U.K. Army Medical and Unit Welfare Officers’ Perceptions of Mental Health Stigma and Its Impact on Army Personnel’s Mental Health Help Seeking

Mary Keelinga, Samantha Bullb, Gursimran Thandic, Samantha Brooksc, and Neil Greenbergc

aUniversity of Southern California, Los Angeles, California; bUniversity of Manchester, Manchester, United Kingdom; cKing’s College London, London, United Kingdom

ABSTRACT
Mental health stigma and barriers to care (BTC) reportedly impede help seeking among U.K. military personnel. Military service providers’ perceptions of this link were investigated. Secondary thematic analysis of interviews with 21 U.K. Army unit welfare and medical officers led to three master themes: military culture, barriers to care, and stigma alleviation success. It was perceived that military culture and associated stoicism create beliefs surrounding legitimacy of mental health problems, confidentiality, and career concerns that affect help seeking. Decreased stigma was perceived and attributed to current stigma reduction interventions. Recommendations for education based stigma reduction methods are made.

KEYWORDS
Mental health stigma; mental health help seeking; military mental health

Introduction
Military operations in Afghanistan and Iraq have exposed many United Kingdom military personnel to danger and violence. Such traumatic events have been linked to mental health problems (Fear et al., 2010; Hotopf et al., 2006). In the United Kingdom, about 7% of combat troops report probable posttraumatic stress disorder, and 22.5% report misusing alcohol after deployment (Fear et al., 2010). Mental health difficulties may also be experienced in relation to nondeployment (e.g., training incidents) or nonoccupational (physical assaults) traumatic events, and general occupational stress (Bridger, Brasher, Dew, & Kilminster, 2011; Jones et al., 2012). Regardless of the cause, research from the United Kingdom, United States, and Canada approximates that only 25%–50% of military personnel with mental health problems seek help (Fikretoglu, Guay, Pedlar, & Brunet, 2008; Hines et al., 2014; Kehle et al., 2010; Stecker, Fortney, Hamilton, & Ajzen, 2007). To date, research addressing the relative lack of help seeking among those diagnosed with mental health problems has focused on military personnel and veteran intentions to seek help. There is, however, no research that approaches the topic of help seeking by examining service providers’ experiences and perceptions of what might affect help-seeking decisions among military personnel requiring assistance.

A systematic review of research investigating mental health stigma and help seeking in the United States, United Kingdom, and Canada reported that the most commonly cited reasons for not seeking treatment are: “My unit leader would treat me differently” and “I would be seen as weak” (Sharp et al., 2015). Zinzow and colleagues (2013) and Blais and Renshaw (2013) reported that self-stigma (when those with mental health problems internalize the negative stereotypes and prejudices held by the public) is associated with being less likely to seek help and that those who have sought help have likely found a way to overcome the self-stigma. Following their systematic review, Sharp and colleagues (2015) propose that self-stigmatization is more likely to determine whether military personnel seek help than public stigmatization.

U.S. active, reserve and veteran personnel reported that beliefs concerning whether psychological problems are severe enough and deserving of intervention to impact help seeking (Britt et al., 2011; Elbogen et al., 2013; Rosen et al., 2011). This is consistent with U.K. research showing increased likelihood of medical help seeking for stress and emotional problems when veterans experienced greater levels of functional impairment and reported two or more mental health problems (Hines et al., 2014). Canadian research investigating illness perceptions and help seeking found that ex-service
personnel with a diagnosis of posttraumatic stress disorder (PTSD) who perceived their mental health to be poor to fair were more likely to seek help compared with those who perceived their mental health to be excellent (Fikretoglu et al., 2008). Despite the fact that a PTSD diagnosis requires the clinical determination that the individual’s symptoms are causing significant functional impairment or distress, this research suggests that not everyone diagnosed acknowledges or perceives themselves to be having mental health difficulties, thus affecting their propensity to seek help. Moreover, the same research found that following the offer of being provided information about their PTSD diagnosis, some declined the information reporting “not feeling they need it” as the main reason (Fikretoglu et al., 2008).

As indicated in the current literature, multiple factors may act as barriers to help seeking such as self-stigmatization, concerns about the legitimacy of the symptoms, perceptions regarding symptom severity, and perceptions of mental health status (e.g., poor versus excellent). A large proportion of existing research has been conducted in the U.S. and Canada. Differences exist between the U.S., Canadian, and U.K. health care systems and militaries that could affect help-seeking behaviors. The U.K. National Health Care Service provides free healthcare allowing military personnel and veterans to access healthcare outside of that provided by the Ministry of Defence. The U.S. military’s deployment patterns of longer operational tours likely impact prevalence of mental health symptoms and help-seeking behaviors. In addition, research to date has primarily investigated military personnel and veterans’ intentions and experiences surrounding help seeking, with no previous research investigating service providers’ perceptions. Understanding how service providers perceive help-seeking behaviors could be a useful insight for informing interventions to encourage help seeking. Consequently, this research aimed to understand help-seeking behaviors among U.K. military personnel by investigating Army medical officers’ (MOs) and Army unit welfare officers’ (UWOs) perceptions and experiences of help seeking among U.K. military personnel.

Method

Sample

As part of a large randomized controlled trial (RCT) investigating the effectiveness of a postdeployment mental health screening tool, UWOs and MOs were interviewed in 2013 to investigate their opinions and beliefs about postdeployment mental health screening. For the purpose of the present study, these interviews were subjected to secondary analysis as the original interviews included questions regarding help seeking for mental health problems. The original interviews were conducted by two of the authors.

Opportunity sampling was used to recruit UWOs and MOs from British Army bases in the U.K. and Germany involved in the RCT. Army units were included in the RCT if they had recently returned from deployments in Afghanistan as part of Operation HERRICK 14, 15 or 16. Names and contact information for MOs and UWOs across 30 units involved in the RCT were identified and study information packs left at all 30 units. MOs and UWOs were also contacted via telephone and sent the study information pack. A true response rate is not known due to information packs being left at some units, some MOs and UWOs may not have seen these invites to participate. Of the UWOs and MOs who were spoken to either in person or over the phone, the majority agreed to take part. In total, 23 consented to take part; of these, two were excluded as they had only been in their role for two or three weeks and may not have had enough experience to respond to the questions posed. Twenty-one participants were recruited; 11 MOs and 10 UWOs. All participants were male except one MO and one UWO. Of the MOs, one was a civilian; the remainder were British Army officers. Details of age range and regiment type were not available.

Materials

As part of the original qualitative study, an interview schedule was developed. Four questions enquired about experiences of working with soldiers with mental health problems, the structure of mental health services in the Army, potential barriers preventing soldiers from seeking help, and soldiers’ perceptions of mental health stigma in the Army. Five questions focused on the proposed introduction of postdeployment mental health screening. Two pilot interviews assessed the suitability of the questions but led to no changes of the interview schedule. These pilot interviews contributed to the sample size of 21 and were recruited as part of the method described above. Had these first two interviews indicated a need to make changes to the interview schedule they would have been excluded from the final analysis.

Procedure

Two researchers (co-authors G.T. and S.B.) conducted all interviews over the telephone except one which was conducted in person, at the participant’s request. All participants were reminded of the voluntary nature of their
participation, confidentiality of their responses, and that their responses would not be interpreted as being indicative of the military as a whole. The semi-structured nature enabled participants to discuss issues important to them; consequently, the interview schedule was not prescriptive in sequence or use of the questions. Interviews lasted between 20 and 50 min. Interviews were transcribed including all spoken words, nonverbal utterances such as laughter and sighs, significant pauses and hesitations.

Analysis

Reanalysis of the data was conducted by a third researcher (M.K.). In line with the present study’s aim, this secondary analysis focused predominantly on the responses relevant to help seeking, mental health stigma, and barriers to care (BTC). The entirety of the transcripts however, were analyzed for information relevant to the present study’s aim. Transcripts were analyzed using thematic analysis (Braun & Clarke, 2006).

Analysis began with familiarization of the interviews by reading and re-reading the transcripts and starting to make initial notes. NVivo10 was used to aid data management during subsequent analysis. Each transcript was subjected to a close line-by-line analysis leading to the development of initial codes. These initial codes highlighted sections in the transcript the analyst identified as reflecting how the participant had spoken about and expressed their experiences and understanding about specific issues relating to help seeking. This process was repeated until clear codes were developed. Initial codes were examined; where they overlapped they were combined or made into a subtheme leading to the development of subthemes. Remaining codes were examined for convergence and divergence leading to the formation of three master themes and subthemes for both the MO interviews and subsequently the UWO interviews. At all stages of analysis, the researcher remained reflective, reexamining the transcripts to confirm themes and connections related to the participant’s responses. A colleague (S.B.S.) highly experienced in qualitative research read and coded a random selection of the interviews to assess reliability. The agreement between the researcher and the colleague on the final themes was very high, though this was evaluated subjectively between the researchers rather than using psychometric measures.

Ethics

The original study was approved in March 2011 by the Ministry of Defence Research Ethics Committee (Ref 187/GEN/1) and the King’s College London Psychiatry, Nursing and Midwifery Research Ethics Subcommittee (Ref PNM/10/11–112).

Results

Three master themes were identified that represented the perceptions MOs and UWOs hold about help-seeking behaviors in U.K. military personnel: military culture, BTC, and stigma alleviation success. Overlap between military culture and BTC are evident. The purpose of the structuring of these themes is to identify military culture as a mechanism in the development of BTC. Master themes and subthemes are shown in Table 1 supported by extracts from the interviews. MOs and UWOs broadly reported similar experiences; there was one subtheme reported only by UWOs (shown in the last row of Table 1). A brief description of each of the master themes and their subthemes follows.

Military culture

UWOs and MOs perceived aspects of military culture and ideology to be associated with mental health stigma which likely create BTC, as represented by three subthemes: being perceived as weak, malingering, and preference for self-management.

Being perceived as weak

Soldiering on and not letting down the team are part of military ideology. The UWOs and MOs reported that many soldiers believe they should be able to cope with the trauma they are exposed to, as most of their peers do, and fear being labeled as weak if they cannot cope. Perceptions of the severity of traumatic experience were seen as a concern for soldiers; experiences have to be severe enough to warrant having a legitimate mental health reaction.

| Table 1. Summary of themes and subthemes. |
|--------------------------------------------|
| Master theme     | Subtheme                                      |
|------------------|-----------------------------------------------|
| Military culture | Being perceived as weak                        |
|                  | Malingering                                    |
|                  | Preference for managing problems on one’s own  |
| Barriers to care | Impact on career                               |
|                  | Concerns for privacy and confidentiality       |
|                  | Not recognizing that they have a problem       |
|                  | Credibility and acceptance of service providers|
| Alleviation and  | Specific stigma reduction initiatives          |
| interventions    |                                               |
|                  | Education                                      |
|                  | Endorsement by the Chain of Command            |
|                  | Requires strength to seek help (unit welfare   |
|                  | officers only)                                 |
Malingering
UWOs and MOs believed that some soldiers reported mental health symptoms as an excuse for bad behavior, debt, relationship and marital problems, to facilitate a posting back to the U.K. when posted abroad, or to ultimately be discharged from service. Although UWOs and MOs experienced malingers, there appeared to be evidence for UWOs incorrectly labeling soldiers as malingers due to a possible lack of understanding of mental health.

All the guys I don’t truthfully believe have had issues are debt related...The guy that has just come back had been in an IED incident, (he) was absolutely fine but recently his wife left him... and it’s almost now that his wife left him that actually he has an excuse that ‘I was in an incident in Afghanistan’ (UWO 2).

Preference for self-management
UWOs and MOs report that many soldiers report preferring to manage their problems on their own; the UWOs and MOs perceive this “self-reliance” as a method to avoid being labeled as or feeling weak, and avoid accusations of being a malingering or not having a legitimate reason for their problems.

Some people are quite proud and don’t want to ask for help because they have never asked for help and they see it, that they know they have to deal with their own problems” (UWO 3).

BTC
Military culture and the associated mental health stigma was identified as creating BTC. This is represented by four subthemes: impact on career, concerns for privacy and confidentiality, not recognizing or acknowledging they have a problem, and perception of competence and acceptability of service providers.

Impact on career
UWOs and MOs reported that many soldiers are concerned that mental illness and associated perceptions of weakness would likely impact their career such as being classified as medically unfit for duties or missing a promotion. Such concerns for a career impact may not be completely unfounded given the military context and the potential of being classified as unfit for some duties because of the arduous nature of some military jobs.

Yeah I think it’s the stigma of ‘it’s gonna go against me on my career if I’m weak and show that I need help it could go against my career’ (UWO 8).

They can’t be fully employed because they’re under the mental health people and they perhaps can’t be armed for example … they are then given very menial jobs (MO 12).

Concerns for privacy and confidentiality
UWOs and MOs reported that soldiers often request for meetings not to be recorded in medical records. These concerns were thought to relate to anxieties surrounding potential career impact and being perceived as weak or a malingering. Confidentiality can be difficult because of the close-knit community of military bases, especially if soldiers have to travel to unit medical centers.

They have to organise transport frequently through the unit…it becomes quite obvious where they’re going and what they’re going for. I think that’s a bit of a barrier. (MO 16).

Not recognizing or acknowledging they have a problem
UWOs and MOS reported having had contact with soldiers’ who either did not recognize or acknowledge that they were experiencing mental health difficulties. This often meant they did not seek help until convinced to do so by an external source such as their commanding officer or a family member. “Reaching the end of their tether” (UWO 13) may also motivate them to seek help, as this forces the individual to acknowledge they need help.

Because sometimes the person themselves is the one that sees it the least, it’s the people around them that recognise that they have got problems (UWO 3).

Perceptions of competence and acceptability of service providers
UWOs and MOs raise the importance of service providers understanding military culture and deployment experiences so soldiers have respect, acceptance, or trust of service providers. Where service providers appear unknowledgeable soldiers are likely to feel uncomfortable using available services.

If you as a MO are accepted in the unit, I think people will…they’ll be a little bit more open with you … if you didn’t deploy with the unit, … I think you might have a little bit of (a) problem initially” (MO 1).

Stigma alleviation success
Despite the reported barriers, UWOs and MOs perceived a decrease in mental health stigma and increased
acceptability of help seeking. These changes were believed to be associated with various military related initiatives, as demonstrated by four subthemes: specific stigma reduction initiatives, education, endorsement by the chain of command (COC), and seeking help requires strength (UWOs only).

**Specific stigma reduction initiatives**
Two specific stigma alleviation programs were reported by some UWOs and MOs, in addition to public broadcast efforts to raise awareness of mental health issues. The specific programs were “Don’t bottle it up” (http://www.army.mod.uk/welfare-support/23386.aspx), which is an education based stigma reduction campaign implemented in the British Army; and, Trauma Risk Management (TRiM) (Greenberg, Langston, & Jones, 2008), a trauma-related peer support programme used in the U.K. military. These efforts were perceived by the MOs and UWOs as having a positive effect on the alleviation of mental health stigma.

…there’s a lot of advertising going on in ‘Soldier’ magazine, on the radios, you know encouraging soldiers to take up the mental health facilities (MO 7).

**Education**
The MOs and UWOs felt that mental health education currently provided by the Ministry of Defence through the “Don’t bottle it up” program and other ad hoc programs at bases should continue to help dispel myths and encourage help seeking. Contact with soldiers who had positive experiences of accessing services and recovering from mental health problems was one preferred method.

… he came in to kind of just speak to them about his personal experience… and how he got help eventually and is on the road to recovery… I think that was received quite well (MO 6).

**Endorsement by the chain of command**
Ensuring the COC is educated to promote positive beliefs surrounding mental health and service use in their units was raised by the UWOs and MOs. Cohesive units with good leadership were reported as important for the early detection of problems by peers and the COC and for creating feelings of safety and support, thus alleviating concerns of being labeled or any negative effect on their career. Leaders who nurture positive attitudes to mental health may encourage new recruits to seek help.

So I would say the barrier to success in any of this strategy is the chain of command … educate the chain of command…to allow soldiers to come and visit. (UWO 15).

**Requires strength to seek help**
Rather than perceiving help seeking as a sign of weakness, UWOs believed that it takes courage to go and talk to someone, that soldiers need to be committed to benefit from mental health interventions, and be strong enough to not worry about what others think.

If you have mental health problems if you overcome them you are a stronger person for that…. It doesn’t make you a weak person, but that’s how people saw it initially. (UWO 3).

**Discussion**
Thematic analysis of interviews led to the emergence of three master themes representing MOs and UWOs perceptions of mental health and help seeking among U.K. Army personnel; military culture; BTC; and alleviation and interventions. This research is novel and adds to existing literature in the filed through its use of service providers to develop an understanding of help seeking for mental health among U.K. military personnel. The results demonstrate consistency between research conducted with military personnel and with research conducted in the United States and Canada. These consistencies indicate that service providers may be a useful alternate source for understanding service use and help seeking, which may be especially useful in settings where service users are reluctant to engage in research or are hard to reach. Moreover, despite the differences between the U.K., U.S., and Canadian health care service provision and features of the military experience, factors impacting help seeking among military personnel appear to be similar.

**Military culture**
Military culture encourages attitudes of toughness, mission focus, and self and group based reliance (Hatch et al., 2013). Consistent with the MOs and UWOs reports, military culture may contribute to the belief that help seeking is a sign of weakness and that strong self-reliant occupationally ready soldiers should be able to soldier on past any problem or injury (Dickstein, Vogt, Handa, & Litz, 2010; Hoerster, Malte, Imel, Ahmad, Hunt, & Jakupcak, 2012; Hoge et al., 2004; Iversen, van Staden, Hughes, Greenberg, Hotopf, Rona, et al., 2011; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Menon, Strychacz, & Viirre, 2012; Osório, Jones, Fertout, & Greenberg, 2013; Rae Olmsted et al., 2011). The effect of concerns surrounding perceptions of weakness and the need to soldier on is soldiers’ feeling that their problems
or trauma exposure must be severe enough to make any resultant mental health problem “legitimate” (Britt et al., 2011; Gibbs, Rae Olmsted, Brown, & Clinton-Sherrod, 2011).

Associated with concerns for legitimacy are the UWOs’ and MOs’ reports of malingerers. Gibbs and colleagues (2011) reported that soldiers who had not deployed but reported mental health problems were believed to be malingerers. Malingers are problematic as they inappropriately consume resources needed by people with genuine problems (Gibbs et al., 2011; Westphal, 2005). Moreover, the existence of malingering may perpetuate concerns surrounding the need for problems to be legitimate for fear of being labeled as malingering. Consistent with existing U.S. and Canadian research (Momen et al., 2012; Zamorski, 2011), soldiers preference for self-reliance was reported by the UWOs and MOs. Preferring to manage problems on their own may be related to concerns surrounding legitimacy of problems and being labeled a malingering (Britt et al., 2011). The detection of potential malingerers is often at service providers’ discretion and would mostly have an impact on soldiers who were potentially attempting to use a health complaint as a way to exit service. However, the detection and treatment of malingers should be managed carefully to not add to existing cultural BTC such as concerns that a problem is not severe enough to be perceived as legitimate and the worry they will ultimately be labeled as a malingering.

BTC

Military culture was perceived to create barriers to help seeking. Career impact was raised as a major barrier to help seeking. Soldiers fear being perceived as weak and incapable of doing their job effectively, that peers will not trust their ability to work, and leaders will give them menial tasks, if others know they seek help for mental health problems. In a U.K. study 47.3% of participants reported “It would harm my career” as a concern if considering seeking mental health care (Iversen, Van Staden, Hughes, Greenberg, Hotopf, Thornicroft, et al., 2011).

Having mental health problems may realistically impact military careers, just as much as having physical health problems, as they may have implications for certain occupational roles such as not being allowed to carry weapons or pilot a military aircraft (Iversen et al., 2010). The more severe the problem, the higher the likelihood it will permanently and seriously impair function and fitness for deployment (Gould et al., 2010). A preventative measure against mental health impacting careers might be for military personnel to be properly advised by service providers that seeking help may assist in potentially circumventing functional impairment and negative occupation-related outcomes (Gibbs et al., 2011; Momen et al., 2012; Zamorski, 2011).

UWOs and MOs report that the feared career impact and being labeled a malingerer or as weak are likely linked to soldiers’ concerns surrounding confidentiality. In a U.S. study with marines, 37.0% reported lack of confidentiality as a concern impeding help seeking (Momen et al., 2012). Existent research suggests concerns regarding the confidentiality of mental health screening results are mostly due to fears of the impact on future promotions (French, Rona, Jones, & Wessely, 2004). Gibbs and colleagues (2011) found that most participants assumed their mental health issues would be known to the Chain of Command. Concern that peers would also know about mental health issues was caused by a concern that attendance at mental health appointments might lead to peers noticing their absence from duty. Attendance at mental health appointments where soldiers have to travel off base often exacerbate concerns that peers will know where they are when absent from duty. Gibbs and colleagues (2011) proposed ways to address confidentiality concerns including offering after hours appointments and education, reassurance, clarification and consistency surrounding confidentiality and mental health.

A lack of acknowledgment of mental health symptoms by soldiers was attributed to a possible lack of understanding of mental health. In some cases military personnel report experiencing distress but not understanding the distress as a mental health problem for which help is available (Fikretoglu et al., 2008; Zamorski, 2011). Zinzow and colleagues (2013) reported encouragement from family members, especially spouses, as a primary reason for seeking treatment.

Murphy and colleagues (2014) found soldiers ignored their symptoms until the problem reached a level of severity whereby they could not continue without help. This is consistent with the UWOs and MOs reports that soldiers seek help when they have reached breaking point. Soldiers appear to avoid recognizing their problems and soldier on despite being in distress and reach what Murphy and colleagues (2014) referred to as a “crisis point.” This highlights a potential dilemma for the U.K. military, where balance needs to be achieved between encouraging some level of soldiering on for the benefit of occupational effectiveness, but for soldiers to know when it is the right time to seek help.

UWOs and MOs reported that having service providers who understand military culture is important for building rapport and respect, increasing the likelihood of soldiers engaging with services; service providers (e.g., Padres, UWOs, MOs, and CPNs) who have deployed are most accepted. U.S. research indicates soldiers with
PTSD reported they would feel more understood by individuals who had also deployed (Stecker, Shiner, Watts, Jones, & Conner, 2013) and that Air Force personnel lack confidence in services and are hesitant to seek help from civilian personnel because of their inability to relate to military personnel, especially deployment experiences (Visco, 2009).

**Stigma alleviation success**

In the UWOs and MOs experience there had been a reduction in stigma and increased acceptance of mental health and help seeking. U.K. research indicates that between 2008 and 2011 the likelihood of service personnel endorsing stigma or BTC had significantly reduced (Osório et al., 2013). U.S. research shows a similar decrease between 2002 and 2011 (Quarana et al., 2014).

Results from a cluster randomized controlled trial showed changes in attitudes to using peer support and TRiM were evident only in those who received the training but this may not have disseminated to the wider military community over the 18-month study period (Greenberg et al., 2010). The UWOs highlighted their awareness of Don’t Bottle It Up, a two-phase antistigma campaign in the British Army using mixed-media delivery methods to reach personnel of all ranks (Ministry of Defence, 2012). Don’t Bottle It Up has not been subject to any formal evaluation at the time of conducting this research.

UWOs and MOs believe education is an effective method of decreasing stigma and increasing help seeking through the normalization of mental health problems, dispelling myths surrounding career implications and confidentiality, and improving perceptions of available services. The effectiveness of education as a stigma reducing method is supported by civilian and military literature (Britt et al., 2011; Corrigan & Penn, 1999; Gibbs et al., 2011). Consistent with a wealth of U.S. research (Clark-Hitt, Smith, & Broderick, 2012; Hipes, 2011) contact with soldiers reporting positive treatment experiences and testimonies was indicated as a further effective method. U.S. research indicates this is especially effective if the person sharing their story had combat experience as this enhanced their credibility to the soldiers (Clark-Hitt et al., 2012). Senior leaders sharing their experiences of treatment are reported to have a positive effect in reducing stigma and increasing help seeking (Gibbs et al., 2011), especially when those leaders are seen to continue their job successfully (Zinzow et al., 2013).

Attitudes and behavior of leaders was reported by the UWOs and MOs as important in the maintenance of stigmatized perceptions. U.S. research using vignettes indicated that officers report more stigmatized beliefs about soldiers with mental health problems (Hipes, 2011). Consistent with the present study, Zinzow and colleagues (2013) proposed that leaders should be educated to show positive behaviors and attitudes toward mental health and help seeking. Such education of leaders may go some way in reducing mental health stigmatization among military personnel. Zinzow and colleagues (2013) found that positive leader behaviors such as allowing scheduling flexibility, engendering trust, and serving as role models are associated with treatment seeking.

Contrary to the belief that having mental health problems and seeking help is a sign of weakness, four of the UWOs indicated beliefs that those who sought help showed strength and courage. Zinzow and colleagues (2013) found that treatment seeking military personnel demonstrated less self-stigma compared to participants who were nontreatment seekers. They interpreted this as evidence that treatment seekers must have overcome self-stigma to seek help and that treatment seeking may play a role in the reduction of feelings of self-stigmatization. Helds and Owen (2013) and Zinzow and colleagues (2013) proposed that stigma reduction methods should include attempts to reframe beliefs such as “seeking help is a weakness,” by emphasizing that seeking help requires strength and courage.

**Implications and recommendations**

This research provides evidence supporting recommendations for future stigma reduction through various education needs consistent with much existent research and recommendations. Programs designed at increasing help seeking for mental health problems should be aimed at assisting military personnel to improve their ability to recognize mental health symptoms. Service providers should also spend time educating military personnel about mental health problems. Military personnel may be more inclined to acknowledge mental health problems if education could go some way in reframing the belief that treatment seeking is a sign of weakness by promoting the ideology that treatment engagement is a sign of strength. Other military cultural ideologies which could be targeted to decrease BTC, could be the belief that military personnel must soldier on, replacing this with the promotion of early help seeking as a useful strategy for avoiding possible negative career implications of untreated mental health problems. Clarity and consistency of confidentiality policy and rules surrounding mental health treatment seeking could help decrease concerns that others will know about military personnel’s mental health problems and treatment seeking.
Education for leaders might go some way in reducing mental health stigma and increasing a propensity to seek help. Such education should include encouraging leaders to promote positive views of symptom recognition and treatment seeking.

**Strengths and limitations**

This is one of few studies examining service providers’ perceptions of mental health stigma in the U.K. Army using a qualitative method. The main limitation of this study is that the results are a secondary analysis of interviews. Although the interviews covered direct questions regarding mental health stigma and help seeking, this was not the main focus of the study. It is possible that those who agreed to take part did so because they held particularly strong views and therefore may not be representative of the profession more broadly. A further limitation is the inclusion of one nonmilitary participant whose perceptions may be different to the other participants who are Army personnel.

**Conclusion**

Military culture and the promotion of strength and stoicisman was perceived by UWOS and MOs as leading to many concerns surrounding stigma that are associated with help seeking among soldiers. Concerns of being perceived as weak or malingered were associated with concerns regarding the effect of mental health on careers. Consequently, confidentiality of treatment seeking appears a great concern for soldiers. The likelihood of these concerns becoming a reality is exacerbated in those who do not seek help for their problems. Perceived desire for self-reliance and/or the lack of knowledge or awareness of mental health symptoms further impede the likelihood of soldiers seeking help. Early help seeking should be encouraged to decrease the likelihood of any mental health problem leading to career implications. Help seeking should be promoted as a sign of strength and soldiers educated to improve symptom recognition. Methods to educate soldiers could be enhanced with the inclusion of contact with those who have successfully sought help, especially by leaders.

**Funding**

This work was supported by the U.K. Ministry of Defence under grant PCPKETC.

**References**

Blais, R. K., & Renshaw, K. D. (2013). Stigma and demographic correlates of help-seeking intentions in returning service members. *Journal of Traumatic Stress*, 26(1), 77–85.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.

Bridger, R. S., Brasher, K., Dew, A., & Kilmartin, S. (2011). Job stressors in naval personnel serving on ships and in personnel serving ashore over a 12-month period. *Applied Ergonomics*, 42(5), 710–718.

Britt, T. W., Bennett, E. A., Crabtree, M., Haugh, C., Oliver, K., McFadden, A. C., & Pury, C. L. (2011). The theory of planned behaviour and reserve component veteran treatment seeking. *Military Psychology*, 23(1), 82–96.

Clark-Hitt, R., Smith, S. W., & Broderick, J. S. (2012). Help a buddy take a knee: Creating persuasive messages for military service members to encourage others to seek mental health help. *Health Communication*, 27(5), 429–438.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54(9), 765–776.

Dickstein, B. D., Vogt, D. S., Handa, S., & Litz, B. T. (2010). Targeting self-stigma in returning military personnel and veterans: A review of intervention strategies. *Military Psychology*, 22(2), 224–236.

Elbogen, E. B., Wagner, H. R., Johnson, S. C., Kinneer, P., Kang, H., Vasterling, J. J., … Beckham, J. C. (2013). Are Iraq and Afghanistan veterans using mental health services? New data from a national random-sample survey. *Psychiatric Services*, 64(2), 134–141.

Fear, N. T., Jones, M., Murphy, D., Hull, L., Iversen, A., Coker, B., … Wessely, S. (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the U.K. armed forces? A cohort study. *The Lancet*, 375, 1783–1797.

Fikretoglu, D., Guay, S., Pedlar, D., & Brunet, A. (2008). Twelve-month use of mental health services in a nationally representative, active military sample. *Medical Care*, 46(2), 217–223.

French, C., Rona, R. J., Jones, M., & Wessely, S. (2004). Screening for physical and psychological illness in the British armed forces: II: Barriers to screening—Learning from the opinions of Service personnel. *Journal of Medical Screening*, 11(3), 153–157.

Gibbs, D. A., Rae Olmsted, K. L., Brown, J. M., & Clinton-Sherrod, A. M. (2011). Dynamics of stigma for alcohol and mental health treatment among army soldiers. *Military Psychology*, 23(1), 36–51.

Gould, M., Adler, A., Zamorski, M., Castro, C., Hanily, N., Steele, N., … Greenberg, N. (2010). Do stigma and other perceived barriers to mental health care differ across armed forces? *Journal of the Royal Society of Medicine*, 103(4), 148–156.

Greenberg, N., Langston, V., Everitt, B., Iversen, A., Fear, N. T., Jones, N., & Wessely, S. (2010). A cluster randomized controlled trial to determine the efficacy of Trauma Risk Management (TRiM) in a military population. *Journal of Traumatic Stress*, 23(4), 430–436. doi:10.1002/jts.20538

Greenberg, N., Langston, V., & Jones, N. (2008). Trauma Risk Management (TRiM) in the U.K. armed forces. *Journal of the Royal Army Medical Corps*, 154(2), 124–127.
Hatch, S. L., Harvey, S. B., Dandeker, C., Burdett, H., Greenberg, N., Fear, N. T., & Wessely, S. (2013). Life in and after the armed forces: Social networks and mental health in the U.K. military. *Sociology of Health and Illness*, 35(7), 1045–1064. doi:10.1111/1467-9566.12022

Held, P., & Owens, G. P. (2013). Stigmas and attitudes toward seeking mental health treatment in a sample of veterans and active duty service members. *Traumatology*, 19(2), 136–143.

Hines, L. A., Goodwin, L., Jones, M., Hull, L., Wessely, S., Fear, N. T., & Rona, R. J. (2014). Factors affecting help seeking for mental health problems after deployment to Iraq and Afghanistan. *Psychiatric Services*, 65(1), 98–105.

Hipes, C. (2011). The stigma of mental health treatment in the military: An experimental approach. *Current Research in Social Psychology*, 18(5), 20–35.

Hoerster, K. D., Malte, C. A., Imel, Z. E., Ahmad, Z., Hunt, S. C., & Jakupcak, M. (2012). Association of perceived barriers with prospective use of VA mental health care among Iraq and Afghanistan veterans. *Psychiatric Services*, 63(4), 380–382.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. L., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351(1), 13–22.

Hotopf, M., Hull, L., Fear, N. T., Browne, T., Horn, O., Iverson, A., & Wessely, S. (2006). The health of U.K. military personnel who deployed to the 2003 Iraq War: A cohort study. *The Lancet*, 367, 1731–1740.

Iversen, A., Van Staden, L., Hughes, J. H., Browne, T., Greenberg, N., Hotopf, M., … Fear, N. T. (2010). Help-seeking and receipt of treatment among U.K. service personnel. *British Journal of Psychiatry*, 197(2), 149–155.

Iversen, A., van Staden, L., Hughes, J. H., Greenberg, N., Hotopf, M., Rona, R. J., … Fear, N. T. (2011). The stigma of mental health problems and other barriers to care in the U.K. armed forces. *BMC Health Services Research*, 11, 31. doi:10.1186/1472-6963-11-31

Jones, M., Sundin, J., Goodwin, L., Hull, L., Fear, N. T., Wessely, S., & Rona, R. (2012). What explains post-traumatic stress disorder (PTSD) in U.K. service personnel: Deployment or something else? *Psychological Medicine*, 43(9), 1703–1712.

Kehle, S. M., Polusny, M. A., Murdoch, M., Erbes, C. R., Arbisi, P. A., Thuras, P., & Meis, L. A. (2010). Early mental health treatment-seeking among U.S. National Guard soldiers deployed to Iraq. *Journal of Traumatic Stress*, 23(1), 33–40.

Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., & Hoge, C. W. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatric Services*, 61(6), 582–588.

Ministry of Defence. (2012). Army launches phase two of mental health awareness campaign. Retrieved from https://www.gov.uk/government/news/army-launches-phase-two-of-mental-health-awareness-campaign

Momen, N., Strychacz, C. P., & Viirre, E. (2012). Perceived stigma and barriers to mental health care in Marines attending the Combat Operational Stress Control program. *Military Medicine*, 177(10), 1143–1148.

Murphy, D., Hunt, E., Luzon, O., & Greenberg, N. (2014). Exploring positive pathways to care for members of the U.K. armed forces receiving treatment for PTSD: A qualitative study. *European Journal of Psychotraumatology*, 5(1). doi:10.3402/eqpt.v5.21759

Osório, C., Jones, N., Fertout, M., & Greenberg, N. (2013). Changes in stigma and barriers to care over time in U.K. armed forces deployed to Afghanistan and Iraq between 2008 and 2011. *Military Medicine*, 178(8), 846–853.

Quarana, P. J., Wilk, J. E., Thomas, J. L., Bray, R. M., Rae Olmsted, K. L., Brown, J. M., … Hoge, C. W. (2014). Trends in mental health services utilization and stigma in U.S. soldiers from 2002–2011. *American Journal of Public Health*, 104(9), 1671–1679.

Rae Olmsted, K. L., Brown, J. M., Vandermaas-Peeler, J., Tueller, S. J., Johnson, R. E., & Gibbs, D. A. (2011). Mental health and substance abuse treatment stigma among soldiers. *Military Psychology*, 23(1), 52–64.

Rosen, C. S., Greenbaum, M. A., Fitt, J. E., Laffaye, C., Norris, V. A., & Kimerling, R. (2011). Stigma, help-seeking attitudes, and use of psychotherapy in veterans with diagnoses of posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 199(11), 879–885.

Sharp, M. L., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews*, 37, 144–162. doi:10.1093/epirev/mxu012

Stecker, T., Fortney, J. C., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatric Services*, 58(10), 1358–1361.

Stecker, T., Shiner, B., Watts, B. V., Jones, M., & Conner, K. R. (2013). Treatment-seeking barriers for veterans of the Iraq and Afghanistan conflicts who screen positive for PTSD. *Psychiatric Services*, 64(3), 280–283.

Visco, R. (2009). Postdeployment, self-reporting of mental health problems, and barriers to care. *Perspectives in Psychiatric Care*, 45(4), 240–253.

Westphal, R. J. (2005). *Fleet mental health: A discourse analysis of navy leaders’ attitudes about mental health problems* (Doctoral dissertation). Retrieved from Dissertation Abstracts International, 65(10-B), 5078.

Zamorski, M. (2011). *Towards a broader conceptualization of need, stigma, and barriers to mental health care in military organizations: Recent research findings from the Canadian Forces*. Retrieved from http://www.dtic.mil/get-tr-doc/pdf?AD=ADA582781

Zinzow, H. M., Britt, T. W., Pury, C. L., Raymond, M. A., McFadden, A. C., & Burnette, C. M. (2013). Barriers and facilitators of mental health treatment seeking among active-duty Army personnel. *Military Psychology*, 25(5), 514–535.