OCCUPATIONAL PSYCHIATRY AND THE FEMALE VETERAN EXPERIENCE: THE ROLE OF SISTERS IN SERVICE

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Supporting Women Veterans in Healthcare

CASE STUDY

Laura, a 34-year-old former British Army combat medic, served in Afghanistan as part of a Female Engagement Team (FET), where she trained and operated as a high-risk searcher. Her role involved searching Afghan women and children during counterinsurgency operations. Her role placed her in frequent proximity to traumatic scenes, including the aftermath of improvised explosive device (IED) attacks. She witnessed catastrophic injuries, and mass casualties, often while under direct threat herself.

Though she performed her duties with professionalism and resolve, these experiences left lasting psychological scars. After leaving the military, she noticed growing symptoms of post-traumatic stress including nightmares, flashbacks, hypervigilance and emotional numbing. She delayed seeking help, instead deciding to focus on establishing her civilian identity.

Determined to continue serving others, Laura enrolled in a university nursing programme. During her obstetrics and gynaecology placement, however, the sight of blood began to trigger vivid flashbacks of battlefield trauma. Her PTSD symptoms resurfaced, now compounded by fear of professional failure, and she considered leaving her course.

INTERVENTION AND SUPPORT: ROLE OF SISTERS IN SERVICE

Laura connected with Sisters in Service, a peer-led organisation supporting women veterans in the NHS. The support process included:

- **Peer Mentorship:** Matched with another veteran-turned-nurse who had similar service experiences, offering understanding, guidance, and psychological safety.
- **Signposting to Therapy:** Encouraged and supported in accessing trauma-focused therapy via a veteran-friendly service.
- **Armed Forces Network Integration**: Introduced to her NHS Trust's Armed Forces Network, fostering belonging and access to tailored occupational health support.

OUTCOMES

With ongoing peer support and professional therapy, Laura was able to remain in her nursing course and adapt her placement to a less triggering environment while her recovery progressed. She later completed her training and now works in community health, where she uses her lived experience to advocate for trauma-informed care.

CONCLUSION

Laura's story highlights the critical importance of culturally competent, gender-aware occupational support for female veterans. Organisations like Sisters in Service bridge the gap between military and NHS life, helping those navigating trauma to continue their path in caring professions.

LITERATURE REVIEW

This case highlights several important themes in occupational psychiatry, particularly concerning veterans transitioning into NHS roles:

Trauma Reactivation in the Workplace: Laura's re-exposure to sensory stimuli resembling those from combat, such as the sight and smell of blood, illustrates how specific workplace environments can inadvertently trigger trauma responses in staff with a history of PTSD, especially those with combat or medical field experience in the military. Unlike acute stress reactions, these responses may be delayed or context-specific, complicating recognition and support.

Gendered Experience of Military Trauma: Female veterans often have distinct deployment roles, such as FET duties, that place them in proximity to trauma while also navigating gender-based barriers to recognition and support. Studies consistently show that women veterans are at higher risk of developing PTSD compared to male veterans, even when accounting for similar trauma exposure. Contributing factors include differences in trauma processing, exposure to military sexual trauma (MST), and internalised distress. Women veterans may not present with typical PTSD symptoms, increasing the risk of underdiagnosis or misattribution to anxiety or mood disorders.

Dual Identity Stress: The shift from military to civilian roles involves both cultural and psychological adaptation.The loss of structure, camaraderie, and defined hierarchy can create disorientation, while new roles (e.g. student nurse) may lack the clarity, authority and recognition veterans are accustomed to. Female veterans may face added pressure as they transition into traditionally caregiving roles, such as motherhood or healthcare careers, which can conflict with their previous identities and exacerbate mental health difficulties.

Barriers to Help-Seeking in the Workplace: Veterans may be reluctant to disclose mental health struggles in professional settings due to fear of stigma, perceived weakness, or potential career implications. In Laura's case, her initial response was to suppress symptoms and persist in her placement, highlighting the need for psychologically safe workplace cultures that normalise mental health support.

Importance of Trauma-Informed Occupational Support: This case underscores the necessity of trauma-informed occupational health practices, particularly for veteran staff. Awareness of military backgrounds, open access to peer support, and tailored mental health services (such as veteran-specific pathways) can reduce attrition and promote recovery.

Peer Support as a Protective Factor: Mentorship from someone with shared lived experience provides a unique form of validation and hope that traditional clinical models may not replicate. In Laura's recovery, peer support not only helped normalise her experience but also restored a sense of belonging and professional identity.

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