Scientific Journal of the Military University of Land Forces
ISSN: 2544-7122 (print), 2545-0719 (online)
2021, Volume 53, Number 1(199), Pages 5-20
DOI: 10.5604/01.3001.0014.8106

Original article

Social support for veterans

Beata Czuba

Faculty of Logistics, Safety and Management, Military University of Technology, Warsaw, Poland,
e-mail: beata.czuba@wat.edu.pl

INFORMATION

Article history:

Submited: 08 May 2020

Accepted: 29 June 2020

Published: 15 March 2021

ABSTRACT

The article aims to outline how mission-traumatized veterans perceive social support. Social support is an essential resource for an individual in coping with the difficulties in everyday life. The subject of the examination is quantitative research with veterans' participation and own qualitative research – free interviews analyzed using the IPA (Individual Phenomenological Analysis) method. The obtained results indicate that social support can be considered in terms of a meta-resource that activates other vital resources of humans, thereby strengthening them in difficult situations. The expected support criteria are met by friendly self-help groups that can operate in military units and complement the help provided by professionals.

KEYWORDS

social support, veterans, trauma, stress management, resources

Introduction

Social support is considered one of the essential resources in coping with stress. Its importance increases in the event of a life crisis, disease, or adaptation difficulties caused by post-traumatic stress. Veterans[1] returning from overseas missions are a group of people that were particularly exposed to traumatic situations. Many of them returned to the country with severe physical and mental injuries, especially after missions in Iraq and Afghanistan, where they took part in regular hostilities. Psychological injuries sometimes show up many years after the mission ended. This postponed – "dormant" – trauma mechanism makes war

[1] According to the Veteran's Center for Overseas Missions, there are currently 22,500 veterans in Poland, of whom 787 are injured veterans (data as of October 21, 2019). The definition of a veteran is contained in Art. 2 of the Act of August 19, 2011 on veterans of activities abroad: "Art. 2. A veteran of operations outside the state, hereinafter referred to as a "veteran", may be a person who, on the basis of a referral, participated in activities outside the state as part of: 1) a peacekeeping or stabilization mission, a police contingent, a Border Guard contingent, protective mission of Government Protection Bureau or state security mission, continuously for the period for which he or she was referred, but not shorter than 60 days; 2) a rescue group of the State Fire Service, in total for a period of not less than 60 days". Act of August 19, 2011 on veterans of activities abroad (Journal of Laws 2011 No. 205, item 1203) [Ustawa z dnia 19 sierpnia 2011 r. o weteranach działań poza granicami państwa (Dz. U. 2011 Nr 205, poz. 1203)].

stress a dangerous weapon that reveals its destructive face years later. Veterans, who have been injured and seriously injured, face new existential challenges. A certificate of disability may be, and most often is, a barrier to continuing a military career. The few veterans with the status of victims[2] are appointed to positions specially created for them, where they can remain in active service, but they perform different duties than before when they were fully healthy. Those who go on a disability pension are forced to look for a new identity and meaning in life. Sometimes injuries during missions mark the soldier's existence and his/her family forever. Things get even more complicated when the veteran experiences difficulties, such as symptoms of traumatic stress disorder or other adaptation problems, and hides his/her ailments for fear of stigmatization.

The veterans' stories included in the interviews (own research) and quantitative research carried out by the Military Bureau of Social Research (WBBS) show that in a crisis after a war trauma, help from the closest family is not the only and expected form of social support [1, p. 245-248]. The perception of support and specific expectations resulting from the type of injury are very important (e.g., the need to buy a good-quality prosthesis, stay in a specialist psychotherapy center, specialist medical assistance). It determines whether the relationship with a person or institution will be treated as helpful, valuable, bringing the desired quality of life to a person experiencing difficulties.

Most of the social research involving veterans is quantitative [See: 2-5]. They allow describing certain aspects of soldiers' functioning in interpersonal relations, but do not provide insight into the subjective interpretations of the meanings that soldiers give to these interactions. Quantitative research does not answer why some types of support are more expected and valued than others. Therefore, qualitative research is needed to understand the world experienced by the respondents. The qualitative approach enables understanding veterans' needs, motivations, and emotions in relationships with other people.

The subject of the research described in this paper is the social support experienced by veterans. The research problem presented in the article is: "What character should social support have to be perceived by the recipient of the aid, in this case – a veteran, as valuable and expected?". The hypothesis formulated for the purpose of this analysis is as follows: "Social support is perceived as expected when a veteran's relationship with a person or institution satisfies his/her need for affiliation, acceptance, and respect, and responds to specific material needs enabling a dignified existence". Understanding the perception of support by people experiencing difficulties after trauma may help train participants of self-help groups operating in the local veteran community, e.g., military units. It can also provide the veteran's family members with knowledge about what makes others' presence have a "supportive relationship" quality.

[2] The Act on veterans, in its Article 3, defines the injured veteran: "Art. 3. A veteran injured in actions outside the state, hereinafter referred to as the "injured veteran", may be a person who, taking part in actions outside the state on the basis of a referral, suffered a health impairment as a result of an accident related to these actions or of a disease acquired while performing tasks or official duties outside the state, for which he or she has been awarded compensation benefits". Act of August 19, 2011 on veterans of activities abroad (Journal of Laws 2011 No. 205, item 1203) [Ustawa z dnia 19 sierpnia 2011 r. o weteranach działań poza granicami państwa (Dz. U. 2011 Nr 205, poz. 1203)].

1. Previous research on social support

Social support in times of erosion of trust and low social capital of Polish society seems to be a fundamental, significant problem in many research contexts of sociology, psychology, pedagogy, and medicine. Individualism strengthening itself as a cultural value inspires a new view of the importance of interpersonal relationships. They often become less vital than the individual's needs – their independence, the right to decide about themselves, and satisfy their needs. What is social support in a world where people increasingly often go alone through life, and if they enter into relationships that, at least in assumptions, are to be more permanent, these turn out to be superficial, unreliable, and irreparable? The circumstances of modern human life, called by Zygmunt Bauman "fluid modernity", relativize identity and undermine the durability of interpersonal relationships: "Fluid life passes or rolls from challenge to challenge and from episode to episode, and the challenges and episodes in nature are generally short-lived" [6, p. 15]. "The fragility of social ties is a significant, or rather defining, feature of fluid modern life. The clear fragility of social ties and the frequency with which they are severed serves as a constant reminder of the mortality of human life" [6, p. 81].

Social support is analyzed in the context of its relationship with health and stress. The relationship between social support and health has been the subject of numerous studies and elaborations since the early 1970s. Social isolation – lack of support – was included in the essential pathogenetic factors [7-21].

Since the 1980s, researchers have focused not so much on building universal, general theoretical models that would explain the mechanism of the support operation, but on analyzing its significance in specific circumstances of an individual's life, bearing the hallmarks of a difficult situation – traumatic stress, unemployment, work stress, disease (patients who have AIDS, cancer, etc.), and adaptation to the new environment [22, p. 7-8; 23-25].

In scientific deliberations on social support, there is a criterion of sub-division into structural and functional support. Structural support is objectively existing social networks that a person can use, both in difficult situations and in the usual circumstances of life. There is a bond between the units that make up the network, interpersonal relationships take place, they have a sense of belonging to a group that can be a source of help. In this approach, it is important to belong to certain groups or networks that potentially constitute a reservoir of support. Objectively existing networks can be treated in terms of sources of support or resources that an individual has. Information on the sources of support is obtained by asking the person whom they can count on in difficult situations (family, spouse, children, friends, professional helpers, e.g., medical staff, psychotherapists, superiors, clergymen, etc.) [26, p. 14-16]. Some researchers distinguish social support systems, which include:

– Family,
– Self-help groups and volunteers,
– Organizations and associations, called intermediate systems,
– Social welfare institutions,
– Health care institutions,
– Educational institutions,
– Economic institutions [27, p. 15].

Support described in the functional paradigm is understood as an interpersonal relationship characterized by specific properties. It is a qualitative approach that uses subjective indicators, such as support perception, adequacy, and availability. The relationship of support

can be in the dyad, between an individual and a group, or between groups. Its essence is the transmission or exchange of information, emotions, or material resources. In a support relationship, one can indicate a recipient, donor, or a person seeking or receiving support. The purpose of the interaction is to reduce stress, meet the need to belong, have support in other people, increase the sense of security, and solve the problem [26, p. 18].

According to B. Dudek and J. Koniarek, the third theoretical approach to support focuses mainly on the way the recipient experiences it. The authors claim that social support is a person's cognitive trait: "their sense of being supported by others, which arises through experiencing specific acts of help and/or kind gestures from others" [28, p. 428]. Perceptual support can be divided, depending on its content, into emotional (empathy, love, kindness, etc.), instrumental (material help of practical importance in solving a problem, coping with stress), informational (information useful in coping with difficulties), and evaluating (information enhancing self-esteem or facilitating the creation of social comparisons) [28, p. 428]. In the perspective of sociological research, social support is analyzed in the context of social integration, ties with significant people and groups, institutional resources, as well as social networks and exchange networks [24, p. 15-24].

Given the functional aspect of the support, one can distinguish perceived and received support. Perceived support is the entirety of knowledge and beliefs possessed by an individual, from whom help can be expected and the extent of its availability. Received support is an objective or subjective assessment of received aid, including – its adequacy [26, p. 20-21].

There is no consensus among researchers regarding the explanation of how social support works. The hypothesis of the buffer effect and the main effect are not sup-ported by all studies. Some results also show negative effects of social support [28, p. 430]. For example, families using social assistance for a long time become utterly dependent on it. Parents' learned helplessness is inherited by successive generations – beneficiaries of social assistance. In response to these problems, in search of a more effective social support formula, the idea of deinstitutionalization is currently being developed, consisting in organizing a support network in the local environment [27, p. 24-28].

One of the explanations for the mechanism of the impact of social support is the main effect hypothesis. Its essence is the assumption that social support is always beneficial for a person. It is a resource that generally strengthens the individual and can be used in various life circumstances. The awareness of belonging to a group, satisfying the need for affiliation, positively affects well-being, strengthens the ego, and improves well-being.

The buffering hypothesis offers another explanation. In a stressful situation, social support acts as a buffer to neutralize the negative impact of the stressor. Support can be compared to a shield that alleviates the "glaring" strength of stressors, or to a prism that allows perceiving new, positive meanings in a problematic situation. Support may change the assessment of the situation by an individual, who then more easily perceives the possibilities of coping with difficulties, assesses threats and losses as less severe, and more often perceives them in terms of a challenge that can be overcome. The moderating effect of social support may also consist in noticing resources that are useful in solving the problem (for example – own competences, increased sense of agency, etc.) [26, p. 24-28].

A person subjected to extreme situations such as participation in a war, cataclysm, catastrophe, mental and physical violence, traffic accident, imprisonment, sexual harassment, killing, seeing people killed, etc., may suffer trauma that leaves a permanent negative effects in the form of Post-Traumatic Stress Disorders (PTSD). These events differ significantly from normal

stressful life events, causing physical and mental trauma [29, p. 258]. According to H. Sęk, the way of reacting to trauma depends on many factors:

1. The nature of the traumatic situation is significant – lost resources, type of physical trauma suffered (for example, permanent disability), harm experienced by relatives, duration of the trauma.
2. Dispositional factors (individual features) – personality, resources used in coping with stress, age, health, sensitivity.
3. Environmental conditions after trauma – support networks, the attitude of the social environment to the traumatized person, prejudices, stigma [29, p. 261].

The criteria for the diagnosis of Post-Traumatic Stress Disorders include three groups of symptoms that persist for at least a month and seriously impair a person's functioning:

1. Persistent images of trauma (recurring images and/or thoughts, unpleasant memories, nightmares about the trauma, experiencing flashback, anxiety and stress attacks in trauma-like situations).
2. Avoidance of stimuli associated with trauma (conversations, thoughts, places, people), difficulties with recalling important information about the traumatic situation, loss of motivation to act, emotional coldness, and distance towards people.
3. Disorders resulting from constant, strong vegetative agitation (problems with falling asleep and the duration of sleep, irritability, anger, difficulties in controlling negative emotions, increased vigilance, inadequate fear reactions, problems with concentration) [29, p. 259].

The mechanism of PTSD development refers to the hypothesis of emotional overstimulation and the cognitive hypothesis. The over-excitation hypothesis implies that all organisms need a certain level of nervous system activation to function effectively. Very high-intensity stimulation is unfavorable for the body – it damages neurons and impairs the functioning of memory and adaptation abilities. This phenomenon is called excitotoxicity. It is believed that in the case of people suffering from PTSD, trauma causes damage to the brain areas responsible for the control of the emotions of fear and the integration of traumatic experiences with existing cognitive structures (beliefs about reality) [30, p. 62].

Another explanation of PTSD disorders – the cognitive hypothesis – refers to the human belief system about the surrounding world, people, and himself/herself. These basic assumptions about reality include the attitude that the world is safe are predictable, and other people are kind. War experiences, such as killing, threatening one's life, seeing a massacre, other people's suffering, cause dissonance with the well-established representation of the world and oneself; a human is unable to include them in the cognitive system. Soldiers often cannot reconcile contradictory beliefs and experiences that undermine their value system, the image of themselves as a person capable of killing, the image of other people as cruel and threatening, which is manifested by disturbances in the emotional, cognitive, and social sphere [30, p. 63-64].

Quantitative social research conducted on veterans of overseas missions of the Polish Armed Forces by the Military Bureau of Social Research (WBBS) allows, among other things, assessing the respondents' perception of social support. The research report as mentioned earlier[3] concerns the issues of social consequences of serving soldiers in missions abroad [5]. The WBBS conducted a survey in 2014 on a sample of 689 mission participants. The selection

[3] This is the most recent WBBS study conducted with the participation of veterans.

criterion for the sample was the service on a mission for at least one month in the perspective of the last 5 years. Most respondents (93%) were participants in the mission in Afghanistan.

The obtained results indicate that almost all soldiers experienced traumatic situations during the mission. Nine out of ten respondents mentioned a real threat to their lives. Most of them also indicated such traumatic situations as: shooting at people, being under fire, as well as seeing killed and injured civilians and colleagues.

Because of being in traumatic situations, soldiers indicated more frequent occurrence of such symptoms as aggressive behavior and irritability, difficulty sleeping, increased consumption of alcohol and sedatives, and difficulties in communication with family and loved ones. Emotional problems and behavioral disorders appeared with a delay of 6 to 36 months after completing the mission and returning to the country [5, p. 7].

From the respondents' reports it can be concluded that most of them could count on the social support of their families and assessed it as effective. Mission participants also experienced help from colleagues and people outside the military environment. In the opinion of 3/5 respondents, support also came from superiors and psychologists. Half of the respondents said that doctors helped them. Every third respondent was supported by clergy.

3/4 of the veterans indicated that they had received emotional and informational support. More than 50% mentioned material, practical, and spiritual support. The respondents appreciated most the emotional support, manifested as showing them concern, interest, and the opportunity to talk about their experiences. More than half of the respondents were not satisfied with the received material, in particular – instrumental (practical), support. People who declared having a small group of people who could support them, more often than veterans belonging to the wider social network, used the psychological help. Every eighth survey participant benefited from psychological or psychiatric help. Psychological help provided before the mission was assessed the best, during the mission it was worse, and the worst – after the mission. Veterans believe that the use of a psychologist's help is risky because it can have negative consequences in the professional and personal spheres, for example, prejudices of superiors and colleagues, loss of job, or negative opinion of family and friends. Every eighth respondent thinks that the psychological care system works poorly and that psychologists are not well prepared to fulfill their function. 1/3 of the respondents claimed that soldiers did not need a psychologist's help because they were mentally strong [5, p. 8-9].

2. Methodology of own research

The purpose of the analysis below is to present the way in which traumatized war veterans perceive social support. It was assumed that the most optimal method of obtaining data would be free, partially structured interviews with soldiers who had at least one experience of staying on an overseas mission and have veteran status. Purposeful sampling was used (snowball method). The selection criterion for the sample was having veteran status by the respondent.

The subject of the analysis is the experience of social support by veterans. The research problem formulated in relation to the subject of research took the form of the question:

"What conditions should be met by a veteran's relationship with a person or institution to consider it as the expected social support?".

The choice of the research method was dictated by the finding of a small number of studies on the perception of social support by veterans of the Polish Armed Forces, including a few

qualitative analyzes [See: 31, p. 13-26]. The research approach contained in the article refers to phenomenology [32] and symbolic interactionism [33, p. 51-52; 34]. Interpretative Phenomenological Analysis (IPA) assumes that "people do not perceive reality passively, but rather tend to interpret and understand their own world, creating biographical stories that give meaning to the experiences" [35, p. 225]. I. Pietkiewicz and J.A. Smith describe the essence of this method as follows: "IPA researchers try to understand, from the perspective of the subject, what an experience (an object or an event) is; in parallel, they also attempt to formulate critical questions about the material: What is the person trying to achieve by this? Was anything significant said here that was not intended? Do I have a feeling that something is happening here that the examined person is not fully aware of? IPA research may, therefore, contain elements of both types of interpretation, thus making the analysis richer and more comprehensive" [36, p. 362].

The author's intention was to reach the subjective meanings given to their own experience by the respondents.

To answer to the research question, the method of partially structured interviews was used. According to Pietkiewicz and Smith, "A partially structured interview enables the researcher and participant to communicate in real time. This type of interview allows flexibility and leaves room for the possible emergence of original and unexpected threads in the conversation, which the researcher can explore with further in-depth questions" [36, p. 364]. Thirty-two soldiers or former soldiers with the status of veterans and injured veterans participated in the project. Twenty-seven interviews were used in the analysis[4]. The interview included questions about:

1. Motivation to participate in the mission.
2. The duties of a soldier on a mission, its course, logistic conditions.
3. Any injuries and the type of assistance received immediately after the event and later.
4. Ways of dealing with the difficulties of life after returning from the mission.

The interviews selected the respondents' statements regarding their relationships in the work environment, in the family, and interaction with representatives of institutions (e.g., non-governmental organizations helping veterans, health care institutions, the Ministry of National Defense, etc.). These statements were interpreted according to the following criteria:

1. Who is seen as a support/assistance provider?
2. What is the support?
3. Is this action in line with the veteran's expectations?
4. What are the functions of support in the process of coping with the difficulties of life?
5. Who does not provide support when it is expected?
6. What is the lack of support?
7. What are the consequences of the lack of support for the process of coping with the difficulties of life?

[4] Five interviews – with two injured and three non-injured veterans – were not used in the analysis due to the lack of confirmation that these persons consented to the publication of their statements.

3. Empirical analyzes

Own research on veterans was conducted in 2016. The semi-structured casual interview technique was used. The respondents were recruited for interviews using the "snowball" method. The Association of Injured and Victims in Overseas Missions proved to be helpful in this process; the author was invited to a canoeing trip with the participation of veterans and psychological workshops for veterans and their families. The author also made contacts with mission participants with veteran status, who attended an English language course at the War Studies University. In the examined sample, consisting of 32 veterans, 18 respondents had the victim's veteran status, 12 people – veteran status, 2 people applied for the victim's veteran status at that time. The largest group – 10 people – was in the age range 31-35, 9 people – 41-45, 6 people – 36-40, 2 people – 51-55, and 2 respondents were older than 60. 1 respondent represented the age range of 56-60 years, 1 – 26-30 years, and 1 – 46-50 years. Most often, soldiers took part in missions in Iraq – 10 indications and in Afghanistan – 19 indications. 4 people were on a mission in Kosovo (KFOR), 2 on a mission in Lebanon (UNIFIL), 1 in Egypt (UNEF), 1 in Bosnia and Herzegovina (IFOR), 1 at the Golan Heights (UNDOF), and 1 in Croatia (UNPROFOR). Non-commissioned officers prevailed in the study sample – 23 people, 6 respondents had an officer rank, 2 respondents had a private rank, and 1 person did not provide information on the military rank. The analysis below includes 27 interviews, which were analyzed using the Interpretative Phenomenological Analysis method. Table 1 provides a numerical breakdown of the number of veterans who have experienced disease or not after trauma.

Table 1. Experiencing trauma and mental disorders

	Yes	No
Experiencing trauma	21	6
Mental disorders (PTSD and other behavioral, emotional and cognitive disorders)	15	12

N=27

Source: Own study.

In the sample of 27 veterans – mostly – participants of missions in Iraq and Afghanistan, whose interviews were analyzed, 6 people did not suffer trauma-like experiences, 21 soldiers suffered a threat to their health and life, or witnessed a threat to the life, killing or death of others people. These experiences caused permanent or temporary disturbances in emotions, behavior, and cognition in 15 people. 12 veterans did not develop any symptoms they perceived as a pathology of emotions, behavior, or cognition.

Social support was mentioned as one of the resources used in the process of coping with stress after trauma (other resources included personality traits, such as conscientiousness, high extroversion and openness to experience, low neuroticism, high level of social competences, high sense of agency, optimism, resilience, high self-awareness, sense of competence, high level of coherence).

In the introduction to the article, the following research problem was included: "What conditions should be met by a relationship between a veteran and a person or institution to consider it as the expected social support?".

Interpretation of the selected fragments of the interviews presented below is to help to answer that question. In the interview 1, the respondent describes the situation of the lack of support that he experienced in his unit from the commander. It was a landmark event that was significant for the soldier's decision to leave the professional military service.

> „He asked me who I was. I replied that I was a soldier of his unit, I was on a mission, you do not know me, the colonel does not know me, because we had no chance to see each other before my departure. Well, he asked where my uniform was. I said that I had not returned to work yet and I came for a referral [for post-mission medical examinations – B.C.] and he said such words that made me decide that I would not serve under his command […]. The commander told me I was fat. He didn't ask if I needed anything or help, but said that I was fat. He asked how it was there. I asked him, Colonel, am I to tell you honestly how it was? I said it was fucked up. He said, "What the fuck are you scaring me?" Because he wanted to go there, too. He didn't have time to talk to me, and his adjutant set up chess. They were just playing chess. And he said … he had no time to talk to me, ask if… if I needed something. Then I needed at least such a question "help you something?", "something happened?". He just treated me like… anyhow. When I left the office, I said that I would come back into civilian life […]" (Interview 1).

The veteran who says these words has returned from a mission in which one of his colleagues was killed during a joint patrol. The veteran felt guilty about his death. Shortly after the accident, he experienced the first PTSD symptoms, which developed after returning home. In the military unit, he felt a lack of interest and empathy on the part of the commander. He felt redundant and offended by his superior's dry reaction. He experienced a completely different treatment than he expected – a friendly, supportive, kind conversation, dedication of attention and time, acceptance, non-evaluation, interest, care, respect, a declaration of help in the face of the difficulties experienced. Neither of these expectations was met. The meeting with the commander deepened the feeling of inadequacy, uselessness, and being redundant. As a result, S. left the Armed Forces and has been working in the civilian profession for several years. S. found acceptance among other veterans (in the Association of Injured and Victims in Missions Beyond the Country) who understand his problems well, because they have experienced similar difficulties themselves.

> "Apart from Jola and Waldek, I didn't know anyone there, I went to the shooting range. I spent the whole day there […]. We didn't talk about our problems, what happened to us, why we were in the association. After shooting, we returned to the hotel. Some dinner, of course, later everyone went to the bar for a beer in this hotel. And, B.S. [33] came, dressed in shorts, and it turned out he didn't have a leg. The man with whom I had spent the whole day at the shooting range had a prosthesis. I felt stupid, I felt sorry. B., I think, noticed it, he came over and said: "Don't worry, everything is fine" […]. And I came back from there with such charged batteries […]" (Interview 1).

Meeting with B. and mutual empathy became the beginning of a long-term friendship. During this report, the veterans treated each other "normally". Nobody was surprised by the difference and did not emphasize it, as if it did not exist, it did not matter. What is a stigma among "normals", in the environment of physically or mentally traumatized people, different standards of mutual acceptance apply.

The next statement concerns the groundbreaking importance of meeting people with similar problems as the veteran.

> "Later, there was such a breakthrough just when I went to that veteran's house and met guys there who were surprised that I jumped out [the veteran contacted after a long time since the accident on the mission – B.C.], and the association already had a lot of people, and then suddenly I and my friend appeared, where we were also badly injured, right? And we started talking about these missions, it all came out somewhere, right? And there was strength in the group, then I felt that it was not so bad, that there were other cases. There I met another colleague, a friend, also very badly injured, then it was not very good when it comes to his mental state. Well, he saw that if one notices people like oneself, it's easier, isn't it?" (Interview 21).

It seems that it is essential, symbolic for the respondent to be aware that he has been noticed and accepted, that his case is important not only for him, but also for others. During the meeting with them, he experienced respect and understanding for his difficult situation (loss of a leg during a mine explosion, lack of a good prosthesis, problems with work, stigmatizing attitude of the social environment felt even in family relationships, etc.). It can be said that, in a sense, it was the discovery of new possibilities of existence in a world that for several years after the accident was perceived as hostile, stigmatizing, where he could not develop professionally or had a sense of inadequacy and being a worse person. As a particularly painful veteran, he perceived the expectations of the social environment concerning the explanation of the reasons why he went to war and risked the loss of his life and health. The veteran read in these questions the suggestion that he was to blame for himself and that he had become disabled "at his own request".

Many veterans experienced PTSD, some were diagnosed with PTSD while being treated in a psychiatric ward. The statement quoted below contains an assessment of the stay at the combat stress treatment unit.

> "At that time, I thought that they did not help me, but when leaving [the hospital – B.C.] I saw my problem. Generally, I was aware of this problem before I entered the clinic, but it gave me such strength, the belief that I was not alone, that there were people with similar problems, because it is the worst to accept that you are different and that you, for example, it's true for me, I would like to return to the mission at any cost. I need this adrenaline and now I look for it everywhere I can and I have these risky behaviors, because I tend to do extreme sports, for example now I do [martial arts – B.C.]" (Interview 22).

In the interview 22, the respondent appreciated not so much the professional support of the health care institution in which he was diagnosed with PTSD, but meeting people like him. Thanks to this, he gained a sense of belonging to the community of people who had experienced similar difficulties. The veteran was aware of his own problems, did not diminish their importance and the need to deal with self-destructive tendencies. Nevertheless, recognizing the existence of other-like-people strengthened him, created a completely new context in which coping with stress was not burdened with such a great sense of loneliness as before the stay at the clinic.

Another statement refers to a supportive relationship between the veteran and the colleague who could accept his unusual behavior, decline in form and manifestations of mental decompensation.

> "However, my colleague, who is my partner [the company that the veteran owns – B.C.], he was also in Iraq, he also had such dramatic experiences, he understands me, he knows when I'm losing my nerves. He knows exactly that then I will get in the car,

> go home, because I am not able to function, and, thus, he completes me. And this is the way he understands me, it is a great support for me that he understands me, that he knows that sometimes my nerves will carry me and I am not able to control myself, and I realize that I do not want to create such different situations there [aggression towards other people – B.C.], so I'd rather just turn off and go just home" (Interview 12).

A colleague from work correctly assessed how to behave so as not to escalate the partner's mental difficulties. The veteran who was fully aware of a disturbance in his own behavior appreciated the attitude and viewed it in terms of a supportive, meaningful relationship. The colleague's attitude enabled the smooth functioning of the company. It was interpreted as real material help – in the time of the respondent's indisposition, a colleague took over his duties. In this way, the continuity of the company's work was ensured and its good reputation was maintained, which was essential to meet the existential needs of the veteran and his family.

The quantitative research and the interviews cited show that veterans most often mention the support received from their immediate family. The respondent's statement quoted below indicates that sometimes the symptoms of disorders make it difficult to use this help. It happens that someone cannot accept it at all.

> "If it weren't for her [wife – B.C.] I do not know how it would have ended [PTSD, suicide attempt, aggression, self-destructive behavior – B.C.]. It could end up much, much worse. The worst thing was that she suffered so badly, but now I can see how much heart she put into it all. I slandered her, accused her, spoke badly of her. In fact, she was the only one who cared about me because… my mother cared, but my mother learned with my father…, my father is an alcoholic, in my opinion, he will never admit it. Well, I remember my childhood, there were times when he really drank a lot. And his mother seemed to indulge him, let him. It was the same in my case. She said don't do it, son, be good, sit with your family and so on and so on, but that was just talking, yeah […] It had no influence. On the other hand, the events related to my wife and her stubbornness in general, this stubbornness about this relationship, and that she fights for it. I no longer really care, even about everything. One day I realized that I didn't even care about my son and it was so horrible for me. Now it's just unthinkable that… I wanted to leave so as not to disturb them. I considered myself redundant in this hierarchy, unnecessary for anything. It certainly left the mission empty, it is a pity that there was not another one […]" (Interview 22).

A key element of the support relationship described above is the wife's persistence in helping, despite her husband's aggressive behavior and ongoing destruction of family life. Her consistent dedication and motivation were finally noticed. It took the veteran time to realize the true importance of these efforts and receive support. Accepting the help made social support a real resource for him in coping with stress.

The framework of this article limits the possibility of citing more veterans' statements relating to the support experienced in difficult situations after missions. The conclusions from the analysis of the interviews and recommendations for people and institutions supporting people experiencing difficulties after the mission are provided below.

Conclusions

Quantitative (mainly by the Military Bureau for Social Research) and qualitative research show that veterans most often see signs of support from their immediate family (spouse,

parents, siblings), other veterans, non-governmental organizations, the Veteran's Center for Overseas Missions (Ministry of National Defense established in 2011 to provide legal, psychological and informational assistance to veterans and their families), health care institutions. Furthermore, quantitative research provides information on the extent to which the support is assessed as effective. However, quantitative research does not indicate what conditions must be met for a veteran's relationship with a person, group or institution to be interpreted as truly valuable. Veterans are members of various groups. Other people are always "at hand", but sometimes relationships with them are viewed as indifferent or even hostile.

The article aims to answer the question of when the presence of others gains the quality of a "supportive relationship". The analysis of the interviews shows the picture of social support as a meta-resource that has the power to activate other resources useful in the process of dealing with the difficulties of life. To support others, it is not enough to simply be next to them. The quality of the accompaniment of the person experiencing difficulties is vital. Despite individual differences related to the coping process, in the case of veterans, some universal features of the expected attitudes of supporting people/institutions can be identified. Veterans expected support from various people and institutions – some of them preferred the help of their closest family members, others appreciated the support of health care institutions, many pointed to the support provided by other veterans or colleagues. Regardless of who/which institution offered support, based on respondents' statements, it is possible to identify features common to these various entities, thanks to which their impact was perceived as valuable, expected, and realistically changing the functioning of the person using the help for better. Table 2 allows for an orderly presentation of the criteria that should be met by the attitude of a person (institution) for their action to be considered supportive.

In this context, social support activates other human resources (listed in the right column of the table), e.g., increasing the sense of agency, self-esteem, obtaining useful information, satisfying the need for security, belonging, love, etc., which could not become available without the existence of a support relationship.

The recommendations that can be formulated from the conducted research are as follows:

The issue of social support for veterans should be the subject of further, in-depth research studies, using qualitative methods that allow to penetrate deeper into the world of the respondents, their interpretations and meanings they give to the experience.

It would be desirable to create self-help groups of veterans in military units. Social support is provided in such groups by non-professionals. An example is the Canadian Armed Forces. For veterans, peer support groups are colleagues. They focus on helping and accepting those affected by a stigma – illness, disability, or loss of important people. They are supported by people who have experienced similar problems and can share their own experience and knowledge. Self-help groups function alongside and complement the institutional system. In Poland, veteran associations play a similar role. However, not every veteran can be an association member, and even if they are, the members are dispersed, meet relatively infrequently, and therefore cannot respond to the immediate support of the needs of the veterans in their daily life.

Contrary to the union bond that binds the members of the association, self-help groups operate in the local environment; they are available and the use of assistance does not require meeting any formal criteria, and there is no need to pay for support. The idea of self-help seems to have only advantages. However, the success of this support formula in Poland depends on enthusiasts, who want to test this solution in practice.

Table 2. Features of the support relationship and resources activated in the aid recipient

Features of the attitude/actions of the person/ institution offering support.	Resources activated in the result of experiencing support
Expressing interest.	Increase in self-esteem. Strengthening the meaning of own actions (while on a mission).
Devoting time and attention.	
Non-judgmental presence.	
Expressing acceptance and appreciation.	
Expressing respect.	
Empathy.	Satisfying the need for closeness.
Patience and persistence in helping.	Increased trust in others.
Selflessness.	
Similar attitudes, experiences and problems.	Satisfying the need to belong.
Sharing information useful in solving the problem.	Obtaining material resources and instruments useful in solving problems. Increased self-awareness and the ability to make the desired changes.
Offering care for everyday activities during illness (rehabilitation).	Satisfying the need for security. Improving health. Return to fitness/independence.
Specialist medical and psychological assistance.	
Financial support	Obtaining the expected objects and conditions enabling the satisfaction of existential and self-realization needs.
Creating the possibility of undertaking the following activities: 1. Participation in social work, e.g., in legislative and organizational activities in formal bodies working to develop systemic (legal, institutional) solutions supporting veterans. 2. Lectures at schools, meetings with authors, sharing knowledge about the mission. 3. Publishing activity (publishing autobiographies, blogs). 4. Activity in the social media.	Increased sense of agency. Increased self-esteem. Building new competencies. Getting a feeling, power, sense of own actions. Satisfying the need for acceptance and belonging.

Source: Own study.

Acknowledgement

No acknowledgement and potential founding was reported by the author.

Conflict of interests

The author declared no conflict of interests.

Author contributions

The author contributed to the interpretation of results and writing of the paper. The author read and approved the final manuscript.

Ethical statement

The research complies with all national and international ethical requirements.

ORCID

Beata Czuba https://orcid.org/0000-0002-2544-6506

References

1. Czuba B. *Świat utracony, świat przeżywany. Zasoby wykorzystywane przez weteranów w radzeniu sobie ze stresem wojennym*. Warszawa: Wydawnictwo Wojskowa Akademia Techniczna; 2018.
2. *Zdrowotne i psychospołeczne skutki udziału żołnierzy WP w misjach poza granicami kraju. Sprawozdanie z badań*. Warszawa: Wojskowe Centrum Edukacji Obywatelskiej; 2010.
3. *Readaptacja żołnierzy powracających z misji poza granicami państwa. Sprawozdanie z badań*. Warszawa: Wojskowe Centrum Edukacji Obywatelskiej; 2011.
4. *Społeczne aspekty służby poza granicami kraju (na przykładzie XI zmiany PKW Afganistan). Sprawozdanie z badań*. Warszawa: Wojskowe Centrum Edukacji Obywatelskiej; 2013.
5. *Doświadczenia i konsekwencje udziału w misjach poza granicami kraju w opiniach uczestników. Sprawozdanie z badań*. Warszawa: Wojskowe Centrum Edukacji Obywatelskiej; 2014.
6. Bauman Z. *Płynny lęk*. Kraków: Wydawnictwo Literackie; 2008.
7. Barrera M. *Social support in the adjustment of pregnant adolescents: assessment issues*. In: Gottlieb BH (ed.). *Social Networks and Social Support*. Beverly Hills: Sage; 1981.
8. Berkman LF, Syme SL. *Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda Country residents*. American Journal of Epidemiology. 1979;109:186-204.
9. Calman W. *Qulity of Life in Cancer Patients – a Hypothesis*. Journal of Medical Ethics. 1984;10:124-7.
10. Chapman CR, Gavrin J. *The role of social support in the etiology of physical disease*. Health Psychology. 1988;7:269-97.
11. Glaser BG, Strauss AL. *Time for Dying*. Chicago: Aldine Publishing; 1968.
12. Hobfol SE, Lerman M. *Personal relationships, personal attributes, and stress resistance: Mothers' reactions to their child illness*. American Journal of Community Psychology. 1988;16(4):565-89.
13. Kunschbeck HW, et al. *Quality of Life in Patients with Inflammatory Bowel Disease*. Psychotherapie Psychosomatik Medizinische Psychologie. 1990;54:110-6.
14. Küchler T, et al. *Quality of Life in Oncology*. European Journal of Cancer. 1991;27:293-4.
15. Marmot MG, Madge N. *An Epidemiological Perspective on Stress and Health*. In: Kasl SV, Cooper CL (eds.). 1987, p. 3-27.
16. O'Reilly P. *Methodological Issues in Social Support and Social Network Research*. Social Science Medicine. 1988;26:863-73.
17. Parsons T, Fox R. *Illness, Therapy and the Modern Urban American Family*. Journal of Social Issues. 1952;8:31-44.
18. Procidano ME, Heller K. *Measures of perceived social support from friends and from family: Three validation studies*. American Journal of Community Psychology. 1983;11:1-23.
19. Quast HH, Schwartzer R. *Social support and stress: theoretical perspectives and selected empirical findings*. In: Schwartzer R (ed.). *The Self in Anxiety, Stress and Depression*. Amsterdam: North Holland; 1984.

20. Singer JE, Lord D. *The role of social support in coping with chronic or life threatening illness*. In: Baum A, Taylor S, Singer JE (eds.). *Handbook of Psychology and Health. Vol. 4. Social psychological aspects of health.* Hillsdale, N.J.: Lawrence Erlbaum; 1984.
21. Thoits PA. *Conceptual, methodological and theoretical problems in studying social support as a buffer against life stress*. Journal of Health and Social Behaviour. 1983;23:145-59.
22. Sęk H, Cieślak R. *Wprowadzenie*. In: Sęk H, Cieślak R (eds.). *Wsparcie społeczne. Stres i zdrowie*. Warszawa: Wydawnictwo Naukowe PWN; 2012.
23. Korlak-Łukasiewicz A, Zdaniewicz M (ed.). *Wsparcie społeczne w sytuacji kryzysowej*. Zielona Góra: Oficyna Wydawnicza Uniwersytetu Zielonogórskiego; 2016.
24. Grotowska-Leder J (ed.). *Sieci wsparcia społecznego jako przejaw integracji i dezintegracji społecznej*. Łódź: Wydawnictwo Uniwersytetu Łódzkiego; 2008.
25. Piorunek M (ed.). *Pomoc – wsparcie społeczne – poradnictwo. Od teorii do praktyki*. Toruń: Wydawnictwo Adam Marszałek; 2010.
26. Sęk H, Cieślak R. *Wsparcie społeczne – sposoby definiowania, rodzaje i źródła wsparcia, wybrane koncepcje teoretyczne*. In: Sęk H, Cieślak R (eds.). *Wsparcie społeczne. Stres i zdrowie*. Warszawa: Wydawnictwo Naukowe PWN; 2012.
27. Kondracka-Szala M. *Wsparcie społeczne osób stygmatyzowanych*. Warszawa: Wydawnictwo Difin; 2015.
28. Dudek B, Koniarek J. *Wsparcie społeczne jako modyfikator stresu – wybrane problemy teoretyczne i narzędzie pomiaru*. Medycyna Pracy. 2003;5(54).
29. Sęk H. *Wprowadzenie do psychologii klinicznej*. Warszawa: Wydawnictwo Naukowe SCHOLAR; 2007.
30. Nash W. *Przystosowanie do stresu i urazy spowodowane przez stres bojowy i operacyjny*. In: Figley ChR, Nash WP (eds.). *Stres bojowy. Teorie, badania, profilaktyka i terapia*. Warszawa: Wydawnictwo Naukowe PWN, Wojskowy Instytut Medyczny; 2010.
31. Baranowska A. *Nieformalne systemy wsparcia społecznego*. In: Maciejewski J, et al. (eds.). *Współpraca samorządu terytorialnego oraz grup dyspozycyjnych w zapewnieniu bezpieczeństwa społeczności lokalnych*. Wrocław: Wydawnictwo Uniwersytetu Wrocławskiego; 2018.
32. Schütz A. *O wielości światów. Szkice z socjologii fenomenologicznej*. Kraków: Zakład Wydawniczy Nomos; 2012.
33. Hałas E. *Interakcjonizm symboliczny. Społeczny kontekst znaczeń*. Warszawa: Wydawnictwo Naukowe PWN; 2006.
34. Babbie E. *Podstawy badań społecznych*. Warszawa: Wydawnictwo Naukowe PWN; 2009.
35. Heszen I. *Psychologia stresu. Korzystne i niekorzystne skutki stresu życiowego*. Warszawa: Wyd. Naukowe PWN; 2013.
36. Pietkiewicz I, Smith JA. *Praktyczny przewodnik interpretacyjnej analizy fenomenologicznej w badaniach jakościowych w psychologii*. Czasopismo Psychologiczne. 2012;18;2.

Biographical note

Beata Czuba – Col. (ret.), Ph.D., research and teaching assistant at the Faculty of Logistics, Security and Management of the Military University of Technology. Author of several dozen articles and four scientific monographs: *Adaptacja zawodowa kobiet* żołnierzy. *Przystosowanie zawodowe, relacje społeczne, emocje – studium socjologiczne* (*Professional adaptation of female soldiers. Professional adaptation, social relations, emotions – a sociological study*). Warszawa: Wyd. WAT; 2015; *Generałowie w Wojsku Polskim* (Generals in the Polish Armed Forces). Warszawa: Wyd. WAT; 2016; *Od zarządzania zasobami ludzkimi do zarządzania kapitałem ludzkim* (*From human resource management to human capital management*). Warszawa: Wyd. WAT; 2017; Świat utracony, świat przeżywany. Zasoby wykorzystywane przez weteranów w radzeniu sobie z *traumą wojenną* (*Lost world, lived world. Resources used*

by veterans in dealing with war trauma). Warszawa: Wyd. WAT; 2018; *Myślące posągi. Percepcja wsparcia społecznego przez żołnierzy* (*Thinking statues. Perception of social support by soldiers*). Warszawa: Wyd. WAT; 2020). Scientific interests – psychology and sociology of emotions and personality, available groups of society (mainly the Armed Forces), social security, gender.

	Wsparcie społeczne weteranów
STRESZCZENIE	Celem artykułu jest przedstawienie sposobu, w jaki weterani, którzy doświadczyli traumy podczas misji, postrzegają wsparcie społeczne. Wsparcie społeczne jest ważnym zasobem jednostki w radzeniu sobie z trudnościami życia. Przedmiotem analizy są badania ilościowe z udziałem weteranów oraz jakościowe badania własne – wywiady swobodne, analizowane metodą IPA (Indywidualna Analiza Fenomenologiczna). Uzyskane wyniki wskazują, że wsparcie społeczne można traktować w kategoriach metazasobu, uruchamiającego inne, ważne zasoby człowieka, umacniające go w sytuacjach trudnych. Kryteria oczekiwanego wsparcia spełniają koleżeńskie grupy samopomocy, które mogą działać w jednostkach wojskowych i uzupełniać pomoc świadczoną przez profesjonalistów.
SŁOWA KLUCZOWE	wsparcie społeczne, weterani, trauma, radzenie sobie ze stresem, zasoby

How to cite this paper

Czuba B. *Social support for veterans*. Scientific Journal of the Military University of Land Forces. 2021;53;1(199):5-20.

DOI: http://dx.doi.org/10.5604/01.3001.0014.8106