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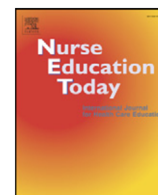

The presentation of depression in the British Army

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SUMMARY

Background: The British Army is predominately composed of young men, often from disadvantaged backgrounds, in which Depression is a common mental health disorder.
Objectives: To construct a predictive model detailing the presentation of depression in the army that could be utilised as an educational and clinical guideline for Army clinical personnel.
Method and Participants: Utilising a Constructivist Grounded Theory, phase 1 consisted of 19 interviews with experienced Army mental health clinicians. Phase 2 was a validation exercise conducted with 3 general practitioners.
Results: Depression in the Army correlates poorly with civilian definitions, and has a unique interpretation.
Conclusion: Young soldiers presented with symptoms not in the International Classification of Disorders and older soldiers who feared being medically downgraded, sought help outside the Army Medical Services. Women found it easier to seek support, but many were inappropriately labelled as depressed. Implications include a need to address the poor understanding of military stressors; their relationships to depressive symptoms and raise higher awareness of gender imbalances with regard to access and treatment. The results have international implications for other Armed forces, and those employed in Young Men's Mental Health. The results are presented as a simple predictive model and aide memoire that can be utilised as an educational and clinical guideline. There is scope to adapt this model to international civilian healthcare practice.
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Introduction

Depression is a diagnosis that acknowledges differences based on severity and frequency, and is classified as mild, moderate or severe (WHO, 2007). Depression is a dynamic disorder which can be used descriptively, based on signs/symptoms, as a reaction to an event, a reactive unhappiness and as a feeling, as a complaint of low mood. This study includes all of the above, and it is this complexity of fitting the continuous variation in depression severity into a categorical definition that poses problems to clinicians when diagnosing depression, and general practitioners (GPs) have only recognised depression in 47% of cases (Mitchell et al., 2009). This is further exacerbated by borderline cases, co-morbid symptoms and complex presentations (drug or alcohol use in tandem with low mood for example). In civilian assessment there is a high likelihood that the mental health (MH) team would utilize the Stepped Care Model to sign-post the type of intervention and treatment based on mild, moderate or severe depression. Mild may be in Step 1 (watchful waiting) or Step 2 (Self-help); whilst moderate depression may instigate a self-help programme or referral for psychotherapeutic and pharmacological management, (Step 3). Care for severe depression would be at Step 4 and include psychotherapeutic and pharmacological intervention and possibly in-patient care if required (Thomas and Drake, 2012).

Literature Search

Young Men's Mental Health

Depression is a common Military Mental Health (MMH) disorder in the British Army (Iversen et al., 2009) where the majority of personnel

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are fit, young, strong white men. These men are often recruited from socially deprived areas of the UK (Dandeker et al., 2008), living away from home and with a large expendable income. This is an important assessment criteria regarding history-taking as early childhood experiences coupled with impact experiences such as military conflict and dependence on alcohol or drugs to manage psychic distress which are well-known precursors to depression (Ross, 2012). Within the UK, this is a group whose mental needs are often neglected and under-researched (Conrad and White, 2010).

Depression in the British Army

There are numerous biopsychosocial factors that may influence the onset of depressive disorders, and any significant alteration in a person's lifestyle or new demands may cause stress and influence the ability to function (NHS Choices, 2012a). How individuals' respond will depend on their coping mechanisms. MH difficulties originate from social interactions and responses to the environment, which for the military are contextually influenced by peacetime and operational settings.

The lead author completed the first in depth exploration study of depression in the British Army (Finnegan, 2011). The findings indicated that depressed army personnel presented with a variety of problems with the most common related to family issues, relationship problems, and occupational stressors (although not battlefield linked) irrespective of rank, age and gender (Finnegan et al., 2007). Up to 50% of these young, junior ranked, male soldiers accessed the Army Mental Health Services (AMHS) because they wished to leave the Army but could not due to the terms and conditions of service. This sample group was also positively linked with self harming ideology (Finnegan et al., 2010a). Their help seeking behaviour often appeared to be dependent on personal gain and they were neither clinically depressed nor concerned by MMH stigma. Operational factors were most commonly reported by senior non-commissioned officers, aged 30–33 years old. The stressors associated with an operational deployment could lead to soldiers presenting with symptoms that could be misdiagnosed as a MH problem such as Post Traumatic Stress Disorder (PTSD), particularly where soldiers were experiencing a temporary adjustment reaction. However, the mounting number and sheer intensity of deployments resulted in exhausted, worn out personnel. These multiple stressors that influenced the onset of depression in the Army were absorbed into 4 major clusters; predisposing factors, maintaining/precipitating factors, secondary coping mechanisms and help seeking behaviour. There were further explainable in relation to contextual differences of peacetime and operational duties; and the provision provided by the Army Medical Services (AMS), Departments of Community MH (DCMHs) and Unit Command and how these influences could either enable or inhibit access to clinical support. These are presented schematically in Fig. 1 (Finnegan et al., 2010b).

Female Soldiers

Despite the fact that the majority of army personnel are male, with a significant number accessing AMHS, female soldiers were significantly more likely to attend for a MH assessment and to be admitted to hospital for a MH disorder. They were also more prone to being diagnosed with depression and stress reactions. It would appear than women were less affected by stigma, and found it easier to seek support because they were more self aware, emotionally expressive, and better at confiding in each other. However, they might also have felt alienated in a male dominated society, and in particular it was single women in this context that struggled (Finnegan et al., 2010b).

Symptoms

In this research, 317 soldiers completed a cross sectional survey and detailed their presentation against depressive symptoms (WHO, 2007; NICE, 2009) with the option to insert other symptoms. The most commonly reported were low mood, followed by sleep disturbance and loss of confidence, with 31% reporting self harming ideology. National Institute for Clinical Excellence (NICE) Guidelines for Depression (2009) provide GPs with direction for management and treatment, yet soldiers reported symptoms not included within WHO diagnostic

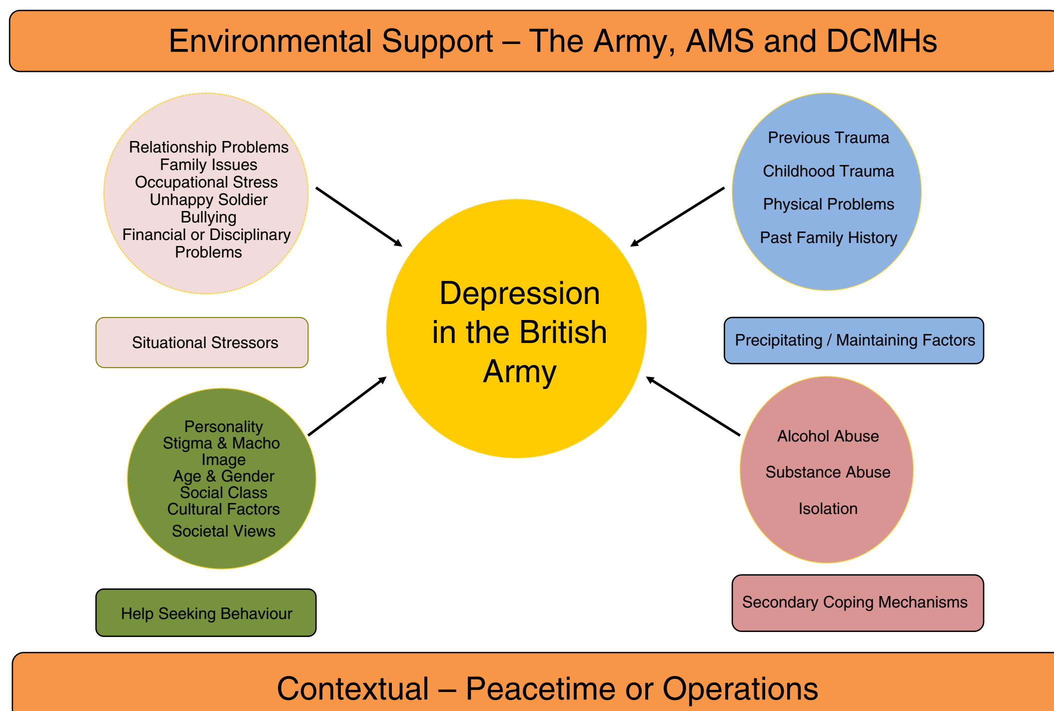

Fig. 1. Major influences leading to depression in the British Army.

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