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Abstract
It has been clinically observed and the literature concurs that military service members often fail to access mental health services in spite of availability of care. The reasons for failure to access care appear to be that military service members are fearful of accessing mental health services for fear of being stigmatized. Failure to receive care for mental health problems can result in deleterious results, some of which may culminate in inability to function or even loss of life. Additionally, failure to access mental health care can result in massive monetary costs in terms of loss and replacement of personnel for the Armed Forces. The purpose of this paper is to investigate military personnel’s attitudes towards mental illness, the effects of stigma on those who attempt to access mental health care and to explore possible cultural alternatives that would foster positive approaches to obtaining mental health care.

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Dedication page

This work is dedicated to the memory of my father Gabriel Jose DelBusto who taught me to love Freedom.

To the memory of my father in-law Herman Louis Cohen, Chief Petty Officer, United States Navy, who fought for that Freedom

And to Colonel F. Strittmatter, United States Army, my mentor at Ft Drum, N.Y.
Abstract

It has been clinically observed and the literature concurs that military service members often fail to access mental health services in spite of availability of care. The reasons for failure to access care appear to be that military service members are fearful of accessing mental health services for fear of being stigmatized. Failure to receive care for mental health problems can result in deleterious results, some of which may culminate in inability to function or even loss of life. Additionally, failure to access mental health care can result in massive monetary costs in terms of loss and replacement of personnel for the Armed Forces. The purpose of this paper is to investigate military personnel’s attitudes towards mental illness, the effects of stigma on those who attempt to access mental health care and to explore possible cultural alternatives that would foster positive approaches to obtaining mental health care.
Military service members’ attitudes towards mental illness and access to mental health services:

A problem of stigma.

The origin of stigma:

Kurzban and Leary, (2001), argue that social exclusion in human culture is due to mechanisms of adaptation that have been observed in other species as well (Darwin, 1859). The authors propose that territoriality, which is observed in various taxonomies, involves behaviors that exclude others. Another example of social exclusion posed by the authors is the establishment of status hierarchies in which organisms of higher status impose restrictions or control on lower ranking organisms. These organisms are frequently denied access to economic and social benefits. Examples of such behaviors have been reported in the sociobiological literature in reference to cases of primates being expelled from their group because of differences in social behavior or disease (Goodall, 1986). The research literature posits that human psychology of social exclusion may be impacted by natural selection processes similar to those observed in other animals (Darwin, 1859),(Kurzban & Leary, 2001). Kurzban and Leary propose that because humans possess psychological mechanisms that encourage them to seek out others socially, adaptations have evolved in order to prevent mistakes in social functioning. The authors then posit that stigma is derived at least in part by dyadic cooperation; that is a host of adaptation mechanisms designed to avoid interaction with inappropriate sociobiological mates who may prove to be poor partners for social exchange. Stigma may also be derived from coalitional exploitation, another set of adaptation mechanisms that is designed to exclude and exploit others from being members in one’s group. Yet another function from which stigma may be derived is from parasitic avoidance, which is another adaptation mechanism designed to exclude those with communicable disease or parasites. Finally, the evolutionary concept of stigma is able to
explicate the consensual nature of stigma. That is to say, that members of a particular group not only agree to exclude others but are able to articulate the shared belief (Kurzban & Leary, 2001).

The concept of stigma:

The concept of stigma applies “when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows the components of stigma to unfold (Link & Phelan, p. 367). The concept of stigma has varied throughout the literature because stigma affects various aspects of people’s lives and it can have tremendous influence in several areas of life such as housing, health, crime involvement and life itself,(Link & Phelan,2001). Social psychologists have done substantial research on the phenomena of stigma by utilizing concepts from social psychology. Social psychologists have used the social cognitive approach in order to comprehend how individuals construct categories and link these categories to stereotyped beliefs. There are numerous definitions of stigma beginning with the dictionary definitions such as “marks of disgrace” (The American Heritage College Dictionary, p. 1353), to definitions proposed by various researchers. For example some researchers have proposed that stigma is a “characteristic of persons that is contrary to the norm of a social unit where norm is defined as a shared belief that a person ought to behave in a certain way at a certain time”,(Stafford & Scott, 1986, p. 80). On the other hand, stigma can be thought of as a relationship between an attribute and a stereotype. This relationship can produce a definition of stigma as a mark, (attribute) that links a person to undesirable characteristics, (stereotypes), (Jones,E., Farina,A., Hastorf,A., Markus,H., Miller,D.T., & Sctt, R.(1984). The concepts of stigma seem to vary because stigma can be applied to any of life’s circumstances. Research on stigma has come from multidisciplinary sources thus approaching the study of the phenomena from various angles and theoretical frameworks. Additionally, research on stigma has
traditionally focused on individuals, or perceptions of individuals versus looking at stigma as a
source of consequences that is persistent, pervasive and causes social exclusion from social and
economic life. Stafford et al., (1986) and Goffman (1963), describe stigma as “the relationship
between an attribute and a stereotype”. Others state that stigma is a process that occurs when
essential events happen simultaneously, (Link & Phelan, 2001). For example, human differences
must be distinguished and labeled. There must exist dominant cultural beliefs that link labeled
individuals to undesirable characteristics, (negative stereotypes). Labeled individuals are then
placed in categories, (pigeon holed), so as to create distances from the stigmatized and the rest of
“us.”Finally, as a result of the process the stigmatized individuals experience loss of status and
discrimination that leads to unequal treatment, (outcomes). Furthermore, in extreme cases of the
process, stigmatized individuals are “thought to be so different from “us” as to be not really
human, and again in the extreme, all manner of horrific treatment to “them” becomes possible”
(Link & Phelan, p. 370). Further examination of the phenomena of stigma suggests that although
there may be some differences in emphasis or focus, stigma and prejudice is basically the same
thing (Phelan, Link, & Dovidio, 2008). However, it has been proposed that there are three basic
functions of stigma and prejudice. The first function involves the area of dominion and
exploitation, (keeping people down). Ideologies that support and perpetuate inequalities are
example of this function. The second function involves the enforcement of social norms,
(keeping people in), which enforces conformity with the set norms. Phelan et al., point out that
this function of stigma and prejudice is aligned with the function of exploitation and dominion in
the sense that the dominant group defines what is acceptable and unacceptable. The third
function of stigma and prejudice is referred to avoidance of disease or (keeping people away).
Phelan et al argue that the rationale for this function lies in evolutionary psychology; avoidance
of individuals that may contribute to unattractive or unhealthy phenotypes. Furthermore, it has been pointed out that this condition is particularly salient towards conditions that are visible such as skin conditions deformities and to “psychological functioning that may appear diseased” (Phelan et al., 2008, p. 363). In summary, from the standpoint of evolutionary psychology, stigma and prejudice result from a social selection process which determines which differences are acceptable or unacceptable. The second aspect of this process, as observed from the lens of social psychology, involves attribution of negative characteristics to the labeled individual(s). There then results segregation between the stigmatized individual(s) and “us” and subsequent loss of status and discrimination. In the end result stigma cannot occur without power (Link & Phelan). This segregation suggests a significant power differential.

The concept of stigma within the context of attribution theory:

Another way to understand the phenomena of stigma is to view the concept within the framework of attribution theory. Attribution theory provides a social cognitive approach to stigma and frames the phenomena in terms of knowledge structures. Knowledge structures are means of categorizing information, (attributes and attitudes), about social groups (Corrigan, 2000, p. ). Corrigan explains that these knowledge structures are considered social because they collectively represent agreed upon notions about groups of people. They are considered efficient because individuals quickly generate impressions and expectations of people that belong to such groups. Attribution theory is a conceptual model of human motivation and emotion. It is based on the assumption that people search for the causal understanding of everyday events, (Weiner & Magnusson, 1988).

There are two constructs within the theory of attribution that affect causal attribution. These constructs are controllability and stability. Controllability of causes pertains to the amount
of willful influence that an individual can exert on a cause. For example, a mentally ill individual has control over the onset of his/her illness. The public is more likely to blame events, (such as the onset of mental illness), as personally controllable. The idea of controllability is further subdivided into onset controllability, that is to say that the onset of disease such as mental illness is controllable as opposed to offset controllability which implies the inability of an individual to control, understand, or cope with their illness. For example, offset controllability would dictate that people with mental illness cannot fully participate in their mental health care because they lack insight, (inability to comprehend), their illness Corrigan et al., (2005).

Stability of causality refers to the temporal nature of causes. (Weiner & Magnusson, 1988), state that attributions of controllability and responsibility are often associated with emotional responses. For example, mentally ill individuals who exhibit psychotic symptoms or emotional lability are more likely to be held responsible for the presentation of their symptoms and evoke responses of anger by the public. Furthermore, individuals who view themselves in similar fashion are apt to experience feelings of shame and guilt.

The impact of stigma on the mentally ill:

Another aspect to consider is the impact that stigma has on individuals. It has been noted that stigma has a dual effect on stigmatized people. For example, public stigma is described as the reaction of the general public towards those individuals who are stigmatized. Self stigma on the other hand, is described as the prejudice that the stigmatized person has towards the self (Corrigan & Watson, 2002). The authors discuss this topic within the context of mental illness and the mentally ill. The researchers propose that both public and self stigma may be understood in terms of three components; stereotypes, prejudice and discrimination. Social psychology views the function of stereotypes as “efficient, social knowledge structures that are
learned by members of a social group” (Corrigan & Watson, 2002, p. 16). Stereotypes are described by the authors as beliefs and prejudice as a cognitive, affective process which is judgmental, and usually generates negative emotional reactions. The third component of stigma involves discrimination or the behavioral expression of the belief. For example, prejudice can generate feelings of anger and rage which can lead to violence. Corrigan reports that in terms of the mentally ill population, prejudice can result in withholding mental health care or replacing this care with the criminal justice system (Corrigan & Watson, 2002,). Additionally, fear may lead to avoidance of the mentally ill person which can lead to economic and financial problems for the individual. Prejudice turned towards the self may result in self discrimination. Additionally, the research suggests that “self stigma and fear of rejection by others lead persons not to pursue life opportunities for themselves” (Corrigan & Watson, 2002, p. 16). Of further interest, the literature suggests that stigmas about mental illness appear to be endorsed more frequently in the Western world than in Eastern cultures. It has been postulated that perhaps the reason for this is that there is lack of differentiation between psychiatric illnesses and medical illnesses in the East (Fabrega, 1991).

Stigmatizing views about mental illness seem to be generated not only by uninformed individuals but by mental health professionals as well (Corrigan & Watson, 2002). There are several themes that accompany misconceptions about mental illness and the mentally ill. These themes involve; fear and exclusion, authoritarianism, and benevolence. The theme of fear and exclusion implies that people with severe mental illness are dangerous and should be feared and avoided. The theme of authoritarianism implies that persons with severe mental illness are irresponsible, cannot fend for themselves and have to be guided by others. This theme implies that the severely mentally ill are not able to make their own decisions and others must do this for
them. Finally, the theme of benevolence implies that the mentally ill are naïve and childlike and need to be taken care of. Corrigan and Watson (2002) report that the behavioral or discriminatory sequelae of prejudicial attitudes of public stigma result in basically four main actions; withholding help, avoidance of the mentally ill person, coercion and segregated institutions.

The research literature further suggests that individuals who have internalized stigma seem to suffer loss of self esteem and self efficacy. Corrigan (2004). Studies suggest that prior to internalization of stigma; these individuals have internalized cultural stereotypes about mental illness. Additionally, when these individuals are diagnosed with mental illness, these stereotypes become relevant to the self and result in isolative and withdrawn behavior, unemployment, and lowered income. Some individuals however, when faced with the above mentioned situation become energized and empowered while others may remain indifferent to the situation. It has been argued that perceived discrimination is not a measure of self stigma but of stigma awareness. However, stigma awareness is a necessary but not sufficient component of self stigma. (Watson et al., 2007, ). The authors point out that “stereotype agreement” occurs when an individual buys into the common public stereotypes. The process becomes self stigmatizing when the individual internalizes the stereotype by applying the belief to the self, stereotype self concurrence. This process generates decrease in self esteem and self efficacy, (Watson et al., 2007, ).

Structural Stigma:

So far, the topic regarding stigma has been discussed in terms of processes that are based on an individual level of a psychosocial paradigm (Corrigan, Markowitz, & Watson, 2004). That is to say, the impact of stigma on people with mental illness that individuals, (or groups of individuals), have on the stigmatized or that the stigmatized have on themselves. The
topic has been discussed within the context of social cognition. In other words, individuals, (the public), perceive a stigmatizing element or “mark” on an individual(s). Negative characteristics, (stereotypes), are generated and subsequently the behavioral aspect of the social cognitive process, (discrimination), ensues. However, a macro social level of analysis reveals that there are a separate set of factors that contribute to the discrimination of the mentally ill. These factors involve structural stigma. According to Corrigan, Markowitz & Watson (2004), structural stigma involves structural or institutional policies of private and governmental institutions that intentionally or unintentionally restrict opportunities of people with mental illness. Structural or institutional discrimination manifests itself in the imposition of rules, policies or procedures by private or governmental entities that are in a position of power to restrict or curtail the rights or opportunities of others. Corrigan et al,(2004), cite the Jim Crow laws as examples of governmental legislation that created sanctions against people of color. These laws resulted in decreased employment opportunities, decreased educational opportunities and segregated public accommodations for African Americans. The Jim Crow laws are an example of intentional restriction of opportunities of others. In addition, unintended discrimination may result in actions such as the administration of admission examinations to colleges and universities which unintentionally may exclude persons of other cultures or physically challenged individuals such as the deaf or blind. Studies conducted to explore statutory discriminatory practices against people with mental illness in all fifty states, revealed that states had passed legislative actions that restricted the civil rights of the mentally ill in five basic areas Corrigan et al., (2005). These included voting, holding elective office, serving jury duty, parenting and remaining married. Approximately 1/3 of the states restrict the rights of people with mental illness to hold elective office, participate in juries and vote. As per the literature, between 42-52% of states limit the
rights of people with mental illness to remain married and more than 40% of states limit custody rights of parents with mental illness (Corrigan et al., 2004, p. 482), (Burton, 1990), (Hemmens, Miller, Burton, & Milner, 2002). Two important trends that the authors noted were that states generally were more restrictive of people with mental illness than those who were deemed incompetent. Another trend noted refers to the lack of change in the number of the states that restrict these rights. This however can be attributed to the lengthy processes usually associated with changing or amending legislation (Corrigan et al., 2004). Another area that is worthy of mention in terms of structural stigma is the dissemination of information regarding the mentally ill through the news media. Survey analysis in several English speaking countries showed that newspapers frequently portray the mentally ill as violent (Corrigan et al., 2004).

Stigma of Mental illness within the military population:

Effects of combat experience on the mental health of military service members, has raised serious issues and concerns. Research conducted on military personnel post deployment experience has shown that deployment stressors and exposure to combat has resulted in risk of development of multiple mental health problems such as Post Traumatic Stress Disorder, (PTSD), Major Depressive Disorder, (MDD), substance abuse, impairment of social functioning, and the ability to work (Hoge, Auchterlonie, & Miliken, 2006, ). The literature reports that there is a strong correlation between combat experiences, such as handling of dead bodies, knowing someone who was killed, or killing enemy combatants, and the development of PTSD. Whereas the rates of PTSD in the general adult population in the United States ranks approximately between 3-4%, studies report that 17% of soldiers and marines who have returned from Iraq alone have screened positive for PTSD, generalized anxiety, depression, estimating these effects to be twice that prior to deployment (Hoge, Auchterlonie, & Miliken, 2006, p. 1023).
It has been estimated that as of April 2008, approximately 303,000 Operation Iraqi Freedom (OIF) / Operation Enduring Freedom (OEF) veterans were suffering from PTSD or major depression, (The Rand Corporation, 2008, p. 5). It has been documented that the prevalence of reporting mental health problems was 15.6%-17.1% among service members who returned from Iraq, (OIF) as opposed to 11.2% who returned from Afghanistan (OEF) and 8.5% from those returning from other locations (Hoge et al., 2006, p. 1027). Additionally, these problems were associated with combat experiences, mental health care referral and utilization, and attrition from military service (Hoge et al., 2004, p. 13), (Kolkow et al., 2007, p. 451). The authors point out that studies conducted on service members years after deployment, show a 15% prevalence of current PTSD among Vietnam veterans and 2-10% among Gulf War veterans (Hodge et al., 2004, p. 20). Longitudinal studies indicate that rates previously reported based on surveys immediately upon return from deployment substantially underestimate the mental health burden. In contrast to rates immediately reported upon return from deployment, soldiers reported increased mental health problems and were referred at much higher rates several months after return. Additionally, mental health concerns were associated with military service attrition (Miliken, Auchterlonie, & Hoge, 2007). Among the 289,328 OIF and OEF veterans entering and using the VA health care from April 1, 2002 to March 31, 2008, new mental health diagnoses increased six fold: from 28 of 439 veterans,(6.4%) in April 2002 to 106,726 of 289,328 veterans (36.9%) by March 2008 (Seal et al., 2009, p. 1652). When examined for mental health problems that included psychosocial and behavioral problems, the prevalence increased from 9.1% to 42.7% (Seal et al., 2009, p. 1652). The prevalence of PTSD diagnoses increased most during the study period from 1 of 439 veterans, (0.2%) to 62,929 of 289,328 veterans (21.8%) (Seal et al., 2009, p. 1652). This was followed by diagnoses of depression which increased from 10 veterans
(2.3%) to 50,432 veterans (17.4%) (Seal et al., 2009, p. 1653). Additionally, the prevalence of new mental health diagnoses increased steadily in cohorts of OIF and OEF veterans entering the VA health care and followed for increasing lengths of time for one to four years. For example, veterans who entered the VA health care in quarter one of 2004, (the last quarter for follow up data), the cumulative proportion for receiving mental health diagnoses increased from 14.6% to 27.5% in four years (Seal et al., 2009, p. 1652). The researchers posit that factors contributing to delayed mental health diagnoses may include stigma of mental illness which may be a contributing factor to reluctance of seeking mental health care until symptoms interfere with functioning. Additionally, the authors state that decrease in support for the war may have contributed to decrease in morale for the troops. Also, the nature of the insurgency in Iraq was that of asymmetrical warfare. That is to say, that there were no definable “front lines” which were characterized by roadside bombs and IEDs (improvised explosive devices). Lastly, multiple and more lengthy deployments also may have contributed to steady increase in mental health problems (Seal et al., 2009, p. 1656).

Hoge et al, (2004), point out that in the military there are unique factors that contribute to service members’ reluctance in accessing mental health care. Some of these factors may be concern over how a soldier may be perceived by peers and leadership. For example, the authors point out that “concern about stigma was disproportionally greatest among those most in need of help and mental health services. Soldiers and Marines whose responses were scored as positive for a mental disorder were twice as likely as those whose responses were scored as negative, to show concern about being stigmatized and about other barriers to mental health care” (Hoge et al., 2004, p. 20). The research literature notes that soldiers reported more discomfort in discussing their psychological problems versus their medical problems particularly when they were
returning with their units. It has been suggested that a major factor contributing to this discomfort is the perceived stigma associated with admitting a problem and seeking help for that problem (Greene-Shortridge, Britt, & Castro, 2007). Additionally, two of the largest identified barriers were concerns that the unit leadership might treat the soldier differently and that members of the unit might have less confidence in the soldier (Warner, Appenzeller, Mullen, Warner, & Griefer, 2008). Another barrier that has been identified in the literature is that there exists a perceived difference in the patient–physician relationship. Military physicians are different from occupational physicians in the sense that they have a responsibility not only to the individual, but also to the organization. There is little doubt that military personnel are well aware of this (Rona et al., 2005, p. 125).

The research literature reports that in the general population, psychiatric illness has been associated with occupational problems including absenteeism, decreased productivity, and unemployment, as well as high use of health care services and social impairment (Hoge et al., 2005). The authors contend that the United States military represents an important segment of the US general working population. It has been documented that among active duty military personnel, psychiatric disorders are the leading cause of hospitalization in men and the second leading cause of hospitalizations in women. Among the 1.4 million service members on active duty, 6-10% receives treatment for mental health problems each year, (Hoge et al., 2005, p. 585), The authors contend that psychiatric hospitalizations were significantly associated with involuntary separations from the Armed Services. For example, in one study 47% of service members who were hospitalized for a mental disorder, separated from military service as opposed to 12% of service members who were hospitalized for medical reasons (Hoge et al., 2005, p. 585), (Hoge et al., 2002, p. 1580). The authors point out that perhaps some of the
contributing factors could be high levels of disability, chronicity of illness, stigma, and/or behavioral problems that may not be acceptable within military service (Hoge et al., 2005). Other studies that have been conducted on returning veterans point to stigma as the main reason for not receiving mental health care. In a study conducted by Stecker et al., stigma was identified in terms of “being crazy” and having consequences to military careers. Additionally, individuals in the study reported fear of being labeled and being concerned with consequences regarding work. Also, individuals thought that trying to get help would interfere with their home leave. “Others stated that there were officers and key non commissioned officers that encouraged soldiers not to say everything they needed to say (on the post deployment health assessment).

Additionally, approximately 45% of 300,000 service members were worried that drug therapies may have unpleasant side effects and an additional, 25% of 300,000 service members thought that even good mental health care was not very effective (The Rand Corporation, 2008, p. 5). Stecker et al. (2007) found that in spite of availability of mental health services, low rates of treatment seeking occurred. As noted, the reasons as to why military personnel hesitate to access mental health services in spite of availability of services, are complex and numerous. Some researchers have found little evidence that psycho-education alone is an effective treatment (Gould, Greenberg, & Hetherton, 2007, . For example, (Corrigan, 2004, Hendin & Haas, 1991), suggest that protesting, (expressing disapproval against stigma), and having contact with people who have mental illness can demonstrate that people with mental illness can have productive lives.

Another point of concern to service members is that their mental health problems remain confidential in the hands of mental health professionals. It appears that one barrier to accessing mental health care within the Department of Defense or the Department Veterans Affairs is that
service members may fear that documentation in the medical record regarding their PTSD related problems might have an adverse effect on their military careers. As a result, some service members opt to see civilian psychiatrists where they are assured that their confidentiality is kept (Friedman, 2006, Hodge et al., 2004).

In lieu of multiple barriers to accessing mental health services it is important to investigate what are the costs or consequences of not accessing mental health care? The Rand Study, commissioned by the Army, in 2008 entitled “The Invisible Wounds of War,” report that the invisible wounds of war go beyond the immediate costs of mental health treatment. The report warns that adverse effects of post deployment impairments may include suicide, reduced physical health, and increased engagement in unhealthy behaviors such as substance abuse, poor performance at work, homelessness, marital strain, domestic violence and poor parent–child relationships. Additionally, these costs may contribute to loss of productivity, reduced quality of life and premature mortality, (The Rand Corporation, 2008, p. 6).

Theoretical perspectives:

The authors of the Rand Study, “The Invisible Wounds of War” offer some theoretical perspectives in order to better comprehend the psychological, emotional, cognitive consequences of the invisible wounds incurred as a result of PTSD, depression, and Traumatic Brain Injury, (TBI) The literature reports that there are mechanisms that might link each of these disorders to specific experiences of war. PTSD is a reaction to a traumatic experience, depression is a reaction to loss and TBI is a reaction to injury, (Karney, Ramchand, Chan Osilla, Barnes Caldarone, & Burns, 2008). The Rand authors suggest that although these illnesses have distinctly different symptoms, they nevertheless have developmental processes that may be common to all three. What follows is a discussion of theoretical perspectives that may offer a
framework to better understand the cognitive, emotional and psychological effects of these illnesses. Karney et al. (2008) refer to the Stress Diathesis theory of illness, which postulates that people vary in their level of diathesis, that is to say, predisposition, (individual and/or environmental) to characteristics that may increase their vulnerability to disease. Some of these vulnerabilities may include pre existing mental health problems, lack of education, prior experience of substance abuse or criminal behavior, and family history of mental illness. Circumstantial sources of vulnerability include poverty, social isolation, lack of adequate employment, and physical distance from resources and potential avenues of support. (Karney et al., 2008, Brewin, 1998, Heanninen & Aro, 1996). The main postulate in the stress diathesis theory is that diathesis or vulnerabilities is not enough to bring about symptoms of illness. Vulnerable individuals will become symptomatic once they are exposed to substantial levels of stress (Karney et al., 2008, Kendler, Gardner, & Prescott, 2002). This implication is important when considering the plight of service members who may be at risk of becoming symptomatic as a result of personal, family or social vulnerabilities in addition to the stress of combat. Karney et al., (2008), argue that although the stress diathesis model is functional as a framework for understanding individuals at risk for development of symptoms, it does not address how mental disorders affect aspects of human development across the life span. The authors address life span theories to elaborate on these issues. Developmental theories describe two main mechanisms that may explicate how mental illnesses contribute to subsequent problems in those who are mentally ill (Baltes, 1987). The first mechanism is called interactional continuity, which maintains that enduring qualities of a person affect the way a person interacts with others and how they respond. The concept of interactional continuity describes how mental health and cognitive conditions can impact how an individual goes through life (Karney et al., 2008). The second
mechanism is called cumulative continuity, that is to say that behaviors and choices at each phase of life have consequences that accumulate and constrain an individual’s options at subsequent stages of life (Karney et al., 2008). Service members who have behavioral problems are likely to have subsequent problems socially and professionally. Furthermore, “applied specifically to service members suffering from mental disorders, the life span developmental perspective suggests that impairments observed immediately after a service member returns from combat may have consequences for a broad range of outcomes through these two primary mechanisms. This may alter the way the service member interacts with family, peer, colleagues, impairing these relationships” (Karney et al., 2008, p. 122). The monograph, “The Invisible Wounds of War”, presents an integrated model of the consequences of post combat mental health and cognitive conditions that include a synthesis of the diathesis model and the life span development perspective. The model proposes that individuals who share a common diagnosis may have symptoms that range from mild to severe. Impairments that result from post combat mental health and cognitive conditions have direct negative consequences for individual outcomes. A service member’s resources and vulnerabilities can alter the immediate consequences of these conditions. Sufficient resources can potentially buffer and protect the individual, whereas vulnerabilities and stress can exacerbate the negative consequences of the condition. Consequences of the illnesses may have long term effects over the life span of a service member and their family. The immediate and emergent results of mental health and cognitive conditions may affect the course of the condition. Of importance to note is that interventions and policies that focus solely on ameliorating the specific symptoms of these conditions may be too narrow. In contrast, comprehensive early interventions may have significantly higher indirect long term benefits. The model suggests that supportive environments
and appropriate coping skills may be important complements to traditional interventions (Karney et al., 2008),

Suicide is the 11th leading cause of deaths in the United States accounting for approximately 30,000 deaths per year. (Center for Disease Control [CDC], 2007, (Martin, Ghahramanlou-Holloway, Lou, & Tucciareone, 2009). The rate of suicide in the civilian population is 11.3/ 100,000 (Center for Disease Control [CDC], 2007). Between 1999 -2004, 54.6% of suicides were attributed to fire arms, 20.4 % to suffocation and 17.2% to poisoning. The literature reports that males are 4 times more likely to die by suicide than females. Males are apt to use firearms in 50-60% of cases, (Martin et al., 2009), (Eaton, Messer, Wilson, & Hodge, 2006).Suicide is the 3rd leading cause of death among the 15-24 year old population. The U.S. active duty military is made up of mostly young adult males. Fifty percent of these service members fall within the range of 17-26 years old. (Eaton et al., 2006). In 2010 the Department of Defense, (DoD), reported that the average rate of suicide in the Army was 21.8 /100,000. This number was projected to climb to 24.1/100,000 in 2011(Department of the Army, 2010).

Additionally, male veterans have doubled the rate of suicide in the civilian population. Veterans are 58% more likely to use firearms to end their lives (Kaplan, Huguet, Mc Farland, & Newsom, 2007). Within the military population, military personnel, by virtue of their jobs have access to lethal means, and are often without social support.

The literature reports that there is consistent evidence that PTSD, MDD and TBI increase the risk for suicide. It has been reported that among persons that have committed suicide, the majority had one or more mental illnesses suggesting that psychiatric problems are one of the strongest contributors to suicide (Karney et al., 2008, p. 128, (Harris & Barraclough, 1997). Psychological autopsy studies of civilians who committed suicide have consistently shown that a
significant number of individuals had probable depressive illnesses (Karney et al., 2008, Cavanagh, Carson, Sharpe, & Lawrie, 2003). As per the National Co-morbidity Survey, (2002) people with a life time history of major depressive episodes were 10 times more likely to report having thought about killing themselves and 11 times more likely to have made non-fatal suicide attempts (Karney et al., 2008, (Kessler, Borges, & Walters, 1999). Among suicides over a one year period across the VA medical Center 30% had an affective disorder (Karney et al., 2008, p. 129),(Lehmann, McCormick, & McCracken, 1995). The literature reports that although PTSD is not as strongly associated with suicide as depression, PTSD is more strongly associated with suicidal ideation and attempts, than any other anxiety disorder (Karney et al., 2008, p, (Kessler et al., 1999). Additionally, the research consistently reports that persons with TBI have a higher rate of suicide than persons without the disorder. As a matter of fact, among patients with TBI, 23% reported suicidal ideation and 18% reported having attempted suicide post injury (Karney et al., 2008, p. 129). It has been documented that persons with concussions, cranial fractures, and cerebral contusions or traumatic intracranial hemorrhages each had at least a three times higher incidence rate of suicide mortality than the general population after adjusting for sex and age(Karney et al., 2008, p. 129). Additionally, it has been documented that with respect to suicide, the standardized mortality ratio for substance abuse disorders was 9-14 times higher than it was for those without disorders (Karney et al., 2008, p. 130),(Wilcox, Conner, & Cane, 2004). As per these findings, females generally had higher mortality rates from suicide than males with respect to substance abuse disorders. Nevertheless, among service members, combat exposure increases the risk of suicide. Vietnam veterans have a greater risk of suicide than non-Vietnam veterans particularly during the first five years post discharge from active duty (Karney et al., 2008, Boehmer, Flanders, McGeehin, Boyle, & Barrett, 2004). A study found that it was
not any particular PTSD symptom but rather combat related guilt that was the strongest predictor of suicidal behavior (Karney et al., 2008, Hendin & Haas, 1991). The literature reports that the majority of fatal suicides result from first attempt. Nevertheless, nonfatal suicides attempts are strong predictors of subsequent fatalities, (Isometsa, 2001, (Joiner, 2005). In his Interpersonal – Psychological Theory of Suicide, Joiner (2005), reports that there are three variables that must co-occur, in order for a person to attempt a lethal gesture. The first is a thwarted belongingness or an unmet need to belong. This basically means that the individual feels unwanted and uncared for by others such as lack of connection to friends and family. The second variable is a perceived burdensomeness. In this case, the individual feels like they are a burden to others. The third is the acquired capability for lethal self injury. Joiner argues that people who are used to fear and suffering have acquired prerequisites for suicidal behavior (Selby et al., 2010, The post traumatic stress literature proposes that there is a correlation between preoccupation with death and environment of war.Laufer,1988, that direct experience with trauma can impact and possibly arrest the psychological development of an individual over a lifetime. Furthermore, trauma causes an imprinting of the experience on the individual. The environment of war and civil peaceful societies are radically different from each other and psychologically at odds. It has been implied that going to war leads to adaptation processes that can produce disruptions within the self and eventually lead to a “fractured self”(Laufer, 1988, p. 40). The result of this process can produce problems for the reintegration into civil society post deployment. For the veteran, the situation is even more deleterious because once the veteran returns home; he/she is publicly stripped of the identity of warrior but nevertheless, the “experience of war is permanently burnt into the psyche, no matter what the character of nature of the war” (Laufer, 1988, p. 40). There results a contradiction between the civilian identity, and the identity that evolves from the
warrior. The warrior identity is based on the repression of the initial civilian adolescent identity. “Veterans of war live in an environment where the warrior experience primarily plays a traumatic role in adult development.” (Laufer, 1988, p. 40). The literature argues that once the person has been subjected to extreme stress, the trauma becomes embedded in the personality and there ensues an interactive relationship between the memory of the trauma and subsequent stages of adult development. Additionally, exposure of the self to a hostile environment fundamentally undermines the ability of the person to mature. This exposure hinders the fruition of a person’s potential development. It has been proposed that the most fundamental structural alteration we impose on soldiers at war, involves reorganization of the basic societal objectives from life enhancement to life taking and life threat. The actuality of killing within an organized unit that legitimates the taking of life and constructs its reality around killing on a day to day basis fundamentally alters the ego and self concept of individuals (Laufer, 1988), argues that war is a transformative experience. He states that war is a process versus an event in which death is the guiding teleological principle. Furthermore, war is personal. The warrior is at risk of loss of any sense of the world of the living and survivors of war become living symbols of the grotesque. Additionally, there remains survivor guilt.”The war self is a truncated self that survives in a timeless dimension. The war self develops under the aegis of the death principle and is never able to free itself from the premature encounter with death or its preoccupation with death and survival” (Laufer, 1988, p. 50).

Governmental response to the plight of warriors:

Since 2006, the Department of Defense, (DoD) and Department of Veterans Affairs have responded to enormous challenges such as overall improvement of quality of care, the re-invention of the disability process, and the coordination of medical and personal services in
response to the overwhelming health care needs of service members. Some of these changes have occurred as a result of guidance and suggestion from Secretary Gate’s Independent Review Group, the President’s commission (President’s Commission on Care for America’s Returning Wounded Warriors, 2007), the Task Force on the Future of Military Care, and the Mental Health Task Force. Steps have been taken to redefine collaboration with the Department of Veterans Affairs and the civilian sector. In 2009, the Department of Defense developed policies and programs which address recommendations related to psychological health including Post traumatic Stress Disorder and Traumatic Brain Injury (TBI). In 2007 the Department of Defense (DoD), embarked upon a comprehensive plan to transform the military system of psychological health and TBI. On February 14, 2008, the fifth Mental Health Advisory Team V (MHAT V) was established by the Office of the US Army Surgeon General. Historically, teams have been formed to support requests from the Army Surgeon General, Multi-National Force-Iraq (MNF-I). However for MHAT V the request from MNF-I was augmented by a request from the Service Chief, Army Central Command, (ARCENT), to examine soldiers in Afghanistan and Kuwait. This current MHAT report contains two separate reports; one for Operation Iraqi Freedom, (OIF) and one for Operation Enduring Freedom, (OEF). (Office of the Surgeon Multi-National Force-Iraq and Office of the Command Surgeon and Office of the Surgeon General United states Army Medical Command, 2008, p. 3). The central findings of OIF report that the percentage of soldiers screening positive for mental health problems was similar to previous years (17.9%), for a combined measure of acute stress, depression and anxiety. The reports stated that unit morale showed a significant increase from 2006. Reported levels of combat exposure varied significantly among units but there was a general decline in reports of combat. The report stated that the decline was most pronounced among soldiers who were deployed 6 months or
less. In terms of behavioral health care delivery, as compared to 2006, soldiers reported more
difficulty accessing behavioral health services, but there was less stigma associated with seeking
care. Behavioral health personnel reported a shortage of behavioral health personnel and higher
burnout. Reports of work–related problems due to stress, mental health problems and marital
separations generally increased with each subsequent month of deployment. However, reports of
mental health problems declined in the last third of the deployment likely due to re-
deployment optimism. Soldiers on the third or fourth deployment were at significantly higher risk than
soldiers on their first or second deployment for mental health problems and work related
problems. In all 11.2% of soldiers met the screening criteria for mild traumatic brain injuries.
Less than half of these, (45.9%) reported being evaluated for a concussion. Soldiers who
received pre deployment Battlemind training, a training that prepares soldiers psychologically for
war, reported fewer mental health problems. Finally, suicide rates continue to elevate relative to
historic Army rates. Most suicides involved failed relationships with spouses or intimate
partners, (Office of the Surgeon Multi-National Force-Iraq and Office of the Command Surgeon
and Office of the Surgeon General United states Army Medical Command, 2008, p. 5).Central
findings from OEF stated that soldiers from OEF reported rates of mental health problems
similar to rates observed in OIF MHAT missions. In terms of combat exposure, Brigade Combat
Teams (BCT) soldiers in OEF reported levels of combat exposure at similar or higher levels than
those reported by BCT s in Iraq. Also, soldiers reported significant barriers to mental health care
and behavioral health personnel reported difficulties getting to soldiers. Soldiers who report high
combat experiences and poor leadership reported very high levels of mental health problems.
Finally, suicide rates were elevated relative to historic Army rates (Office of the Surgeon Multi-
National Force-Iraq and Office of the Command Surgeon and Office of the Surgeon General
United States Army Medical Command, 2008, p. 5). Key recommendations of the (MHATV) included integration of government service or having contracted mental health personnel imbedded in theatre of war in order to augment military personnel. Recommendations called for creation of Behavioral Health Officer and Non Commissioned Officer, (NCO) positions in Aviation Brigades. Additionally, it mandated all combat medics to receive Battle mind Warrior Resiliency Training before deploying to OIF/OEF in order to augment mental health personnel. The recommendations called to maximize the impact of mental health personnel and mitigate multiple deployment effects, by ensuring adequate dwell time between deployments. The recommendations encouraged reduction of suicide risks by increasing resiliency. Finally, the report encouraged continuation of Battlemind Training, enhancement training at Warrior Leader Course, and continuation of training on ethics.

The Breaking Down Barriers Program of Mental Health America assembled a group to discuss the challenges to access to mental health care for military service members of San Diego County. The purpose of the meeting was to organize the group’s wisdom about barriers to optimal mental health services to active duty, reservists, National Guard, veterans and their families in the San Diego region. Additionally, the group sought to prepare short and long term recommendations for the county in order to bring awareness of barriers to mental health care and to explore what actions could be taken in order to improve mental health support systems for active duty, reservist, National Guard and veterans. Another goal of the group was to ensure that recommendations focused on solutions and to ensure that the scope of recommendations is thorough and relevant to the needs of those involved. Finally, the group re-committed their skills and passions as a diverse and collaborative group in improving the quality of life of our Armed
Forces service members and retired veterans and the quality of community life, (Mental Health America of San Diego County, 2009, p. 2).

On March 3, 2009 Ellen P. Embrey, Deputy Assistant Secretary of Defense for Force Health Readiness and Protection, and Brigadier General Loree K. Sutton, M.D. Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, testified before the House Appropriations Committee Sub Committee on Defense. It was reported that in November of 2007 the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury were established. Approximately, $58.2 million was obligated for these efforts (Embrey & Sutton, 2009, p. 3.). Additionally, the Department of Defense (DoD), introduced a new clinical evaluation tool, the Military Acute Concussion Evaluation Tool to assess the likelihood of mild TBI. There was also initiation of a certification process for TBI programs in medical treatment facilities. Additionally, standardization of decision process for returning service members to full duty or to US for further treatment was developed. The DoD, in conjunction with the VA, implemented a standardized training curriculum on evidence based psychotherapy for PTSD. In addition, training for medical providers on treatment of TBI was implemented. The departments have trained more than 2,700 providers on evidence based treatments for PTSD and TBI. The Defense Centers for Excellence, (DCoE) has collaborated with the Intrepid Fallen Heroes Foundation to support the design of a new facility, the National Intrepid Center of Excellence, (NICoE). The center will provide an interdisciplinary team dedicated to holistic evaluation and treatment for mental health conditions and TBI injuries that don’t respond to traditional methods. In 2009, for the first time, the DoD and the VA co-sponsored a conference on suicide prevention called “Building Community Connections: Suicide Prevention for the 21st Century” in order to foster partnerships between suicide prevention
experts in government, medicine and communities. Approximately $32.6 million was given for improvement of quality and consistency of mental health and TBI care. A telehealth network for delivery of health care was also implemented. Approximately $227 million were allocated for these projects.

Another important area of work that was undertaken was the anti-stigma campaign which addressed strengthening resiliency to decrease psychological stress and reduce stigma. A number of effective outreach and educational initiatives were established. For example, in November, 2008, with the assistance of the Service Vice Chiefs, DCoE began development of “Real Warriors, Real Battles, Real Strength” campaign which stressed the effects of war on service members and pointed out that seeking help for psychological problems is a sign of strength. Additionally, the DCoE began a project with the nonprofit organization behind “Sesame Street” to produce 700,000 DVDs to help families and children cope with deployed parents and loved ones. Another initiative, named “SimCoach,” is a program that allows warriors and their families to electronically query top experts in psychological health and TBI. Approximately, $32.2 million was spent in addressing the above projects. Yet another program is the caring for patients in transition. The DoD has worked with federal and private sector to eliminate gaps in the care of patients in transition through various health systems or different duty locations. An example of this is the assisted living pilot program in Johnstown Pennsylvania that attempts to improve functionality and independent living after TBI (Embrey & Sutton, 2009, p. 8). Other programs initiated by the DoD were the screening and surveillance program designed to ensure early detection and intervention of mental health and TBI issues. Additionally, the DoD began conducting neuro-cognitive assessments on active and reserve personnel prior to deployment. In order to promote continuity of care, the DoD/VA implemented
a common DoD/VA post deployment TBI assessment protocol in order to help clinicians to collect and assess the same information (Embrey & Sutton, 2009, p. 8). Another implementation was the Mental Health Self Assessment Program which offers service members and their family’s opportunities to identify their symptoms and seek intervention in a timely manner. This tool may be accessed by phone or taken anonymously on line. If intervention were to be needed, after completion of the assessment tool, persons received referral information through TRICARE, the military health insurance system, or Military One Source and/or VA Vet Centers. Approximately $59.9 million were allocated for early detection and intervention programs. Yet another enterprise of the DoD included an expedited intramural (DoD facilities) multicenter randomized clinical trial of hyperbaric oxygen therapy in chronic and mild to moderate TBI.

In 2007-2008, the DoD executed more than $446.5 in research development, testing and evaluation appropriation to further science in the area of TBI and psychological health (Embrey & Sutton, 2009, p. 10). As of April 1, 2009, Ms Embrey testified before the Senate Armed Services Committee, Subcommittee on Personnel in terms of implementation of Wounded Warrior Policies and Programs. Clinical Practice Guidelines for depression were updated and revised. Additionally, Clinical Practice Guidelines on PTSD were initiated based on best practices. In 2008, the DCoE and the National Institutes of Health, (NIH), the Office of Research on women’s Health and the VA co-sponsored a meeting to identify and explore trauma spectrum disorders like PTSD and TBI. On October 27, 2009, the VA formed an Advisory Committee on Women Veterans. In April 2008, the DoD and the VA formed the DoD/VA Interagency Program Office, (IPO) in response to Section 1653 of the National Defense Authorization Act for fiscal year 2008, which required the creation of an entity to serve as a single point of accountability for the rapid development and implementation of electronic health record, (EHR) systems between
the departments. On April 9, 2009, the President, along with Secretary Gates and Secretary Shinseki announced that the DoD and VA had taken the first steps in creating a joint Virtual Lifetime Electronic Record, (VLER). President Obama directed the two departments to “work together to define and build a seamless system of integration with a simple goal: When a member of the Armed Forces separates from the military, he or she will no longer have to walk paperwork from DoD duty station to a local VA health center; their electronic records will transition along with them and remain with them forever” (Timberlake, 2009, p. 3). Major General Elder Granger, MD, the Deputy Director TRICARE Management Activity testified before the Military Personnel Subcommittee Armed Services Committee, United States House of Representatives on April 29, 2009 in order to account for some of the latest accomplishments of TRICARE, a component of the Military Health System. For example, the office was responsible for the combination of TRICARE National mail order pharmacy with the National Retail pharmacy and incentivized the contractor to migrate prescriptions, (including expensive specialty drugs), from retail to mail order in order to reduce costs. Effective, January 1, 2009, TRICARE reduced the rates for TRICARE Reserve Select, (TRS), thereby reducing monthly premium rates 44% from $81.00 to $47.51 for individual coverage and reducing family coverage 29%, from $253.00 to $180.17. This is an option for the Guard and reserve force. This program saved approximately $30 million in cost avoidance (Granger, 2009, p. 3). In response to the needs of Wounded Warriors and their families, the department established a program called Behavioral Health Care Provider Locator and Appointment Assistance Service in order to facilitate access and provide help for active duty service members and their families. Finally, the National Defense Authorization Act for fiscal year 2005 required the Secretary of Defense conduct a pilot program at two or more installations. The purpose of these pilot programs was to
test initiatives that build cooperative health care arrangements and agreements between military installations and local non-military health care systems. (Casscells, 2007. The location of these pilot programs were Fort Drum, N.Y, and Yuma, Arizona. In terms of the Yuma pilot program, timely access to mental health care remains problematic due to lack of available mental health professional at hand. In 2007, the current use of psychiatric services by Yuma area TRICARE beneficiaries was 6.0 visits/year per 1000 beneficiaries. However, in terms of Fort Drum, a substantial partnership was established between Fort Drum and the local Watertown medical community. An example of this is the formation of the Fort Drum Regional Health Planning Organization, (FDRHPO). Several committees have been organized under the authority of the FDRHPO such as the Emergency Medical Services /Disaster Preparedness Committee, Behavioral Health and quality Standards.

On 2009, the Iraq and Afghanistan Veterans of America (IAVA), published a monograph enumerating the various accomplishments that have been achieved on behalf of our service members. For example, as of May 2008, the Department of Defense,(DoD), announced that it would remove a well known question on the security clearance forms which asked if the applicant had sought mental health treatment in the past seven years (Iraq and Afghanistan Veterans of America [IAVA], (2009), . Additionally, the Army Mental Health Advisory Team, (MHAT), recommended increasing troops’ rest time to 18-36 months or decreasing deployment lengths since extensive exposure to combat is the leading factor for psychological injury (IAVA, (2009) . However, in spite of significant governmental response to the existing mental health care crisis in the military population, significant problems plaguing the military population still exist. For example, young troops who tend to be exposed more to combat have higher rates of psychological injuries. Additionally, the rates of traumatic brain injury, (TBI) and PTSD are
higher among hospitalized troops. “According to a 2006 study of over 600 hospitalized battle injured soldiers, early severity of physical problems was strongly associated with later PTSD or depression”, (Grieger et al., 2006), (IAVA, 2009, p. 7). Legal problems may be a sequela of stress injuries such as PTSD. Military studies suggest that troops who test positive for mental health problems are twice as likely to become involved in unethical behaviors such as legal entanglements. Marital and family issues are an area of growing concern in the military community. As per the IAVA 2009 report; between 2005-2008 female service members’ divorce rates have increased by 2% as opposed to .1% for male service members. Additionally, children of deployed parents have shown to have an increase in behavioral problems as compared to children without a deployed parent. Although the literature reports that soldiers are reporting substance abuse problems at a rate of almost 12% only approximately 0.2% are being referred to treatment. Part of the reason for this is that alcohol treatment is presently not confidential. The current policy is that “accessing alcohol treatment triggers automatic involvement of a soldier’s commander,” (IAVA, 2009, p. 9). The 2009 IAVA report indicates that in 2007 approximately 154,000 veterans were homeless. Furthermore the report states that 45% of homeless veterans have psychological illness and more than 70% suffer from substance abuse, (Department of Veterans Affairs, March 6, 2008), (IAVA, 2009, p. 10).

In spite of availability of services, there are several reasons as to why service members are not receiving the care they need. According to the American Psychological Association, there are barriers to care that exist in the DoD and the Veterans Affairs system because these systems are “passive systems leaving the burden on service members or veterans to self diagnose and seek out care. Secondly, there are gaps in the availability of services, thirdly, the quality of care may be inconsistent, and finally service members are often hesitant to access mental health care
because of stigma. The IAVA report states that “stigma is “a major obstacle attached to mental health care. Admitting a psychological wound can also slow troop’s reunification with their family after a combat tour and many troops are concerned about the effect of mental health diagnosis on their career”(IAVA, 2009, p. 14). Nevertheless, progress continues. For example, the nonprofit Intrepid Fallen Heroes Fund has constructed a $70 million research and educational center called the National Intrepid Center of Excellence for psychological health and traumatic brain injury, (IAVA, 2009). Another area of improvement has been in documentation. The Post Deployment Health Assessment (PDHA) and the Post Deployment Health Reverse Assessment, (PDHRA) have started to include questions about TBI since 2008. It is important to note that the VA mental health budget has doubled since 2001. The reported budget in 2009 was $3.5 billion dollars and it was scheduled to increase to $3.9 billion dollars in 2009. The VA has devoted $37.7 million dollars to placing mental health professionals in primary care clinics. The VA has recruited more than 17,000 professionals in staff positions and has become the largest employer of psychologists in the country. Additionally, the VA has launched a national suicide prevention hotline which took 55,000 calls in its first year in 2008. Other measures include the addition of 61 new Veteran run Vet Centers which will bring the total to 268 centers nationwide, (IAVA, 2009, p. 16). Other innovations include an increase to the budget of the National Center for PTSD by 2 million dollars, introduction of TBI assessments for all Afghanistan and Iraq veterans seen at VA facilities, and the development of Traumatic Brain Injury Veterans Health Registry. The DoD and the VA have also collaborated on an expanded national program of Polytrauma Rehabilitation Centers. A 2011 survey conducted on 935 respondents, reports that 62% tried to get mental health treatment from a VA facility. The reported results indicated that getting timely appointments for mental health treatment was a frequent problem, (Mental Health and Family
In view of the pressing demand for adequate timing of care delivery, the Wounded Warrior Project asked Secretary Shinseki to take three immediate steps to improve timeliness and access to care. These included better utilization of the VA’s 200 plus Vet Centers, and allocation of resources to those centers. Another recommendation included integration of peer to peer support to help sustain warriors in mental health treatment. Finally, coverage of private care options could be offered if VA resources are limited and so taxed, that warriors cannot be seen on a timely manner. Additionally, congress has specifically mandated or authorized several steps through legislation directing the VA to provide mental health services to OEF/OIF family members whose own stress may diminish their capacity to provide emotional support for returning warriors.

Within the legal system, specialized law enforcement programs for justice have been developed for individuals with co-occurring disorders. Recognizing that many adaptive behaviors for operating in combat are not appropriate to civilian life, crisis intervention strategies have been developed for improving law enforcement interactions with people experiencing a behavioral health crisis. The crisis intervention team model was first developed by the Memphis Police Department. It includes essential elements such as training for law enforcement officers, community collaboration, and involvement of people with lived experience and family members, and law enforcement friendly crisis stabilization center. Other training includes military culture, deployment and reintegration issues, adaptive behaviors and triggers for veterans of OIF/OEF wars, and techniques for engaging veterans and de-escalating crises.
Additionally, specialty courts such as court based jail diversion programs would place individuals into community-based services and supervision instead of incarceration. Some of these court-based programs have specialized docket programs such as mental health courts or drug courts. In addition to specialty courts, law enforcement programs include re-entry programs.

The approach for jail transition planning involves assessment of the clinical and social needs and the public safety risk of the inmate, plan for treatment and services required to meet the inmate’s needs, identification of required community and correctional programs responsible for post-release services, and coordination of the transition plan to ensure implementation and avoidance of gaps in care.

Military culture and warrior ethos:

The military culture has been described as “unique, consisting of a collection of shared values, practices, and attitudes. The focus of the culture is national protection and defense. It has been suggested that what contributes to the uniqueness of the culture is not its array of beliefs but the hostile environment in which it exists, (Flick, 2011, p. 27). Flick proposes that the military culture is based on the strong bonds forged among battle buddies who often risk their lives for each other. Furthermore, Flick suggests that “the pressure to live up to this ideal, this culture of “siblings” has the potential to influence an individual’s decision heavily. In an environment in which the support of one’s fellow means the difference between life and death, this bond can be crucial to one’s existence (Flick, 2011, p. 27). Flick further suggests that this support is integral to a soldier’s mental health whether in combat or in garrison. As a matter of fact, researchers report that low levels of unit support have been associated with depression and PTSD, whereas high unit support has been associated with promotion of positive mood, job performance, and organizational commitment, Flick, (2011), . Flick notes that the values and beliefs of the group
exist through the values of the individual’s inculcated core beliefs. If the cultural message of the group is that seeking help for one’s psychological problems is a sign of weakness, people’s thinking within this culture will be influenced by the cultural belief. This observation is substantiated by the work of other researchers such as Corrigan (2004).

In addition to group dynamics and accessing mental health services, Flick (2011) further suggests that even when soldiers decide to engage in psychotherapeutic services, they may believe that they are not worthy of receiving help, or that the therapist is powerless to help them because of public and self stigma. Flick proposes that part of the reason why military service members hesitate in accessing mental health care is because of classical conditioning. What this basically means is that cultures condition their members to accept accurate and inaccurate understanding of different aspects of life. This is particularly important in controversial issues. Flick argues that the military is not immune from this conditioning. In fact, because of the transient nature of its members, (most people stay to fulfill their contracts), this classical conditioning is essential. “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 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, short comings and mistakes, begin to foreshadow the perception of personal weakness or the self- perception of imperfection,” (Flick, 2011, p. 29). Furthermore, soldiers may learn to postpone reporting problems due to the belief that postponement of one’s need is preferential to the subsequent detriment or delinquency of failure to carry out the mission. Flick suggests that soldiers at times either minimize or even deny the existence of symptoms out of a sense of duty. Another reason why service members may hesitate to seek care may be due to
misattribution of negative effect. That is to say that a response may be generated by negative emotions as a result of fear, or frustration. A previous example given in this paper is the anger that may be generated by the public when viewing a psychotic individual. In a similar fashion, a depressed soldier who may fail to up keep their personal appearance may be viewed negatively by peers which in turn may result in segregation and isolation of the individual, (Corrigan, 2000, Flick, 2011, p. 31). Flick suggest that the military culture is dominated by “just world thinking”, an idea borrowed from the “Just World Hypothesis” (Ottati, Bodenhausen, & Newman, 2005), (Flick, 2011, p. 33). The motivation to perceive justice in the world is a powerful force that can influence reactions to individuals in a wide range of unfortunate circumstances including persons with serious mental illness, (Ottati et al., 2005, p. 105). Ottati and colleagues point out that the belief in a just world revolves around the idea that people get what they deserve. For example good people get positive outcome whereas bad things happen to bad people, (Ottati et al., 2005,, Lerner, 1980). This implies that “people get what is coming to them”. For example if one works hard, one is entitled to the subsequent benefits of one’s hard work. Conversely, if something bad or negative happens to the self, it is because they deserve it (Flick, 2011, p. 33). Ottati and colleagues (2005) further state that the root of this idea stems from the desire to preserve the self and not to tempt fate. For example, if one is good and behaves oneself, fate won’t strike down. In addition, when one observes others experiencing calamity it tends to elicit defensive attributions of responsibility that emphasize the victim’s role in creating their own misfortune. Flick reports that the concept of just world thinking thrives in the military culture because in the military, proper preparation averts disaster. The thinking is that in a war zone, proper caution and preparation is imperative to carrying out the mission and avoiding peril. Improper preparation may put the mission in danger and may even cause death. Within the context of this ideation,
symptoms of mental illness may be interpreted as the individual not being prepared enough to ward off symptoms. If the soldier were strong and mentally prepared, he/she would not become ill. In contrast, a soldier who shows symptoms may be perceived as not capable of being responsible for the safety of other soldiers. This may be interpreted as the soldier being weak, lazy or irresponsible. Therefore, the soldier is to blame for his own misfortune (Flick, 2011).

Another phenomenon observed in military culture is that of authoritarianism and social dominance. Ottati et al., (2005), state that “the authoritarian personality is marked by submission to authority, strict adherence to middle class norms, rigid thinking, and aggression toward individuals who differ from the mainstream”,(Ottati et al., 2005, p. 106),Social dominance is a mechanism in which those that are perceived as weak are pushed down by the strong. Social dominance requires absolute submission to authority. It requires strict adherence to middle class idea of reward for hard work and punishment for the lazy. Additionally, social dominance is characterized by rigid thinking, and lastly, social dominance encourages aggression toward those outside the mainstream. These four doctrines are considered the pillars of military society (Flick, 2011).

The four doctrines or so called pillars of military society can be further explicated in terms of the evolutionary theory of human behavior that was initially discussed in this paper. For example, the Army can be thought of as a tribe of mostly males, which Darwin (1871) describes as “including many members who, from possessing in a high degree the spirit of patriotism, fidelity, obedience, courage and sympathy, were always ready to aid one another and to sacrifice themselves for the common good, would be victorious over most tribes and this would be natural selection” (Van Vugt, 2008, p. 3)). Evolutionary theory explains that intergroup aggression may be the result of a variety of factors. For example, due to a long, ancestral history of male to male
coalitional conflicts, males have developed cognitive mechanisms that enable them to form alliances with other males (Van Vugt, 2008). The author calls this phenomenon the “Male Warrior Hypothesis”, (MWH). Van Vugt, states that the MWH can account for the gender differences in social behavior. He explains that in human females, as in most other mammals, mothers invest more heavily in their offsprings and as a consequence, it would be genetically and physiologically costlier for women to be openly aggressive. Because men are not as invested in offsprings as females, and under certain conditions, it can be deemed attractive for men to be aggressive, and to form aggressive coalitions for the purpose of acquiring and protecting valuable resources. Van Vugt refers to Tooby & Cosmides’ (1988) risk contract of war as the evolutionary logic of the hypothesized gender difference in warrior psychology. For example the risk contract calls for four basic conditions for the evolution of coalitional aggression. Males will engage readily in warfare when they are confident of success if; they are assured of victory, if there is assurance that risk of death among the participants is of random distribution, (Van Vugt refers to this as men going into battle cloaked in a veil of ignorance about who will live or die), if there is assurance that there will be a fair compensation of the spoils of war, and that mating opportunities will favor participation in coalitional aggression,(Tooby & Cosmides, 1988, p.6).

Warrior Ethos has been described as an overriding credo for the American Soldier, a unique set of values to complement the Army values. The values of a Warrior Ethos would be particular to the needs of an Army which is required by the Nation to fight, but at the same time is required to be in consonance with the character, sentiments and beliefs commonly held by the American people. The purpose of a set of values used to underpin or describe an Army level Warrior Ethos may be to engrain the belief that failure by an Army and its Soldiers is not acceptable while the means to fight exists...Warrior Ethos is at the heart of the expectation of a soldier who performs
required duties in a harsh and unforgiving environment which directly involves killing and also
provides potential for being killed. Warrior Ethos is implicit in the Army’s Code of Conduct; it
is explicit in the historical records of the Army’s combat heroes, particularly those recognized by
the Congressional Medal of Honor, the Distinguished Service Cross and the Silver Star, (The
Wexford Group, 2004,p.1). Warrior Ethos is to transform the soldier into a warrior. Warrior
Ethos is based on four basic tenets which state that a soldier will always place the mission first.
He or she will never accept defeat, nor never quit. A soldier will never leave a fallen comrade.
Warrior Ethos is a soldier’s code of honor, a way of life, a path of the warrior. Moreover, it
indicates a disposition of being intellectually or emotionally motivated to think, perceive, act, or
forbear with respect to something or someone to which the individual is bound beyond the task at
hand. Treatment of Warrior Ethos, or its inculcation, must address the cognitive and social
implications of commitment (The Wexford Group International, 2004, p. 4). The implication of
commitment applies to the organization, regardless of the size at hand that is required for the
execution of the mission. Commitment extends to peer with the understanding that Warrior Ethos
is a code of honorable conduct for Warriors that is motivated by something greater than the self.
Altruism, selflessness, cooperation, commitment are desirable qualities of this code. The concept
of “mission first” demands that the soldier prioritize, be cunning and adaptable in the face of
danger. The concept of “never quit” demands that the soldier be physically and mentally tough
and spiritually fit, (denoting faith in the unit, leaders and a Higher Being). The concept of “never
quit” denotes total commitment to the welfare of battle buddies and not letting peer nor the
mission down. The concept of “never leaving a fallen comrade behind” assures soldiers that no
matter what may happen in combat, they will never be abandoned. Warrior Ethos transcends
leadership qualities and strengthens the will of the warrior In situations such as combat,
perseverance and strength and qualities of endurance often derive from an inner will or
realization that there is something greater than the self. This ideation is referred to as the
soldier’s moral discipline. There are seven attributes that are considered as key elements of the
Warrior Ethos. These are perseverance, the ability to prioritize, the ability to make tradeoffs, the
ability to adapt, the ability to accept responsibility for others, the ability to accept dependence on
others, and being motivated by a higher calling to duty, honor and country.

Within recent years, military culture has begun to experience cultural and social changes
or paradigm shifts which has produced struggles and repercussions between the military’s
traditional and exclusionary combat masculine –warrior belief system and the evolving model of
military culture of egalitarianism and inclusiveness (Dunivin, 1997). The author suggests that in
order to survive and thrive in a dynamic world, culture must adapt to changing conditions. In her
paper, Dunivin proposes that the military is going through a paradigm shift from a model of
exclusionary masculine warrior system toward an inclusionary system as evidenced by the
inclusion of women and homosexuals in the military. The author posits that the military’s raison
d’être is combat and to win wars. Traditional combat exclusionary masculine warrior, (CMW)
has denoted that combat is men’s work, but recent inclusion of women and homosexuals has
begun evolution of a model of inclusion and egalitarianism versus one of conservatism and
exclusion. The author warns that “until the military’s paradigm and model of culture
complement each other, the military will continue to resist social change that it finds
repulsive”(Dunivin, 1997, p. 16). Furthermore “drawing from a paradigm of inclusion and
equality, evolutionists note that the military as a servant of society must reflect societal core
values or be labeled an anachronism. Without a paradigm shift, the military runs that risk-divorcing itself from society. In turn, this insular military, may lose public confidence, respect,
and support” (Dunivin, 1997, p. 20). In her paper, Colonel Dunivin recommends voluntary embracing by the American military of social diversity, endorsement of cultural pluralism and decrease of exclusionary practices. Additionally, paradigm pioneers must step forward and take risks, and lastly, there must be examination of traditional identity of exclusionary combat practices (Dunivin, 1997, p. 23). The author exhorts that “the military must define a professional warrior as one whose role extends beyond conventional combat arms and whose ability transcends one’s sex or sexual orientation (Dunivin, 1997, p.23).

A proposed solution to the stigma of mental illness in the military population:

The concept of evolution is a theme that has permeated this paper from its inception and one that is critical to the solution of the problem of stigma. The concept of evolution by its very nature demands change and transcendence for future fruition and growth whether in society or a microcosm of society. Failure to change almost certainly leads to death and stagnation. The author of this paper proposes an integrative approach towards the eradication of stigma that calls for evolution, growth and vitality. The proposed integrative approach encompasses three major target areas. The first area reflects the work of Corrigan and Watson (2004) who appeal to efforts in education, protesting and contact in order to reduce the stigma of mental illness. It is imperative, that the American military effectively educate its service members about mental health issues and address topics of detection, treatment and prevention. Accurate information must replace myths and inaccurate material. Having said this, the delivery of this information must be within the context of emotional safety, respect and acceptance. The four tenets of the Warrior Ethos comes into play in a variety of topics such as honorable behavior in the care and handling of mentally ill comrades making sure that comrades are not abandoned through segregation or fear. The mission of healing must come first. The military must never quit nor
accept defeat but instead, continue the fight against ignorance and discrimination that permeates the military community. Provision of accurate information in order to replace inaccurate stereotypes must be provided, (Corrigan & Watson, 2002), (Watson et al., 2007).

Massive efforts must continue not only in the enlisted sector but in the leadership. Educational efforts must take into consideration the emotional context and implications for those receiving the message. Fear and feelings of vulnerability often preclude effective learning. The educational content must be easy to comprehend and digest. Instructors must be sensitive to the emotional climates that exist in different units. For example, the emotional climate that exists in an Infantry unit may be different than in a MEDDAC unit. It has been suggested that facilitation of partnerships between fleet leaders and mental health providers would help reduce barriers to mental health services Westphal, (2007). Protesting or making a moral appeal by asking people to change their thinking to a more correct thinking (Corrigan & Watson, 2002, 2007) necessitates courage and leadership qualities. The leadership must set and maintain a milieu of respect and acceptance in units.” Fallen comrades” must be protected and supported. “Expectations of leaders, particularly in regards to mental health issues, can produce dramatic differences in the use of mental health services and the outcomes of interventions” (Westphal, 2007, p. 1138).

In addition to personal accountability and courage, protesting can be done through various media means as well as forums such as briefings and formations. Protesting is an area in which the tenets of the Warrior Ethos would do well in terms of inculcation. For example, education, and protest would do well to begin in Basic Training and subsequent schoolings. Education and protesting against stigma of mental illness would contribute to the formation of a warrior who would execute functions of a soldier that would place the mission first by promotion of cohesion and respect within a unit. Such a warrior would be endowed with leadership qualities
that would maintain climate safety and support within units. Contact with the mentally ill has been described as the most effective method of fighting stigma of mental illness (Corrigan & Watson, 2002, VanVugt, 2007, 2009). Contact demands that the mentally ill individual be respected and accepted as a member of society. Contact with mentally ill persons would provide an opportunity to see the individual as a person who has an illness versus an ill individual. Contact would provide exposure to the person’s abundance of humanity from whence flow the person’s qualities, talents and contributions to the team. It is imperative that the vulnerability of a comrade be protected, supported and held as sacred. In this respect, a climate of evolutionary inclusion of which Dunivin (1997) refers to is tantamount. Social diversity and pluralism are integral to evolution.

Clarification of military values and customizing patient care:

Clarification of the Warrior Ethos is important in the eradication of stigma of mental illness because it is imperative to demystify any possible beliefs that in order to be a good soldier an individual must be perfect. In fact perfectionism is delusional and dysfunctional. The seven attributes that contribute to the Warrior Ethos testify to a mindset of cooperation and interdependence. Perseverance demands that the soldier have faith and trust in the self and the actions that come from this mindset. It is important that the leadership foster a climate of trust and acceptance of soldiers that would contribute to the acceptance of self and the potential of self growth. This climate can only be maintained within an environment of respect, acceptance, and tolerance. The mentally ill soldier must first be accepted and valued as an individual and as a valuable member of a team; who has an illness. Only within this context can the mentally ill soldier feel safe to ask for help and accept the help. The climate of respect, acceptance and tolerance must exist within every area of the military instillation. It must exist in battalion,
platoon, and individual unit. It must exist within every clinic in the MEDDAC and it must be reflected by every professional that comes in contact with the mentally ill soldier. Within the safety of such an environment, the soldier can endure and persevere the hardships of mental illness or for that fact any illness. Soldiers must be taught and encouraged to effectively and appropriately prioritize in order to conserve energy, sustain the self and be able to navigate turbulent waters. Mental illness or any illness often results in pain, discomfort, anxiety, fear and other emotional and spiritual turbulence. The mentally ill military client needs sustenance and support to navigate these turbulent waters. Prioritizing often demands effective, supportive and respectful communication in which the individual may ask for help or for a hiatus in order to think and regroup or perhaps for self clarification.

Military service members must be encouraged to care for the sacred self in order to be able to carry out the mission and be effective members of a team. The ability to make tradeoffs denotes an attitude of flexibility, tolerance, strength and self knowledge. It is the antithesis to perfectionism. The soldier, who is able to appropriately make tradeoffs in order to accomplish a mission, is a soldier who trusts the self and trusts the abilities of the self. The mentally ill soldier must be supported and sustained as the patient makes effective and healthy tradeoffs in order to effectively cope with the illness. It is vital that the military patient be sustained and supported by his military family which is represented by command, peer and any mental health professional that is part of this “family”. Adaptation to any situation often demands communal action as discussed throughout this paper. In military situations, a soldier’s ability to adapt to new situations often demands the collective actions of the team. Illness of any nature often requires that the patient adapt to limitations or losses whether temporary or permanent. For example, the patient requiring a radical mastectomy needs to adapt to a new image of the self. This
A transformative process requires grieving, expression of feelings, and finally acceptance of the self. Mental illness may result in temporary or permanent loss of cognitive function or emotional functioning. The patient may experience fear, anxiety, and anger and may eventually need to mourn the previous self as perceived by the patient and others. It is imperative, that the integrity of the soldier’s personhood be guarded and protected in order to encourage healthy adaptability. The concept of acceptance of responsibility for others brings to mind the Ignatian motto of “Men and Women for Others”. ("Men and women for others", 2008). This concept implies that one must actively fight for social justice and equality for all in all aspects of society.

Acceptance of responsibility for others within the context of the Warrior Ethos also implies active participation in the mental and physical welfare of soldiers by all soldiers. It calls for the moral appeal of correction of negative stereotypes. It calls for the courage to stand and never leave a fallen comrade. Acceptance of responsibility for others needs to permeate the work of all personnel involved in the care of the military soldier whether personnel are military or civilian. Acceptance of responsibility for others results in cohesion, promotion of a culture of trust and respect. When soldiers become responsible for others, it enhances a degree of intimacy and comradery. The ability to accept dependence on others demonstrates a soldier’s wisdom. A soldier is always aware that the success of any mission is contingent on the synergy of the members involved. Mission is the work of the team. This concept is central to the prevention of mental illness and the eradication of stigma of mental illness. A mentally healthy individual is one who is grounded and connected to others. The mentally healthy individual recognizes that asking for help and accepting help is integral to carrying out the mission of being and staying mentally healthy. The ability to accept dependence on others is a message that needs to be translated into mental health. Asking for help and direction is a sign of wisdom and courage. A
leadership that truly embraces dependence on others is a leadership who understands the value of humility and wisdom.

Finally, knowledge that the Warrior Ethos is motivated by a “Higher Calling,” a duty to honor and country, appeals to the spirituality of the warrior. The concept of a “Higher Calling” demands that the warrior be mindful of something greater than the self. In Viktor Frankel’s book, Allport, states that “a prisoner must make larger sense of his apparently senseless suffering. It is here that we encounter the central theme of existentialism: to live is to suffer; to survive is to find meaning in suffering. If there is a purpose in life at all, there must be a purpose in suffering and dying. In a concentration camp every circumstance conspires to make the prisoner lose his hold. All the familiar goals in life are snatched away. What alone remains is “the last of human freedoms”- the ability to choose one’s attitude in a given set of circumstances” (Frankl, 1984, p. 9). The care of the mentally ill military patient requires that the psyche as well as the spirit be sustained and supported. Laufer (1988) reminds us that post deployment invisible wounds of war result in soldiers existing in a culture of death. Selby et al., (2010) warn that feelings of burdensomeness, lack of belonging and habituation to fear and suffering can lead to self destruction.

It is imperative that clinicians impart and encourage their clients to introspect, find meaning in their lives and pursue a culture of life and living. In this respect, the clinician must be seasoned and possess a maturity that will sustain such a therapeutic relationship. The clinician must impart a sincere sense of caring and empathy that will sustain the fragility of the patient. There must exist the hope that the therapeutic relationship is of temporary nature until the patient can regain vitality, strength and energy. Until then, the clinician must sustain faith and hope for the client.
In conclusion, the clinician who serves the military population must customize their care, tailor their care to the developmental and holistic needs of the client so that the client may experience a sense of truly being comprehended, respected and understood for who they are. Our military service members deserve no less.
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