UK Army Medical and Unit Welfare Officer's perceptions of mental health stigma and its impact on Army Personnel's mental health help-seeking.

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Abstract

Mental health stigma and barriers to care (BTC) have been reported as impeding help-seeking among UK military personnel. A deeper understanding of the impact of stigma and BTC on help-seeking may be accessible via the perceptions of UK military health service providers. Secondary thematic analysis of interviews with 21 UK Army Welfare Officers and Medical Officers was conducted to investigate their perceptions of how mental health stigma, BTC, and stigma alleviation efforts impact UK Army soldiers' help-seeking. Three master themes were identified; Military culture; Barriers to care: and, Stigma alleviation success. The Welfare and Medical Officers perceived that military culture and its promotion of stoicism lead to certain beliefs surrounding legitimacy of mental health problems, confidentiality, and concerns for career impacts that affect UK Army personnel seeking help. They also reported perceiving stigma to have decreased and attributed this to some of the stigma reduction interventions currently in place. Recommendations for education based stigma reduction methods are made, including reframing beliefs surrounding the need to "soldier on" and that help-seeking is a weakness, providing consistent advice about confidentiality of health service attendance, and education for leaders to promote symptom recognition and treatment seeking.

Key words: Mental health stigma; Mental health help-seeking; Military mental health.

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Military operations in Afghanistan and Iraq have exposed many UK 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 UK, about 7% of combat troops report probable Post-Traumatic Stress Disorder (PTSD) and 22.5% report misusing alcohol post-deployment (Fear et al., 2010). Mental health difficulties may also be experienced in relation to non-deployment (e.g. training incidents) or non-occupational (physical assaults) traumatic events, and general occupational stress (Bridger, Brasher, Dew, & Kilminster, 2011; Jones et al., 2012). Regardless of the cause, research from the UK, US, 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 impact help-seeking decisions among military personnel requiring assistance.

A systematic review of research investigating mental health stigma and help-seeking in the US, UK, and Canada, reported that the most commonly cited reasons for non-treatment seeking are "My unit leader would treat me differently" and "I would be seen as weak" (Sharp et al., 2015). Zinzow et al. (2013) and Blais and Renshaw (2013) report that self-stigma (when those with mental health problems internalise 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

et al. (2015) propose that self-stigmatization is more likely to determine whether military personnel seek help than public stigmatization.

US 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 UK 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 PTSD who perceived their mental health to be poor to fair were more likely to seek help compared to 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 impacting 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-stigmatisation, 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 US and Canada. Differences exist between the US, Canadian, and UK health care systems and militaries that could impact help-seeking behaviours. The UK National Health Care Service (NHS) provides free healthcare allowing military personnel and veterans to access healthcare

outside of that provided by the Ministry of Defence. The US military's deployment patterns of longer operational tours likely impact prevalence of mental health symptoms and help-seeking behaviours. Additionally, 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 behaviours could be a useful insight for informing interventions to encourage help-seeking. Consequently, this research aimed to understand help-seeking behaviours among UK military personnel by investigating Army Medical Officers (MOs) and Army Unit Welfare Officers (UWOs) perceptions and experiences of help-seeking among UK military personnel.

Method

Sample:

As part of a large Randomised Controlled Trial (RCT) investigating the effectiveness of a post-deployment mental health screening tool, UWOs and MOs were interviewed in 2013 to investigate their opinions and beliefs about post-deployment mental health screening. For the purpose of the current 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 UK 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 the 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 post-deployment 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 GT and SB) 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 minutes. Interviews were transcribed including all spoken words, non-verbal utterances such as laughter and sighs, significant pauses and hesitations.

Analysis:

Re-analysis of the data was conducted by a third researcher (MK). In line with the current study's aim this secondary analysis focused predominantly on the responses relevant to help-seeking, mental health stigma, and BTC. The entirety of the transcripts however, were analysed for information relevant to the current research aim. Transcripts were analysed using thematic analysis (Braun & Clarke, 2006).

Analysis began with familiarisation 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 sub-themes for both the MO interviews and subsequently the UWO interviews. At all stages of analysis, the researcher remained reflective, re-examining the transcripts to confirm themes and connections related to the participant's responses. A colleague (SBS) 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 behaviours in UK military personnel: Military culture, Barriers to care (BTC), and Stigma alleviation success. Overlap between military culture and barriers to care are evident. The purpose of the structuring of these themes is to identify military culture as a mechanism in the development of barriers to care. Master themes and sub-themes are shown in table 1 supported by extracts from the interviews. MOs and UWOs broadly reported similar experiences; there was one sub-theme reported only by UWOs (shown in italics in table 1). A brief description of each of the master themes and their sub-themes follows.

Master theme	Sub-themes
Military Culture	Being perceived as weak Malingering Preference for managing problems on one's own
Barriers to Care (BTC)	Impact on career Concerns for privacy and confidentiality Not recognising they have a problem Credibility and acceptance of service providers
Alleviation and interventions	Specific stigma reduction initiatives Education Endorsement by the Chain of Command Requires strength to seek help

Military Culture

UWOs and MOs perceived aspects of military culture and ideology to be associated with mental health stigma which likely create barriers to care, as represented by three sub-themes: 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 labelled 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:

Malingering:

UWOs and MOs believed that some soldiers reported mental health symptoms as an excuse for bad behaviour, debt, relationship and marital problems, to facilitate a posting back to the UK when posted abroad, or to ultimately be discharged from service. Although UWOs and MOs experienced malingerers, there appeared to be evidence for UWOs incorrectly labelling 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

labelled as or feeling weak, and avoid accusations of being a malingerer 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).*

Barriers to Care (BTC)

Military culture and the associated mental health stigma was identified as creating BTC. This is represented by four sub-themes: Impact on career, concerns for privacy and confidentiality, not recognising 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 classed as unfit for some duties due to 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 malingerer. Confidentiality can be difficult due to the close knit community of military bases, especially if soldiers have to travel to unit medical centres:

> *"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 recognising or acknowledging they have a problem:

UWOs and MOS reported having had contact with soldiers' who either did not recognise 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 (CO) 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 sub-themes; 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 within the UK military. These efforts were perceived by the MOs and UWOs as having a positive impact 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 MoD 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 labelled or any negative impact 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 UK 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 UK military personnel. The results demonstrate consistency between research conducted with military personnel and with research conducted in the US 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 UK, US 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 et al.; Hoge et al., 2004; Iversen, van Staden, Hughes, Greenberg, Hotopf, Rona, et al., 2011; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Momen, Strychacz, & Viirre, 2012; Osorio, Jones, Fertout, & Greenberg, 2013; Rae Olmsted et al., 2011). The impact 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 et al. (2011) reported that soldiers who had not deployed but reported mental health problems were believed to be malingerers. Malingerers 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 labelled as malingering. Consistent with existing US 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 labelled a malinger (Britt et al., 2011). The detection of potential malingers 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 barriers to care such as concerns that a problem is not severe enough to be perceived as legitimate and the worry they will ultimately be labelled as a malingerer.

Barriers to Care:

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 UK 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 labelled a malingerer or as weak are likely linked to soldiers' concerns surrounding confidentiality. In a US 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 et al. (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 et al. (2011) propose 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 et al. (2013) report

encouragement from family members, especially spouses, as a primary reason for seeking treatment.

Murphy et al. (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 recognising their problems and “soldier on” despite being in distress and reach what Murphy et al. (2014) refer to as a “crisis point”. This highlights a potential dilemma for the UK 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. US 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 due to 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. UK research indicates that between 2008 and 2011 the likelihood of service personnel endorsing stigma or BTC had significantly reduced (Osorio et al., 2013). US research shows a similar decrease between 2002 and 2011 (Quarana et al., 2014).

Results from a cluster Randomised Control 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 anti-stigma 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 normalisation 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 US research (Clark-Hitt, Smith, & Broderick, 2012; Hipes, 2011) contact with soldiers reporting positive treatment experiences and testimonies was indicated as a further effective method. US 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 impact at 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 behaviour of leaders was reported by the UWOs and MOs as important in the maintenance of stigmatised perceptions. US research using vignettes indicated that officers report more stigmatised beliefs about soldiers with mental health problems (Hipes, 2011). Consistent with the current study, Zinzow et al. (2013) propose that leaders should be educated to show positive behaviours and attitudes towards mental health and help-seeking.

Such education of leaders may go some way in reducing mental health stigmatization among military personnel. Zinzow et al. (2013) found that positive leader behaviours 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 et al. (2013) found that treatment seeking military personnel demonstrated less self-stigma compared to participants who were non-treatment 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 et al. (2013) propose that stigma reduction methods should include attempts to reframe beliefs such as “seeking help is a weakness”, by emphasising 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 recognise mental health symptoms. Service providers should also spend time educating military personnel about mental health symptoms. 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 barriers to care, 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 UK 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 non-military participant whose perceptions may be different to the other participants who are Army personnel.

Conclusion

Military culture and the promotion of strength and stoicism 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 malingering were associated with concerns surrounding the impact 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.

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