Serving within the British army: research into mental health benefits

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Abstract
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. However, the authors feel that there are distinct benefits to serving within the Army, and that it provides effective occupational medical, MH and welfare support. This research study explores potential benefits and stressors of being in the Army and provides an overview of Army mental health services (AMHS) through the perspectives of AMHS personnel, 84% of which were nurses. The study indicated that the Army can provide a protective community, sharing a bond based on common values and experiences. The Army can provide soldiers with career opportunities that are not available in civilian life, and there are opportunities to develop an employment profile, enhanced by internal and external educational training, and encapsulated within a progressive career pathway. The Army can also be seen to offer an escape route, preventing soldiers entering a life of crime, and supplying the stable family these soldiers had never experienced. The provision of leadership, within an environment where soldiers are valued and stigma is not tolerated can potentially shield against MH problems.

Key words: Defence nursing ■ Mental health ■ Army ■ Military

Potential advantages of joining the British Army
MH and wellbeing are not just an absence of mental illness, but about people getting the best from their lives (Conrad and White, 2010). Few studies have focused on the benefits of serving within the British Army and the occupational, environmental, welfare and medical support that it provides. In this context, enlisting in the British Army is an attractive proposition, especially for young men: they get to learn a trade or profession, become employable, do things that are adventurous and see places they would never otherwise see (British Army, 2011). For university graduates, funding is available to support them through their studies, a very attractive salary, working environment and career pathway (GradFutures, 2011). Added to this, there is the satisfaction of belonging, living and working as part of a bonded team (Goffman, 1963; Busuttle, 2010) and doing a job that is useful to society, and in which they can take pride.

Potential stressors within the British Army
MH in the British Army is predominantly about young men’s issues. In both civilian and Army life, they are subject to multiple sources of stress that include: 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; Audit Scotland, 2007). Difficulties of this nature are rarely reported in the press. Army life, like any other occupation, produces certain particular stressors. It is a challenging environment in which significant alterations in lifestyle or new demands may influence personnel’s ability to function (Deu et al, 2004; Finnegan et al, 2010b). These can be examined from several perspectives.

First, for new recruits, there is the process of adapting to the military environment and changes in personal circumstances (Deu et al, 2004). They will be required to undergo a number of assessments to ensure that they are physically and mentally fit and to match them to a number of suitable career options; those with a previous history of MH problems are either excluded or deferred entry. Some young men find this process of adapting to Army life very difficult. There is the option to leave during basic training, but it may take much longer than this for them to become fully aware of some of the consequences of their decision to enlist. Separation from family and friends, restriction of freedom and privileges and physical conditioning leads them to feel that enlisting was a mistake and so they decide to leave only to be faced with the realization that they have signed a legally binding, fixed-term contract; leaving early is not an option. Working out
the period of notice required may increase their levels of stress resulting in self-harming or other negative behaviours (Crawford et al, 2009).

For more experienced soldiers there are additional pressures to be faced. The working environment is inevitably macho and one in which it can be difficult to admit to having problems (Finnegan, 1997). Deployment to operational areas of conflict (Black et al, 2004) and psychological adjustment to operationally linked traumatic events is very demanding (Scott and Stradling, 1992). The pace of military operations and the number of tours place a strain on families both as a result of the soldiers’ absence and by their re-entry into family life (Britt and Dawson, 2005; Tarn, 2006; Dandeker et al, 2008; Norton-Taylor, 2008). Wessely (2005) has predicted that overstretch and the increasing number of deployments, with the adverse affect on family life and wellbeing, will be a more significant cause of MH problems than conventional psychiatric disorders including PTSD. Finally, sources of stress can be viewed from the perspective of those who join the Army for inappropriate reasons. Young men who enlist from dysfunctional families (Patterson, 2002) or have a history of childhood abuse (Bagley and Ramsey, 1986) may join the Army as a means of escaping from their situations (Busuttil, 2010). At the recruitment stage, the Army’s assessment procedures may not identify the types of problems experienced by these young men; the men themselves may not realize the extent of their difficulties or that they actually have problems. It is only when the demands of Army life begin to accumulate that these young men cannot cope and begin to seek out pathways to discharge.

**Common military mental health problems**

It is important to acknowledge that all soldiers, depending on the level of stressors they face, have a breaking point (Wessely, 2005). However, serious mental illness is rare in the British military. The majority of service personnel do not experience MH problems. Approximately 1600 soldiers leave each year on medical grounds but only 150 of these are because of MH problems (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 and Greenberg, 2009). To date, research from recent conflicts has not indicated a significant increase in operationally-linked problems and rates of PTSD have remained relatively low (Finnegan et al, 2007; Jones et al, 2008; Iversen and Greenberg, 2009; Iversen et al, 2009; Fear et al, 2010) even though in the media, ‘there has certainly been an epidemic of stories about PTSD’ (Wessely, 2005: 461). US studies have indicated that operational tours, since the commencement of Gulf War 1 in 1991, have had a negative MH impact on troops (Black et al, 2004; Hoge et al, 2004). This contrasts with a UK study that concluded that well motivated British troops, fighting in low intensity conflicts, were not negatively affected in large numbers by combat stress reactions and that troops generally do well (Hacker-Hughes et al, 2005), and ‘there are those for whom active service remains the best thing that ever happened to them’ (Wessely, 2005: 459).

UK studies have also indicated that MH problems were not associated with involvement in hostile exchanges with enemy forces and so, were not the major reason for operational evacuations. Turner et al’s (2005) Iraq War II (2003) study indicated that 68% (N=79) of MH evacuees were non-combatants, and that their evacuations were attributed to environmental, separation and inter-personnel difficulties. More recent studies have shown that operational referrals for MH problems are most likely to result in diagnoses of adjustment disorders, mood disorders and cases where it was not possible to assign a diagnostic category owing to the medicalization of normal reactions to difficult circumstances; very few cases of PTSD were identified (Jones et al, 2008). In addition, there does not appear to be an epidemic of psychological disorders once soldiers return from operations; few reports of MH problems among returning soldiers were directly attributed to a deployment (Jones et al, 2008).

**Defence mental health services**

For soldiers to function effectively it is essential that they are provided with the tools to help them manage their emotions. Consequently, the UK Ministry of Defence (MOD) invests a significant amount of time, effort and money in aiming to provide an effective occupational MH service that is accessible, readily available and appropriate 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 maximizing the psychological support offered to service personnel through the provision of immediate MH support with the expectation that they will return to duty as soon as possible. Numerous performance indicators (PIs) have been instigated to demonstrate that the DMS provides a measurable effective service; monitoring whether urgent MH referrals were assessed within one working day, routine referrals within 20 working days and when necessary that a hospital bed was identified within 4 hours. These PIs have been achieved in 95% of occasions, which indicates an exceptional standard of service provision, reflected in a satisfaction survey where 93% (N=284) of soldiers rated their MH services highly (Finnegan and Finnegan, 2007).

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 through reintegration 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. There are also specific policies and measures in place to address problematic issues such as alcohol abuse. For those nearing the end of their careers, there is resettlement training, and MH support available for late onset MH problems that emerge after discharge from the forces.

The remainder of this paper focuses on research into the views of MH practitioners in the Army MH Services (AMHS) regarding the benefits of serving within the British
Army. These results are drawn from a much larger study that explored and critically analysed factors leading to depression within the British Army (Finnegan, 2011).

Method
The research sample was drawn from 61 AMHS personnel with five or more years’ AMHS clinical experience, as they were capable of providing reliable detail of how a soldier’s world functions, particularly in differing peacetime and operational settings while existing within the military ‘family’. This depth of occupational knowledge may not have been obtained from a similar sized non-clinical military cohort.

A grounded theory approach was selected (Silverman, 2005), and data was gathered through semi-structured interviews conducted by the first author. These commenced in July 2006, with respondents providing detail on aspects of army life including military ethos, operational experience, help-seeking behaviour, stigma and team cohesion. Each participant was interviewed once only because geographical limitations restricted the opportunity for repeated meetings. All interviews were digitally recorded and transcribed by the first author, and continued until saturation was achieved in August 2007 (Charmaz, 2006). The first author’s experience in the AMHS provided a familiarity with both the phenomena and the clinical and military nuances of language.

Nineteen AMHS personnel agreed to take part. Interviews lasted between 32–63 minutes and produced nearly 14 hours of information. The mean age of respondents was 42 years, with a median of 42 years and a mode of 47 years. Seventy-nine percent (n=15) of the respondents were male and 21% (n=4) were female. In terms of clinical background 84% (n=16) were nurses and 16% (n=3) were consultant psychiatrists. The mean and median number of years in the MOD was 20 years, mode of 16 years, and 95% (n=18) had been deployed on an operational tour of duty, with the mean being 3.6 tours and the median and mode being 3 tours.

Informed consent was obtained as required by UK guidelines (Central Office for Research: Ethics Committee, 2005); ethical approval was provided by the Ministry of Defence (MOD) Research Ethics Committee.

Findings
The data indicated that there were measurable benefits associated with employment within the British Army. Five key themes were identified: respondents’ views of their service and the soldiers they serve, measurable benefits of Army life, rewarding the team player, a caring and supportive organization and excellent medical and MH support. Presentation of the findings is intended to protect the anonymity of respondents by coding their responses, for example AA, BB, and no further information is provided.

Discussion
Respondents’ views of their service and the soldiers they serve
Participants perceived the AMHS as a capable, multidisciplinary clinical organization, providing soldiers with a medium for sharing problems, while providing recognized treatments such as cognitive behaviour therapy (CBT), and acting as the soldiers’ advocate. All interviewees had experience of treating disorders such as adjustment reactions, and responded to serious risk issues, such as a soldiers’ capability to handle a live weapon. Participants recognized that the service differed from civilian practice by providing an occupational MH service that made recommendations regarding a soldier’s suitability for service, while assuming that soldiers with MH problems would return to work. Consequently, they may inform the chain of command of a soldier’s condition while assisting units to address MH issues. The majority 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 recognized that they only assessed soldiers’ experiencing MH problems:

‘I think it’s difficult because being in mental health you can get a very skewed vision of a lot of the guys.’ CC

Measurable benefits of army life
All recruits wishing to join the Army undergo a MH assessment, and those with severe MH disorders were screened out during the enlistment/commissioning process, and not allowed to join. This process alongside physical and medical assessments meant that soldiers were fitter than the national average and reduced the presentation of MH disorders:

‘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.’ FF

After enlistment, military life impacted on all aspects of a soldier’s existence, and financial incentives provided significant measurable benefits: guaranteed employment, good regular income, an excellent pension and ample annual leave. Reasonable housing was available and improved as the soldier progressed in rank. Soldiers were well fed, clothed, had access to 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 opportunities to develop an employment profile, enhanced by internal and external educational opportunities. The Army provided status and recognized 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 them. Army doctrine is enshrined within an ethos of strong team ethic rather than individual performance, and once recruits have enlisted/commissioned, the Army begins to shape them to best meet this doctrine. This remoulding leads to enforced restrictions that impacted on personal control, but many soldiers were said to welcome this, especially those who preferred to be directed:

‘I think, the transition from no boundaries to boundaries is one of the very positive things the Army does for people who come from pretty poor backgrounds.’ EE

The Army promotes group cohesion, through employment, tasks, uniforms and symbols, offering stability, camaraderie and homogeneity; achieved through social bonding, living in close proximity and projected in a strong allegiance to their unit. The Army thereby provided a protective community based on shared values, experiences, and socializing. This was enhanced when recruiting from local areas, and through overseas postings, when a whole unit deployed together, providing a better infrastructure for support. This bonding could be extremely rewarding, as CC explained, giving a ‘sense of belonging, a feeling of worth’ and team players did very well; soldiers learnt to depend on and trust their colleagues. Nevertheless, units could and did accommodate introverted personnel. The result was a workforce of predominately young fit men who were extremely proud of the job they performed, who had a sense of belonging within the organization, and prioritized fighting for colleagues above political aims: and would go to extraordinary lengths to demonstrate their loyalty, even dying for each other.

‘Cause most of the boys, again go back to xxxxx, 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.’ FF

The Army rewarded personnel who made an effort, where soldiers were given responsibility, allowing them to cultivate and demonstrate their strengths, and the majority thrived regardless of their background. For those from underprivileged parts of the country or from dysfunctional families, even abusive childhoods, the Army could provide an escape route, offering a previously unknown stability and preventing young men from entering a life of crime:

‘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.’ CC

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.

Care and support

Participants stated that, contrary to popular perceptions, the Army was generally a very supportive, caring organization, especially to senior personnel, and should a soldier incur hard times or MH problems, the Army were more responsive than civilian employers: 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 who’s 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 problems such as alcohol misuse, participants reported a positive progressive shift, owing to better education. There were many examples of excellent units, with strong and fair leadership, and Commanders who were fully versed in the MH of their troops, and there was early identification of vulnerable personnel, and problems were caught early on. Smaller, more technical units in particular, such as the Army Air Corps, Royal Artillery and Royal Engineers, provided very good support. Fully engaging with the soldier’s family, especially with younger inexperienced staff, was beneficial. Stability gained through extended periods in one location, fewer disruptive postings and allowing personnel to influence where they served also helped. 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 a soldier with a compassionate posting. The end result was an extremely loyal and committed workforce, who did not feel stigmatized or weak:

‘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.’ NN
Medical and mental health support

When appropriate, soldiers were encouraged to seek formal medical support for themselves but a small number were referred for MH assessment as a result of a third party intervention, such as being directed by the chain of command. These paternalistic interventions could prove effective, beneficial and supportive, especially when the soldier had no insight into their problems or no understanding of what the Army Medical Services (AMS) could offer. Those aware of the care available respected the service, and when they had a problem, accessed help voluntarily. This help-seeking trend was said to be owing, in part, to their Army training that had taught them to be fit for task, in both mind and body:

‘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...’ FF

Soldiers are aware of 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. To the civilian population, the AMS can seem an intolerant, tough organization but soldiers are assessed and treated much more quickly than in civilian practice. Flexible treatment protocols administered by practitioners who understood their clientele meant that sick leave was often avoided. Consequently, a MH problem need not affect a soldier’s career, with soldiers receiving care before they reached crisis or self-harm, and most were retained in the Army. Everyone was treated equally, irrespective of rank, although practitioners recognized that senior personnel could find it difficult to access support. The majority of participants stated that soldiers were not concerned about medical confidentiality, even in sensitive cases, and when medical information was provided back to the unit the soldiers agreed to the disclosure:

‘I think a lot them will not care whether their unit knows or not. 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 very often will have a very good working relationship with their chain of command’ LL.

The important things was that:

‘Patients are confident that medical 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’ NN

Limitations

The lead author’s role as a recognized 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.

Conclusion

Significant numbers of predisposing factors 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 recognized factors leading to depression can reduce mental illness, and if these problems are attended to within an appropriate multi-layered assessment, 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 enlist 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 recognized 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.

Conflict of interest:
Alan Finnegan and Robin Simpson are serving within the AMS. The views expressed are those of the authors, not the MOD.

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