The Stigma of Mental Health Problems in the Military

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The present review addresses the perceived stigma associated with admitting a mental health problem and seeking help for that problem in the military. Evidence regarding the public stigma associated with mental disorders is reviewed, indicating that the public generally holds negative stereotypes toward individuals with psychological problems, leading to potential discrimination toward these individuals. The internalization of these negative beliefs results in self-stigma, leading to reduced self-esteem and motivation to seek help. Even if soldiers form an intention to seek help for their psychological difficulty, barriers to mental health care may prevent the soldier from receiving the help they need. An overall model is proposed to illustrate how the stigma associated with psychological problems can prevent soldiers getting needed help for psychological difficulties and proposed interventions for reducing stigma in a civilian context are considered for military personnel.

Introduction

A recent press statement has reported that 30% of troops returning home from the Iraq war have experienced some type of mental health problem; difficulties have usually included anxiety, depression, nightmares, anger, and inability to concentrate.[1] Additionally, 15 to 17% of troops returning from Iraq in 2004 experienced acute stress or post-traumatic stress disorder (PTSD).[2] The most common stressors reported by soldiers and Marines during the war included roadside bombs, length of deployment, handling human remains, killing an enemy, seeing dead or injured Americans, and being unable to stop a violent situation.[2] More than 90% of soldiers and Marines returning from Iraq reported encountering these stressors, with 12% of them reporting being wounded or injured. The rates of PTSD among soldiers and Marines returning from war have been associated with these stressors.[2]

Although many soldiers experience psychological problems from the stressors encountered in combat, there is a lag of soldiers who actually seek help for their difficulties. Britt[3] examined the stigma attached to having a psychological versus medical problem among service members returning from a peacekeeping mission. All soldiers underwent a mandatory psychological and medical screening before returning to their home station. Soldiers who scored above a "cut-off" point on one or more of the psychological questionnaires (assessing PTSD, depression, and alcohol abuse) were required to have a brief interview with a mental health professional (e.g., social worker or clinical psychologist), and soldiers who indicated medical symp-

toms had such an interview with a medical professional (e.g., nurse or medical doctor). Soldiers reported more discomfort in discussing potential psychological problems than medical problems, especially when they were returning with their unit. In addition, soldiers reported a lesser likelihood of following through with a psychological referral than a medical referral.[3]

Similarly, Hoge et al.[2] found that of the soldiers and Marines who met the criteria for being diagnosed with a mental health problem, only 38 to 45% indicated an interest in receiving help; furthermore, within the previous year, only 23 to 40% reported actually receiving professional help. The troops who scored positively for a mental health problem were twice as likely than other troops to report fear of stigmatization and concern about barriers to obtaining psychological help.[2]

What leads soldiers experiencing psychological problems to not seek help from a mental health professional? In the present article, we argue that a major factor is the perceived stigma associated with admitting a problem and seeking help for that problem. Little research has been conducted on the stigma attached to admitting a psychological problem in a military context. The present article draws from civilian and military research to present a model for how the stigma of admitting a psychological problem can prevent soldiers from seeking help for these problems. The model is presented in the context of a soldier experiencing symptoms of PTSD and having to decide whether to admit this problem and seek help for the problem. We consider the public stigma attached to psychological problems and how soldiers may internalize that stigma as a function of attributions they make for the problem. We also consider the perceived barriers to accessing mental health care. Finally, we examine potential interventions to reduce the negative consequences of stigmatization for help-seeking.

Defining Stigma

In considering the impact of stigma on seeking help for a psychological problem, it is first necessary to define stigma and distinguish between public stigma and stigma as internalized by the individual. Corrigan and Penn[4] have defined stigma as a negative and erroneous attitude about a person; it is a prejudice or negative stereotype. Corrigan and Watson[5] note the differences between public stigma and self-stigma. Public stigma is the reaction of the general public toward people with mental illness, whereas self-stigma is the internalization of how the general public portrays people with mental illness and the belief in that portrayal. Although distinct in definition, both public and self-stigma are composed of stereotypes, prejudice, and discrimination.[5] Stereotypes are defined as knowledge structures that are learned by members of society.[5] Stereotypes typically lead to prejudice, where individuals engage in these knowledge structures and generally hold a negative view of a subpopulation.[5] Discrimination is the behavioral reaction of prejudice.[5]

The Consequences of Societal Stigma

There are three themes reported in the stigma literature with regard to beliefs the public holds about individuals with severe mental illness.[4,6] The first of the themes is "authoritarianism": individuals with a mental illness are seen as irresponsible and unable to tend for themselves. The second belief is in reference to "fear and exclusion": individuals with a mental illness should be feared and restricted from society. Lastly, the public tends to hold a theme of "benevolence" toward people with a psychological problem. Individuals with mental illnesses are seen as childlike, naive, and innocent.

Admitting a psychological problem such as PTSD can have detrimental societal consequences for an individual. Link et al.[7] used vignettes depicting individuals with psychiatric conditions to assess whether the public recognizes mental illness, their beliefs about the causes of mental illness, how dangerous people are with a mental illness, and the amount of social distance desired from people with mental illness. The vignettes depicted people with schizophrenia, major depressive disorder, alcohol and drug dependence, and an individual with subclinical problems and worries. Respondents desired the most social distance from the cocaine-dependent person, followed by the individual with alcohol dependence, schizophrenia, major depression, and lastly the troubled person. Nearly half of respondents indicated they would be very or somewhat likely to socially distance themselves from an individual with major depressive disorder.

Corrigan[8] uses components of attribution theory to explain why society tends to stigmatize those with mental health problems. Attribution theory is concerned with understanding how individuals assign causality for different types of events (e.g., the development of a mental illness), and the consequences of such attributions for emotional and motivational reactions to the situation. Weiner et al.[9] found that individuals with psychological problems were seen as more responsible for their difficulties than those with physical problems and that attributions of controllability were related to decreased pity and increased anger toward the individual possessing the problem. In examining previous research, Corrigan[8] also found that illnesses are usually understood in terms of controllability. Society tends to look at whether people are responsible for their illnesses and if they are coping with the illness.[8] Psychological disorders, as compared to physical disorders, are viewed as more controllable.[10] Furthermore, individuals who are seen as responsible for their disorder(s) are more likely to be reacted to angrily.[8,9]

Within a military context, service members experiencing symptoms of PTSD and considering admitting they have a problem to someone else will likely be aware of public beliefs about psychological problems, perhaps anticipating negative consequences from different individuals (e.g., fellow service members, commanders). If soldiers fear social exclusion because they have symptoms of PTSD, they may forgo seeking help due to apprehension about societal stigma. Furthermore, soldiers' perceptions of society holding them accountable for their psychological problems may further inhibit treatment seeking. If the soldier comes to personally endorse the negative beliefs and attributions held by the public, he or she will experience a stronger sense of self-stigma, the consequences of which we now consider.

The Consequences of Self-Stigma

Past research has revealed specific factors that contribute to differences in levels of treatment seeking and perceived stigma. Cooper et al.[11] have reported findings from two nationwide studies suggesting that 50 to 60% of individuals who could seek help for a psychological problem do not. Additionally, Cooper et al.[11] found that individuals with a mental illness are less likely to seek treatment if they view themselves as being responsible for their disorder(s). Mechanic et al.[12] have hypothesized that an individual with a mental illness may incorporate stigma into one's sense of self, and, consequently, lower one's self-esteem. This inhibited sense of self-esteem could lower one's motivation to seek psychological treatment.

Mechanic et al.[12] have also hypothesized that those individuals with a psychological problem that attribute their condition to a physical, medical, or biological condition will be more satisfied with their social relationships and life in general than those individuals who see themselves as being responsible for their mental illness. Again, it is likely that those individuals who perceive themselves as responsible for their disorder also perceive a greater degree of stigma than those individuals who attribute their disorder to a cause not under personal control. Mechanic et al.[12] conducted telephone surveys with family members of people with schizophrenia and also with the clinically diagnosed individual. Interview questions pertained to the quality of life, illness attribution, depressive symptoms, and social and clinical factors of those with schizophrenia. It was found that a higher quality of life was significantly correlated with rejecting mental illness as a cause for one's problems. Individuals reporting a higher quality of life also reported little or no side effects from medication, fewer difficulties in everyday functioning, higher self-esteem, more personal control, and higher family empowerment. Furthermore, quality of life was found to be negatively correlated with stigma and depression symptoms.

Other variables influencing psychological treatment seeking have been examined in a military context. Britt et al.[13] examined the predictors and consequences of seeking treatment for a psychological problem in a military setting. More than 3,000 soldiers completed measures assessing whether they were experiencing a psychological problem, the perceived stigma of seeking help for psychological problems, psychological distress, and whether they had sought help for a psychological problem and from what source (e.g., military mental health professional, civilian medical doctor). The authors also assessed quality of leadership and the existence of a family friendly unit climate. The stigma of seeking help was negatively related to the reported quality of noncommissioned officer leadership and the existence of a family friendly unit climate. Furthermore, once psychological distress was controlled for, among those soldiers who indicated they had a psychological problem, those who sought help from either a military or civilian mental health professional reported lower perceived stigma than soldiers who did not seek help from this source. However, there were no differences found in perceived stigma in seeking help from chaplains or medical doctors. Britt et al.[13] hypothesized that this pattern of results could be a function of two factors: (1) perceiving less of a stigma with seeking help may result in a greater likelihood of seeking help for mental health professionals and (2) once soldiers seek

help from mental health sources and have a positive experience, their perceptions of stigma may decrease.

Winerman[14] has also reported that men of all ages and ethnicities are less likely than women to seek help for depression and stressful life events, even though men encounter these stressors just as much or in greater occurrences than women. American Psychological Association President Ronald F. Levant has also described the difficulties males have as a function of the fear of admitting mental health problems.[15] This finding has important implications for the military in that the majority of soldiers exposed to combat are males. If men experience greater anxiety when seeking psychological treatment, and thus fail to seek help due to fear, then the numbers reported of individuals with a psychological problem in the military may be vastly underrepresented.

The Overall Model

The overall model detailing the process of potential stigmatization that a soldier could encounter during the period from initially being exposed to a traumatic event during war to seeking mental health care for possible symptoms of PTSD is presented in Figure 1. Exposure to traumatic events is a requirement for diagnosing a soldier as experiencing PTSD.[16] Given that 90% of soldiers returning from war have encountered stressors such as roadside bombs and handling human remains, it becomes clear that the great majority of soldiers are exposed to traumatic events while at war.[2] Once exposed to a traumatic event and symptoms of PTSD begin occurring, soldiers may encounter a societal stigma within the military culture. For instance, some military personnel may begin socially distancing themselves from soldiers they perceive as having mental health problems. These individuals may be uncomfortable around soldiers with PTSD and perhaps even blame them for the development of the problem.

If soldiers internalize the stigmatizing behaviors of those around them, they will likely develop self-stigma. The development of self-stigma has been hypothesized to lower one's self-esteem,[12] which in turn, could inhibit one's ambition to seek mental health care. Furthermore, given the finding of Cooper et al.[11] that individuals are less likely to seek help if they view themselves as responsible for their disorder, soldiers may further avoid seeking mental health care if they believe that they should have control over their condition and/or feel responsible for experiencing symptoms of PTSD.

Additionally, Hoge et al.[2] found that the soldiers and Marines in their study who met the screening criteria for a mental health problem were twice as likely to report concerns about stigma and other barriers to care than those respondents who did not meet the screening criteria. Perceived barriers to care include such items as "I don't trust mental health professionals" and "I don't know where to get help."[2] Thus, if soldiers decide to seek mental health care but perceive specific barriers (such as time, money, transportation) in this process, they may avoid seeking mental help altogether. Britt et al.[13] found an uncorrected correlation of 0.37 ($p < 0.001$) between perceived stigma and psychological symptoms. We would argue that individuals who are experiencing mental health symptoms would be especially likely to consider the potential stigmatizing consequences of seeking mental health care because of the immediate relevance of the decision. Individuals who are not experiencing symptoms will likely not actively consider these consequences, leading to reduced reports of perceived stigma. This finding has important implications for interpreting the average perceived stigma of seeking care for a mental health problem among respondents. It is likely that such a value is an underestimate of the actual stigma felt by individuals actually possessing extensive mental health symptoms.

Given findings from past research on societal and self-stigma, barriers to care, and the current statistics on rates of soldiers encountering traumatic events and experiencing symptoms of PTSD, it is not hard to see why soldiers would avoid seeking mental health care altogether. In the remainder of this article, we consider potential interventions for reducing the stigma of seeking help for psychological difficulties among military service members.

Interventions for Reducing Stigma in the Military

Interventions for reducing the stigma of mental health problems should address both societal and self- stigma. Corrigan and Penn[4] have proposed three methods for reducing the stigma attached to mental illness by society and these strategies may provide insights into interventions in a military context. The first
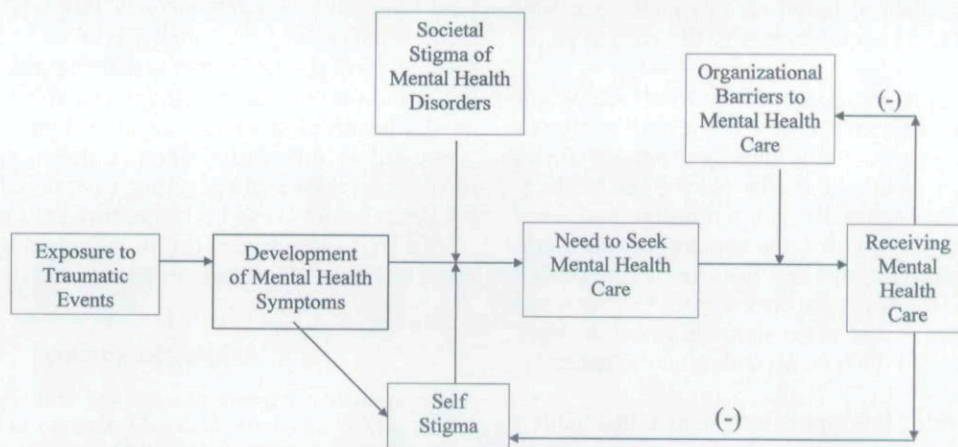
Fig. 1. A path diagram reflecting how stigma and barriers to care can affect getting treatment for psychological problems.

strategy involves protesting; in using this strategy, an attempt is made to suppress stigmatizing attitudes and behaviors by informing society that they should not possess negative stereotypes about mental illness. It has been found that this method generally does not have a significant effect in reducing stigma and that protesting stigma may actually lead individuals to recall more negative information about persons with mental illness when instructed to suppress their stereotypes.[4] Therefore, it is not enough to simply demand that people eliminate the stereotypes they hold about mental illness.

The second technique involves educating and providing factual information to society's members about mental disorders.[4] This technique has been met with some success, although the type of information provided about mental health problems is important. This type of intervention should provide realistic descriptions of problems, including accurate information on the underlying causes of the problem, and emphasize that many problems can be addressed through different forms of treatment. The provision of accurate information about the etiology and treatment course of psychological problems can help decrease the negative stereotypes surrounding the problem and also change the public's view regarding the controllability of the disorder. One popular program for reducing stigma among men seeking psychological help for depression is the media campaign, "Real Men. Real Depression."[17] This program has been directed specifically for men who believe they are weak (e.g., not "real men") as a result of experiencing mental health problems such as depression and therefore not wanting to admit they have the problem or seek treatment for the problem. It has been estimated that more than 345 million people are aware of this campaign that attempts to reduce stigma and educate men and their families about the symptoms and treatment of depression.

Within a military context, accurate information about the causes and treatment of problems such as PTSD[18] may influence the way in which the broader military culture views such disorders. Clearly, soldiers are exposed to traumatic events that tax even the most resilient.[4,19] The presence of such a strong environmental determinant of problems such as PTSD should do a lot to reduce the stigma associated with seeking help for such problems. Although many people exposed to the same traumatic events do not develop mental health disorders, the controllability attributions for the development of PTSD should be capable of being modified based on information showing the importance of environmental factors in the etiology of the disorder.

The third strategy, promoting contact with individuals who have a mental illness, has been shown to be the most successful technique in reducing stigma.[4] This strategy involves reducing negative beliefs about mental illness by placing the public in direct contact with the stigmatized group. Couture and Penn[6] cite past research suggesting that the contact method works best when the stigmatized individual has one-on-one contact with members of society, when the environment is cooperative (rather than competitive), and when status is viewed as equal between the stigmatized individual and other members of society.

The possibility of using this type of intervention in a military context has not been adequately explored. Certainly, many units have experiences with members who have developed problems such as PTSD, although it is likely that contact with these individuals does not occur under the ideal circumstances described above. Unit-level interventions could involve having soldiers who were successfully treated for PTSD discuss their experiences in a supportive unit environment akin to an after-action review. Fellow unit members could ask soldiers questions about various aspects of the problem, thereby increasing their understanding of mental health difficulties and seeing that mental health care can successfully reduce maladaptive symptoms. Such an approach may lead to an increase in soldiers who seek help during the early stages of developing a mental health problem, leading to a greater likelihood that the soldier will successfully deal with the problem and return to the unit as a fully functioning member. Future research will be necessary to assess the effectiveness of these types of interventions in a military context.

In addition to the interventions suggested by previous civilian research, we also recommend additional strategies likely to be especially effective in a military context. The first such strategy we label leader/supervisor support. Such an intervention would encourage leaders to take an active role in identifying and assisting soldiers in receiving mental health support. Senior leader treatment of service members needing help for mental health problems will likely have a major impact on the stigma perceived by service members. If leaders emphasize the importance of treatment early in the development of a mental health problem, service members will know their leaders understand the importance of seeking help and therefore the stigma associated with seeking help will most likely be reduced. Leaders at all levels are capable of creating a climate where mental health problems such as PTSD are recognized as potential responses to traumatic events and that seeking help for these difficulties early in their development is an effective strategy for allowing the service member to be a fully functioning part of his or her unit. In this sense, it becomes the responsibility of leaders to help service members receive help for a mental health problem.

In addition to leader/supervisor support, an additional way of reducing stigma would be to implement organizational policies and programs aimed at supporting soldiers in getting mental health support. Examples of changes to existing policies that would support soldiers receiving needed help include soldiers not losing their job or security clearances for seeking mental health support, being able to seek mental health support during the duty day, and having their visits to mental health professionals be anonymous. Future research is needed to investigate whether these types of programs result in service members getting treatment for mental health problems before these problems turn into more severe difficulties that compromise the unit's mission and the service member's own adaptive functioning.

Acknowledgments

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