Military Mental Health Stigma Challenges: Policy and Practice Considerations
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ABSTRACT
All providers are challenged to reduce mental health stigma through awareness of service member mental health needs and advocacy. Individually stigmatizing perceptions and beliefs that interfere with mental health care become internalized into a service member’s identity, persisting in veterans after military service. Years to decades can pass before a service member seeks professional help for psychological problems, and, therefore, practitioners need to be sensitive to subtle indications of distress. Furthermore, care that supports military members is culturally sensitive, innovative, and taps into resources for evidence-based interventions that maximize function and quality of life for service members and their families.

Keywords: collaborative care, mental health stigma, military, psychological distress, substance abuse

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The Department of Defense’s (DoD’s) concern regarding mental health access for service members and the ongoing stigma associated with seeking assistance for mental and behavioral health care received considerable attention by House and Senate Appropriations Committees in support of Defense Health Programs for fiscal year 2014 (http://appropriations.house.gov/news/documentsingle.aspx?DocumentID=343918). Mental health stigma and access to care are veteran and service member issues also acknowledged by the American Nurses Association. The American Nurses Association partnered with First Lady Michelle Obama’s Joining Forces campaign, which is dedicated to calling attention to and addressing critical issues facing veterans and military families. Of significance to this joint initiative is that one third or more of service members returning from Iraq (Operation Iraqi Freedom) or Afghanistan (Operation Enduring Freedom) suffer psychological problems (ie, post-traumatic stress disorder [PTSD], depression, alcohol abuse) resulting from their war exposures, a finding that is likely not unique to these conflicts because the horrors of war have left their marks on warriors involved in conflicts during other times in history.

Months after combat deployments, a large percentage of troops (20%-30.5%) continue to experience moderate to severe symptoms of PTSD. Unfortunately, only about 50% or fewer service members who would benefit from mental health services use these, and of those who do seek care, a large percentage abort therapy before achieving remission of post-traumatic stress symptoms. These are the most recent available estimates, and, therefore, it appears that soldiers do not seek or receive mental health services commensurate with the high needs for treatment. Despite positive changes in prevention and intervention strategies, stigma and other barriers to care continue to interfere with optimizing mental health treatment for service members and their families.

Personal and systems-related factors influencing help-seeking behaviors and access to care can be understood through traditional health care utilization models. However, stigma (ie, prejudice and discrimination) is of particular concern because together social (eg, public or organizational) and individual (eg, personal or self) stigmatizing beliefs and behaviors influence service members’ willingness to seek professional help. Empirically supported, militarily-relevant barriers to care have been synthesized (Figure). A means for overcoming these obstacles and ensuring mental health care depends on support from family, friends, and leadership as well as convenience, affordability, and privacy. Our greatest concern lies with those who have mental health symptoms because they are more likely to perceive stigma and barriers to care and, subsequently, fail to seek treatment.

The progress regarding stigma and challenges accessing care can be evaluated through current research as well as policy and practice changes in the military health system and the general health care community. Increasing rates of mental health diagnoses and concomitant increases in overall health care system burden regarding the greater use of evaluation and treatment resources seem to indicate better access and utilization of mental health services. It is important to recognize the significant job risk for military personnel referred for mental health services while needing to meet strict standards for access to classified information or weapons and the ambiguity they face when making mental health-seeking decisions. Thus, the purpose of this article is to identify current challenges to mental/behavioral health care for active duty and reserve military personnel, National Guard, other veterans of service, and their families in an effort to reduce barriers to care and improve quality of care.

**CHALLENGE: DISPEL THE MYTH THAT A MENTAL HEALTH PROBLEM MEANS “WEAKNESS”**

Social stigma leads to disenfranchisement and disempowerment of groups, and in the case of the military, this social stigma stems from cultural beliefs and attitudes about mental health that influence negative beliefs psychologically distressed service members have about themselves. In other words, military culture unintentionally perpetuates a mental health stigma through military leaders as well as other aspects of the health care and military environment. Within the military, 2 important shifts in approaching mental health involve leadership
changes and decreasing misinformation through a multimedia campaign that crosses all services.\textsuperscript{17-19} Military leaders have taken an advocacy role for their service members and set the responsible example that sends the message that seeking out treatment when needed is “good.”

Public understanding and perception, which are shaped by the media, also play critical roles in mental health and substance abuse treatment help-seeking behaviors. Posters with slogans reading “Comprehensive Soldier & Family Fitness: Strong Minds*Strong Bodies” or “Warriors Don’t Fight Alone: Knowing When to Get Help Takes Strength” have been part of the effort to reduce stereotyping and discrimination within the services.\textsuperscript{23} A tremendous antistigmatizing effort has had some impact on the help-seeking belief that it is shameful to have a mental illness. Personal communication (February 2014) from the current Army Surgeon General’s office indicates that in 2008 the US Army had about 800,000 total behavioral health encounters, whereas in 2013 there were almost 2 million. In addition, fewer soldiers required inpatient care for acute crises and fewer committed suicide, both indications that more soldiers were receiving care earlier in the course of their illnesses.

According to the Associated Press (http://bigstory.ap.org/article/apnewsbreak-military-suicides-drop-unclear-why), active duty military suicides dropped 22\% in 2013, and the hope is that new programs instituted across all services, targeting what the DoD perceives as an epidemic, have been effective. Military suicides are not well understood because many of those who committed suicide never served on the warfront.\textsuperscript{24} Concurrent increases in the suicide rate among the general US population indicates the possibility that broader societal trends and pressures might be responsible and that suicide is perhaps more of a public health problem than an issue unique to the military.\textsuperscript{25} Increased risk for military suicide is correlated with junior rank, male sex, and active duty status; however, a high incidence is also noted in Reserve and National Guard members. Additional factors identified by LeardMann et al\textsuperscript{24} are mood disorders, such as bipolar disorder and depression, and alcohol abuse—problems that can be assessed in primary care and effectively treated when recognized.
Military and community leaders as well as peers have been called on to assist with primary prevention (eg, President Obama executive order). The US Army has committed an organized approach to the prevention of behavioral health problems and the identification of high-risk behaviors by guiding military and civilian leaders who interact with troops to encourage the use of mental health services when they experience trouble coping with stress caused by separation, deployments, financial pressures, and other work or relationship issues. Army leadership established a Comprehensive Soldier and Family Fitness program, putting mental fitness on the same level as physical fitness. A similar program was instituted by the US Air Force called the Comprehensive Airman Fitness program to promote positive behaviors (eg, caring, committing, connecting, and communicating), again recognizing the need to treat the whole person. A similar holistic program has been adopted by the Navy and is known as the Combat and Operational Stress Control program. The Marines have targeted substance abuse reduction because of its association with suicide and have instituted a “buddy care” mechanism for fostering connections to others, empowering and sensitizing service members to their mental health needs. Despite these efforts, media campaigns and peer support programs will not be effective if military members continue to witness or experience career impact when they seek mental health assistance.

CHALLENGE: MILITARY CULTURE, SERVICE MEMBER IDENTITY, AND MENTAL HEALTH STIGMA

In June 2010, the then Vice Chief of Staff for the US Army, General Peter Chiarelli, testified before the Senate Armed Services Committee on the devastating impact of the invisible wounds of war. He spoke of his responsibility to reduce the numbers of service member suicides and properly diagnose those with traumatic brain injury, PTSD, and other behavioral health problems. He highlighted the fact that throwing time, money, and people at the issue was not enough to control the problems of individual suffering and suicides. He drew our attention to a larger issue, namely that the best of intentions may not be enough and that the solutions may be better understood when considering military culture, identity, and the influence of these on mental illness stigma.

Military culture is defined as both a written and unspoken system of beliefs, values, language, manners, customs, courtesies, traditions, and expected behaviors evidenced in rank structure, creeds, Profession of Arms, regulations,housing, social groups, lifestyles, and behaviors. Military indoctrination, ethos, and culture shape a service member’s identity. Military creeds connect the “who I am” (eg, I am an American Airman, I am a Warrior) with core values (eg, integrity, service before self, and excellence in all we do) and the skill sets of “what I do” (fly, fight, and win) to complete the mission. Each creed is unique to its service branch, yet there are common threads of obedience; service; mission first; and never failing, quitting, or leaving another service member behind. Therefore, military identity is closely tied to the warrior ethos and to each service member’s job, which means having an income and professional pride.

Service-specific organizational creeds that shape military values, beliefs, and attitudes regarding service, failure, and mission are likely the same forces that shape attitudes and behaviors toward help seeking. Stigma is pervasive, influencing personal identity, psychological health, community, and organization. As such, military stigma is evident in warrior ethos (eg, “I don’t need help. I can handle things myself. If I need help, I am weak.”) coupled with a legitimate fear that military career and promotions may be jeopardized by receiving treatment; therefore, providers can understand why this population is difficult to reach. Individually stigmatizing beliefs become internalized and so much a part of the service member’s identity that they persist in veterans who are no longer in the military.

CHALLENGE: EMBRACE THE COLLABORATIVE CARE DELIVERY SYSTEM

Barriers to mental health care do not only exist within the military health system but also are considered a global problem, with a large proportion of persons with mental illness not receiving treatment from trained professional staff. A lack of knowledge about mental illness, ignorance about accessing treatment, prejudice against those with mental health problems,
and expected discrimination if diagnosed with mental illness are factors that obstruct mental health care worldwide and are not unique to the military. As our nation steadily evolves from the current individual-oriented, fee-for-service, illness focused approach to a systems-oriented, wellness approach, the behavioral and psychosocial-emotional aspects of care will become increasingly critical. The current president of the Institute of Medicine believes that dealing equally with health care for mental, substance use, and general health conditions requires a fundamental change in how we as a society and health care system think about and respond to these problems and illnesses. Mental and substance abuse problems and illnesses should not be viewed as separate from and unrelated to overall health and general health care, whether delivery occurs within the civilian or military health system.

There is a movement toward evidence-based models of collaborative primary care management involving team care approaches to screening, care management, and enhanced specialist involvement. Care model recommendations to military leadership were made by the National Institute of Mental Health because of their success in reducing suicidal ideation among patients with depression and reducing stigma and other barriers to care. Newer models of care that reduce service member stigma and simultaneously maximize access to mental health care are already in existence. For example, primary care mental health clinics housed near the Veterans Administration primary care clinics offer a less stigmatizing experience to veterans, lead to a combined effort on the part of primary care and mental health providers, and eliminate the need for outpatient consultation request. Re-engineering Systems of Primary Care for PTSD and Depression is another example of a US military medical effort to develop a collaborative care model that enhances the diagnosis, treatment, and follow-up of mental health symptoms in returning service members through interface with specialty mental health services as needed. Because of its success, the US Army Medical Command has directed wide implementation of Re-engineering Systems of Primary Care for PTSD and Depression in Army primary care facilities.

Collaborative care models, although beneficial when applied to high-risk populations, would likely have a greater impact if used with all military members and their families. Integrating mental health and primary care could mitigate the perception that a mental health diagnosis categorizes service members as “abnormal.” Whether a mental or physical complaint, in order to alleviate an illness, it has to be identified and treated using evidence-based approaches and then reassessed for resolution. Health outcomes of individual service members and their families could be improved by embracing the body-mind connection and affirming the need to treat the whole person in terms of primary, secondary, and tertiary prevention. The continued presence of stigma associated with mental health problems and the unique fear military members have concerning medical boards and promotions if they seek treatment are areas that require the attention of health care providers, military leaders, and policy makers.

HOW CAN PRACTITIONERS BE ADVOCATES FOR MILITARY PATIENTS AND THEIR FAMILIES?

In 2012, President Obama issued an executive order calling for “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.” The DoD, Veterans Affairs, and Health and Human Services are to work collaboratively to address the mental health needs of veterans, military personal, and their families. By doing what is best for the patient, providers will work toward changing the culture, building trust, and encouraging help seeking.

Providers need to be “champions” for military members and their families, increasing awareness within their practice and their community and educating themselves about the wide array of resources available (Table 1). The Interagency Task Force on Military and Veteran Mental Health was established by executive order in August 2012 in an effort to improve access to mental health services for veterans, service members, and their families. The public awareness campaign and resources, launched to reduce misperceptions about veterans’ mental health and substance abuse issues, are intended for laypersons and professionals. Additional
ways in which practitioners can advocate for service members and their families are outlined in Table 2. On a personal level, nurse practitioners can facilitate service member and veteran care by being sensitive to issues affecting mental health care seeking behaviors and choices and by educating themselves about available alternate care options (eg, Vet Centers: http://www.vetcenter.va.gov/, http://www.giveanhour.org/) that offer confidential counseling.

In the general community, patient confidentiality (eg, access to clinical records) is viewed as particularly important to a successful therapeutic process by most mental health providers; however, this is not always possible in the military. It has been suggested that patient confidentiality for service members be adjusted to approximate civilian standards except when there is an imminent threat to a combat-related mission.33 In addition, the view that a diagnostic label negatively impacts service members’ recovery and function should be aborted and replaced with a current perspective of the ill individual as someone capable of overcoming adversity, healing, and more likely than not remaining engaged with work and other responsibilities during this process. The well-defined circumstances that require military supervisor attention and a breach of patient-provider confidentiality have yet to be redefined. In the interim, we recommend careful consideration of individual cases so that military members have the confidence to seek mental health assistance.

Many service members and their families choose to use accessible and affordable community mental health care resources. Access to care has been

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<th>Champion’s Toolbox</th>
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| Military cultural competency training | The curriculum for this training will encourage military cultural competency in health care professionals through the provision of interactive online training in the requisite knowledge, skills, and attitudes. | http://www.deploymentpsych.org/military-culture
Select “Take the Course.”
Launch each module.
Download fillable PDF for continuing education units. |
| Help veterans “see themselves” and recognize they are not alone | Stories from veterans who have successfully overcome mental health and addiction challenges | www.maketheconnection.net
https://www.facebook.com/VeteransMTC
https://www.youtube.com/user/VeteransMTC
http://www.eiconline.org/VAMentalHealth.pdf |
| Mental Health First Aid USA Public Education Program | 12-hour interactive course with 5-step action plan intended for use by professionals and laypersons | http://www.mentalhealthfirstaid.org/cs/what_you_learn |
| Psychological health care tools for veterans, service members, their families, and the health care providers who care for them in the community | Web-based tools that can be accessed anywhere, anytime, by any individuals | http://www.afterdeployment.org/
https://militarykidsconnect.org/
http://www.militarymentalhealth.org/ |
| Mobile apps for education, self-assessment, and assistance with finding professional help | Apps are intended to complement, not replace, professional mental health care | Breathe2Relax: Diaphragmatic breathing to calm the fight or flight response
T2 Mood Tracker: Customized scales to help measure and manage mental health problems and symptoms
PTSD Coach: Assessment of PTSD symptoms and recommended sources of support, including emergency hotlines |

PTSD = post-traumatic stress disorder.
maximized for service members and veterans, with mental health professionals and agencies offering free or significantly reduced cost services. Also, a growing body of research is showing that technology-based interventions are similarly efficacious to in-person interventions.7 Regardless, it can take years to decades before a service member seeks professional help, if they seek it at all, and for this reason practitioners need to be sensitive to subtle signs of personal and family problems.38 Research indicates that men and service members who have no previous experience with behavioral health care are identified as taking longer to seek help, whereas service members who are married are more likely to seek help14 and, interestingly, may or may not choose to see a traditional mental health provider. The bottom line is that being able to offer a wide variety of care options to all veterans and service members, while remaining sensitive to their individual needs, only enhances our ability to engage individuals and their families and makes it possible for them to access care and remain in treatment.

FINAL THOUGHTS

The US military’s mental health care delivery system has been strained for more than a decade, concentrating on case identification and treatment. We have an opportunity to embrace the full spectrum of veteran, military member, and military family mental health care delivery (from prevention to continuing care) and change the paradigm. Maximum use of behavioral health promotion and illness prevention efforts will increase resiliency within the military. Both civilian and military health care providers are challenged to reduce military mental health stigma by supporting the individual, understanding the culture, maintaining confidentiality, and delivering innovative care. Furthermore, by using available resources for evidence-based interventions and treatments, providers can maximize function and quality of life for active duty and reserve military personnel, National Guard, other veterans of service, and their families.

Table 2: Mental Health Stigma: Changing the Paradigm

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<th>Level of Involvement</th>
<th>Target Behavior</th>
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| Local advocacy       | • Develop military cultural competence in your practice setting  
                      | • Role model stigma-reducing behavior in your practice setting  
                      | • Evaluate your business practices for unintended stigma  
                      | • Identify and isolate barriers to care within your practice/care system  
                      | • Apportion part of clinical practice time to both promotion and prevention of mental health problems through direct patient questioning and screening |
| Regional advocacy    | • Create best practice partnerships with local military and veteran care systems  
                      | • Participate in local stigma-reduction programs and campaigns  
                      | • Partner with regional advocacy groups supporting military mental health (eg, local Veterans of Foreign Wars Chapter) |
| National advocacy    | • Partner with national advocacy groups supporting military mental health (eg, First Lady’s Joining Forces Initiative)  
                      | • Be active with nursing, medical, and other specialty organizations that advocate effective legislative action supporting of military mental health |

References

3. Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. 2006;295:1023-1032.