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Stigma and mental health in the Royal Navy: A mixed methods paper

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Abstract

Background: US research suggests that military personnel suffering from mental health problems are reluctant to seek help because of stigma.

Aims: First, to identify the prevalence of mental health stigma beliefs in a UK military sample. Second, to investigate whether distressed personnel report more stigma than those who are not distressed.

Method: A survey of 1599 naval personnel was undertaken as part of a larger trial prior to examining the effectiveness of a novel trauma support program.

Results: The presence of internal stigma was substantial and significantly higher for distressed personnel. The prevalence of stigma about other people's mental health problems was low. Junior personnel reported being more uncomfortable in discussing emotional issues with their peer group than senior staff.

Conclusions: Internal stigma remains a significant barrier to help seeking within the Royal Navy, especially for distressed personnel. This may be especially problematic for junior personnel who are known to be particularly vulnerable to developing mental health problems.

Keywords: *Military culture, mental health, stigma, barriers to care*

Introduction

Many people who might benefit from mental health services and treatments choose not to access them (Corrigan, 2004). Stigma, defined as a sign of disgrace or discredit that sets a person apart from others, is one of the many reasons why people don't seek help (Bolton, 2003). Stigma is especially problematic for military forces for whom physical and psychological resilience in the face of adversity is a key value (Rona, Jones, French, Hooper, & Wessely, 2004).

Military culture embraces strong masculine norms which can lead to difficulties for individuals who challenge the culture by seeking help for mental health problems or report suffering with stress. For example, military personnel report that admitting to a psychological problem is much more stigmatizing than admitting to a medical one (Britt, 200). As a result

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personnel are much less likely to attend a psychological referral than a medical one (Britt, 2000).

Hoge et al. (2004), investigated help seeking and barriers to care among United States soldiers and discovered that, despite a high burden of mental health problems in the Armed Forces there was often a great reluctance to actively seek help. Hoge's study found that only 38–45% of participants who reported symptoms of mental health problems were interested in receiving assistance for their problems and only 23–40% had actually sought any care. Iversen et al. (2005) described similar findings in UK military veterans with only half of those who reported problems (while in service) admitting to seeking help.

Although papers have examined the health of UK Armed Forces personnel (Hotopf et al., 2006) relatively limited research concerning the attitudes and opinions that military personnel hold about mental health problems. Within the UK the Royal Navy (RN) uses a peer-support system called Trauma Risk Management (TRiM) which aims to positively alter Service personnel's perceptions toward seeking help for mental health problems especially stress-related issues (Greenberg et al., 2005).

This paper examines a group of RN personnel, surveyed prior to TRiM implementation, in order to test two hypotheses: (i) that stigmatizing beliefs (internal and external) about mental health issues are prevalent within the RN, and (ii) that distressed personnel would express more stigmatizing beliefs than those who were not distressed. In this study we distinguished between external stigma, the beliefs one holds about those who suffer with mental health problems, and internal stigma when these negative attitudes become especially salient to an individual (Corrigan, & Watson, 2002).

Methods

Data were collected as part of the baseline investigations of a trial which was to investigate the efficacy of TRiM versus standard care in the management of individuals following traumatic events. The study incorporated both qualitative and quantitative data collection at baseline and follow-up, using one-to-one semi-structured interviews and a questionnaire. Approximately 30 one-to-one semi-structured interviews were conducted on each of the ships by researchers accustomed to naval terminology. Stratified sampling was used to ensure the ranks of those interviewed were proportional to the range of ranks within any particular vessel. Informed consent was gained from all participants; no personnel refused to be interviewed.

During the interviews, individuals were asked to respond to the following stigma-related question: ''how do you think your peer group regards stress and stress-related problems?'' Definitions for both stress and stress-related problems were provided. Qualitative analysis, described below, was undertaken through discussion of the contents of the interviews between researchers (NG and VL).

The quantitative questionnaire enquired about respondents' opinions of stress and stress-related problems in the Armed Forces and included General Health Questionnaire-12 item (GHQ-12) (Goldberg, & Williams, 1988) and Post Traumatic Stress Disorder Checklist (PCL-C) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Caseness was defined as a score of 4+ or more on the GHQ-12 and or a score of 50+ on the PCL-C. Service personnel were defined as a ''stress case'' if they scored as a case on either of the above outcomes measures.

Personnel's rank was categorized as ''Junior'' for the ranks of Leading Hand and below, ''Senior'' for the ranks between petty officer and warrant officer and ''Officers'' for those who were commissioned.

The study received full ethical approval from the Ministry of Defence (Navy) Personnel Research Ethics Committee.

Statistical analysis

The statistical software package STATA, version 8 was used for statistical analysis. Statistically significant differences between the proportions were identified using Pearson's χ^2 statistic; with p values of less than 0.05 taken to indicate statistical significance. Odds ratios (ORs) were calculated and 95% confidence intervals (CIs) were computed unadjusted and adjusted by multivariable logistic regression. All analyses were conducted with and without adjustment for age, rank, marital status and gender.

Qualitative analysis

During the piloting phase the interviews were taped but participants frequently voiced suspicion so for the main study notes in all interviews were recorded by hand. Grounded theory was used to analyse the interviews (La Rossa, 2005). The process followed four main steps: (i) breaking down continuous free text into discrete segments representing unique comments, (ii) grouping comments that describe the same factors into subcategories, (iii) grouping subcategories into discrete themes, and (iv) using the theme to describe how respondents regarded and would act towards stress and stress-related problems.

Results

This is a mixed methods paper using the study's baseline assessment data which incorporated questionnaires (Group A) and semi-structured interviews (Group B). The baseline study group ($N = 2598$) included 1559 individuals who completed the questionnaires (69% of the opportunistic sample) and 374 individuals who participated in the one-to-one interviews (Officers = 61, Seniors = 114, Juniors = 199).

Demographics

The characteristics of the Group A population are described in Table I. Median age was 26 years with the inter-quartile range being 21–33 years. Nearly half (47.5%) of the RN population was single and 45.3% cohabiting. Female respondents represented 10.3% of the study sample which was representative of the serving female RN population (9.4%) (Defence Analytical Services Agency [DASA], 2006). The rank categories within the RN population were proportional to the range of ranks within any particular vessel.

For Group B the median age was 28 years and the inter-quartile range was 23–35 years (Table II). Female respondents represented 8.6% ($n = 32$) of the study sample which was again representative of the serving RN female population (9.4%).

Group A results

Twenty seven per cent ($n = 406$) of the sample were ''stress cases''; that is they were cases on either the GHQ-12 or PCL-C. Co-morbid cases, scoring above the threshold on both measures, made up 5% ($n = 77$) of the stress cases.

Table I. Demographics for quantitative questionnaires and interviews.

Variable	Group A* ($N=1559$) *n* (%)	Group B* ($N=374$) *n* (%)
Age (years):		
<20	272 (17.6%)	42 (11.2%)
21–25	476 (30.8%)	103 (27.5%)
26–30	264 (17.1%)	78 (20.9%)
31–35	211 (13.7%)	63 (16.8%)
≥36	321 (20.8%)	88 (23.5%)
Gender:		
Male	1392 (89.8%)	342 (91.4%)
Female	159 (10.3%)	32 (8.6%)
Marital status:		
Married/Cohabiting	706 (45.3%)	Data not available
Divorced/Separated/Widowed	102 (6.7%)	
Single	730 (47.5%)	
Rank:		
Officer	187 (12.1%)	61 (16.3%)
Senior Non-Commissioned Officer	338 (21.8%)	114 (30.5%)
Junior Non-Commissioned Officer	1027 (66.2%)	199 (53.2%)

*Some categories do not add up because of missing data.

Table II. Opinions towards stress and stress-related problems*.

Statement	Agree *n* (%)		Disagree *n* (%)		χ^2	df	$p^\dagger$
	Stress case	Non-case	Stress case	Non-case			
"People who experienced a stress-related problem are weak"	24 (6.6)	61 (6.8)	339 (93.4)	835 (93.2)	0.016	3	0.900
Officers ($n=148$)	3 (10.3)	4 (3.4)	26 (89.7)	115 (96.6)	2.52		0.112
Seniors ($n=273$)	6 (9.0)	12 (5.8)	61 (91.0)	194 (94.2)	0.80		0.370
Juniors ($n=837$)	15 (5.6)	45 (7.9)	252 (94.4)	525 (92.1)	1.42		0.234
"Any in-service support would be confidential"‡	155 (49.4)	498 (65.5)	159 (50.6)	262 (34.5)	20.74	3	0.000
Officers ($n=146$)	17 (53.1)	63 (55.3)	15 (46.9)	51 (44.7)	0.71		0.41
Seniors ($n=251$)	28 (46.7)	132 (69.1)	32 (53.3)	59 (30.9)	5.02		0.025
Juniors ($n=676$)	110 (49.5)	302 (66.5)	112 (50.5)	152 (33.5)	16.2		0.000
"Most people have a mental health problem at some point in their life"	179 (62.8)	300 (45.8)	106 (37.2)	355 (54.2)	22.98	3	0.000
Officers ($n=116$)	13 (29.2)	43 (46.7)	11 (45.8)	49 (53.3)	0.42		0.517
Seniors ($n=218$)	34 (63.0)	71 (43.3)	20 (37.0)	93 (56.7)	6.30		0.012
Juniors ($n=605$)	132 (63.8)	186 (46.7)	75 (36.2)	212 (53.3)	15.85		0.000

*Some categories do not add up because of missing data. Neutral comments omitted.
†Pearson's χ^2 test of significance.
‡Denominators (n) vary according to PCL and GHQ completion.

The majority, independent of caseness, reported generally positive attitudes towards mental health problems in others (external stigma) with approximately 92% from all ranks in both groups disagreeing with the notion that individuals suffering from stress and

stress-related problems were weak (Table II). Some results showed a difference when the data was analysed by rank; in general the associations between external stigma and rank were strongest for Juniors.

However reporting of internal stigma was more prevalent (Table III) for all ranks although the results were less substantial for Officers than they were for other ranks. The difference between the prevalence of internal and external stigma was also significant, for example, when comparing the prevalence of an external stigmatizing belief that "in-service support would not be confidential" (39% from $n = 1083$) to the internally stigmatizing belief: "I would be less likely to be given roles/tasks of responsibility" (60% from $n = 1094$), revealed a significant difference ($\chi^2 = 14.04$, $p < 0.001$) as did the comparison of the externally stigmatizing belief that "people who experience a stress-related problem are weak" (7% from $n = 1272$), to the internally stigmatizing belief that "it would adversely affect my promotion prospects" (43% from $n = 1061$) ($\chi^2 = 12.58$, $p < 0.001$) (Tables II and III).

Stress cases reported significantly more internal stigma than non-cases, with unadjusted odds ratios ranging from 1.5 to 4.4 (Table III). There was little affect in adjusting the findings for socio-demographic variables although the associations between caseness and

Table III. Prevalence and detail of internally stigmatizing beliefs.

In-service support factor‡	Stress Case* *n* (%)	Non Case* *n* (%)	Unadjusted OR (95% CI)	Adjusted OR† (95% CI)
"I would be perceived as weak by the Chain of Command"				
Officers ($n = 124$)	17 (70.8)	55 (55.0)	1.99 (0.76–5.21)	4.14 (3.05–5.62)
Seniors ($n = 255$)	46 (76.7)	83 (42.6)	4.43 (2.29–8.59)	
Juniors ($n = 684$)	112 (56.6)	121 (24.9)	3.93 (2.77–5.65)	
"It would adversely affect my promotion prospects"				
Officers ($n = 127$)	16 (66.7)	59 (57.3)	1.49 (0.59–3.79)	2.88 (2.12–3.89)
Seniors ($n = 250$)	42 (76.4)	95 (48.7)	3.40 (1.72–6.73)	
Juniors ($n = 671$)	102 (52.6)	137 (28.7)	2.75 (1.95–3.88)	
"I would be less likely to be given roles/tasks of responsibility"				
Officers ($n = 139$)	19 (82.6)	82 (70.7)	1.97 (0.62–6.22)	2.19 (1.62–2.95)
Seniors ($n = 243$)	42 (75.0)	107 (57.2)	2.24 (1.15–4.39)	
Juniors ($n = 701$)	150 (69.4)	253 (52.2)	2.08 (1.48–2.93)	
"I would be embarrassed asking for help"				
Officers ($n = 131$)	21 (80.8)	54 (51.4)	3.97 (1.39–11.31)	3.36 (2.52–4.48)
Seniors ($n = 251$)	49 (76.6)	95 (50.8)	3.16 (1.66–6.03)	
Juniors ($n = 750$)	176 (71.5)	217 (43.1)	3.33 (2.40–4.62)	
"My peers would find out and treat me badly or tease me"				
Officers ($n = 126$)	4 (23.5)	15 (13.8)	1.93 (0.55–6.70)	3.17 (2.36–4.26)
Seniors ($n = 226$)	29 (53.7)	37 (21.5)	4.23 (2.22–8.08)	
Juniors ($n = 686$)	114 (54.0)	135 (28.4)	2.96 (2.11–4.14)	

*Neutral comments were omitted.
†ORs adjusted for age, sex, marital status, rank.
‡Denominators vary according to PCL and GHQ completion.

internal stigma become slightly stronger for Officers and Juniors and marginally reduced for Seniors.

Group B results

Junior and Senior ranks were more negative about how their peer group regarded stress; 43% of Juniors ($n = 99$) and 48% of Seniors 48% ($n = 62$) being negative about how their peer group regarded stress compared to 31% of Officers ($n = 21$). Officers were also more likely to report positive comments about their peers' attitudes towards stress; 34% ($n = 23$) of Officers reported positive views compared to 11% ($n = 26$) of Juniors or 7% ($n = 9$) of Seniors. The most prevalent negative peer group beliefs about stress-related issues included; the matter being perceived as a joke, a stigma attached to mental health problems (i.e., it being perceived as a weakness), suspicion over whether a stressed individual was genuine and the lack of openness regarding the subject (Table IV).

Juniors held more negative beliefs compared to Seniors and Officers when considering how their peer group would act towards and handle individuals suffering from stress. Fifty one per cent of Juniors ($n = 109$) stated that their peer group would act negatively towards an individual suffering from stress compared to 36% ($n = 44$) of comments by Seniors and 34% ($n = 22$) by Officers. Only 30% of Juniors ($n = 65$) and 31% of Seniors ($n = 38$) thought their peer group would react positively compared to 43% ($n = 28$) of Officers. Some of the themes identified about how peer groups acted towards stress-related problems included believing that peers would not act seriously about stress-related problems (i.e., it would be perceived as a joke) and that individuals claiming stress-related problems would be avoided or told to essentially "crack on with work" rather than the problem being addressed. Many personnel also believed that there was a general lack of understanding and awareness of stress in the military (Table V).

Discussion

Our results show that, in general, the prevalence of externally stigmatizing beliefs about mental health difficulties in Royal Naval personnel was minimal. However, in comparison,

Table IV. Main themes about how one's peer group regarded stress and stress-related problems.

Theme	Response rate	Quote example
Stress being perceived as a joke	Junior: 15% ($n = 30$) Senior: 6% ($n = 7$) Officer: 0% ($n = 0$)	"Take the pi**, banter, not really taken seriously" (08024) "The lads don't take it seriously at all and joke about it a lot" (04009)
Stigma attached to stress (i.e., it being perceived as a weakness)	Junior: 11% ($n = 22$) Senior: 17.5% ($n = 20$) Officer: 10% ($n = 9$)	"It is a taboo issue best kept to oneself" (06025) "... if you seek help then you've failed to cope" (10008) "There is a big stigma attached to mental health, if they say anything they will get laughed at" (09007)
Suspicion (i.e., over whether a stressed individual was genuine)	Junior: 8% ($n = 18$) Senior: 9% ($n = 11$) Officer: 3% ($n = 2$)	"There is a tendency to perceive people who claim to be stressed out as malingerers" (06018) "Suffering from stress is frowned upon as it is seen as swinging the lead" (08015)
Lack of openness regarding stress	Junior: 10.5% ($n = 21$) Senior: 2.6% ($n = 3$) Officer: 0% ($n = 0$)	"The term stress is not used and [the] subject is not openly talked about" (08014) "Peers don't seem to like to talk openly about stress" (02012)

Table V. Main themes about how one's peer group act towards and handle stress and stress-related problems.

Theme	Response rate	Quote example
It would be seen as a joke	Junior: 12.6% ($n=27$) Senior: 6.5% ($n=8$) Officer: 0% ($n=0$)	"Laugh at them: everything seems to be a joke in the Navy" (11114) "Take the mickey, especially some of the younger lads" (00000)
Individuals would be avoided	Junior: 8.4% ($n=18$) Senior: 4% ($n=5$) Officer: 0% ($n=0$)	"Don't really go out of their way to assist individuals" (05159) "Try to avoid it and not get involved ..." (11094)
'Tough love'	Junior: 7% ($n=15$) Senior: 6.5% ($n=8$) Officer: 9.2% ($n=6$)	"Old school lads a lot would say 'suck it up' you are in the Navy" (11127) "Stiff upper lip attitude" (03001)
Lack of understanding and awareness in the Navy	Junior: 9.8% ($n=21$) Senior: 11.4% ($n=14$) Officer: 4.6% ($n=3$)	"Misinterpreted – a lot say they are stressed when they aren't" (08029) "A lot of them don't realize how much stress there is in the service" (11033)

internally stigmatizing beliefs about how personnel might be treated and perceived themselves, if distressed, were common. Furthermore we found that distressed personnel reported internal stigma two to three times more often than those who were not distressed. Stress cases were also more sensitive to barriers to care and were less likely to believe that any help they might receive would be rendered confidentially. Our qualitative analysis revealed that Juniors were less likely to feel comfortable discussing emotional issues with their peer group than senior staff.

Limitations

This study used cross sectional data and therefore reports association rather than causation. Also we were unable to contact all personnel and if they were not present during data capture periods they did not receive a questionnaire. Therefore the data represents an opportunistic sample although there was no reason to think that distressed personnel, unless unwell, should not have been as likely to have been onboard as non-distressed ones during data capture periods. Also, in keeping with all studies that use self report questionnaires, the reported caseness rates may be overestimates although there is no reason to think that this should have affected the associations reported. Lastly these findings may have less relevance for Royal Marines, Army and Royal Air Force personnel who work in units that are structured differently.

Main findings

We predicted that both external and internal stigma towards mental illness would be prevalent within this RN population (Hoge et al., 2004). However, our finding that external stigma beliefs were uncommon (with the exception of those who were measurably distressed) and instead the majority of the quantitative sample appeared generally supportive and positive towards mental health represents a change from the stigmatizing attitudes once prevalent among the UK Armed Forces (Holmes, 1985). Such changes may simply be a reflection of societal changes or might perhaps be due to changes in military policies over recent years.

In keeping with other authors we found internal stigma was common (Britt, 2000; Cawkill, 2001; Hoge et al., 2004). Thus whatever societal or policy changes that might have affected military personnel's increased ''faith in the system'' did not extend to how they thought they would be treated themselves. This very much reflects the findings of Cawkill (2001) who surveyed UK military commanders (equating to Seniors and Officers) about mental health issues. Commanders appeared positive about supporting their subordinates but reported that they would not seek help themselves even if they might need it.

We also found differences between how the stress cases and non-cases in terms of stigma and the perception of the confidentiality of in-service support. Distressed individuals reported more negative opinions towards in-service support as well as higher levels of internal stigma than non-distressed personnel. Although it may have been that these individuals held more negative views as a function of their symptoms, such findings have been found previously in US military personnel (Hoge et al., 2004) and also UK military veterans (Iversen et al., 2005). Therefore it seems that at the very time when military personnel most need help, stigmatizing beliefs make it less likely that individuals believe it is safe to do so. However as the statistical differences between cases and non cases was only slight in real terms, it may be that with effectively targeted encouragement individuals might be encouraged to overcome the barriers to seeking help for their problems.

A further important finding of this study, from both the quantitative and qualitative data, was that the majority of Juniors reported negative opinions about how their own peer group regarded distressed comrades. Previous research has found that UK military junior personnel are at the highest risk of developing mental health problems (Ismail et al., 2000) and also that military personnel generally favour peer support over more formal mechanisms for assistance (Solomon, Mikulincer, & Avitur, 1998; Greenberg et al., 2003). Our data suggests that although Juniors may use colleagues for general social support, which might prevent them from becoming distressed, they are not likely to turn to peers once they have become unwell. Being unwilling to access informal peer support when distressed may represent another substantial barrier to care, as individuals in the lower ranks possess fewer military and general life experiences which might allow them to readily access other sources of support.

Conclusions

Although this study has found that most naval personnel are positive about dealing with the mental health of others, it points towards internal stigma remaining a significant barrier which is likely to prevent personnel from seeking help if they should suffer a mental health problem. This problem appears especially relevant for those who are distressed and for junior personnel, which given their vulnerability to developing mental health issues is a potential concern. The study was not able to determine what the causes were of the reported stigma or indeed whether the concerns that personnel reported were supported by reality; it is likely that the military cannot support employment of personnel with any health difficulty in perpetuity although this applies equally to physical as well as mental health difficulties.

However our results suggest that there is still work to do for the UK military to encourage appropriate help seeking behaviours. Delay in personnel presenting for formal support, where needed, is unfortunate as their problems may be easier to deal with at an early stage. Prolonged delay and a subsequent lengthy period of treatment may in itself disrupt an individual's career sufficiently to cause an early retirement from Service. Whilst cultural changes take time, our results suggest that continuing to reduce stigma and other barriers to care is a worthwhile, if complex, endeavour.

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