Remembering the veterans

Phil Boyes with the second in our series for budding writers (see p.929)

As I write, the 'Concert for Heroes' is on BBC1. This event marks the nation's appreciation of those who have served (veterans), and those who continue to serve in Her Majesty's Armed Forces (HMAF). Events such as this concert, regular media discourse, images of the Afghanistan campaign and the high-profile work of the forces charity 'Help for Heroes', encourages public support and government investment in services for serving and former personnel.

However, with the Afghanistan campaign drawing to a close, maintaining such support and investment may become difficult when veterans' issues have dropped off the public agenda, and media interest has moved on. This will have process and structural implications for the public and private sector organisations that provide services to veterans. It also provides a rationale for developing services today, to meet the demands of tomorrow's veteran population.

Veterans are a unique service-user group, who, due to the intensity of experience in service life, have poor help-seeking behaviours, or present with a range of comorbid mental health problems (Omerod, 2009). Here I would like to provide an insight to veterans' mental health problems, and describe my own recently developed group intervention. I speak as a veteran and Psychological Wellbeing Practitioner.

Before continuing, there is a risk that – through a discourse centred on needs – veterans may be perceived as a vulnerable and needy group. This is not true. Think of veterans such as the Olympian Dame Kelly Homes, or the explorer Sir Ranulph Fiennes, or even my own example of moving from 'educational write-off' at school, to first class honours graduate in psychology. Being in HMAF can be beneficial for many people, and veterans can be very successful in their civilian careers.

Some, though, will experience problems that require the assistance of the NHS, which is responsible for the treatment of the 20,000 people leaving HMAF every year to become veterans (DASA, 2008). In addition, current speculation over defence cuts, and plans to discharge those deemed medically unfit (who may have been injured in combat), mean there is likely to be a sudden surge in the veteran population in the next few years.

How many of these veterans will require psychological services? It's a difficult question to answer, due to the lack of a national data recording procedure, and veterans' reluctance to seek help (Snell & Tusaie, 2008). However, the 2007 launch of six community mental health pilot schemes for veterans will help illuminate prevalence rates, if the evaluation process recommends the service be rolled out nationally (Ministry of Defence, 2008).

Why soldiers are poor help seekers for mental health problems is a question worthy of a separate article, but themes of stigma prevail (Omerod, 2009). Reasons *for* help seeking are cited as difficulty coping with anger, and pressure to attend from the veteran's partner (Snell & Tusaie, 2008). This last point would indicate single veterans are perhaps at extra risk.

Amongst those who do not seek help, the suicide rate is worrying. There are suspicions that suicide rates amongst veterans of the Falklands Conflict outnumber those killed in action. As for the first Gulf War, where 16 British lives were lost, 175 veterans have recorded suicide or open verdict deaths. The Ministry of Defence (MOD) claim this figure is not statistically significant, compared to an in service comparison group of those not deployed to the Gulf of 158 deaths (DASA, 2010). However, there is a danger here of making post-hoc links, and each tragedy should be individually examined before attributing 'being a veteran' as a cause of death.

There is little doubt, however, that veterans can become service users. After a sustained period of peace-keeping, combat and humanitarian operations over the past three decades there is reason to believe that this service-user group will only grow in numbers. But do these veterans need dedicated services, and what should those services provide?

The first step could be screening. Thomas Richardson (The Psychologist, Forum, August, 2010) suggests screening all returning service personnel for PTSD. Whether screening on immediate return

references

Frueh, B.C., Hammer, M.B., Cahill, S.P. et al. (2000). Apparent symptom overreporting in combat veterans evaluated for PTSD. *Clinical Psychology Review, 20*(7), 853–885.

Defence Analytical Services and Advice (2008). *UK Defence Statistics 2008*. Retrieved 20 September 2009 from www.dasa.mod.uk

Defence Analytical Services and Advice (2010). *UK Defence Statistics 2010*. Retrieved 12 September 2010 from www.dasa.mod.uk

Grey, N. (2007). PTSD: Treatment. In S. Lindsay & G. Powell [Eds.] *The handbook of adult clinical psychology* (3rd edn). London: Routledge.

Jenkins, R. (2008). *Social identity* (3rd edn). Abingdon: Routledge.

Ministry of Defence (2008). *The nation's commitment: Cross-government support to our armed forces, their families and veterans*. London: The Stationery Office.

NHS (2010). *Military mental health*. Retrieved 12 September 2010, from tinyurl.com/3xnw3co

Omerod, J. (2009). Working with military veterans. *Psychiatry, 8*(8), 325–327.

Snell, F. & Tusaie, K.T. (2008). Veterans reported reasons for seeking mental health treatment. *Archives of Psychiatric Nursing, 22*(5), 313–314.

from a combat theatre would result in false positives requires further investigation. It may be more beneficial to screen for depression, anxiety, and substance misuse symptoms, as well as PTSD, six months after returning from operations, and certainly prior to discharge from HMAF. Figures show PTSD to have a 75 to 90 per cent comorbidity rate with affective, substance abuse and other anxiety disorders (Grey, 2007). Figures for in-service personnel show 1384 cases of adjustment disorder, 738 cases of depression and 180 cases of PTSD (NHS, 2010). Therefore, questions always need to be asked about which condition is the primary diagnosis, and whether any assumptions have played a part in achieving that diagnosis.

Assumptions arise when a mental health practitioner categorises the veteran as a member of the group 'veterans', which includes the representation 'veteran = PTSD sufferer'. Such an assumption might then influence the questions asked, the way they are asked, and which responses from the veteran the practitioner picks up on. Would this assumption result in confirming the practitioner's hunch that the veteran was suffering PTSD?

Frueh et al. (2000), think so, finding that PTSD symptoms are over-reported in the veteran population. They suggest that veterans maybe 'seduced' into over-reporting their symptoms in order to assume the role of veteran that they thinks the practitioner expects them to play, or has assigned to them due to categorisation.

Assuming a role is explained by Henri Tajfel's social identity theory, a theory which can aid the practitioner in conceptualising the veteran's problems. The practitioner needs to be aware of the within-group identity of what it is to be a veteran, and not interact with the veteran based on their own perception of the veteran as a member of the category of veterans (see Jenkins, 2008, for a comprehensive discussion of the differences between these two concepts).

Constructing a strong self-esteem boosting identity as a member of a powerful, professional army, a 'Band of Brothers', is a necessity in military training where the emphasis is on team building, working and leading. The unique interdependent environment of working, playing and resting together, as part of a self-sufficient community, reinforces this identity. Often amongst different (and sometimes hostile) communities, it is easy to see how service personnel can have difficulty adjusting to a much more varied independent civilian community. If social identity is a construct of similarities and differences (Jenkins, 2008), then veterans leaving a community of strong similarity for a community in which they perceive themselves as different may suffer damage to their self-esteem and thus be at risk of developing mental health problems such as adjustment disorder, depression and anxiety.

Hence, through the theory of social identity, a target of cognitive behavioural treatment is identified; changing the core beliefs and behaviours of 'being different' into self-esteem boosting beliefs and behaviours of being similar, belonging and participation.

In addition there are certain 'traditions and customs' in service life that are contrary to good mental health. I recall standing on parade as a young soldier and being inspected by my sergeant major, who, critically looking me up and down, bawled: 'Boyes! Were you drunk last night?' 'No, Sergeant Major,' I quivered, not calling him Sir as he had previously informed me that he worked for a living and so was not a Sir. 'Why the fuck not?' came the serious reply.

So, how best to provide services to veterans, and what should those services provide? My own NHS Trust (Tees Esk and Wear Valleys NHS Foundation Trust) provides an integrated veterans' service under the leadership of Consultant Clinical Psychologist Symon Day. This model consists of staff who are veterans, or who have received veterans' familiarisation training; learning what it is like to be part of the group and not the categorisation, working in each service team. Whichever team a veteran is referred to, a veterans' champion will be on hand to facilitate the veteran's journey through, and participation in, our services.

In addition, I have recently developed a psycho-education self-help Veterans' Wellbeing Group, informed by social identity and cognitive behavioural therapy. This group targets the common presentations of veterans; anger, anxiety (including social anxiety), depression, substance abuse, as well as having guest facilitators providing guidance on employment and training. It also consists of a social identity module called Managing the Military Identity, which helps the veteran focus on similarities rather than differences. We develop self-esteem boosting identities, and facilitate the veteran's integration into civilian life. Those veterans who present with PTSD symptoms are referred on for assessment and trauma work with a specialist veterans' trauma clinician.

Does it seem contrary to suggest that veterans need help in adjusting their military identity, but then propose a group treatment? Well, the aim of this group is to firstly encourage help-seeking, which I hope to achieve by having a service-user specific service. Secondly, we aim to address the common presenting problems of veterans so that they may be able to protect and improve their mental health. Thirdly, having a group will facilitate mutual problem solving.

Of course, an integrated service model and psycho-education group by themselves will not tackle poor help-seeking behaviour. What is needed for this service-user group, and other poor help-seeking groups, is a paradigm shift from the traditional medical model of referral – patient feels unwell, goes to the doctor, is referred to a specialist service. We need a model that embraces a proactive marketing approach, that lets the veteran know there is a service available, which the veteran can access by self-referral. Establishing and publicising services like this now will, I believe, pay dividends in the future as the veteran service-user population grows, but the funding and publicity shrink.

Phil Boyes *is a Psychological Wellbeing Practitioner with Tees Esk & Wear Valleys NHS Foundation Trust*
Philip.Boyes@tewv.nhs.uk

Calling 'new voices'

This section of *The Psychologist* is where we give space to new talent and original perspectives. We are looking for sole-authored pieces by those who have not had a full article published in *The Psychologist* before. The only other criteria are that the articles should engage and inform our large and diverse audience, be written exclusively for us, and be no more than 1800 words.

The successful authors will reach an audience of 48,000 psychologists in print, and many more online. And as if that wasn't enough, the best contributors to 'New voices' will receive free membership of the Society for a year.

So get writing! Discuss ideas or submit your work to jon.sutton@bps.org.uk.

Dr Jon Sutton
Managing Editor, The Psychologist