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A Conceptualization of Treatment Stigma in Returning Veterans

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DISSERTATION

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Dedication

This dissertation project is dedicated to the memory of Lieutenant Commander Clifford Eugene Pollock. His counsel as a leader, a mentor, a shipmate, and an honorable man are sorely missed. My hope is that a glimpse of your wisdom touches this body of work, so that it can continue your legacy of one generation handing down the hard-learned lessons of the past to the next. Your instruction, advice, and friendship are fondly remembered.

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I want to acknowledge the contributions of many people who spent time and energy to make this project a reality. This project would never have been possible without the encouragement and support of my wife Sarah. Her undying devotion to my development as a compassionate professional is matched only by her ability to remind me of the importance of this endeavor. Along with her, I want to thank my son, Maxwell, for his ability to remind me to take perspective on life and its many splendors and intrigues.

I also want to acknowledge the support of my family. My parents and my parents-in-law, who have supported me on this and many other journeys in life, have given both inspiration and motivation not only to do well, but also to be well while doing so. The support of my siblings and has also been valuable, as these are the people who helped form me into the person I am today. From my extended family, many of whom are veterans of various eras, I found the courage to lead, even into hostile territory. To my other family—my military brothers and sisters—standing beside you while defending this great nation gave me the drive to stand next to you today in both this project and in my clinical practice.

Finally, I want to express my gratitude to my dissertation committee. Colby, your counsel and inspiration are unmatched in the creation of this body of work. Amanda, you have challenged me, but what is more is that you have always encouraged me to continue challenging myself. Jim, your lesson, seemingly regardless of the situation, is to look at the world always from a different perspective than seems natural. Each of you encouraged me to improve as a clinician, and your leadership will always be appreciated.

Table of Contents

List of Figures

Abstract

The dissertation project combines three theoretical models that inform conceptualizations of the origins, manifestations, and consequences of stigma: the Social Psychological model (SPM), the Sociological model (SM), and the Cognitive-behavioral model (CBM). These models merge into a single, integrative lens, through which stigma can be examined on both cultural and individual levels. This lens is then applied to the cultural and individual manifestations of the stigma of seeking psychological treatment experienced by veterans who have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Through this lens, an understanding of the inception, maintenance, and effects of this treatment stigma is presented. Strategies for the reduction of this stigma are then offered, including a review of current stigma-reducing programs in which the branches of the military are currently engaged. As the purpose of the creation of this integrative lens is to provide a foundation of understanding about the cultural and individual implications of stigma, future directions in stigma research, treatment implications, and influences on public policy are also discussed.

Keywords: cultural stigma, self-stigma, military, Iraq, Afghanistan, veteran, OIF/OEF

Preface: The Stigmatization of a Hero

The following narrative is a condensed version based on the story of one of three Marines editorialized in an article that was recently published in *Gentleman's Quarterly*. The article, entitled "The Few, the Proud, the Broken" was researched, interviewed, and written by Karen Dobie (2010), and the account that follows is from the interviews that she performed with Major Gamal Awad, a highly decorated Marine officer and Operation Iraqi Freedom Veteran.

Prior to the morning that would forever change his life, Captain Gamal Awad had spent his career climbing the United States Marine Corps ladder. He was a highly motivated Marine who vigorously took on every challenge. Having been hand-picked to serve on the Commandant's Office in Washington, he was not surprised when the call came in for a last-minute meeting at the Navy Annex, a complex near the Pentagon. The morning was September 11, 2001. Shortly after the meeting began, the sound of a low-flying jet caught the attention of everyone in attendance. When the crash followed, Gamal broke from the meeting and rushed across the street to the crash site to see if he could help. To this day, the sights, smells, and emotions of what followed haunt him.

With little regard for his own personal safety, Gamal entered the smoldering Pentagon building with the knowledge that his fellow Marines, service members, and civilians were inside. His goal was to help as many of them to reach safety as possible, and he searched through the smoky, burning building at great personal risk. As he lost count during the confusion, it is unknown how many lives he saved that day; but he most vividly remembers one victim he could not save. He came upon the woman in a darkened, smoke-filled passageway. She was badly burned and barely conscious, and Gamal could do little more than help her into a more comfortable position where she sat on the floor. However, when he pulled on her arm to help her

sit up, her charred skin slid off into his hand. He summed up the memory of this interaction by saying that "she died right there and I didn't add to her comfort." The image of this woman haunts his dreams today, and the memories of the day have changed him forever.

Captain Gamal Awad was awarded the Navy Commendation Medal, one of the highest medals awarded to sailors and Marines outside of combat. The award certificate that accompanied the medal lamented the "heroic achievement" that he displayed in helping his fellow service members and government employees escape the peril of a terrorist attack. The Marine Corps had decorated him for his service, but soon the repercussions of his heroism would threaten to jeopardize and even end his career as a Marine.

Months after his gallant acts, Gamal found himself waking from nightmares about September 11th. His daily routine was overtaken by severe bouts of negative emotion, flashbacks, and the fatigue that set in from going long periods with little or no sleep. When his colonel began to notice this drop in his performance, Gamal explained that he thought that he needed to seek some form of mental health intervention. The expression on his Colonel's face was one of disgust and distaste, and his reply was "as long as it doesn't interfere with your duties" (p. 218). The message was clear to him that this was not the way a Marine found strength. In fact, it was apparent to him that the very idea of entering therapy was far worse than his drop in performance. Gamal did not seek therapy for over a year after this incident. Instead, he began self-medicating his symptoms with alcohol.

After a year of heavy drinking, Gamal realized that it had taken over his life and that it was affecting his career. He decided to speak to a psychiatrist about his depressive symptoms, but he kept his symptoms of Post-traumatic Stress Disorder a secret. The psychiatrist prescribed an anti-depressant and sent him back to duty. Upon telling his colonel; however, he was told that

his medical record was reviewed when he went up for advancement in rank and that the use of a prescribed anti-depressant would likely tarnish his career beyond repair. Again, the message was clear, his actions showed weakness not characteristic of a "good" Marine.

Out of a sense of shame, Gamal did what he thought was the only available venue to bring redemption to a weak, dishonored Marine: he volunteered for duty in Iraq. He thought that this act would counter the damage done to his career by the choice to take anti-depressants. Furthermore, he thought that it would help him lessen his feelings of shame that came along with his perception of being a "bad" Marine. He stopped taking his medication and left for Iraq in search of redemption that would never come.

Although he had set out to serve in Iraq to become a "good" Marine, Gamal's self-perception almost immediately sank to new depths. Within several months of his arrival in Iraq, Gamal began romancing the idea of dying in battle. He became obsessed with thinking about how easy it would be to die in a firefight, and he considered that this would be seen as more honorable in the eyes of the Marine Corps than surviving as a coward. This thinking began to affect his actions as an officer, and soon he was putting himself in harm's way.

Gamal, recently promoted to the rank of major, found himself standing in the open to fire his weapon when situations made the enlisted men in his charge dive for cover. He began volunteering for unnecessarily risky assignments. One of these assignments was that of the night convoy; a task far below the pay grade of a Major, but one of the most risky in the Iraq campaign. As the ranking officer of these convoys, he led from the front rather that the rear, often putting himself in the most dangerous situations.

One night, a civilian van ignored the convoy's verbal commands to stop and stay back. Even when the convoy fired warning shots at the van, it kept coming. Gamal ordered open fire

upon the van thinking that it might be a vehicle-based suicide bombing on the convoy. When the smoke cleared, the investigating Marines found that the van held a man, his wife, and their young child. The mother and child were both dead; the father was wounded. As the wounded man was being handcuffed, he caught Gamal's eye and held it intently for a long moment. This image still haunts his thoughts during the day and intrudes on his dreams.

With images of death swirling through both his sleeping and waking moments, Gamal found himself seeking treatment again. Careful not to disclose anything that might be detrimental to his career, he was cleared for duty with the label of having "passive suicidal ideation" (p. 219). On one hand, he believed that he could not disclose the truth. On the other, he felt that nobody was listening to his pain and certainly not acknowledging his behavior. He again began taking his treatment into his own hands.

Two respites were found that alleviated his constant obsessive thoughts and psychological pain. The first was his old method of swilling gin to remain in a state of functional oblivion. Like so many other soldiers in a war-torn country, he found that inebriation took the edge off his stressful, never-ending days. His excessive drinking had become more frequent and of such a quantity that he began stashing it in his locker to maintain a constant supply. Many nights, it was the only way to sift through his mental torture long enough to fall asleep. He began drinking and walking around on base looking for a private place where he could cry without being discovered by his fellow Marines. His frustration at his plight is best described in his own words: "I mean, to not be able to tell someone you feel like blowing your brains out? And having to still shoot your weapon, to be out there when planes are flying overhead and helicopters are taking off, on no medication, no therapy, nothing."

Gamal's second respite was sex. After several months in Iraq, he began engaging in an

extramarital affair with a fellow Marine. She was much younger than him and was enlisted, causing a severe conflict in the chain of command. He also began buying copious amounts of pornography. In combination with his drinking, sex had become an escape in which his pain subsided for a short time.

When the authorities arrived at his barracks room, they found the young enlisted woman, wearing nothing but her underwear and Gamal's T-shirt, hiding in his locker. Both Marines were intoxicated and a search of the room revealed copious amounts of pornography and alcohol in Gamal's locker. Although he was embarrassed and humiliated, some small part of Gamal was glad to have been caught because he thought that someone would finally heed this cry for help. He was mistaken.

By the Uniform Code of Military Justice, the Marine Corps' governing set of laws, he was guilty of fornication and fraternization, two rather serious charges that would normally halt an officer's advancement, if not end it. Gamal decided to request that he be able to resign his commission and leave the Marine Corps, a decision that pained him greatly. The chain of command denied this request. Having reviewed his record, the perception of his superiors was that his record showed a pattern of weakness that was unbecoming of a Marine officer. He was to be drummed out dishonorably, preventing him from receiving benefits. These denied benefits include the ability to go to the Veteran's Administration for medical and psychological treatment.

Gamal's perception is that his actions were a direct result of both his and the Marine Corps' stigma of mental illness and its interpretation of seeking treatment for such ailments as "weakness." Given that his drinking and sexual encounters were the only means he could find to minimize his symptoms, he believes that the Corps' rejection of him as a "dishonored deviant" is

unjust. He maintains that he was trying desperately to reclaim his status as a "good" Marine. After all, he was a hero who risked his life and gave up his own mental health to save his fellow Americans during the attacks of September 11th, 2001. Perhaps he puts it best in his closing statement in the Dobie article by saying "they break us, blame us for allowing ourselves to be broken, and we feel guilt that we are broken" (p. 219).

The description of Gamal's experience highlights several themes central to the conceptualization of how the seeking of therapy by OIF/OEF veterans is stigmatized. It highlights the difference between self-stigma and public stigma. Self-stigma involves the personalization of one's self into the stigmatized category. In this case, Gamal saw himself as a "bad Marine" simply because he sought out treatment. The vignette also describes the significance of public stigma of those who seek psychological treatment within the military. As public stigma emerges from within the culture itself, it has substantial impact on self-stigma. This vignette describes the dimensions that are paramount to the understanding of the conceptualization of stigma.

However, it is important to point out that this vignette does not adequately describe the complete intention of this dissertation project. It is an extreme example of treatment stigma that culminated in extreme circumstances and outcomes. It is important to recognize that the following body of work is interested in a global understanding of treatment stigma by OIF/OEF veterans. This vignette was chosen because it embodied all of the elements that will be described in the conceptualization of an integrated lens for understanding treatment stigma in the military. Deployed service members experience a plethora of stressors both related and not related to combat situations. The model upon which this dissertation is built encompasses these stressors in a universal way. The purpose of this universality is because of the dissertation project's multiple

purposes. It seeks to lay a conceptual foundation of treatment stigma for the facilitation of future research, promote the understanding of factors that affect treatment, and inform policy changes.

Another issue with the above vignette is that it has a flavor of blaming specific individuals, such as commanding officers, for the execution of treatment stigma. This tone was necessary to explain the events of the vignette and display how cultural stigma is sometimes communicated throughout the military. It is crucial for the reader to recognize that the intent of this research is not to place blame on any individual, group, or social class of soldier. Culture-based stigma is not the fault of any single person or even any group of people within the culture, regardless of the power wielded. As the relationship between the cultural and individual levels is reciprocal in regards of influence upon the other, it is imperative to recognize that both offer the chance to maintain stigma as well as the opportunity to reduce it.

A Conceptualization of Treatment Stigma in Returning Veterans

Chapter 1: Treatment Stigma in the Military

Since the inceptions of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) in 2003 and 2001 respectively, nearly two million American troops have served in these conflicts, many serving multiple deployments (Hefling, 2009). The numbers of service members entering treatment, however, is not rising equally with the number of those deployed. This may be accounted for by the stigma that impedes veterans from seeking treatment. Soldiers fighting in OIF/OEF encounter both self-stigma and stigma from the culture of the military, giving them both internal and external reasons for minimizing or denying mental illness.

Watson and River (2005) report that the stigmatization of mental illness leads to lowered self-efficacy and self-esteem by those suffering from the subsequent symptoms. They state that fear of stigmatization also directly affects the tendency toward the denial of mental illness. This denial hosts the possibility of promoting an avoidance of the very interventions that could provide symptom management and even symptom diminishment.

Thus, as illustrated in the preface vignette, an explanation for the avoidance of entering treatment is the stigma of mental illness and the subsequent stigma attached to seeking therapy. This dissertation project seeks to describe how treatment stigma exists in the military culture and in the individual soldier through the examining of the mechanisms that cultivate and maintain core beliefs that mental illness is synonymous with negative attributes such as weakness and cowardice. The project also describes how the cultural norms of the military influence the individual soldier's core beliefs as well as how the soldier's own core beliefs affect his or her likelihood of seeking treatment.

An unfortunate benchmark of the level to which military members avoid mental health

treatment is that of the current suicide rate among OIF/OEF veterans. Of those who have served in Iraq or Afghanistan, 1621 attempted suicide in 2009. Ninety-eight of those who attempted suicide during this time frame were successful, including four women (Maze, 2010). An article in *Time* magazine in April 2010 reported that between the inception of Operation Enduring Freedom in 2001 and the summer of 2009, the number of service members lost in combat in Afghanistan was 761. During the same time frame the military lost 817 to suicide (Thompson, 2010). The United States Veterans Administration (VA) reports that across all eras approximately 950 veterans attempt suicide each month. They also indicate that those who seek and receive treatment within the VA system show lower numbers of both attempted and completed suicides than veterans who do not seek VA treatment (Maze, 2010).

Jakupcak and Varra (2011) state that earlier intervention for symptoms of mental illness such as PTSD and depression in OIF/OEF veterans would also prevent lifelong maladjustment, allowing veterans to experience a higher quality of life after serving. As treatment stigma houses the potential to prevent these earlier interventions, it is the purpose of this study to build a lens through which this stigma can be understood and reduced. This dissertation project seeks to provide a lens for understanding the creation and maintenance of treatment stigma across both cultural and individual levels. This understanding makes use of an integrative outlook based in three conceptual models of stigma. The view provided by this lens facilitates an understanding for how treatment stigma manifests in the military population which then sheds light on possible ways of reducing this stigma. Hopefully, this project will be instrumental in informing and facilitating the strategic planning for preventing growth and encouraging reduction of treatment stigma for those serving in the military.

Population

Although adaptable to members of the military who have served in other conflicts, the intended population for this project is that of returning service members deployed to Iraq, Afghanistan, and other countries in the Persian Gulf area in support of the OIF/OEF campaigns. The integrative lens developed in this dissertation does not focus on soldiers who have served during OIF/OEF without deployment, or served during a time of peace. Furthermore, the project encompasses members of all branches of the armed forces. It should be noted that this not only includes the Army, Navy, Air Force, and Marine Corps; but their Reserve commands, the National Guard, and the Coast Guard as well. The dissertation project uses the term "soldier" to include all members of the armed service branches unless making specific distinctions.

Although the vignette in the preface showcases specific, combat-related PTSD and depression, it is crucial to understand that this population is not exclusively targeted by this project. Such mental health problems are prevalent in the military during wartime, and a significant number of OIF/OEF veterans suffer from these ailments; however, the purpose of this dissertation project is to provide a more global view of treatment stigma across a multitude of clinical disorders. For those who have and have not experienced direct combat, there are a multitude of other factors that affect the soldier's mental health. These include: separation from family, culture, and other facets of their home environment; stresses of performance; dissatisfaction with their mission or its purpose; biological factors; and general fatigue. Those not serving in a forward area may experience distress that they are not contributing more to the outcome. Others close to the fray may experience a looming sense of dread that takes its toll on their stress level. These stressful factors are as widely ranged as the soldiers who experience them, and each has the potential to influence the creation of maladaptive psychological

symptoms. Therefore, it is essential that this project cover a wide range of causes and effects for both the mental illnesses initiated during deployment and the stigma of seeking treatment for them.

Veterans returning from OIF/OEF are a complex group. Viewpoints of their service range from a proud sense of accomplishment to disappointment, anger, or disillusionment about what they survived in Iraq and Afghanistan. Many have served in multiple deployments, causing stressors on family relationships and adding multiple traumatic experiences. Others have returned and attempted to integrate into an unforgiving economy, causing financial distress and homelessness. On many other levels, navigating the path of reintegration from the military culture into mainstream American civilian life involves many hurdles. However, when there are symptoms of mental illness associated with being in combat, this task is much more difficult. Stigma-oriented core beliefs created while serving in the military are frequently a factor in the veteran's decision to avoid treatment long after his or her service is over.

Upon attempting to reintegrate with civilian culture, veterans often find that those around them have had vastly different experiences. They may feel stigmatized for developing symptoms of mental illness, and they may worry that other people fear them. This detachment may fuel stigma by making the veteran feel alienated from the rest of the population. Similar to the veteran's experience in the military culture, he or she may feel the need to hide symptoms so that he or she can integrate with the cultures of college settings, workplaces, and communities.

Hundreds of thousands of American veterans have survived and returned from OIF/OEF. Each of them has returned to find that they differ greatly from when they left. It is important that the approach to this dissertation project recognize that there are many distinct and individualized sets of core beliefs and reasons for the maintenance of treatment stigma. It is also essential that

the lens through which the study of treatment stigma focuses during this dissertation project takes these complexities into account.

Rationale. As the number of service members serving in Iraq and Afghanistan continues to climb beyond the point of two million, a third of whom have served in multiple deployments, it is imperative to address treatment stigma. Studies have shown that earlier intervention for ailments such as PTSD and depression in these veterans prevent lifelong maladjustment, allowing them to experience a higher quality of life after serving (Jakupcak & Varra, 2011). For those serving in multiple deployments, it could also provide them with strategies and skills to recognize, understand, and enter treatment earlier for future symptoms, making future deployments easier to survive.

The integrative lens created by this dissertation project serves as a means through which to view treatment stigma in the military. The understanding generated by the application of the integrative lens will hopefully facilitate the planning of strategies to overcome treatment stigma where it exists as well as prevent the creation of this stigma where it does not. It is anticipated that a clearer picture of stigma will develop as the integrative lens is applied, and an approach to lessening the barriers to entering treatment will emerge.

Acknowledgement of Researcher Bias

The inception of both this dissertation project and the application of the integrative lens undoubtedly received influence by the military and academic experiences of the writer. An upbringing in a veteran-laden family further shaped by three deployments in the Persian Gulf ensured the influence of personal experience on this project. Through building the scholastic knowledge base essential for developing as a psychologist, the influence of academia was equally inevitable. It is important for the reader to recognize that the facets of cultural and

individual stigma described in this body of work are not purely formed by either academic or experiential information, but rather from a combination of both. These influences both informed the conceptualization of treatment stigma in the military through the integrative lens in the chapters that follow.

Chapter 2: The Integrative Lens

The integrative lens used in this dissertation project and applied to cultural and individual treatment stigma is a compilation of three distinct, established conceptualizations of general stigma. The integration of these independently developed formulations was necessary because of the incredibly complex nature of treatment stigma because of its many influences from both the culture and the individual. As these separate models of stigma come from individually developed perspectives, yet describe the same phenomenon, they collectively share characteristics. As descriptions of the separate conceptualizations of stigma unfold, this may have the effect of appearing repetitive to the point of being redundant. The decision to include all three models came from each offering unique characteristics, despite the general overlap of some ideas. The inclusion of each into the integrative lens allows for greater breadth and depth of understanding stigma.

Conceptual Models

As stigma exists at both an individual and cultural level, the project considers how stigma develops both in the military culture and within the individual soldier. The approach to this investigation makes use of thee conceptual models of stigma: the Social Psychological Model (SPM), the Sociological Model (SM), and the Cognitive-behavioral Model (CBM). SPM and SM combine to conceptualize the manifestation of treatment stigma in the military culture, whereas the CBM conceptualizes self-stigma. The necessity of inclusion of all of these models in this project arises due to the complex, bi-directional nature between cultural stigma and self-stigma described in the literature. SPM and SM illustrate many influences that cultural stigma imposes upon the core beliefs of the individual. CBM describes how these core beliefs affect the individual's experience of stigma toward himself or herself and how this influences the veteran's

decision not to seek therapy. For example, if two soldiers were experiencing similar depressive symptoms but receiving different cultural influences, their core beliefs about the implications of their symptoms on what it means to be a soldier may differ. If these core beliefs are different, their thoughts on therapy-seeking may also differ, causing different emotional and behavioral reactions. If one soldier understands that the chain of command requires him or her to "tough it out" or be a "good" or "strong" soldier, he or she may feel ashamed of these symptoms and hide them, effectively avoiding treatment. On the other hand, a soldier without these influences and pressures may consider psychological treatment as a way to maintain health. The latter soldier is more likely to have more positive beliefs about seeking treatment and be more likely to choose to enter treatment to lessen symptoms and maintain the ability to function in the field.

Social Psychological Model (SPM). Ottati, Bodenhausen, and Newman (2005) explain that stigma exists because of cognitively and emotionally derived motivation. Outside forces that shape the individual in powerful ways through the use of cognitive and emotional motivation affect the construction of that individual's core beliefs. Through presenting these cognitive and emotional stimuli, the culture influences the individual to develop a certain viewpoint. Although individual differences between people dictate the level of influence on the individual's core beliefs, the desire for acceptance by the culture wields overwhelming power in the assimilation of values into the person's core beliefs.

This model's selection into the integrative lens came because the culture of the American military impacts the core beliefs of individual soldiers in this way. From the individual's first day in basic training, a constant inundation of the military culture's stance on how the individual soldier should think, feel, and act exists. From mundane tasks such as folding socks to highly specialized protocols for the transfer of nuclear weapons, military bearing dictates the proper and

accepted ways of carrying out daily business. Because these conditioned behaviors require the individual to think and feel a certain way, it is essential to the military's success that these facets also be influenced.

Elements of the SPM described by Ottati et al. (2005) explain ways in which core beliefs of the individual form. Among many other facets of military life is the stigma of mental illness. Although service members are not directly told to hold negative emotional responses to mental illness, lessons involving acceptance of strength and teamwork, and lessons of rejection of weakness or failure inadvertently bring about such associations. The elements of SPM used in the integrative lens include classical conditioning, misattribution of negative affect, just world thinking, and social dominance.

Classical conditioning. Ottati et al. (2005) explain that classical conditioning pressures the members of a culture to accept inaccurate understandings about mental illness. Beliefs about the mentally ill are often thrust upon individuals by their culture inadvertently or as a byproduct of other influences. The culture's values and beliefs persuade the values and beliefs of the individual through repetitively exposing him or her to this information. In the case of mental illness, the culture may contend that the mentally ill are weak, useless, or even a threat to the culture's goals. If that culture's members experience symptoms of mental illness, this conditioning may push these members to deny the symptoms and attempt to overcome them alone to prove that that the member is not weak, useless, or a threat.

For example, throughout military training and in the field, the support of concepts such as personal strength and teamwork exist because they are necessary values for the success of the military. The inadvertent lesson may be that anything that causes failure in these areas, including the symptoms of mental illness, is equivalent to personal failure, weakness, or shortcoming.

Misattribution of negative affect. Ottati et al. (2005) state that misattribution of negative affect can also strengthen emotionally driven prejudices. Redirecting emotions such as fear, anger, or disgust away from a situation and toward a person seen as being at fault for the circumstances strengthens the core belief that the person's shortcomings are to blame. Blaming the shortcomings of the person for the negative event that caused these negative emotions may lead to stigmatizing behaviors toward either that particular person, or other people who exhibit similar attributes.

For example, if a soldier hesitates during a firefight because of a symptom of mental illness and another soldier dies, the rest of the platoon may blame him or her for the death because of the hesitation. Rather than attribute the loss to the chaotic nature of combat, the perception may be that the loss related to that individual's lack of fortitude because he or she was too weak to prevent the symptom. Others may ostracize or punish the soldier because he or she is seen as weak or defective. Other soldiers who exhibit similar symptoms are also likely to be subjected to this prejudice through generalization. This could cause the individual's core beliefs and self perception to shift, ultimately causing him or her to deny or hide these symptoms.

Just World Thinking. Ottati et al. (2005) contend that the Western ideal that people deserve what positive and negative events happen to them because of their own actions or attributes also reinforces core beliefs in stigmatizing mental illness. They contend that this type of thinking is a mechanism built from a desire to feel safe. In many cultures, people tend to believe that if they work hard and are good productive members of society, they will not need to worry about catastrophe. The inverse is that, if something negative happens to someone, it is because that person is defective in some way or was not strong enough to prevent or withstand it. This perception suggests that the more severe the misfortune, the more the person deserved it for

being too weak or unmotivated to avert it.

For example, a soldier with symptoms of depression is likely to experience constant fatigue, poor diet, sleep problems, and may not perform at his or her peak ability. This individual may be seen as weak, incompetent, or lazy because the other members of that soldier's unit do not share these symptoms. If that person misses a promotion in rank, others may perceive this as just. They may believe that it is the person's own fault for not taking a deeper initiative to work effectively. Others might even believe that losing the promotion should act as a motivator to do a better job for the next round of promotions. However, if a factor that contributes to the person's depression is low self-esteem, the perception of the rest of his or her unit may fuel the individual's depressive symptoms through confirming personal fault.

Social dominance. Ottati et al. (2005) describe the social dominance phenomenon as a mechanism by which those perceived as strong and capable push down those perceived as weak to elevate themselves. The writers note that this rigid phenomenon often becomes a cornerstone of authoritarian cultures. They describe four aspects of social dominance. First, they contend that submission to a strong authority characterizes the phenomenon, which in turn creates the basis for the elevation of the strong and the forced submission of the weak. Second, the strict adherence to the middle-class norm of hard work as rewarded and lethargy as punished causes the view of subpar performance as the result of laziness and deserving of punishment. Third, rigid thinking furthers social dominance through the use of cold logic and unwavering judgment. Fourth, aggression toward those outside the mainstream promotes the idea that those who lose favor with the "in-crowd" are seen as being inferior. These four attributes combine to produce a force of stigma imposed upon those seen as weak by those perceived as strong.

In the case of mental illness, someone who seeks treatment for his or her symptoms may

be cast into the lower ranks of the order. This could cause the person to self-stigmatize and keep these symptoms hidden rather than alert others to their existence. A soldier who chooses to engage in treatment might not receive a specific assignment because of a sense that he or she needs to be punished for the shortcoming of being defective. If that soldier decides to continue treatment despite this, he or she could experience challenges to his or her future in the military such as continually failing to gain promotions or assignments. To those higher up in the chain of command not privy to the reasons for these decisions, the soldier may seem unmotivated or apathetic, causing other problems for the individual's future in the military.

Sociological Model (SM). SM is a model that considers the creation and maintenance of stigmatizing core beliefs about mental illness as represented in the language and labels used to describe it and those who suffer from it. Markowitz (2005) describes the sociological model of mental illness stigma as coming from labeling theory. He indicates that labeling theory stems from the symbolism of the interactionist tradition, which states that the meanings of social objects, such as people and actions, are social constructs. Labeling theory is the verbal manifestation of that meaning and wields the power to reduce that person or action to a word. If that word is derogatory, the meaning that it brings with it is also derogatory. Because one word cannot sum up an object accurately, this label is simplistic and discounts all aspects of the object that do not fall under the label. In other words, labeling a person or action as "bad" or "worthless" denotes both a derogatory tone and over-simplicity.

The basic premise of SM is that objects, including people, have meanings constructed by society based on their perceived value. Objects viewed as high in value to society are also seen as high in value to the person within that society, whereas objects of low value to the community or culture have a minimal value to the individual. The culture gives these objects simple,

generalized labels that encompass many attributes and levels of positivity or negativity. In doing so, many positive attributes are lost due to the focus on a singular negative attribute that appears to carry more weight. The placing and acceptance of this label also has the potential to cause the labeled person to act accordingly to the label.

Because people also become objects in labeling, it is possible for the individual to be objectified and for the value of that individual to be heavily influenced by the label given to the person. Again, a highly valued label, for example "intelligent," would evoke a positive self-appraisal. This could also cause the person to behave accordingly, such as pursuing higher educational goals or entering a profession that society values. On the other hand, a negative label, such as "crazy," could have the opposite effect. Because military society devalues the mentally ill, someone given this label may have a devalued sense of self. He or she may also act accordingly while trying to live up to the label given by the culture (Markowitz, 2005).

Often handed down from superiors, these labels come in the form of comments, fitness reports, or orders. The role identities of either a "good soldier" or a "bad soldier" offer two options about the expectations of the society. They also offer two sets of values for self-appraisal by the person carrying those labels. A *good soldier* might do anything within his or her power to maintain that label in the military society. Overt symptoms may result in a negative label such as *bad soldier*. Therefore, a *good soldier* who begins experiencing symptoms of depression might attempt to hide these symptoms for fear of a shift to the label of *bad soldier*. In terms of treatment stigma, a soldier who seeks therapy or other treatment for mental illness symptoms may experience labels such as "whacked," "nut job," or "dangerous." If these labels are synonymous with *bad soldier*, the soldier might avoid treatment to avoid these labels.

For example, a soldier who is constantly irritable because of anxiety symptoms may

begin to lash out at his comrades during times of stress. The other members of his unit may begin to think negatively about him and may attribute this change in his demeanor to his personality. They might call him or her "jerk" or "worthless," not recognizing that he is only sleeping one hour per night, his or her diet has dwindled, or that he or she maintains an internal stress level that keeps him or her in a constant state of physical arousal. If he or she is concerned about the labeling repercussions of seeking treatment for these symptoms, this fear of stigmatization may overcome the desire to have these symptoms alleviated. When the day comes where he or she is under stress from both internal thought processes and external stressors resulting in verbal retaliation to a superior officer, his or her fitness report might include labels such as "insubordinate," "poor military bearing," or *bad soldier*. The soldier might be that much more reluctant to add stigmatizing labels about seeking mental health treatment to those labels.

Furthermore, once a soldier receives a *bad* label, it is also likely that he or she would begin to act out that identity, causing it to become even truer. Markowitz (2005) explains that people often live out the roles that society provides to fulfill the expectations that their culture has of them. This can activate a cycle of *bad* actions followed by *bad* perceptions that lead back and forth, causing a downward spiraling effect. In the case of mental illness, this could increase symptoms. The soldier from the example above might begin living into that role by taking on the *bad solder* persona. He or she might think that if that label is already cast upon him or her, there is nothing else to do about it but live into the role. If that label consists of stigmatization of mental illness, the soldier may begin acting erratically or dangerously so as to live into the role of the label.

Cognitive-Behavioral Model (CBM). The CBM concept of individual stigma, as described by Corrigan and Kleinlein (2005), states that the individual's core beliefs influence

thoughts, feelings, and behaviors. Built upon Cognitive-behavioral theory, it proposes that core beliefs directly affect automatic thoughts. This model centers on the principle that what a person believes about general situations becomes central to how he or she interprets the current situation. If the core belief is that mental illness is equivocal to weakness, the automatic thought is likely to reflect this stigmatizing belief. These thoughts elicit an emotional response based on the judgment of the implications of the thought. Again, if the core belief is that mental illness is synonymous with weakness, the emotional reaction might be that of self-disgust. The emotional response prompts the person to react to the thought and emotion, causing a behavior. In this case, the behavior may be to avoid allowing anyone else to know about the perceived weakness or denying its existence completely. The components of the CBM of stigma are stereotypes, prejudice, and discrimination. The writers describe these three components as manifestations of thoughts, emotions, and behaviors respectively.

Stereotypes. Stereotypes are categorical groupings people create through the knowledge accumulated from various sources throughout life. Through the CBM lens, it is understood that stereotypes are comparable to the automatic thoughts derived from core beliefs. Although many people consider stereotypes as negative thoughts, in their purest form they are often helpful and allow people to manage life. For example, the thought that "snakes are dangerous" may only be accurate for a small percentage of venomous vipers in the world. However, the avoidance of snakes has kept many people safe.

Stereotypes in and of themselves are relatively harmless until the person considering the stereotypes either endorses or discards them. Because stereotypes have the power to evoke strong emotional responses and affect behaviors if they are accepted, it is in these emotional responses that they gain power. For example, if a negative stereotype is accepted, the emotion that follows

might be that of fear or apprehension, which could lead to avoidance or other negative behaviors. By this model, the emotional response, referred to as "prejudice," and the behavior, called "discrimination," quickly follow (Corrigan & Kleinlein, 2005). Stigma gains power to dissuade someone from the stereotyped object, person, or idea because of the power of his or her emotional and behavioral reactions. For example, the soldier's belief may be that weakness in any form makes him or her less of a soldier. The thought that "I am experiencing mental illness symptoms which make me weak, and I am therefore a weak soldier" would be an example of a stereotype.

Prejudice. Prejudice is an emotional reaction to an accepted stereotype. The acceptance of a negative stereotype evokes a certain emotional response depending on its nature. The approval of a positive stereotype such as "soldiers are strong" may evoke positive emotions like awe, optimism, and trust. On the other hand, the acceptance of a negative stereotype, such as "I am experiencing mental illness symptoms which make me weak, and I am therefore a weak soldier" might evoke emotions like shame, fear, or disgust. These emotional responses wield a great deal of power in dictating how people react to situations.

Discrimination. Discrimination occurs when stereotypes and prejudices result in action or abstinence from action. From the CBM viewpoint, discrimination is a behavior influenced if not directly produced by the stereotype and prejudice that preclude it (Corrigan & Kleinlein, 2005). Once a person has had a strong, negative emotional response, it is likely that person will act negatively. To continue the example, a negative reaction to the stereotype that symptoms make the soldier weak and the prejudice that manifests as fear and shame might elicit the act of avoiding treatment simply to keep another person or the chain of command from recognizing the soldier's weakness.

Integration of the Models into a Conceptual Lens

This dissertation project combines the SPM and SM to conceptualize stigma in the military culture and consider how it affects the individual's core beliefs. The project incorporates the CBM in a way that illustrates how these cultural influences on core beliefs shape self-stigma through thoughts and emotions and how these influences lead to the individual's actions about whether or not to enter or continue treatment. Figure 1 provides a visual representation of the integrative approach in combining these three models.

In the coming chapters, this integrative lens will be applied to the cultural and individual influences on the stigmatization of seeking mental health treatment by soldiers and veterans of OIF/OEF. Chapter Three involves the application of the cultural components from the integrative lens to the culture of the military to describe the influences of cultural stigma on the core beliefs of the individual soldier. Chapter Four builds from the creation of these core beliefs and displays how the individual soldier's stigmatizing core beliefs create stereotypes, prejudices, and discriminations involved with making the decision not to engage in treatment. The following chapters involve strategies for the reduction of both cultural and individual treatment stigma, reviews of several stigma reduction programs offered by the different branches of the military, and possible future applications of the integrative lens.

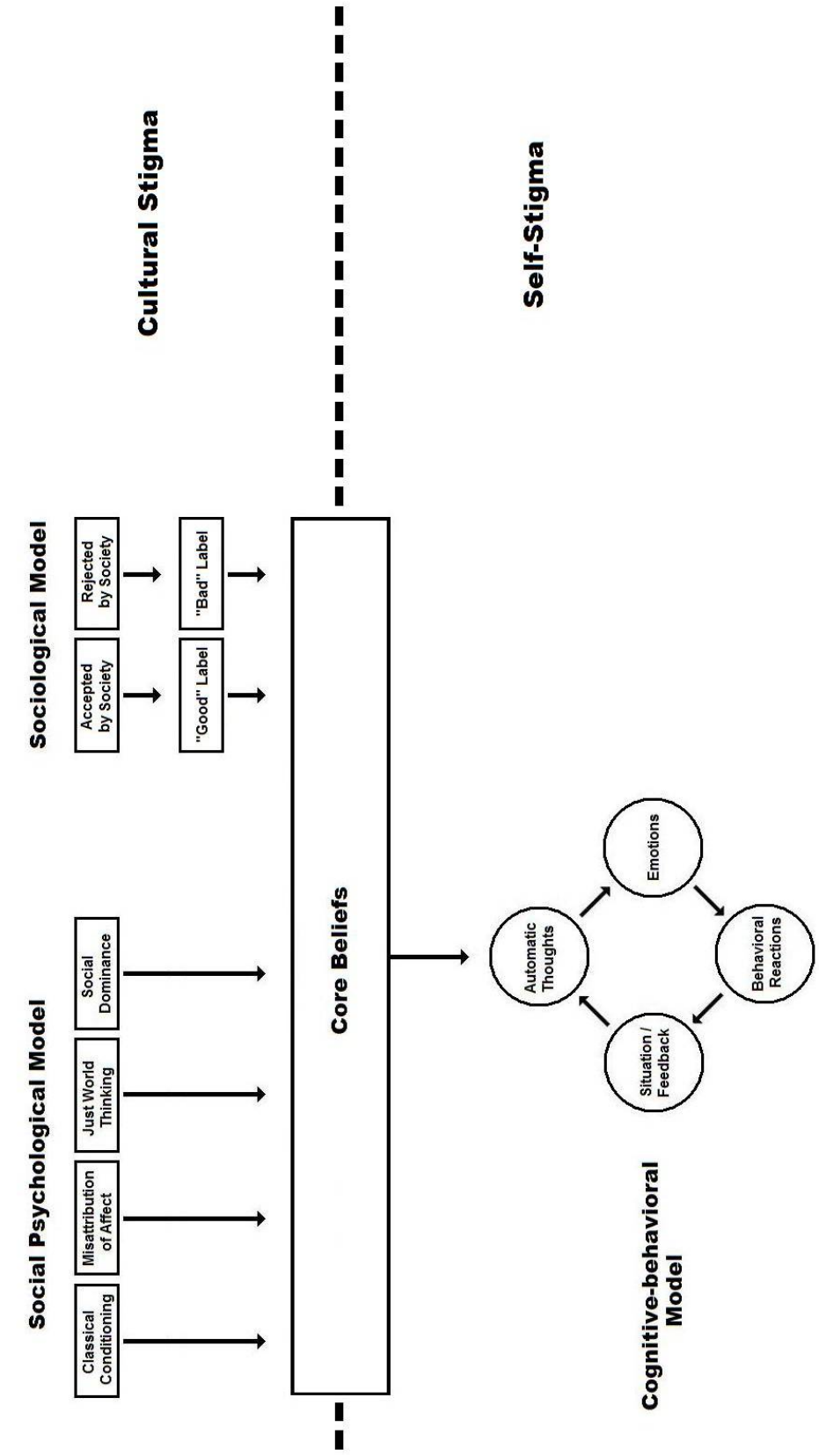

Figure 1. An integrative model for cultural stigma and self-stigma showing influences on core beliefs and how those core beliefs influence automatic thoughts, emotions, and behaviors.

Chapter 3: Cultural stigma in the military

The culture of the military is unique. Consisting of a collection of shared values, practices, and attitudes, the culture stands upon the central idea of protecting the country and its interests. What makes this culture so unique is not its array of beliefs but the hostile environments in which it exists. By design, the military is meant to enter aggressive situations in which destruction and death are likely. The result is the placing of its members in harm's way.

Among the situations that forge the cultural beliefs of the military, the necessity for its members to find solace, guidance, and camaraderie from the group has been appreciated across the ages. Over the centuries, countless veterans of combat have explained that, regardless of their initial intent, they fought as hard as they did to protect their friends and comrades. The famous quote from the Saint Crispin's Day speech of William Shakespeare's *Henry V* sums the understanding of this powerful connection so perfectly that it has been adopted as the mottos of many military units over the last four hundred years: "We few, we happy few, we band of brothers. For he today that sheds his blood with me, shall be my brother" (Brown, 1998, p. 168).

The pressure to live up to that ideal, to belong to this culture of "siblings" has the potential to influence an individual's decisions heavily. In an environment in which the support of one's fellows means the difference between life and death, this bond can be crucial to one's very existence. Pietrzak, Johnson, Goldstein, Malley, and Southwick (2009) illustrate that this support is crucial for the soldier's mental health outside the battlefield as well. They indicate that low levels of unit support are associated with depression and PTSD, whereas high unit support promotes positive mood, job performance, satisfaction with the tasks they perform, and organizational commitment.

The values and beliefs of the group exist through the values of the individual by an influence on that individual's core beliefs. If the cultural message is that seeking treatment for psychological distress denotes weakness, it will flavor the individual's core beliefs about seeking treatment. For example, in the military culture, many service members may avoid coming to therapy out of a desire to avoid being seen as defective by other culture members. Corrigan and Kleinlein (2005) also explain that even when people in this situation do enter treatment, they often have problems engaging fully in therapy because doing so includes certain implications. For example, the soldier may believe that he or she is not worthy of receiving help or cannot become "normal." The soldier may also believe that a therapist is powerless to help him or her given the labels that have already been attributed to him or her. When therapy does not instantly remove all suffering, many clients see this as confirming their biases, and they stop coming to treatment. This may also influence the soldier's decision about whether or not to seek treatment in the future.

The cultural stigma aspect of the integrative lens includes the components of the SPM and SM. The SPM lends some understanding of how core beliefs perpetuate the stigma of mental illness, and the associated stigma of seeking therapy, in this culture. Their model stands upon the pillars of classical conditioning, misattribution of negative affect, just world thinking, and social dominance. These pillars explain that exposure to the values of the culture go a long way in the creation and maintenance of core beliefs in line with the cultural values.

As the SPM explains the "what" of the cultural manifestations of stigma, the SM provides the "how." Through the use of labeling, soldiers provide simplistic monikers for equipment, situations, and even each other. These nomenclatures provide a quick reference to somewhat more complex ideas, and they have the potential to provide the attitude that the labeler

experiences toward the labeled. In conjunction with the elements of SPM mentioned above, the labels created have the potential to create and maintain specific core beliefs about the labeled. The next chapter considers the impact of these core beliefs on behavior.

Social Psychological Model

The model by Ottati et al. (2005) explains that stigma exists because of motivational reasons designed to create distance between the stigmatized and those engaging in stigmatizing. As these cognitively and emotionally derived motivations build, they construct and change the individual's core beliefs. Through presenting these cognitive and emotional stimuli, the culture influences the individual's core beliefs, developing certain viewpoints and perspectives. SPM describes four ways in which military culture enacts such motivations upon soldiers.

Classical conditioning. Cultures classically condition their members to accept both accurate and inaccurate understandings of different facets of life. This is especially true of controversial issues that have no clear "right" or "wrong" answers, or at the very least have valid points on both sides of the debate. Influences on how people think and feel about these issues provide a constant bombardment of conditioned stimuli in the hopes of swaying the members of the culture in one direction or the other. This conditioning is not necessarily devised to do so; rather, it can manifest as the culture continually validating itself.

Military culture is not immune from this conditioning. Because the military consists of relatively few permanent members (e.g. career soldiers) and many more transient members (e.g. soldiers who plan to complete only one or two enlistments), this classical conditioning is essential. The military uses classical conditioning in a plethora of ways. The relatively short weeks of basic training transform raw recruits from civilians into soldiers through the use of classical conditioning. During this time, values become instilled in the budding soldier including

the importance of being a functioning part of a team, the significance of personal strength, and the consequences for not living up to the role of a soldier. A soldier's failures, shortcomings, distress, and mistakes begin to foreshadow the perception of personal weakness or the self-perception of imperfection. The actions that fall short of perfection being synonymous with personal fault continue as the soldier realizes that the culture will not tolerate weakness in any form. The emphasis on the ideals of personal strength and teamwork encourage the soldier to strive to maintain a sense of strength both on his or her own and within the team. When unavoidable shortcomings do appear, it becomes the conditioned reaction of the soldier to compensate for them.

Unintended pairings sometimes find their way into military life. An example of this is the reporting of a concern by a soldier, such as a medical problem. Naturally, when the soldier reports this medical problem to a superior, he or she is sent to receive care. However, the inadvertent message in this is that some facets of care will take precedence over others in the soldier's training. Soldiers learn that they can hold off on reporting certain problems deemed as less important than the training or mission that he or she would miss due to seeking care. If this care carries a mental health orientation, the person may postpone it for a long time because of the perception of the sacrifice it would take to do so.

When leaving for deployment, a soldier might minimize, underreport, or even deny the existence of anxiety symptoms because of a sense of duty to his or her unit and a desire not to miss duty. Another soldier might avoid mentioning depressive symptoms during Post Deployment Health Assessments (PDHA) because of the conditioned stimulus of being taken from the usual timeline. Excited to return home and be with their families, returning soldiers might consider reporting mental illness symptoms as jeopardizing to that reunion and postpone

the report to a time after he or she achieves the ultimate goal of going home.

Misattribution of negative affect. Misattribution of negative affect is a situation in which the response generated by negative emotions such as fear, frustration, or anger about a situation is attributed to a person rather than to the situation. This blaming phenomenon targets the specific person, lessening or eliminating the perception of the situation's role in producing the negative emotion. Ottati et al. (2005) note that unawareness of negative affect can also strengthen prejudices. Attributing either positive or negative emotions, such as pride and elation or fear and anger, to interactions with a person or a stereotyped category of people undoubtedly flavors the perception of that person. First impressions of people often happen this way. The perception of anxiety when around a person for the first time might lead to the belief "that person makes me feel uneasy." This belief often has enough power that this impression might take a long time to change. It also houses the clout to cause avoidance of that person.

Members of the military culture may view fellow soldiers experiencing mental illness symptoms in this way. For example, if an enlisted soldier who was outgoing and energetic during training becomes introverted and despondent during a deployment because he or she is experiencing depressive symptoms, the other members of his or her unit will undoubtedly take notice. The other members might not recognize these symptoms as depression; rather they might perceive the soldier as being less fit or less reliable in a combat situation. Misattribution of the negative affect that follows might include changes in the way the unit members talk to the soldier. They might label this soldier as "weird" or "changed" and might begin alienating him or her because being in that person's presence makes the other members feel uncomfortable. Unfortunately, in a situation such as this, the removal of social support is likely to cause the soldier to isolate further and his or her symptoms may worsen.

In a situation in which the person is known to be suffering from symptoms of mental illness, this misattribution of negative affect may be even more pronounced. The addition of labels such as “depressed” or “PTSD” might give license to others to act upon their emotional responses to the person. Soldiers understood as being mentally ill can strengthen or alter prior perceptions of that person in a negative way. This can also cause blaming of the person for consequences of the symptoms, of which the blamed person has no control. Powerful emotions about the situation and its outcome might weave into the blame directed at the person.

If, for example, a squad of soldiers is sent on a dangerous mission, the members of the squad may be experiencing several emotions. They may feel fear of what could go wrong, anger at the military for forcing them to return for a third deployment, pride at their selection for such an assignment, or disgust with the entire war situation. If the mission ends in tragedy, those emotions might be attributed to one or several members. If one or more members in question are seen as suffering symptoms of mental illness, these members may become scapegoats for the failure of the mission or the loss of a comrade. Even when the situation would have been unavoidable had these symptoms not been present, the existence of symptoms might offer an easy target for blame.

As mentioned above, such a phenomenon may isolate a soldier from the unit, causing that soldier to isolate and affording symptoms the opportunity to worsen. After receiving this blame, a soldier who is already questioning his or her resolve in combat because of the existence of symptoms might begin to internalize this blame. The soldier could embrace the blame for the loss of a comrade in battle, especially if he or she thinks that the symptoms prevented him or her from acting properly. The repercussions of this can be psychologically devastating and lifelong. Symptoms could become worse, and the soldier might spend his or her entire life regretting that

he or she did not have the fortitude to act properly.

Just World Thinking. Another facet of the integrative lens comes from what Ottati et al. (2005) refer to as the "Just World Hypothesis" (p. 105). As the discussion of this term in popular culture grew, it became known as a motivator to encourage and shore up one's core beliefs. The writers contend that the *Just World* idea is the Western ideal that people "get what is coming to them." They also indicate that this is an intellectualizing mechanism built from a desire for the person's sense of self to feel safe, secure, and righteous. Through interpreting good fortune as a product of being or doing what is right and misfortune to being or doing what is wrong, people can separate from others less worthy of good fortune.

For example, people tend to believe that if they work hard and are good productive members of society, they will not need to worry about catastrophe. The belief contends that simply acting in socially acceptable ways will provide some kind of moral defense against negative repercussions. Reinforced when people look at their own good fortune and attribute it to their sense of self, this idea appears valid. People may believe that they are good positive members of society, despite their inevitable shortcomings because they see themselves as successful. When judging someone else, these shortcomings are often not as easy to overlook.

The other side of *Just World Thinking* is that if something negative happens to someone, it is because they deserved it. When tragedy strikes, it is because something is wrong with the person. Perhaps he or she did not work as hard or diligently at being a positive member of the culture or society. Maybe it is because he or she was not strong enough or too lazy to prevent it from happening. Either way, the perception is that the person endured the same situations as others experienced, but he or she is the only one affected by it. Therefore, logic would explain that he or she deserved to be affected by it in this particular way because of some unforeseen

personal inadequacy.

The concept of a just world thrives in military culture. An environment in which proper preparation is the key to averting disaster enables the logical leap that improper preparation must be to blame when disaster strikes. The reinforcement for this concept comes from the just world carrying a level of truth. Those who prepare for a situation often do better in that situation than do those who do not. In a warzone, lack of preparation may lead to failure of a mission, injury, or death. Therefore, the lack of preparation in a given situation is simply unacceptable.

A central tradition in the military is that of ongoing inspection cycles. The purpose for these inspections is two-fold. It affords the upper echelon a chance to assess the state of preparedness in the unit to understand its assets prior to planning and executing a plan. The other purpose is to enforce mandatory preparedness. Repairing broken equipment, giving everything a fresh coat of paint, and training of unit members constitute some of the hallmarks of preparation for an inspection. When the inspection team arrives, those responsible for the unit's readiness try to ensure that the inspectors recognize the preparation. Units that have prepared well tend to pass; units that do not tend to fail. Logically, this produces a reciprocal relationship in which those who did not prepare must fail and those who failed must not have prepared. This application of cold logic to the status quo "proves" that the world is just.

Translated into the existence of mental illness symptoms, this concept blames people for not preparing successfully to ward off symptoms. A soldier who begins showing or reporting symptoms of mental illness might be seen as either choosing not to prepare himself or herself or lacking in some way that prevented mental preparation for the task. The perception may be that he or she is too weak, too lazy, or too unmotivated to have defended against the onset of these symptoms. In that case, it is possible for that soldier to be blamed for his or her own misfortune.

This is especially true if others who have endured the same hardships have not experienced similar symptoms.

Ottati et al. (2005) propose that the perception also suggests that the more severe the misfortune, the more the person was weak or unmotivated, and therefore more deserving of the catastrophe. This idea is likely to encourage a soldier who was dealing with symptoms to minimize or deny the existence of symptoms to sidestep the blame that would inevitably follow.

The effect that Just World Thinking has on core beliefs is that of placing praise and blame. As both of these entities are judgments, it allows the soldier to blame the self or others for shortcomings in what he or she perceives as his or her mental toughness or personal fortitude. These inaccurate judgments have the potential to build a belief structure of the self that might end not only in the denial of symptoms but also in their exponential worsening.

Social Dominance

Ottati et al. (2005) also describe the social dominance phenomenon as a mechanism by which those perceived as strong push down those perceived as weak to elevate the strong and capable. They explain that this authoritarian phenomenon stems from four factors. These factors can be associated with integral cornerstones of the military structure. Although the military could not function without the current structure of command, it is important to acknowledge how these facets of social dominance feed the stigma of seeking treatment.

First, social dominance requires submission to authority. This is the basis for the elevation of the strong and forced suppression of the less strong. Second, the strict adherence to the middle-class norm of rewarding hard work and punishing laziness causes those whose results are subpar to be seen as inadequate or lazy. Third, they point out that rigid thinking also furthers social dominance. Finally, a global aggression toward those outside the mainstream furthers this

ideal**.**

***Submission to authority*.** The chain of command stands as the fundamental structure of the military. At the bottom of the chain of command, the soldier's scope of understanding is more immediate. For example, a soldier may not know why he or she is in a specific location beyond the orders that he or she has been given. From this limited information, it is impossible to gain a full view of the mission. Furthermore, he or she has little authority to influence the situation beyond following orders as they are given. As a soldier traverses up the chain of command, the worlds of recognition and influence grow. As this happens, the soldier ventures farther from the frontlines but maintains influence on those in the lower ranks by handing down orders. Because of this structure, the following of orders is essential to both accomplishing the mission at hand and maintaining the relative safety of those involved. Therefore, submission to authority is an indispensable part of the military and cannot be compromised.

Recognition of how this indispensable facet of the military constitution affects the stigma of entering treatment becomes crucial to understanding stigma at the cultural and individual levels. For example, if the dignity of a soldier at his or her place in the chain of command is seen as more vulnerable because of an action, he or she might shy away from deciding to engage in that action. The core belief that engaging in such an action poses the threat of jeopardizing a soldier's promotional potential, whether genuine or perceived, undoubtedly influences the soldier's decision regarding whether or not to disclose the existence of mental health symptoms.

***Middle-class norms*.** The Army's recruiting tagline from the 1980s, "We get more done by 9:00 AM than most people do all day," sums up the military work ethic. Soldiers take on the tasks appointed to them diligently and work to the best of their ability to succeed. Hard work brings rewards through promotions and esteemed assignments. On the other hand, perceived

laziness or lack of initiative results in punishment with the removal or prevention of these things.

A soldier might believe that anything short of a full performance of his or her duties is the equivalent of lacking initiative. If that soldier considers his or her symptoms to be interfering with the performance of his or her duties, he or she may go to extreme lengths to hide these symptoms out of fear that there will be repercussions. This fear could also lead the soldier to keep from entering treatment, especially if that soldier perceives treatment as a possible means of communicating his or her inability to maintain the proper work ethic to the chain of command.

Rigid thinking. The concept of rigid thinking can be attributed to the military as well as to all large, governmental bodies. Each of the branches under the Department of Defense are broken down into different divisions based on their purposes. These are further broken down into smaller and smaller units for the diffusion and delegation of responsibility. With this rigid structure comes a certain level of rigid thinking. Given that new, unproven ideas are dangerous to employ, change from either direction in the chain of command becomes a long, tedious process. When radical new ideas implemented too soon or too quickly have significant impacts, they often end in disaster. Many changes encounter politically or emotionally charged objections that cause them to be debated from both sides for long periods, slowing the change process.

The military's ongoing rigidity of thinking about whether or not homosexual Americans should be allowed to serve constitutes one of the longest lasting examples of rigid thinking in the military. Slated to train the troops of the American colonies to serve more effectively in the American Revolution, Baron Von Steuben, stood as one of the most promising military minds in Europe. He was released from duty upon the discovery that he was a homosexual, making him the first American service member discharged for homosexuality (Lurie, 2001).

In 1916, the Uniform Code of Military Justice (UCMJ) officially made sodomy a capital

offense. This means that any service member found to be engaging in homosexual activity could be put to death if found guilty by court martial. Between 1941 and 1945, during the American Military's most desperate years of World War II, nearly 10,000 service members received "blue discharges" for being homosexual. During this time, in 1942, orders to military psychiatrists gave instructions to discriminate between homosexual and "normal" troops to discharge them on psychiatric grounds. According to Lurie (2001), the military deemed "unsuitable for military service" those who "habitually or occasionally engaged in homosexual or other perverse sexual practices" (p. 151).

In response to the 1992 murder of Naval Petty Officer Allen Schindler because of his homosexuality, President Clinton enacted a compromise the following year. This guiding principle came to be known as the "Don't ask, don't tell" policy. Under this regulation, military members were no longer allowed to be questioned about their sexual preferences by the chain of command. On the other hand, they were also not allowed to admit to being homosexual (Lurie, 2001). The message was clear: If a service member is gay and wants to serve in the military, he or she will need to hide it from the rest of the culture. The message also translated into another proclamation about stigma in general: If a service member possesses a trait that the military culture finds as compromising his or her ability to serve, he or she must keep it hidden to avoid the tribulations that will ensue if discovered.

Aggression toward those outside mainstream. Rebellion has its places in civilian culture. Protesting and free speech encouraged in communities and college campuses across the nation have no place in military culture. The structure of the military is such that those who rebel will encounter difficulty. These infractions range from disobeying a direct order up to mutiny, which in war time is punishable by death. Being outside the mainstream is not just about infractions and

punishments. In a combat zone, knowing that those around the soldier are willing to put their own lives in danger to protect his or hers is crucial. Therefore, stepping outside the mainstream culture can be a dangerous prospect. As mental illness is seen by the culture as out of the ordinary, a soldier with symptoms of mental illness might be seen as outside of the mainstream. The desire to stay within the mainstream might also influence the soldier's perception of the consequences of admitting to the experience of mental illness.

Admission of symptoms of mental illness may pose a problem for a soldier in that the other members of his or her unit could begin to distance from him or her. This alienation could be devastating both mentally and in terms of safety in the field. Even outside the bounds of the combat zone, a soldier must consider life without the support of his or her comrades in the future. Not only might the soldier be alienated during the active symptoms of mental illness, but there might be animosity toward him or her long after the symptoms have subsided.

Collectively, these four elements of social dominance lead the military culture to be an environment that has the potential to be intolerant of what it considers weak, unfit, or flawed. Those who suffer from mental illness are often included in these categories. Unfortunately, however, the military's engagement in combat presents a paradox. The contradiction is that a culture so potentially intolerant of mental illness engages in active combat: an activity where such symptoms are inevitable. Furthermore, because the culture is so intolerant of such symptoms, the members of the culture who experience mental illness are less likely to admit to or seek treatment for it. By the culture's own logic, the military culture is potentially weakening itself through its own intolerance and misguided attempts at maintaining strength.

Sociological Model

As noted, while the description of the SPM explains what happens to promote stigma in

military culture, the SM explains how its enactment manifests through the language that soldiers use. Proposed by Markowitz (2005), SM developed from sociology's labeling theory. The basic premise of this theory is that objects, including people, have meanings constructed by the society in which they exist. Objects seen as high in value to society are seen as high in value to the person within that society whereas objects of low value have a minimal value to the individual within that society. These meanings are assigned and not always overt. They can differ from one subculture to the next in their level of value. Some objects have the power to influence the person's or culture's behavior; whereas others do not.

Military language. The language of the soldier is extremely unique. From the relentless use of acronyms to the perversion of language into slang, military language whittles down multifaceted and complex ideas into single syllables in the name of conveying a vast amount of information in a short period. Consolidation such as this has its merits, as a combat situation might not lend itself to lengthy explanations. Quick communication of complex ideas might mean the difference between life and death in a combat situation. Furthermore, the use of unique slang adds to unit cohesion through differentiating that unit from others. However, there are other considerations to recognize during this transition. For illustrative purposes, a glossary of OIF/OEF specific terms can be found in Appendix A. This short list is not exhaustive, as many units develop their own slang for people, things, places, and situations, but the intent of the glossary is to give the flavor of some of this slang.

As military language creates, churns, and condenses in the name of conveying more information in less time, it inevitably loses details. An example of this is the term "battle rattle," meaning any gear carried into a combat situation. This could include a soldier's body armor, helmet, ammunition, weapon, boots, clothing, rations, rucksack, knives, dog tags, or any other

element of equipment that could produce noise if not properly secured prior to entering the combat situation. Rather than needing to point out everything listed above, a commander might use the phrase “check your battle rattle” before entering a suspected insurgent area. Quickly deciphered by the soldiers, they carry it out instantly.

The use of simplifying words may also lead to greater confusion or animosity. The use of a word such as “POG” (pronounced like “rouge”) is such an example. The word is an acronym meaning “people other than grunts.” The initial purpose to this word was to communicate that people within a convoy or group were not infantry. In the case of being attacked, these soldiers or civilians would likely need to be protected or instructed in the moment. However, the term POG has developed into a somewhat derogatory term, engulfing anyone who is not infantry. This includes other soldiers who engage in combat such as mechanized troops and air assault troops. It also includes support troops such as chaplains and cooks, civilians such as contractors or visiting politicians, and even upper echelon officers. This wide-ranging category has lost some of its original meaning, making the abbreviation less useful and more confusing if used in its original sense. As it has evolved into a derogatory term, the potential exists for those referred to as “POGs” to be devalued, thus less likely to be protected in an attack.

This also points out another useful facet of understanding military language: the conveyance of a point of view. Military slang reflects attitudes about the described entity, sometimes even when unintended. As long as they have existed, the different branches have had derogatory names for members of the other branches. Among a plethora of different monikers, soldiers are called “pukes,” sailors are referred to as “squids,” Marines are labeled as “jarheads,” and airmen are known as “wing nuts.” Even within the branches, different types of soldiers throw lingual jabs back and forth. Infantry units refer to armored troops as “tread heads” or

"DATs" (Dumb Ass Tankers). Tank drivers refer to infantry soldiers as "speed bumps." Navy engineering personnel call ship's crewmen "deck apes;" while others refer to engineers as "snipes." Although these appear to be derogatory terms, they tend to be used paradoxically as terms of endearment.

Other terms are meant to be more derogatory. Throughout OIF/OEF, the proliferation of a 360-degree frontline has created the need for a focus on the use of forward operating bases (FOBs). Built from some of the characters of J. R. R. Tolkien's *The Hobbit,* who did not display interest in leaving their safe homes in a search for adventure, a "Fobbit" is a derogatory term for a soldier in a support position who rarely leaves the relative safety of the FOB. Those who do leave the FOB on a regular basis, especially to engage in combat, use this term as a way to degrade those who do not. Although FOBs are often hit with mortar attacks or other dangerous scenarios, soldiers minimize these dangers and discarded them through the use of this derogatory term. This is an example of social dominance mentioned above: the valued combat may use such a term to put down a devalued support soldier.

A third consideration in the labeling of people is the idea of dehumanizing or downplaying the individuality of the enemy. Terms such as "Johnny Jihad," "Ali Baba," and "Haji" describe enemy combatants. This de-identification is not new to the American Military. In World War II, American soldiers called German troops "Jerry," and in Vietnam they called the enemy "Charlie." Similar to Vietnam, these derogatory names for Iraqis and Afghans are growing to include not only enemy combatants but also civilians, officials, and even allied troops training to support the country after the war ends.

Language and core beliefs. The expression of language is a key part of the development of both cultural and individual stigma patterns. As previously mentioned, individuals also fall

prey to this labeling. This makes it possible for the individual self to be an object and for the value of that individual self to be heavily influenced by how culture sees it, or at least how the individual perceives the culture's value of them. The desired effect of placing this label on the person is to communicate specific information about that person. In doing so, this communication also brings with it a certain level of meaning. This meaning also creates an emotional response about the person labeled. If the label is seen as positive, the emotional response is likely to be positive. If the label is negative, it is likely to be negative. Either way, core beliefs about the labeled entity build upon the label and the connotations that come with it.

It stands to reason that a highly valued label in society, for example "intelligent," would evoke a positive appraisal by both the labeled person and those who agree with the label. In both, the acceptance of this label would likely be followed by a positive emotional response. This may also cause the person to behave accordingly, such as pursuing higher educational goals or entering a profession that society values. On the other hand, a negative label, such as "crazy," could have the opposite effect. Because society devalues the mentally ill, someone given this label may have a devalued sense of self. Others who accept this label might also devalue him or her. He or she may also act accordingly while trying to live up to the label given (Markowitz, 2005).

In a military setting, these labels come in the form of comments, reports, and orders. The role identities of "strong soldier" and "weak soldier" offer two options regarding the expectations of the society. They also offer two sets of values for self-appraisal by the person carrying those labels. A "strong soldier" might do anything within his or her power to maintain that label from the military society. Because mental illness is seen as a deviation from the norm, thus giving it a negative connotation, it might be seen as a means of passage from positive to

negative. It stands to reason this belief could cause a "strong soldier" who begins experiencing symptoms of PTSD or clinical depression to hide these symptoms for fear of taking on the identity of "weak soldier." The example in the preface illustrates that this can also take place simply from the act of seeking a mental health intervention, even without other overt symptoms. Here, the label "bad Marine" replaced the label "good Marine" simply because he sought to alleviate symptoms. This single-syllable change made the world of difference in his self-perception and greatly influenced his decision to discontinue treatment.

Once labeled as "bad," "deviant," or "weak" a soldier may begin to act out that identity, causing it to become even truer. Markowitz (2005) explains that one often lives out the roles that society provides to fulfill the expectations of that society or culture. This can activate a cycle of "bad" actions followed by "bad" perceptions that lead back and forth, causing a downward spiraling effect. This also can be seen in the story in the preface. Gamal's inhibitions of what constituted acceptable behavior dropped as he lived into the role of the "bad" Marine. He began an affair with an enlisted Marine, drank heavily, and acted upon his desire to be killed in battle by volunteering for increasingly dangerous assignments. Conceding his values, though also caused by the desire to escape mental pain, eventually led to the end of his military career, which proved him to be the ultimate "bad Marine."

Corrigan and Kleinlein (2005) explain that the moniker "deviant" also leads others to see the person within that role. In the case described in the preface, the commanding officer's opinion of Gamal's decision to take anti-depressants as being weakness undoubtedly followed Gamal throughout the rest of his career. The labels that this commander might have used would not have reflected the decision, but rather just the opinion of it. Furthermore, the punishment of separation from the Marine Corps under less than honorable conditions creates another "deviant"

label; one that he will carry the rest of his life. Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) explain that members of the public also discriminate against those with such a label, even without the presence of abnormal behavior or even a full understanding of the cause of such a label. Furthermore, when symptoms of mental illness diminish and abnormal behavior disappears, the label does not necessarily disappear with them. Discriminative labels can follow a person indefinitely, long after the symptoms for which the label originated are gone.

One of the chief reasons service members avoid coming to therapy is the avoidance of labels such as "mental patient," "weak," or "dishonored." Corrigan and Kleinlein (2005) point out that, even when people do come into treatment, they often have problems engaging in therapy because they have carried the label with them for so long that they believe that they are not worthy of receiving help or cannot become "normal." The individual may also believe that a therapist is powerless to help him or her given the labels that have been attributed to him or her over the years. When therapy does not instantly remove all suffering, many clients see this as confirming their biases and stop coming to treatment. Unfortunately, this also prevents many of them from seeking other treatment in the future, as this failure has simply proven the core beliefs built by the various labels to be true.

Summary

In summary, the culture of the military affects the core beliefs of its individual soldiers through shaping what is acceptable and unacceptable within that culture. Through the different means of information conveyance, the message to soldiers is that certain traits, behaviors, reactions, and identities are of lower value than others. To maintain higher value, the soldier must distance himself or herself from the stigmatized entity. One manifestation of this is the

perception that experiencing mental illness symptoms is synonymous with being weak, dishonored, or abnormal and that this devalues them as a soldier.

As mentioned in the introduction, the flavor of this application of the integrative lens recognizes a single direction of effect. It is important to recognize that the interaction between culture and the individual is bidirectional. Although it appears that culture forces its will upon the individual, the individual or groups of individuals within the culture do have the power to change the culture. An example of this is the creation of slang mentioned above. As the individual soldier and units within the overall culture engage in the military's mission, they alter the culture by defining how it views certain entities, people, and situations. This recognition may be imperative to changing military culture in a way that reduces stigmatizing beliefs about mental illness. The following chapter describes how the cultural influences on the core beliefs of the soldier might affect the individual stigmatization of seeking psychological treatment.

Chapter 4: The Soldier's Self-stigma

In his book, *War and the Soul,* Edward Tick (2005) describes the process by which a man or a woman becomes a warrior. He points out that the term "warpath" has been misused in American culture for centuries. He states that being on a warpath means going through the process of becoming a warrior. It begins with the decision to become a warrior, which leads to putting that decision into action. In the modern military, two major rites of passage are also involved between entrance and discharge: the stripping of one's identity during basic training and the loss of innocence at exposure to the threat of death.

Arrival at basic training for enlisted members or induction into a military academy or Reserve Officer Training Corps for officers constitutes the first step of becoming a warrior. This step includes the stripping of the prior individual identity to allow the person to take on the identity of the soldier. Physically, this comes in the form of removal of civilian clothing and issuing of uniforms, shaving of men's heads, cutting of women's hair to regulation length and style, and marching in formation for endless hours in all weather. The message is clear: the soldier no longer exists as an individual but as a piece of a larger entity.

Mentally and emotionally, the new recruit also begins to change. New recruits quickly recognize that they can no longer live for themselves, but that existence itself is for the sole purpose to uphold the integrity of the group. Classes are held informing the soldier what to think, how to think, and what is and is not acceptable within the bounds of this new collective identity. Speeches by chaplains influence the soldier's core beliefs on topics such as racism, safety, unprotected sex, and the responsibility that accompanies offering one's life in service of his or her country. Wielded to diminish individualism and build unity, symbolic language involving courage, honor, commitment, duty, and country abound. Shortcomings such as weakness,

self-centeredness, disobedience, and lethargy take on negative connotations, conditioning the soldier further in understanding that he or she is no longer an individual.

The removal of individual identity is not for malicious gain. It becomes essential for the members of the military to lose their individualism to become an integral part of a team. Furthermore, this removal of individual identity does not necessarily leave a gaping hole within the person. Ideally, the soldier begins to assimilate a new, communal identity, and his or her new identity of being a warrior grows. As this transition takes place, the soldier draws from these influences to create and expand core beliefs. For those who do not adapt to this change, becoming a warrior is a painful and dysfunctional process, and serving often becomes a burden.

In terms of the stigma associated with seeking treatment, many of the forces that influence the soldier to stereotype treatment are not intended to do so. Rather, it is the individual's interpretation of what makes a soldier "weak" or "flawed" that enacts individual stigma. If weakness is not associated with mental illness, there will be little or no stigma, but if it is seen as weakness, which is an unacceptable value to the warrior, stigma will exist on higher levels. For example, if two soldiers leave the frontlines because of inability to perform their duty, they may be seen differently. If the first has a broken leg, which he or she perceives as an injury rather than a flaw, that soldier will undoubtedly enter treatment to be returned to full capacity. However, if the soldier leaves the front because of symptoms of mental illness, such as depression, anxiety, or psychosis, and these symptoms are seen as flaws rather than injuries, the soldier may attempt to minimize them and avoid treatment. On the contrary, if the second soldier's symptoms are seen as injuries from engaging in the unit's mission, stigma will not play as much of a factor in his or her decision to enter treatment.

Cognitive-behavioral Model

This chapter includes the application of the third element of the integrative lens: the Cognitive-behavioral Model (CBM). Applying the CBM involves the use of discriminative stimuli leading to cognitive mediators that evoke emotionality and incite behavior. Doing so allows a forum for understanding the process through which individuals use core beliefs to shape thoughts, feelings, and behaviors. The CBM describes how one's thoughts on a certain situation elicit the feelings or emotions that the person experiences and ultimately influences his or her behavior. These thoughts, known as automatic thoughts, happen so quickly that many consider them to be instant. Automatic thoughts build from core beliefs developed over a lifetime of interactions with the world. With these core beliefs being the ultimate target for change in cognitive-behavioral therapy, it is understandable that they hold immense sway over maladaptive thought, feeling, and behavior cycles. The cycle of stigma is no different. Therefore, it is essential that the core beliefs that produce the stigma of seeking treatment be targeted for change if this stigma is to be reduced.

Components of the CBM include stereotype, prejudice, and discrimination. Discriminative stimuli exist in the form of signals from either the external world or from within the person who acts as the stigmatized object (including the self). An example of this is a soldier suffering from depression who is understood to be lethargic or lazy. Next, cognitive mediation comes in the form of stereotypes. The stereotype in this case may be that lazy soldiers are worthless. In the next part of the cycle, an emotional reaction to either the acceptance or rejection of the stereotype may occur. If the soldier rejects the idea that all lazy soldiers are worthless, he or she avoids stigma. However, if he or she does endorse the stereotype, an emotional reaction is likely to follow. In this case, it may be that of disgust or anger. Finally, the behavior component

of the model comes in the form of discrimination. This is a behavioral response to the acceptance of the stereotype and may take the form of passive or active action against the stigmatized entity (Corrigan & Kleinlein, 2005).

Stereotypes. As mentioned above, stereotypes are categorizations that created from the knowledge that one accumulates throughout life. These thoughts have the potential to evoke emotions and cause behaviors. Although stereotypes have a negative connotation because of the tendency to generalize complex entities based on arbitrary factors, in their purest form they are often helpful and allow people to get through life. Stereotypes in and of themselves are relatively harmless until either endorsed or discarded. Recall that most people have encountered the stereotype that *all* persons with mental illnesses are dangerous at one time or another. The difference in this stereotype's effectiveness lies in the decision about whether or not the stereotype is true.

From the example above, the stereotype "lazy soldiers are worthless" had no power until it was accepted. Once accepted, however, the person who accepted it is likely to have experienced an emotional reaction. The prejudice that follows may be a powerful emotional reaction such as disgust, anger, or spite, which could lead to avoidance or other negative behaviors toward that person (Corrigan & Kleinlein, 2005).

Prejudice. As mentioned, prejudice is the acceptance or denial of a stereotype. This comes with the acceptance or denial of two basic ideas. First, is whether the person, thing, or idea falls into a stereotype. For example, the depressed soldier in the example might not be seen as lazy. The perception might be that he or she is resting after a particularly hard mission or, more accurately, as experiencing depressive symptoms. If the perception of the person is not such that he or she falls into the category, the cycle stops. When the decision is made that he or

she does fall into the category (e.g. the soldier is lazy), the person considers whether or not the stereotype is true. The acceptance of the stereotype as true or not dictates the response to it. This acceptance or denial also evokes a certain emotional response (e.g. fear, disgust, anger). These are often strong and can influence the decision-making process heavily (Corrigan & Kleinlein, 2005). To continue the example, if the perception of the soldier is *lazy*, the question becomes whether or not *lazy soldiers are worthless*. If accepted, the emotional reactions of disgust or anger are likely to follow. It is important to note that such a reaction aimed at the self can produce negative self-perceptions such as helplessness, hopelessness, and worthlessness often associated with depression, and are known as risk factors for suicidal ideation.

Discrimination. When one acts upon these stereotypes and prejudices, stigma becomes outwardly problematic and leads to the third and most destructive part of stigma. Discrimination is an action against a person or group because of an association with the stigmatized category. Discrimination is the behavior produced by the thoughts and emotions that preclude it. Corrigan and Kleinlein (2005) describe discrimination as the behavioral reaction to prejudice.

For example, if a stereotype describes the mentally ill soldier as *lazy* and states that *lazy soldiers are worthless*, and the person agrees with the stereotype and experiences anger or disgust, the logical result involves negative behaviors toward that soldier. The soldier may find himself or herself relieved of duty, passed over for advancement, or even removed from the military altogether. Again, this is a place in the equation in which overly generalizing one's prejudices to equal that of a stereotype is a harmful and anti-productive pursuit that leads to the exclusion of people from situations based on arbitrary perceptions (Corey, 2005; Corrigan & Kleinlein, 2005).

Summary

As a soldier progresses through the path of the warrior, he or she finds that much of his or her individual identity has been replaced with a collective identity. As the warrior exchanges this autonomous self to become part of the larger entity of the military, the consideration of personal wants and needs become secondary to that of the group. The influences of the military culture upon core beliefs mentioned in the previous chapter produce stereotypes. When the soldier accepts stereotypes involving negative reactions to the idea of entering therapy, strong emotional prejudices are likely to follow. This cycle may culminate in active discrimination against seeking treatment or negative behaviors against those who do enter therapy. Repetition of this cycle is also likely to reinforce the core beliefs that feed treatment stigma.

Chapter 5: Strategies to Reduce Treatment Stigma

Viewed through the integrative lens, the stigma of soldiers toward seeking mental health treatment involves a complex array of factors. As the creation and maintenance of treatment stigma has so many factors, the tactics and strategies that yield successful intervention strategies must take these factors into account. This chapter describes three cultural strategies implemented with the intention to dispel cultural stigma. The chapter concludes with a description of the use of empowerment as an intervention for individual stigma.

Cultural Interventions

Watson and Corrigan (2005) describe three intervention strategies for lessening the cultural stigma of mental illness and seeking treatment: protest, education, and contact. Each of these strategies brings with it a different level of investment as well as different results. Generally recognized as the least effective, the protest strategy tends to carry with it less investment by the intervening party. The strategy of providing education for a stigmatizing culture yields more positive results but involves great investment of both money and time. The strategy that encourages direct contact between those who stigmatize and members of the stigmatized population typically gives the highest level of reduction of stigma, but the logistics of providing that contact is often expensive and in the case of the military may prove to be dangerous.

Protest. The protest strategy of stigma reduction involves the use of moral appeal to dissuade people from thinking a certain way with the hope that they will assimilate to the protester's line of thinking. Contrary to the label placed on it, the protest strategy does not necessarily entail a band of people chanting and holding picket signs, though outside the military, this form is popular. Protest strategy attempts to make an appeal to change values to

what could or should be seen as morally correct. Often it uses a "shame on you" attitude and portrays what "should be done" in the hopes that those targeted by the protest will recognize the flaws in their ideals. Other times, it uses symbolism and language aimed at stirring strong emotions within the person to which the message can attach itself (Watson & Corrigan, 2005).

A downside to the protest strategy of change is its relatively short half-life. Although the use of protest can sometimes grasp the masses of a culture in a powerful way, these effects tend to be temporary. Wielding slogans and images aimed at stirring powerful emotional responses can also backfire drastically. Resistance such as "I believe differently" or "who are you to tell me how to think" can develop into negative reactivity. This reactivity, for example as "I will not allow you to change my mind," simply entrenches the beliefs, causing them to be stronger. Another serious problem with the protest strategy of stigma reduction is that it can find its way into the other two strategies. If enacted from the motivational standpoint of taking the moral high ground against those who engage in stigmatizing behaviors, the embodiment of the education or contact strategies could create the same stigma-entrenching reactions (Watson & Corrigan, 2005).

The military manifestation of this strategy typically involves coupling with the education strategy. Educational media, such as videos, shown during stand down trainings often involves the use of emotion-driven symbolism. For example, a video designed to educate troops about suicide while deployed may begin by zooming out from an American flag while the background music plays "My Country 'Tis of Thee" and the announcer speaks about how it is the duty of the soldier to be safe. Although many of the soldiers who watch such a video may feel a burst of patriotic pride while watching the video, this does not mean that it will continue into the desired action of avoiding suicide. Some may even find such a ploy to be manipulative.

Education. The strategy of education is the most employed strategy for cultural stigma reduction. This is because it finds a balance between effectiveness and cost. Contrary to the protest strategy's tactic of making a moral appeal to change the minds of those enacting stigma, the education strategy looks to provide information and allow the target audience to recognize discrepancies in logic on their own. The education strategy attempts to replace inaccurate stereotypes with more accurate information, providing more complete and comprehensive details about the stigmatized group, and contrasting myths with these facts. Invited rather than pressured by the offering of information, those who engage in stigmatizing behaviors come to see a viewpoint different from their own (Watson & Corrigan, 2005).

The manifestation of the education strategy in the military comes in the form of stand downs and trainings. Information sanctioned by the chain of command passes down through the ranks and presents on many levels to deal with different problems or to head off potential tribulations in the future. For example, during basic training, many forms of education inform troops. Chaplains often provide company-sized preventative trainings on racism, and medical officers give graphic lectures on maintaining one's medical health and safety. Prior to leaving for deployments to Iraq and Afghanistan, soldiers attend pre-mobilization events where they receive an education on what to expect on deployment. After returning from a deployment, these soldiers attend post-mobilization events where debriefing about such topics as recognizing mental illness symptoms and reintegrating into society occur.

Several limitations to the education strategy of stigma reduction exist. First, the tone of the education must remain free of moral bias. Otherwise, the distribution of information used to "prove" the moral standpoint taken in the protest strategy becomes lost. Doing so is not the education strategy, but a perversion aimed at making the protest strategy appear more legitimate.

The disadvantage of using education in this way is that the strategy becomes susceptible to the resistance mentioned above. Those targeted for stigma reduction may feel manipulated by the strategy and react with resistance. If such resistance includes the reaction of not wanting to be told how to think, stigma might become more entrenched and harder to reduce in the future. For example, a training video that ends by protesting to soldiers how to think on the subject of stigma of mental health may be met with resistance as mentioned above (Watson & Corrigan, 2005).

Because the education strategy involves leading the proverbial "horse to water," one still cannot make the horse drink. What this means in the context of using education as a strategy for the reduction of stigma is that it becomes extremely difficult to teach a culture something that they perceive to already know. Less attention might be paid to the information if the person receiving it perceives it as something of which he or she is already aware (Watson & Corrigan, 2005).

Contact. The strategy that appears to yield the greatest level of success and the longest lasting effects is that of direct contact (Watson & Corrigan, 2005). In implementing this strategy, those who stigmatize a population are put into situations in which they come into direct contact with members of the stigmatized population. This interpersonal contact, if properly executed, allows for the dispelling of stigma through the recognition that prior stereotypes are not supported.

Considered one of the classic studies on enacted stigma and prejudice, Allport (1979) outlines four elements that the employment of the contact strategy for stigma reduction should include for optimal effectiveness. First, he states that equal status must exist between groups. In other words, neither the stigmatizing or stigmatized group can be in a position in which they are submissive to the other group. Allport notes that this is fundamentally different from other

relationships where a power differential must exist. He uses the examples of employer-employee and doctor-patient relationships as not being appropriate as there is a distinct power differential between those involved. Next, Allport states that the two groups must share a common goal or goals. In order for true contact to happen, members of the two groups have to work together to achieve a common goal, such as solving a problem or working together to accomplish a task. It is important that during this interaction, the members work together and are not segregated. Segregation could cause the problem that constitutes Allport's third point, which is the removal of competition. He points out that competition between the two entities would be likely to drive stigma, rather than lessen it. He states that the tone of the contact should be that of a concerted effort where members of both the stigmatizing and stigmatized group must rely on each other. Allport's final point is that the interaction above must be done under a common authority. In other words, sanctioning by an authority to which members of both entities subscribe must occur. This sponsorship from above offers both parties a common bond and a shared interest in the outcome of the contact.

Although Allport (1979) describes contact as direct exposure between those stigmatizing and those being stigmatized, such a feat would prove to be unsafe for many reasons in an active theater of war. However, a surrogate for those being stigmatized could include mental health professionals that could work and serve alongside soldiers in the field. The Marine Corps' Operational Stress Control and Readiness (OSCAR) program involves such contact. The program embeds Marine officers who are trained as mental health providers into infantry units to make treatment situations commonplace and dispel treatment stigma. Further information on this program and others provided by all branches of the military are available in Appendix B.

As mentioned above, direct contact proves to be the most effective of the strategies for lessening stigma. The major hurdle to its implementation is that it tends to be impractical to create a situation in which all four elements mentioned above are present, yet the members of both parties become invested in the outcome if done correctly.

Individual Intervention

With the vast size of the military, individual intervention for the reduction of stigma presents a problem. Because the nature of self-stigma prevents the individual from seeking intervention, such an endeavor would need to be enacted by the soldier, rather than those doing the intervention. If those hosting the intervention were to attempt to reach out, such an action would need to envelop all members of the military to be completely effective. Therefore, cultural interventions could act as baseline tools for promoting stigma reduction. However, strategic placement of individual interventions for stigma-vulnerable soldiers could supplement the cultural interventions. Such places may include chaplains' offices, medical facilities, legal departments, and psychiatric settings. Although the same basic strategies of protest, education, and contact used for cultural intervention would still be employed, one other element is crucial to individual intervention: empowerment.

Although the relationship between cultural stigma and the individual's stigma is bi-directional, the cultural influences on stigma are numerous and of a powerful nature. Much of the influence on self-stigma comes from strong emotional reactions to how that individual is seen by the culture and its members. The soldier may feel trapped by these forces and powerless to challenge them. Watson and River (2005) write that the most important facet to lessening self-stigma in the individual is the fostering of empowerment. Watson and River believe that empowerment is the opposite of self-stigma and that self-stigma robs the person of the power to

act on his or her own behalf.

Higher levels of empowerment are not only associated with higher levels of seeking treatment but with higher levels of success in that treatment (Anthony, 2000). Fostering empowerment that leads to greater recovery involves providing more choices. Anthony points out that "recovery demands that a person has choices" and states that "the notion that one has options from which to choose is often more important than the particular option one initially selects" (p. 164). He reasons that this happens because the person who has choices perceives himself or herself to be more in control of his or her own fate. From this perception builds the initiative to engage in treatment for the sake of improving.

The following example displays how a soldier may navigate the strategic placement of information about choices aimed at empowering him. A combat soldier who has spent several months in the mountains of Afghanistan returns to a FOB that houses medical, legal, spiritual, and psychological services. During his time in the mountains, he contracted a medical condition and had become injured. He fought through the pain of these ailments for the second half of his time out, but spent the entire time in mental torment about his impending divorce upon returning home. As the weeks wore on, he realized that his sleep had dwindled and that he was not eating all of his rations. Any time not spent actively engaged with his unit was spent alone. He no longer railed about his belief in the political motivations for their presence in the country as he used to because he was just no longer interested. When he thought of his impending divorce and the possibility of no longer seeing his daughter when he went home, the soldier found a secluded spot so that his comrades would not see him cry.

Upon arrival at the FOB, the soldier planned to go to medical. His medical condition and injury were beginning to affect his performance, so they were of the highest priority. As the

medical doctor treated him, she asked him about symptoms of depression, which he endorsed. She explained that the chaplain and psychology department offered a plethora of services and explained what each entailed. He thanked her and went to the legal department to tend to his impending divorce. The clerk, trained to do so, mentioned that soldiers dealing with such things as divorce are encouraged to encounter some form of intervention because of the high rate of depression. He also said that many soldiers choose not to do so because of the perception of others, but that this sometimes led to worsening symptoms leading to problems in the field. Still, the legal clerk gave him information on medical interventions, the chaplain, the psychology department, and a support group for deployed soldiers encountering divorce.

As the soldier walked out of the legal outpost, he considered the clerks comments and how much his spirituality had suffered since his arrival in Afghanistan. He decided that going to the chaplain for his counsel would benefit him. During his interaction with the chaplain, he explained his depressive symptoms. Again, the chaplain provided options available to the soldier: medication, counseling, individual therapy, group therapy, and support groups. He also emphasized to the soldier that the decision to engage in any of these interventions was his. Because the soldier was presented with different treatment options and reminded that he also had the option not to engage in any of the treatments, his level of empowerment rose. He found himself in control, making it easier to choose one of these interventions.

Summary

The use of the strategies of protest, education, and contact for the reduction of cultural stigma becomes a balancing act between practicality, level of expense, and effectiveness. Possible negative reactions are also considerations in the decision of which of these strategies to use for a specific population, setting, or problem. Protest appears to involve the lowest levels of

cost but houses the potential to backfire if the person receiving the message rejects it. Use of this strategy can cause that person to be more entrenched in his or her prior beliefs, causing future intervention to be harder. Education, as the next chapter will describe in further detail, is typically the chosen strategy of stigma-reduction in the military. This is due to its avoidance of protest's dangers as well as the cost and practicality issues of the contact strategy. Direct contact displays promising results, but it is both expensive and often unpractical.

Chapter 6: Future Directions and Conclusion

The purposes of creating an integrative conceptual lens for understanding treatment stigma include providing a foundation for future research, influencing current interventions, informing treatment, and affecting public policy. With these purposes in mind, this chapter will discuss the implications for the uses of the lens.

Future Directions

The integrative lens purposely took on a general tone so that its usefulness could cross multiple cultural contexts, systems, groups, and populations both within and outside of the military. This chapter is not an exhaustive list of possibilities. In fact, it is possible that some of the populations for which this lens may be applied in the future do not yet exist. As the world evolves and specific cultures and subcultures arise, the generalist nature of this lens will allow it to be used across multiple settings, with different populations, and for a multitude of specific psychiatric disorders.

Settings. Although this project applied the integrative lens to members of the military, its global nature allows for generalization to other settings. Prisons could benefit from using this lens because of the high rate of stigma attached to appearing weak to other inmates. Another setting in which cultural stigma and individual stigma might combine to prevent the individual from seeking treatment is that of emergency personnel. Emergency medical technicians, police officers, and fire fighters all live within a specific sub-culture and work in jobs that involve exposure to high stress situations and trauma. The application of the integrative lens in these settings could help to understand how the cultural values of the settings affect the individual's personal stigma of seeking treatment. This knowledge could influence public policy that would help to alleviate these effects, increasing the chance of treatment the individuals in these settings.

Populations. Although the integrative lens has been used to view treatment stigma in OIF/OEF veterans in this dissertation project, the nature of the lens allows its utilization across many populations, both within and outside of the military. Specific populations in which the lens could be most useful include those most vulnerable to symptoms of mental illness and those most likely to be motivated to prevent disclosure of these symptoms. However, the population needs might dictate specific parameters that arise in the future.

For example, the descriptions of current interventions listed in the last chapter placed an emphasis on suicide prevention. Because suicide rates among those who served in Iraq and Afghanistan remain high, this issue warrants specific attention. As this may not always be the most important issue, future research, public policy, and intervention strategies may need to adjust specifically to the needs of future soldiers. What this lens could provide in this case would be an understanding of the cultural context and individual factors that led to the soldier avoiding psychological treatment. This information would add a deeper understanding of the soldier's struggle and help the developers of future stigma-reducing programs to design more effective means of intervention for future soldiers likely to confront the same plight.

Diagnoses. As with different populations, different symptoms carry distinctly different flavors for the study of treatment stigma. Future directions in research, public policy, and intervention could include placing the specific symptomology patterns associated with specific diagnoses within each population. The global integrative lens produced during the creation of this dissertation forms a foundation upon which future treatment stigma research can attain understanding. However, adding a specific set of symptoms to a specific population within a specific culture would produce much finer brush strokes for the understanding of the plight of that specific group of people. That information will help build more effective strategies for both

treatment stigma reduction and treatment.

As the basis for psychiatric diagnosis undergoes new changes with the highly anticipated fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), the importance of understanding the nuances of stigma in terms of specific diagnoses becomes more crucial. With each diagnosis perceived differently by members of different cultures, the concept of treatment stigma becomes more complex.

In future applications, the integrative lens can focus on the stigma of seeking treatment by members of a specific culture, in a specific setting, and regarding a specific diagnosis. Understanding such pinpoint information could inform specialized interventions aimed at reducing stigma. Hopefully, this knowledge will also inform public policy in ways that will prevent or diminish stigma as well as inform current practitioners of what role stigma affects the treatment of clients.

Conclusion

Military life is not an easy prospect. Stress, ranging from the physical demands of service to rigors of placing oneself in mortal danger, houses the potential to affect the soldier's psychological well-being. At the same time, cultural and internal forces combine in an attempt to dissuade the affected soldier from seeking treatment that would alleviate some of the effects of this stress. The purpose of this avoidance stems from a desire to project strength, both to the self and to others.

Stigma is a powerful force that has the potential to prevent those who need treatment from considering it as an option. The study of the stigma of seeking mental health treatment is a complex, but necessary endeavor for the improvement of the lives of those who are avoiding treatment because of its influences. Because both cultural and individual factors feed stigma's

power over the decision-making process, the strategies for understanding stigma and intervening to alleviate its effects must be equally complex.

The integrative lens formulated and applied to the military culture and the individual soldier in this dissertation project provides a glimpse into the stigmatization of mental illness in the military. This project takes a step in the direction of understanding the influences of stigma. As the integrative lens is applied and study shifts to more specific populations, settings, and problems, it will undoubtedly evolve to integrate new and different ways of understanding treatment stigma and the forces that create and support it.

Upon donning the identity of a warrior, changes occur within the soldier. Elements such as misattribution of affect, "Just World Thinking," and social dominance, exercised through classical conditioning and the use of labels, transform the soldier's core beliefs. Many of these core beliefs are essential for the success of the mission of the military, but some of them stand to promote the stigmatization of the mentally ill and the idea of entering treatment for mental illness. Once established, those core beliefs affect the soldier's thoughts, emotions, and behaviors in the form of stereotypes, prejudices, and discriminations. This dissertation project centered on a single discrimination: the avoidance of mental health treatment.

Several strategies discussed in this dissertation outlined possible ways to prevent and negate cultural stigma. The use of protest, education, and direct contact were shown to each have certain values as well as certain costs. Although the protest strategy was shown to have short-term effects, the education and contact strategies appeared to be feasible for the reduction of cultural stigma in the military culture. The project displayed the usefulness of offering multiple choices as a means to encourage empowerment for the self-stigmatized soldier. Different programs that employ these two strategies were also listed and analyzed. The resulting

commentary showed that each military branch has made strides in countering treatment stigma's effects.

The project listed future applications of the integrative lens and the stigma reducing strategies across a broad spectrum of cultural settings, populations, and diagnoses. This specific information could lead to better understanding of a culture's stigma patterns at both the macro and micro levels. Hopefully, this understanding of treatment stigma will help inform the various mechanisms in place for stigma reduction. The appreciation of treatment stigma from the viewpoint of the soldier regarding its cultural and individual influences is crucial to reducing it. The application of the integrative lens provides a view of influences such as misattribution of affect, just world thinking, social dominance, and the use of language on the soldier's core beliefs about mental illness. The integrative lens also displays how the individual translates these core beliefs into thoughts, emotions, and behaviors. This knowledge is a stable foundation for the evaluation of current interventions, the planning of future interventions and research, and the enactment of public policy aimed at alleviating the cultural and individual mechanisms that propagate treatment stigma.

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Appendix A

Glossary of OIF/OEF Specific Slang

Afghanization	Afghan-led development, often refers to the training of Afghan soldiers and police to take over security responsibility from foreign troops.
Air jockey	Fighter pilot or a fixed-wing pilot. On rare occasions, might refer to a helicopter pilot.
Ali Baba	Slang for enemy forces. (Actually originated in the Persian Gulf War).
Angel	**A** soldier killed in combat, used among some US medical personnel as a euphemism for KIA.
Back in the World	Back in the United States, as they remember it. An expression that actually began in the Vietnam War, it denotes that from the warzone, home feels like a different planet.
Battle rattle	Slang for combat gear. "Full battle rattle" means wearing and carrying everything (helmet, body armor, weapons).
Beltway clerk	A derisive term for a Washington political operative or civilian politician.
Blackwater	Specifically, a private security firm operating in Iraq. Used as slang, can mean any private security firm. "Gone to Blackwater" indicates that a soldier quit the armed services and went to work for a private security firm.
Bombaconda	Slang for Logistics Support Area Anaconda, a major supply base near Balad, Iraq. Balad is also called "Mortaritaville."
Casper	Slang for someone who always disappears when there's work to be done.
Echelons Above Reality	Higher headquarters where no one has an idea about what is really happening.
Fobbit	Derogatory term for soldiers who never leave an FOB (Forward Operations Base).
Geardo	Derogatory term for the soldier who has to have all the latest and greatest gear on his uniform, even though he does not know how to use it.
Groundhog Day	Every day of your tour in Iraq.

Grunt-proof	Unbreakable, resistant to being done or used incorrectly, idiot-proof.
Haji	Derogatory slang for an Iraqi or Afghani, but may mean any Middle Easterner who hails from a predominantly Muslim country.
Haji Armor	Improvised armor, installed by troops hiring Iraqis to update the vehicles by welding any available metal to the sides of Humvees
Haji Mart or Haji shop	Any small store operated by Iraqis to sell small items to Americans. Frequently found near the PX, the "Haji" shop would sell everything from cigarettes to knockoff sunglasses to pirated DVDs.
Haji patrol	1: An escort detail involving protecting one or multiple locals 2: Local National unit is also referred to as the Haji patrol, with all the projects that are being performed by the local nationals.
Idiot stick	Slang for an M16 (or any weapon).
Johnny Jihad	Slang for a Muslim or Muslim combatant.
Mookie	Nickname for Iraqi Shiite leader Muqtada Sadr.
Oz	Australia. Hence "Ozzies" — Australians.
POG	People Other than Grunts. Pronounced like "rogue." Used by grunts as a derogatory word for everyone else.
PUC	Person Under Custody, this term replaces POW. (Pronounced like “puke”)
Red Zone	The area outside the Green Zone. "Haifa Street" is a main drag in the Red Zone.
RUMINT	Rumor level intelligence. A variant is BOGINT — bogus intelligence.
Rummy's Dummies	A derogatory name for the U.S. military under the leadership of former Secretary of Defense Donald H. Rumsfeld.
Semper I	Pejorative Marine lingo for being overly concerned with one's own personal interests.
Single-digit midget	A member of the armed services who has nine days or less remaining on his tour of duty.
Slackman	Nickname for the team heavy machine-gunner (Typically carrying the Squad Automatic Weapon (SAW) machine gun). The name comes from

	the American Idiom “taking up the slack.”
Speed bumps	A tanker's derogatory term for infantry soldiers. Operation Desert Storm-era slang still occasionally used.
Tread head	A soldier serving in an armor (tank) or armored cavalry (armored recon) unit.
Waxed	To get hit hard or get killed.

Appendix B: Suicide-focused Stigma Lessening Programs Currently Used by the Military

Derived from: Ramchand, R., Acosta, J., Burns, R.M., Jaycox, L.H., Pernin, C.G. (2011). *The war within: Preventing suicide in the U.S. Military.* Santa Monica, CA: Rand Corporation.

Branch	Program Name	Description	Evaluation
Army	Army Suicide Prevention Program	Mandatory training for the prevention of suicide, required for all soldiers Goal: minimize suicidal behavior among soldiers Strategy: Targeted Outcomes: Learn coping skills, encourage help-seeking behavior, lower stigma of seeking treatment, conduct suicide investigations	No Data Available
	Three-part Training	Annual training using existing training resources Goal: Booster to other suicide prevention programs Strategy: Education Targeted Outcomes: Understand risk factors, recognize warning signs, learn how to intervene, reduce overall suicidal behavior	No Data Available
	Strong Bonds	Chaplain-led weekend retreats for returning deployed troops, spouses, and families Goal: Stronger family and community bonds to encourage holistic healing and restoration Strategy: Education Targeted Outcomes: Foster resilience, build stronger family relationships, connect soldiers to community health systems	Multiple University-based evaluations in progress
	Ask, Care, Escort	Relies heavily on the "Battle Buddy" system, Peer-led interventions by trained NCOs Goal: Implement platoon-based prevention and intervention Strategy: Education Targeted Outcomes: symptom recognition, reduce stigma, increase confidence to ask / tell others about suicidal ideation, encourage contact to chaplains, chain of command, or behavioral health provider	Reviewed by three suicide prevention experts; found to meet accuracy and safety standards

Branch	Program Name	Description	Evaluation
	Army Resiliency Training (formerly known as the BATTLEMIND program)	What to expect on and after deployment is trained using multimedia curriculum Goal: Greater resilience to stresses of deployment Strategy: Education Targeted Outcomes: Increased mental preparedness for deployment, reduce PTSD, depression, sleep problems, and reduce the stigma of seeking treatment	3 random-ized controlled studies found fewer MH symptoms in theater
Navy	Annual Suicide-prevention training	General Military Training (GMT) required of all sailors via multimedia presentation Goal: Educate sailors on warning signs and risk factors of suicide Strategy: Education Targeted Outcomes: Recognize risk factors, warning signs, and protective factors; Sailors understand available resources and how to get assistance	Assessed to have overall self-efficacy, knowledge, and compliance
	Command Level Prevention Program	Different commands are required to create and implement tailored intervention plan Goal: Suicide prevention Strategy: Education Targeted Outcomes: Develop standard operating procedures for suicide prevention training & response	No Data Available
	Reserve Psychological Health Outreach Program	Provides operational stress control awareness and clinical assessments requested by reserve units Goal: Recognize MH needs and implement interventions Strategy: Education Targeted Outcomes: Identify MH needs, ensure those reservists receive care, mitigate impact of completed suicide on the affected command	No Data Available

Branch	Program Name	Description	Evaluation
	Operational Stress Control	Provides training about the effects of stress for sailors, leaders, and families Goal: Making sailors and families aware of stress and provide counseling Strategy: Education Targeted Outcomes: Address stress through training about its effects and available interventions	No Data Available
Air Force	Landing Gear	Standardized training program that acts pre and post-deployment to prepare and reintegrate Goal: Encourage use of services and facilitate reunion to family Strategy: Education Targeted Outcomes: Facilitate use of services by lowering treatment stigma	No Data Available
	Air Force Suicide Prevention Program (ASFPP)	11 initiatives use an inclusive, community-based approach for suicide prevention Goal: Reduce stigma and promote treatment-seeking Strategy: Education Targeted Outcomes: Increase treatment-seeking, decrease suicidal behavior, educate community	Random-ized study found 33% reduction in suicide after imple-mentation
Marine Corps	Annual Suicide-prevention Awareness Training	Annual training for all Marines, intention is to teach Marines to recognize symptoms and react to suicidal ideation Goal: Recognition and action strategies for suicide Strategy: Education Targeted Outcomes: Definition of suicide, risk factors, warning signs, and proper reactions	No Data Available
	Combat Operational Stress Control	Training to recognize and understand combat stress-related injuries Goal: Maintain fighting force Strategy: Education Targeted Outcomes: Protect Marines by educating them on the effects of stress	No Data Available

Branch	Program Name	Description	Evaluation
	Suicide-prevention Module for the Marine Corps Martial Arts Program	Suicide-prevention training done during annual martial arts training. Goal: Overcome stigma by pairing MH training with learning hand-to-hand combat techniques Strategy: Education Targeted Outcomes: Raise awareness of signs and symptoms of suicide and help encourage utilization of services	No Data Available
	Operational Stress Control and Readiness (OSCAR)	Bridging the gap between front-line troops and MH professionals by embedding trained professionals into infantry regiments Goal: Treatment stigma reduction Strategy: Contact & Education Targeted Outcomes: Reduce stigma of seeking treatment, increase awareness of MH principles, increase access and utilization of treatment modalities	No Data Available