Injunctive Norms for Mental Health Treatment-Seeking in a Sample of Canadian Armed Forces (CAF) Recruits and Officer Cadets

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IMPORTANT INFORMATIVE STATEMENTS

The research study described in this report received approval from the DRDC Toronto Human Research Ethics Committee (HREC).

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Abstract

Background: Accumulating research suggests that military members, including Canadian Armed Forces (CAF) personnel, may be at an increased risk of suffering from mental health problems. Military organizations have devoted significant efforts to increase mental health literacy and to ensure military members access appropriate mental health services in a timely manner. However, mental health service use is still underutilized by military members in need of mental health treatment. Research points to the important role social factors (e.g., perceived influence of others, i.e., social norms) may exert on mental health treatment (MHT)-seeking, and suggests both perceptions of what others would do (i.e., descriptive norms) and perceptions of what others expect one to do (i.e., injunctive norms) may be important. Perceptions of social approval/disapproval for mental health treatment-seeking (i.e., injunctive norms) may be especially complex in the military setting. Military members may perceive different levels of approval/disapproval from military peers, immediate supervisors, and military leadership. They may hear conflicting messages regarding treatment seeking from the CAF as an organization and the (civilian) society at large. Injunctive norms may evolve over time as military members spend more time in the military versus the civilian setting.

Objectives: To examine injunctive norms regarding mental health treatment seeking at the beginning of the military career.

Design: Eighty-four CAF recruits enrolled in Basic Military Qualification and Basic Military Officer Qualification were interviewed at the Canadian Forces Leadership and Recruit School in Saint-Jean-sur-Richelieu, Quebec. Participants were presented with a short vignette describing a hypothetical situation where an individual contacts their primary care physician for symptoms consistent with depression and anxiety; participants were asked to assume the perspective of the character in the vignette. Following, participants' beliefs and attitudes towards mental health and MHT-seeking were explored via a semi-structured interview. Transcribed interview responses from 69 participants underwent an in-depth, comprehensive content analysis intended to capture injunctive norms for MHT-seeking.

Results: On average, recruits mentioned significantly more social sources who would approve of seeking MHT in comparison to those who would disapprove it. Most common sources of perceived approval for MHT-seeking were family (particularly spouses and parents), friends (particularly close friends), and the CAF. Other less common but predominantly approving sources included members of religious communities (e.g., chaplains) and support groups. Most common sources of perceived disapproval for MHT-seeking were the general public, the CAF, employers/coworkers, and family members (particularly parents and siblings). Overall, family and friends were found to be more supportive than unsupportive. The general public and employers/coworkers were perceived to be largely unsupportive of MHT-seeking. Critically, the CAF was mentioned as a source of approval and disapproval for MHT-seeking in approximately equal proportions.

Significance to defence and security

Due to the high-stress nature of military occupations, maintaining a psychologically healthy and resilient force is imperative for military organizations. Accordingly, military administrations, including the Canadian Armed Forces (CAF), have devoted significant efforts to increase mental health literacy and to ensure military members access appropriate mental health services in a timely manner. An individual's intention to seek and utilize mental health services may in part be driven by perceived social standards regarding mental health treatment (MHT)-seeking. Exploring perceived social standards regarding MHT-seeking can inform interventions to increase mental health services use in the CAF.

Résumé

Contexte : De plus en plus de recherches donnent à penser que les militaires, y compris le personnel des Forces armées canadiennes (FAC), sont davantage susceptibles de souffrir de problèmes de santé mentale. Les organisations militaires ont consacré des efforts considérables afin d'accroître les connaissances en matière de santé mentale et d'assurer aux militaires un accès adéquat à des services de santé mentale en temps voulu. Malgré tout, les militaires qui nécessitent des soins de santé mentale ont peu recours à ces services. Les recherches en cours mettent en évidence le rôle important que peuvent jouer certains facteurs sociaux (tels que l'influence perçue des autres, c.-à-d. les normes sociales) dans la demande de soins de santé mentale et laissent supposer que la perception de ce que les autres feraient (c.-à-d. les normes descriptives) et de ce à quoi ils s'attendent que l'on fasse (c.-à-d. les normes subjectives) pourraient toutes deux avoir de l'importance. La perception de l'approbation ou de la désapprobation sociale à l'égard du recours aux soins de santé mentale (soit les normes subjectives) peut s'avérer particulièrement complexe dans un environnement militaire. Les militaires peuvent percevoir différents degrés d'approbation ou de désapprobation chez leurs pairs, leurs supérieurs immédiats et les chefs militaires. Ils peuvent aussi recevoir des messages contradictoires des FAC en tant qu'organisation et de la société (civile) en général concernant le recours aux soins de santé mentale. Les normes subjectives peuvent évoluer au fil du temps, puisque les militaires passent davantage de temps dans un environnement militaire que dans la société civile.

Objectifs : Examiner les normes subjectives relatives au recours aux soins de santé mentale en début de carrière militaire.

Conception : Quatre-vingt-quatre recrues des FAC inscrites à la qualification militaire de base et à la qualification militaire de base des officiers ont été interrogées à l'École de leadership et de recrues des Forces canadiennes de Saint-Jean-sur-Richelieu, au Québec. On a présenté aux participants une brève capsule décrivant une situation hypothétique dans laquelle une personne consulte son médecin de premier recours pour des symptômes associés à la dépression et l'anxiété, puis on leur a demandé de se mettre dans la peau de cette personne. Les participants ont ensuite fait part de leurs croyances et de leur attitude à l'égard de la santé mentale et du recours à des soins dans le cadre d'une entrevue semi-dirigée. Les réponses de 69 participants interrogés ont été retranscrites et ont fait l'objet d'une analyse de contenu exhaustive et approfondie dans le but d'établir les normes subjectives relatives au recours aux soins de santé mentale.

Résultats : Les recrues ont mentionné en moyenne, et de manière significative, plus de sources sociales qui approuveraient le recours aux soins de santé mentale que de sources qui le désapprouveraient. La famille (particulièrement le conjoint/la conjointe et les parents), les amis (surtout les amis proches) et les FAC sont généralement perçus comme des sources qui approuvent le recours aux soins de santé mentale. Les membres d'une communauté religieuse (p. ex. un aumônier) et les groupes de soutien sont des sources qui font un peu moins l'unanimité, mais qui sont tout de même perçues comme étant généralement favorables. Le grand public, les FAC, les employeurs, les collègues de travail et les membres de la famille (surtout les parents et les frères et sœurs) constituaient les sources les plus communément considérées comme défavorables au recours aux soins de santé mentale. Globalement, la famille et les amis étaient plutôt perçus comme étant d'un grand soutien. Le grand public, les employeurs et les collègues étaient perçus comme étant en grande partie défavorables au recours aux soins de santé mentale.

Fait important, les participants ont mentionné dans des proportions presque égales les FAC comme étant une source favorable et défavorable au recours aux soins de santé mentale.

Importance pour la défense et la sécurité

En raison du niveau de stress élevé que subissent les militaires, il est impératif pour les organisations militaires de maintenir une force à la fois résiliente et en bonne santé psychologique. En conséquence, les administrations militaires, y compris les FAC, ont consacré des efforts considérables afin d’accroître les connaissances en matière de santé mentale et d’assurer aux militaires un accès adéquat à des services de santé mentale en temps voulu. La volonté d’une personne de faire appel aux services de santé mentale pourrait être motivée en partie par des normes sociales perçues relatives au recours à des soins. Explorer ces normes sociales perçues permettra d’orienter les interventions destinées à accroître le recours aux services de santé mentale au sein des FAC.

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1 Introduction

1.1 Background and objectives

Accumulating research suggests that military members, including Canadian Armed Forces (CAF) personnel, may be at an increased risk of suffering from mental health problems (Fear et al., 2007; McFarlane & Hodson, 2011; Park, 2008; Statistics Canada, 2003). For instance, research with CAF personnel has demonstrated that the prevalence of suicidal ideation, major depressive disorder, and generalized anxiety disorder is significantly higher than that of the civilian population when controlling for important sociodemographic and clinical factors (Rusu et al., 2016). Critically, mental disorders may have wide-ranging negative consequences across multiple domains, including social functioning, vocational capacity, and quality of life (Harnois et al., 2000; Mendlowicz & Stein, 2000; World Health Organization, 2001); ensuring the timely delivery of appropriate mental health interventions can mitigate this risk. Military organizations have devoted significant efforts to increase mental health literacy and to ensure military members access appropriate mental health services in a timely manner (Bailey, 2015; 2014; Thomas et al., 2016). Despite these efforts, mental health service use is still underutilized by military members in need of mental health treatment (MHT) (Fikretoglu et al., 2016; Hom et al., 2017).

Several perceived facilitators of and barriers to MHT-seeking have been identified among military members, including income, insurance coverage, and perceived confidentiality (Zinzow et al., 2013). Critically, research also alludes to the important role social networks and social norms may play in encouraging MHT-seeking. Namely, beliefs propagated by the military culture, positive leadership behaviour, leadership support, and family support have all been found to affect MHT-seeking (Zinzow et al., 2013). Indeed, aligned with the well-established theoretical framework detailing how attitudes can affect behaviors, Theory of Planned Behaviour (TPB) (Ajzen, 1991; see Annex A for model illustration), research investigating the barriers and facilitators of treatment-seeking have suggested that social factors may exert a strong influence on MHT-seeking; among such social factors, perceptions of whether important others in one's network would be supportive or not of help-seeking (i.e., perceived injunctive social norms or perceptions of whether those in one's social network approve or disapprove of the behaviour in question) may be particularly influential (Cialdini et al., 1990). Specifically, if individuals expect others in their social network to disapprove of MHT seeking, they may be less likely to reach out for help. An added complexity in military populations is that a military career predisposes one to experience social disturbances, where social networks and group identity may fluctuate across time and context. For instance, many military members may be disconnected from civilian social networks for prolonged periods of time due to training or deployments, spending the majority of the time interacting with military peers and superiors. As a result, the military-based social network may represent a substantial source of subjective norms for military personnel, including norms related to mental health and MHT-seeking; perceived norms from the military social network may or may not be in conflict with perceived norms outside of the military (i.e., civilian family and friends).

The Road to Mental Readiness (R2MR), a mental health literacy program delivered to CAF personnel throughout the military career, seeks to address many barriers to seeking MHT,

including those related to personal attitudes (Bailey, 2015). The R2MR program has three central goals: increase the CAF members' knowledge of mental health and ability to identify mental health issues, change attitudes regarding mental health and MHT, and teach coping skills to ameliorate psychological distress. R2MR can potentially target descriptive and injunctive norms around MHT-seeking, dispel stigma related to MHT-seeking, and build an institutional social culture that facilitates MHT-seeking. Understanding the nature of CAF personnel's perceptions of social norms is central to the implementation of effective, evidence-based, theory-driven interventions aimed at promoting mental health and MHT-seeking.

Using two theoretical models, the Self-Regulatory Model (SRM), which outlines how appraisals and coping processes can be invoked to influence one's thoughts behaviors and feelings to reach goals (Leventhal et al., 1992; see Annex B for model illustration) and the TPB (Ajzen, 1991), Fikretoglu and colleagues (HREC Protocol # L829) conducted a qualitative study to 1) understand how CAF members think about mental health problems, and 2) identify what attitudinal barriers exist with regard to MHT-seeking at the beginning of the military career at the Basic Military Qualification (BMQ). BMQ represents the first exposure to mental health education via R2MR. Based on the results of this study, a previous qualitative analysis and report by Fikretoglu et al. (2017) found that recruits identified support for treatment seeking from their social networks as a facilitator of treatment-seeking but also found that many recruits recognized inconsistency in their social networks when it comes to supporting MHT-seeking (e.g., "some of my friends would totally support me and others would disapprove of me seeking help" or, "some of my family members would be supportive whereas others would not"). Given that the initial analysis out of the study was limited to identifying the most commonly occurring themes in response to standard SRM and TPB questions, including questions regarding who would approve/disapprove treatment seeking, we decided to undertake a deeper analysis of responses surrounding injunctive norms related to MHT-seeking in the current report.

2 Method

2.1 Study sample and procedure

The analyses presented in this report are sourced from a dataset previously collected and described by Fikretoglu et al. (2017). In brief, eighty-four CAF recruits enrolled in BMQ and Basic Military Officer Qualifications (BMOQ) were interviewed at the Canadian Forces Leadership and Recruit School (CFLRS) in Saint-Jean-sur-Richelieu, Quebec by three trained researchers from Defence Research and Development Canada (DRDC)-Toronto Research Centre. Participants were presented with a short vignette (see Annex C) describing a hypothetical situation where an individual contacts their primary care physician for symptoms consistent with depression and anxiety. The vignette ends with the physician labeling the symptoms as depression and anxiety and recommending MHT-seeking from a professional specializing in the treatment of such symptoms (such as a psychologist or psychiatrist). Participants were asked to assume the perspective of the character in the vignette. Subsequently, participants were queried via a semi-structured interview intended to explore beliefs and attitudes towards mental health and MHT-seeking (see Annex D). Data analysis was limited to Anglophone interview responses from 69 participants (34 CAF NCM recruits and 36 CAF officer cadets). Due to the potential presence of cultural and linguistic nuances related to the perception of mental health, results from Francophone interviews will be presented in a separate report. All participants provided consent to participate in this research study. All study procedures and measures were reviewed and approved by the DRDC Human Research Ethics Committee (HREC). Refer to Fikretoglu et al. (2017) for a detailed description of participant selection and recruitment, study sample characteristics, and data collection procedures.

2.2 Data analysis

Transcribed interviews were imported into NVivo 10 (QSR International, Australia) for in-depth, comprehensive content analysis. Data were analyzed in three stages and data-analytic strategy was guided by the Framework Method (Gale et al., 2013). First, interview transcripts were individually assessed in full by one rater and any excerpts that met the following conditions were identified:

1. a social source was mentioned, in reference to:

2. its perceived positive (support, approval, facilitation), neutral, or negative (disapproval, source of negative consequences) stance on MHT

Within each excerpt, the social source was classified and paired with a valence node (negative, neutral, positive). The second stage of thematic classification involved a second pass of all interview responses to confirm and/or adjust the unique social sources identified in the first round of classification. To ensure that all instances of the established social sources were identified across all interviews, the third round of data processing comprised of an automatic full-text search for each source, its synonyms, and related terms. Any additional relevant matches were subsequently coded. Although our focal question of interest was “Are there individuals or groups who would approve/disapprove of your seeing a mental health professional for treatment of

problems such as anxiety and depression" (Question 7; see Annex D), due to the flexible nature of a semi-structured interview, transcripts were analyzed in full to ensure the comprehensive capture of any relevant excerpts.

Care was taken to ensure that only the responses that pertained to the recruit's perception of their social network were included in the analysis. In other words, responses that mentioned hypothetical scenarios or the experiences of others (not related to their own social matrix) were excluded (e.g., "my parents are supportive [included], but for some people, parents may not be supportive [not included]"). Finally, to avoid contamination of data due to response bias, responses to interviewer questions that specifically inquired about social network nodes were excluded from analysis. For instance, several follow-up questions specifically inquired about the CAF or healthcare professionals, and therefore, inclined the respondent to mention those social sources. Only freely evoked social nodes were included in the analysis. Perceived support or disapproval from healthcare professionals was not explored in this study.

Finally, we applied quantitative statistical methods to characterize responses further. Some have criticized the use of quantitative statistics for analyzing qualitative data (Pope et al., 2000); nonetheless, we carefully employed this approach as it provided additional insights into the nature of injunctive norms for MHT-seeking perceived by CAF recruits. Test of normality of coding frequency data was conducted using the Wilk-Shapiro Test. Due to the predominantly non-normal distributions, we employed two-tailed non-parametric statistical tests (e.g., Wilcoxon, Spearman) to conduct within-group analyses of coding frequencies. Statistical analysis was conducted using SPSS 21 (IBM, USA). An alpha level of 0.05 was set for all analyses.

3 Results

Qualitative analysis of 69 interviews identified 345 instances in which a social source was mentioned with regard to its perceived positive (i.e., supportive, approving, facilitating), neutral, or negative (i.e., disapproving, source of negative social consequences) stance on MHT. A total of 15 unique social sources were identified and grouped accordingly (see Annex E).

3.1 Most frequently endorsed social sources of approval and disapproval for MHT

Within the sample, the most frequently mentioned social sources of influence with regard to mental health and MHT included family members (mentioned by 78% of sample), CAF organization and personnel (70%), friends (67%), general public (58%), and employer (23%).

On average, recruits mentioned significantly more social sources/nodes that would approve of seeking MHT in comparison to those who would disapprove it ($Z = -2.91$, $p = .004$; mean for approval: 1.89; mean for disapproval: 1.36). Excluding recruits' beliefs about how the public may perceive them when seeking MHT decreased the mean number of disapproving social sources to 0.87. Approximately 7% of sample expressed that no one in their social life would approve of them seeking MHT (this proportion did not change after excluding recruits' beliefs about how the public would perceive them seeking MHT). Approximately 27% of the sample mentioned that no one in their life would be disapproving of seeking MHT. Another 14% of the sample had no one disapproving of MHT if perceptions about the general public were excluded. The number of reported social sources of approval and disapproval were not intercorrelated ($p > 0.05$).

Family and friends were explicitly identified to be supportive of recruits' MHT-seeking by 71% and 52% of the sample, respectively. Within our sample, 39% of recruits believed that the CAF would approve of them seeking MHT. Non-CAF religious sources were perceived to be supportive by 10% of sample. With regard to the disapproval of MHT-seeking, the most commonly referenced sources were the general public (mentioned by 49% of sample), the CAF (35%), employer/coworkers (22%), friends (17%), and family (13%) (see Figure 1).

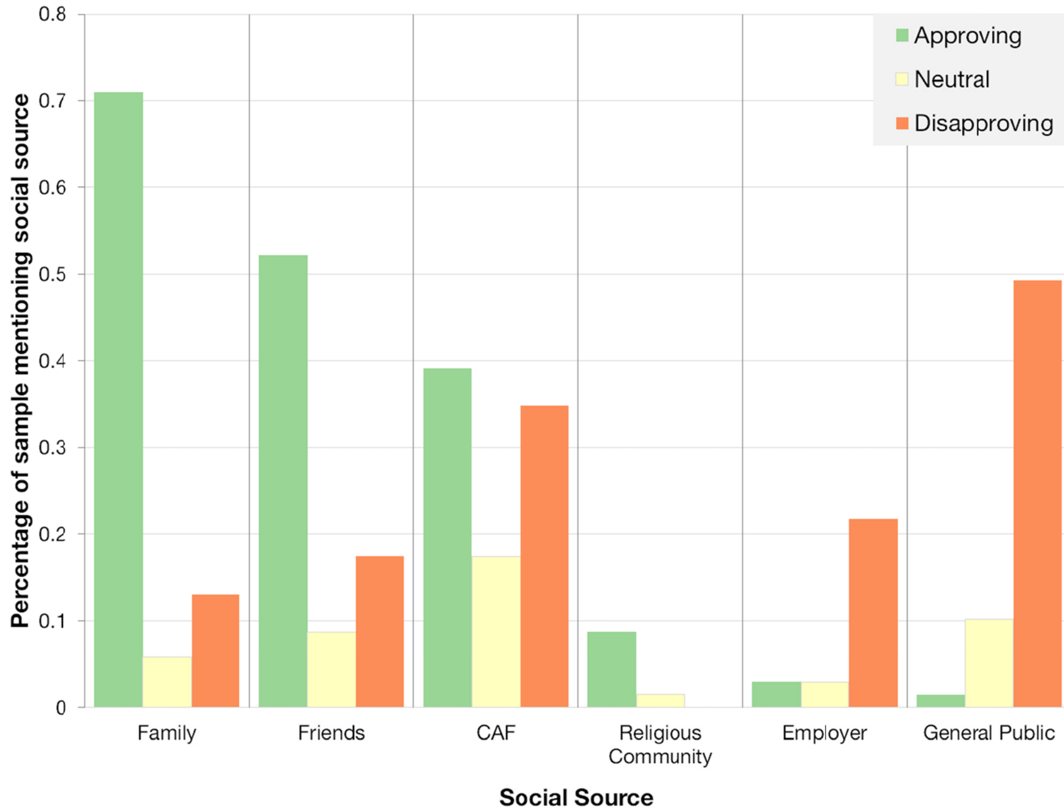

Figure 1: *Most commonly mentioned social sources perceived to be approving/disapproving of MHT-seeking.*

3.2 Most supportive and non-supportive social sources

To determine the relative extent to which sources of CAF recruits' social networks were perceived as either supportive of MHT-seeking, unsupportive of it, or both, we calculated ratios of the frequencies of positive to negative valences for each social source (see Figure 2). From the top five most commonly mentioned social sources, family (5.4 approving: 1 disapproving) and friends (3 approving: 1 disapproving) were perceived to be most supportive. The CAF was perceived to be supportive and unsupportive at equal rates (1.1 approving: 1 disapproving). Employers and/or coworkers (not specific to organization or industry) were perceived to be largely unsupportive (1 approving: 7.5 disapproving). Finally, recruits' perceptions of the general public's attitude towards MHT were mostly negative (1 approving: 34 disapproving) (see Figure 2).

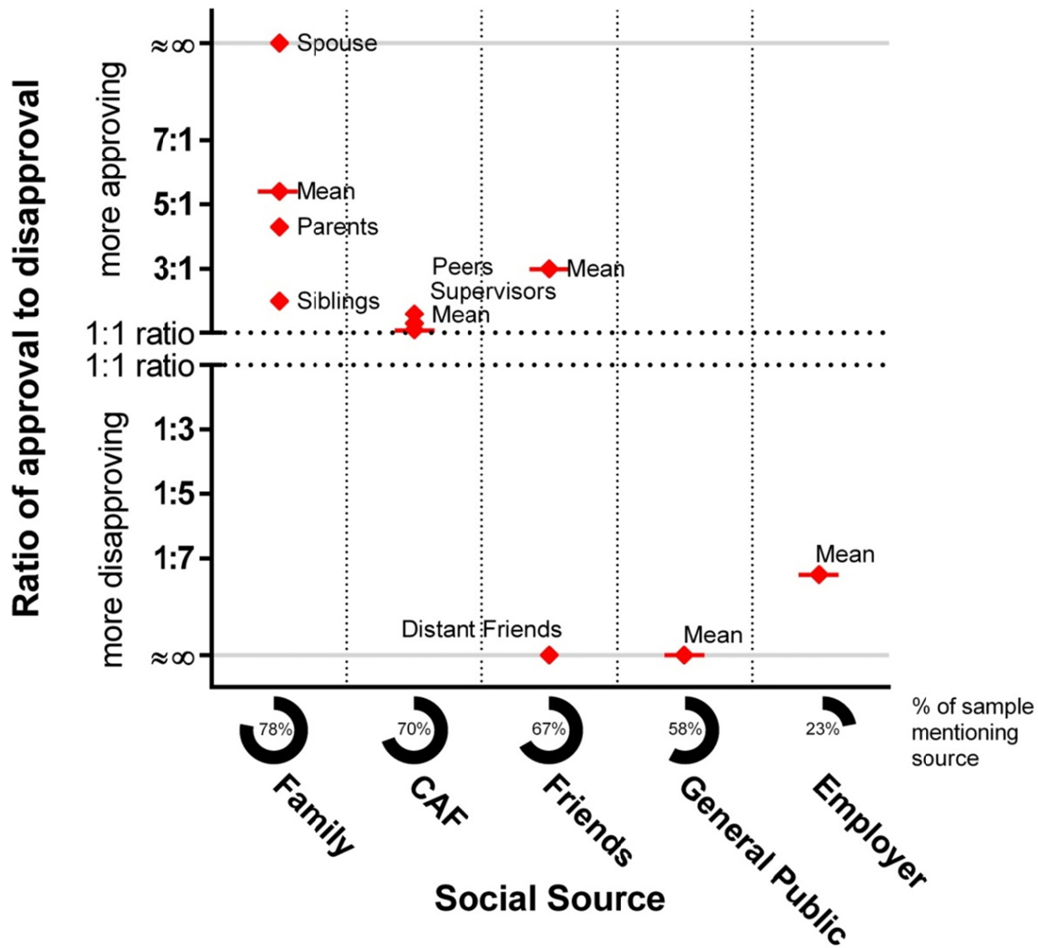

Figure 2: *Ratio of perceived approval to perceived disapproval from most cited social sources regarding MHT-seeking.*

For a more granular analysis, the family, friends, and CAF social nodes were further subdivided. Within the family node, all individuals who mentioned spouses (representing 10% study sample) found them to be approving. Parents were mentioned by 23% of the sample and were found to be approving (vs. disapproving) at a ratio of approximately 4.3:1. CAF peers were mentioned by 25% of the sample and were found to be approving (vs. disapproving) at a ratio of 1.6:1. Immediate CAF supervisors were mentioned by 23% of the sample, with an approval (vs. disapproval) ratio of 1.3:1. For some excerpts that mentioned the CAF, we could not distinguish with confidence whether they referred to CAF policy, CAF leadership, or CAF organization as a whole.

Other unanimously supportive, albeit less frequently mentioned, social sources included those related to spirituality and religion (mentioned by 14% of the sample). Specifically, none of the references to the CAF Chaplain (mentioned by 6% of the sample) and other non-CAF religious sources (mentioned by 10% of sample) were classified as unsupportive of the recruit seeking MHT.

Similarly, support groups (e.g., Alcoholics Anonymous) were also perceived as approving (mentioned by 6% of sample; all references were categorized as approving).

3.3 Reasons behind perceived approval of MHT-seeking

Considering that individuals were not probed to provide reasons behind perceived approval by their social network, our analysis of why certain social sources were considered to be approving by CAF recruits is limited. Nonetheless, several patterns were discovered.

3.3.1 CAF

With regards to immediate CAF supervisors (referenced by 13% of sample) and CAF peers (referenced by 16% of sample) the predominant responses referencing reasons for approval/disapproval of MHT-seeking revolved around:

1. belief that others would be able to recognize and understand mental health problems due to their own previous experiences (i.e., others probably have gone through the same experiences)

2. belief that the recognition of mental health problems is the duty of immediate supervisors

3. belief that others would help you in MHT-seeking in order to maximize the collective strength of the group

Referencing immediate CAF supervisors:

> *"…because I know that they have been here for a while, and* ***they have probably gone through the same situation****" (emphasis added)*
>
> *"People in the CF, in a superior position to mine,* ***who look out for these things****…" (emphasis added)*
>
> *"As much as they push you, they are* ***here at the end to help you out****…" (emphasis added)*

Referencing CAF peers:

> *"There is no competition;* ***you want everybody in your group to succeed****…" (emphasis added)*
>
> *"He's had some experience before in search and rescue with stuff like that so he* ***knows how important it is to force those bonds****." (emphasis added)*

Referencing CAF in general:

> *"* ***They*** *[the CAF]* ***do not want me to be mentally ill****, especially in a situation like this where you are put to your max stress level every day." (emphasis added)*
>
> *" Working for the CF, I am sure that they would definitely support it,* ***because they want the best for us****." (emphasis added)*

3.3.2 Family and friends

Excerpts mentioning reasons for family and friends' support for MHT-seeking revolved around:

1. Belief that the relative closeness of specific relationships would facilitate family/friends' ability to understand psychological changes in the recruit better than others
2. Belief that if a friend/family member provided support in the past for other things they would also provide support for MHT-seeking

Referencing parents:

> *"…they want the **best for their children**." (emphasis added)*

> *"…they are **more concerned** about [my] well-being" (emphasis added)*

Referencing parents and spouse:

> *"…they're going to be the ones who **know you better**…" (emphasis added)*

Referencing family as a whole:

> *"…they **have always been supportive** of me…" (emphasis added)*

> *"… know that you're going through a lot of stress or that you've changed or a different person…"*

Referencing friends and family:

> *"If* [I] *had changed in the last few weeks, they would not like to see this different version of me. **After a few weeks of seeing me as a shade of my former self, they would**—should I choose to seek professional help—**probably drive me there if I were too lethargic or tired to go**." (emphasis added)*

3.4 Reasons behind perceived disapproval of MHT-seeking

3.4.1 CAF

Within our sample, 34% of recruits believed that the CAF (organization as a whole), CAF peers, or immediate CAF supervisors would disapprove of them seeking MHT. Although respondents were not explicitly asked why certain individuals or groups of individuals were perceived to be approving or disapproving of MHT-seeking, several recruits revealed reasons and justifications behind the perceived disapproval. With regards to immediate CAF supervisors (referenced by 10% of sample) and CAF peers (referenced by 10% of sample), the predominant negative belief behind disapproval for MHT-seeking centred on the fear of being perceived as weak and unreliable.

Referencing immediate CAF supervisors:

> *"The ones who are here to* ***see how far you can go before you break****." (emphasis added)*

> *"As superiors, they would almost feel like* ***you've almost failed them*** *because that's their whole point is to try to break you down and make sure you're going to be resilient." (emphasis added)*

> *"I would be afraid that my superiors—especially as a new recruit—****would think that I am not worthy of being in the military****; that I am* ***not strong enough****." (emphasis added)*

Referencing CAF peers:

> *"…sometimes they will say 'You're going to mental health because* ***you're weak.****'" (emphasis added)*

> *"They* ***might not think that you are reliable*** *if your head is not in the game." (emphasis added)*

3.4.2 Friends

Within our sample, 17% of recruits believed that some or all of their friends may be disapproving of seeking MHT. Recruits frequently mentioned that it would be distant (versus close) friends who would be disapproving of MHT. We identified two predominant negative beliefs with regards to friends:

1. Would be judgmental and/or see them in a different light
2. Would not be able to understand the full scope and magnitude of the situation

> *"…their opinion of you might slightly change because they* ***may think you are not mentally sound****." (emphasis added)*

> *"…maybe your peers would kind of* ***think you were a little crazy*** *or something…" (emphasis added)*

> *"…if they have never gone through something like that,* ***they will not fully understand.****" (emphasis added)*

> *"…****they don't really understand*** *what's going on." (emphasis added)*

3.4.3 Family

Within our sample, 13% of recruits mentioned that their family members would disapprove of MHT-seeking. Similar to the responses given about friends, the majority of responses around family members' disapproval centred on:

1. Fear of judgment

2. Minimization—family members dismissing the potential mental health problems and treating them as non-issues

> *"Parents also can be **very judgmental**." (emphasis added)*
>
> *"They **may look down** on that." (emphasis added)*
>
> *"…a lot of the times they [parents] just **believe you are overreacting**." (emphasis added)*
>
> *"They [siblings] **think you are just being selfish** and just want all of the attention." (emphasis added)*

3.4.4 General public

Within our sample, 49% of recruits expected disapproval from the general public if they were to seek MHT. The majority of responses centred on:

1. Fear of judgment/getting labeled

2. Others not understanding the importance of mental health

> *"If you tell somebody that you are going to a psychologist they **may think you're not right.**" (emphasis added)*
>
> *"Others would say 'Oh, that guy's crazy.'"*
>
> *"I think it would be more of people who would just sort of quietly say 'that guy's, you know, **you should just suck it up and deal with it**. You should not have to go see a mental health professional.' kind of thing." (emphasis added)*
>
> *"The general perception is that if you go to a mental health clinic or a psychologist, then there **must be either something wrong with you or you must be crazy**." (emphasis added)*
>
> *"A lot of people do not understand depression."*

3.5 Secondary patterns

Secondary to our objectives, two other patterns emerged within this dataset. Despite not being explicitly queried, 23% of respondents revealed that they have previously experienced mental health problems. Although outside the scope of this investigation, it was apparent that those who have had past mental health problems generally had a positive outlook on MHT-seeking, presumably due to positive experiences when previously seeking MHT. Finally, a small portion of the sample mentioned the disapproval of MHT-seeking by certain segments of the population. Specifically, those who are younger, older, or from other cultures were perceived to be disapproving of MHT-seeking.

4 Discussion

Using interview data from a sample of CAF recruits, we identified and characterized the social sources that CAF recruits would perceive to be approving and disapproving of MHT-seeking in a hypothetical scenario. Most common sources of perceived approval for MHT-seeking were family, friends, and the CAF. Other less common but predominantly approving sources included members of religious communities and support groups. Most common sources of perceived disapproval for MHT-seeking were the general public, the CAF, employers/coworkers, and family members. Family and friends were perceived to be more supportive than unsupportive. The general public and employers/coworkers were perceived to be largely unsupportive of MHT-seeking. Critically, the CAF was mentioned as a source of approval and disapproval for MHT-seeking at approximately equal proportions. Results presented here signify the complex nature of perceived injunctive norms relating to MHT-seeking and the heterogeneity of injunctive norms for MHT-seeking among CAF recruits.

In our sample, CAF recruits made several, and at times, subtle distinctions between social sources that modified the extent to which those sources were perceived to approve or disapprove of MHT-seeking. This finding is in keeping with TPB's quantitative approach to measuring injunctive norms around specific behaviours. Ajzen (1991) quantifies subjective norms as a function of normative beliefs one perceives about each social source (e.g., my dad would approve of MHT-seeking) and one's motivation to comply with that source's expectations (e.g., it is really important for me to do what my dad expects me to do with respect to MHT-seeking). For instance, although our sample has mentioned distant friends as being largely disapproving of MHT-seeking, the influence this disapproval has on MHT-seeking behaviour may be minimal due to the social source's relative unimportance (i.e., when compared to the influence of close friends). A self-report instrument measuring TPB constructs (including injunctive norms), developed based on the findings from the qualitative study described here, is indeed measuring both normative (injunctive) beliefs and motivation to comply for all social sources/referenced identified here.

Outside of the TPB literature, other research exploring the relation between mental health and positive and negative social interactions alludes to the detrimental and, at times, overpowering effect of negative social ties on mental health; this line of research suggests that for mental health, the lack of negative interactions *may be more important than* the abundance of perceived positive interactions (Bertera, 2005; Rook, 1984; Schuster et al., 1990). Applied to MHT-seeking, this research would suggest that despite having the majority of social sources being perceived as approving of MHT-seeking, disapproval by a select few may be disproportionately influential. It is unknown whether this pattern exists in relation to injunctive norms and MHT-seeking. The exploration of the interaction between social sources' injunctive norms regarding MHT-seeking and motivation to comply in CAF recruits is currently underway; findings thus far do not point to disproportionate influence from a select few social sources, although examination of disproportionate influence is not the main aim of ongoing research efforts with CAF recruits (Fikretoglu, personal communication). Future research exploring this interaction is warranted.

As a final point demonstrating the heterogeneity of beliefs surrounding injunctive norms among CAF recruits, almost one-third of our sample could not identify a single individual or group who would disapprove of them seeking MHT, demonstrating overwhelming facilitation of

MHT-seeking through injunctive norms; meanwhile, 7% of the sample had no one in their social network who would approve of MHT-seeking. The drastic variation in the nature of social networks and perceived injunctive norms underscores the difficulty in creating a single mental health education program that would be uniformly effective across all CAF members; targeted interventions should be explored.

Previous research has demonstrated that individuals are more likely to seek MHT if provided encouragement from friends and family (Warner et al., 2008). Although the majority of our sample found their friends and family to be a source of support during MHT-seeking, critically, a proportion of the sample explicitly mentioned that some or all of their family and friends would be disapproving of such behaviour. Interventions that include educational resources for family and friends aimed at maximizing encouragement for the CAF member to seek timely MHT may want to address the tension between perceived injunctive norms from family/friends, perceived injunctive norms from CAF (the organization, immediate superiors, peers), and as well CAF values (Wilson et al., 2015). Furthermore, in our sample, we found that within the family social domain, spouses were perceived to be disproportionately more approving of MHT-seeking compared to parents and siblings. Individuals who are married or are in committed relationships may be at an advantage as they would possess a unique social support source that may further encourage timely help-seeking. Indeed, in a nationally representative survey exploring past-year mental health service use of CAF military members, Fikretoglu et al., (2008) found that those who were married or in a common-law relationship were more likely to seek MHT in the past year in comparison to those who were single (controlled for predisposing and enabling factors, military variables, perceived need for care, and the diagnosis of common psychiatric disorders). Future research should explore whether the increased MHT-seeking behaviour by those in committed relationships is driven by perceived injunctive norms of those close to the CAF member (e.g., pressure from spouse to seek MHT). Interventions such as R2MR may also need to specifically target those who are young and single in persuasive messages around MHT-seeking.

Cultural and demographic factors should also be considered when assessing social networks and designing interventions aimed at facilitating treatment-seeking (Koenig, 1998; Mackenzie et al., 2006). For instance, several participants perceived that both younger and older cohorts would be disapproving of seeking MHT. Participants mentioning disapproval from younger generations alludes to minimization behaviours that potentially arise from a lack of life experiences—younger individuals may dismiss mental health concerns and perceive those who seek treatment as weak. Interestingly, participants who perceived older generations to be disapproving also mentioned that MHT-seeking would be seen as weak, albeit this was presumably caused by a lack of mental health literacy as opposed to a lack of life experiences. Finally, some responses from our results underpin the influence of culture on approval/disapproval for MHT-seeking (i.e., those from other cultures and religions were perceived as not approving of MHT-seeking). Unfortunately, the small sample size and low frequency of references mentioning religion and culture prevent further analysis in the current study. Critically, beliefs regarding age and culture/religion may moderate injunctive norms, increasing the complexity in this field of study. For instance, in comparison to older CAF supervisors, younger CAF supervisors may be seen as more approving of MHT-seeking, but only from the viewpoint of younger cohorts. More research is required to address the intricacies of the interactions between different social roles/sources, demographics, and culture.

Considering that the majority of Canadians identify as either religious or spiritual (Government of Canada, 2013) (N.B. published data on religious affiliation in CAF members are currently lacking), the importance of religious/spiritual well-being and the support and guidance that members of religious communities may provide should not be underestimated. Although religious sources (e.g., chaplains) were mentioned by a small proportion of the sample, our results indicate that they are seen by CAF recruits as overwhelmingly supportive with regard to mental health treatment-seeking, Chaplains have traditionally played an important role in maintaining psychological health and well-being (Besterman-Dahan et al., 2012) and can likely be leveraged as “gatekeepers” to services with mental health professionals such as psychologists, psychiatrists, and social workers, much in the same way as primary care physicians. A collaborative model that blends chaplain services and traditional mental health professionals may facilitate both mental health screening and the delivery of timely interventions. Furthermore, characteristics of such overwhelmingly supportive resources (e.g., CAF chaplain, spouses, support groups) should be investigated and considered for implementation in other social nodes that are perceived to be less supportive (e.g., implementing the same level of confidentiality in CAF mental health services as perceived with the CAF chaplain).

The meaning, maintenance, and dissemination of social norms rely on social interactions. Cialdini’s and Kallgren’s focus theory of norms (Cialdini et al., 1990; Kallgren et al., 2000) hypothesizes that activation of norms is triggered by cues in the environment—the more accessible the normative belief cues are, the more likely that those normative beliefs will be activated in memory, and, in turn, more likely to influence behaviour. This is particularly important for individuals in transitional phases in life (such as recruits in the BMQ) as their social and physical environment may fluctuate. CAF members (and in this case, NCM recruits) are frequently disconnected from interactions with friends, family, and significant others—social nodes that are perceived by CAF recruits to be overwhelmingly approving of MHT. Additionally, if the network of social interaction is limited to those who are perceived to be disapproving of MHT, then they will be less likely to reach out for help. Lack of exposure and communication with the civilian segment of the social network during training and deployments increases the pressure on the CAF to ensure positive messaging about MHT is maintained; this messaging must be executed frequently and across different contexts. Finally, the degree of influence that social norms have on behaviour is maximized when the opportunity or need for the behaviour is presented (e.g., when the military member recognizes the need for care or when they are provided information about MHT access). The CAF can capitalize on these findings by ensuring that when messages of availability of MHT are communicated, they are paired with messages targeting injunctive and descriptive norms (e.g., “you are not alone, many others have sought treatment”, “we’re here to ensure CAF members are healthy”, “your leaders and peers are here to support you”). As a result of the current and subsequent research by DRDC Toronto Research Centre, such targeted messages are being incorporated into the BMQ version of R2MR.

Finally, in our sample, almost 1 in 4 endorsed experiencing mental health problems in the past, with many of these individuals seeking MHT. Accumulating evidence suggests that previous MHT-seeking may act as a strong facilitator of future MHT-seeking. Potential mediating factors behind this relation may include increased mental health literacy acquired during the treatment-seeking process (Gulliver et al., 2010), a better appreciation of the advantages of MHT-seeking, and the correction of misconceptions regarding MHT or mental health professionals. Research has demonstrated that being exposed to MHT experiences of others has been found to encourage MHT-seeking; individuals are more likely to engage in MHT-seeking

when their social network includes those who have received MHT in the past (Vogel et al., 2007). The CAF may explore ways to provide these individuals with a platform to act as “model peers” and drivers of attitudes within CAF peer networks; propagating positive messaging based on past experiences by those who are perceived to be similar (i.e., group identity) may have a substantial effect on altering normative beliefs.

4.1 Limitations

These results should be interpreted with care. The modest sample size is a key limitation of this investigation. Our findings cannot be generalized to all CAF recruits, without further research. Although qualitative coding was reviewed and confirmed by an additional member of the research team (W.S.K.) with qualitative research experience in CAF, only one rater (A.N.) conducted the analytical pipeline (identification and coding of excerpts using the technique outlined in Section 2.2). Future investigations into the social barriers and enablers of mental health service use should employ study designs that would facilitate the use of several independent raters to confirm the accuracy and precision of thematic discovery and quantification. In instances where ‘employers’ or ‘friends’ nodes were mentioned, there is a potential that respondents may have been referring to the CAF and CAF peers, respectively; future studies should ensure these distinctions are clarified at the time of data collection. Similarly, some references mentioning the CAF were ambiguous as to the sub-node they referred to; delineating CAF leadership, CAF policy, immediate CAF supervisors, and CAF peers with regard to beliefs about approval/disapproval of MHT was, at times, impossible. Future studies of investigating social networks in CAF personnel should ensure respondents specify and contrast different members, roles, and hierarchies of the CAF, in addition to exploring perceptions of institutional policy. For instance, future research may investigate whether personnel perceive CAF policies as being essentially supportive but leadership not (or vice versa); this has implications for interventions relating to the facilitation of MHT-seeking.

Help-seeking behaviour for psychological distress has been previously found to differ between sexes, where men tend to initiate help-seeking at significantly higher levels of psychological distress in comparison to women (Biddle et al., 2004). The dampened help-seeking behaviour may be due to social roles surrounding masculinity, where men may feel more pressure to avoid displaying weakness. Exploration of sex-differences and normative beliefs regarding MHT-seeking in future research is thus warranted. Finally, most vignette-based research on MHT-seeking has focused on a specific disorder (e.g., schizophrenia) and there may be distinct beliefs and attitudes regarding MHT-seeking associated with different disorders. In this study, only depressive and anxious symptoms were explored in relation to treatment seeking; future investigations should explore normative beliefs across a range of mental health issues.

4.2 Conclusion

To maximize the psychological resilience of CAF personnel, the CAF must ensure that its members can identify mental health problems, recognize the need for care, seek treatment in a timely manner, and be a part of a supportive social matrix for peers who may seem to be struggling. Considering that personal attitudes, normative beliefs, and perceived barriers/facilitators can be fundamental driving forces of MHT-seeking behaviour, understanding the nature of CAF personnel’s social networks and the perceptions of social norms is central to

the implementation of effective interventions aimed at promoting MHT-seeking. The findings of this report begin to highlight the potentially complex nature of perceived injunctive norms and the heterogeneity of injunctive norms for MHT-seeking among CAF recruits. Interventions for incoming CAF recruits should recognize the heterogeneous nature of their civilian social networks with regard to MHT-seeking and emphasize the supportive role that the CAF network can play. Considering that incoming CAF recruits quickly become embedded the CAF social matrix, interventions aimed at increasing MHT-seeking in CAF recruits must capitalize on the constant interactions among CAF members and implement frequent, consistent positive messaging targeting descriptive and injunctive norms (e.g., avenues may include the use of peer role models). It is recommended that the CAF ensures personnel has timely communication access with individuals/resources who are perceived to be approving of MHT and provide leadership training to ensure that the importance of seeking MHT is communicated effectively and consistently. Finally, the CAF should strive towards ensuring that MHT-seeking messages that members receive are *unanimously* positive across the entire CAF social network; implementation and enforcement of policies that can ensure belittling, ridiculing, or scapegoating of individuals will not be tolerated within the CAF are advised. It is also recommended that the CAF explore ways of extending mental health literacy programs to family and friends of CAF members, as they represent a substantial source of normative beliefs with regard to MHT. Critically, a portion of our sample reported that they had no one in their social network who would approve of them seeking MHT. Considering that R2MR has been shown to have a protective effect (i.e., prevents norms from progressing in the direction of being unsupportive over the course of the BMQ), identifying CAF recruits and personnel that lack supportive social capital may allow for early interventions aimed at provisioning additional mental health education and reframing normative beliefs such that positive injunctive norms are perceived from institutional social sources.

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Annex A Theory of planned behaviour

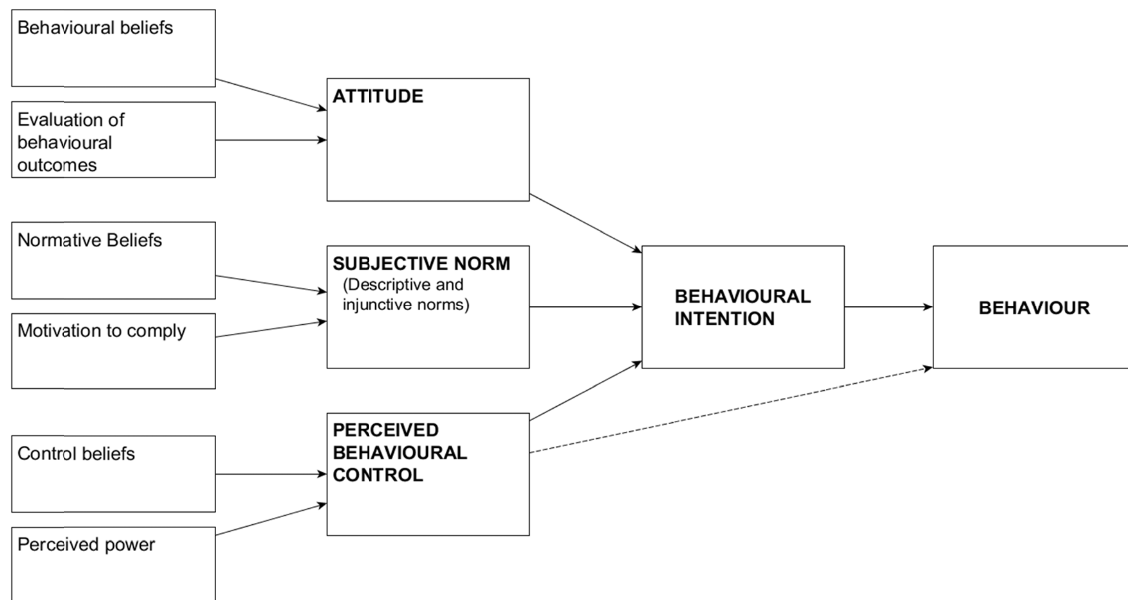

Figure A.1: *Theory of planned behaviour. Figure adapted from Azjen (1991).*

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Annex B Self-regulatory model of illness

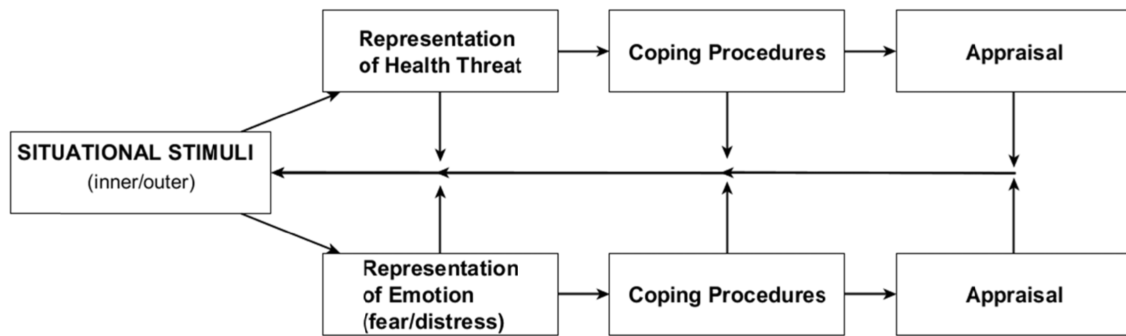

Figure B.1: *Self-regulatory model of illness. Adapted from Leventhal et al. (1992).*

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Annex C Vignette with hypothetical scenario

Please imagine that you went to your primary care physician at your local Canadian Armed Forces (CAF) Medical Clinic or at a civilian primary care clinic because you have problems handling your everyday life. For a few weeks you have been feeling weak and without energy. During the day, you feel muscle aches, tension, and soreness in your body. Although you feel tired all day, you cannot sleep well, you constantly wake up in the middle of the night, and then cannot fall asleep again. You feel tense and nervous and are constantly on edge. You have also noticed that you are much more irritable and annoyed at things and people than before. You can hardly concentrate on your work or simple things such as reading a book or watching TV. Different from before, you need a lot of time for everything you do and you can hardly manage your normal workload. You do not feel like doing anything anymore, nothing is of interest to you. Instead, you mull over the future the whole time, and don't know what will be next. You have the feeling that you are no good and that you do everything wrong. In the past two weeks, you have thus been feeling nervous and on edge, and also, sad and depressed, without having any particular reason for feeling this way. Now try to imagine that your primary care provider tells you there is nothing physically wrong with you and all your blood tests are OK. He or she thinks that it is possible you might be suffering from anxiety and depression and suggests that you should seek treatment for the problems you have been experiencing from a psychiatrist, psychologist, psychotherapist or other mental health professional at a military/civilian mental health clinic.

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Annex D Semi-structured interview used in the study

Please imagine that you went to your primary care physician at your local Canadian Armed Forces (CAF) Medical Clinic or at a civilian primary care clinic because you have problems handling your everyday life. For a few weeks you have been feeling weak and without energy. During the day, you feel muscle aches, tension, and soreness in your body. Although you feel tired all day, you cannot sleep well, you constantly wake up in the middle of the night, and then cannot fall asleep again. You feel tense and nervous and are constantly on edge. You have also noticed that you are much more irritable and annoyed at things and people than before. You can hardly concentrate on your work or simple things such as reading a book or watching TV. Different from before, you need a lot of time for everything you do and you can hardly manage your normal workload. You do not feel like doing anything anymore, nothing is of interest to you. Instead, you mull over the future the whole time, and don't know what will be next. You have the feeling that you are no good and that you do everything wrong. In the past two weeks, you have thus been feeling nervous and on edge, and also, sad and depressed, without having any particular reason for feeling this way. Now try to imagine that your primary care provider tells you there is nothing physically wrong with you and all your blood tests are OK. He or she thinks that it is possible you might be suffering from anxiety and depression and suggests that you should seek treatment for the problems you have been experiencing from a psychiatrist, psychologist, psychotherapist or other mental health professional at a military/civilian mental health clinic.

1. Would you agree with the diagnosis or label (i.e., anxiety and depression) that your primary care physician gave you? Or would you use a different label or name for the symptoms in this situation?

2. Would you think the symptoms described constitute a condition that is something that will go away after a couple of days, such as a cold; will come and go, such as an allergy; or you will have forever, such as diabetes?

3. What do you think might be the consequences or the impact of such symptoms on your life?

4. What do you think might be the causes of these symptoms?

5. What do you think you could do to deal with these symptoms?

6. What do you believe are the advantages/disadvantages of seeing a mental health professional for treatment of problems such as anxiety and depression?

7. Are there individuals or groups who would approve/disapprove of your seeing a mental health professional for treatment of problems such as anxiety and depression?

8. What factors or circumstances would enable you/make it difficult for you to see a mental health professional for treatment of problems such as anxiety and depression?

9. When you think about what it means to be a member of the Canadian Forces, and the values that define a CF member, how does the idea of seeing a mental health professional for treatment of problems such as anxiety and depression align with that picture?

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Annex E Unique social sources identified in the study

1. Family
    a. Parents
    b. Siblings
    c. Spouse
    d. Nonspecific
2. CAF
    a. Immediate Supervisors
    b. Peers
    c. Chaplain
    d. Nonspecific/Organization
3. Friends (non-specific; N.B. All references that referred to friends within the CAF are classified under Node 2.a)
    a. Close Friends
    b. Distant Friends
    c. Nonspecific
4. Religious Community
5. Employer (non-specific)
6. General Public
7. Support Groups

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List of symbols/abbreviations/acronyms/initialisms

BMOQ	Basic Military Officer Qualification
BMQ	Basic Military Qualification
CAF	Canadian Armed Forces
CFLRS	Canadian Forces Leadership and Recruit School
CFMHS	Canadian Forces Mental Health Survey
DRDC	Defence Research and Development Canada
MHT	Mental Health Treatment
NCM	Non-Commissioned Members
R2MR	Road to Mental Readiness
SRM	Self-Regulatory Model
TPB	Theory of Planned Behaviour
U.S.	United States

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Background: Accumulating research suggests that military members, including Canadian Armed Forces (CAF) personnel, may be at an increased risk of suffering from mental health problems. Military organizations have devoted significant efforts to increase mental health literacy and to ensure military members access appropriate mental health services in a timely manner. However, mental health service use is still underutilized by military members in need of mental health treatment. Research points to the important role social factors (e.g., perceived influence of others, i.e., social norms) may exert on mental health treatment (MHT)-seeking, and suggests both perceptions of what others would do (i.e., descriptive norms) and perceptions of what others expect one to do (i.e., injunctive norms) may be important. Perceptions of social approval/disapproval for mental health treatment-seeking (i.e., injunctive norms) may be especially complex in the military setting. Military members may perceive different levels of approval/disapproval from military peers, immediate supervisors, and military leadership. They may hear conflicting messages regarding treatment seeking from the CAF as an organization and the (civilian) society at large. Injunctive norms may evolve over time as military members spend more time in the military versus the civilian setting.

Objectives: To examine injunctive norms regarding mental health treatment seeking at the beginning of the military career.

Design: Eighty-four CAF recruits enrolled in Basic Military Qualification and Basic Military Officer Qualification were interviewed at the Canadian Forces Leadership and Recruit School in Saint-Jean-sur-Richelieu, Quebec. Participants were presented with a short vignette describing a hypothetical situation where an individual contacts their primary care physician for symptoms consistent with depression and anxiety; participants were asked to assume the perspective of the character in the vignette. Following, participants' beliefs and attitudes towards mental health and MHT-seeking were explored via a semi-structured interview. Transcribed interview responses from 69 participants underwent an in-depth, comprehensive content analysis intended to capture injunctive norms for MHT-seeking.

Results: On average, recruits mentioned significantly more social sources who would approve of seeking MHT in comparison to those who would disapprove it. Most common sources of perceived approval for MHT-seeking were family (particularly spouses and parents), friends (particularly close friends), and the CAF. Other less common but predominantly approving sources included members of religious communities (e.g., chaplains) and support groups. Most common sources of perceived disapproval for MHT-seeking were the general public, the CAF, employers/coworkers, and family members (particularly parents and siblings). Overall, family and friends were found to be more supportive than unsupportive. The general public and employers/coworkers were perceived to be largely unsupportive of MHT-seeking. Critically, the CAF was mentioned as a source of approval and disapproval for MHT-seeking in approximately equal proportions.

Contexte : De plus en plus de recherches donnent à penser que les militaires, y compris le personnel des Forces armées canadiennes (FAC), sont davantage susceptibles de souffrir de problèmes de santé mentale. Les organisations militaires ont consacré des efforts considérables

afin d’accroître les connaissances en matière de santé mentale et d’assurer aux militaires un accès adéquat à des services de santé mentale en temps voulu. Malgré tout, les militaires qui nécessitent des soins de santé mentale ont peu recours à ces services. Les recherches en cours mettent en évidence le rôle important que peuvent jouer certains facteurs sociaux (tels que l’influence perçue des autres, c.-à-d. les normes sociales) dans la demande de soins de santé mentale et laissent supposer que la perception de ce que les autres feraient (c.-à-d. les normes descriptives) et de ce à quoi ils s’attendent que l’on fasse (c.-à-d. les normes subjectives) pourraient toutes deux avoir de l’importance. La perception de l’approbation ou de la désapprobation sociale à l’égard du recours aux soins de santé mentale (soit les normes subjectives) peut s’avérer particulièrement complexe dans un environnement militaire. Les militaires peuvent percevoir différents degrés d’approbation ou de désapprobation chez leurs pairs, leurs supérieurs immédiats et les chefs militaires. Ils peuvent aussi recevoir des messages contradictoires des FAC en tant qu’organisation et de la société (civile) en général concernant le recours aux soins de santé mentale. Les normes subjectives peuvent évoluer au fil du temps, puisque les militaires passent davantage de temps dans un environnement militaire que dans la société civile.

Objectifs : Examiner les normes subjectives relatives au recours aux soins de santé mentale en début de carrière militaire.

Conception : Quatre-vingt-quatre recrues des FAC inscrites à la qualification militaire de base et à la qualification militaire de base des officiers ont été interrogées à l’École de leadership et de recrues des Forces canadiennes de Saint-Jean-sur-Richelieu, au Québec. On a présenté aux participants une brève capsule décrivant une situation hypothétique dans laquelle une personne consulte son médecin de premier recours pour des symptômes associés à la dépression et l’anxiété, puis on leur a demandé de se mettre dans la peau de cette personne. Les participants ont ensuite fait part de leurs croyances et de leur attitude à l’égard de la santé mentale et du recours à des soins dans le cadre d’une entrevue semi-dirigée. Les réponses de 69 participants interrogés ont été retranscrites et ont fait l’objet d’une analyse de contenu exhaustive et approfondie dans le but d’établir les normes subjectives relatives au recours aux soins de santé mentale.

Résultats : Les recrues ont mentionné en moyenne, et de manière significative, plus de sources sociales qui approuveraient le recours aux soins de santé mentale que de sources qui le désapprouveraient. La famille (particulièrement le conjoint/la conjointe et les parents), les amis (surtout les amis proches) et les FAC sont généralement perçus comme des sources qui approuvent le recours aux soins de santé mentale. Les membres d’une communauté religieuse (p. ex. un aumônier) et les groupes de soutien sont des sources qui font un peu moins l’unanimité, mais qui sont tout de même perçues comme étant généralement favorables. Le grand public, les FAC, les employeurs, les collègues de travail et les membres de la famille (surtout les parents et les frères et sœurs) constituaient les sources les plus communément considérées comme défavorables au recours aux soins de santé mentale. Globalement, la famille et les amis étaient plutôt perçus comme étant d’un grand soutien. Le grand public, les employeurs et les collègues étaient perçus comme étant en grande partie défavorables au recours aux soins de santé mentale. Fait important, les participants ont mentionné dans des proportions presque égales les FAC comme étant une source favorable et défavorable au recours aux soins de santé mentale.

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mental health; treatment-seeking; injunctive norms; normative beliefs; recruits; social sources