

## ORIGINAL ARTICLE

# Contrasting beliefs about screening for mental disorders among UK military personnel returning from deployment to Afghanistan

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*J Med Screen* 2012;1–6  
DOI: 10.1258/jms.2012.012054

**Objective** The objective of the study was to elicit beliefs and experiences of the value of a screening programme for mental illness among 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. Noted barriers to seeking help included: 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 programme for mental illness, the barriers to seeking help for mental illness appear deep rooted and reinforced by the value ascribed to hardiness.

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Accepted for publication  
19 September 2012

## INTRODUCTION

Less than half of military personnel returning from deployment with mental health symptoms seek health care for their problems.<sup>1–4</sup> It is likely that many military personnel do not receive treatment which may benefit them.<sup>1,2,5</sup> Many factors may deter them from seeking help, including stigma, mistrust of health-care professionals, a desire to deal with problems on their own, lack of recognition of their own mental health issues and perceived practical barriers to accessing care services.<sup>2,5,6</sup> Considering the introduction of a screening programme is a common response from policy-makers and practitioners as they perceive that there would be 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.<sup>7–9</sup> 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 whether to introduce one. The effectiveness of screening depends on the validity of the tests, the efficacy of available treatments, acceptability of the programme to service personnel and the commitment of the professionals involved. The acceptability of the screening programme includes the willingness to be tested, the acceptance of advice received and willingness 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.<sup>6,7,10,11</sup>

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.<sup>12</sup>

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.

## METHODS

### 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 postdeployment screening for mental illness. The first screening session included 52 male personnel from the first of the two companies, all of whom completed the online screening questionnaire. For the purposes of the current study 21 of the possible 52 male personnel completed an interview in relation to their beliefs about postdeployment mental

**Table 1** Positive reception to screening: subthemes and verbatim extracts from interviews**Yeah it's good**

'Yeah it was good like' (Fred: Pg 1. Line 12)

'Yeah it's useful' (Ian: Pg 1. Line 6)

**Raises awareness**

'It might hit home, they might start thinking right okay, I do need the...I think seeing it on screen...they'll start to realise they need to get help' (Brian: Pg 3. Line 80)

'You do notice the changes in yourself with the series of questions and it starts to hit home a wee bit more like so that's what I liked about it' (Pete: Pg 2. Line 51)

**Relevance**

'It was quite dead on, let me know, it was bang on' (Daniel: Pg 3. Line 84)

'A couple of questions that related to me and a couple of the boys' (Jason: Pg 1. Line 3)

**Confidential**

'Boys are too scared to go to the doctors or places they need to go to say I need help with this and that so that's obviously all confidential, and you get that bit at the end...makes it easier for the boys' (Brian: Pg 1. Line 9)

'It's a very private thing that they can do themselves without other people knowing' (John: Pg 1. Line 21)

'Well what if you were afraid to tell other people, you could say so now' (Henry: Pg 1. Line 16)

health screening (referred to as the in-depth interview). The remaining 30 participants completed a structured interview related to the online questionnaire, covering subjects such as the questionnaire design, clarity and ease of understanding (referred to as the questionnaire, but not included in this report).

Opportunity sampling was used to initially recruit 22 service personnel. One of the 22 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 assigned to completing the in-depth interview or the questionnaire. This was decided based on the next available interviewer. As completing the in-depth interview took longer than the questionnaire, more participants were assigned to the questionnaire. A smaller sample size was appropriate for the nature of the qualitative study. There were 21 participants. The median and interquartile range age in the pilot study was 22 years (20–24 years), the youngest being 18 and the oldest 31.

**Materials**

A semistructured 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 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. Probes were included to assist if participants did not understand a question or if the interview became tangential. All interviews were recorded using Dictaphones.

**Table 2** Criticisms of the screening process: subthemes and verbatim extracts from interviews**Computers are impersonal**

'Like a computer telling me that I need to seek help I would have probably been like you don't need to tell me!' (David: Pg 2. Line 58)

'It's only a computer' (Fred: Pg 3. Line 82)

'I don't think just cos the computer says there's something wrong with them they're going to immediately go' (Ed: Pg 3. Line 101)

**Not all problems are related to the military:**

'Everyone goes through different problems...my problems are nothing to do with decompression like some people have compassionate problems' (Simon: Pg 1. Line 25)

**Procedure**

Four researchers, with prior experience of qualitative interviewing, were briefed and trained in using the interview schedule. The semistructured interviews were conducted in private rooms on the military installation. Interviews lasted 5–20 minutes. The semistructured nature enabled participants to discuss issues they felt were 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.

**Analysis**

The transcripts were analysed following the procedures outlined as recommended for thematic analysis.<sup>13</sup> This method involved a detailed and interpretive analysis where themes and concepts were identified within and across the transcripts. This was a purely data-driven inductive approach, with no existing coding or theoretical frame.

Each participant's transcript was analysed by the individual researcher who conducted the interview, and a table of themes was created for each of the 21 participants. The four researchers met three times, for up to four hours at a time, to identify patterns and connections across the 21 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 five master themes, each encompassing their own sub-themes. 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 is not a weakness. The master themes included subthemes 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.

**Table 3** Barriers to seeking help: Sub-themes and verbatim extracts from interviews**Avoidance**

'Er, I didn't do the advice. ...it said yes or no to the advice and I just went no' (Fred: Pg 2. Line 43)

'No I didn't ask for none' (Mark: Pg 1. Line 22)

'I didn't look at it to be honest' (Luke: Pg 2. Line 47)

**Got to be strong**

'The army's all about being strong you know mentally, physically, tough all the time. ...umm I think deep down there is some underlying tones there that I can't be weak' (David: Pg 4. Line 127)

'Even the likes of going sick with a normal injury, boys wouldn't do it because it looks bad and you get quite a lot of stigma about it too, which isn't a good thing' (Daniel: Pg 4. Line 132)

'Some lads are afraid to be seen as soft or something' (Keith: Pg 5. Line 126)

**Fear what others will think**

'They'll start knowing your problems, you might start thinking ah they're looking at me differently, that sort of thing' (Brian: Pg 4. Line 100)

'Boy's wouldn't do it cos it looks bad. And you get quite a lot of stigma about it too which isn't a good thing' (Daniel: Pg 4. Line 129)

'What your peers think. People might think they're mad. ...you see someone going to get help and you think they're a nut job' (Luke: Pg 1. Line 25)

**Easier to talk to mates**

'If us boys got problems then we speak to each other get down to our own level' (Mark: Pg 1. Line 31)

'Tell them and maybe have a laugh and a joke about it between yourselves or something' (Pete: Pg 4. Line 113)

'We talked about every patrol. ...debriefing patrols, then the boys go off in their own little groups and that or just talk together about what we seen' (Brian: Pg 5. Line 139)

**Fear of impact on career**

'The boys that will be wanting a promotion and wanting to get further but might panic if I say something and they might not get promoted or something' (Mark: Pg 3. Line 94)

**Table 4** 'Got to be forced to do it': subthemes and verbatim extracts from interviews

'If they see a letter and it just says whatever on it they just going to go ok. ...so if they came back and did this again it'd be much handier' (Brian: Pg 6. Line 179)

'They won't do it unless someone's making them do it. ...if it said you've now got an appointment booked with the welfare officer they'd go then cos they've got no choice' (Carl: Pg 2. Line 47)

'Not in the post, you'll probably have to get them in their room, sit down, and make them do it, like to be honest. They'll probably sack it off like 'nah it doesn't matter'' (Ed: Pg 1. Line 21)

**Positive reception to screening**

All participants expressed positive perceptions of post-tour screening. Five subthemes represent the different elements of the positive reception to screening. Table 1 shows verbatim statements illustrating each of the subthemes. This theme 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 5** Mental health is not a weakness: subthemes and verbatim extracts from interviews

'I think it's great that the army actually tries to erm say that it's stigma it's not that you are weak or anything, but you have problems everyone has them' (David: Pg 4. Line 138)

'I mean that some lads, you know lads its all their experience, and some people just have a bad experience, like it's nothing to do with their weakness or anything, it's just the way it is' (Kieran: Pg 3. line 75)

*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.

*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 subtheme it shows a more active interest.

*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, in turn potentially increasing the likelihood of accepting any advice received.

*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 willingness to participate in screening and to provide honest responses.

**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 accepted or utilized.

*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.

**Barriers to seeking help**

While the participants had positive attitudes towards screening, there were several reasons that may prevent them from seeking help. Table 3 shows verbatim statements illustrating each of the subthemes of barriers to seeking help.

*Avoidance:* Almost half of the participants discussed experiences, attitudes or beliefs indicating they have avoided 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 of 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 from others.

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

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

*Easier to talk to mates:* Some of the participants suggested a preference for talking 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 does not necessarily have to be an alternative to seeking help, but is more than likely where some will start.

*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.

### 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, it seems unlikely that they will act on any advice.

### Mental health is not 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 be 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.

## DISCUSSION

This study illustrates the presence of a complex set of beliefs about screening for mental illness among the UK military. While many participants made positive remarks about the advantages of screening, these were tempered by some criticisms of the process, and the advantages appeared detached from participants' own needs. Despite positive attitudes towards screening, 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 participants. This suggests that a personal approach to giving advice may enhance the likelihood of its acceptance. However, interviewees provided a wide range of reasons why they would refuse 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. Making the screening process mandatory through the chain of command was perceived as a potentially effective way of lowering barriers and resistance to seeking help. However, widespread support for this may be difficult, because any mandatory intervention among people who do not lack mental capacity raises serious issues of ethics, informed choice and autonomy.

Most participants' beliefs corresponded to a reflective assessment of the way they or their comrades would act. There were generally positive responses to screening and its suitability. However, many participants voiced scepticism of 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 with mental health issues on their own and the lack of interest in receiving tailored advice, would reduce the impact of screening. Previous quantitative studies show most of these barriers both in military and civilian populations.<sup>1-6</sup> Fewer studies have emphasized the belief that people want to tackle mental health issues on their own,<sup>5</sup> and none have shown the reluctance to even read tailored advice that might potentially be beneficial.

Despite showing a willingness to be assessed, an unexpectedly large group of participants did not want to receive the advice available. 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 USA showed that 60% of those who screened positive for mental disorder were not interested in receiving help.<sup>6</sup> In a study carried out in 2002, before the outbreak of the most recent hostilities in Iraq and Afghanistan, we found reluctance among participants to respond to an invitation to visit their medical officers after completing a set of screening questions.<sup>10</sup> The current study shows that this reluctance persists, despite the large numbers of service personnel who have been killed and injured in the recent conflicts and the various efforts of the UK Armed Forces to support the mental health of its personnel, for example, the Trauma Risk Management programme (TRiM).<sup>14</sup> Several participants indicated that they should be strong and able to deal with stress on their own. 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,<sup>15,16</sup> and engendering mental fortitude is an important aim of training in the Armed Forces. In this

respect, the health message that one should recognize 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, whereas some suggested 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,<sup>17,18</sup> and TRiM<sup>19</sup> aim to reinforce camaraderie, and in doing so help to eliminate barriers. Our results indicate, perhaps unsurprisingly, that not all service personnel are prepared to talk about their problems to their commanders, welfare personnel or medical officers.

The strength of this study is the willingness of those who were approached to share their beliefs. This may have been enhanced by the perception that the researchers, although acquainted with the ethos of the Armed Forces, were not part of the chain of command. An additional strength is that respondents were able to voice cogently their own views, rather than have to select from a set of rigid response options in 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 wider military, although this seems unlikely because the responses of participants reaffirm opinions from a study carried out in 2002.<sup>12</sup> These results are also consistent with research on health-seeking behaviour.<sup>1-3,11</sup> 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 programme.

## CONCLUSION

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 military personnel to seek help should not appear to contradict values inculcated through training.

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

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