Reducing the Stigma of Help-Seeking Behavior

A Monograph

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The stigma of mental healthcare and other fortified barriers to care are age old and enduring without meaningful organizational change. Stigmas towards mental healthcare are not unique to the armed forces, increasing the importance of developing an organizational propensity towards positive coping mechanisms. This monograph identifies multiple gaps in behavioral health theory supporting the current Comprehensive Solider Fitness program (CSF) and approach to reduce barriers to care within the Army. These theoretical gaps require additional studies to validate the CSF program and to identify the true link between the stigma of health seeking behavior and mental health disorders.

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Abstract

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The stigma of mental healthcare and other fortified barriers to care are age old and seemingly enduring without meaningful organizational change. Stigmas towards mental healthcare are not unique to the armed forces, increasing the importance of developing an organizational propensity towards positive coping mechanisms. This monograph identifies multiple gaps in behavioral health theory supporting the current CSF program and approach to reduce barriers to care within the Army. These theoretical gaps require additional studies to validate the CSF program and to identify the true link between the stigma of health seeking behavior and mental health disorders.

The CSF program, aimed at building resilient fighting formations, must be realistically scoped with a manageable sample size and variables to provide organizational leaders practical empirical data. Behaviors displayed by formal leaders within an organization percolates conclusively, achieving overarching influence if verbal/nonverbal cues are reciprocated and adopted by the population. A leader's influence can become a catalyst for social change or deviance if behaviors are replicated by this guided coalition or corrected by organizational members. For leaders to reduce barriers to care within their organizations, they must acknowledge those perceptions and incorporate inclusive policies and procedures promoting healthy coping mechanisms and help seeking behavior amongst organizational members. An organization absent of this promotion and continued negative attitudes regarding mental healthcare will continue to act as risk factors decreasing help-seeking behavior.

Contents

Acronyms

ADP	Army Doctrine Publication
APA	American Psychological Association
AEF	American Expeditionary Force
CSF	Comprehensive Soldier Fitness
DOD MHTF	Department of Defense Mental Health Task Force
DSM	Diagnosis and Statistical manual
GWOT	Global War on Terror
HQDA	Headquarters, Department of the Army
OSD	Office of Secretary of Defense
OIF/OEF	Operation Iraqi/ Enduring Freedom
PDHA	Pre-Deployment Health Assessment
PTS(D)	Post Traumatic Stress Disorder
PWMHDS	People with Mental Health Disorders
TBI	Traumatic Brain Injury
VA	Veteran Affairs

Illustrations

Introduction

A new culture of warriors appeared from the ashes of the World Trade Center following the September 11, 2001 terrorist attacks. Men and women throughout the nation joined the ranks of the United States (US) military to eradicate violent extremist organizations. Two decades of contingency operations have claimed the lives of 7,000 service members and rendered over 50,000 wounded. As the longest American conflict in history, the Global War on Terror (GWOT) coincides with a growing suicide epidemic amongst service members. According to psychologist Brandon Kuehn, military suicides reached an unprecedented level, surpassing the civilian rate in 2008, reaching twenty suicides per 100,000 soldiers each year in the United States Army alone.[1] This phenomenon has increased the importance to study the driving force behind the loss of individuals who selflessly laid their lives on the line for their country, but willingly took their own.

Understanding the relationship between the stigma of mental healthcare in Army organizations and unit readiness has become increasingly prudent with growing global threats to the United States of America. The resurgence of near-peer adversaries, with the added implications of multiple contested domains, will continue to strain service members and the force as the nation faces emerging threats. Service members conducting prolonged operations during multiple deployments are frequently exposed to combat related stressors. These traumatic events often create an alternate negative perception of how veterans see the world and themselves. Soldiers return home with negative perceptions and lifelong disorders due to exposure to warfare. Despite the increase in operational tempo for combat arms organizations, the attention to unit preparation requires military personnel to maintain the perception of 100% mission readiness. This perception of unit and personal readiness is seemingly integral to remain competitive for

[1] Brandon Kuehn, "Soldier Suicide Rates Continue to Rise: Military, Scientists Work to stem the Tide," *Journal of the American Medical Association*, 301, no. 11 (March 2009): 1111-1113, accessed October 9, 2018, https://www.ncbi.nlm.nih.gov/pubmed/19293405.

promotion despite the pervasiveness of mental health disorders in the military. Today, soldiers fear the negative "high-risk soldier" labels and unit isolation associated with requiring or seeking mental healthcare. This growing stigma surrounding mental healthcare discourages help-seeking behavior for many soldiers suffering from mental illness.

It is imperative to understand the concepts of institutionalization and mental healthcare stigmatization in relation to military culture and leadership. Army organizational leadership is essential to decrease the effects of the stigma through cultural change and to increase unit readiness in the future. The purpose of this body of work is to review the vast literature regarding the organizational cultural effects on the stigma of mental healthcare, and to identify theoretical frameworks to reduce barriers of help-seeking behavior. This monograph will explore topics such as prolonged mental health, emotional intelligence, negative and positive coping mechanisms, and the operational impact of degraded mental fitness in relation to the anticipated range of military operations. Identifying positive cultural molding methodologies for organizational leaders will help increase understanding of the military's leadership role in increasing individual soldier resilience and unit readiness.

The goal of this work is to aid in constructing resilient soldiers and to invest in their well-being beyond their military service obligation, and to build resilient organizations capable of conducting limited and large-scale operations in austere environments. Adopting a prolonged mental healthcare regimen for Army organizations will facilitate the unit leadership's understanding of counseling and will yield an increase in help-seeking behavior amongst service members. To better understand the US Army's stigma of seeking behavioral health, this monograph will describe the sub-culture of combat arms units, define the stigma of seeking mental healthcare, and provide the historical significance of service members forgoing mental health and its societal effects. Lastly, this body of work will challenge the Army's current paradigm regarding help-seeking behavior in efforts to change the culture of combat arms organizations.

It is necessary to first discuss the nature of the combat arms sub-culture within the Army. Exploring Albert Bandura's social learning theory, Sarah Redmond's military organizational culture, and Tiffany Greene-Shortridge's theory on organizational climate, provides a body of work to understand the nature of the combat arms organization.[2] Focusing on organization behavior, a heavily saturated topic in the field of social science, displays the nature of Tanya Chartrand's "chameleon effect," and the leadership's role in influencing their organization.[3] The ample literature and a depth of supportive documents outlining the pervasiveness of organizational barriers to care will reinforce the necessity to explore this topic further.

To alter the combat arms sub-culture, Army leadership must delineate the types of stigma and their relationship with their organizations and mental health. Exploring topics such as the barriers to seek mental health care, as outlined by Patrick Corrigan, provides a theoretical background on the differing types of stigmas which effects an individual's help seeking behavior.[4] Arutruo Castro's instrumental work describing the "paradox of the combat veteran" will facilitate the integration of ideas of the dilemmas veterans face when returning home and the inadequacies service members encounter when help-seeking behavior contradicts their social construct of the combat arms organization.[5]

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[2] Albert Bandura, *Social Learning Theory* (Englewood Cliffs, NJ: Prentice Hall, Inc 1977), 3; Sarah Redmond, et al., "A Brief Introduction to the Military Workplace Culture," *Work* 50, no. 1 (January 2015): 11, accessed October 09, 2018, https://www.ncbi.nlm.nih.gov/pubmed/25547167; Tiffany M. Greene-Shortridge, Thomas W. Britt, and Carl Andrew Castro, "The Stigma of Mental Health Problems in the Military," *Military Medicine* 172, no. 2 (February 2007): 157–161, accessed July 4, 2018, https://academic.oup.com/milmed/article/172/2/157-161/4578015.

[3] Tanya Chartrand, "The Chameleon Effect: The Perception-Behavior Link and Social Interaction," *Journal of Personality and Social Psychology* 76, no. 6 (June 1999): 893, accessed October 09, 2018, https://psycnet.apa.org/record/1999-05479-002.

[4] Patrick Corrigan and David Penn, "Lessons from Social Psychology on Discrediting Psychiatric Stigma," *American Psychology* 54, no. 9 (September 1999): 765-776, accessed October 09, 2018, https://www.ncbi.nlm.nih.gov/pubmed/10510666.

[5] Jeffery Thomas and Carl Castro, "Organizational Behavior and the U.S. Peacekeeper, "*The Psychology of the Peacekeeper: Lessons from the Field*," Praeger Publishers/Greenwood Publishing Group, (April 2003): 127-46, accessed October 09, 2018, https://psycnet.apa.org/record/2003-88224-008.

Understanding the sub-culture of the combat arms organization and the pervasiveness of barriers to mental healthcare will lay the groundwork to understand the suicide epidemic the US military faces today. With an average twenty-two veterans committing suicide daily, it is imperative to comprehend the historical and cultural underpinnings of this trend. This monograph will explore generational factors, Post Traumatic Stress Disorder (PTSD), care after conflict and its implications with readiness as the military prepares for large-scale combat operations. The research to support this monograph will explore the concepts which lay the foundation for organizational change. Eugina Weiss' scholarship regarding the influence of military culture and mental health practices provides feasible options for meaningful and lasting changes to the organizational culture and the organization's perception of help-seeking behavior.[6]

Using a breadth of literature describing the vast variables of stigmas associated with help-seeking behavior, the sub-culture of the combat arms organization, and the epidemic of suicide and high-risk behavior due to the lack of the mitigation, this monograph will describe the relationship between the three topics. An analysis of *AR 350-53*, the Army's *Comprehensive Solider Fitness Program* (CSF), will give the organizations formal answers to suicide prevention. The concepts explored throughout this process will prove the current policy falls short in encouraging help-seeking behavior in combat arms organizations. This body of work will provide a theoretical framework to reduce the stigma in combat arms organizations, enabling mission command and unit readiness to counter global emerging threats.

Defining Culture

To adequately portray the necessity for Army organizations to reduce barriers to seek care, a distinct definition of culture must be considered. The analysis of how organizational

[6] Eugenia Weiss, Jose Coll, and Michael Metal, "The Influence of Military Culture and Veteran Worldviews on Mental Health Treatment: Practice Implications for Combat Veteran Help-seeking and Wellness*," International Journal of Health, Wellness & Society* 1, no.2 (2011): 75, accessed October 09, 2018, https://doi.org/10.18848/2156-8960/CGP/v01i02/41168.

culture works will provide an understanding of how and why organizations evolve and under what conditions do these organizations successfully undertake positive evolution. Organizational culture is defined as the "pattern of basic assumptions that a group has invented, discovered, or developed, in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems."[7] To define a culture adopted by an organization, it must be analyzed at various depths to appreciate the diverse variables affecting individual behavior within the paradigm. Visible and audible artifacts contain the socially constructed environment of the organization and is easily identifiable by members within the unit. These attributes include behavior patterns, public policies, and physical makeup of the organization and its occupants to provide a depiction of organizational culture.

Members of organizations learn to endure behaviors portrayed by the group's leadership through internalization. This dialectical point of view accentuates the "how" organizational members interact with other members and society outside of its organization. The meanings of behaviors portrayed by organizational leaders become imbedded in the culture and aids institutionalization.[8] Group members adopt attributes displayed by their leadership and legitimizes the behavior patterns and language of the organization. Behaviors of the group become a part of the organizational institution regardless of the negative or positive attributes adopted. These concepts further support the notion that society is a human product and man is a social product.[9] For societies to perpetuate role-specific knowledge and maintain the legitimacy of the institution, aspiring members must continue to adopt the values of the society and foster the

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[7] Edgar Schein, "Coming to a New Awareness of Culture," *Sloan Management Review* 25, no. 2 (January 1984): 3-15, accessed October 09, 2018, https://sloanreview.mit.edu/coming-to-a-new-awareness-of-organizational-culture.

[8] Peter Berger and Thomas Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (New York: Doubleday, 1966), 14.

[9] Berger and Luckmann, *The Social Construction of Reality*, 26.

status quo of the organizational culture.[10] For organizational culture to survive, the group must have shared significant problems, solve these problems, and also observe the outcomes of their consensual effects of their solutions. These solutions to shared problems must be adopted by new and aspiring members in order to be a cultural adopted behavior or construct. These experiences define an organizational culture with set rules, and behavior to be adopted by members worthy of indoctrination and assimilation within the culture. Shared experiences are imperative for groups to survive, recruit, and solve problems in the future.

Organizations with a vast history, comprised of many challenges and shared experiences, will have a strong sense of culture which is both resilient and stable. Younger organizations, void of adverse encounters, lack shared experiences for the "group as a whole to have a defined culture."[11] Large organizations with a vast history can host multiple subcultures within the aggregated corporate culture. These subcultures are often born from occupational background of the overarching organization.[12] These subcultures are able to coexist in a given organization with varying behaviors and policies to ensure groups are capable of completing the end state of the organization as a whole. Though new members bring in new ideas and outside experiences, the group as a whole must empirically settle their implementation. The introduced paradigm must adequately pass and be ratified in order to reaffirm its validity. The complexity of socializing organizational culture further lends to the intricacy of changing an established culture.

Espousing a positive culture change effort in Army units emphasizes the importance of studying the purpose of culture and the methods to shape a culture to meet the organizational leader's intent. Edgar Schein suggests four approaches to gather organizational cultural data necessary to decipher an organizational paradigm. The four methods call for an analysis of organizational outliers, responses to challenges, collective beliefs, and assumptions. By analyzing

[10] Berger and Luckmann, *The Social Construction of Reality*, 28.

[11] Schein, "Coming to a New Awareness of Culture," 15.

[12] Ibid., 8.

the process and content of socialization of new members, basic elements of socialization are clearly presented to aspiring members.[13] Analyzing responses to critical incidents in the organization's past provides the historical context to determine the purposes of the cultural formation. Early underlying assumptions of an organization provides themes and motivations for the structure and behavior of a culture.[14] Examining the beliefs and values of a group's formal leadership will display the goals and methods of achieving the organization's desired end state. Lastly, exploring anomalies within an organization discloses basic assumptions that displays their interrelation in the cultural paradigm. Furthermore, understanding an organizational biography will allow leaders, and outside agencies, to forecast discourse and inefficiencies impeding the growth of an organization, its culture and subcultures. Organizational culture can only be efficiently managed and changed by discovering and considering the sources of stability and dialectic the organization contains, identified through thoughtful analysis. A positive organizational culture is the key to reduce internal stressors, bolster individual readiness, and increase unit proficiency.

Combat Arms Subculture

The US Army is a storied organization within the Department of Defense and an integral part of American society, portrayed in literature, theatrical and other entertainment mediums since its inception. The organization has successfully solidified its place in American culture as a legitimate subculture with its own language, rules and customs.[15] Like the United States Army, combat arms organizations have unique workplace cultures unlike other military or civilian organizations. Army recruits begin their indoctrination early on in their military career. This rite of passage process transforms individual citizen recruits, challenge their worldview, and provide

[13] Schein, "Coming to a New Awareness of Culture," 10.

[14] Ibid, 11.

[15] Ibid.

them with a Warrior Ethos mantra necessary to operate as a team in arduous and ambiguous situations. This team building and exhaustive process exposes the recruits to their new norms, language, and codes.[16]

Each phase of this indoctrination process promotes group cohesiveness by providing the once individual with identical haircuts, uniforms, diets, and living quarters. For newcomers to assimilate in unknown social situations such as the Army units, individuals will unconsciously imitate gestures, postures, behavior, speech, and practices they observe from more experienced leaders within an organization.[17] Social psychologists Tonya Chartrand and John Bargh suggests individuals unconsciously mimic adopted social norms within an organization culture. They coin this occurrence as the "chameleon effect," where individuals imitate others in order to achieve inclusion into the majority or the "standard."[18] Compliance to each level of the basic training process proves the recruit's commitment to the military profession and their country.[19] Incoming recruits are taught to be stoic and to internalize feelings necessary to bear the burden of combat.[20] The sacred indoctrination process bonds insensible recruits together, promotes stoicism into the meek, and initiates the once individual into a "warrior society."[21] The Army utilizes the "Warrior Society" mindset to form a way of life for all military members. The culture embodies the

[16] Redmond, et al., "A Brief Introduction to the Military Workplace Culture," 11.

[17] Pierre Bourdieu, "The Logic of Practice," *Cambridge Studies in Social and Cultural Anthropology Book* 1, no. 1 (January 1990): 25-30, accessed October 09, 2018, https://monoskop.org/images/8/Bourdieu_Pierre_The_Logic_of_Practice_1990.pdf.

[18] Tonya Chartrand and John Bargh, "The Chameleon Effect: The Perception-Behavior Link and Social Interaction," *Journal of Personality and Social Psychology* 76, no. 6 (January 1999): 893-910, accessed October, 09, 2018. http://dx.doi.org/10.1037/0022-3514.76.6.893.

[19] Redmond, et al., "A Brief Introduction to the Military Workplace Culture," 11.

[20] Weiss, Coll, and Metal, "The Influence of Military Culture and Veteran Worldviews on Mental Health Treatment," 78.

[21] Ibid.

"Warrior Ethos," founded on basic Army principles: placing the mission first, not accepting defeat, never quitting, and never leaving a fallen comrade.[22]

New soldiers adopting the authoritarian structure of the US Army remains an integral principle in adopting the demanding nature of selfless service to the constitution of the United States. As previously discussed, culture is defined as a product of the social environment that includes a shared sense of values, norms, ideas, and meanings.[23] Driving factors like social identity attracting young Americans to combat units are the commonalities which make up the combat arms sub-culture.[24] The role of the aforementioned indoctrination process is to minimize individualism in order to achieve the unit's common goal: mission completion. This final step provides military leaders with the ability to plan combat operations with soldiers who are willing to complete the mission at all cost, even if it costs them everything. The ability for military leaders to lead their soldiers into hell and back is the epitome of unit readiness.

The US Army societal sub-culture is unique due to the authoritative curtailments willingly placed on each soldier entering the Armed Forces.[25] Soldiers, along with their families, are "bound by military laws, regulations, traditions, norms, and values that differ from civilians. The Uniform Code of Military Justice (UCMJ) outlines military specific laws intended to maintain the requisite level of good order and discipline, conceptualized as the chain of command, which categorizes military service."[26] Soldiers willingly give senior members authority over their wellbeing to achieve the greater good for the country. Military personnel are herein bound by law to the hierarchical structure of senior and subordinates, placing complete

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[22] US Department of the Army, *Army Doctrine Publication (ADP) 6-22, Army Leadership* (Washington, DC: Government Printing Office, 2012), 7.

[23] Redmond, et al., "A Brief Introduction to the Military Workplace Culture," 17.

[24] Ibid., 18.

[25] Ibid., 11.

[26] Ibid., 14.

authority with senior service members. In turn, "senior military personnel must issue lawful orders that junior military personnel must execute."[27] Some scholars describe this unique relationship as reciprocal, where the human elements of trust between the leader and the subordinate must exist.[28] The trust of the subordinate is what legitimizes the leader, providing the greatest chance for mission success. The leaders in these organizations must be confident in the soldiers receiving specific orders; completing the mission as prescribed within the commander's intent. The destruction of the link of trust between the two parties leads to the detriment of good order and discipline and creates an organizational climate of toxicity and unit dysfunctionality.[29]

To mitigate the breakdown of the authoritative chain, ceremonial acts of discipline, such as shoe shining, uniforms, and salutes, were integrated into the military to create functional discipline.[30] As expected, soldiers who personal lives overlap congruently with the combat arms sub-culture tend to prioritize the military mission and values over individuals who view military service as a temporary occupation.[31] Soldiers who successfully assimilate to this culture have higher chances of remaining very much institutionally oriented. "Furthermore, instilling this mindset in all service members is crucial for maintaining a highly effective and committed force by encouraging individuals to think and behave in ways that show perseverance; responsibility for others; motivation by a higher calling; and ability to set priorities, make tradeoffs, adapt, and accept dependence on others."[32]

The institutionalization process is necessary to meet the operational readiness needs of Army organizations, consequently it often presents inherent challenges to individuals integrating

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[27] Redmond, et al., "A Brief Introduction to the Military Workplace Culture," 13.

[28] Ibid., 15.

[29] Ibid.

[30] Ibid., 19.

[31] Ibid.

[32] Ibid.

into other societal constructs. “Returning from combat and deployment often involves transitioning back to the home environment, and in some cases back to the civilian environment, known as reintegration.”[33] Reintegration is challenging for some military personnel in its own rights. Eugina Weiss postulates that redeployment contributes to the mental diminution of soldiers who have undergone traumatic experiences. Often soldiers develop defense mechanisms against expressive feelings when family members desire emotional connectivity. Post-combat soldiers often feel “numb” due to the fear of becoming overwhelmed by their emotions, choosing to remain distant for their mental stability.[34] Ten years of continuous warfare has consequently exposed thousands of Armed Forces personnel into the brinks of combat, returning home from extended deployments exposed to stressors. Many veterans return home without noticeable effects from the deployment, however others present with debilitating medical and mental ailments. Despite the military’s efforts to mitigate war effects on soldiers, it is impossible to identify who will struggle during the reintegration process and who will not.[35] Soldiers often deploy with mental health issues, which become more severe and treatment-resistant.[36] Service members often return from deployment with three prevailing mental health issues stemming from serving in a combat environment: depression, post-traumatic stress disorder and traumatic brain injury (TBI). The growing mental health issues will continue to negatively impact unit readiness if organizations continue to fail to mitigate internal barriers to care. The mental degradation of many service members not only impact the current generation of service members, it will hinder the integration of recruits in the future.

[33] Redmond, et al., “A Brief Introduction to the Military Workplace Culture,” 19.

[34] Weiss, Coll, and Metal, “The Influence of Military Culture and Veteran Worldviews on Mental Health Treatment,” 78.

[35] Redmond, et al., “A Brief Introduction to the Military Workplace Culture,” 19.

[36] Ibid., 20.

The growing Millennial Generation Z population within the military has increased the emphasis on mental health issues and treatments. Millennial's are categorized as individuals born between 1980 and 2001, and the Generation Z cohort are born between 2001 and 2020.[37] The Army of today must embrace Generation Z warriors who are less affected by the stigma of seeking mental healthcare and more apt to seek help for mental health concerns. However, Generation Z recruits are generally less resilient than previous cohorts, emphasizing the necessity for the Army as an organization to cultivate an atmosphere promoting positive mental health trends and mental strength to meet future operational needs. Military missions cannot succeed out without mentally fit men and women manning warfighting organizations capable of closing with and destroying the nation's adversaries in a wide range of military operations. The multitude of these forces vary deeply on the range of military operations engaged across the globe in the future amongst state and non-state actors.

The Army's ability to recruit mentally capable and physically fit candidates is critical for the overall national security plan outlined by the leaders of this country. Paragraph C, section 467 of the Military Selective Service Act (Title 50, of the U.S. Code), established the all-volunteer force on July 1, 1973, which naturally poses recruitment challenges amidst two decades of protracted warfare.[38] Force management in the wake of the incoming Generation Z soldiers will present ideological constraints pertaining the availability and use of mental healthcare within the current Army organizational culture. The burden of high operational tempo and multiple deployments will continue to challenge the force mentally and physically without cultural and organizational shaping to meet the future needs of the Army. The persistent combat stress

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[37] Sezin Baysal Berkup, "Working with Generations X and Y in Generation Z Period: Management Of Different Generations In Business Life," *Mediterranean Journal of Social Sciences* 5, no. 19 (September 7, 2014): 218, accessed April 17, 2019, http://www.mcser.org/journal/index.php/mjss/article/view/4247.

[38] Barbara Jones, *Post-Traumatic Stress Disorder in United States Legal Culture: An Historical Perspective from World War I Through the Vietnam Conflict* (Ann Arbor, MI: UMI A Bell and Howell Company 1998), 79.

suffered by GWOT soldiers will continue to hinder the Army's ability to generate and maintain forces for the future fight without reducing the stigma of seeking mental health. True to every US conflict, a casualty represents a loss to fighting power and it is in the realm of organizational leaders to mitigate potential threats to the fighting force. The Army's approach to mental health has minimally changed throughout the history of the force, precluding necessary changes to meet the needs of service members and reduce the mental attrition of soldiers today.

Invisible Wounds: From Shellshock to PTSD

The erosion of mental health during combat has impacted unit readiness since the inception of the force. The perception of individuals with combat related mental ailments and how we view these disorders over time has changed sparingly since the world wars. As early as 1915, Army psychologist David Forsyth observed soldiers suffering from a multitude of symptoms ranging from depression to paralysis, at that time attributed to spinal cord disease during the Great War. The occasional delay of these symptoms became problematic for the neurologically-trained physicians to diagnose the influx of soldiers suffering from concussive type ailments. Experts coined the term "shell shock" to describe these "obscure injuries of the nervous system," as a form of neurasthenia (exhaustion paired with depression) and hysteria (emotional outbursts and hallucinations).[39] Due to the sweeping effects mental health degradation had on force management, physician Norman Fenton and the American Expeditionary Force (AEF) were charged to study emerging "shell shock" treatment models with intentions to implement within the US Army. He concluded multiple studies from 1917 to 1924 and indicated a significant relationship between exposure to traumatic events and an individual's onset of "shell shock" symptoms. He also concluded "educated soldiers" were just as prone to neurosis as the "degenerates."[40] Although a sect of military doctors believed the emotional versus physical

[39] Jones, *Post-Traumatic Stress Disorder in United States Legal Culture,* 35.

[40] Ibid., 26.

typology of "shell shock," the condition was never declared an official diagnosis by the AEF.[41] Other experts during this time attempted to mitigate the Army's overarching mental health issues by denying mobilization for recruits and service members "susceptible" to mental health disorders. Leading military psychologists "extended Sigmund Freud's theories that predisposition to neurosis, not the combat situation, was the key 'trigger' to the onset of the disorder."[42] Electro-shock and the antiquated version of immersive therapy became the catalyst for front-line treatment, deemed most suitable for suffering soldiers and mission readiness. Soon after the term was coined, the Army's inaction to mitigate "shell shock" exposed the lack of systematic diagnosis and emphasized the military medicine's aims of returning soldiers to the frontline expediently.

The World Health Organization attempted to standardize symptoms and classifications of mental disorders in the 1948 revision of the Manual of the National Classification of Diseases, Injuries, and Causes of Death.[43] However, this manual failed to describe diagnosis operationally rather than etiologically, establishing a gap of knowledge regarding stages, progression and characteristic of war-related stressors paired with empirical data. To achieve a collective mental health baseline, the American Psychiatric Association's (APA) developed the Diagnostic and Statistical Manual (DSM) in 1952, replacing age old systems used throughout the military and Veterans Affairs (VA).[44] "Shell shock" symptoms of World War I and World War II slowly developed into "gross stress reaction," as defined by the initial DSM. Unfortunately, this diagnosis did not account for chronic or delayed stress prevalent in 1% of evacuated soldiers at the height of the Vietnam War's 1968 Tet Offensive.[45] Military psychiatrists credited the

[41] Ibid., 28.

[42] Jones, *Post-Traumatic Stress Disorder in United States Legal Culture,* 30.

[43] Ibid., 64.

[44] Ibid., 65.

[45] Ibid., 78.

significant reduction of combat related mental health disorders to the incorporation of one-year rotations and rest and relaxation opportunities for soldiers. “Mental health professionals back home, however, were beginning to see the victims of delayed stress reactions.”[46] With growing medical and public pressure, the psychiatric profession, and the architects of the DSM-III rightfully adopted statistical measurements to test current diagnostic criteria. These efforts helped shape the systematic acceptance of Post-Traumatic Stress Disorder (PTSD) in the 1980 publication of DSM III.[47] Unfortunately, the modern psychological and medical discrepancies regarding the etiologically of mental health disorders amassed after the exposure of war-related incidents continued to drive the inadequacies of military treatment of these disorders and their accompanied stigmas.

Today, suicide is the second leading cause of death to military personnel, active duty and veterans.[48] PTSD, TBI, depression, and anxiety disorders coupled with substance abuse, has contributed to the epidemic of twenty two veterans committing suicide daily. The growing trend of onset depression shows in 14% of post combat soldiers and rises to 27% after their third deployment.[49] PTSD also affects 14% of returning veterans and male combat arms soldiers are twice as likely to die by suicide compared to their civilian counterparts. TBI was found in 19% of returning combat veterans which complicates accurate diagnosis of mental health disorders upon redeployment.[50] Recent studies pertaining the GWOT generation across the country hypothesize the increase of suicides amongst the nation’s veterans with these variables in mind. Consequently, soldiers are prescribed medication to numb their physical and mental aliments to encourage an

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[46] Jones, *Post-Traumatic Stress Disorder in United States Legal Culture,* 78.

[47] Ibid., 80.

[48] AnnaBelle Bryan, Craig Bryan, and Jacqueline Theriault, “Self-forgiveness, Posttraumatic Stress, and Suicide Attempts Among Military Personnel and Veterans,” *Traumatology* 21, no. 1 (March 2015): 40-46, accessed October 09 2018, https://www.academia.edu/Self-Forgiveness_Posttraumatic_Stress_and_Suicide.

[49] Redmond, et al., “A Brief Introduction to the Military Workplace Culture,” 11.

[50] Ibid., 19.

accelerated return for suffering soldiers similar to the shell shock era of military mental health. Over-prescription, paired with the mission first mantra, often encourages soldiers to adopt negative coping mechanisms such as drugs and alcohol abuse.[51]

Many researchers argue morality presents an additional risk factor for suicide ideation and suicide attempts.[52] Craig Bryan described "a morally injurious event are situations in which an individual is required to perpetuate or cause harm to others such as aggression, and disproportionate violence, or if they are unable to prevent a negative outcome such as saving a friend's life, or witness events that violate their moral beliefs (e.g., severely injured children)."[53] Morally ambiguous situations requiring decisions that may lead to life or death situations to service members or civilians can drastically contribute to psychological injury.[54] Moral injury displays similar symptoms as PTSD (e.g., nightmares, intrusive memories, emotional detachment), however, it is unique to professions which may encompass psychological straining events such as taking or protecting lives.[55]

The American Psychiatric Association provides the national standard for the diagnosis and treatment of individuals with mental health disorders, including PTSD. DSM-5, the most current systematic diagnostic tool describes PTSD in four categories. Healthcare professionals increased understanding of the traumatic events calls for the assessment of patients re-experiencing traumatic events, avoiding distressing memories, negative cognition and mood, and alterations in arousal paired with reckless destructive behavior.[56] Research has improved

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[51] Jones, *Post-Traumatic Stress Disorder in United States Legal Culture,* 79.

[52] Bryan, Bryan, and Theriault, "Self-forgiveness, Posttraumatic Stress, and Suicide Attempts Among Military Personnel and Veterans," 40.

[53] Ibid., 41.

[54] Ibid., 40.

[55] Ibid., 44.

[56] Posttraumatic Stress Disorder, *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition ed. Washington, DC: American Psychiatric Association; 2013), 309.

professional knowledge since the World Health Organization's attempts to standardize the diagnosis of shell shock during World War I. Today, categorizing and diagnosing multiple overlapping symptoms and disorders proves to be complex and fluid in the world of medicine. Considering the timing of symptom display after a traumatic event could start immediately after or emerge years later. The attributes of these invisible wounds often to the underdiagnosis of mental health disorders. The fear of the stigma associated with mental disorder diagnosis and a lack of awareness among physicians and patients led to unhealthy coping mechanisms such as alcohol/drug abuse and suicide.[57]

Figure 1. PTSD Diagnostic Criteria.
Source: Joie Acosta, et al., "Mental Health Stigma in the Military," RAND Corporation Publications, RR-426-OSD (January 2014): 12, accessed March 28, 2019, https://www.rand.org/pubs/research_reports.

Combat arms military operation specialty organizations are compromised of the Army's greatest suicide risks, men between the ages of 22-27 with the greatest likely of traumatic combat

[57] US Department of Veterans Affairs. *National Center for PTSD: Complex PTSD*, last modified January, 10, 2019, accessed January 14, 2019, http://www.ptsd.va.gov/PTSD/professional/PTSD-overview/complex-ptsd.asp.

exposure.[58] Unsurprising to many mental behavior experts dissecting the surge in suicide rates amongst GWOT soldiers, researchers continue to explore the increase of traumatic events combat MOS soldiers are exposed to during deployments.[59] Combat arms MOS soldiers are most frequently exposed to traumatic events during deployments, thus will have a higher propensity for developing various mental health issues.[60] The greatest contribution to high risk behavior and suicide is directly correlated to the negative coping strategies soldiers develop upon redeployment. Coping strategies such as obsessive alcohol use, drug abuse, divorce, and other trauma related mental health ailments as the number one contributors and indicators of suicide.[61] The Army's focus on identifying high risk behavior and mitigating factors have allowed the units to concentrate assets and efforts in order to reduce suicide attempts and other negative coping mechanisms throughout the force.

In 2011, the Army sought to bolster organizational performance and readiness by increasing individual mental health and resiliency. Today, the force principally relies on AR 350-53, the Army's *Comprehensive Solider Fitness Program* regulation, to measure the mental fitness of soldiers and families. The high-risk identification process unfortunately tends to associate soldiers with mental health needs with low-performing soldiers obstructing the readiness of the unit. Unit readiness, rightfully impacted by the mental readiness of its soldiers, will influence the perception of soldiers enrolled in the unit's high-risk soldier identification program. Prominent suicide studies in the past decade have identified factors which combat suicidality in order to arm leaders of the Armed Forces with effective preventative measure options. These studies named

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[58] Tammy Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior: A Phenomenological Study" (PhD diss. University of Phoenix), 25, accessed September 5, 2018, ProQuest dissertations and Theses, https://ezproxy.columbusstate.edu.

[59] Sebrina Posey, "Veterans and Suicide: A review of potential increased risk," *Smith College Studies in Social Work* 79, no.4 (January 2009): 368, accessed October 09, 2018, http://dx.doi.org/10.1080/00377310903131447.

[60] Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior," 28.

[61] Ibid., 29.

social support, hope, spirituality, and mental health treatment as factors that can reduce the chances of self-harm. These methods must be introduced through effective leadership/personal relationships to effectively increase individual resilience.[62] "Various theories have linked social support, sociocultural and spirituality as positive mitigating factors essential for soldiers integrating into civilization and their homes post deployment."[63] The fluctuation of a soldier's mental health also drastically effects their home life upon redeployment. "In more than 70% of couples where the veteran had PTSD, relationship distress was reported, while for couples without PTSD just around 30% indicated distress."[64] Furthermore, the degradation of the combat soldier's personal life could radically increase the chances of suicide upon redeployment.

Interpersonal theory contributes high risk attributes to identify soldiers who are more apt to engage in suicidal thoughts and manifesting those thoughts into actions.[65] According to interpersonal theorist, most combat MOS soldiers who are high risk of engaging in life-ending behavior typically portray the following factors: a high resistance to pain, self-hate triggered by extremely distressing experiences, and finally, access to lethal means.[66] Bruce Bower identified a relationship between combat soldiers and high-risk behavior during his research on redeploying personnel. "Combat soldiers are fearless and relatively impervious to pain, even before enlisting," which encourages the perception of mental weakness if help-seeking behavior is identified by organizational leaders and peers.[67] "Personal traits that may predispose people to volunteer for combat may also up their chances of attempting suicide if war experiences trigger intense guilt

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[62] Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior," 35.

[63] Posey, "Veteran Suicide," 368.

[64] Redmond, et al., "A Brief Introduction to the Military Workplace Culture," 18.

[65] Bruce Bower, "Over the Edge," *Science News* 189, no. 1 (January 2016): 22, accessed October 09, 2018, https://www.sciencenews.org/article/suicide-rates-rise-researchers-separate-thoughts-actions.

[66] Ibid., 22.

[67] Ibid.

and shame."[68] This phenomenon can be attribute the growing suicide trend to the American combat soldiers' desensitization of death before, during and after deployments.[69] AnnaBelle Bryan discovered links during her study, portraying soldiers who are exposed to protracted violence during their adolescences possess attributes which drives individuals to combat arms MOS'. Recruits exposed to violence are hypothesized to possess higher levels of pain tolerance and fearlessness.[70] Exposure to traumatic events during deployments coupled with guilt, shame and self-hate, produces increased suicide promoting reactions.[71] The negative perception of mental healthcare paired with continued exposure to combat related stressors will continue to hinder unit readiness and barriers to care.

Barriers to Care: Defining the Stigma

The DoD Task Force on Mental Health (MHTF) was charged to identify ways to mitigate the increasing suicide epidemic the force faces today. During the team's review of mental health literature, over ninety-eight distinct definitions of stigma were identified. "The lack of conceptual clarity makes it difficult to understand what construct was actually being measured or discussed and consequently makes it difficult to identify how best to intervene to reduce stigma."[72] The MHTF incorporated various descriptions of stigma to produce a definition within the military context. The tasks force incorporated a definition of the stigma as "a brand or mark of infamy associated with a specific subgroup or identity which indicates that one is an outside of what is normal or acceptable, which in turn, allows for differentiation process."[73] The inadvertent or intentional differentiation or labeling process isolates individuals who possess undesirable

[68] Ibid., 23.

[69] Bryan, Bryan, and Theriault, "Self-forgiveness, Posttraumatic Stress, and Suicide Attempts Among Military Personnel and Veterans," 42.

[70] Bower, "Over the Edge," 22.

[71] Bryan, Bryan, and Theriault, 40.

[72] Acosta, et al., "Mental Health Stigma in the Military," 38.

[73] Ibid., 8.

characteristics including mental health seeking. The process of isolating individuals who are deemed as different, by acting outside of the context of the general organization, results in the discrediting or a loss of status for the individual. The MHTF conclusively defined mental health stigma as "a dynamic process by which a service member perceives or internalizes this brand or marked identity about himself or herself or people with mental health disorders. This process happens through an interaction between a service member and the key contexts in which the service member resides."[74] This process of stigmatization perpetuates the behavior throughout the organization and is adopted within the culture once deemed acceptable behavior. It is important to note the task force believes the stigma is relationship and context-specific that does not reside in the person but rather within a specific social context.[75] The MHTF created a conceptual model to link long-term outcomes to immediate outcomes in order establish an individual measure for the stigma of seeking healthcare to best meet the needs of soldiers who have mental health issues. The team identified long-term outcome such as work productivity, treatment seeking, and treatment success as positive measures of a stigma reduction program. Immediate outcomes such as individual positive coping mechanisms and increase in self-esteem were outlined as short-term indicators. Unfortunately, the MHTF concluded a verity of other factors enabling soldier's willingness to seek mental healthcare.[76] The researchers contributed availability of providers and time off work to seek cares as clear links to the barriers to care soldiers face today.

Mental health stigmas are negative attitudes associated with mental health conditions limiting a soldier's willingness to seek mental healthcare. These stigmas act as barriers to care, reducing the likeliness individuals would seek help in the future. The stigma of mental healthcare can be analyzed on three varying levels: societal, individual, and the institutional. Societal

[74] Acosta, et al., "Mental Health Stigma in the Military," 3.

[75] Ibid., 38.

[76] Ibid., 39.

stigmas, also known as public stigma, encompasses the misperceptions and reactions toward individuals with emotional psychological problems.[77] Soldiers also face individual stigmas which occur when individuals internalize the general public's negative perception of those with mental disorders; common to service members who have been exposed to combat situations. Institutional-level stigmas can be found within the verbiage of institutional policies and even within the practices and the unconscious actions of organizational leadership regarding mental health issues.[78] The institution's inadvertent or intentional practices regarding mental health can unreasonably limit an individual's opportunities within the organization if members seek help for mental health issues. The self or internal stigma, commonly adopted by service members, is defined as the "internalization of public and institutionalized stigma."[79] The MHTF believes the conceptualization of institutional and public stigma do not necessarily define stigma but the context of which the stigma is cultivated. To understand the stigma of seeking mental health care in the military context it is appropriate acknowledge the process by which someone perceives or internalizes interactions with specific people in specific contexts."[80]

There are many factors that may produce a stigma towards seeking mental health found within cultural artifacts of combat arms organizations. The treatment of soldiers who seek mental health at the organizational level could perpetuate barriers to seek help. Assigned unit leaders, as well as socially constructed unofficial organizational leaders can inadvertently or purposefully create an atmosphere denouncing mental health seeking behavior. Individuals expressing negative attitudes and discriminatory behaviors towards soldiers who seek help or those who suffer from mental health disorders define the contextual framing of stigma developing climate and accepted

[77] Corrigan and Penn, "Lessons from Social Psychology on Discrediting Psychiatric Stigma" 765.

[78] Ibid., 766.

[79] Acosta, et al., "Mental Health Stigma in the Military," 38.

[80] Ibid., 3.

behavior throughout the organization. The MHTF's findings reflect a differing opinion regarding the development of a mental health stigma and the origins of the devaluation of persons with mental health disorders. The researchers believe the development of service members' individual stigmas are internalized by negative attitudes and stereotypes about mental illness toward themselves and not socially constructed during military service.[81] The MHTF currently attributes lower self-esteem, reduced treatment-seeking, and poor adherence to treatment as the results of individual service member's stigmas towards mental health disorders. This internalizing of negative beliefs, attitudes, and the perception of predatory policies toward persons with mental health disorders drives the negative stigmas found within combat arms organizations. These negative beliefs also influence an organization's long-term mental fitness and quality of life outcomes, reducing the effects of mental health treatment if actively engaged in mental health therapy. The MHTF described the lack of compelling evidence that these internalizations negatively affect whether service members initiate treatment-seeking, despite the fact that such a relationship is often hypothesized.[82] The current objections of the etiologically of mental health stigma is identical to the denouncing of organizational links to the phenomenon over 100 years ago. The current antiquated approach to mental healthcare throughout the force will continue to hinder unit and personnel readiness in the future.

The MHTF report, researched and published for the Department of Defense, utilizes Bruce Link's 1987 theoretical approach, which emphasized the interactions between people and their environments as the modified labeling theory.[83] Through the context of Link's theory, the MHTF postulates that negative conceptualizations of mental illness in the form of devaluation of people with mental health disorders develop early in life. The theory encourages the belief that

[81] Acosta, et al., "Mental Health Stigma in the Military," 6.

[82] Ibid., 3.

[83] Ibid., 6.

when someone is officially labeled as mentally ill, the societal and organizational meaning associated with mental illness label becomes personally relevant. This label leads soldiers to believe society, their assigned unit, and friends and family will reject them.[84] Though this theoretical framework deviates from the literature investigated for this body of work, it is important to dissect the differences between the MHTF's hypothetical development of individual stigmas occurring during adolescences, and the development of stigma due to organizational norms as discussed in the social learning theory conferred throughout this monograph.

Defining the mental health stigma in a military context is both dynamic and complex. A stigma is not a static concept with a consistent consensus throughout the mental health community. Stigmatization is a dynamic process that can change in relationships and context. The MHTF addressed the multi-dimensional barriers to care, prevalent throughout the DoD in multiple contexts and variables through their research.[85] The MHTF's research displays the importance of increasing mental health care usage amongst service members with mental health disorders. Findings include the theoretical linkage between stigma and its adverse effects on help seeking, and mental health recovery for individuals in the long run. Their recommendations called for stigma reduction within the military in order to increase help seeking behaviors among the services most vulnerable population. The stigma-reduction methods proposed by the MHTF suggest an anti-stigma public-education campaign using mental health conditions facts and evidence. Various mental health experts recommended the "realistic descriptions of mental health problems and emphasize the success of proven treatments to soldiers with mental health disorders."[86] This DOD campaign aims to reduce stigmatizing attitudes about PTSD, shifting the

[84] Acosta, et al., "Mental Health Stigma in the Military," 7.

[85] Ibid., 38.

[86] Ibid., 39.

military community and public's notion that PTSD results from exposure to extremely stressful experiences rather than weakness of character.[87]

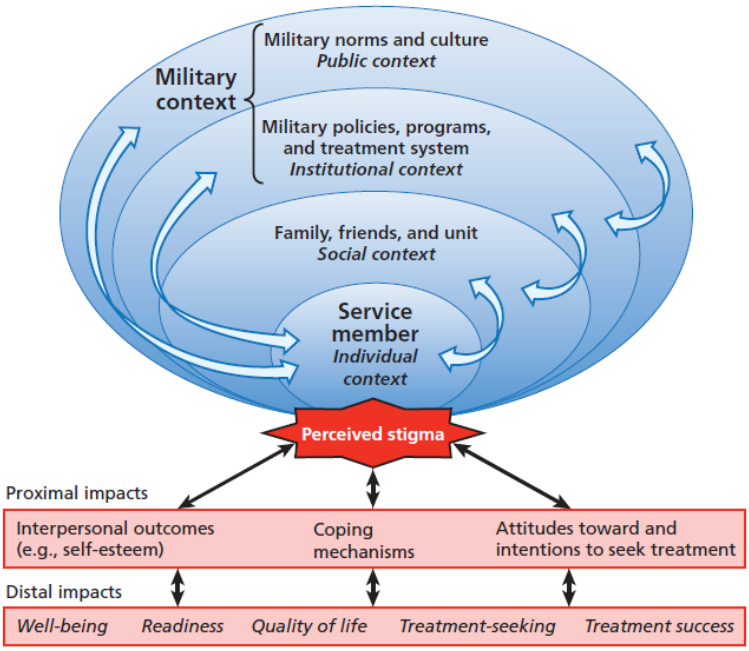

Figure 2. Mental Health Stigma in the Military Cultural Context.
Source: Joie Acosta, et al., "Mental Health Stigma in the Military," RAND Corporation Publications, RR-426-OSD (January 2014): 12, accessed March 28, 2019, https://www.rand.org/pubs/research_reports.

The DOD, believe the anti-stigma public-education campaign will increase the well-being and quality of life among service members and promote mission-readiness in the face of emergent threats. Unfortunately, there is limited evidence that public-education campaigns can influence attitudes toward mental health conditions.[88] To understand the relationship between public-education, in a military context, and the reduction of mental health stigmas, the DOD must conduct further research amongst the targeted audience for the campaign to be effective. The MHTF prescribes a mired of additional stigma reduction methods aiming to defeat the self-perceptions associated with receiving mental healthcare however, the do not indicate a

[87] Ibid.

[88] Ibid.

preventative measure of reducing the stigma associated with seeking mental health. The published report failed to include recommendations to alleviate grave concerns amongst service members who need or might need mental health therapy, negative career consequences associated with seeking/using mental health services. Their inability to identify and address organizational policies or behaviors which perpetuate barriers to care, emphasizes the cultural ineptness to identify and destroy service member's barriers to seek mental healthcare. The concertation on rehabilitative measures, on part of the MHTF, exasperates the necessity for the US Army to reduce the stigma of seeking mental healthcare by addressing the organizational cultural views of soldiers who seek mental healthcare.

Reducing the Stigma of Help Seeking Behavior

Leading social scientists and mental health experts draw connections between military culture and the propensity of service members to possess barriers to care. The correlation of mental health stigmas and combat arms culture has lacked meaningful methodology to test the root cause of the perpetuation of cultural stigma in the military. The sensitivity of this subject, presumably due to the negative impact of openly "criticizing" military leaders, could impact the limited open studies aimed to decrease barriers to care for soldiers.

Soldiers are uncomfortable seeking help, emphasizing mental healthcare, because they feel ashamed, uneasy, or labeled, believing asking for assistance is an indication of weakness or failure.[89] Carrying the burden of the nation to combat has been a defined characteristic in service members culture since the inception of the armed forces. Constant deployments have driven the necessity for unit readiness and many soldiers are not willing to let their comrades down by admitting physical or mental weakness. Many of these soldiers return from deployments and resort to negative coping mechanisms culturally accepted by society and the Army subculture

[89] Aphroditi Zartaloudi, Michael Madianos, "Stigma Related to Help-Seeking from a Mental Health Professional," *Health Science Journal* 4, no.2 (January 2010): 77, accessed December 31, 2018, www.hsj.gr/stigma-related-to-helpseeking-from-a-mental-health-professional.pdf.

(e.g. alcohol and drug abuse). Soldiers struggling with mental health ailments in isolation have led to the staggering trend of suicides today. Inadvertently, Army culture silently condemns help-seeking behavior by penalizing soldiers who navigate these personal invisible wars, forcing the country's volunteer force to "suck it up" or face the inevitable consequences of seeking mental healthcare. These effects will continue to hinder unit readiness and recruitment necessary to meet the manning needs of an all-volunteer force in today's dynamic operating environment. This silent condemnation of help seeking behavior will continue to reduce the efforts of future mental health task forces studies if the organizational culture of the Army does not promote a more proactive approach to mental healthcare.

Army Regulation 350-53, Comprehensive Soldier Fitness (CSF), is the current guideline to increase personal resilience and enhance the performance of soldiers in the wake of growing mental health disorders and concerns affecting the force. The regulation champions the necessity for universal resilience to meet the operational needs of the force in an uncertain operating environment. The Army defines resilience as the "mental, physical, emotional, and behavioral ability to face and cope with adversity, adapt to change, recover, learn, and grow from setbacks."[90] The aim to develop mentally fit individuals to leverage emotional and intellectual skills remains the objective of the Army as it strives to enforce CSF throughout the organization despite addressing the innate organizational attributes which reinforce barriers to care.

The regulation describes the importance of service members emotional states and characterizes our ability to solve problems with emotional control as critical to operational success. The regulation also believes this emotional control, found in psychologically healthy soldiers, is the foundation to resilient organizations. According to the regulation, "resilience in soldiers helps prevent moral injuries in the complex environment of combat," which will be

[90] US Department of the Army, *Army Regulation (AR) 350-53, Comprehensive Soldier Fitness* (Washington, DC: Government Printing Office, 2014), 17.

increasingly salient as the force prepares for large-scale combat operations against a near peer competitor in the future.[91] Despite the mentally agility described as necessary to prevail in future combat, the Army utilizes the Global Assessment Tool and the Pre/Post Deployment Health Assessment to gauge the mental wellbeing of service members annually. In line with AR 350-53, the GAT, an online based Likert scale measure (ranging from 1-5), intended to "assess one's ability to approach life's challenges in a positive, optimistic way and to demonstrate self-control, stamina, and good character in choices and actions."[92] It is a tool to help identify high-risk soldiers within the formation and encourage personal and professional growth for the force.

The CSF Program, with 1.1 million subjects, is the largest research study the American Psychology Association (APA) has been involved in. However, the Army's Ready Resilient Campaign describes the CSF Program as training to assist operational readiness.[93] The program is a derivative of the Penn Resiliency Program (PRP), the largest depression research initiative in the world. The PRP is a program that attempts to teach assertiveness, coping mechanisms and positive decision-making skills. The program, however, primarily focuses on interventions with non-military participants, and only produced small reductions in mild self-reported depressive symptoms.[94] The CSF Program, designed from the inconsistently effective PRP treatment, is problematic to service members who require specific needs to meet their mental health concerns following exposure to combat related incidents. The PRP is not designed to provide intervention for large mass quantities of participants without trained psychologists available to consistently administer therapy. The CSF Program intended to mitigate this risk by incorporating Master Resiliency Trainers within organizations however, the expertise found within the therapist

[91] US Army, AR 350-53 (2014), 35.

[92] Ibid.

[93] US Army, AR 350-53 (2014), 3.

[94] Roy Eidelson, Marc Pilisuk, and Stephen Soldz, "The Dark Side of Comprehensive Soldier Fitness," *American Psychologist* 66, no. 7 (2011): 643–644, accessed March 28, 2019, http://doi.apa.org/getdoi.cfm?doi=10.1037/a0025272.

administering the PRP therapy would require the Army to invest in years in academics in order to match the education of accredited psychologist and psychiatrist for such a large participant pool. The CSF Program is undoubtably a major intervention employed on the largest scale according to the APA. Programs of this scope, scale and implications should be carefully examined and investigated to mitigate potential negative effects to service members and organizational culture and climate towards seeking mental healthcare. Unfortunately, the APA has provided no indication that preliminary studies of CSF were conducted, thus emphasizing the need for the Army to re-evaluate how to reduce the negative effects of mental disorders by reducing the barriers to care within our organization.[95]

The CSF Program along with the Resilient Ready movement are in line with the US Army's historical approach to mental health. The measures, as discussed previously, continue to display reactive policies focusing on building resiliency and healthy coping methods without addressing the root cause of the declination of soldiers' aptness to seek mental health when desperately needed. The Army's current programs and campaigns have proven to be reactive with issues facing mental readiness of soldiers. For example, immediately following the return from a deployment, where exposure to traumatic events are eminent, service members complete the Post Deployment Health Assessment (PDHA) and is often seen by a credentialed healthcare professional.[96] After completing a mental health questionnaire, health care providers are prompted based on the soldier's responses to questions regarding alcohol use, violent and or suicidal thoughts. The results of the PDHA are then maintained in the soldier's permanent medical records and integrated into the Defense Medical Surveillance System database. This

[95] Eidelson, Pilisuk, and Soldz, "The Dark Side of Comprehensive Soldier Fitness," 643.

[96] Charles W. Hoge, Jennifer L. Auchterlonie, and Charles S. Milliken, "Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning From Deployment to Iraq or Afghanistan," *JAMA* 295, no. 9 (March 1, 2006): 1023, accessed September 14, 2018, http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.295.9.1023;

gauntlet of mental health screens are typically the final step prior to the service member's reunion with their family. The check the box application of mental health screening, prior to the service members most likeliness exposure to traumatic events, becomes routine with limited usefulness, producing inevitably flawed data due its timing and proximity to much needed reunions and rest and relaxation.[97] The reactive process, though well intended, further perpetuate the notion of mental health therapy as an inevitable obstacle one must avoid. The perception of the PDHA, and mental fitness at the organizational level is displayed and implemented as an afterthought, further aiding the organizational stigma towards to mental health treatment.

The current mental health treatment cycle of the Army focuses on promoting therapy after a mental health disorder or crisis discovery. Many experts in the psychological field believe counseling can be beneficial in the absence of mental health disorder or when a problem exits and not within the threshold of mental health crisis to the individual.[98] Preventative therapy exposes various services and treatments soldiers could take advantage of to build resilience prior to exposure to traumatic events or situations. "Many traditional psychiatric and therapeutic intervention seek to treat diagnosable conditions however, there are many counseling practices that can serve as prevention and early intervention models for combat veterans in need of support that do not constitute psychiatric treatment."[99] Organizations who promote preventative measures increase the mental efficiency of their individuals. Leaders who engage in these methods provide a variety of coping mechanisms and an understanding of mental health triggers displayed by subordinates. Leader's devotion to mental fitness also promotes the message of Total Soldier

[97] Hoge, Auchterlonie, and Milliken, "Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning From Deployment to Iraq or Afghanistan," 1023.

[98] David Napier et al., "Culture and Health," *The Lancet* 384, no. 9954 (November 1, 2014): 1607–1639, accessed March 28, 2019, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61603-2/abstract.

[99] Ibid., 1607.

Concept, promoting the necessity for mental astuteness thus, reducing barriers to care for their subordinates.

Army leaders possess the latitude to positively or negatively influence the forces perceptions of seeking mental healthcare. Commanders, and informal unit level leaders are the "primary shapers of organizational context that in turn is a primary influence on employee's interpretation of their work environment as well as their responses to these environments."[100] An organizational leader's explicit behavior at altering a unit's perception of mental healthcare within the institution could positively alter a soldier's range of actions.[101] Organizational leaders must internalize and display, through actions, the necessity for increased mental fitness within the force. "The cultural stigmatization model established the leader's roles in fostering a positive organizational culture and interlinking theories and concepts on coping, resiliency."[102] Bandura's social learning theory should be applied to Army organizations in order to achieve the adoption of mental fitness. The theory describes organizational learning as observed from subordinates to leaders to which the model behavior is learned and accepted.[103] Social learning is displayed by leaders and accepted by unit members, providing the opportunity to build resilient organizations through the adoption of mental fitness attributes such as consistent mental health therapy before, during and after mental health issues are discovered.[104]

Reducing the barriers to care for soldiers lies within the purview of organizational leaders and informal leaders. The current Army CSF campaign to reduce the stigma and increase mental

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[100] Thomas, and Castro, *The Psychology of the Peacekeeper,* 127-46.

[101] Sieweke Jost, "Imitation and Processes of Institutionalization – Insights from Bourdieu's Theory of Practice," *Schmalenbach Business Review* 66, no. 1(January 2014):24-42, accessed March 28, 2019, https://www.researchgate.net/publication/Imitation_and_Processes_of_Institutionalization_-_Insights_from_Bourdieu's_Theory_of_Practice.

[102] Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior," 25.

[103] Bandura, *Social Learning Theory,* 3.

[104] Ibid.

healthcare usage will not work without the leaders adopting the concept of mental fitness and openly benefit from therapy on a regular basis. The current self-medicate and continue mission culture has facilitated the declination of unit readiness due to mental health ailments left untreated. Accepting these negative coping mechanisms as apart of Army culture has and will further negatively influence soldiers and positive help seeking behavior.[105] Developing a proactive, commander led initiative, to reduce barriers to mental healthcare prior to crisis will encourage personal satisfaction, resiliency, and personal growth throughout the force.[106] Army leaders are the "primary shapers of organizational context that in turn is a primary influence on employees' interpretation of their work environment as well as their responses to these environments."[107]

To achieve a common mental health base in military organizations, individuals must vehemently acknowledge the consequences associated with mental health disorders and accept the sickness for what it is, a disease. The notion of "only the weak seeks mental healthcare," will become void with the implementation of a prolonged mental health regimen in army units. The willing participation of commanders and organizational leaders engaged in mental health counseling will reduce the stress or embarrassment of peers and subordinates alike. Leaders will then provide the social acceptance of engaging one on one with a mental health provider on regular basis, reducing the organizational stigmatization of seeking and engaging with therapy.

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[105] T.K. Lunasco et al., "One Shot-One Kill: A Culturally Sensitive Program for the Warrior Culture," *Military Medicine* 175, no.7 (July 2010): 509-13, accessed March 28, 2019, https://www.ncbi.nlm.nih.gov/pubmed/20684455.

[106] Steven Jones, "Improving Accountability for Effective Command Climate: A Strategic Imperative," *Carlisle Barracks Strategic Studies Institute, U.S. Army War College* (June 2003): 14, accessed November 25, 2018, https://www.globalsecurity.org/military/library/report/2003/ssi_jones.pdf.

[107] Thomas, and Castro, *The Psychology of the Peacekeeper,* 127-46.

Conclusion

The stigma of mental healthcare and other fortified barriers to care are age old and enduring without meaningful organizational change. Stigmas towards mental healthcare are not unique to the armed forces, increasing the importance of developing an organizational propensity towards positive coping mechanisms. These steps are imperative for recruitment, and to minimize generational and cultural discourse within the force. The Army subculture has relied on aspects of the social learning theory as means to prepare for operations in the past however, the battlefield of the future will require resilient and flexible soldiers capable of mitigating the inevitable stressors of prolonged warfare. Social learning theory is also age old and provides the Army with a blue print on how to alter the beliefs and actions can shape the overall perception of mental health seeking behavior collectively. "Negative public perceptions about mental health care in general may promote, at least in part, the internalization of negative beliefs about mental health treatment, which may increase perceptions of stigma and reduce self-esteem and motivation to seek help."[108] Many leading psychologist believe behaviors displayed by formal leaders within an organization percolates conclusively, achieving overarching influence if verbal/nonverbal cues are reciprocated and adopted by the population. A leader's influence can become a catalyst for social change or deviance if behaviors are replicated by this guided coalition or corrected by organizational members.[109] For leaders to reduce barriers to care within their organizations, they must acknowledge those perceptions and incorporate inclusive policies and procedures promoting healthy coping mechanisms and help seeking behavior amongst organizational members. An

[108] Greene-Shortridge, Britt, and Castro, "The Stigma of Mental Health Problems in the Military," 157–161.

[109] Mary Bardes Mawritz et al., "A Trickle-Down Model of Abusive Supervision," *Personnel Psychology* 65, no. 2 (June 2012): 325–357, accessed December 24, 2018, http://doi.wiley.com/10.1111/j.1744-6570.2012.01246.x.

organization absent of this promotion and continued negative attitudes regarding mental healthcare will continue to act as risk factors decreasing help-seeking behavior.[110]

The collective body of literature explored during the development of this monograph emphasizes the importance of unit support in order to perpetuate positive notions of help seeking behavior.[111] This monograph identifies multiple gaps in behavioral health theory supporting the current CSF program and approach to reduce barriers to care within the Army. These theoretical gaps require additional studies to validate the CSF program and to identify the true link between the stigma of health seeking behavior and mental health disorders. To gain an understanding of the effects of barriers to care on how leaders in the future will effectively employ operational art, the US Army must articulate the need to change, or not, with the use of empirical data. Given the current CSF programs aimed at building resilient formations for the Army writ large, a defined scope on a realistic sample size and variables are necessary to conduct meaningful research. Smaller homogeneous organizations, brigade and below, might present the greatest opportunity to explore leadership's behavior on individual barriers to care within a manageable sample size.

Tammy Fanniel's phenomenological qualitative study aimed to identify soldier's perceptions and experiences of explicit and tacit leadership behaviors that might influence help-seeking behavior within their organizations.[112] Her study results displayed a significant relationship between army leadership and negative perceptions toward help seeking behavior. The study also displayed a correlation between generational gaps between help-seeking behaviors amongst junior soldiers and senior leaders.[113] The data collected during the qualitative study

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[110] Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior," 45.

[111] Robert Pietrzak,et al., "Perceived Stigma and Barriers to Mental Health Care Utilization among OEF-OIF Veterans," *US National Library of Medicine National Institutes of Health* 60, no.8 (August 2009): 1118-22 accessed 1 January, 2019, https://www.ncbi.nlm.nih.gov/pubmed/19648201.

[112] Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior," 120.

[113] Ibid., 190.

indicated senior Army leaders as less likely to seek mental health care for ”fear of reprisal, career progression, pride, fear, and shame,” despite supporting stigma reducing programs such as the Ready Resilient initiative.[114] Her study, though limited in participants and resources, shows organizational leader’s tacit actions may have “subconsciously nurtured an environment which criticized soldiers who sought mental health care.”[115] Despite the vast rank structure of the armed forces, service members refute mental health concerns due to the fear of adverse effects to their careers.[116] According to Fanniel, “The cultural stigmatization model established the leader’s roles in establishing organizational culture and interlinking theories and concepts on coping, resiliency, and personal hardiness.”[117] A prolonged qualitative study on larger scale could lead to data capable of measuring the relationship between organizational leadership and the unit’s stigma of help-seeking behavior.

Army leadership is solely responsible for unit social learning throughout the force due to their prominent status and influence.[118] Additional studies and research should seek to understand the relationship between the Defense Equal Opportunity Management Institute Climate Survey in order to identify the strength of the relationship between chain of command and their influence on individual’s barrier to mental healthcare. Utilizing the already accessible data could provide various research opportunities to identify and mitigate barriers to care amongst service members. By using established organizational metrics such as the command climate survey, soldiers would complete the digital fifty-question Likert scale questionnaire indicating the moral in/adequacies of the command team. Considering the anonymity of questioner responses, soldiers could provide

[114] Ibid., 191.

[115] Ibid., 192.

[116] Jennifer Neuhauser, “Lives of Quiet Desperation: The Conflict between Military Necessity and Confidentiality,” *Creighton Law Review* 44, no.1 (January 2011): 42, accessed January 19, 2019, https://dspace.creighton.edu/42_44CreightonLRev.

[117] Fanniel, 190.

[118] Bandura, *Social Learning Theory,* 5.

significant feedback to incite positive organizational change. Research instruments, such as the Perceived Stigma and Barriers to Care for Psychological Problem, were developed to understand the strength of the relationship of the stigma of mental healthcare within an organization. These two research measures could potentially determine the strength of the relationship between the aforementioned variables, providing an indication of how organizations can reduce the stigma through social learning.

Additional measures to reduce the stigma of mental health care should incorporate the indoctrination of prolonged mental healthcare amongst unit members. These studies should measure two similar organizations, controlled and experimental, and provide the experimental group the opportunity to engage in prolonged counseling for a predetermined time. The experimental group would attend mental health counseling on a regular basis, followed by the scientific measure to indicate a reduction of perceived sigma within the controlled organization. The US Army along with scientific experts alike should strive to develop mental fitness programs with aims of seeking empirical data capable of producing predictive mitigating measures necessary to reduce mental disorders for the sake of unit and individual soldier readiness. Conducting research and monitoring select organizations with methods and measures previously described, could encourage meaningful dialogue to identify a responsible way to reduce suicide ideation, suicide, and the stigma and barriers to seek mental throughout the Army. Future studies should strive to distinctively measure the relationship between Bandura's social learning theory and the strength of organizational stigma towards mental health care, with hopes to be able to proactively combat disorders associated with mental healthcare stigmas.

Glossary

Terms used throughout the study will be defined below to ensure a common understanding of terms:

Combat Arms / Maneuver Fire and Effect (MFE): Combat arms are units and soldiers who close with and destroy enemy forces or provide firepower and destructive capabilities on the battlefield. Combat branches of the US Army include Air Defense Artillery, Armor, Aviation, Engineers, Field Artillery, Infantry, and Special Forces (SOF)[119]

Command: Positional authority, rank, and power of an officer over subordinates. Command includes the "principles of leadership, authority, responsibility, and accountability for effectively using available resources and planning the employment of, organizing, directing, coordinating, and controlling military forces to accomplish assigned missions."[120]

Command Climate: The organizational foundation for achieving group effectiveness in the Army.[121]

Military Culture: A "set of long-held values, beliefs, expectations, and practices shared by a group that signifies what is important and influences how an organization operates."[122] Military culture is based on members of the organization being ethical allowing them to accomplish missions because of the standards they adhere to and is built on "facets that are infused during basic training to strengthen soldiers' ability to thrive in and survive combat environments."[123]

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[119] US Department of the Army, *Field Manual (FM) 3-0, Operations* (Washington, DC: Government Printing Office, 2017), 13.

[120] US Army, *FM 3-0* (2017), 39.

[121] Steven Jones, "Improving Accountability for Effective Command Climate,"14.

[122] US Army, *FM 3-0* (2017), 4-7.

[123] Lunasco, et al., "One Shot-One Kill," 509-513.

Personal hardiness: Hardiness protects against mental illnesses stemming from traumatic events and individuals with personal hardiness recover more quickly from the trauma and ill effects of combat stress.[124]

Post-traumatic Stress Disorder (PTSD): A psychological disorder happening after the occurrence of a traumatic event regardless of whether the individual was harmed. PTSD was initially recognized in veterans but has branched out to individuals who have experienced any type of traumatic incident, from a mugging or rape to a car accident.[125]

Public Stigma: The reaction of the general public toward people with mental illness.[126]

Resiliency: The ability of a person psychologically to recover quickly from traumatic experiences or stressful situations while still being able to carry out a mission.[127]

Self-stigma: The internalization of how the general public portrays people with mental illness and the belief in that portrayal.[128]

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[124] US Department of the Army, *Field Manual (FM) 3-0, Operations* (Washington, DC: Government Printing Office, 2017), 26.

[125] US Army, *FM 3-0* (2017), 39.

[126] Greene-Shortridge, Britt, and Castro, "The Stigma of Mental Health Problems in the Military," 157.

[127] Fanniel, "U.S. Army Leadership's Effect on Help-Seeking Behavior," 35.

[128] Greene-Shortridge, Britt, and Castro, 157.

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