

The contrasting beliefs of screening for mental disorders in UK military personnel returning from deployment to Afghanistan

UK soldier's beliefs of screening for mental disorders

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Declarations:

Professor Neil Greenberg is member of the Royal Naval Service, Mohammed Fertout is member of the British Army and Duncan Sharp is member of the Royal Air Force. All other authors declare no conflict of interest.

The authors are grateful to the Ministry of Defence for its help, in particular the Surgeon General's Department.

Funding: United States Army Medical Research Acquisition Activity (USAMRAA): W81XWH-10-1-0881.

Abstract

Objectives: The purpose of this study was to elicit beliefs and experiences on the value of a screening program for mental illness in UK military personnel.

Method: Three months after returning from Afghanistan 21 Army personnel participated in a qualitative study about mental health screening. One to one interviews were conducted and recorded. Data-driven thematic analysis was used. Researchers identified master themes represented by extracts of text from the 21 complete transcripts.

Results: Participants made positive remarks on the advantages of screening, several barriers to seeking help were noted, such as: unwillingness to receive advice, a wish to deal with any problems themselves and a belief that military personnel should be strong enough to cope with any difficulties. Participants believed that overcoming barriers to participating in screening and seeking help would be best achieved by making screening compulsory.

Conclusions: Although respondents were positive about a screening program for mental illness, the barriers to seeking help for mental illness appear deep rooted and reinforced by the value ascribed to hardiness.

Less than half of military personnel returning from deployment with mental health symptoms seek health care for their problems (1-4). It is likely that many military personnel do not receive treatment which may benefit them (1, 2, 5). Many factors may deter them from seeking help: including stigma, mistrust in health care professionals, a desire to deal with the problem on their own, lack of recognition of their own mental health issues and perceived practical barriers to accessing care services (2, 5, 6). Considering the introduction of a screening program is a common response from policy makers and practitioners as they perceive that doing so will lead to an improvement in the mental health status of those who are screened.

The US Department of Defence (DOD) introduced a screening programme for mental disorders in 1998 (8-10). In contrast the UK military has not developed such a programme and is waiting for information on the effectiveness of a screening programme for mental disorders before deciding to introduce one. The effectiveness of screening depends on a number of factors including the validity of the tests, the efficacy of available treatments, the service personnel's acceptability of the programme and the commitment of the professionals involved. The acceptability of the screening programme includes the willingness of those who the programme aims to help to accept the invitation to be tested, for those screened to accept advice received, and to act upon advice. It is frequently expected that the issues preventing service personnel from seeking health care will fade away in response to screening advice. However, this view is not supported by the literature on the use of screening (6, 8, 11, 12).

A qualitative study would help to conceptualize the range of issues raised by military personnel in relation to screening. Few studies have explored military personnel's beliefs about screening for mental illness (13).

As part of a pilot study to test the tools for a Randomized Controlled Trial (RCT) of screening in the UK Armed Forces we carried out this qualitative study to elicit beliefs about the perceived utility of introducing a screening programme.

Method

Participants

Two companies of British Army troops, with approximately 100 personnel in each, who had returned from Afghanistan within the previous three months, were recruited to take part in a pilot study to assess the effectiveness of post-deployment screening for mental illness. The first screening session included 52 male personnel from the first of the two companies, all of which completed the online screening questionnaire. For the purposes of the current qualitative study 21 of the possible 52 male personnel completed an interview in relation to their beliefs about post-deployment mental health screening (referred to as the in-depth interview). The remaining 30 participants completed a structured interview related to the online questionnaire such as its design, clarity and ease of understanding the questionnaire (referred to as the questionnaire, but not included in this report).

Opportunity sampling was used to initially recruit 22 service personnel. One out of the 22 selected participants was excluded during the interview as he disclosed a mental health difficulty that required immediate action. Potential recruits were asked, on completion of the screening questionnaire, if they would be happy to take part in a one to one interview. All 52 male personnel from the first of the two companies agreed to take part. The participants were then assigned to completing the in-depth interview or provide views on the suitability of the questionnaire. This was decided based on the next available interviewer. If the next available interviewer was assigned to complete the in-depth interviews the participant would complete this, however if the next available interviewer was assigned to complete the questionnaire the participant would complete that. Due to the nature of the two types of interviews the time taken to complete the in-depth interview was longer, therefore more participants were assigned to completing the questionnaire. Furthermore due to the nature of the qualitative investigation a smaller sample size was appropriate for this type of study. This study included 21 participants; the median and interquartile range age in the pilot was 22 years (20 to 24 years), the youngest being 18 years and the oldest 31 years.

Materials

A semi-structured interview schedule consisting of open-ended questions was designed to encourage participants to talk openly about their beliefs of post-tour screening for mental health. The schedule consisted of eight questions covering the following issues: opinions and feedback on the screening questionnaire and process, likelihood of and barriers to using the advice offered, attitudes towards future screening, and barriers to follow-up screening. The schedule included probes to assist if participants did not understand a question or if the interview became tangential.

All interviews were recorded using Dictaphones.

Procedure

Four researchers, with prior experience of qualitative interviewing, were briefed and trained in using the interview schedule. Following completion of the screening questionnaire participants were allocated based on next available researcher.

The semi-structured interviews were conducted in private rooms on the military installation; interviews lasted between 5 and 20 minutes. The semi-structured nature enabled participants to discuss issues they felt important; consequently the interview schedule was not prescriptive in sequence or use of the questions. All interviews were transcribed including all spoken words, non-verbal utterances such as laughter and sighs, significant pauses and hesitations.

Ethics

The protocol of all aspects of the study was appraised by three ethics committees: The Ministry of Defence Ethics Committee (Ref 187/GEN/10, the King's College London Psychiatry, Nursing & Midwifery Research Ethics Subcommittee (Ref PNM/10/10/11-112) and the US Army Medical Research and Materiel Command (Ref W81XWH-10-1-0881).

Analysis

The transcripts were analyzed following the procedures outlined as recommended for thematic analysis (15). This method involved a detailed and interpretive analysis where themes and concepts were identified within and across the transcripts. This was an inductive approach with no existing coding or theoretical frame; the analysis was purely data-driven.

Each participant's transcript was analysed by the individual researcher who conducted the interview and a table of master themes created for each of the 21 participants. The four researchers met three times, for up to 4 hours at a time, to identify patterns and connections across the 21 master theme tables. The researchers considered how themes in one case might illuminate those in another. The different themes in the 21 cases were merged and connected to create new master themes. A master table of themes consisting of five master themes each encompassing their own sub-themes was produced. At all stages of analysis the researchers remained reflective, re-examining the transcripts to ensure themes and connections related to the participant's experiential responses. The analysis was independently audited by other members of the research team.

Results

The five master themes were: positive reception to screening; criticisms of the screening process; barriers to seeking help; got to be forced to do it; and mental health isn't a weakness. The master themes included sub-themes which illustrated the participant's perceptions, experiences and beliefs about post tour screening for mental health. A selection of extracts from the interviews is provided in support of the themes in Tables 1 -5.

Positive reception to screening

All participants expressed some positive perceptions of post tour screening. Five sub-themes each represent a different element of the positive reception the screening received. Table 1 shows

verbatim statements illustrating each of the sub-themes. Positive reception to screening demonstrates the contrast of a generic, slightly ambivalent experience, to more involved and connected feelings of positivity. The more connected positive responses, such as perceptions of raising awareness, relevance, and confidentiality, create positive perceptions and lead to an increased willingness to participate in post tour screening, but the views about their likelihood to accept advice and seek help are subdued.

(Table 1 about here)

Yeah it's good: The first question aimed to draw out the participant's initial thoughts and experiences of the post tour screening they had completed. A common feature was to provide a general positive response. Although positive, these generic responses were succinct and suggested some level of indifference (Table 1).

Raises awareness: Positivity towards post-tour screening grew from the belief that it can help initiate a reflective process in the soldiers, in turn raising awareness of symptoms or possible difficulties and even an interest in seeking help. In contrast with the previous sub-theme it shows a more active interest (Table 1).

Relevance: Some of the participants felt positive about the screening as it was relevant to them. It appears that the relevance the soldiers experienced lead to their positive attitude towards the screening process which in turn could increase the likelihood of accepting any advice received (Table 1).

Confidential: Participants showed positivity towards the screening process due to its confidential nature. Confidentiality around mental health issues is important to military personnel. The perception of confidentiality increased their willingness to participate in screening and provide honest responses (Table 1).

Criticisms of the screening process

Despite being positive about the screening process participants offered some insight into possible shortfalls. Table 2 shows statements illustrating each of the criticisms of the screening process.

Computers are impersonal: A few of the participants felt that using computers to conduct screening was impersonal and decreased the likelihood of any advice given being taken seriously, accepted, or utilized (Table 2).

Not all problems are related to the military: One participant raised the issue that just because they are in the military not all their problems are going to be a consequence of their military activities (Table 2).

(Table 2 about here)

Barriers to seeking help

Whilst the participants had a positive outlook towards screening there were several reasons that may prevent them from seeking help even if needed. Table 3 shows verbatim statements illustrating each of the sub-themes of barriers to seeking help.

Avoidance: Almost half of the participants discussed experiences, attitudes or beliefs indicating they have or would avoid dealing with personal or mental health related issues. Although providing previous positive attitudes to screening and the advice it gives, some participants do not actually want to engage with it. Their positivity towards screening may be passive or to show a preference to deal with issues on their own, suggesting reluctance to disclose mental health issues to others and avoidance to seeking help. These extracts exemplify a belief that even if people are told they need help they would not act on this advice. The narrative used is about problems that may affect others, but not themselves, or they would hide the problem to others (Table 3).

(Table 3 about here)

Got to be strong: Some participants experienced beliefs that soldiers must show strength regardless of their feelings. Some of the thoughts suggest they may be influenced by their training and a general attitude of the military towards hardiness (Table 3):

Fear what others will think: Many participants expressed concern about other people knowing they have personal problems or were seeking professional help. These concerns highlight the stigma attached to mental health difficulties and how these lessen the likelihood of people talking about and seeking help for their problems (Table 3).

Easier to talk to mates: Some of the participants suggested they would prefer talk to their peers about their difficulties and concerns as they can “get down on their own level”. Talking to each other is an important part of coping with their experiences. This doesn’t necessarily have to be an alternative to seeking help, but is more than likely where some of them will start (Table 3).

Fear of impact on career: This theme emerged from just one participant’s experience in this study, but may be a concern for many soldiers (Table 3).

Got to be forced to do it!

Participants were asked if they thought people would get involved in future screening. A few participants believed that people will only participate in screening and maybe act on advice if they are forced to do so (Table 4). This further highlights that despite soldiers being well disposed towards screening, the likelihood of them acting on any advice seems to be unlikely.

(Table 4 about here)

Mental health isn’t a weakness

Despite some participants’ experience that illness is often perceived as weakness, two participants held the view that having a mental health problem is not a weakness and things should and are being

done to address this stigma (Table 5). These beliefs indicate that although there are some reports of a prominent negative stigma attached to mental illness as shown above, these views are not held by everybody.

(Table 5 about here)

Discussion

This study illustrates the presence of a complex set of beliefs about screening for mental illness in the UK military. Whilst many participants made positive remarks about the advantages of screening, these were tempered by some criticisms of the process and these advantages appeared detached from participants' own needs. Despite positive attitudes towards screening and assessment, it appears that, in keeping with previous research findings, several barriers to accepting advice and seeking help following any advice given may exist. These included: unwillingness to receive advice, a desire to deal with psychological issues on their own, belief that military personnel ought to be strong to cope with any mental problems and concern about what others may think if they sought help. Some participants noted that mental health problems should not be construed as a sign of weakness. The view that computers are impersonal was expressed by some of the participants. This suggests a personal approach to giving advice following an online screening questionnaire may enhance the likelihood of advice being taken, received, and accepted. However, interviewees provided a wide range of reasons why they would refuse the offer of advice during the screening process (Table 3); this gives rise to doubt that personnel would return on a further occasion to receive advice, even if provided in a personal manner. There was also the view that one effective way of lowering barriers to seeking help would be if the chain of command made the screening process mandatory and this might also decrease resistance to seeking health care through screening. However, it is difficult to envisage that this line of action would receive widespread support, since any mandatory intervention in people who do not lack mental capacity raises serious issues around ethics, informed choice and autonomy.

Most beliefs corresponded to a reflective assessment of the way they or their comrades would act. On the whole there were positive responses to screening and its suitability. However, many participants voiced their scepticism in the utility of any future screening programme because barriers to seeking help in terms of stigma, the belief that they should show fortitude and deal on their own in tackling mental health issues, and the lack of interest in receiving tailored advice about their own mental health status, would reduce the impact of screening. Previous studies have shown most of these barriers in quantitative analyses both in military and civilian populations (1-6). Fewer studies have emphasised the belief that people want to tackle mental health issues on their own terms (5) and none have shown the reluctance to even read tailored advice that might potentially be beneficial.

Despite showing a willingness to be assessed through the screening process, an unexpectedly large group of participants did not want to receive the advice based upon their answers to the screening questions, about their mental health status. These opinions were consistent with the wider findings of the pilot study that approximately 50% of those in the intervention arm of the study choose not to receive specific advice regardless of their mental health status. Another study in the US showed that 60% of those who screened positive for mental disorder were not interested in receiving health care help (6). In a previous study carried out in 2002 before the outbreak of the most recent hostilities in Iraq and Afghanistan, we found reluctance amongst participants to respond to an invitation to visit their Medical Officers (MOs) after completing a set of screening questions (11). The current study shows that this reluctance has persisted despite the large numbers of service personnel who have been killed and injured in the recent conflicts and the various efforts that the UK Armed Forces have put in place to support the mental health of its personnel. Examples of such interventions include the establishment of a through career and deployment related mental health training program and the establishment of Trauma Risk Management programme (TRiM) across all branches of the military. In addition, MOs have been trained to be vigilant and sensitive to mental health issues in service personnel and the role of other informal services (e.g. Chaplains) in

supporting the mental health of personnel have been strengthened. Several participants indicated that they should be strong and able to deal on their own with stress. These characteristics could be construed as a component of hardiness. An important element of hardiness is the belief in one's power to control or influence events experienced (16, 17) and engendering mental fortitude is an important aim of training in the Armed Forces. In this respect the health message that one should recognise mental health problems and seek help appears to contradict the ongoing theme of hardiness in military personnel. As the theme of both physical and mental hardiness is pivotal in military training and doctrine, the message to accept screening for mental illness and accept help to tackle mental illness should be presented without appearing to contradict this concept of hardiness. If screening were to be adopted by the UK military, this would be a challenge for the Armed Forces as current mental health briefings would need to be amended to take account of this central issue of screening.

Some soldiers were concerned about others in the military knowing if they had mental health issues, but at the same time some expressed that soldiers are happy to share emotional issues with comrades. The willingness of comrades to share problems provides opportunities as well as disincentives to seek help. Battlemind in the US military (18, 19) and TRiM (14) aim to reinforce camaraderie and in doing so help to eliminate barriers. However, our results indicate, perhaps unsurprisingly, that not all service personnel are prepared to talk about their problems to their commanders, welfare personnel or MOs.

The strength of this study is the willingness of those who were approached to share their beliefs with us; this may have been enhanced by the perception that the researchers were not part of the chain of command, but nevertheless acquainted with the ethos of the Armed Forces. A strength is that respondents were able to cogently voice their own views rather than have to select from a set of possible views presented to them on a survey. A weakness of our study is that the views of the personnel interviewed may correspond solely to those of the company participating in the study and

not to the rest of the military. However, this seems unlikely because the responses of participants reaffirm opinions from a previous study carried out in 2002 (13), where resistance to accept an invitation to visit their MO was reported (11). These results are also consistent with research on health seeking behaviour (1-3, 12). Our results cannot be extrapolated to women in the services or to personnel who have exited the military. The RCT for screening for mental illness which we are undertaking will help to gauge the impact of the opinions of service personnel towards a screening program.

This qualitative study indicates that, within the interviewed sample, despite overall positive attitudes to screening and assessment, barriers to accepting advice and seeking help for mental disorders were deep rooted. Some aspects of military training such as those related to the development of physical and mental fortitude may be seen as an impediment for seeking help. Prevention programmes for mental illness should ensure that advice to seek help in military personnel should not appear to contradict values inculcated through training.

Acknowledgements

We thank the UK Ministry of Defence for their cooperation and the United States Army Medical Research Acquisition Activity (USAMRAA) award number W81XWH-10-1-0881 for funding the study.

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