

PTSD, stigma and barriers to help-seeking within the UK Armed Forces

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ABSTRACT

Among the general public, much is known about the longer-term consequences of not seeking support for mental health difficulties. However, within military populations, and in particular, the UK Armed Forces, less is known. Understanding the factors that present barriers for UK service personnel with mental health difficulties accessing support is important because this may provide a means for support personnel to seek help sooner. This paper explores the literature relating to the impact of untreated post-traumatic stress disorder (PTSD) among military personnel, attempts to draw conclusions about the barriers that may prevent personnel seeking help and the efficacy of previous interventions to address these. Stigma has been highlighted as the key barrier to help-seeking behaviours, in particular, internal stigma, which can be classified as negative beliefs about the self that an individual may hold as a result of experiencing symptoms of PTSD.

INTRODUCTION

Over the last decade, there has been growing awareness of the prevalence of post-traumatic stress disorder (PTSD) in military personnel who have been involved in operations in Iraq and Afghanistan. Evidence from both sides of the Atlantic has documented the high levels of exposure to traumatic events for service personnel during these deployments. A recent review of the mental health of the UK military reported that overall, rates of PTSD are lower than comparable samples of US service personnel,¹ with the authors concluding that this was evidence of resilience in UK personnel. However, we also know that UK service personnel experiencing mental health difficulties struggle to engage in help-seeking behaviours. This paper discusses the impact of not seeking support for mental health difficulties on military personnel, what the reasons for this may be, and goes on to review recent interventions introduced by the UK Defence Mental Health services to address them.

EPIDEMIOLOGY OF PTSD IN THE UK AND US MILITARY

Starting in 2001 and 2003, respectively, there have been military operations in Iraq and Afghanistan. The UK military mission in Iraq ended in 2009 and is due to end in Afghanistan at the end of 2014, and large-scale surveys investigating the psychological health of US and UK service personnel were set up shortly after the initial mission in Iraq.

Studies in the USA have indicated that PTSD is the most common mental health illness reported by military personnel; 13% met criteria for PTSD after deployment to Iraq or Afghanistan since

Key messages

- ▶ The majority of the UK Armed Forces do not experience mental health difficulties. However, for those that do there appears to be significant barriers present that prevent a significant proportion of suffers engaging with mental health services.
- ▶ Studies on both sides of the Atlantic has observed that veterans with untreated mental health difficulties are at increased risk of social exclusion.
- ▶ Stigma connected to mental health problems has been highlighted as the key barrier that prevents serving and ex-serving personnel seeking help. Stigma has been theorised to consist of internal and external stigma. Internal stigma is connected to how one views oneself as a result of experiencing mental health problems and appears to act as the strongest barrier to help seeking.
- ▶ The UK Armed Forces have introduced a number of interventions to support help seeking behaviour. However, to date there is little evidence that these have actually made a significant difference in the rates seeking help.
- ▶ Whilst there is evidence of changing views towards mental health difficulties in the Armed Forces, future research will need to explore specific interventions to directly target internal stigma.

2003, and 18% 4 months later.² However, this study did not employ a longitudinal design as it compared different cohorts of military personnel who had returned from Iraq or Afghanistan. A different study in the USA which randomly selected a representative cross-sectional sample also observed that rates of PTSD were higher in the deployed group (3% vs 8%). Furthermore, 13% of participants met criteria for alcohol problems and 18% for symptoms of anxiety and depression.^{3 4} Importantly, increased rates of PTSD have also been observed in prospective studies that surveyed personnel before and after deployment to Iraq or Afghanistan.⁵

A study of UK military personnel selected a random sample of approximately 10% of the British Armed Forces. The first wave of data collection was completed in 2006 and observed rates of PTSD to be 4% and anxiety and depression to be 20%;⁶ this sample was followed-up 4 years later, and these rates of mental illness remained similar.⁷

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When the authors restricted their analyses to only combat soldiers, they observed an increase in PTSD rates to 7%. The observed difference in the prevalence rates of PTSD between US and UK forces is intriguing. Authors comparing between the UK and US studies suggested that the differences could be explained because US soldiers typically deploy for 18 months compared with 6 months for UK soldiers, and that UK soldiers were more likely to have deployed previously which has been suggested to be a protective factor.⁸ Overall, rates of PTSD in UK military personnel have not increased following deployments to Iraq or Afghanistan; however, specific subgroups are at increased risk of PTSD.

PTSD AND SOCIAL EXCLUSION

Studies from both the US and UK have observed significant rates of mental health difficulties in service personnel, but less is known about the longer-term implications for these personnel. It has previously been reported that US service personnel who served in the Vietnam War had higher rates of PTSD^{9–10} and social exclusion^{11–13} than their peers who did not deploy to Vietnam. Higher rates of social exclusion have also been documented in US veterans who deployed to the 1991 Gulf War.¹⁴ Less research has been conducted within the UK Armed Forces. The UK military has a turnover rate of approximately 10% which equates to between 18 000 and 20 000 service personnel leaving the Armed Forces each year.¹⁵ Research into the mental health of veterans has been limited, but various media stories have reported on those who do badly after they leave the Armed Forces in terms of mental health problems and social exclusion.^{16–17} A study within the UK Armed Forces, that was able to explore this population, followed-up 1276 service personnel who had been involved in a 6-year longitudinal study 3 years later.¹⁸ The authors reported that the majority of veterans are not at risk of social exclusion following their military service. However, they noted that 3 years later, individuals who reported symptoms of mental illness prior to leaving were at increased risk of being unemployed and with continued mental illness.¹⁸ One limitation of this study was that it may have been more difficult to recruit individuals who were more socially excluded which could have resulted in an underestimation of the consequences of suffering from mental health difficulties at the same time as leaving the Armed Forces. This was supported by the fact that non-responders had worse mental health than responders at last contact.

Despite the recorded rates of mental health difficulties, figures released by the MoD demonstrate lower rates of personnel accessing services for these problems than would be expected; documented prevalence rates of PTSD are 4%, but only 0.8% accessed services.¹⁹ This discrepancy between the rates of service personnel who experience mental illness and those who are able to engage in help-seeking behaviour has also been observed by a research team at King's who reported that only 23% of UK service personnel who experienced mental illness had received formal support from mental health professionals.²⁰ The cost of not receiving help appears to be high—it has been observed that suicide rates among US service personnel have reached a historical high.²¹ Overall, suicide rates are lower in the UK Armed Forces than among the general public, except for young men in the Army, who have an increased risk of suicide compared with their counterparts in the general public.²²

While most individuals who leave the Armed Forces do well, service personnel suffering from PTSD are at increased risk of continuing problems once they leave. Due to this, there is a

pressing need to ensure that as many individuals as possible receive support while they are still in service; however, the majority of service personnel who experience mental health difficulties find it hard to engage mental health services. Understanding why this is, and how some personnel are able to access services, will be important to increase the numbers accessing support.

STIGMA AND MILITARY CULTURE

Stigma has been defined as a '*sign of disgrace or discredit that sets a person apart from others*'.²³ Historically, it has been argued that stigma was encouraged within the Armed Forces to act as a general deterrent against disobedience.²⁴ For example, the term 'lack of moral fibre' was introduced in 1940 with the intention of stigmatising Royal Air Force personnel who, without a medical reason, refused to take part in military operations.²⁵ While these policies were subsequently changed after World War II, the longer impact on the culture of the Armed Forces is unclear.

Evidence has been reported that military leaders viewed service personnel who had accessed mental health services more negatively than their peers;²⁶ furthermore, there is also evidence of an association between children accessing mental health services and concerns by their parents that this may impact negatively on their own military careers.²⁷ Interestingly, in families where one parent was employed by the military and the other in the civilian sector, this association was stronger for military parents than their civilian partners.²⁷ More recently, it has been observed that soldiers with mental health problems who are evacuated from deployments are more likely to be prematurely discharged from the UK Armed Forces.²⁸

It has been argued that external stigma has always been prevalent in the UK Armed Forces,²⁹ whereas, studies into internal stigma were commenced only more recently. Greene-Shorridge *et al*,³⁰ have argued that negative public stigma about mental health within the Armed Forces has been internalised by service personnel to form negative beliefs which are activated by symptoms and negatively influence self-esteem and motivation to seek help.

Stigma towards mental health difficulties is especially problematic within military populations because, due to the nature of their work, psychological resilience when faced with adversity is highly valued.^{31–32} Research supports these inferences about cultural beliefs towards mental health in military populations. It was observed in US military personnel that having a psychological problem is associated with much more stigma than suffering from a physical health problem;³³ UK military research has suggested that it is viewed as more legitimate to suffer from a physical illness than a mental health illness,³⁴ which is again supported by research that observed UK service personnel are much less likely to attend a first appointment for a psychological referral than a medical one.³⁵ This apparent reluctance to attend appointments for psychological symptoms could be hypothesised as another factor for why, despite high rates of mental health problems and the availability of services, uptake of treatment is low within military populations.

These factors seem to map onto work by Corrigan³⁶ which distinguishes between internal and external stigma as causes of barriers to seeking help. They argue that public beliefs about mental health inform individuals' beliefs,³⁷ so that negative public stigma predicts the formation of negative beliefs about mental health within an individual; these fit within two categories, internal and external stigma.³⁸ Further, that stigma prevents

individuals seeking help because it has a damaging effect on self-esteem.^{39–41}

Internal factors are how the individuals' beliefs about themselves having a mental health disorder impacts on their self-esteem. External factors are related to the presence of external barriers and an individual's perception of the legitimacy of these barriers. This model suggests that internal and external barriers act in different ways to prevent help-seeking, and that both negatively influence self-esteem.³⁸

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

Numerous studies have explored the barriers to accessing care for military personnel experiencing symptoms of PTSD. A study of help-seeking set within the US military drew its sample from combat personnel who had recently returned from deployment to Iraq or Afghanistan.² Within this sample, there was a high prevalence rate of PTSD and there was also a high reluctance to access help. It was observed that only 40% of participants who reported suffering from PTSD reported being interested in accessing services, while only 25% actually received treatment from military health services.² Stigma was reported to be the biggest barrier to accessing care. External stigma acted as a barrier (in particular, about organisational barriers) irrelevant of participants' mental health status. Interestingly, those suffering from PTSD reported significantly higher levels of internal stigma. Additionally, higher levels of symptom reporting was associated with increased internal stigma.² An example of an internal barrier was self-stigma related to feeling 'weak' for suffering from mental illness.

A review of barriers to accessing care in the US military concluded that while stigma was the most important factor for preventing help-seeking, organisational barriers cannot be overlooked,³⁰ such as not having supportive military leaders or logistical difficulties attending appointments.³⁰ This is supported by a recent study exploring help-seeking behaviours, which concluded that stigma should be considered as a separate construct to barriers to care because stigma predicted work stress, while other barriers did not.⁴² This finding is interesting because it suggests that stigma may 'contribute' to mental health difficulties.

An exploration of help-seeking experiences within a sample of 'high-risk' participants who had left the UK military⁴³ drew a sample from a longitudinal study that was established to survey the mental health of service personnel who deployed during the 1991 Gulf War which collected data at three time-points in 1995,⁴⁴ 1997⁴⁵ and 2001.^{46–47} Iversen *et al*,⁴³ restricted their sample to only include participants who had left service and were deemed to be at 'high risk', with 'high risk' defined as either having met criteria for mental health difficulties at each of the three previous waves of data collection, or having left service at the first wave of data collection and still being unemployed at the last wave (ie, 5 years later). The study concluded that help-seeking behaviour was low. Internal stigma was the most common barrier for not seeking help, with many participants endorsing that they should be able to 'deal with problems themselves'. Interestingly, help-seeking was lower while participants were employed by the Armed Forces than after they had left. Being unemployed was associated with help-seeking behaviour. Age, sex, service arm, marital status and last rank held in the military (which was used as an indicator of social status) did not appear to influence help-seeking behaviour.¹⁸

An opportunistic study within the Royal Navy surveyed data from another study that involved 1599 naval personnel,⁴⁸ to investigate the prevalence of stigma within the Royal Navy and

how stigma influenced help-seeking.⁴⁹ It was observed that both internal and external stigmas were present. However, levels of external stigma were lower than predicted. Furthermore, participants who met criteria for common mental health difficulties reported between two and three times more internal barriers to care. Additionally, distressed participants reported more negative perceptions towards military mental health services.⁴⁹

Another study within the UK Armed Forces explored help-seeking behaviours within a sample deemed to be suffering from mental health problems.⁵⁰ This sample was selected from participants who reported mental health difficulties from an ongoing longitudinal study set up in 2003 to monitor the mental health consequences of deploying to Iraq or Afghanistan.^{6–51} This found that only 23% of still-serving participants identified as having PTSD had accessed mental health services.²⁰ Additionally, a significant number of personnel met criteria for a diagnosis but did not admit that they needed support with their difficulties. Interestingly, it was reported that subjective functional impairment predicted help-seeking better than diagnosis.²⁰ The authors reported that rates of personnel seeking help were similar to rates in the general public,²⁰ for instance, 22% of individuals in the UK general public who screen positive for PTSD will access services for help,⁵² which is also in line with UK⁵³ and US samples.⁵⁴ However, one may have expected the rates of help-seeking to be higher with military samples because, due to their occupation, they may be at increased risk of psychological distress.^{55–57}

Another study using this same sample aimed to describe in detail what the barriers to accessing care are.⁵⁸ Participants were asked to endorse, or not, a range of potential barriers that had been identified by the research team. The authors concluded that barriers could be fitted into three categories:⁵⁸ 'access' barriers included factors such as 'not knowing where to access help from' or it 'being difficult to schedule an appointment'; 'stigma' barriers included both internal and external stigmas, of which internal stigma was more common, and included factors such as believing 'members of my unit might have less confidence in me' or 'I would be seen as weak'; the last category was 'attitude towards mental health care/providers' and included factors such as 'I don't trust mental health professionals'. Mistrust in UK military medical services has been documented previously;^{59–60} additionally, it was observed that internal stigma was a more common barrier for serving personnel and external stigma more common for people who had left the forces.⁵⁸

All this research demonstrates that there are significant numbers of serving and ex-serving personnel with PTSD who are not accessing services. In particular, concerns about internal stigma appear to be the most significant barrier.

INTERVENTIONS TO SUPPORT HELP-SEEKING IN UK ARMED FORCES

In recent years, the UK Armed Forces have introduced interventions aimed at supporting service personnel with PTSD to access Defence Mental Health services. Underpinning these interventions is the principle that military personnel favour peer support over other potential support sources³⁴ and that disclosures of distress to peers has been endorsed as positive and helpful.⁶¹

Decompression

The aim of decompression was to help service personnel adjust to life back home following deployment to war fighting zones, reduce negative psychological reactions and increase help-seeking behaviour. It involves stopping in a safe environment after leaving deployment which, for the UK military leaving

Afghanistan typically has meant spending between 24 and 36 h in Cyprus and attending a structured programme. To date, decompression has not been subject to randomised controlled trials (RCT) to establish its efficacy at reducing negative psychological reactions or improving rates of help-seeking, but a review of decompression concluded that while there is no evidence that it is associated with improved psychological health, there is also no evidence that it causes harm, and given that is viewed positively by service personnel, should continue to be used.^{62 63}

Trauma risk management

Trauma risk management (TRiM) involves training a number of individuals within each unit to monitor and identify risk factors in individuals exposed to potentially traumatising situations.⁶⁴ Importantly, these trained individuals are not members of the Defence Mental Health services, rather it is led by the chain of command. By using individuals that are integral parts of the military unit they are in, rather than Defence Mental Health professionals, this approach has been argued to reduce stigma which may have prevented individuals who need help actively seeking it.² The practitioners are trained to give advice to military commanders about published guidelines in relation to traumatic stress⁶⁵ and identify individuals who exhibit symptoms of psychological distress and may need extra support following exposure to traumatic events.⁶⁶

A cluster RCT study of TRiM's efficacy demonstrated that no significant changes in psychological health or internal or external stigmatising beliefs and help-seeking were observed at the 18-month follow-up in the intervention arm, but there was moderately better organisational functioning on the ships with TRiM practitioners on board.⁴⁸ The authors concluded that they may have observed a lack of a positive result because the ships in the study only encountered a low number of traumatic incidents during the study period and that not enough time had passed to allow for cultural changes in stigmatising beliefs to have occurred.⁴⁸ Overall, it has been demonstrated that TRiM is well received by service personnel.⁶⁷ This may be related to it being viewed as informal rather than formal support.

Battlemind

Battlemind was developed by the US army with the aim of enhancing resilience following deployment by building upon individuals' existing coping skills and helping them recognise when they may need extra support to cope with psychological problems, how to get it and normalising these reactions following deployment to reduce internal stigma.⁶⁸ This intervention was evaluated through a cluster RCT in US forces which reported that following battlemind training, participants reported fewer symptoms of PTSD and sleep difficulties.⁶⁹

Given these promising findings, a trial of battlemind has been conducted in the UK Armed Forces.⁷⁰ A cluster RCT design was employed and compared between treatment as normal (mental health briefs during decompression) in the control arm and battlemind in the intervention arm (instead of the standard decompression briefs). No differences in psychological health were observed between the two arms of the study, but rates of binge drinking were significantly lower in the intervention arm.⁷⁰ It is interesting to note that this study did not replicate the findings from the US military and reflect on some of the differences between these groups. There may be cultural differences in the expression of symptoms; for instance, US service personnel report higher rates of PTSD than UK Armed Forces following deployment,⁸ while UK Armed Forces report higher rates of alcohol problems following deployment.^{71–73}

The evidence suggests that while these interventions are well accepted by service personnel, there is no confidence that they have significantly increased help-seeking behaviour.⁷⁴ A common aim of the interventions was to reduce stigma so as to remove it as a barrier to seeking help, but the evidence is mixed about whether the interventions were able to do this.

A three-method model for reducing stigma has been proposed.⁷⁵ The first of these methods includes attempting to eradicate stigmatising beliefs. For example, this may be done by endeavouring to suppress stigmatising beliefs by providing information contradicting negative beliefs or demonstrating how unhelpful negative beliefs can be. However, while several studies purport this as a successful method for reducing stigma, others have shown that this method may actually lead to an increase in negative views.⁷⁶ The second method to reduce stigma is educating individuals about mental health. For this to be successful, it has been argued that psycho-education is not enough, but should also include information about causes of mental illness, prevalence and evidence-based treatment options.⁷⁷ The final method advocated by Corrigan and Penn is to promote contact between individuals who have experienced mental health difficulties and the wider public. There is convincing evidence for the efficacy of reducing stigmatising beliefs for interventions that do this.⁷⁸

CONCLUSIONS

Studies of members of the US and UK Armed Forces who have deployed to the conflicts in Afghanistan and Iraq have reported that significant numbers of personnel are suffering from symptoms of PTSD, with marked differences between US and UK personnel (8%–18% vs 3%–7%). However, only a modest number of military personnel with PTSD are able to access treatment. While the reasons for this reluctance to seek help are unknown, there are a number of potential barriers which collect into three areas: internal stigma, external stigma and access factors (eg, being unable to attend appointments or not knowing what services are available). Several trials have been conducted to improve the numbers of people seeking treatment by aiming to reduce stigma, however, there has been little evidence of the efficacy of these interventions.

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