

Service families: a new perspective for the general practitioner

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SUMMARY. *The psychological problems among the dependants of armed servicemen presenting to general practitioners are discussed, with particular emphasis on how the peculiarities of service life contribute to their aetiology and presentation. Within the UK, primary health care for service dependants is increasingly being provided by National Health Service general practitioners who have no knowledge of service life. An understanding of this minority group with its different lifestyle and subculture is important for management of these disorders.*

Introduction

AT a seminar for general practitioners who looked after service dependants at a nearby army barracks the author was surprised at the poor knowledge that many civilian doctors had about service life. This is likely to be a deterrent to effective management of these patients and indeed many general practitioners mentioned the difficulties they face dealing with service families. The end of national service has meant that for the new generation of doctors life inside the barrack gates is a mystery. The purpose of this paper is to open these gates a little and allow a brief glance inside. Coming from a service family, and having served two years as an army general practitioner in Germany before entering psychiatry, the author feels able to speak knowledgeably on this issue.

A recent publication by Jolly¹ shows that the essential features of military life are common to all three armed services. The problem can best be approached by studying it under three separate headings: population; lifestyle; and culture.

Population

Most soldiers leave the army by the age of 40 years, so service wives are usually young. Service families tend to have a higher than average number of children, usually of toddler or young school age. A significant minority of wives are foreign-born, especially German, and may well resent being in the UK which to them represents a 'foreign posting' with none of the compensations that might usually accompany an overseas tour for UK families. Their children too might have spent much of their early life abroad, and find the UK strange.

Although this article refers throughout to servicemen and their families, it should be remembered that a significant minority of service personnel are women, who are provided with the same level of comprehensive medical care as their male colleagues. However, only a minority of servicewomen are married, usually to servicemen themselves, and very few such couples have children. For practical purposes, therefore, a service family will be linked to the military through the husband.

Lifestyle

Life in the armed forces requires soldiers to move at frequent intervals, which in military jargon is called 'turbulence'. Servicemen receive a posting order to move on average every 15 to 19 months. This necessitates a change of school for their children and rupture of the family's social contacts. Although ameliorated to some extent by the military system, a posting still constitutes a major stressful life event. Some families overcome this by staying put and not accompanying the soldier. However, this really only substitutes one problem for another, as separation can lead to difficulties within the relationship.

Service families spend considerable time away from their relatives, even when posted in the UK. This denies them a useful network of support with which to meet the usual family crises and they may therefore gravitate at this time towards their local medical facility.

As well as living far from relatives, in an area not necessarily to their liking, service families also have to endure frequent temporary absences by the husband. Because present defence commitments and economic stringencies require servicemen to fulfil more than one role, many soldiers can expect to be away from home for two to three months each year, sometimes in short unpredictable periods. This can lead to psychological difficulties. Morrice and colleagues² reported psychological distress, described as the 'intermittent husband syndrome', among the wives of Aberdeen oil-field workers. Symptoms were particularly prevalent just before the departure of the husband, and also on his return when many women found it hard to re-adjust their role and give up many functions they had shouldered adequately during their husband's absence. The problem is even more acute for a soldier's family, since his departure on exercise or operations may be unpredictable, the date of his return is uncertain, and the soldier himself may need a period to unwind after active service.

Contrary to popular myth, service families are not immune from financial problems. Jolly¹ mentions how social workers can be surprised at the volume of work generated from service bases where the male unemployment level is zero. Some service families receive supplementary benefits. Servicemen pay full commercial rates for heating and electricity, and their rents are not cheap. Fewer service wives obtain regular full-time employment than their civilian counterparts, because of the reluctance of employers to train such a nomadic workforce. Servicemen and their wives are as keen as anyone else to own their own home but find it difficult because they cannot rely on the income from two salaries.

Living in Ministry of Defence 'married-quarters' brings its own difficulties. The worst aspect of living in such accommodation involves the ritual handing back of the property at the end of a tour, the so-called 'march out'. During this process the property is subjected to a ruthless scrutiny. Any deficiencies or defects are subject to a financial penalty. The author has seen cases of anxiety neurosis precipitated by the ordeal.

Culture

There is no predominant personality type among military families. Almost the only common factor is that a significant percentage of servicemen and their wives themselves come from service families. There is a general agreement among those with

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service experience that the profession of arms is more than a job, it is a way of life; Jolly¹ documents well how many service wives feel they have not only married a soldier, but the army as well. To some extent, service life has its own culture, separate from the rest of society, rather like other minority groups. Kleinmann² emphasized how culture not only shapes the way an illness presents, but also the way it is perceived.

Presentation of psychological distress

Figure 1 refers to one possible model of classifying the way in which a patient presents psychological distress, based on the work of Pilowsky.⁴ The commonest method employed by service families is shown. Since the armed forces all emphasize physical fitness and actively encourage sport and stamina training, it is only natural that psychological distress should present in physical terms. This is the 'acceptable' sick role. However, symptom production is unconsciously motivated, since with conscious motivation it might be perceived as malingering, which in a service environment has a powerful taboo and could attract sanctions. This may explain why the Munchausen syndrome (a mental disorder in which the patient persistently tries to obtain hospital treatment for a non-existent illness, first described by Asher⁵) is rare in the armed forces. Not surprisingly, therefore, it can be difficult to get patients to discuss readily the underlying causes of their somatization.

Attitudes to chronic problems

Problems that become chronic are poorly tolerated by the armed forces. The forces try to be as self-contained as possible, and aim to provide services to meet most needs. On a base you will find a paymaster to give financial advice, a NAAFI shop, and an estate warden to administer and repair the houses. The same dedication given to logistic support in battle is applied to family welfare, but sometimes the reductionist approach to problem solving can be counterproductive. The common military expression 'get it sorted' reflects a rather naive assumption that every problem has a solution, and that a problem only becomes a chronic one if it is either not taken to the appropriate agency, or the appropriate agency is dragging its heels. Clearly, if this assumption is applied to chronic disease or to intricate psychosocial difficulties (as it is), then patient dissatisfaction can all too easily arise. By a similar argument, it is easy to understand why servicemen and their families are overly willing to consult medical advice for minor problems at all hours.

Confidentiality

An underlying anxiety frequently mentioned by civilian doctors caring for service families is the fear by these families that approaching the army for help through official channels (which includes the army medical services) will result in a loss of confidentiality which might then adversely affect the husband's career. Therefore difficulties of a sensitive nature are sometimes kept closely guarded by individual families, thereby hindering effective intervention. In fact confidentiality (be it medical or otherwise) is given great importance in the armed forces, and regulations exist to guard against its loss. Guidelines on medical confidentiality are issued to all serving doctors, and these are frequently subject to revision. The current guidelines have the approval of the General Medical Council, who recognize that the service medical officer is in a special position with dual responsibility to the needs of the service as well as the welfare of his patients. Nevertheless, there are very few occasions when a service medical officer is permitted to break medical confidentiality. The majority of these are in situations where a similar dilemma confronts a civilian practitioner, as for example in a case of suspected child abuse. The service medical officer is, in some respects, in a stronger position, since he will have firm

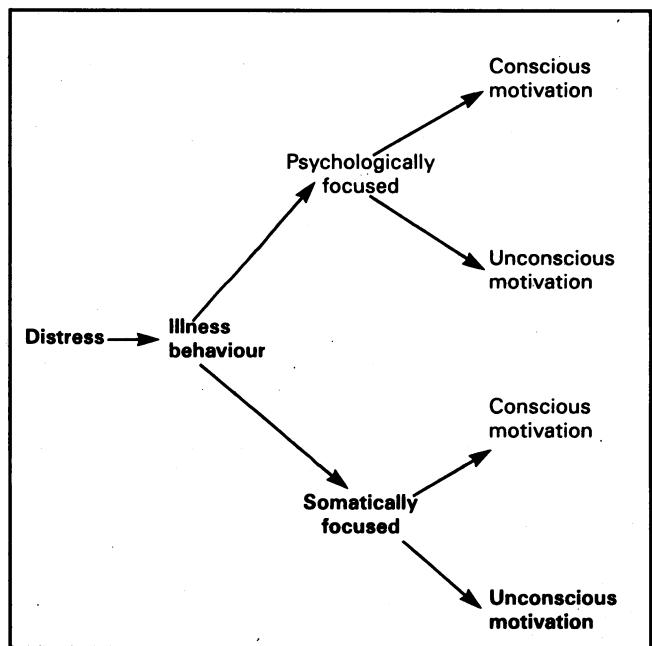


Figure 1. Model of presentation of psychological distress (from Pilowsky⁴), showing the usual pathway of symptom production among a service population.

guidelines as to whose attention he should bring such information. In general this is always the commanding officer of the unit, and such information must be the minimum required, and should be passed verbally and in private. The care with which such information is subsequently handled is subject to further strict regulations. It might, however, be added that, for the more mundane welfare problems for which a breach of medical confidentiality is not permitted, the unit administration often already knows about the situation owing to the close nature of the community.

Provision of medical aid

A service family can present to a civilian general practitioner in a number of different settings. First, while staying with relatives at home on leave. Secondly, where the medical care for service families from a nearby base is provided by the local civilian general practice. In these situations it is often the case that the base medical facility looks after just the service personnel, but it should be remembered that on some UK military installations total medical care for the serviceman and his family is provided. Moreover on overseas stations this is invariably the case. Thirdly, where all medical care, including that of the uniformed personnel, is provided through the local civilian practice, but this arrangement is not common.

Psychological disorders

The psychological disorders to which service dependants are prone have been usefully summarized by Wawman,⁵ and more recently investigated by O'Brien.⁶ They become more comprehensible if the above mentioned lifestyle and cultural factors are borne in mind.

Neurotic depression

Young wives of servicemen are particularly vulnerable to neurotic depression. Brown and Harris⁷ have shown risk factors to include having no job, three or more school aged children, and no close confiding relationship, for example, with their husband who is frequently absent. It is important to be alert to the risk of deliberate self-harm and postnatal depression.

Anxiety neurosis

Service dependants will frequently present with multiple somatic complaints.

Adjustment reactions

Adjustment reactions occur in service dependants because of the high frequency of stressful life events owing to new postings. Generally these disorders are short-lived, but the frequency of the disruptions encourages adverse coping strategies, including alcohol abuse.

Childhood disorders

The frequent dislocation of a child from his or her settled environment can predispose to enuresis, school refusal and behaviour disorders. A six year old boy may only wet the bed when his father goes on an exercise. Parents have the additional worry of paying for any resultant mattress stains.

Atypical bereavement reaction

A military population is a young one in which death in peacetime is uncommon. An unexpected death can provoke uncomfortable images of personal vulnerability in war. Some soldiers said after the Falklands conflict 'I never joined the army to go to war'. The word death is rarely mentioned among military men, being generally substituted by a jocular synonym. A family who have sustained a loss may be living far from relatives and, after a spell of compassionate leave, will be expected to return to the base where their neighbours will not necessarily have known the deceased. Expectations that the bereaved 'should be over it by now' will be high, and the opportunity for a full and complete expression of grief may be thwarted.

Alcohol abuse

Historically the soldier has always been regarded at high risk for alcohol abuse. With cheap alcohol readily available abroad, together with long periods of solitude, the soldier's wife has become increasingly vulnerable too. Many women drink considerably more than the Royal College of Psychiatrists⁸ safe guidelines of two units of alcohol per day. It makes sense for the general practitioner always to ask him or herself to what extent alcohol abuse is involved in any problem.

Management

The medical management of psychological disorders will follow conventional lines, but as is so often the case, environmental manipulation will be necessary and may hold the key to the solution. A principal difficulty here is the need to reassure a wife that making use of the available agencies for help will not necessarily damage her husband's career. On the other hand, calling a soldier back from a deployment to sort out recurrent domestic crises could damage his chances of promotion, and should be avoided where possible. It is therefore a good idea to establish links with the nearby service medical officer responsible for the care of the servicemen. This allows the general practitioner to break free from the constraints of having influence over the health of only half the family. The regimental medical officer (RMO as he is known in the army) will have a good knowledge of current problems in his unit and will have access to various army welfare agencies that may not be known to civilians, that is social workers and health visitors employed by the Soldiers, Sailors and Airmen Families Association (SSAFA), Womens Royal Army Corps (WRAC) welfare assistants and the unit families officer. He could also provide an introduction to the various voluntary self-help agencies that have appeared in recent times, such as the Help Information Volunteer Exchange (HIVE) centres and Home Start (voluntary home visiting)

schemes. These are funded by the Ministry of Defence but are run by service wives for service families. They are outside the chain of command, but are guided by much the same rules of confidentiality as the medical officers. These agencies provide a useful source of effective and confidential welfare back-up.

The sensible service medical officer will welcome any approach from a civilian colleague wishing to discuss a difficulty of mutual concern. Clearly this joint method of working will be helped if informal links are established first. These will ensure that the civilian practitioner is aware of what local welfare resources are available from the services, and what likely response can be expected from the local military administration to any request made for help through the service medical officer. The civilian general practitioner need not fear that some automatic administrative response detrimental to the patient will be set into motion if issues of concern are brought forward for discussion. This is because the services' administrative response to 'medical' problems relies on the advice given to the command structure by its doctors, probably to a degree not matched in civilian life. This is a potent instrument to harness for the benefit of the civilian doctor's patients. By combining resources, many problems that might have proved intractable can be overcome. Particular success can be achieved with alcohol abuse. Effective intervention with a referral of the husband to a service alcohol treatment unit by the regimental medical officer can provide great relief for a wife who may be repeatedly presenting in distress to her civilian general practitioner. Clearly some degree of liaison with the service medical establishment is essential if results are to be achieved.

Conclusion

Service dependants suffer from the usual range of psychological difficulties. However, it is important to bear in mind certain features peculiar to service life which can have an important influence on aetiology, presentation and management. There is evidence that the armed forces are becoming more aware of some of the problems of service life, and are considering ways of overcoming them. Such changes may well lessen some of the psychological problems discussed in this article. Nevertheless, it may be helpful to look on service families under one's care almost as a special minority group with a different lifestyle.

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