Societal Factors that Negatively Affect the Mental Health Support for the British Army's Service Personnel Involved in Major Trauma

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SUMMARY: This paper provides details from a pilot study that aimed to identify sociological factors that deter Service personnel involved in major traumas from seeking medical health support.

Introduction

The nature of military employment is such that Service personnel may be exposed to traumatic experiences of such intensity as to make the development of Post Traumatic Stress Disorder (PTSD) a strong possibility (1,2). This paper explores the effect that factors such as psychiatric labelling and stigma have upon Service personnel requiring post trauma mental health support.

The article begins with a succinct literature review concerning stigma and psychiatric labelling within Western society, and includes a summary of the consequences of post trauma difficulties within a family context. The paper progresses to provide details from a pilot study in which sixteen Ministry of Defence General Practitioners expressed their opinions regarding the reluctance of Service personnel to seek post trauma mental health support. Finally, there are recommendations for reducing psychiatric stigma within the Army.

Social Support and Stigma

Foy et al considered the effects of social rejection on PTSD development in Service personnel returning from Vietnam, and illustrated how many of the difficulties arose from being stigmatised (1). These Service personnel were angry at the lack of sympathy and were subsequently unable to express their feelings. Their re-adjustment to civilian life was impeded by insufficient societal support, stigma and a changing political position that deemed their actions in Vietnam to be immoral (1,3). Such social difficulties and rejection lead to secondary trauma.

Secondary Trauma

Secondary trauma occurs when society holds the victim as being partly/wholly responsible, for example the serviceman fighting for the wrong cause(1) or the person who has cancer because he worked for an asbestos company(4). This form of social rejection and blame is considered to be a contributory factor to post trauma psychological problems(5). Sociological studies have proposed that hostility to trauma survivors may often be a standard reaction (6). By blaming the victim, society can maintain an internal feeling of immunity from disaster. As such, casualties are shunned and separated from a society dreading guilt by association(3) or 'courtesy' stigma (7).

PTSD and the family

The individual's social context is influential in determining how a survivor will contend with difficulties following a traumatic event(8). Stress experienced by one family member will often adversely affect other family members(9). As such, family and friends of a person experiencing PTSD symptomology are often emotionally affected(8,10). "Episodes of violence, unpredictability, unreliability, and emotional stability (sic) can adversely affect the children and the spouse"(11). The survivor may feel out of control(12); irritable and/or withdrawn(13), and use alcohol or drugs as a coping mechanism(2,14). Such changes can increase stigmatisation and be associated with dissociative episodes related to the PTSD phenomena(15), such as fighting between soldiers and civilians that affects the whole local community. Additional problems will arise from the nature of the trauma, i.e. a soldier who has been attacked may fear going out. Any of these symptoms within a family context is likely to alter the family dynamics for the worse, and cause difficulties with communication and intimacy(14).

A survivor may wish to protect his or her spouse from the trauma, and therefore not disclose his or her feelings concerning the traumatic experience(16), thus leading to emotional disengagement. There are examples of the devastating effect that the survivor's altered behaviour can have within a marriage(17). Home difficulties inevitably reflect back on the survivor's ability to work (13), and Service personnel may leave the Army following marital difficulties secondary to post trauma symptoms.

There are inherent difficulties associated with research methodology and PTSD(18). These problems are more pronounced when soldiers avoid mental health services due to stigma and psychiatric labelling. Therefore, PTSD and the effect upon family members is an under-represented area of research as theorists have difficulty
Assessment of PTSD and Somatic Presentation

In addition, soldiers who are reluctant to seek medical support may present with a somatic type presentation (20). This can cause problems for the GP who may fail to recognise psychological problems for reasons such as short appointment times (21,22). However, it has been shown that clients presenting with a covert psychiatric illness have as many psychological problems as those disclosing their psychological distress, and do not have a better prognosis for recovery without assistance (23).

In addition to the effect of psychiatric labelling, there are unique problems associated with the detection of post major trauma psychological problems. These are:

(i) PTSD is commonly not recognised due to comorbidity with other clinical diagnosis, such as depression or alcoholism (2,24,25,26)
(ii) PTSD symptomology may not start until many months after the initiating trauma (27)
(iii) PTSD symptomology may continue for many years after the initiating trauma (28) and
(iv) individuals severely disturbed following a traumatic incident may avoid treatment fearing that the treatment process will be distressful (29).

Method

A postal questionnaire was sent to twenty Ministry of Defence General Practitioners employed within the British Army's Southern District. The study group composed of a selected stratified sample of primary health care doctors, all of whom were responsible for the care of Service personnel who have been employed within an operational zone. For comparative purposes the doctors were divided into two distinct groups, ten Army and ten civilian doctors. Five of the civilian doctors worked full time for the military, the other five worked more than one day per week. From the initial group of twenty, sixteen questionnaires were returned in time for analysis within the pilot study. Of these, nine were Army doctors and seven civilian doctors, thirteen worked full time for the military and fourteen were male. The doctors answered the question “In your opinion, are Service personnel reluctant to seek mental health support following a traumatic event?” If the doctor answered yes, then he/she was requested to clarify and expand on his/her answer.

Analysis was completed using the Statistical Package for Social Sciences (SPSS) computer database.

Results

The doctor’s response to the aforementioned question is indicated in Table 1.

A majority of respondents felt that stigma continued to prevent Service personnel from seeking psychological support following a major trauma.

Four major difficulties were highlighted:

Table 1

<table>
<thead>
<tr>
<th>Question</th>
<th>Army Drs</th>
<th>Civilian Drs</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Depression</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Discussion

Combat induced psychological problems are now widely recognised (30,31,32). As a result, there has been a concerted drive within the military to eliminate stigma associated with psychological problems due to traumatic stress. Pre tour briefings emphasis that everyone is prone to traumatic stress and the normality of the post trauma response, i.e. shock, distress, confusion etc (18). This format of placing psychological difficulties within the medical model may reduce the stigma attached to psychological problems (33,34). Additionally, the Army psychiatric treatment protocol of immediacy, expectancy and proximity (35), has resulted in Approved Community Psychiatric Nurses and Registered Mental Nurses being routinely deployed into operational zones to provide psychological support.

In this pilot study, the Army doctors appeared more sensitive than the civilian doctors to the reluctance of Service personnel to seek mental health support. One reason is that doctors often have experiential knowledge of the soldier’s experiences and social dynamics. However, the Army doctor has a defined dual role with responsibility to both the Army and the soldier (36). Manor et al describe this as the 'pivotal' position, in that the Regimental Medical Officer is the Commanding Officer's primary adviser on all health matters (34). This may have a negative side, for example, an Army doctor who has not experienced trauma may be less understanding to the plea of a soldier who has been in...
similar operational circumstances but is having difficulties. The doctor may therefore not acknowledge the soldier's distress and feeling of failure. The knowledge that some information may be relayed back to the Commanding Officer makes some Service personnel suspicious of the medical services (37). However Porter & Johnson have indicated in U.S. military studies that treatment within the mental health services does not adversely affect a Service person's career, although this may not be the popular belief amongst soldiers (38).

Soldiers may also find it difficult to distinguish between an officer giving orders and the doctor dressed in an officer's uniform who is there to offer psychological welfare. There may be fear of disclosing to a senior rank and therefore a resistance to seek aid from an Army doctor. However, Army doctors are clearly identified as 'one of the family'. They understand the Army mentality that one must soldier on and that a soldier may feel weak in seeking psychological support.

The civilian doctors are sometimes viewed as being detached from the Army and therefore potentially less threatening. This is reflected in the results where three out of seven of the civilian doctors felt that stigma was not a problem. However, they are not clearly identified as part of the 'family' and are often detached from the cultural dynamics of the military.

The armed forces and close knit organisational teams are often reliant on each other. If it emerges that one of the team is at less than optimal functioning, then it can arouse doubts in the mind of other team members. The client is therefore apprehensive that disclosure of psychological problems will result in a loss of respect or in failure to be promoted within the organisation(38). Therefore, individuals will not seek help from the organisation's psychological support teams even when they are available, and will only go to see a mental health practitioner when formally referred. Even then, the involuntary client does not create a suitable therapeutic environment(39).

Despite this, a notable trend within the Army's Southern District over the past four years has been the substantial increase in the number of psychiatric referrals. This suggests that the aforementioned factors have only a small influence over soldiers seeking psychological support. However, experience gained from working within this community mental health team indicates that referrals have increased due to:

- Pressure to recruit and retain means that Service personnel are being identified who cannot cope with the requirements of the modern army;
- Doctors referring more regularly due to effectiveness of the community mental health team.

Increased demand for psychological support is also a reflection of the increased stressed in the Army. Force reductions have resulted in job insecurity, and this is recognised as a 'severe psychosocial stressor' (20). This has combined with increasingly frequent operational tours and separations from families and/or social supports. The regular need to adjust to different settings can increase family strain that may affect mental health. Additionally, adjustment reactions can be exacerbated by the speed that soldiers are transported from home to theatre or vice versa. Without having access to specific research, one can only hypothesise that troop ships gave Service personnel time to adjust to their new surroundings and therefore lessened adjustment reactions. Current day transportation means that Service personnel are moved from domestic/cultural support to a foreign and often hostile environment within a very short time span. The result is the Army's interpretation of the "culture shock".

These factors contribute to the increasing level of referrals, but often do not reflect Service personnel with psychological problems who are deterred by sociological factors such as psychiatric labelling. Additionally, the above mentioned factors do not account for Service personnel who seek psychological support outside the Army service(38).

Conclusion

Societal factors that cause post trauma psychological complications continue to be an area that requires addressing. For the Army to work to its optimum capacity it needs to have a structure that allows Service personnel to freely seek mental health support without fear of being stigmatised or losing their job. Although this paper has not directly questioned non medical service-personnel, it does suggest that the doctors employed within the military recognise the problems and indicates that current protocol needs to be further developed. It is disquieting that an individual may face the social consequences of being psychiatrically labelled due to symptoms that occur almost universally after severe trauma.

A means of addressing these sociological factors is to:

- increase mental health education within units(25), and reduce the detrimental effects of stigma. This can be achieved by increasing:
  (i) the current number and scope of uniformed community mental health teams;
  (ii) the involvement of the psychiatric services within the military units and:
  (iii) mental health education for Service personnel and their families. This would lead to earlier intervention in post trauma and psychological problems, improved societal support, increased
understanding and awareness of post trauma problems.

- Place traumatic incidents into the medical model, in so much as the soldier is educated of the normality of experiencing post trauma difficulties the emphasis being that post trauma difficulties can affect anyone, and are not a sign of inherent personal weakness.

Finally, further research may prove useful in defining whether societal factors such as psychiatric stigma are an issue that is markedly affected by the environment, e.g. home or operational setting.

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