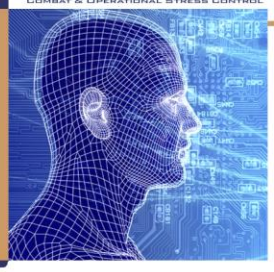

Stigma of Mental Health Care in the Military

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Overview

While anti-stigma efforts have been employed throughout all branches of the military, research shows that the stigma of mental illness in the military remains high (Hoge et al., 2004; Hoge et al., 2006). Military anti-stigma efforts include but are not limited to the following: (a) the Department of Defense's (DoD) $2.7-million campaign focused on decreasing stigma in all military branches by inviting service members to share their stories of seeking help; (b) implementation of the combat and operational stress control continuum, allowing service members to be classified as "ready," "reacting," "injured" or "ill" rather than the dichotomous labels of "ready" or "ill"; (c) the "Real Warriors Campaign" anti-stigma initiative that invites successfully treated service members to share their experiences about the effective mental health treatments available; (d) the Operational Stress Control and Readiness (OSCAR) program developed by the Marine Corps that embeds mental health professionals in infantry regiments, logistics groups and air wings to aid in early identification and treatment of combat stress; and (e) the integration of psychology into primary care settings throughout all branches of service. In addition, post-deployment mental health screenings have been mandated for all military personnel returning from combat that aim to better identify and refer to specialty care, service members who are suffering from post-traumatic stress, depression and alcohol problems. Unfortunately, many at-risk service members do not follow through with needed treatment (Milliken, Auchterlonie, & Hoge, 2007; Bray et al., 2009). Several factors influence an individual's level of stigma and resulting treatment-seeking behaviors, such as (a) attitudes of higher ranking military leaders, (b) potential repercussions of admitting to mental health issues, (c) gender, (d) marital status and (e) previous history of seeking treatment. Considering that military service members are exposed to significant traumas and other situations not experienced by the general U.S. population, it is important that these individuals believe it is acceptable to receive mental health treatment. The many factors influencing stigma and treatment-seeking behavior in the military population are discussed throughout this review.

Post-deployment Mental Health Assessments

All service members are asked to complete post-deployment mental health assessments immediately upon return and at about six months post-deployment. These assessments were implemented in order to better triage service members to the appropriate level of

care, to signify the importance of mental healthcare, as well as to de-stigmatize such issues and treatments. Some research shows that service members may be responding inaccurately on these mass surveys. For example, one study included an anonymous mental health survey that was identical to the Post-deployment Health Assessment (PDHA), (the mental health assessment given to service members upon return from deployment) (Warner et al., 2011). The only difference between the two surveys was that the PDHA was not anonymous, and responses indicating mental health issues on the PDHA resulted in a mental health referral. Results showed that soldiers reported significantly higher rates of mental health symptoms on the anonymous survey when compared to the PDHA. Moreover, 12.1% of soldiers who completed the anonymous survey (n = 207) met criteria for either PTSD or depression, compared to only 4.2% of soldiers who completed the PDHA. The overall rate of soldiers needing services or screening positive was 17.2% on the anonymous survey compared to only 6.3% on the PHDA. The same study found that 20.3% of soldiers screening positive for PTSD or depression reported discomfort and another 28.0% reported feeling "neutral" in responding honestly on the PDHA. In comparison, of those who screened negative, only 8.4% reported feeling uncomfortable responding honestly, while 18.7% reported feeling "neutral." A similar study compared two nearly identical surveys assessing PTSD symptoms in service members returning from combat deployment. One sample of service members was given an anonymous survey that had no potential to result in mental health referrals. Another sample of service members was given a survey that contained personally identifiable information and had the potential for mental health referrals. Again, results showed that scores on the anonymous PTSD survey were significantly higher when compared to that of the personally identifiable survey (Bliese et al., 2008).

Results of these studies suggest that the stigma of mental health issues in the military is still quite strong and significantly influences the accuracy of responses on post-deployment health assessments. It is also possible that the repercussions of admitting to mental health issues in the military prevent service members from responding accurately to post-deployment surveys. Some such repercussions include (a) fear that reporting mental health issues will hinder ability to take leave after deployment and (b) belief that symptoms will decrease or resolve upon return from combat (Milliken et al., 2007; Bliese, Wright, Adler, Thomas, & Hoge, 2007).

Mental Healthcare Utilization

The stigma of mental health issues not only prevents the report of such symptoms but may also deter people from seeking treatment. Research shows that many individuals suffering from mental health issues, both military and civilian, do not seek treatment

(Brown et al., 2011; Rosen et al., 2011; Wang et al., 2005). For example, one study asked service members whether they would (a) seek professional help for a mental health problem and (b) refer a trooper under their leadership whom they believed to have a mental health problem. While 66% were willing to refer both themselves and their trooper, 28% were only willing to refer the trooper, 7% were not willing to refer themselves or the trooper, and zero percent were willing to refer themselves but not their trooper (Johnston, Webb-Murphy, Raducha & Abou, 2011). Factors that have been found to influence whether service members will seek mental health treatment include (a) history of previous treatment, (b) ability to recognize that there is a problem, (c) level of impairment, (d) military branch, (e) marital status, (f) gender and (g) nature of psychological issues. For example, research shows that service members with a history of previous mental health treatment are more likely to report intentions to seek help again (Blais & Renshaw, 2013; Brown et al., 2011). Such findings may be related to an increased belief in the efficacy of such treatment. Further, exposure to mental health treatment in the past may have decreased their perception of the attached stigma. Interest in receiving help has also been associated with recognizing that a problem exists (Brown et al., 2011). Psychoeducation may be helpful for service members who are unaware of the symptoms of mental health issues. One study found that initiation of psychotherapy was related to greater level of psychological impairment but was not related to stigma (Rosen et al., 2011). It is therefore possible that when an individual is experiencing a significant amount of emotional distress, stigma is less of a concern, while feeling better is more a priority. Other research has shown that being married was related to higher likelihood of the intention to seek psychological help (Blais & Renshaw, 2013). Therefore, efforts at reducing stigma should focus strongly on unmarried service members who have no history of prior treatment.

Another (qualitative) study examined stigma and barriers to care among 21 male Vietnam veterans screening positive for military sexual trauma (MST). Barriers to MST-related treatment was coded into three main categories, including stigma-related, gender-related and knowledge barriers. Overall, stigma-related barriers were the most common theme (Turchik et al., 2013). While many of the veterans reported that men often don't want to talk about their problems or share feelings with a professional, they noted this is especially the case with men seeking care for sexual trauma (Turchik et al., 2013). Therefore, the patient's gender and the nature of the psychological distress play an important role in whether they will seek help. One study found that certain mental health care providers are more stigmatized than others. For example, a study of 163 patients presenting to four different U.K. Armed Forces Departments of Community Mental Health found that 5% preferred to be seen by a uniformed mental health professional, 30% by a non-uniformed clinician and 65% reported no preference (Gould, 2011). Further, research shows that females serving in the Royal Navy are more likely to prefer treatment from a non-uniformed clinician, while serving in the Army was related to the

preference of being seen off-site (Gould, 2011). Results of these studies show that branch of service and whether a provider is uniformed are also factors that influence stigma and decisions to seek mental healthcare in the military. However, the latter may be related to service members' concerns regarding confidentiality.

Treatment Seeking: Military Versus Civilian Populations

Research shows that avoidance of mental health treatment seeking in the military population is not necessarily different from that of the civilian population. For example, one study found that 58% of Veterans Administration patients with a recent diagnosis of post-traumatic stress disorder (PTSD) initiated psychotherapy within a year of diagnosis (Rosen et al., 2011). Of these participants, one third had completed eight or more therapy sessions (Rosen et al., 2011). Another study found that more than 75% of combat veterans who had screened positive for PTSD, depression or generalized anxiety disorder three months after returning from Iraq recognized that they had current psychological concerns. Yet, only 40% reported interest in receiving help (Brown et al., 2011). In comparison, within the U.S. civilian population, 41.1% of individuals meeting criteria for a DSM-IV disorder sought mental health treatment (Wang et al., 2005). Within a non-military sample of college undergraduates, 37% to 84% who screened positive for depression or anxiety did not receive services. Reasons for not receiving treatment included lack of perceived need, being unaware of services or insurance coverage, skepticism about the effectiveness of treatment, low socio-economic status and being Asian or Pacific Islander (Eisenberg et al., 2007). Therefore, while some might surmise that the stigma of mental health issues would be higher in the military population (due to a larger percentage of males and a culture that is expected to be tough), it seems that this is not the case.

Influence of Military Leadership

The attitude of high-ranking military leaders has been shown to significantly influence the stigma and treatment-seeking behaviors of other military personnel. One study of randomly selected active-duty soldiers from a brigade combat team who had been deployed to Afghanistan for 15 months examined the influence of non-commissioned officers (NCOs) and commissioned officers on the reported stigma and barriers to care (Britt, Wright, & Moore, 2012). While positive and negative NCO and officer behaviors were related to stigma and practical barriers to treatment, only positive and negative NCO behaviors were uniquely predictive of stigma. In addition, both positive and negative NCO behaviors and positive officer behaviors were uniquely related to practical barriers to care. Such findings suggest that military leaders who are in direct

contact with their service members (such as NCOs), are more likely to influence the level of stigma than are leaders in less direct contact with their troops (officers). Participants from another study reported that the rank, experience and overall credibility of the source (of attitude regarding mental healthcare) was essential in decreasing the stigma of mental health treatment in other military personnel. This study found that service members most respected the values and opinions of senior-level leaders who have been exposed to combat themselves (Clark-Hitt, Smith, & Broderick, 2011). Therefore, future efforts at reducing stigma in the military should begin with such high-ranking officials.

Stigmatization of Specific Types of Treatment

Some research shows that certain types of treatment are more stigmatized than others. For example, Army soldiers deployed to Iraq for at least one month between ages of 18 and 65, reported favoring one of two forms of exposure therapy (Prolonged Exposure [PE] and Virtual Reality Exposure [VR]) over medication therapy (Reger et al., 2013). Soldiers preferred PE and VRE over medication for such reasons as embarrassment or shame, concerns about career impact and perceived debasement for accessing the treatment. PE was perceived as more favorable than medications when responding to items about their willingness to recommend treatment and their confidence in that treatment. A common reason reported for avoiding psychotropic medication treatment was the risk of side effects. However, soldiers with a history of mental health treatment viewed psychotropic medications as more favorable when compared to soldiers with no history of mental health treatment. Such results further suggest that exposure to mental health treatment in the past decreases one's level of perceived stigma. Therefore, a mandatory mental health check-up post-deployment may be a useful way to (a) make sure that service members struggling with mental health symptoms do indeed receive treatment and (b) expose the majority of military personnel to a basic mental health check-up with the purpose of decreasing stigma.

Conclusion

Overall, it is evident that mental illness and receipt of mental health treatment is stigmatized within the military and within the U.S. civilian population. Such findings indicate the need for change in our society regarding negative attitudes toward mental health issues. While the stigma of mental health treatment for civilians seems to be centered on cultural and financial issues, stigma within the military population is more related to fears of negative career impact and perception of being weak. Therefore, while military anti-stigma efforts are needed to focus on altering these

specific beliefs, changes may also be needed in the system to ensure that seeking mental health treatment is (a) truly confidential and (b) not indeed related to negative career impact or perceived weakness. It should be recognized that service members may under-report mental health symptoms on the PDHA and the Post-deployment Health Reassessment due to the lack of anonymity. In addition, external repercussions, such as inability to take leave immediately after deployment, may also influence service members' decisions to report mental health issues on these surveys. It may be helpful to lower the clinical threshold required for referrals or treatment recommendations on post-deployment assessments as a result. Considering that many individuals with mental health issues do not seek treatment, psychoeducation focused on identifying signs of mental health issues in peers and co-workers may be helpful. Some individuals may not know that they are experiencing symptoms, and others may simply avoid treatment due to stigma or fear of repercussions. People with a history of previous treatment who are married, female and not of Asian descent tend to seek mental health treatment more often than others. Therefore, single males of Asian descent with no history of mental health treatment may be at higher risk for not receiving needed treatment. Such statistics should be included in the education provided to military personnel. Service members should be informed and reminded that mental health symptoms post-deployment are important to report even if the individual believes that the symptoms will resolve after combat. In addition, demonstrating the effectiveness of current mental health treatments through continued initiatives such as the "Real Warriors Campaign" initiative should help to encourage treatment-seeking behaviors. As shown by the research, attitudes of high-ranking military officials significantly influence that of other military personnel. Therefore, strong efforts should be made to decrease the stigma of mental health problems and treatment in military leadership. Considering the significant stressors that military service members experience, small changes in procedures as suggested above (e.g., lower clinical threshold on the PDHA, and implementation of psychoeducation programs) are important and would make a significant difference in the mental health and overall wellbeing of our troops.

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