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Wendy Ashley[a] & Jodi Constantine Brown[a]

[a] Department of Social Work, California State University-Northridge, Northridge, California, USA

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The Impact of Combat Status on Veterans' Attitudes Toward Help Seeking: The Hierarchy of Combat Elitism

Wendy Ashley and Jodi Constantine Brown

Department of Social Work, California State University–Northridge, Northridge, California, USA

Many veterans do not seek assistance for mental health concerns despite the staggering prevalence of trauma-related symptomatology. Barriers to service provision include personal and professional stigma and inter-veteran attitudes that dictate who is more or less deserving of services. Veteran attitudes are shaped by military culture, which promotes a hyper-masculine paradigm upholding combat experience as the defining feature of the "ideal soldier." The stratification of soldiers into combat or non-combat status creates a hierarchy of combat elitism that extends far beyond active duty. This pilot study surveyed veterans ($n = 24$) to explore how combat experience may affect attitudes toward help seeking. Findings indicate combat and non-combat veterans are less accepting of non-combat veterans' help-seeking behavior, supporting the notion that veterans' attitudes toward help seeking are influenced by combat status. Despite limitations, the results of this study reflect a need for increased attention to the attitudes veterans have about each other and themselves.

Keywords: Veterans, combat, attitudes, help seeking

Despite considerable availability of prevention and intervention programs, a significant number of veterans are not receiving the mental health care they need (Rae Olmstead et al., 2010; Warner, Appenzeller, Mullen, Warner, & Grieger, 2008; Wheeler & Bragin, 2007). The prevalence of mental health disorders for returning war veterans is high, however, the likelihood of veterans seeking help for them is disturbingly low (Stecker, Fortney, Hamilton, & Ajzen, 2007). The RAND Corporation (Savych, Klerman, & Loughran, 2008) found that only 53% of service members needing treatment for posttraumatic stress disorder (PTSD), traumatic brain injury, and depression actually sought help. Research consistently reflects that veterans' attitudes and beliefs inhibit their help seeking for mental health concerns (Burnam, Meredith, Tanielian, & Jaycox, 2012; Coll, Weiss, & Yarvis, 2011; Franklin, 2009; Tanielian & Jaycox, 2008; Vogt, 2011). Soldiers identify stigma as a primary barrier to help seeking, classifying intra-personal stigma (feeling inadequate, incompetent, ashamed, or weak) and interpersonal stigma (fear of being looked at differently by the unit or colleagues, being treated as incompetent and inadequate by peers, or harm to career) as the primary sources of distress (Dahn, 2008; Vogt, 2011; Warner et al., 2008). In this pilot study the authors explore veterans' attitudes toward help seeking by their peers, and examine the concept of combat elitism relative to mental health treatment and services.

Address correspondence to Wendy Ashley, Department of Social Work, California State University–Northridge, Northridge, 18111 Nordhoff Street, Northridge, CA 91330-8226, USA. E-mail: wendy.ashley@csun.edu

Traditional Masculine Military Culture

Hoge and colleagues (2004) found that soldiers and veterans meeting criteria for a mental disorder were twice as likely as those not meeting criteria to express concern about stigma in accessing and receiving mental health services. Stigma felt by soldiers and veterans may be due, in part, to military culture (Beder & Jones, 2012; Dunivin, 1994; Hall, 2011; Keats, 2010; Warner et al., 2008). The military itself is a culture with clearly defined norms. The values and practices of the military are predicated on seeking war victory, in turn fostering attitudes, beliefs, and behaviors constructed around combat (Keats, 2010). Military culture promotes a hyper-masculine paradigm, upholding war heroism and combat arms to exemplify the ideal soldier (Dunivin, 1994; Garcia, Finley, Lorber, & Jakupcak, 2011; Jakupcak, Osbourne, Michael, Cooke, & McFall, 2006; Laurence, 2011). Further, military training inculcates "core values of masculinity" including aggression, competitiveness, distrust of others and emotional insensitivity (Brooks, 1999, p. 9; Dunivin, 1994; Keats, 2010, p. 296). Adherence to this paradigm may result in veterans' expectations of stoicism or self-reliance, putting masculine expression and behaviors at odds with seeking mental health treatment (Garcia et al., 2011; Hall, 2011). Keats (2010) adds that the habits developed in adapting hyper-masculine behaviors to manage stress during military service inhibit the skills needed for effective adaptation, resilience, and flexibility upon returning home.

Heroic Combat Warriors

Dunivin's (1994) Combat-Masculine-Warrior (CMW) paradigm elucidates the role of the soldier (masculine values and lifestyle) and the functions of the military profession (war, defense, and combat). This paradigm is highly exclusionary, barring any challenges to the hyper-masculine norms and values that pervade military culture. A consequence of the CMW paradigm and the exclusionary policies that support it is reinforcement of the perception that combat experience or exposure is the defining feature of a "real soldier." As a result, military personnel are bifurcated into two groups: those with combat exposure/experience and "others." The combat experienced masculine warrior is awarded with heroism, honor, and respect. Others may be dismissed, devalued, or denigrated to categories of outsiders or deviants (Dunivin, 1994).

Combat Elitism

The differentiation between combat and non-combat experienced soldiers may have a divisive impact among military personnel. The military abounds with group division, separating members by branch, rank, unit, occupational specialty, and myriad other classifications. While these divisions reinforce organization and uniformity, they also promote hierarchies within military culture. Status hierarchies are accepted and respected by military personnel; however, there is a relative fixedness to these hierarchies, which may be maintained and experienced as a loss by veterans after returning to civilian life (Hall, 2011; Teeter, 2011). In addition to the aforementioned hierarchies, soldiers and veterans will classify themselves (or be classified as) combat or non-combat experienced. The stratification of soldiers into combat or non-combat status creates a hierarchy of *combat elitism* that extends far beyond active duty. Combat elitism is defined as the assumption that those with combat status are preferred, desired, and more masculine than non-combat personnel. The ideal soldier, characterized by strength, valor, and heroism becomes synonymous with combat experience, leaving non-combat experienced veterans ignored or devalued (Dunivin, 1994; Keats, 2010).

The attribution of positive characteristics to combat veterans and negative qualities to non-combat veterans creates a fundamental fragmentation of inter-veteran support. Veterans seeking mental health support may be impacted by internalized beliefs and attitudes that they are not worthy

of services or that others are more (or less) deserving. Fraser and colleagues (2010) found military personnel to be more sympathetic to persons suffering from PTSD if they had combat experience. Many veterans feel that the only people who will understand their needs are other veterans; the potential for hopelessness increases if help-seeking veterans face dismissive attitudes originating from within the hyper-masculine military culture (Fraser et al., 2010; Schneiderman, Lincoln, Curbow, & Kang, 2004; Warner et al., 2008). These attitudes are likely to isolate veterans, increase the negative effects of combat stress and/or PTSD, impact utilization of vital mental health services, and ultimately decrease help-seeking behavior.

In this pilot study the authors explore whether combat experience, exposure, or status affects veterans' attitudes toward help-seeking behavior in other veterans. Veterans may be likely to view their peers as being more or less deserving of mental health treatment based on combat experience. In turn, these ingrained attitudes could negatively affect their perception of support, help-seeking behavior, and the need for treatment for themselves and for other veterans.

METHODOLOGY

Sample

We used a convenience sample of adult veterans ($n = 24$), men and women, who served in the U.S. military during any war or time period. Reservists were not included in the sample. A snowball sampling method was employed whereby known veterans were asked to forward the anonymous, online survey to their friends, colleagues, and contacts. One respondent posted a link to the survey on Facebook which resulted in 14 of the 24 responses.

Measures

The online survey, available only in English, includes service information (branch, specialty, time served, post), demographic information (age, gender, ethnicity), an updated version of the Gallops Revised Combat Scale (1981), the 17-item PCL–M (PTSD–Military) scale, and vignettes exploring attitudes toward help seeking.

The Combat Scale–Revised (Gallops, Laufer, & Yager, 1981). The Gallops Revised Combat Scale was developed as part of the Legacies of Vietnam study conducted in the mid-1970s (Gallops et al., 1981). The scale consists of 12 dichotomous (yes/no) items, with particularly traumatic experiences given more weight than less traumatic experiences. The minimum score is 0 (no combat) and maximum score is 14 with higher numbers reflecting greater combat exposure. Watson, Juba, and Anderson (1989) found the Gallops and colleagues (1981) scale "more sensitive to combat history than to the presence of PTSD" (pg. 101) and consider it a "more nearly 'pure' combat measure" (pg. 101) than three other combat scales which were highly related to PTSD. Wording in the scale was altered slightly to be applicable to all soldiers, not just Vietnam-era veterans. The word "Vietnam" was replaced with "enemy" (e.g., "saw enemy killed" instead of "saw Vietnamese killed"), the modern word "IEDs" replaced "mines or booby-traps", and the word "patrol" was used in lieu of "unit patrol" to maintain consistency with the rest of the survey.

PCL–M (PTSD–Military) scale. The PCL–M (Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report questionnaire corresponding to the 17-item *DSM–IV* criteria for PTSD. The PCL–M is a well-validated, frequently used, reliable measure of PTSD. Total symptom severity scores range from 17–85, with higher numbers reflecting more symptoms.

Attitudes toward veterans' help seeking. Participants were given three vignettes describing a military person returning from his second tour of duty who has just been given 30 days stress leave for PTSD (Fraser et al., 2010). All hypothetical military personnel were enlisted, male, married with one child, between 29 and 34 years old, and a dependable team player maintaining an excellent fitness report who was regarded highly by his superiors. Soldier A had a Military Occupational Specialty (MOS) of cartography (mapmaker) and was assigned to a headquarters company. Soldier B had a MOS of infantry assigned to a recon company. Soldier C had a MOS of logistics assigned to a tank company and was evacuated by medevac during his second deployment with injuries to his left knee. After reading the description, participants responded to eight statements about the soldier in the vignette. Participants were asked to rate Soldiers A, B, and C using a six-point scale from *"very low"* to *"very high"* on their resilience, need for PTSD treatment, whether or not they deserved treatment for PTSD (help seeking), likeability, performance level upon returning to work, and the respondents' assessment of how much they would enjoy working with Soldiers A, B, and C (character). Vignettes have been successfully used as attitudinal measures in the social sciences (Goerman & Clifton, 2011; Spalding and Phillips, 2007; Stecher et al., 2006) and "used alone or in conjunction with other research techniques, [vignettes] can be valuable research tools in the study of people's lives, their attitudes, perceptions, and beliefs" (Hughes & Huby, 2002, p. 385).

In addition to the three vignettes, respondents were asked to respond to an *agency assistance* question to get a rank-order perception of need. Respondents were asked to imagine they are the director of a not-for-profit agency serving veterans; the agency recently received $50,000 to distribute among six programs: job training, mental health counseling, and support groups for combat and non-combat veterans. Respondents were asked to rank order the programs where 1 = *most money* and 6 = *least money*. Each program could only receive one ranking; respondents could not rank mental health counseling for combat veterans equally with mental health counseling for non-combat veterans.

Design

In this exploratory pilot study we used a one shot case study design and collected data anonymously via an online survey. Upon consenting to participate in the study, participants were asked first about their service information including number of tours of duty, branch of service, MOS number and description, whether or not they were drafted, total amount of time served in training (stateside and overseas), their post, and whether or not they were in a recognized conflict. Demographic information, including age, ethnicity, and gender followed the service information. Attitudes, including the agency assistance question and vignettes, made up the third section of the survey, followed by combat exposure, with PTSD/stress level as the last section of the survey.

Data Analysis

Univariate statistics are presented for all demographic variables describing the sample. Bivariate analyses were conducted to examine relationships between variables. The small sample size and resulting lack of power preclude the use of higher level statistics (e.g., MANOVA) appropriate to determine differences between multiple related dependent variables.

RESULTS

Demographics

Respondents ($n = 24$) are primarily Caucasian men who served overseas in the army. Table 1 lists demographic information for the sample. The total amount of time served ranges from 8 months to

TABLE 1
Univariate Statistics for Service, Demographic, and Combat Exposure Variables

Variable	*Attributes*	*Frequency (Percentage)*
Complete more than one enlistment tour?	Yes	7 (29.2%)
	No	17 (70.8%)
Service branch	Army	16 (66.7%)
	Navy	2 (8.3%)
	Air Force	3 (12.5%)
	Marines	3 (12.5%)
Drafted?[a]	Yes	0
	No	14 (100%)
Serve overseas?	Yes	16 (66.7%)
	No	8 (33.3%)
Ethnicity	African American	2 (8.3%)
	Asian American	2 (8.3%)
	Caucasian/White	15 (62.5%)
	Hispanic	4 (16.7%)
	Other	1 (4.2%)
Gender	Male	18 (75%)
	Female	6 (25%)
Combat exposure	No/Low	14 (58.3%)
	High	10 (41.7%)

Note. [a]This question was asked during the second and third iteration of the pilot survey in response to Vietnam Veterans' suggestions. No Vietnam Veterans completed the second or third iteration.

15 years, with an average of 5 years (SD = 3.5 years). Combat exposure ranged from 0–13 on the Gallops Combat Revised Scale where 0 = *no combat* and higher scores indicate greater combat experience. Due to the distribution of scores, combat exposure was dichotomized reflecting no or low combat exposure (0–3 on the Gallops' scale) or high combat exposure (8 + on the Gallops' scale). PCL–M scores ranged from 17–81 (M = 33.29, SD = 16.35), where higher scores indicate greater likelihood of PTSD.

Allocating Resources by Veteran Status

Respondents were asked to imagine they were the director of a not-for-profit agency that serves veterans. The agency recently received $50,000 to distribute among six agency programs. Responses were re-coded from 1 = *most important* and 6 = *least important* to 1 = *the least amount of money* and 6 = *the most amount of money*, resulting in higher numbers meaning greater importance. Mean and median responses are seen in Figure 1. Overall, respondents rank services for combat veterans higher than services for non-combat veterans.

Attitudes Toward Help Seeking

Means were computed for the five items used to determine participants' evaluations of veteran's character, and the three items used to assess help seeking. As seen in Table 2, findings suggest that all veterans are less accepting of non-combat veterans' help-seeking behavior, and combat veterans are less accepting of other combat veterans' help seeking. Non-combat veterans are the least likely to be seen as resilient, needing help for PTSD, or being deserving of help for PTSD by combat veterans ($M = 11.11$, $SD = 4.56$) and non-combat veterans alike ($M = 12.33$, $SD = 3.31$).

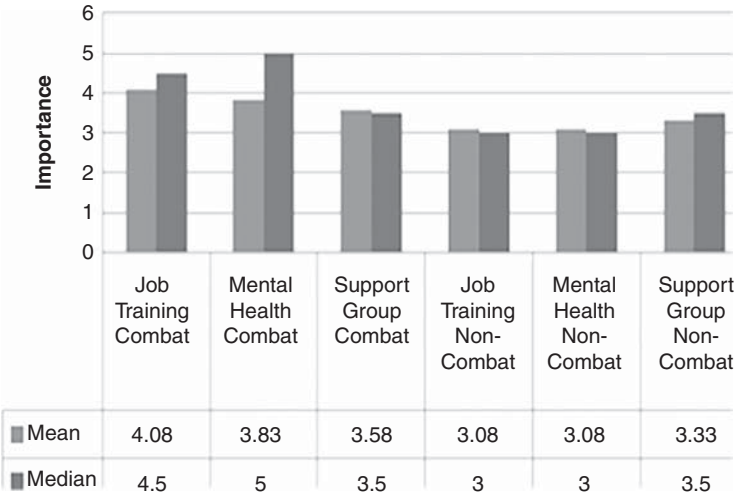

FIGURE 1 Rank order of importance by type of assistance.

Additionally, non-combat veterans are rated as less well-liked by combat veterans ($M = 16.56$, $SD = 5.81$) and their non-combat veteran peers ($M = 17.58$, $SD = 5.12$) than combat veterans. Combat veterans without injuries are the most well-liked by other combat veterans ($M = 20.44$, $SD = 3.74$), whereas non-combat veterans rank combat veterans with or without injuries equally, and above, non-combat veterans.

Results of a Mann-Whitney U Test for differences between two independent groups revealed no statistically significant difference in attitude toward Soldier A ($U = 39$, $z = -1.06$, $p = .29$, $r = -.23$), Soldier B ($U = 53$, $z = -.07$, $p = .94$, $r = -.02$) & Soldier C ($U = 37.5$, $z = -.81$, $p = .42$, $r = -.18$) by level of combat exposure, nor any significant difference in PTSD levels of combat veterans ($Md = 36, n = 8$) and non-combat veterans ($Md = 26, n = 12$; $U = 24, z = -1.85$, $p = .06$, $r = -.415$).

DISCUSSION

While much of the current research on veterans concerns the identification of risk factors for the development of PTSD and the importance of clinically sound, evidenced based treatment strategies

TABLE 2
Mean (SD) Attitude Scores Toward Veterans' Help Seeking and Character by Combat Exposure

	Soldier A—non-combat	*Soldier B—combat*	*Soldier C—combat with injury*
Total			
Combat exposure	34.89 (11.82)	42.67 (6.89)	39.88 (9.80)
Non-combat	39.25 (6.98)	42.33 (5.41)	42.58 (6.27)
Help seeking			
Combat exposure	11.11 (4.56)	13.44 (2.74)	13.38 (3.92)
Non-combat	12.33 (3.31)	14.83 (2.44)	14.92 (2.77)
Character			
Combat exposure	16.56 (5.81)	20.44 (3.74)	18.12 (4.94)
Non-combat	17.58 (5.12)	18.42 (3.57)	18.42 (4.01)

(Black, Gallaway, Bell, & Ritchie, 2011; Jakupcak et al., 2006; Koenen, Stellman, Stellman, & Sommer, 2003; Schneiderman et al., 2004; Tolin, Steenkamp, Marx, & Litz, 2010; Warner et al., 2008), the present research is one of the first studies in which researchers examine the effects of combat on veterans' attitudes toward help seeking for mental health services. Widely available treatment options are irrelevant if veterans do not seek services.

Through this study the authors provides preliminary evidence that within the veteran population, a hierarchy based on combat status defines who is most deserving of mental health treatment and services. Combat veterans are better liked, are perceived as more resilient, help-seeking behaviors are more accepted, and they are deemed more deserving of mental health services than non-combat veterans by combat *and* non-combat veterans. These findings are congruent with the CMW paradigm that upholds the combat exposed/experienced veteran as a "real soldier," devaluing or denigrating those without combat status (Dunivin, 1994). The skills so vital for success in combat arms—aggression, competitiveness, and distrust of others are potentially detrimental to combat exposed veterans attempting to adapt to civilian life (Brooks, 1999; Keats, 2010). Further, these ingrained values impact the attitudes veterans demonstrate toward one another, increasing negative judgment and decreasing much needed peer support.

The data indicate that combat veterans *without injuries* were perceived as well liked and more worthy of help-seeking behavior and services than any other veterans, including injured combat veterans. These findings suggest a hierarchy that places combat experienced or exposed veterans at the top, non-combat veterans at the bottom, and injured combat veterans in the middle. It appears that physically injured combat veterans are perceived as worthy of treatment and services, but less than non-injured combat veterans. Perhaps physically injured combat veterans challenge the CMW paradigm, merging the hyper-masculine norms of military culture with an inference of dependency or weakness. This potential explanation, however, does not take into account the differences between physical and mental injury. Mental health needs and treatment contain stigma not found with physical health. Stigma in seeking mental health services is laden with gender, cultural, and other assumptions about mental illness and the incapacity for recovery. Because PTSD, depression, anxiety, substance abuse, and traumatic brain injury are invisible injuries, combat veterans returning from war may feel a greater obligation to maintain the stoicism and masculine expression expected of them as heroic combat warriors, and may have that same expectation of their peers. Veterans with mental health symptoms may disproportionately experience concern about stigma because they have the most to lose from peers and by leadership (Hoge et al., 2004). The non-injured combat veteran upholds the CMW paradigm by "pushing through it," "sucking it up," and "taking it like a man" (Dahn, 2008). The ironic consequence of his fortitude is that even if he suffers from mental health symptoms, he is likely to be seen by his peers as courageous, resilient, and more deserving of assistance.

Attitudes toward injuries, whether physical or mental, may affect others' perception of mental health needs and/or deservedness of treatment. It is possible that injury moderates attitudes toward help seeking by combat exposure. Future research should further examine the role of injury, specifically whether injured non-combat veterans are perceived differently by their peers than non-injured, non-combat veterans. There appears to be a line of demarcation between the *combat elite* and "others," but the nuances of the hierarchy are yet to be discovered. If this combat hierarchy exists, it is likely that the opinion of military peers will impact veterans' willingness to seek help. Understanding these internal barriers to treatment access and utilization is critical in developing effective programs and services veterans will use.

Limitations

Given the correlational study design, causality cannot be inferred. It is presumed that military training affects combat exposure, which in turn affects attitudes toward help-seeking behavior. However, it is possible that soldiers who do not believe in seeking assistance for mental health issues are more likely

to seek out branches of the military that will increase their level of combat exposure, thus increasing the likelihood that they experience combat (Baker, 1985). In turn, their initial combat warrior beliefs are supported and further ingrained by military training. This alternative explanation for veterans' attitudes toward help seeking cannot be controlled for with the current study design.

Future research should consider reservists as a separate demographic category. The present study did not distinguish between active duty military and reservists. Despite having identical combat, combat support, or non-combat roles and experiences as their active duty comrades, serving for limited periods interspersed with a return to civilian life may provide a different perspective from the experiences of lifetime military veterans. The inclusion of this variable in future studies may permit a more comprehensive exploration of the impact of combat status on veteran's attitudes toward help seeking.

The small sample size precludes the use of higher level statistics (e.g., MANOVA) that would control for the increased risk of Type I error. Despite the small sample size, preliminary results point toward different attitudes toward veterans depending on their combat status, and future research should include a larger sample to provide greater power to discover potential significant effects or differences between groups.

CONCLUSION

Military veterans have astounding numbers of suicide, homelessness, and unemployment, indicating the critical level of need in this population. This project provides initial information regarding the attitudes of veterans to decrease the gap in service provision, access to resources, and stigma of mental health treatment. As indicated by these preliminary findings, the attitudes and beliefs of veterans may influence help seeking and utilization of mental health treatment. Despite limitations, the results of the current study reflect a need for increased attention to the attitudes veterans have about themselves and each other. Combat and non-combat veterans perceive their combat experienced or exposed peers as more deserving of mental health services and treatment, which in turn may have treatment implications for veterans. Veterans often report that no one understands them except their peers, and if those relationships are fraught with judgment and minimization, whether real or perceived, the potential for isolation and hopelessness increases. Because this population is already at significant risk for suicide, PTSD, and substance abuse, the level of risk for veterans is substantial. Inter-veteran attitudes may be a key element in developing services and programs to veterans that are accessed, utilized, and effective.

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