Understanding Military Culture for Clinicians: Implications for Clinical Work

Dr Sara Melly, Cons. Clinical Psychologist, Defence Clinical Psychology Service
Sgt Darren Bambridge, Queen Alexandra’s Royal Army Nursing Corps
Aims for today

- Increase delegates’ appreciation of features of military culture which can impact on clinical work
- Give information about mental health difficulties experienced by armed forces personnel & what support is offered during a military career
- Order of presentation will mirror progress of a soldier through their career
- Help increase delegates’ confidence in interacting with armed forces personnel, veterans & their families
Knowledge, experience & confidence in dealing with military and ex-military personnel

Exercise in 4 parts:

1. Rate yourself
2. Share briefly with others – Groups different, or similar levels of experience
3. Begin to explore what is Military Culture?
4. What is different about being in or having been in the military?
Differences

- More than a job - 24/7, short notice deployability
  - Communal living
  - Social group
  - Identity
  - Housing… but that is more than just having house provided…

- Impermanence – 2 or 3 year postings, separations, lack of usual social support network

- May never have navigated – own accommodation, having to find a GP, dentist, plumber, electrician etc. Decisions about where to live, when to eat etc.
Why is it important to consider military culture?

- Shared understanding forms a basis for therapeutic relationship
- Conversely, not feeling understood = barrier to engagement
- Assumptions – of person, of job, of nature of problems:
  - Not all combat related PTSD!
  - E.g. Expecting oneself to be perpetually strong can be a weakness.
Presenting Problems

- Alcohol misuse
- Depression
- Anxiety disorders
- OCD
- Eating disorders
- Post trauma reactions – PTSD, anger, feeling cut off
- Anger, violence – domestic violence
- Drug misuse
Facts & Figures

- Prevalence/incidence of different problems
  - Alcohol
  - Common mental health disorders
  - Trauma
- Kings Centre for Military Health Research (KCMHR) Cohort Study – approx. 10% of UK military personnel deployed to Iraq
- Phase I = interviewed between 2004-2006
- Phase II inc. ‘replenishment from deployment to Afghanistan, interviewed 2007-2009.’
Facts & Figures 2

- **Phase I:**
  - Alcohol: Deployed = 30% > Non-deployed = 25% >> general population.
  - PTSD: Deployed = non-deployed = 4%
  - Combat role = 7% > deployment = 4%
  - CMD: Deployed = non-deployed = 15%

- **Phase II: 2007-2009**
  - PTSD, alcohol misuse & general MH rates remained stable
  - More deployments correlates with better MH outcomes
Avoid biased perception: only a minority will have significant difficulties.

But…it does depend on interpretation…


- Main finding = 64.3% men, 49.4% women in armed forces were reporting 8+ on AUDIT = hazardous drinking; compared with 33.2% men & 15.7% women in civilian populations.
Who is most vulnerable?

- Regulars v Reserves v Veterans?
- More deployments v fewer deployments?
- Younger v older?
- Male v female?
Why? Answer 1 – Recruits

- Vulnerabilities
- Background, demographics, social circumstances pre-enlistment, etc
- High rates substance misuse
- Abuse and neglect in childhood
- Definition of veteran
- Vulnerable early service leavers
Why? Answer 2 Training & conditioning

- Role & training & being in the military
- Each man or woman has a role to play
- Laying down your life for the guy next to you and expecting the same in return.
- Honing resilience
Training & conditioning *continued*

- Positive Mental Attitude – If you try hard, you WILL succeed!
  - Reluctance to pass problems up CoC because response is work harder, longer.
  - Leaves one vulnerable when faced with impossible demands.
- Faulty syllogistic reasoning - If $X$ then $Y$; not $Y$, therefore not $X$
Role, Training, Being in the Military

- Expectations – codes etc
- Video – Fothergill
Competing, Rank-Forming Mentality

Compassion Focused Therapy - Deborah Lee 2008

- Distress insensitive
- Low sympathy
- Competitive
  - Get ahead, exert control
  - High judgement
  - Concern with what others think, relative power/abilities
  - Submissive-assertive behaviour
  - Distress intolerant, vigilant to error and failure
  - Social comparison
Hierarchical Organisation

Ranks
- Exercise
- Discussion

Organisation
- See flipchart
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<thead>
<tr>
<th>Corps &amp; Regiments</th>
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<tr>
<td><strong>Royal Armoured Corps</strong></td>
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<td><strong>Army Air Corps</strong></td>
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<td><strong>Royal Regiment of Artillery</strong></td>
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Queen Alexandra’s Royal Army Nursing Corps

Queen Alexandra’s Royal Army Nursing Corps (QARANC) nurses have worked at the sharp end of military life throughout the last century. Nursing Officers, Nursing Soldiers, Healthcare Assistants and Student Nurses of the QARANC deliver a high quality, adaptable and dedicated nursing care wherever the Army needs it.

Army nurses and healthcare assistants can find themselves working in a variety of settings. These can vary from NHS hospitals with military units, to ground based environments such as medical regiments and field hospitals.

QA personnel deal with a wide range of medical situations, with civilian and military patients in the UK, to military casualties of war and conflict. Work locations vary between clinical roles, instructional positions at training bases and other interesting jobs such as recruiting.

Currently Army nurses are based and deployed in the UK, Germany, Cyprus, Canada, Poland, Brunei, Nepal, Kenya and Sierra Leone.

What are we?
PROTECTING OUR NATION'S INTERESTS
ROYAL MARINES
3 Squadron

Badge:

On a monolith, a cockatrice - approved by King George VI in September 1937. The cockatrice was chosen because in mythology it was the first creature to fly.

Motto:

Tertius primus erit - The third shall be the first. This is a reference to the fact that No 3 Squadron, RFC, was the first to be equipped with heavier-than-air machines.

Key Dates:
Why? Answer 3

- Experiences
- Deployment v non-deployment
- ‘front line’ v rear/support roles
- Traumas
  - Loss
  - Responsibility
PTSD – The Perfect Storm

- Pre-trauma vulnerabilities including early life trauma
- Role expectations
- Trauma experiences often including loss, guilt etc
- Resulting in problems – perceived weakness
- Likely loss of role, identity, protective environment etc.
Support & Medical Treatment in Service

- Improved access / understanding of mental health
- Still significant barriers to effective engagement
- TRiM
- Occupational health system
- DCMH referrals
- Treatment & problems associated with treatment
- Murrison period follow-up
Confounders to treatment

- Stigma – increased in theatre
- Stigma
  - Internal
  - External
- Guardedness/under-reporting
- Normalised (hyper)-vigilance
- Career implications
  - The school trap
  - Downgrading
End of Career

LOSS
- of role
- of identity - “lesser”
- social group
- housing
- income
- Structure to career
Impact on Clinical Work

- Language
  - TLAs
  - Nicknames
  - Less obvious appropriations of words
Language

- CONTACT
- REPATRIATION
- MINIMISE
- BIFF
- HERRICK
- CHALLENGER
- HESCO
- OC
- IED
- TELIC
- BOSS
- WARRIOR
- FULL SCREW
- IDF
- RPG
- SANGAR
- SECTION
- BRIGADE
- UNIT
- 5 & 20s
- MERT
- KIA
- FOB
- AFGHAN
Attitudes & Expectations: Perceptions of Military Culture

- Aggression
- Bullying & harassment
- Sexism
- Sexual assault
- Disapproval of militarism (& disillusion)
Impact on Clinical Work

- Emotionality
- Risk
- Directive approach
- Peer support
Review of Ratings & Evaluation

- Re-rate confidence & understanding
- Questions, feedback and evaluation

Thank you