MILITARY PSYCHOLOGY, 23:1–5, 2011

ISSN: 0899-5605 print / 1532-7876 online
DOI: 10.1080/08995605.2011.534397

Stigma as a Barrier to Substance Abuse and Mental Health Treatment

Les McFarling, Michael D'Angelo, and Marsha Drain
U.S. Army Center for Substance Abuse Programs, Alexandria, Virginia

Deborah A. Gibbs and Kristine L. Rae Olmsted
RTI International, Research Triangle Park, North Carolina

This article provides an overview of stigma associated with mental health and substance abuse treatment in military settings and discusses articles included in this issue. These articles examine the predictors of and barriers to treatment entry; assess the influence of military culture and unit influences on attitudes toward treatment; examine unique challenges associated with reserve personnel; and address policy changes to improve access to care. We review challenges associated with reducing stigma and the importance of policy, culture, education, and leadership to effect the desired changes.

Numerous studies have addressed the attitudes and beliefs contributing to stigmatization of mental health issues generally (Corrigan, 2000; Corrigan & Watson, 2002; Vogel, Wade, & Haake, 2006; Vogel, Wade, & Hackler, 2007) and within military populations (Dickstein, Vogt, Handa, & Litz, 2010; Hoge et al., 2004; Science Applications International Corporation [SAIC], 2010). However, stigma associated with substance abuse is less well understood. If evidence suggests that stigma has prevented soldiers from seeking essential help with substance abuse issues, it is critical to effectively reduce stigma so that soldiers can receive the help they so urgently need. The articles in this issue are intended to broaden the body of knowledge about stigma and to stimulate solutions by which it can be reduced.

We see the development of stigma as a systemic issue, deeply rooted in the traditions of the military. From basic training to their first duty assignment, soldiers

Correspondence should be addressed to Dr. Mike D'Angelo, 4501 Ford Ave., Alexandria, VA 22302. E-mail: michael.s.dangelo@us.army.mil

are conditioned to be physically strong and mentally tough—in other words, macho. This ethos is exemplified by such military service marketing slogans as "Army Strong" and "The Few, the Proud, the Marines." The value placed on strength within military culture creates the risk of stigma for any situation in which weakness is perceived. Accordingly, if substance abuse treatment is associated with weakness, servicemembers may be ridiculed by peers to the point that treatment seeking becomes untenable.

Military policy toward substance abuse and its treatment has evolved in response to a changing situational context (Department of the Army, 2009). Sometimes these changes have resulted in unintended consequences, including the creation of stigma for treatment. In the post-Vietnam era, drug use among servicemembers was quite common and did not engender the stigma that it does today. As military acceptance of drug use ceased, stigma associated with drug use increased. Attitudes toward alcohol abuse have also shifted over time. In the mid-1980s, senior Army leaders recognized that heavy drinking had reached unacceptable levels. By using policies of compassionate treatment and deglamorization, they were able to reduce heavy drinking without stigmatizing those affected (Department of the Army, 1985, 2009). However, in the post–Cold War drawdown of forces of the 1990s, substance abuse behaviors were sometimes used to disqualify members from service—thus introducing the stigma that we live with at present. Today, 10 years of war and its consequences may have mitigated the stigma associated with seeking combat-related mental health treatment. However, the stigma associated with substance abuse treatment remains, albeit for different reasons than one might expect.

The articles in this issue address an important question raised by a clinician during a focus group session on stigma—in the current military environment: Is it "better to be drunk or crazy?" To this we add a follow-up question: What can be done to reduce barriers to treatment for both substance abuse and mental health issues among military personnel? The articles in this issue describe stigma from a variety of perspectives. In doing so, they lay the groundwork for responding to the normative attitudes toward substance abuse and mental health issues, as well as ameliorating the factors that undercut efforts to treat associated problems. Specifically, they describe the prevalence of harmful drinking, barriers to treatment, determinants of perceived stigma for treatment, predictors of treatment entry, perceptions of treatment programs, and novel ideas for treatment of substance abuse.

As shown by Ramchad and colleagues (this issue), a significant proportion of military personnel in need of treatment services for either substance abuse or mental health issues do not seek them. As military personnel return from deployments, they may abuse alcohol for numerous reasons, including the desire to cope with uncomfortable feelings or memories, deal with stress, or facilitate camaraderie with other personnel. Ramchand and colleagues present new, nationally representative data to examine the prevalence of harmful drinking behaviors

in military personnel, as well as how those behaviors vary with respect to military status (Guard/Reserve, active duty, and veterans). The authors place these data in context by comparing rates of alcohol abuse among deployed military personnel with those of a similar civilian population, as reported in nationally representative samples.

Who is at risk for substance abuse and behavioral health issues, and is that risk a valid predictor of treatment entry? The answer to this question has the potential to inform screening and referral effort, as well as planning for treatment resources. Clinton-Sherrod and colleagues use extant data from Post Deployment Health Reassessment (PDHRA) records to determine risk for substance abuse and/or behavioral health issues. They evaluate the degree to which that risk relates to actual treatment entry and identify discrepancies between rates of treatment for substance abuse and mental health issues. Their findings point to several important questions about how these issues are addressed within the military.

In what ways might military culture provide context for attitudes toward alcohol abuse and/or mental health issues? How do these attitudes influence the ways that soldiers think about treatment? Gibbs and colleagues use focus group interview data to describe distinctions between alcohol abuse and mental health issues within the military and examine how these differences shape attitudes regarding treatment for each condition. The authors examine the degree to which perceptions of responsibility for the condition and danger to others influence stigma. They also suggest opportunities to address negative attitudes toward treatment for alcohol abuse.

Soldiers in treatment for behavioral health or substance abuse issues may perceive barriers to care differently from their counterparts who are not receiving treatment. Logic suggests that those in treatment would have lower perceptions of stigma associated with their care than soldiers who are not in treatment, based on their understanding of their condition. Alternatively, they may perceive greater stigma, based on reactions they have experienced from others. Which model is supported by data? Rae Olmsted and colleagues compare perceptions of stigma among soldiers in treatment and those not in treatment. Their findings, which suggest that the very people who need treatment the most may be least likely to seek it, have important implications for efforts to encourage treatment.

Attitudes toward treatment among active duty servicemembers are understandably influenced by the military environment in which they live and work. But what factors prevent veterans from seeking care? Kim and colleagues examine negative beliefs about treatment and the impact of those beliefs on treatment-seeking behaviors among veterans of Iraq and Afghanistan operations. Their results may guide efforts to reduce negative attitudes that may keep veterans from seeking needed care.

Conceptual theories and paradigms can often be used to understand and address complex social and behavioral phenomena. Britt and colleagues propose the theory of planned behavior as a useful tool for application to this difficult question. They analyze data from a survey of Reserve Component veterans to identify beliefs about psychological problems and attitudes toward treatment. Their findings are discussed in terms of novel interventions that can be used to modify perceptions of behavioral health problems.

Negative attitudes toward treatment seeking are frequently based on soldiers' perceptions of how others will respond to their treatment status. Gibbs and colleagues look at an innovative pilot program that combats stigma by offering soldiers treatment for alcohol abuse without command notification. These preliminary data suggest that the option of confidentiality may encourage self-referral to services among soldiers who are motivated to seek treatment.

As evidenced in the articles in this issue, stigma in any form is a problem for the military because it potentially diminishes individual and unit effectiveness. Moreover, if stigma creates a barrier to treatment, dramatic changes will be required to make it acceptable for servicemembers to receive treatment. One effort has already taken hold: rewording questions for security clearances to make it less damaging for a servicemember to have received counseling for substance abuse issues. Similarly, the innovative confidential treatment pilot initiated in July 2009 has seen success in the number of soldiers coming forward for help (Steele, 2010). The vision for future service delivery and policy may include separating treatment from the commander's use of military discipline for substance abuse infractions. This is a worthy goal because it would pave the way to reducing stigma and would foster a supportive environment for soldiers asking for and receiving assistance.

Effectively removing barriers to treatment will also entail a change in military culture. It will take time to establish the belief, beginning in basic training, that it takes courage to ask for help. Doing so will require all military leaders to take positive, progressive, and consistent steps to remove stigma for those seeking help with a problem. The military has led the civilian world in addressing prejudice in other areas, such as desegregating the military force and becoming a champion of equal opportunity (Moskos, 1966). Time will tell whether we can achieve the social, policy, and cultural challenges necessary to reduce stigma for substance abuse and mental health treatment.

REFERENCES

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology - Science and Practice, 7*(1), 48–67.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology - Science and Practice, 9*(1), 35–53.

Department of the Army, Chief of Staff. (1985). *Letter, 25 March 1985, subject: Department of the Army Alcohol Policy*. Washington, DC: Author.

Department of the Army. (2009). *Army Substance Abuse Program (ASAP): Army Regulation 600-85*. Washington, DC: Author.

Dickstein, B. D., Vogt, D. S., Handa, S., & Litz, B. T. (2010). Targeting self-stigma in returning military personnel and veterans: A review of intervention strategies. *Military Psychology, 22*(2), 224–236.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*(1), 13–22.

Moskos, C. C., Jr. (1966). Racial integration in the Armed Forces. *The American Journal of Sociology, 72*(2), 132–148.

Science Applications International Corporation. (2010). *Stigma associated with seeking behavioral health care: Reducing stigma/assessing efforts to reduce stigma.* Washington, DC: Author.

Steele, D. (2010). Inspired care for the invisible wounds. *Army: The Magazine of the Association of the United States Army, 60*(7), 65–67.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*(3), 325–337.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*(1), 40–50.