that emerge after discharge from the forces.

For those deploying on operations, there is significant investment in psycho-educational training, peer support such as Traumatic Risk Management Training (TrIM) (Jones et al, 2003) and measures in place such as decompression to support soldiers to reintegrate on return from operations. MH clinicians also deploy with troops into hostile environments thereby providing local support and ensuring a seamless pathway of MH care is available.

Aim

This paper is a discrete part of a much larger study that undertook an exploration and critical analysis of the factors leading to depression within the British army (Finnegan, 2011). The aim of this paper is to reflect part of this larger study, by evaluating and detailing Army mental health services (AMHS) clinicians' views regarding the benefits of serving within the British army.

Method

A grounded theory approach was selected (Silverman, 2005), and the research sample were 19 experienced MMH psychiatrists and nurses with five or more year's AMHS clinical experience. Information was gathered through semi-structured, in-depth interviews conducted by the first author. These commenced in July 2006, with informed consent obtained as required by UK guidelines (Central Office for Research, 2005); and ethical approval was provided by the UK Ministry of Defence Research Ethical Committee. All interviews were digitally recorded and transcribed by the first author, and continued until saturation was achieved in August 2007 (Charmaz, 2006). The first authors' experience in the AMHS provided familiarity with both the phenomena and the clinical and military nuances' of language. A fuller explanation of the methodology were detailed in a sister publication (Finnegan et al, 2010b).

Results

The results indicated that there were measurable benefits associated with employment within the British army, including rewards for team players; a caring and supportive organisation, and excellent medical care and MH support.

Discussion

The Respondents' Views of their Service and the Soldiers they Serve

Interviewees were members of the AMHS, which they perceived to be a capable, multi-disciplinary clinical organisation, providing soldiers' with a medium for sharing problems, whilst providing recognised treatments such as Cognitive Behaviour Therapy (CBT), and acting as the soldiers' advocate. They recognised that the AMHS differed from civilian practise by providing an occupational MH service that made recommendations regarding a soldier's suitability for Service, whilst assuming that soldiers' with MH problems would return to work. AMHS clinicians had experience treating disorders such as adjustment reactions, and responded to serious risk issues, such as a soldier's capability to handle a live weapon. As a result, clinicians may inform the chain of command of the patient's condition whilst assisting units to address MH issues. The critical mass of army personnel are fit, young, strong men, and they provided the majority of department of community mental health (DCMH) patients, but a key point was that AMHS personnel recognised that they only assessed soldiers' experiencing MH problems, as highlighted by CC:

> "*I think it's difficult because being in mental health you can get a very skewed vision of a lot of the guys*."

Measureable Benefits of Army Life

There were factors that reduced the presentation of depression in the army. Moderate to serious depressive illness, along with other severe MH disorders were screened out during the

enlistment / Commissioning process, and soldiers were fitter than the national average. FF reflected on this issue:

> "*People who come to the army are generally well, and do not come in if they have mental health problems in the past. So all those things are protective factors."*

Once a soldier had enlisted, military lifestyle impacted on all aspects of their existence, and incentives provided significant measurable benefits. These remunerations were available before the soldier joined with university bursaries, and then there was guaranteed employment, good regular income, an excellent pension and ample annual leave. Reasonable housing was available, and as the soldier was promoted then the accommodation improved. They were well fed, clothed, had access to tremendous adventure training, and physical fitness which enhances MH was promoted. The army provided soldiers' with career opportunities that were not available in civilian life, and they had exceptional opportunities to develop an employment profile, enhanced by internal and external educational opportunities. The army provided status and recognised achievements with military awards. CC explained some of these factors:

> "*Yes, there are some incredible positives. There is the group cohesion issue..... the feeling of belonging, the feeling of worth. There is the commonality issue; we all wear the same uniform, even though we are from very different areas and different backgrounds. They have fantastic opportunities for development; there are things such as adventure training where you are paid to go away. There is a feeling that you have done a good job. Feel that you have been brave, the parades, the medals ... when the whole nation is behind you, I think a lot of the guys are really proud."*

Rewarding the Team Player

The army sets high standards, and expects personnel to meet these principles. Army doctrine is enshrined within an ethos of strong-team ethic rather than individual performance, and once recruits have enlisted / Commissioned then the army begins to shape them to best meet this doctrine. This remoulding of the individual enforced restrictions that impacted on personal control, but many soldiers choose this life style, welcoming a structure that appealed to personnel who preferred to be directed. As EE realised:

> *"I think, the transition from no boundaries to boundaries is I think one of the very positive things the army does for people who come from pretty poor backgrounds."*

Thereby the army promotes group cohesion, through employment, tasks, uniforms and symbols, offering stability, camaraderie and homogeny; achieved through social bonding, living in close proximity and projected in a strong allegiance to the Regiment. The army thereby provided a protective "family", with a community based on shared values,

experiences, and socialising. This was accelerated when recruiting from local communities, and through overseas postings, when with Infantry Regiments, the whole unit move and deployed together, providing a better infrastructure for support. This bonding could be extremely rewarding, as CC stated giving a "*sense of belonging, a feeling of worth*" and team players did very well, sharing a supportive Esprite de Corps and soldiers learnt to depend on and trust their colleagues. Even then, high-quality units could accommodate introverted personnel who did well, and everyone in a unit would have some friends. The result was a community, of predominately young fit men who were extremely proud of the job they performed, with a sense of belonging within this caring organisation, and prioritised fighting for colleagues above Government and foreign policy, and would go to extraordinary lengths to demonstrate their loyalty, even dying for each other. FF stated:

> "*Cause most of the boys, again go back to x xxxx, that battle group scenario, most of them go out there cause they are with their friends and they are fighting for their friends, not for the Queen, not for the government or foreign policy. They are going out there to enjoy it, cause that is what they are trained for, they are going to do a job that they know they can do and they are capable of, but they do these things for each other, for the name of the Regiment, for the history of the Regiment, the cap badge."*

The army rewards personnel who make an effort, whilst penalising those who under-perform, and those who have served for several years were immersed into the system. Soldiers' were given responsibility, allowing them to cultivate and demonstrate their strengths, and they thrived. Whilst personnel from stable backgrounds did very well; the army also provided opportunities to people from poor, under privileged areas and dysfunctional, even abusive childhoods. The army provided an escape route, preventing soldiers' entering a life of crime, and provided the stable family these soldiers' had never experienced, and adversity in youth could prepare them for the hardships that followed. CC identified these issues when he stated:

> " *I think when you are looking at people coming from some very hard areas; I think we often do get some very damaged people. It's why people join; it's what I was going to talk about, those who are actually running away from something. Well, the army is the here and now. I think, equally we recruit some very, very damaged people. And a lot of them do very well, but a lot of them have come from, you know, physical abuse, sexual abuse, drug, heavy drug background, and so on."*

They used the military to hold their life together, and enlisted or commissioned for these reasons, and performed extremely well and build excellent careers, despite the mounting pressures.

A Caring and Supportive Organisation

The respondents stated that despite common perceptions, the army was generally a very supportive, caring organisation, especially to senior personnel, and should a soldier incur

hard times or MH problems then the army was more responsive than civilian employers in supporting depressed employees. VV outlined how this works:

> " *There is a more rigid and tighter framework of what is acceptable conduct and behaviour and appearance. Among soldiers, anybody who steps outside of that framework is going to get picked up much earlier. So that in civilian life you may have someone whose unkempt, unshaven, abusing alcohol, you know, not caring for himself, loss of motivation, for weeks or months or even years, before anybody is bothered. That can only go on for a couple of days within the army, and so we nip an awful lot of problems in the bud."*

Even with traditional problems enmeshed within army cultural such as the acceptance of alcohol misuse, the interviewees reported a positive progressive shift, due to better education. There were many examples of excellent units, with strong and fair leadership, and Commanders who were fully versed on the MH of their troops, and there was early identification of vulnerable personnel, and problems were nipped in the bud, including those who drink excessive amounts of alcohol. In particular, smaller, more technical units provided better support, such as the Army Air Corps, Royal Artillery and Royal Engineers. Fully engaging with the soldier's family, especially with younger inexperienced staff, was beneficial. Also was the stability gained through extended periods in one location, and fewer disruptive postings; allowing personnel to influence where they served. Excellent welfare support was provided including financial advice, and medical care. Troops were supported, and Commanders would remove troops from duties and do everything they could to help, such as providing soldiers' with a compassionate posting. The end result was an extremely loyal and committed workforce, who did not feel stigmatised or weak. NN provided an overview of the process:

> "*We speak to the unit, and say is there any way we can get this guy on a detachment because he needs to be near to his family for the next 6 months because his mother is dying. OK, we will put him in a recruiting office in his home town for 6 months or a year, will that do? Well amazingly his low mood, depression and everything is cleared. And the army is wonderful, going out if it's way to do this for him. So you have a soldier with far better loyalty."*

Excellent Medical and Mental Health Support

When appropriate, troops are encouraged to seek formal medical support, and referrals made to a suitable agency. There remained a small number who attended for a MH assessment as a result of a third party intervention, such as being directed by the chain of command, however even these paternalistic interventions could prove effective, beneficial and supportive, especially when the patient had no insight into their problems and those that had no comprehension of what the AMHS offer. Those aware of the care available within the AMS, respected the service, and when they had a problem, the vast majority accessed healthcare voluntarily, willingly seeking assistance, for appropriate reasons. This help seeking trend was in part due to their army training that had taught them to be fit for task, in both mind and

body, and they were an open and honest group. FF highlighted how these factors proactively influence the referral:

> "*If someone has an alcohol related, violent crime being investigated, then they may say that you need to go and get some help with your anger because we believe that it is attributable to operational service. And the soldier will usually listen to that advice as they respect their seniors. And therefore they say go and get help from the doctor,r and then subsequently us, then that is what you should do. But I think the majority would come because something has happened and there is a realisation that it has gone on for 3 months. My wife has been chipping away at me, my girlfriend, my family have been chipping away at me, my boss has mentioned it and maybe enough is enough so I have to do something about it. So something might be a eureka moment."*

Soldiers' are aware of the specific MH treatments, having accessed the Internet for details of depression and management options such as anti-depressants and CBT, and they expect good treatment and a positive outcome. The Army Medical Services (AMS) then provides an occupational health service, in medical centres that are normally collocated with army units, and contain general practitioners (GPs), nurses, and other clinicians. To the civilian population, including medical colleagues, the AMS can seem an intolerant, tough organisation, where GPs are persuasive regarding MH referrals, although these are nonetheless appropriate. However, there is rapid assessment and treatment that is much quicker than in civilian practice, with soldiers' more likely to be seen by a doctor rather than taking sick leave, as they would in the NHS. For older, senior personnel, the Unit Medical Officers (UMOs) are very supportive, providing a wide choice of treatment options. For these reasons, proportionally fewer Warrant Officers and Officers are referred to military DCMHs.

The AMHS clinicians view depression as a treatable illness, and soldiers' are cared for before they reach crisis or self harm, and most are retained in the army. AMHS personnel are flexible regarding treatment protocols, understanding their clientele, and not always adhering to NICE guidelines such as "watchful waiting". Patients are allocated at least an hour per interview, and there is sufficient time to build a therapeutic relationship. DD explained how this occurs:

> "W*e have the time to speak to them as to why they are here and what our goals are, and just as importantly explaining what we can't do as what we can do. And the idea I give to people is that the chances are that they are not going to be mentally ill and at the end of the assessment they will get a certificate saying pretty much that. Not many of us have a sane check and they will, well you know, they are worried about you and like I said there is nothing to be worried about and away you go. So once they are here it's fine.*"

Irrespective of rank, everyone is treated equally, although AMHS clinicians are sensitive to how difficult it is for Officers and seniors to access support, and how distressed they are. The majority of interviewees stated that soldiers are not concerned about medical confidentiality,

even in sensitive cases, and when medical information is provided back to the unit, the patient agrees to the disclosure; and medical confidentially is not compromised, and only occasionally do things go wrong. LL touched on this issue:

> "*I think a lot them will not care whether their unit knows or not knows. I think a lot of them will want their unit to know that they are being seen. They may think that there is some sort of secondary gain. Or on a more positive note they might actually want the unit to know so they, they very often will have a very good working relationship with their chain of command.*"

which is reinforced by NN:

> "*Patients are confident that medical in confidence will be maintained...and the vast majority of patients have a great deal of faith and trust in the military medical services and the way we run things.*"

When treatment is completed, in these capable units the soldiers are welcomed back from illness, not stigmatised, and generally a MH problem does not negatively affect their career.

Conclusion

There are significant numbers of predisposing factors that lead to MH problems in the army, in particular relationship problems, family issues and occupational stressors. These issues have to be addressed, as proactive interventions that tackle the recognised factors leading to depression can reduce mental illness, and if these problems are attended to within an appropriate multi-layered assessment, then patients can be supported and treated locally. However, it is equally important to provide a balanced debate when discussing the MH implications of a career within the Army. Many soldiers make a conscientious and informed decision to join the Army and thoroughly enjoy their career. Many from disadvantaged backgrounds can excel and access trades and develop skills that may have eluded them in civilian employment. For all Army personnel, there are measurable benefits regarding finances, accommodation, a career pathway and educational opportunities, and many never regret their decision to enlist.

There still remains significant room for further research that needs to be conducted to ensure that soldiers are provided with the occupational, welfare, environmental, social and medical support that they deserve. However, this paper has highlighted issues that are well recognised by personnel who have served within the army, and there are elements of military culture, when encapsulated within a supportive and emphatic atmosphere, provide potential shielding from MH problems. The importance of leadership, presented in an environment where soldiers are valued, stigma is not tolerated, and support offered for those experiencing problems is vital. Therefore, it is important that the army acknowledges the importance that practical steps can have in supporting soldiers, and ensure that wherever possible these procedures are positively implemented.

Limitations

A.F's role as a recognised member of the interviewee group introduced the potential for bias, and was addressed through a strategy based on self awareness, an open mind, and mentorship. The views are those of civilian and uniformed MMH practitioners and not Soldiers. The results are only related to a UK Army population, may not be transferable to other nations' armed forces personnel or to a non military audience.

Conflict of interest

Lt Col Alan Finnegan and Col Robin Simpson are serving within the Army Medical Services. The views expressed are those of the authors, not the Ministry of Defence.