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Facilitating Mental Wellness by Targeting Stigma

Think Tank Group 3

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Being fit to fight means more than just being physically fit. With all of the demands on our Airmen and their families, psychological and emotional health are just as important to our overall fitness, and to our readiness as a command.

– General William M. Fraser, II
Former Commander, Air Combat Command

As members of the United States Air Force, Airmen employ the most powerful combat force in the world. It's a rewarding and demanding mission, and it comes with variety of challenges. Managing mental wellness is one such challenge. As Company Grade Officers (CGO), we have been asked to provide answers to important questions based on our unique perspective. What unique aspects of the Air Force missions, culture, or structure influence when and how an Airman seeks mental health care? How does the Air Force encourage airmen to acknowledge when "something is wrong" and self-refer to a mental health professional? What, if any, stigmas do CGOs perceive are associated with mental health diagnoses, such as PTSD, and what can the AF do to ensure Airmen provide an honest, accurate appraisal during routine and pre and post deployment health assessments? In addressing these questions, we identify how Air Force culture may play a role in the development of a stigma that prevents Airmen from seeking treatment when dealing with mental health issues. We argue that in order for Airmen to effectively manage their mental wellness, this stigma must be targeted and reduced by annual mental health evaluations and a coordinated educational initiative.

DEFINING THE PROBLEM

Too often the dialogue surrounding mental health in the Air Force focuses on combat-related disorders and the tragedy of suicides. However, every Airman faces challenges in their daily life that stress their mental wellness. Along the mental health continuum published by the Defense Centers of Excellence, issues range from stress reactions such as irritability or

difficulty sleeping to debilitating problems like aggression or deep depression.[1] Left untreated, these problems can become so severe that the afflicted person becomes a danger to himself or others.

As a result of combat trauma, long separations from loved ones, and high operations tempo, members of the Air Force face stressors that aggravate mental health issues.[2] In Pflanz's 2002 study of AF personnel at F.E. Warren AFB, WY, over one-quarter of respondents reported that they were suffering from significant work stress, and one in five reported that this stress caused substantial emotional distress.[3] These Airmen experienced recognizable mental health issues, but how many are getting help or support for these early symptoms of mental health problems? A 2012 survey of veterans returning from Iraq and Afghanistan revealed that only 23-40 percent of those indicating mental health disorders reported seeking mental health services.[4] Why would approximately 75 percent of Airmen needing mental health treatment not seek assistance? Allowing such a significant portion of our Airmen to engage these serious health issues without the support of medical professionals could lead to the degradation of the Air Force's overall combat effectiveness. It is critical that the barriers keeping these Airmen from needed help be identified.

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[1] Greenberg, Langston, and Gould, Culture: What is its Effect on Stress in the Military?
[2] American Psychiatric Association, Military.
[3] Pflanz, Work Stress in the Military.
[4] Christensen and Yaffe, Factors Affecting Mental Health Service Utilization Among Deployed Military Personnel.

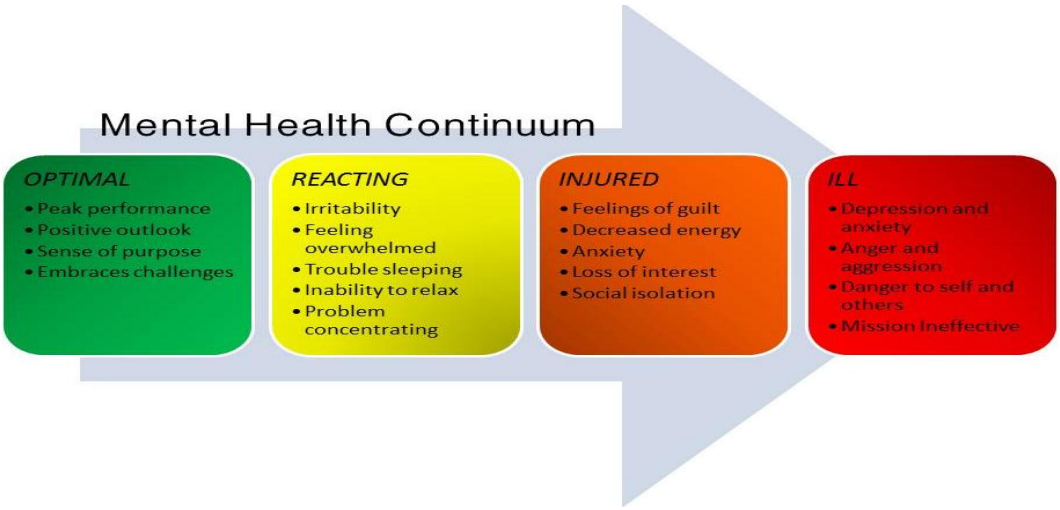

Figure 1 Defense Center of Excellence's Mental Health Continuum

STIGMA AS A BARRIER TO CARE

Exploring these perceived barriers reveals that fundamental ideals and values espoused by our Air Force culture may inadvertently foster negative attitudes towards mental health. For example, Airmen embrace a warrior ethos typified by competence, courage, and strength. "I will not falter, and I will not fail," states the Airman's Creed. "Service Before Self," the core value instilled in each of us, demands "discipline and self-control."[5] If mental health symptoms are perceived as personal weakness, or lapses in self-control, then the afflicted Airman will feel he cannot live up to these fundamental values. He experiences stigma, or the feeling of being discredited, tainted, or discounted from his culture's values.[6] If this stigma surrounding mental health is widely held by the culture, the Airman will perceive that he is branded, or marked, as weak. This stigma becomes a barrier to seeking care in cases of mental health problems. In order to facilitate the use of mental health services at an early stage of the mental health continuum, this stigma must be understood, targeted, and eventually reduced.

[5] United States Air Force, Our Mission.
[6] Link and Phelan, Conceptualizing stigma.

Link and Phelan conceptualize stigma as "elements of labeling, stereotyping, separation, status loss, and discrimination co-occur[ing] in a power situation."[7] Labeling is the natural tendency to place people or things into categories based on certain characteristics or attributes. These distinguishing characteristics are based on several factors, including the current "social, economic, and cultural" environment.[8] Stereotyping takes place when a labeled person is subsequently associated with other negative attributes based on cultural beliefs. At its basic level, stereotyping is a psychological function that allows humans to make quick decisions based on cultural norms, past experiences, and overall context. Once a stereotype has attributed negative characteristics to a labeled person, separation takes place. Distilled down, this is a separation of "us" and "them." Finally, status loss takes effect as the labeled, stereotyped, and separated person is placed lower in the social hierarchy, ultimately enabling individual or structural discrimination to take place. When analyzed within this framework, an Airman seeking mental health is labeled as ill, or unstable, and then stereotyped. Dickstein, et al, describe the most commonly held stereotypes about those needing mental help "are that they are dangerous and violent, incompetent and unaccountable, and personally responsible for becoming, and continuing to be, mentally ill."[9] Under the burden of such a stereotype, the afflicted Airman does not see himself living up to the fundamental values of the Air Force. His weakness separates him from the warrior culture, eventually leading to isolation, status loss, and eventually, discrimination.

Studies show that these stereotypes exist among Air Force members. Visco found that Airmen returning from a deployment reported that feeling "embarrassed, weak, cowardly" acted

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[7] Ibid, 367.
[8] Ibid.
[9] Dickstein et al., Targeting stigma in returning military personnel and veterans, 226.

as a barrier to seeking mental health treatment.[10] In a 2013 survey of Company Grade Officers attending Squadron Officer School, 56.2 percent of respondents felt that the potential of being viewed as weak would inhibit their seeking mental health services. Additionally, 50.5 percent of respondents said that it would be too embarrassing. When asked to describe a typical person that seeks mental health, CGOs responded most often with "stressed," "depressed," "troubled," "confused," and "unstable." In the graphic below, the size of the word reflects the number of times it was repeated by the respondents. They represent the stereotypes CGOs place on those seeking mental health services. As long as these stereotypes surround mental health treatment, the common Airman may not feel comfortable seeking mental health support at early stages of experiencing mental health problems.

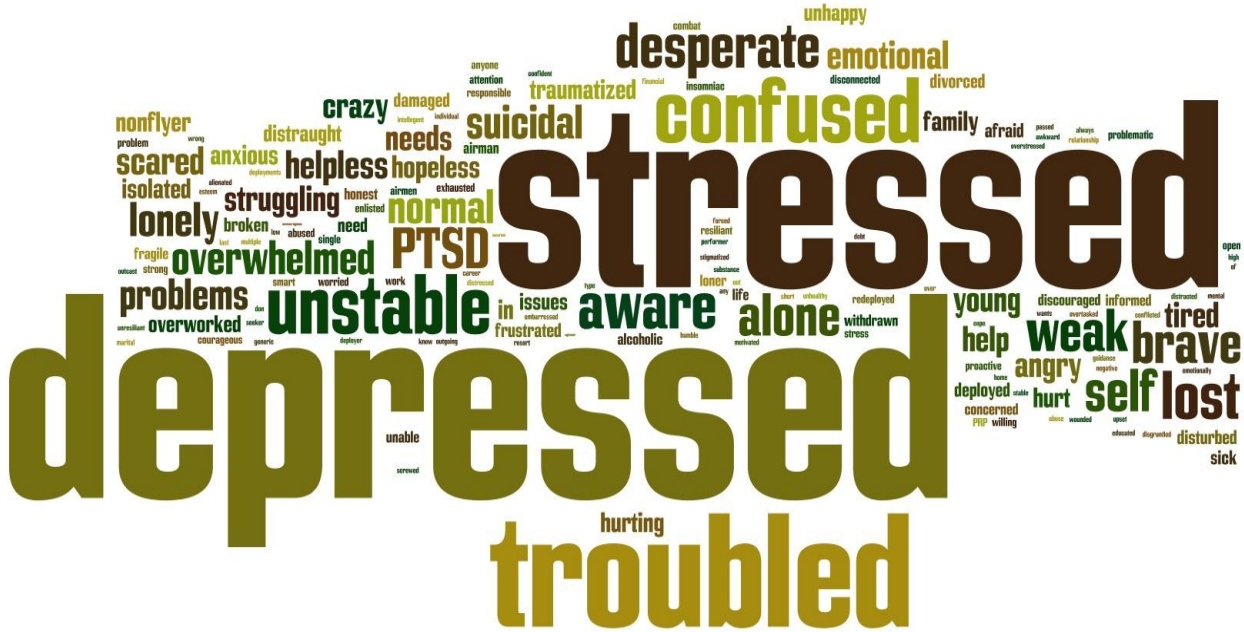

Figure 2 Result from 507 CGOs surveyed

[10] Visco, Postdeployment, Self-Reporting of Mental Health Problems, and Barriers to Care, 248.

Within Link and Phelan's framework, power relationships play a major factor in reinforcing stigma. If someone in a position of power over an Airman holds negative views of mental health problems, then confidentiality is critical when seeking care. However, reinforcing the stigma surrounding mental health is the perception that mental health services lack confidentiality and can therefore negatively impact an Airman's career. While there are circumstances that may require mental health providers to notify commanders, it is only in cases that may involve harm to self, others, and the mission, or in special circumstances.[11] These circumstances are defined as issues in which "proper execution of the military mission outweighs the interest served by avoiding notification as determine by the Surgeon General or the Military Treatment Facility commander at the O-6 level or above."[12] This clause can be viewed as particularly subjective, leaving the interpretation of what influences the mission in the hands of the medical professional. The medical professional's opinion could lead to the loss of confidentiality for a patient. As discussed previously, the possibility of status loss, separation, and discrimination combined with the power to affect status loss and discrimination are huge contributors to the development of a stigma.

Rowan and Campise highlighted a 2002 Department of Defense survey in which 49 percent of service members believed that seeking behavioral health care "definitely would" or "probably would" damage their careers.[13] Visco also identified "career concerns" as a barrier to Airmen seeking mental health services.[14] When asked in a survey what perceptions inhibit them from seeking mental health services, 85.8 percent of responding CGOs believe it will harm one's career, while 70.4 percent believe that unit leadership might treat the officer differently.

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[11] United States Air Force, Mental Health (AFI 44-172).
[12] Ibid., 34.
[13] Rowan and Campise, A Multisite Study of Air Force Outpatient Behavioral Health Treatment-Seeking Patterns and Career Impact, 1123.
[14] Visco, Postdeployment, Self-Reporting of Mental Health Problems, and Barriers to Care, 248.

Likewise, 67.5 percent believe members of the unit might lose confidence in the officer, and 41.4 percent believe there is not enough confidentiality. Another dimension which may influence the decision of an individual to self-refer to mental health services is whether or not the individual is assigned within a special duty status such as the Personnel Reliability Program (PRP), presidential support, military training instructor (MTI), or flying status. This is due to the inherent subjectivity of what conditions a mental health provider (MHP) believes impacts a high-importance mission. Regardless of actual confidentiality regulations, the overwhelming perception is that an Airman no longer has control over his career decisions once he steps inside a mental health facility for treatment. While this is not necessarily the case, the fear of status loss is powerful enough to reinforce the stigma surrounding mental health treatment.

ADVANTAGE OF EARLY SELF REFERRAL

When dealing with symptoms on the mental health continuum, intervention or treatment is most effective at early stages. Because these less-serious problems are not easily detected by others, it is critical that Airmen self-refer in order to address the issues before they develop into debilitating problems. A self-referral means that an individual self-identifies a need for mental health assistance and seeks help on his own. If problems begin to impact job performance or the safety of an individual or unit, a commander can direct the member to a mental health provider for evaluation. This type of referral is known as a commander-directed evaluation. Comparing the outcomes of self-referrals versus commander-directed evaluations reveals that self-referrals result in more positive outcomes for the Airman receiving mental health treatment.

In a study of non-deployed Air Force personnel, Rowan and Campise found that only 11 percent of 699 mental health self-referrals were reported to commanders. Only 3 percent of

these self-referrals resulted in negative impact to their career status. By contrast, 38 percent of commander-directed evaluations experienced negative career impact.[15] According to a similar study by Christensen and Yaffe based on deployed service members, 19 percent of self-referrals were reported to the member's unit. Of these same self-referrals, 12 percent included a duty restriction. Of the five commander-directed evaluations of these deployed service members, all had contact with their unit and two resulted in a duty restriction.[16] The term "negative impact" in these studies is defined as a change in duty status or discharge as a result of the mental health condition of the patient. These statistics combined reveal that a commander-directed evaluation is nine times more likely to result in negative career impact than a self-referral to mental health. No commander-directed evaluation maintained confidentiality, as each was monitored by the member's commander.

[15] Rowan and Campise, A Multisite Study of Air Force Outpatient Behavioral Health Treatment-Seeking Patterns and Career Impact, 1126.
[16] Christensen and Yaffe, Factors Affecting Mental Health Service Utilization Among Deployed Military Personnel, 279.

	Self Referred		Encouraged		Directed	
Recommendations	**Non-deployed**	**Deployed**	**Non-deployed**	**Deployed**	**Non-deployed**	**Deployed**
No Contact With Unit	621 (89%)	77 (81%)	74 (25%)	32 (61%)	0 (0%)	0 (0%)
Supportive Recommendation	54 (8%)	7 (7%)	208 (75%)	15 (28%)	43 (61%)	3 (60%)
Negative Career Impact	24 (3%)	11 (12%)	15 (5%)	6 (11%)	27 (39%)	2 (40%)
Total	699	95	297	53	70	5

Table 1. Deployed and non-deployed referral data (Combined from Christensen & Yaffe (2012) and Rowan and Campise (2006)

Self-referred service members have more confidentiality and a decreased chance of negative career impact compared to those that are commander-directed to mental health services. Therefore, an Airman suffering from mental health issues benefits from self-referred mental health support. In order to facilitate self-referrals among Airmen that suffer from early symptoms of mental health distress, the stigma surrounding mental health treatment must be targeted.

REDUCING THE STIGMA

By reducing the stigma surrounding mental health issues, the Air Force can shape an environment in which Airmen can use available resources in order to properly manage mental health challenges. Recently the Air Force has adopted a framework, known as the Comprehensive Airmen Fitness (CAF) program, upon which this environment can be cultivated. This program is modeled after products of both the Army's and Marine Corps' efforts to address mental health issues within their respective services. Within the Air Force's CAF program, mental wellness is one of four "pillars" of a balanced Airman.[17] Using the policy tools within this program, we developed recommendations that reduce the stigma surrounding mental health

[17] ACC Comprehensive Airmen Fitness.

and, as a result, facilitate Airmen's use of mental health resources as they manage their mental wellness.

The CAF program defines mental well-being as the ability to effectively cope with unique mental stressors and challenges required to ensure mission readiness. The core tenets within this mental pillar are awareness, adaptability, decision-making, and positive thinking. Additionally, there are six leadership directives within the CAF program. Our focus will concentrate on steps five and six: Tiered Resilience Training and Master Resilience Trainers (MRTs).[18] The overarching goal of our recommendations is to reduce stigma through exposure to mental health, physically and educationally. This will normalize the concept of seeking mental health assistance and naturally encourage more self-referrals. Our approach is two-fold: 1) mandatory check-ups at the mental health clinic for all Airmen; 2) educational initiative to promote resource and medical knowledge.

Recommendation 1. Our first recommendation is to make mental health screening mandatory and universal through annual checkups at the mental health clinic. As shown in the figure below, this is a Tier 1 element of the Air Force's tiered training model. By creating an environment in which everyone is required to be seen and speak with a mental health provider (MHP), the elements of the stigma process are negated. Additionally, these visits to the clinic provide all Airmen a foundational understanding mental wellness. An Airman sitting in a mental health clinic's waiting room might be there for an annual checkup or for a self-referred visit. A distinction would not be apparent to anyone else in the clinic. As a result, the labeling, stereotyping, and separation elements of the stigma process are interrupted. In addition to targeting the elements of the stigma process, these face-to-face checkups facilitate self-referrals. Since each Airman will be required to sit down with a MHP, the Airman need only address

[18] Ibid.

existing mental health concerns. Requiring yearly interaction with mental health also creates a baseline experience with a MHP. According to a study produced by Skopp, et al, regarding public and self-stigma in the military, "a good experience with a therapist, or knowledge of someone who has had such an experience, may reduce self-stigma."[19] During these sessions, as they become familiar with the mental health structure of the Air Force, Airmen will understand the regulations governing confidentiality and career impact. This knowledge mitigates the status loss and discrimination elements of the stigma process.

Admittedly, this recommendation requires a significant investment of time, manpower, and funding. However, to create the necessary environment to achieve mental wellness, the Air Force must engage the stigma and aggressively break it down. The benefits of annual face-to-face checkups make this recommendation particularly effective at targeting the stigma process and facilitating mental wellness.

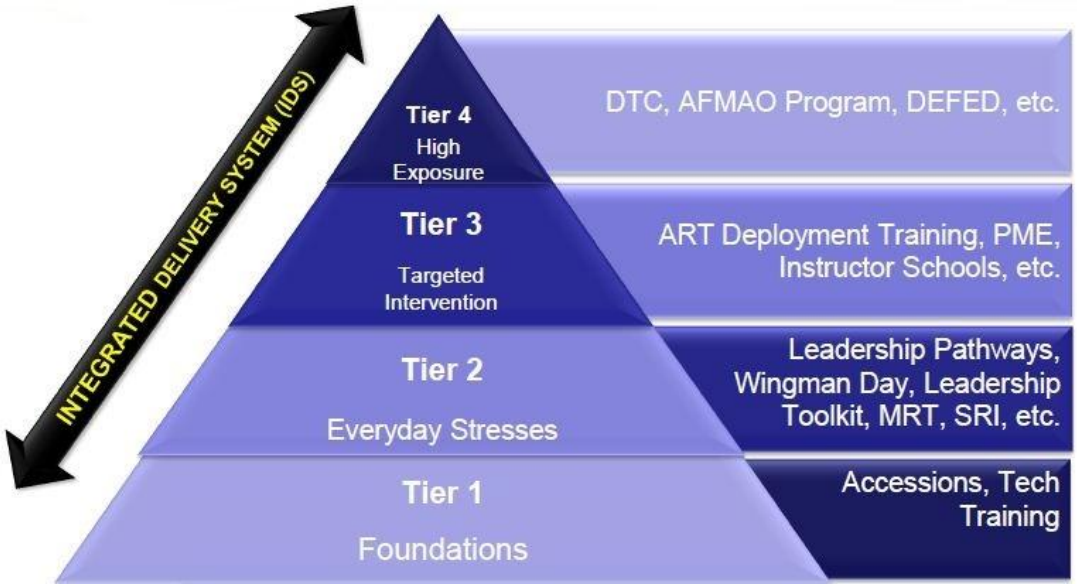

Figure 3 CAF program tiered training strategy

[19] Skopp et al., Development and initial testing of a measure of public and self stigma in the military,1038

Recommendation 2. Our second recommendation is an educational initiative comprised of three primary topics: 1) understanding resources and policies; 2) explaining the science behind mental health; and 3) disseminating mental health success stories. As seen in the figure above, this training fits within Tier 2 of the training model to effectively teach coping skills for everyday stressors. However, if a base commander chose to target a specific audience, such as those on flying status, this training could also be incorporated into Tier 3, "Targeted Intervention." Like the first recommendation, this educational initiative is designed to target the stigma process. It does not focus on teaching resiliency skills.

Step 1. First, understanding available resources, programs, and the confidentiality rules that govern them is critical to reducing the stigma elements of separation, status loss, and discrimination. Currently, the resources available to Airmen through the CAF program's Integrated Delivery System (IDS) are poorly understood and underutilized. Education must be a priority because Airmen do not seem to understand what resources are available to them.

The previously referenced survey of CGOs asked if members were familiar with the existence of current programs – Mental Health Clinic, Chaplain, Military One Source, and Military and Family Life Counseling (MFLC). The graphic shows that roughly 20 percent and 27 percent had never heard of Military One Source and MLFC, respectively. Interestingly, nearly 8 percent reported having no knowledge of the Mental Health Clinic. When it comes to addressing the confidentiality rules governing those programs, the knowledge level drops even more dramatically.

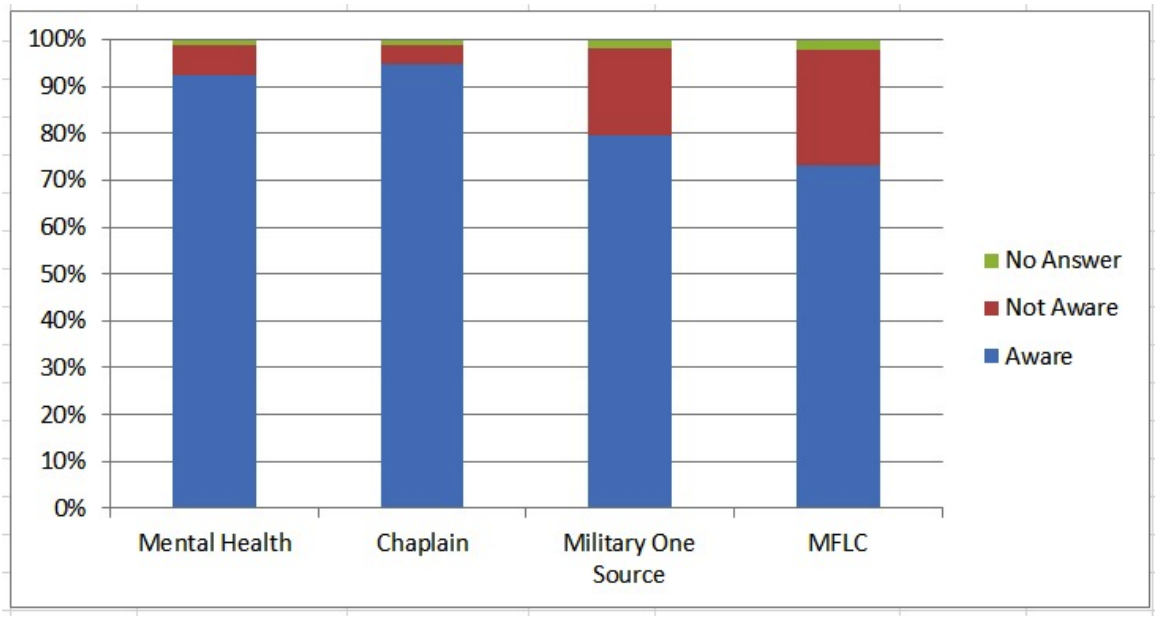

Figure 4 Results on the question of mental resources available

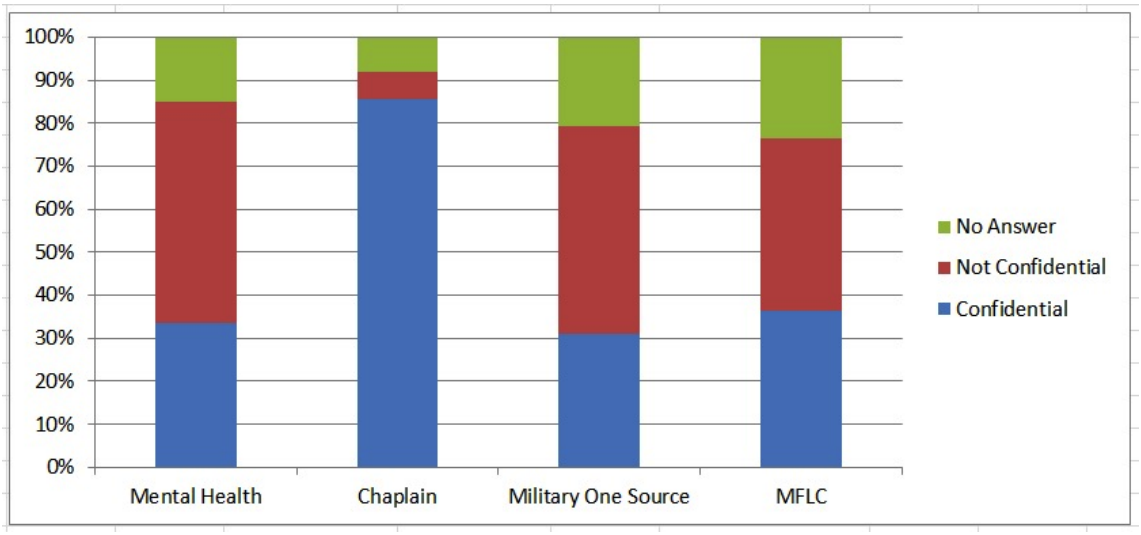

Figure 5 Results on the question of confidentiality

Of the CGOs surveyed, only 31 percent reported knowing that Military One Source counseling is confidential; the number increased slightly to 36 percent for MFLC. In reality, both of these programs are fully confidential provided the MHP does not believe the Airmen to be a harm to himself or others. CGOs roughly equated the confidentiality rules for both of these programs with those of the mental health clinic (excluding the chaplain program). In fact, the

rules are slightly different. As addressed in the previous section, while MHPs within the base mental health clinic "operate from a presumption of non-notification," they are endowed with latitude beyond "harm to self or others" as a measure for both commander notification and duty restrictions.[20] The fear of duty restrictions, which equates to status loss, serves as a primary barrier to mental health self-referral. Thus, it is imperative that Airmen, especially those that have special duty statuses, fully understand the resources available to them through the IDS, and the policies that govern them.

Step 2. Educating Airmen on the science behind mental health would encourage them to view mental health through a medical lens. More than just listing the symptoms of illnesses such as depression or PTSD, Airmen would learn the neuroscience behind certain disorders. For example, PTSD is caused by finite and measurable chemical changes within the brain. These are induced by certain contextual factors, such as repeated exposure to psychological or physical trauma and pervasive stress. The intent is that Airmen begin to understand that mental illness is not a choice, and that mental health is a process for everyone. By clearly articulating the biology of mental disorders, we can create an environment where the degree to which stigma manifests itself is decreased, as labeling and stereotyping become less common.

Step 3. Disseminating mental health success stories targets stigma by demonstrating how individuals have successfully dealt with mental health challenges in the past. We suggest bringing the "Real Warrior" concept to the base and unit-level. Real Warriors is an organization that encourages military members to share their personal stories of dealing with and overcoming a mental health challenge.[21] This would send a profound message to Airmen that they are not alone, in addition to shattering stereotypes about mental health. These stories should be

[20] United States Air Force, Mental Health (AFI 44-172), 34.
[21] Real Warriors Campaign.

solicited from all levels of base leadership. However, lower-level leaders, such as CGOs and NCOs, would better connect with lower-grade Airmen. If the audience knows and respects the member telling their story, we begin to build genuine investment in the issue. The stories will ostensibly span the gamut of mental health issues and should highlight resources used and medical experiences. This will incorporate all primary topics into the anecdote to reinforce educational objectives. Base leadership could use Wing Public Affairs to film their story, which could be used in unit-level training as well as posted on the base website and Facebook account. Having Wing and Group Commanders tell their stories helps decrease the perceived power imbalance that contributes to the stigma elements of status loss and discrimination. When a leader tells a personal story, he is able to connect with Airmen and temper the fear of negative career impacts for self-referrals. This naturally decreases the us vs. them mentality that is often perceived by those suffering from mental health problems, and reduces the likelihood that an Airmen will fear status loss and discrimination from a superior should he seek help.

All three educational objectives can be accomplished through unit-level, small group discussions. The CAF's strategies for increasing resiliency rely partly on using front-line supervisors and small groups or peer-to-peer learning. Wingman days should be utilized to implement training curriculum in small group discussions with no more than 10-15 members per group. These groups are not intended as counseling sessions. Instead they focus on implementing the three education objectives of providing resources, educating Airman on the science of mental health, and providing Airman mental health success stories. The CAF's sixth leadership initiative includes training four MRTs per base; those MRTs will then train Resilience Training Assistants (RTAs). The CAF does not explicitly mandate the number of RTAs per base, but we believe that one per unit is necessary. RTAs can then facilitate the core

curriculum within specific units, tailoring as needed for time and depth. For example, perhaps a unit with a preponderance of members on PRP or flying status should include more information on confidentiality rules vice scientific training.

Essentially, MRTs would develop a base-wide curriculum founded on AF and MAJCOM-level objectives, which RTAs would then facilitate within units. The three topics listed above should be the foundation of this curriculum. While units should be encouraged to be innovative with the curriculum during implementation, it should be clearly understood that a standardized curriculum is crucial to ensuring appropriate, AF-wide education. These classes, however they are executed at the unit-level, can easily be accomplished on scheduled Wingman or Resiliency down days. Both unit commanders and RTAs should use the "Leadership Toolkit" as outlined in the CAF to obtain tools and knowledge for discussion facilitation. Then, as best practices are developed, the Leadership Toolkit can be further enhanced.

Finally, RTAs play critical roles within this framework. They provide a crucial link between the squadron and wing levels of oversight. They should be incorporated in a way that is slightly analogous to a safety representative. In this role, RTAs would not only be responsible for facilitating training, but would also serve as a sounding board and a valuable resource repository, offering advice on the best resources and describing confidentiality rules to Airmen with questions.

CONCLUSION

By implementing both an annual mental health assessment requirement as well as a coordinated educational initiative, we hope to reduce the stigma that acts as a barrier to seeking mental health treatment. As CGOs, we believe that over time Air Force leaders can help change

attitudes about mental health care and cultivate an environment that places adequate emphasis on mental wellness. In this environment, Airmen seeking mental health support at early stages of the mental health continuum will be able to receive support without feeling the negative effects of the stigma process. An Air Force that successfully manages mental health challenges will continue to accomplish the critical missions required of the most powerful fighting force in the world.

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