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Reducing Mental Health Stigma in The Army

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REDUCING MENTAL HEALTH STIGMA IN THE ARMY

by

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Abstract

Mental health stigma has been identified as a barrier to accessing needed mental health care among soldiers. With the prevalence of mental health concerns identified among soldiers returning from overseas operations and the current number of suicides among veterans, efforts to reduce stigma need to be implemented. Commanders and other key leaders within Army units are in a key position to assist in changing mental health stigmas. Literature was reviewed to learn about research guided interventions targeting mental health stigma and to develop a presentation to deliver to line commanders (within the 88th Regional Support Command area of operation) based upon the evidence. However, limited research was available that discussed interventions to be implemented at a unit level. As a result gaps were also identified for further research to improve upon current interventions.

Introduction

Prior to the conflicts in Iraq and Afghanistan, just over seven percent of all adults aged 18 years or older in the United States (US) reported having a serious mental health illness, and less than half of those individuals reported seeking care (Substance Abuse and Mental Health Services Administration, 2002). In 2012, the number of US adults reporting mental health illnesses increased to 18.6% (Substance Abuse and Mental Health Services Administration, 2013). While it is unknown how many of the surveyed adults reporting mental illness were veterans, numerous studies indicate that soldiers returning from deployment in Iraq and Afghanistan have a heightened risk of developing mental health conditions due to combat exposures. Nearly 20% of veteran soldiers returning from conflicts in Iraq and/or Afghanistan have been identified as having a mental health concern following a Post-Deployment Health Assessment (PDHA) screening (Hoge, Auchterline, & Milliken, 2006). This assessment is utilized by the Army and other military forces to assist in the early identification of deployment related illnesses and injuries. The PDHA is administered either prior to the soldiers leaving theater or at the demobilization site upon returning to the United States. In 2005, the Department of Defense implemented a second screening, the Post-Deployment Health Reassessment (PDHRA), which is conducted between 90-180 days after the soldiers have returned from deployments (Department of Defense, nd). The timing of the PDHRA is significant, as mental health concerns may not manifest until several months after deployment, well into the reintegration process (Milliken, Auchterline, & Hoge, 2007).

Unfortunately, it was found that less than half of the soldiers reporting mental health concerns sought care after undergoing post-deployment health assessments and receiving mental health care referrals (Milliken, Auchterline, & Hoge, 2007). In addition to this concern is the fact

that the average number of deaths by suicide among veterans has remained between 18 – 22 deaths per day since 2001 (Kemp & Bossarte, 2013).

The low number of soldiers seeking treatment has been attributed to barriers to health care access and stigma (Vogt, 2011). Barriers to care can include knowledge deficits of available resources, geographical distance to resources, and limited financial means or health insurance coverage (Kim et al., 2011). Stigma, referred to as a negative perception or prejudice, can be internalized by the individual or represent the beliefs held by others and reflect a social norm (Dickstein, Vogt, Handa & Litz, 2010). While Goffman (1963) had theorized that stigmas could be classified into three categories of prejudice, those implicating physical inadequacies, others that suggest character shortcomings or psychological illness, and the third pertaining to 'tribal' or cultural traits, Weiss et al (2006) proposed a new definition of stigma from a health related perspective which encompasses a cross-cultural approach as well:

> Stigma is a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation, that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted (p 280).

The stigma perceived by soldiers has also been related to the military culture of needing to be physically and mentally strong. The recruiting catch phrases used by military forces, such as "Army Strong," may inadvertently build upon the stigma (McFarling et al., 2011). Acknowledging having a mental health condition demonstrates weakness based upon this stigma. In addition, obtaining treatment is a viewed as admitting to failure or a weakness where soldiers

have been found to believe that mental health issues should be handled by themselves (Wright et al., 2009).

Other stigmas are related to career outcomes or consequences of having a mental health condition. These stigmas may stem from the organizational structure of the military and the regulations or guidelines published by the Department of the Army. The Army follows medical readiness guidelines to ensure that soldiers, and the units they are assigned to, are prepared to accomplish mission requirements. Based upon the guidelines, soldiers may be found unfit for duty depending on physical or psychological conditions, prognosis, treatment and limitations (Department of the Army, 2007). Generally, in order for soldiers to be deemed 'unfit' or 'un-retainable' based upon the regulation, their condition must have met the medical retention determination point which indicates there is little or no chance for improvement in the soldier's condition or limitations (Department of the Army, 2007). Therefore, having a diagnosis of a mental health condition does necessarily indicate the soldier will be discharged. Yet, there remains potential for the condition to impact career, and soldiers may feel discouraged from seeking care or disclosing a condition.

Purpose

The purpose of this independent project is to review best practices which may reduce mental health stigma. It is hoped, that through the dissemination of this evidence, mental health stigma may be reduced while increasing the utilization and perceived accessibility of mental health care, and shift towards a health promotion and illness prevention outlook. It is intended that the information learned through the literature review will be utilized by commanders and health care professionals with the US Army Reserves to build upon available resources targeting

mental health stigma and improving medical readiness. Information gathered through this literature review will be disseminated through briefings to the Army's Operational and Functional Training and Support (OFTS) Commands at training events facilitated by the 88th Regional Support Command, located at Ft. McCoy, Wisconsin.

Significance

By identifying evidenced based methods to counter existing stigma, the goal is to impact military leaders in positively influencing the medical readiness and the overall health of their soldiers by supporting them to seek health care as needed. The knowledge gained through this project will be put into direct practice by disseminating the findings to Army leaders. Ultimately, it is hoped that those leaders will transfer the knowledge into their own command philosophy thereby positively changing social norms related to mental health illnesses that health seeking behaviors will increase among soldiers and suicide rates will decline.

Theoretical Framework

The theory of planned behavior was chosen as the framework for this project as it identifies the importance of an individual's perceptions and beliefs on impacting motivations as applicable to health seeking behaviors. The theory of planned behavior was developed to predict individual's actions based upon their intentions or motivations (Ajzen, 1991).

Naturally, the presence of actual resources directly impacts the individual's ability to make decisions. The planned behavior theory focuses on three main constructs related to motivation, while noting that external factors such as availability of physical and financial resources, in addition to opportunity must be present in order for the behavior to occur (Ajzen, 1991). The three constructs which have been shown to impact decisions are attitudes, social

norms, and perceived controls. Attitudes relate to the individual's beliefs pertaining to the behavior outcome. Social norms are defined as the beliefs related to the behavior held by the individual's community or significant others. These beliefs can include expectations regarding the behavior or decision of the individual (Nejad, Wertheim & Greenwood, 2005). Finally, perceived controls refer to the individual's ideas relating to their ability or self-efficacy to perform the behavior. These three factors impact each other as well as comprise the individual's intention to perform the behavior. Intention refers to how motivated the individual is to follow through with the behavior and what they will put forth, in order to achieve the behavior or desired outcome (Ajzen, 1991).

Provided the health care resources are physically and financially accessible, the theory of planned behavior is applicable to efforts focused on reducing mental health stigmas through the demonstration of how the stigmas impact an individual's motivations for accessing needed care. The social norms or public stigmatization of mental health illnesses and treatment are based upon prejudices which can directly impact the attitudes and perceived control on the illness and treatment by individuals who have a mental health illness, if they believe the stigmas to be true (Dickstein, Vogt, Handa, & Litz, 2010). Therefore, by targeting mental health stigma within the military, it can be concluded that soldiers may be more likely to seek mental health care when needed as social norms would not negatively influence intentions to do so.

Process

With the use of PsycInfo, PubMED, CINAHL and Google Scholar, 119 articles pertaining to mental health stigma within military forces were found. Search terms used included: Stigma, Mental Health, and Military. Articles written prior to 2005 were excluded as

the health assessment screenings used by the military had changed and were implemented in 2005, improving the early identification of soldiers in need of medical care and specifically mental health care (Department of Defense, Deployment Health Clinical Center, nd). Of the total articles, 43 were retained for content focused on mental health stigmas and stigma interventions which are able to be applied by company level commands. Those articles excluded examined system approaches utilized by health care entities outside of the US military forces which cannot be influenced directly by military commands, as well as mental health stigmas pertaining to veterans from world conflicts prior to 9/11. In addition to the articles found during the search, information available through the Department of Defense, Veterans Health Administration, the Department of the Army and the US Department of Health and Human Services were utilized for background information. While economic and physical barriers to accessing care exist, the focus of this literature review was to learn about the impacts of mental health stigma as it relates to seeking treatment and specifically, methods to reduce mental health stigma among Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans.

Literature Review: Evidence Based Strategies to Reduce Stigma

Numerous studies have been conducted to examine the various barriers to accessing mental health care among soldiers and specifically OIF/OEF veterans. The military has a culture unique from the civilian sector. It is engrained within the military culture that soldiers are supposed to be physically and mentally 'strong'. Having a mental illness is seen as a weakness and fosters feelings of inability to perform duties, especially in a combat environment (Wright et al., 2009). These perceptions have been found to be more prevalent among the individuals who disclosed having mental health illness and is a barrier to accessing needed care (Wright et al., 2009). In contrast, a study by Elbogen et al. (2013), found that veterans reporting severe mental

health needs were more likely to seek care. However, they were also more likely to report perceived stigma. It was noted within the same study that the stigmas associated with the care or treatment varied depending on the veterans status, meaning that stigmas endorsed by veterans participating in care are different from those who do not seek mental health care. Stigmas held by participants may hinder them from fully engaging in care and returning for follow-up care. (Elbogen et al., 2013).

Protesting

Two of the articles retained in the literature search explained general intervention strategies for targeting stigma. These articles reviewed previous studies related to mental health stigma within the military and discussed three types of interventions (protesting, education, and contact) identified by Corrigan and Penn's (1999) article. The first class of interventions targets public stigma by 'protesting' or outwardly discouraging the endorsement of the stigma (Greene-Shortridge, Britt, & Castro, 2007). This strategy can take the form of public service announcements or similar communication techniques which dictate to society or populations that stigmas they shouldn't endorse stigmas. While a feasible intervention, this was discussed as the least effective of the three strategies as it can lead to undesirable outcomes if individuals recall negative experiences pertaining to mental health illnesses and stigmas (Greene-Shortridge, et al., 2007). By recalling negative experiences, protesting may trigger an endorsement of stigmas that had once been resolved or discredited by individuals. In addition, Corrigan and Penn (1999) concluded that this phenomenon occurs as a rebound effect of the protesting method when the stigma is not replaced with a positive attitude or thought. In these instances lacking positive promotions with rationale, protest method may strengthen a stigma the audience recalls through negative association.

Education

The second strategy is to provide education pertaining to mental health illnesses and treatments to general populations who may or may not have a mental health illness. Because mental health stigma can include a component of causality, education should include descriptive etiology to counter the individual with the illness as being the cause of it (Greene-Shortridge, et al., 2007). Educational interventions have been discussed as contributing to a change in behavior (Dickstein, et al., 2010) although the authors of the review indicated there was limited research available to link to long-term changes of endorsed or discredited stigmas. A study conducted to examine the effects of educational strategies on countering mental health stigmas held by medical students, indicated that short term changes occurred, but did not remain six months following the intervention (Friedrich et al., 2013). Medical students completed baseline and incremental post-intervention questionnaires to determine duration and degree of perception changes. Results of the study led to the conclusion that further research is needed to examine the effects of utilizing education along with another approach or having multiple educational sessions (Friedrich et al., 2013).

Contact

The final class of stigma interventions is referred to as 'contact'. As the name implies, this strategy would allow for interactions between soldiers/veterans with and without a mental health illness. An example of a contact approach could include a presentation by an individual with a mental health illness describing their personal experience of having the illness or life story (Dickstein, et al., 2010). The contact strategy is thought to be most effective at reducing mental health stigma by yielding positive experiences and countering stigmas. The two reviews differ in

the method or approach to this strategy. While Dickstein, et al. (2010) describe an approach of the individual with the mental health illness speaking to a group of people, Greene-Shortridge, et al. (2007) concluded that this strategy works best in a one-on-one environment.

Social contact interventions were studied for differences in the effectiveness of attending an education lecture (control group), experiencing a live presentation, or a filmed documentary as related to discrediting mental health stigma (Clement et al., 2012). It was found through a randomized controlled trial that there were no significant differences in the impacts of a live presentation versus a recorded documentary. Both intervention groups demonstrated positive changes immediately after the encounter when compared to the control group, and these changes were maintained four months post-intervention. Baseline and incremental post-intervention beliefs and knowledge were measured in all three groups of participants. (Clement et al., 2012)

Several research articles described the utilization of peers and unit leadership as impacting stigma and the overall climate or culture within a military unit. The specific interventions discussed are considered both education and contact strategies. Peer and leadership-based interventions were identified for how individuals can directly influence each other. Finally, a third more specific intervention, titled Battlemind Training, encompasses the use of peers and leadership to implement training which instills understanding of mental health concerns in a group environment (Adler, Bliese McGurk, Hoge & Castro, 2009).

Battlemind Training

The Walter Reed Army Institute of Research (WRAIR) developed a training program with the goal to strengthen mental health coping strategies for successful reintegration of soldiers following deployment, while developing unit cohesion and guiding leaders to assist soldiers. The

training initially titled 'Battlemind Training,' focused on associating the coping strategies soldiers use in a combat environment for survival to events in the past and retraining soldiers on effective coping mechanisms for current, noncombat, situations in the present (Adler et al, 2009). This strategy normalized traits, such as hyper vigilance, as a survival trait in a combat environment and assisted soldiers to realize that these qualities will remain for a period of time during the reintegration phase while the soldier adjusts to a non-combat environment. In addition, Battlemind Training allowed soldiers to openly discuss stressful experiences pertaining to reintegration in a supportive group environment without going into detail of specific traumatic events. While the training has been linked to a decrease in posttraumatic stress symptoms, it was also found to reduce stigma associated with seeking mental health treatment by normalizing help seeking behaviors. Participants in a study who underwent Battlemind Training reported less affects from stigma as compared to participants who underwent stress education or debriefing sessions following combat deployment (Adler et al, 2009). The stress education sessions were used as control group as that was standard practice of the Army for returning soldiers. The debriefing sessions were similar to Battlemind Training by reframing traits utilized during deployment but had participants focus and describe specific stressful experiences from their deployment. In contrast, the Battlemind Training group not only reframed survival traits but educated the participants in ways to assist themselves and each other through the reintegration phase of post-deployment (Adler et al, 2009). The effectiveness was measured through a baseline questionnaire as well as immediately after the sessions. In a similar study, it was concluded that Battlemind training conducted four months post-deployment, yielded positive results in reduced mental health symptoms and decreased perceived stigma at a six month post-

intervention follow-up screening (Castro, Adler, McGurk, & Bliese, 2012) indicating that long-term positive effects of Battlemind Training exist.

It was found that soldiers who participated in Battlemind training would be over one and a half times more likely to seek mental health care if referred from a military screening than other soldiers (Warner et al, 2008). While Adler et al. (2009) found that efficacy of the training was dependent on the level of combat exposure; Castro et al. (2012) results differed, with soldiers exposed to varying combat levels reporting results with no significant differences. Battlemind training has since become a requirement for all returning units by the Army, in part, to reduce units/soldiers from being ostracized during reintegration due to combat exposures which could potentially create or build stigma (Adler et al, 2009). This intervention became an organizational requirement in 2008 (US Army Medical Department, 2013).

Battlemind training has since evolved into "Resiliency Training," which captures the needs of soldiers throughout the deployment cycle as well as during formal Army training schools such as Basic Combat Training or Officer Candidate School. The program also aims to support the needs of a soldier's family in pre- and post-deployment transitions. As a peer intervention, soldiers are trained to become certified "Master Resilience Trainers" to lead learning sessions and assist others within their units (U.S. Medical Department, 2013).

Similar to Combat Operation Stress Control (COSC) and Battlemind training, Bryan and Morrow (2011) researched and developed a program where a psychologist was imbedded in an Air Force unit to provide skilled psychological training to the members of the unit. The program utilized language and tactics existing within the airmen's culture to build upon coping strategies to maintain emotional and mental health for optimum wellbeing, in addition to meeting military

retention standards. Over 190 airmen participated in the program with greater than two thirds indicating approval of such a program. While this study did not address the effectiveness of the program to overcome mental illness, its purpose was to study the acceptability of having a mental health professional work alongside and potentially change the perspective of mental health care utilization to one of prevention and health promotion (Bryan & Morrow, 2011). Further research is needed to determine the efficacy of this intervention to reduce stigma and the feasibility of imbedding mental health professionals within other branches of the military.

Peer/Family

Peer or family relationships are also described as interventions to combat mental health stigmas. Pfeiffer et al. (2012), utilized interviews and focus groups to gather perspectives from 30 National Guard soldiers regarding the use of peers to periodically follow-up and guide soldiers to professional mental health care when needed (Pfeiffer et al., 2012). Findings indicated there was a general consensus among soldiers in the study that they would support the use of peer based interventions in the presence of existing unit cohesion. However, the researchers identified that within units lacking cohesion and supportive networks, there was a strong resistance to the utilization of a peer based intervention program by those who need it most, due to a lack of trust in their peers (Pfeiffer et al., 2012). Another concern regarding peer based interventions is that the needs of an individual may exceed what a peer group is able to provide, in which case the individual may be reluctant to seek care as they may perceive this as failing the group (Langsdon, Gould, & Greenberg, 2007). This concern could be countered through training prior to implementation of an organized or formal peer intervention and ensuring the knowledge of available resources such as described in the strategy "Peer Mentoring Care and Support" (PMCS) (Keller et al., 2005). Within this formal strategy, soldiers were selected to participate in

training to assist in a risk assessment of peers who were subjected to a potential traumatic event or circumstance. The purpose of PMCS is for the early identification of a soldier who is in need of professional mental health care and to assist others in further developing coping skills during distressing events thereby increasing unit cohesion and decreasing stigma by allowing the unit to care for and support the soldier (Keller et al., 2005). While a number of articles were found to describe peer relationships as a method to assist in discrediting stigmas and referring soldiers/veterans to needed care, research examining the efficacy of this approach is still needed.

In addition to the utilization of soldier peer groups, spouses and significant others have been identified for their role in the early identification of needed mental health care. When soldiers return from deployment spouses, significant others, or parents, are invited to participate in re-integration seminars (Yellow Ribbon Program) during which, information is discussed pertaining to the emotional aspects of re-integration from the perspective of both the families and the veteran. These seminars are currently scheduled throughout the deployment cycle, (pre-during and post-deployment).This provides families the opportunity to learn about means to assist their soldier and themselves in seeking care if/when signs and symptoms of a mental health concern arise (Buchanan et al, 2011).

Leadership

Positive leadership attributes have been linked to greater mental resiliency and successful re-integration of soldiers in multiple studies. Wright et al. (2009) discussed findings that regardless of the level of combat exposure, leadership qualities contributed to how closely soldiers followed 'battlefield ethics' and soldiers' overall mental health during deployment cycles. Leadership has the capability of setting a command climate that fosters a genuine concern

of soldiers' wellbeing, demonstrated through personal actions and interactions with subordinates and colleagues. A positive command climate builds unit cohesion which coincides with developing supportive peer relationships. In Wright et al's (2009) study, veterans completed a questionnaire focused on their own psychological symptoms, unit and command attitudes or behaviors, stigma, and health care access barriers, three months after returning home. The results indicated that stigma and health care access barriers were inversely related to positive leadership attributes, such as genuine concern for soldiers, and unit cohesion (Wright et al., 2009). Within a positive, supportive environment soldiers are more likely to seek care and perceive less stigma regarding mental health illness and treatment (Wright et al., 2009).

Additionally, genuine concern for soldiers will likely motivate leaders to assist with organizational or practical barriers for soldiers who are in need of care (Britt, Wright & Moore, 2012). For example, while in theater in Afghanistan, Combat and Operational Stress Control (COSC) teams, which are usually comprised of a mental health provider and an enlisted mental health specialist, were deployed to various forward operating bases (FOB) to perform outreach services and provide mental health support to soldiers in more isolated areas (Ogle, Bradley, Santiago & Reynolds, 2012). Transportation of the COSC members to the various locations consumed space among vehicles that would otherwise be used for transporting supplies and mail. Despite these logistic impediments, the COSC were routinely requested by commanders to be present for their soldiers (Ogle, Bradley, Santiago & Reynolds, 2012). This action clearly demonstrated the commands' concern and understanding of the importance of their soldiers' wellbeing. The internally maintained records of the COSC team (weekly activity reports) demonstrated that soldiers sought out group and individual services. The overall COSC utilization was attributed to the supportive environment instilled by the leadership efforts to have

and maintain a COSC presence as a regular ancillary service for the soldiers (Ogle, Bradley, Santiago & Reynolds, 2012).

Discussion

Interpretation of evidence

Given the prevalence of mental health concerns among veteran soldiers from the OIF/OEF wars, it is important that soldiers and their families are aware and accessing needed healthcare so as to prevent deterioration of health and difficulties with re-integration. As soldiers and families continue the transition of adjusting to life post-war, it is likely that mental healthcare needs within the military and veteran services will continue, if not increase. Soldiers and family members should not feel hindered from seeking care from fear of stigma. Medical readiness of individual soldiers, as well as units, is impacted in a negative manner when health conditions deteriorate. Seeking healthcare in a timely manner can prevent negative outcomes for both the individual and units.

Limited research is available to determine an evidenced based method for reducing mental health stigma at this time. Within the reviewed research, the contact method was identified as being the best practice for discrediting mental health stigmas. Despite this finding, it may not be the most feasible method within a military setting due to career impacts of certain health conditions. Regardless, efforts continue by the Army with its ongoing Resiliency Training program, utilizing a combination of the protest, education and contact methods identified by Corrigan and Penn (1999) to target the effects of negative stigmas. Based upon the available research, programs combining the methods are probable with some success, although it is unknown to what degree at this point in time.

The impacts of senior leadership and unit cohesion were also discussed within studies as providing positive support for soldiers in need of mental health care. In particular, leaders are charged with knowing personal aspects of soldiers. Expressing genuine concern was found to instill a sense of support from the leaders as well as unit cohesion. The overall culture of military units may vary depending upon the nature of their mission. Therefore leaders must also take into account the unique relationships and motivations among the group.

Nursing implications

Research

Further research is needed to determine the efficacy of interventions, such as Resilience Training, with the hopes of reducing mental health stigma. To date, little research is available to determine the most effective intervention to impact cultural views of mental health illness and treatment. Careful attention should also be placed on determining specific long term methods for discrediting stigma. In addition, future interventions studied should include impacts for non-veteran soldiers. While not having combat experience, non-veteran soldiers are not excluded from potential mental health care needs. Soldiers may have entered the military with pre-existing mental health conditions and through the natural progression of illnesses or exposures to various situations, experience exacerbations or reoccurrence of their symptoms.

As the program is currently implemented, Resilience Training is not routinely conducted outside of school and deployment settings. The possibility of implementing Resilience Training at additional times or routine frequencies should be considered and studied for impact. This could potentially capture soldiers who would otherwise have limited exposure to the training.

In addition to determining impacts on health seeking behaviors, stigma interventions should be studied for correlations to suicide rates to determine any impacts. With the continued rise of deaths by suicide among service members, interventions are clearly needed. Interventions targeting mental health stigma may have additional benefits of contributing to a decline in suicide rates by encouraging health seeking behavior.

Finally, existing interventions targeting mental health stigma need to be studied and carefully planned so as not to cause an 'attitude polarization' as discussed by Dickstein, Vogt, Handa, and Litz (2010). This has been described as an event that creates stigma by directing blame or causality towards select individuals, in this case soldiers/veterans with mental health illnesses. Few of the research articles retained in the literature review discuss this phenomenon which would strengthen existing stigmas by either recalling or creating negative experiences related to mental health issues. In particular, it is possible that soldiers may place blame upon individuals with mental health concerns, for having to attend specific training or seminars pertaining to mental health or resilience. More research is needed to determine how to assess for the presence of this phenomenon as well avoidance of 'attitude polarization'.

Practice

Army and Veteran Administration (VA) nurses are in a valuable position to educate soldiers on the positive impacts of preventive mental health care and foster resiliency to stressful situations. Nurses should capitalize on the ability to reach out to a large audience and be encouraged to participate in re-integration seminars as presenters and subject matter experts to disseminate mental health information to both soldiers/veterans and their families as a means to target public stigma. Education is needed to ensure that soldiers are aware that seeking or

accepting treatment of a mental health illness does necessarily indicate that the soldier will be discharged from the Army. Rather, health seeking behavior should be encouraged as a means of maintaining or improving quality of life, therefore preventing a decline in the soldier's medical readiness and fitness as viewed by the Army.

Army and VA nurses should also capitalize on the utilization of the various periodic health assessments in order to identify soldiers in need of mental health interventions and/or referrals to mental health providers. Case management initiatives should also be supported to assist soldiers in prevention of mental illness exacerbations and management of chronic conditions through the various mental health resources available in the military and civilian sectors. Partnering with the US Army Reserve Regional Support Command Surgeon Office would allow nurses to work with the Directors of Psychological Health to assist with outreach and case management services.

In addition to caring for the soldiers, nurse case managers, as well as the providers involved in the periodic health assessments, should capitalize on the opportunity to discuss resources available for the soldier's family members. While currently the VA healthcare system does not provide health care for families of veterans, services such as Military One Source are available at no cost for mental health care. By further developing and directing assistance specifically for family members, strategic level providers within the military would be demonstrating positive leadership traits of concern for the holistic soldier and their family.

Education

In order to appropriately care for soldiers and veterans, nurses need to be culturally aware of the differences between military and civilian populations. Soldiers and veterans have been trained to react to combat situations and various traumatic events which put them at risk for developing mental health illnesses such as Post Traumatic Stress (Greenberg, Langston & Gould, 2007). Due to the unique culture within the military, cultural competence will assist nurses as well as other health care providers to understand the stigmas surrounding mental health illness within the military. With the increasing number of veterans due to OIF/OEF, it is important for nursing students to be aware of their unique mental health needs and culture.

Health care resources available to soldiers and veterans are unique to their status and physical location. While active component has immediate access to military treatment facilities (MTF) located on military installations, US Army Reserve soldiers must utilize private sector facilities or Veteran Health Administration sites unless they are in a temporary active duty status. (AR 40-400, 2010) Nurses must be educated regarding the support networks within both the military and civilian sectors.

Policy

Nurses should work alongside public and military officials, as public health advocates, to create legislation and regulation aimed at preventing discrimination of individuals with mental health illnesses. In addition, nurses should lend support to efforts aimed at increasing individual resilience as outlined by the Army Medicine 2020 Campaign (Department of Army, 2013), with the purpose of "improving stamina" within the Army. Within the military, nurses should involve themselves with the organizational review of Army medical readiness and retention standards

(AR 40-501, 2007) in order to ensure soldiers are allowed appropriate time to treat and stabilize mental health illnesses prior to being evaluated for military separation. Furthermore, as subject matter experts, Army nurses are in the position to ensure that AR 40-501 is implemented correctly by advising commands appropriately on the medical fitness of their soldiers.

Summary

Soldiers are required to meet medical readiness standards to ensure they are physically and mentally prepared to accomplish military missions. Disclosure of mental health conditions has long been viewed as a weakness or failure on behalf of the soldier. While the Army has implemented strategies to assist in the early identification of illnesses among soldiers returning from deployment, efforts are still needed to encourage soldiers to follow-up with referrals for mental health care needs. Reducing stigma associated with mental health illnesses is a vital component to addressing health seeking behavior among soldiers as it impacts soldiers' motivation or intention of seeking care.

Research has demonstrated that peers and leadership have the capability of impacting the culture or climate within units. Genuine concern of leaders and peers has been found to positively impact stigmas by reducing the barriers to accessing care and the perceived negative outlook of others upon the individual or illness. Currently the Army utilizes a program which capitalizes the use of peers to assist in teaching effective coping mechanisms for difficult situations. Ensuring unit leadership is aware of the available resources to assist soldiers is imperative. Leadership figures such as commanders are in a key position to directly influence the wellbeing of soldiers by encouraging the participation in 'Resilience Training' among soldiers

and families thereby working to create a positive and supportive environment to train to improve and maintain health. As the name implies, the purpose of Resilience Training is to ensure soldiers are resilient and able to effectively cope with situations, in or out of combat. However, much remains to be learned regarding how effective the training is for mental health prevention and promotion as well as its impact on mental health stigma.

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Appendix:

Presentation to be given to 88th Regional Support Command

Subordinate Operational, Functional, Training and Support Commands

June 2014

Reducing Mental Health Stigma

CPT Jacqueline R. Sieber
BSN, RN
University of North Dakota
June 9th, 2014

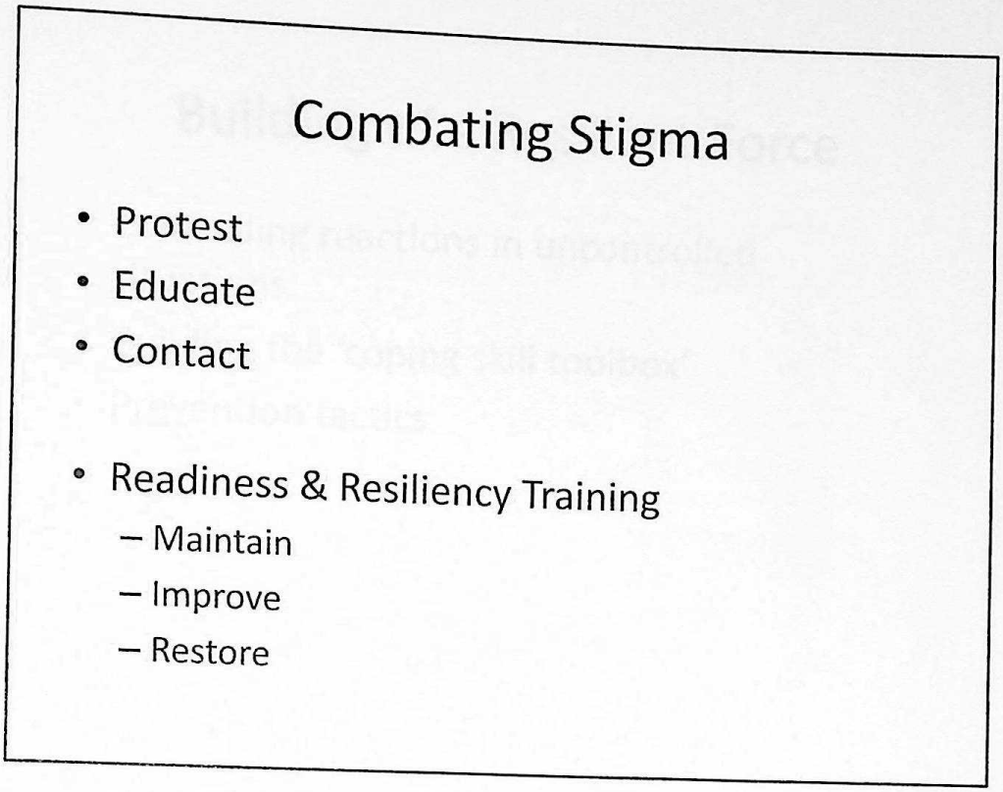
Stigma as a Barrier

- Stigma is a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation, that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted. (Weiss et al, 2006)

- Impact of stigma
  - Fear of career outcomes
  - Perceptions of others
  - Self perception

Medical Readiness Implications

- AR 40-501 Ch 3 & 9
  - Soldier's responsibility to report changes in medical conditions which impact medical readiness.
  - Profile limitations
  - Medical accession & retention standards
- Periodic Health Assessments
  - Self reporting of conditions
  - Basic age-related health risk screening



Corrigan & Penn (1999) Three basic intervention tactics were discussed for combating mental health stigma:
Protest: PSA – directs against stigma
Education: lecture/seminars – correct misconceptions through learning activities
Contact: Exposure to individual w/ MH illness – personifies condition/story while discrediting stigma

AMEDD 2020 Campaign, DoA (2013):
Army's mental healthcare campaigns have evolved from post-deployment debriefings at 'DEMOB' platforms to embedded Combat Operational Stress Control teams and Battlemind Training. Studies on Battlemind Training have captured information that the methodology utilized within the training assists with the reduction of mental health stigma. Specifically the training focused on normalizing experiences pertaining to combat environments (survival instincts that are otherwise not 'normal' in a noncombat situation i.e. hyper vigilance, driving tactics) and assisting soldiers to understand the transition process/reintegration. Battlemind training has since evolved into Resilience training which focuses building coping skills to allow soldiers to maintain emotional 'control' in stressful situations and be prepared for a various life stressors. Resilience Training has become a
R2 training: Through the creation of a System for Health (SFH), the Army healthcare providers are working to partner with soldiers, families, leaders, and communities to promote **Readiness, Resilience & Responsibility**

-Maintain health through fitness and illness/injury prevention (health promotion / primary & secondary care)

-Restores health through patient centered care

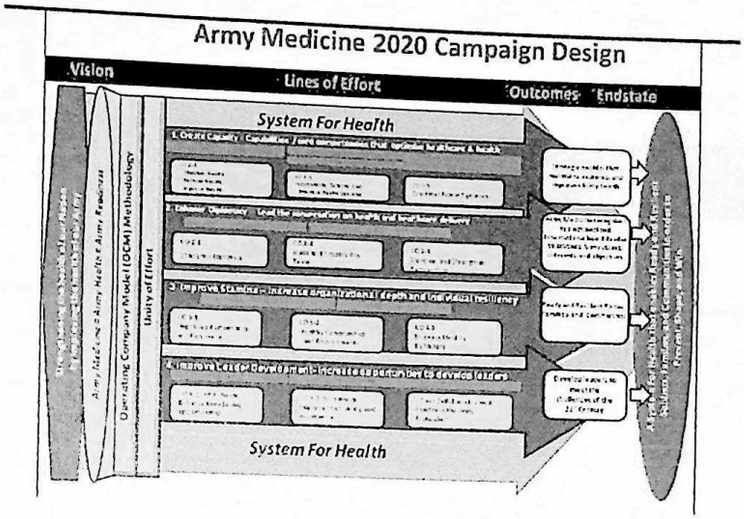
- Improve health through informed choices in the **Lifespace**(1/3 sleep, 1/3 work, 1/3 family & friends/leisure)

Performance Triad: Activity, Nutrition, Sleep: balance

Building of a Resilient Force

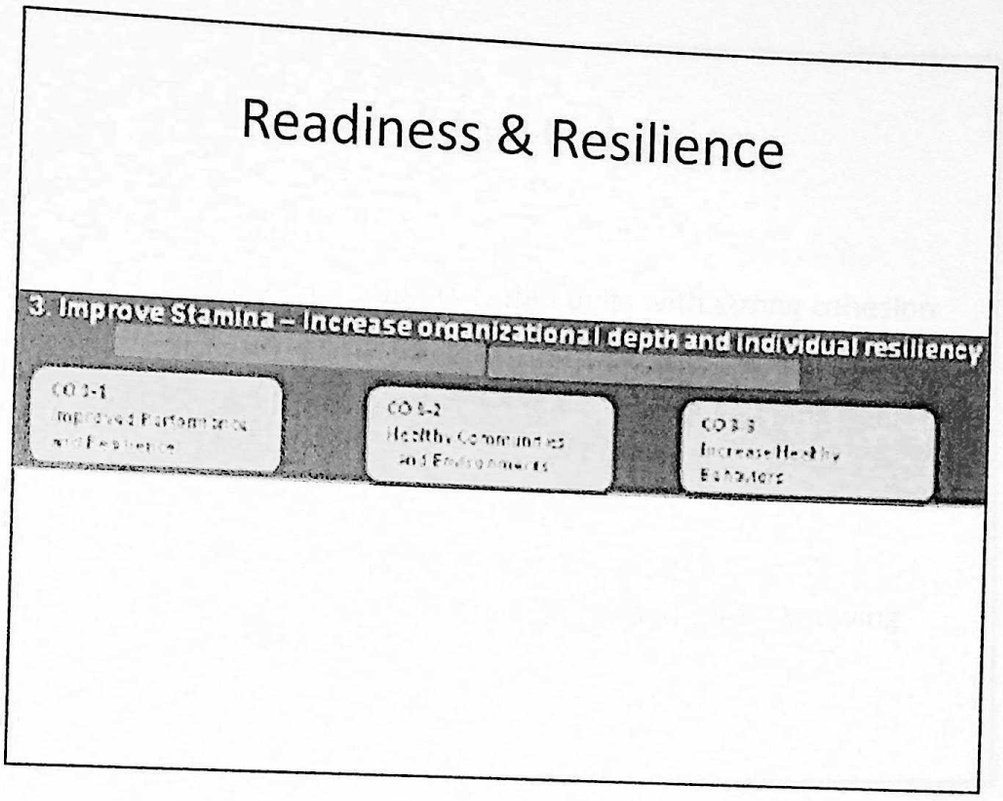
- Controlling reactions in uncontrolled situations
- Building the 'coping skill toolbox'
- Prevention tactics

AMEDD 2020 Campaign



AMEDD 2020 Campaign, DoA, 2013

End state of campaign: promotion of System for Health focused on health promotion, as well as Ready & Resilient Campaign



Line of Effort #3 pertains to Resilience building with health promotion education and activities.

It utilizes the Performance Triad as well as the Health Infrastructure to support all three areas of: Improved performance and resilience, Health Communities & Environments (edu re: health choices/responsibility), Increase of healthy behaviors (responsibility)

All three operations utilize the 'Maintain, Restore, & Improve'

Peers/Unit Cohesion

- Peer Group
  - Endorsed by soldiers within units with strong cohesion
- Peer Mentoring Care and Support (PMCS)
  - Formal training program to assist in developing peer support groups
- Limitations:
  - Knowledge of peers
  - Ability to refer individuals to needed care – knowing own abilities.

Pfeiffer et al, 2012
Keller et al, 2005

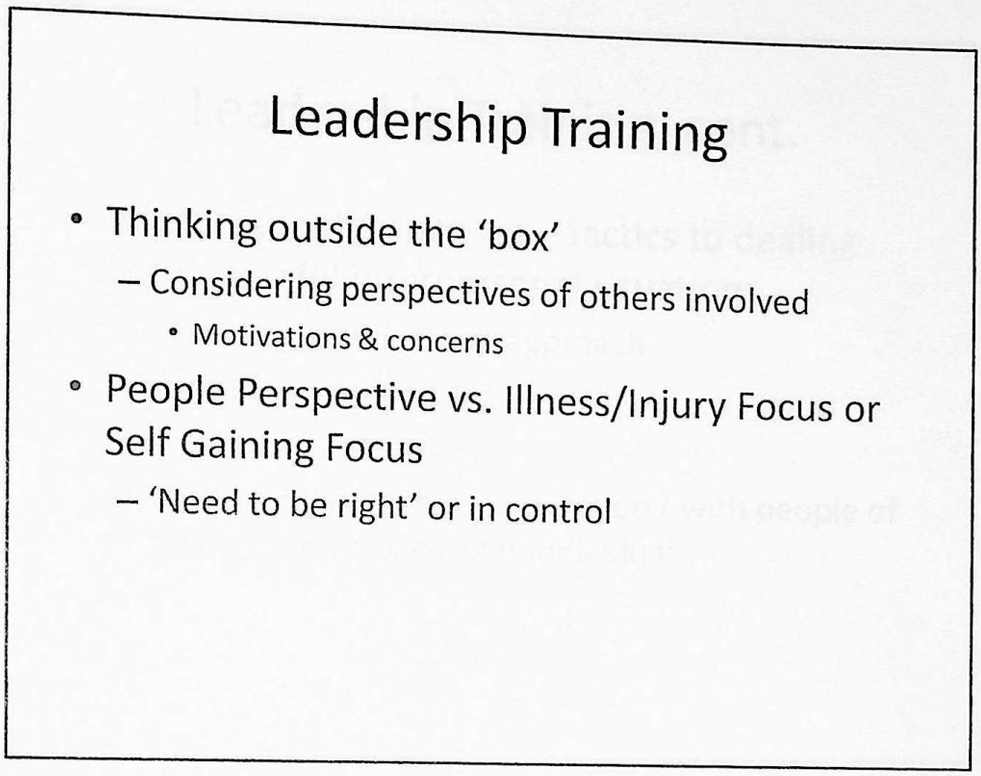
Motivating Leaders

- An ***Army leader is anyone who by virtue of assumed role or assigned responsibility inspires and*** influences people to accomplish organizational goals. Army leaders motivate people both inside and outside the chain of command to pursue actions, focus thinking, and shape decisions for the greater good of the organization. (FM 6-22, DoA, 2006)

Impact of Positive Command Climate

- Genuine concern of soldiers' wellbeing
  - Demonstrated through personal actions and interactions with subordinates and colleagues.
- Builds unit cohesion which coincides with developing supportive peer relationships.
- Fosters support for medical readiness/wellness of soldiers
- Increases resiliency & eases re-integration following deployments
- Discredits mental health stigma through demonstrated concern
- Increases likelihood of soldiers seeking healthcare

Wright et al, 2009



Arbinger, 2013

Leadership Training, cont.

- Interpersonal responses – tactics to dealing with stressful interpersonal situations
  - Correct – authoritative approach
  - Teach & Communicate
  - Listen & Learn
  - Building relationships with others/ with people of influence on a particular individual

Arbinger, 2013

Moving Mission/Unit Philosophy forward

- *When you are commanding, leading [Soldiers] under conditions where physical exhaustion and privations must be ignored; where the lives of [Soldiers] may be sacrificed, then, the efficiency of your leadership will depend only to a minor degree on your tactical or technical ability. It will primarily be determined by your character, your reputation, not so much for courage—which will be accepted as a matter of course—but by the previous reputation you have established for fairness, for that high-minded patriotic purpose, that quality of unswerving determination to carry through any military task assigned you.* General of the Army George C. Marshall, Speaking to officer candidates (1941)

FM 6-22, DoA, 2006

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