Culture: What Is Its Effect on Stress in the Military?

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Culture provides the unwritten rules that inform and shape expected behaviors. To date, little research has been conducted into the attitudes or opinions that service personnel hold toward mental health issues. This article examines current literature and research into the recognition of mental health problems in the military and potential organizational barriers to care including stigma and the specific characteristics of a military culture such as the significant reliance on buddy support. We conclude that the barriers to care which operate in both military and civilian populations are not insignificant. Western militaries in fact currently face an uphill struggle to combat the substantial barriers to care that exist.

Introduction

Military personnel are at a high risk of exposure to potentially traumatic events. As such, this makes them an “at-risk group” who are vulnerable to suffering from psychological distress and mental health problems including depression, family violence, substance abuse, and post-traumatic stress disorder (PTSD), all of which are problems for the military services and a threat to occupational functionality. The impact of mental health on decision making is especially of significance given the high technology, fast-paced warfare of the 21st century, the battlefield which leaves little margin for error. Furthermore, many military forces have to cope with increasingly complicated conflicts with an ever decreasing number of soldiers available to fulfill these duties. Troops therefore need to function at peak efficiency and inefficiencies imposed by work stress and mental health problems may have very serious consequences.

Recent claims from soldiers and commanders inside the theaters of Iraq and Afghanistan have raised questions about the state of mental health in the U.K. military. This article attempts to explore the issue of military culture in relation to stress (traumatic or otherwise) and examines how the military environment may exacerbate psychological problems because of barriers to care including stigma.

The Different Types of Stressors within a Military Environment

The potential of being exposed to traumatic stressors is an ever present issue for individuals who choose the military as their occupation. Furthermore, additional work-related stressors, such as length of deployment or exposure to adverse living condition, may exacerbate the effects of traumatic stress. In this section, relevant research on the two different types of stressors will be discussed.

Studies have shown that the degree of psychological trauma from operational duties is proportionally related to the type of warfare fought. One of the adverse outcomes of wartime trauma is PTSD. Rates of PTSD in combat veterans have been measured on numerous occasions and vary from 15 to 31%. These rates are in excess of the 2 to 3% prevalence of PTSD symptoms recorded in the U.K. general population. However, focusing on PTSD alone may not give the full picture of operationally induced psychological distress. For instance, it has been reported that up to 50% of Falkland War veterans have symptoms of PTSD even though they may not have sufficient or intense enough symptoms to warrant a formal diagnosis of PTSD.

Some of the variation in rates of PTSD and prevalence of traumatic stress symptoms may be accounted for by differences in study design. For instance, there are many types of instruments used to measure PTSD and many different ways of classifying military missions. Furthermore, questionnaires usually overestimate the prevalence of psychiatric conditions.

Studies which use semistructured instruments such as the Clinician-Administered PTSD Scale are likely to give a better estimate of the true prevalence figure. Studies also vary in their use of terminology and it is important to remember that suffering with PTSD symptoms does not always prevent individuals from working or having fulfilling social lives. Symptoms are not the same as disorder, although it would be foolish to merely dismiss subdiagnostic symptoms as being irrelevant: they may well affect quality of life.

Aside from operationally related traumatic stress, there are numerous other work-related stressors which significantly affect the lives of service personnel. Pflanz et al. investigated sources of stress and their prevalence in the U.S. military. Significant work stress was reported by 26% of troops and another 15% described significant emotional distress related to work stressors. The study revealed that being in combat, exposure to heavy casualties, and unexpected deployments all correlated with increased levels of psychological distress.

Mental disorders, whether they are the result of traumatic or work stressors, appear to have had a significant impact on manpower and retention rates. Hoge et al. conducted a population-based analysis of hospitalizations occurring at U.S. military facilities between 1990 and 1999 among active duty personnel. Results showed that mental disorders were the leading cause of medical discharge among men and the second leading category among women, accounting for 13% of all hospitalizations. Overall, 23% of all inpatient bed days were attributed to mental disorders.

The significant costs involved in recruiting, training, and retaining military personnel make it important to identify robust
psychological support systems to avoid the loss of valuable personnel to the effects of psychological trauma. From an organizational perspective therefore, the military have a moral and legal duty to consider the psychological welfare of their workforce. However, significant organizational obstacles and barriers to care must be overcome in order for such systems to be worthwhile. Not only must any support given be effective, but it is also important to ensure that those in need of help feel able to come forward and ask for it or at the very least receive it, even if they feel too ashamed or embarrassed to ask for help themselves. These barriers to care will be further examined later.

The Importance of Morale and Homecoming Experience

Interestingly, it appears that the level of stress felt by personnel is reflected by the nation’s attitudes toward the military as well as unit morale. It has been suggested that one of the reasons for the poor psychological condition of many of American Vietnam veterans was the hostile attitude that many of their fellow countrymen took toward the war in the late 1960s and 1970s. The converse also appears to be true in that lower levels of distress were reported by U.S. peacekeepers following a positive homecoming experience. Labuc highlighted how morale in the army correlates with the incidence of combat stress reactions; after analyzing a number of campaigns by Israeli and British soldiers, he comments: "It can be seen that when morale is high stress casualties are low, and vice versa". He argues that unit cohesion and support are important factors which determine morale and can therefore influence the psychological state of those personnel who serve within a unit. Thus, when a military force can foster high morale among troops, the likelihood of that force suffering substantial numbers of stress casualties is lower. An example of this was the Falklands War, where morale was high and the stress casualty rate was in the region of 4%. However, the Malta campaign of 1942 was associated with low morale in the British troops and as a result, the number of stress casualties was substantial, estimated as at least 25% of the deployed force. This may have been as a result of varying factors including poor leadership, extensive physical hardship, and physical casualties.

Culture and Stigma: What Significance Do These Factors Hold in a Military Context?

In this section, the significance of stigma toward help-seeking behaviors will be discussed within the context of military culture. Culture itself provides the unwritten rules that inform and shape expected behaviors and can be defined as a way of life that is learned and shared by human beings and is taught by one generation to the next.

Stigma is one of several reasons that might help to explain the behavioral choices people make toward mental health care; one definition of stigma is a sign of disgrace or discredit which sets a person apart from others. The consequences of stigma associated with mental illness are well cited. Stigma may occur at all stages of mental illness from help-seeking to treatment and discharge and has been commented as being more “devastating, life-limiting and long-lasting than the primary illness,” meaning that the effects of stigma can often be felt long after the original problems have disappeared. According to the World Health Organization: “The single most important barrier to overcome in the community is the stigma and associated discrimination toward persons suffering from mental and behavioral disorders.” Stigma based on Goffman’s notion of spoiled identity refers to a discrediting social attitude toward mental illness. For example, Britt investigated the stigma of psychological problems among active service personnel returning from the U.S. peacekeeping mission in Bosnia. He found that admitting to a psychological problem was much more stigmatizing than admitting to a medical problem and personnel were much less likely to follow through with a psychological referral than with a medical referral. More than one-half of the participants believed that their career would be affected if they disclosed a psychological problem and almost half felt that admitting to a psychological problem would cause a coworker to maintain a distance from the service member.

In 2002, a number of ex-service personnel brought a court case against the Ministry of Defence for the failure to identify PTSD issues at an early stage and to provide support and effective treatment. Stigma was a continual theme throughout the proceedings: the case was both lengthy and costly. The judgment was found in favor of the Ministry of Defence, although in coming to his ruling, Justice Owen stated: “There can be no doubt that . . . there was a stigma attached to psychiatric/psychological disorder. It was seen to be a sign of weakness which, if revealed, would expose an individual to ridicule, and would be the ‘kiss of death’ to a military career.”

Discrimination in comparison refers to unfair treatment of people with mental health problems which results in the denial of the justified rights and responsibilities of a particular organization on an interpersonal or institutional level. For example, recently, a staff sergeant in the U.S. forces was initially charged with cowardice after he attempted to seek help for a combat stress reaction, although these charges were later dropped and resulted in the individual “voluntarily” leaving the army.

Western culture has become more accepting and less stigmatizing of mental health problems in recent years. However, many aspects of military life remain potentially “prostigmatic.” For instance, military culture encourages mutual support between personnel, known as the “buddy system” which encourages individuals to learn to closely rely on each other, both for physical and potentially psychological needs, when deployed or otherwise. In a study surveying U.K. peacekeepers, 98% of personnel felt able to talk to military friends or peers in the same deployment and only 8% had used formal support networks (such as the use of medical or welfare services). Furthermore, only 15% had spoken to the chain of command about their experiences. Notably for most participants, there was a significant association between talking about their experiences and having lower psychological distress scores.

However, the buddy system can be a hindrance when one’s close community cannot provide the necessary support. A distressed individual may feel that they have let themselves and their buddies down if they ask for help outside of their peer group (those who challenge any culture are often ostracized by those who strongly identify with it). In Greenberg et al.’s research,
study, older peacekeepers were significantly less favorable to the concept of formal debriefing for all, probably representing an “old school” approach of not talking about distress, often described as the “stiff upper lip.” Greenberg further suggests that the results also show that older peacekeepers are more likely to make use of social networks and the chain of command and thus may not feel that any formal sources of support are required.29 This is especially important, as experienced and senior personnel are likely to influence the attitudes and help-seeking behavior of others in their command. The close community, reliant on mutual support, therefore, may act as a hindrance acting as an organizational barrier that prevents personnel from using appropriate support and mental health care to fit in with the existing military culture ethos.

Hoge et al.11 investigated help-seeking and barriers to care among U.S. soldiers and Marines after deployments to Iraq and Afghanistan. Personnel completed a questionnaire which included an expanded version of a stigma rating scale developed earlier by Britt20 along with a range of medical and psychological screening measures. Findings indicated that of those who scored above the cutoff on screening for outcomes, including major depression, generalized anxiety, and PTSD, only 38 to 45% indicated an interest in receiving help; even then, only 23 to 40% had actually sought mental health care. Worries about stigmatization were almost twice as likely among personnel who scored above the cutoff compared to the rest of the group. The main concerns expressed by those who filled in the questionnaires included being perceived as weak, being treated differently by unit leadership, and members of the unit having less confidence in them. In response to the findings, the authors emphasized the importance of reducing stigma and barriers to care in the military through education, outreach programs, and changes in health care delivery.11

The Influence of Stigma in Attitudes of Mental Health

Within the military, there has been relatively limited research into the attitudes military personnel hold about mental illness although it is well documented that service personnel are reluctant to receive help in the first place. A study by Schneider et al.,30 one of the few studies that investigated attitudes to combat stress in the U.S. military, revealed that only 35% believed that they or someone else in their platoon might experience combat stress and 40% would not trust a returning stress casualty to be an effective soldier.30 Within the Israeli Defence Force, officers’ attitudes to combat stress reactions also revealed that an officer was expected to be more responsible for his own recovery than an ordinary soldier.31 The higher ranking the respondent, the less he viewed the possibility that psychological help might be effective and the more he advocated disciplinary methods.31

Research in the attitudes of British military personnel found that many believed that those who experienced stress were weak.32 A triservice study conducted by Cawkill,33 with anonymous questionnaires sent to those in leadership positions (junior noncommissioned officers and above), revealed that 85% thought that seeking in-service support for stress and stress-related problems would have some detrimental effect in their career. Respondents suggested that help seekers would be less likely to be promoted, less likely to be given roles/tasks of responsibility, be perceived as weak, and would not be trusted by their peers. Although the majority considered it acceptable to suffer from stress, they did not trust that others would have the same view and therefore said that they did not and would not disclose their difficulties.30 It is noteworthy that the response rate in this study was approximately 50% and it is possible that the views reported may be heavily subject to response bias.

The Management of Stress and Stigma

The management of both traumatic and work stress has proved a difficult and controversial topic within both civilian and military settings. In particular, the military is a challenging environment in which to provide any medical and psychological treatment. Numerous physical barriers to care exist on operations such as logistical constraints, difficult terrain, a wide dispersion of personnel, limited practitioners, and hostility to outsiders.14 This section does not aim to be exhaustive, but aims rather to outline some of the key features in the treatment of stress including front-line treatment, single session psychological debriefing, and intervention programs.

The most widely accepted treatment for battlefield combat stress reactions is front-line treatment.34 It is known that the further to the rear of the battlefield a stress casualty was evacuated, the less likely that casualty was to be successfully treated and returned to combat. The treatment is in accordance with three basic principles (PIE): proximity: on or as near as possible to the battle zone; immediacy: as soon as possible after the injury is sustained; and expectancy: that the soldier will return to his unit and resume his former duties.31 Such treatment is reputed to be quick and in many cases successful.31

“Quick fix” approaches to preventing PTSD have been advocated by some including single-session psychological debriefing, a process by which forced emotional ventilation was purported to prevent the onset of PTSD.35 It is now clear that single-session debriefings are not beneficial in reducing psychological distress and preventing the onset of PTSD and in some cases may be associated with deterioration in an individual’s emotional state.35.8 The U.K. Military Surgeon General and the Department of Health36 have banned the use of single-session debriefing. As well as potentially causing further traumatization by re-exposing people to negative aspects of an event,35 the reliance on debriefing may undermine the beneficial effects of peer support.31 One could speculate that the heated debate around the ineffectiveness of single-session psychological debriefing may have further damaged military personnel’s reluctance to ask for help when they are distressed. It is easy to see why military leaders who are told that single-session de briefing, a routine practice in the U.K. Armed Forces before 2000, is ineffective and may cause harm could have led to reinforcing leader’s beliefs that their subordinates should not be encouraged to seek help. To date, this possibility has not been formally investigated.

Research has demonstrated that anti-stigma interventions, unlike single-session debriefing, can significantly modify attitudes and behavioral intentions. Wolff et al.37 conducted an educational campaign and surveyed attitudes of local residents before and after the opening of a new supported house for the mentally ill. Participants who were exposed to the didactic component of the intervention showed reduced fearful and rejecting attitudes and increased social integration with mental health clients.37 However, the durability of short-
term interventions into reducing stigma and adopting culture change can be questioned as no findings have been investigated over a substantial period of time. As yet, there is no robust and conclusive evidence that simple education is definitely effective in reducing stigma in those who are educated. There is some evidence that long-term persistent programs aiming to address a population’s stigmatizing beliefs can be effective. For instance, Corrigan et al. state it is generally agreed that there are instinctive and social forces that drive both the stigmatization process and its activation in relation to people with mental illnesses.

Powerful efforts to moderate stigmatizing beliefs need to be continuous and to come at the problem from several directions with the full panoply of “protest,” “education,” and “contact.” The U.K.’s Royal College of Psychiatrists undertook a wide reaching anti-stigma campaign with doctors, children, and adolescents, the workplace, the media, and the general public. The results of the 5-year program were modest at best and “included small but sometimes significant reductions in reported negative opinions in respect of communication/empathy difficulties.” Long-term anti-stigma programs which take account of military culture need to address how to reduce organizational barriers that camaraderie and peer support may foster so that people feel able to seek help outside of their immediate community. What perhaps is needed are organizational policies and programs which are acceptable both to mental health professionals, but more importantly to those in positions of command, aimed at supporting soldiers in getting mental health support.

Conclusions

We conclude that the organizational barriers to care which operate in the military are not insignificant. There is substantial evidence that stigmatizing attitudes are present in many military personnel and physical barriers to asking for and receiving care exist. Many personnel describe substantial concerns that being labeled as a psychiatric patient will be detrimental to their career. Perhaps most importantly are the hidden barriers created by camaraderie and peer support which may make it difficult for individuals to seek help from the outside.

In the U.K. Armed Forces, there are numerous military mental health professionals, both uniformed and civilian. Their mission is to treat those who present with psychological problems and to educate the Armed Forces to accept that it is more detrimental to a sailor, soldier, or airman’s career if the patient is not the individual who has mental health problems but is instead the military culture itself. There can be no doubt that an effective fighting force requires robust and resilient personnel to undertake the arduous duties which are a feature of operational deployments. Senior officers need to address the balance of making the accessing care acceptable with the maintenance of fighting efficiency. We suggest the “therapy” is likely to take many years and will require a gradual cultural shift.

References

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