

# MENTAL HEALTH IN THE MILITARY CONTEXT: EMOTIONAL STATES AND HELP-SEEKING BEHAVIOURS DURING CONSCRIPTION

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## Abstract

*Introduction:* Mental health problems and help-seeking behaviours for them in the military context has become an important topic of research. Most of the current studies address the topic among service members and mission veterans. These studies indicate that the fear of being stigmatized is a considerable obstacle towards seeking help. There is, however, something of a knowledge gap concerning mental health among conscripts. Traditionally, the military ethos has promoted self-reliance, duty, as well as other masculine qualities. These qualities are instilled in conscripts during their time in the service. A strict adherence to the military ethos and these masculine values can, however, hinder help-seeking behaviours among recruits.

*Purpose:* To explore changes in the mental wellbeing of conscripts and their attitudes towards help-seeking during the conscription period by analysing their emotional states and tracking their interactions with support services.

*Method:* In order to research changes in the mental wellbeing of conscripts during their conscription service, an emotional state questionnaire (EST-Q2) was administered three times over the course of the service period. The questionnaire was part of a more complex survey. In order to evaluate how well the conscripts were able to adapt to the service and cope with stressors, the results, in relation to the symptoms of depression, anxiety and other problems, were analysed. Help-seeking behaviours among conscripts finishing their service were also analysed in order to provide more information about the use of mental health support services.

*Results:* The prevalence of symptoms related to depression and anxiety increased during the course of conscription, whereas the problems related to social phobias, mental exhaustion and sleep disturbances somewhat decreased. According to the results, approximately half of the conscripts present during the 3<sup>rd</sup> phase of the survey did not have any contact with any of the designated support services (a psychologist, social worker, or chaplain).<sup>1</sup>

**Keywords:** *mental health, conscript service, help-seeking, stigma*

**Võtmesõnad:** *vaimne tervis, ajateenistus, abi otsimine, stigma*

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## 1. Mental health in military

The military culture can be characterised by its combat oriented, self-reliant masculine-warrior ethos<sup>2</sup>. In the context of health behaviours, internalizing the ideological position that men should be tough, competitive and emotionally inexpressive can have detrimental effects on a man's physical and mental health<sup>3</sup>. Addis and Mahalik concluded that help-seeking behaviours are often dependent on the degree to which an individual adheres to these particular masculine gender-role norms that are often incongruent with seeking professional help<sup>4</sup>. In their study, Acosta et al. pointed out that there is a greater stigma associated with men seeking help than there is with women seeking help. Assistance is often seen as a last resort, and men often feel that there is an expectation to be stoic, self-controlled and self-sufficient.<sup>5</sup>

Mental health problems among active duty military personnel and service members returning from deployment have gained significant research attention in recent years<sup>6, 7, 8</sup>. There are multiple studies highlighting the prevalence of post-traumatic stress disorder, major depression, substance abuse, sleep disturbances and suicide attempts among military servicemen and veterans<sup>9</sup>. At the same time, several studies have found that those military personnel suffering from psychiatric problems tend to underutilize the available

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<sup>2</sup> **Dunivin, K. O.** 1994. Military culture: Change and continuity. – *Armed Forces & Society*, Vol. 20, No. 4, p. 533.

<sup>3</sup> **Courtenay, W. H.** 2000. Constructions of Masculinity and Their Influence on Men's Well-Being – *Social Science & Medicine*, Vol. 50, No. 10, pp. 1385–1401.

<sup>4</sup> **Addis, M. E.; Mahalik, J. R.** 2003. Men, Masculinity, and the Contexts of Help Seeking – *American Psychologist*, Vol. 58, No.1, p. 8.

<sup>5</sup> **Acosta, J. D. et al.** 2014. Mental Health Stigma In The Military. – RAND National Defense Research Institute, p. 12. [**Acosta** 2014]

<sup>6</sup> **Hoge, C. W. et al.** 2002. Mental Disorders among US Military Personnel in the 1990s: Association with High Levels of Health Care Utilization and Early Military Attrition – *American Journal of Psychiatry*, Vol. 159, No. 9, pp. 1576–1583.

<sup>7</sup> **Zinzow, H. M. et al.** 2013. Barriers and Facilitators of Mental Health Treatment Seeking among Active-Duty Army Personnel – *Military Psychology*, Vol. 25, No. 5, pp. 514–535.

<sup>8</sup> **Sareen, J. et al.** 2007. Combat and Peacekeeping Operations in Relation to Prevalence of Mental Disorders and Perceived Need for Mental Health Care: Findings from a Large Representative Sample of Military Personnel. – *Archives of General Psychiatry*, Vol. 64., No. 7, pp. 843–852.

<sup>9</sup> **Hom, M. A. et al.** 2017. A Systematic Review of Help-Seeking and Mental Health Service Utilization among Military Service Members. – *Clinical Psychology Review*, Vol. 53, p. 60. [**Hom** 2017]

mental health services<sup>10</sup>. Mental health among conscripts is substantially less researched. Nevertheless the influence of the conscription service on the mental health of soldiers could be of the utmost importance at both the personal and national levels, especially for those countries that presently use, or have reinstated conscription. As national compulsory conscription introduces a wide spectrum of young men into the military environment, the culture, skills and values that are taught in that environment are instilled into a remarkably large proportion of the nation's population.

Hom *et al.* found that there is a stigma attached to mental health disorders and to seeking help in general that is particularly ingrained in the military culture<sup>11</sup>. Acosta *et al.* defined the mental health stigma as a dynamic process by which service members perceive or internalize a marked identity about themselves, or others around them, in terms of a mental health disorder. In the military context, a mental health stigma is defined as 1) The experiences of service members in response to military institutional factors leading to discriminatory treatment; 2) The attitudes, beliefs and behaviours of others towards the service members who exhibit symptoms of or have been diagnosed with mental health disorders, or who seek treatment.<sup>12</sup> A stigma can be unintentionally perpetuated through the warrior ethos, and the mindset of: "I don't need help. I can handle things myself. If I need help, I am weak." – as well as through military leaders and other aspects of the health care and military environment<sup>13</sup>. Pury *et al.* noted that the preference for self-management of mental health problems may be one manifestation of self-stigma, as service members may believe that by not being able to solve the problem on one's own, it is a sign of weakness and cowardice<sup>14</sup>. Vogt shows that these negative beliefs about mental health and treatment seeking are a key barrier towards military personnel and veterans seeking assistance for mental issues.<sup>15</sup>

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<sup>10</sup> *Ibid.*, p. 68.

<sup>11</sup> *Ibid.*, p. 62.

<sup>12</sup> Acosta 2014, p. 12.

<sup>13</sup> Gibbons, S. W. *et al.* 2014. Military Mental Health Stigma Challenges: Policy and Practice Considerations. – The Journal for Nurse Practitioners, Vol. 10, No. 6, p. 368.

<sup>14</sup> Pury, C. L. S. *et al.* 2014. Blended Courage: Moral and Psychological Courage Elements in Mental Health Treatment Seeking by Active Duty Military Personnel. – The Journal of Positive Psychology, Vol. 9, No. 1. pp. 30–41; Hom 2017, p. 63.

<sup>15</sup> Vogt, D. 2011. Mental Health-Related Beliefs as a Barrier to Service Use for Military Personnel and Veterans: A Review. – Psychiatric Services, Vol. 62, pp. 135–142.

Nash and colleagues have traced the historic origins of the military and veteran mental health stigma. World War I brought with it tremendous casualties, as well as the problem referred to as ‘shell shock’ or ‘*nervenshock*’. This condition became undeniably relevant and in 1916, a special “War Congress” was held in Munich, where the leading psychiatrists and neurologists of the day adopted the view that “persistent distress or functional impairment following exposure to a traumatic stressor could only occur in an individual with “hysteria”, a pre-existing personality weakness”. The particular choice of wording is undoubtedly, intentionally stigmatizing, especially when applied to male service members who understood it to be a term with feminine connotations. As a political consequence, the German government was relieved of its obligation to pay disability pensions to veterans suffering from combat stress. The French, British, and later, the Americans followed suit by adopting a similar doctrine and policy.<sup>16</sup>

Support from military leadership and peers may facilitate help-seeking among service members<sup>17</sup>. Britt *et al.* have shown that leadership can have a profound effect on whether a mental health problem either becomes a stigma with the consequent barriers, or receives adequate treatment. Leaders who employ negative behaviours (e.g. embarrassing unit members in front of others) may be more likely to create a work atmosphere that contributes to higher levels of stigma related to mental health care, whereas leaders who engage in more positive behaviours may be more likely to remove the practical impediments that prevent seeking care, and make accommodations for those who wish to seek treatment.<sup>18</sup> Research shows soldiers will suffer more from the effects of loneliness and combat stress if their officers are emotionally and instrumentally less supportive.<sup>19</sup>

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<sup>16</sup> **Nash, W. P.; Silva, C.; Litz, B.** 2009. The Historic Origins of Military and Veteran Mental Health Stigma and the Stress Injury Model as a Means to Reduce It. – *Psychiatric Annals*, Vol. 39, No. 8, pp. 789–794.

<sup>17</sup> **Hom** 2017, p. 65.

<sup>18</sup> **Britt, T. W.; Wright, K. M.; Moore, D. W.** 2012. Leadership as a Predictor of Stigma and Practical Barriers toward Receiving Mental Health Treatment: A Multilevel Approach. – *Psychological Services*, Vol. 9, No.1, pp. 26–37.

<sup>19</sup> **Solomon, Z.; Mikulincer, M.; Hobfoll, S. E.** 1986. Effects of social support and battle intensity on loneliness and breakdown during combat. – *Journal of personality and social psychology*, Vol. 51, No. 6, pp. 1269–1276.

## 2. Relevance in conscription

Conscription service is comparatively less common than voluntary military service, thus there is significantly less literature related to mental health problems and help-seeking behaviours among conscripts. Among the EU countries conscription is used by Austria, Denmark, Lithuania, Cyprus, Greece, Finland, Estonia<sup>20</sup> and – Sweden<sup>21</sup>. In the three former countries, service is either not mandatory, or can be regarded as strongly recommended, as recruits are mainly volunteers. In the latter five countries, conscription is mandatory.<sup>22, 23</sup> Sweden reintroduced conscription in 2018. The variance and temporal changes in the conscription practices among countries is often the upshot of a country's population and the perceived threat level. For smaller nations the number of voluntary recruits may often not be enough to meet the quota necessary to address national security concerns. Mental health problems can also have an impact on the number of recruits needed to address security concerns. Schei<sup>24</sup> found a high incidence rate (48%) of mental distress among Norwegian army conscripts. This was manifested in scores that surpassed the cut-off point of the screening questionnaire (GHQ<sup>25</sup>) that was used. He points out that psychological discontent can have a negative influence on a soldier's motivation to learn the intended skills and attitudes. A significant rate of mentally distressed conscripts during parts of the training can have a deleterious influence on an army's overall efficiency in critical situations. In the given sample, psychiatric diagnoses accounted for 56% of all of the medical dismissals during the service.

<sup>20</sup> **Bieri, M.** 2015. Military conscription in Europe: new relevance. – CSS Analysis in Security Policy, No. 180, p. 2.

<sup>21</sup> **Government Offices of Sweden.** 2017. Sweden reactivates conscription. – Government of Sweden. <<http://www.government.se/articles/2017/03/re-activation-of-enrolment-and-the-conscription>> (20.03.2018).

<sup>22</sup> **Schilde, K.** 2017. European Military Capabilities: Enablers and Constraints on EU Power? – JCMS: Journal of Common Market Studies, Vol. 55 (1), pp. 37–53.

<sup>23</sup> **European Organisation of Military Associations** 2017. Conscientious objection to military service – input for Office of the United Nations High Commissioner for Human Rights. <<http://www.ohchr.org/Documents/Issues/RuleOfLaw/ConscientiousObjection/EUROMIL.pdf>> (20.03.2018).

<sup>24</sup> **Schei, E.** 1994. A Strengthening Experience? Mental Distress during Military Service. – Social Psychiatry and Psychiatric Epidemiology, Vol. 29, No. 1, pp. 40–45. [Schei 1994]

<sup>25</sup> **Goldberg, D.; Williams, P.** 1998 [1988]. A user's guide to the General Health Questionnaire. Windsor: NFER-Nelson.

Social environment for conscripts is highly influenced by military leaders and the leadership style of a leader can have a strong influence on shaping the overall military experience for conscripts. Thus, attitudes amongst service members (towards mental illnesses and help-seeking) can indirectly shape the views and values of the conscripts. As Salo *et al.* have pointed out, the quality of leaders and training is critical in order to insulate the conscripts from stress and support them through their coping and adjustment period. Moreover, the main psychosocial functions of a leader who acts as a role model is to serve as an effective counsellor. Counselling can help provide the recruit with the means of facing adversity as a healthy and whole person. It can foster social and coping skills, as well as encourage problem recognition and solution finding. In this way leaders can make it possible for conscripts to direct their behaviours towards more constructive outcomes instead of finding negative ways to cope with problems.<sup>26</sup>

It must be noted that there are significant situational factors that differentiate the active duty military service from (peacetime) conscription. Conscripts do not take part in military combat, therefore, they are less susceptible to physical and mental trauma and the chance of suffering from PTSD is significantly reduced. The issues affecting active duty servicemen are therefore less relevant in the conscription service. Nevertheless, the start of service for a conscript can be compared to a dealing with a catastrophe, or a civilian disaster situation when all resources and skills are needed to deal with multiple situational stressors in a new environment<sup>27</sup>.

The main stressors of social experiences in conscription arise from the specific nature of the situation, such as isolation from family and friends, the constant presence of unknown people, and being under multiple demands of authority<sup>28</sup>. It is also often the first time a person has lived away from home<sup>29</sup>. For this reason the stress in the beginning might be even more relevant. Salo points out that in during the course of conscription, training, and the learning of new skills can help reduce anxiety and stress. This is because routine behaviour patterns require less attention, and produce less

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<sup>26</sup> Salo, M. 2008. Determinants of military adjustment and attrition during Finnish conscript service. – *Maanpuolustuskorkeakoulu*, p. 36.

<sup>27</sup> *Ibid.*, p. 23.

<sup>28</sup> *Ibid.*, p. 47.

<sup>29</sup> *Ibid.*, p. 28, 38.

of a cognitive load<sup>30</sup>. After basic skills and knowledge have been learned, military training may even support functional coping and help to ease the adjustment to the military service. Maladjustment problems can be reduced by telling the recruits exactly what is happening to them, when it will be happening, and why it will happen. Confusing information and an uncertain future can increase the recruits' state of anxiety.<sup>31</sup>

### 3. Conscription in the Estonian Defence Force

In Estonia, conscription is compulsory for all male citizens from ages 17 to 27, while women can enter service on a voluntary basis. Service lasts for eight or eleven months. A military rank is obtained upon completion. As all of the call-up selectees need to pass a medical examination, which may deem them unfit for service, drafted conscripts serve as a cross-section of young, physically and mentally healthy men.

In Estonia, the number of call-up selectees has steadily decreased since 2010, mainly due to diminishing birth rates. In 2016, the number of call-up selectees entering the service was 3272, along with 33 women joining voluntarily, bringing the total number of new conscripts to 3305. In general, after the medical examination, a relatively large group of men are exempted from conscription due to problems with physical or mental health. In 2016, 32% of call-up selectees were deemed fit for service, 44% were given temporary exemptions, and 24% were determined to be permanently unfit for service.<sup>32</sup> Based on data from the last 5 years, the main reasons for exemption have been relatively persistent, with diseases of the musculoskeletal system and connective tissue<sup>33</sup> (i.e. problems with joints or muscles) being the main diagnosis group. In 2016, psychiatric and behavioural disorders constituted 25% of temporary exemptions from the service and 42% of the permanent

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<sup>30</sup> **Orasanu, J. M.; Backer, P.** 1996. Stress and military performance. – Series in applied psychology. Stress and human performance. Ed. by Driskell, E.; Salas, E. Hillsdale, NJ, US: Lawrence Erlbaum Associates, Inc., p. 108, referenced through **Salo** 2008, p. 27.

<sup>31</sup> **Salo** 2008, p. 28.

<sup>32</sup> **Estonian Ministry of Defence** 2017. Report on the performance of the national defence obligation and the organisation of the service in the Defence Forces for 2016.

<sup>33</sup> Subgroup of diagnoses in accordance with ICD-10 (International Classification of Diseases) codes M00-M99.

exemptions.<sup>34</sup> Attrition has remained relatively stable in recent years. In 2016, the rate of attrition was 19.3% with the main causes for ending the service prematurely being medical. Attrition due to other reasons was insignificant.

## 4. Aims and methods

### 4.1. Study aims

This present study seeks to examine:

- I. Changes in the prevalence of the symptoms of mental distress during conscription;
- II. The ways in which the emotional state in the beginning of the conscription service is related to: a) Entering the service voluntarily, as opposed to being called up; b) Attrition from service;
- III. The rate of contact with medical and support services and the perceived helpfulness of different agents of support as seen by conscripts who are about to finish their service;
- IV. Help-seeking behaviours in conscripts reporting symptoms of mental distress.

### 4.2. Sample

Data from the 2016 Estonian Conscript Survey was analysed. The data was gathered at three different times during the conscription period, with the first phase taking place during the first month, the second phase occurring after basic training (at 4<sup>th</sup>–5<sup>th</sup> month) and the third 1–2 weeks before the end of service<sup>35</sup>. The cross-sectional sample sizes of the survey are the following: The 1<sup>st</sup> phase (N = 2677), the 2<sup>nd</sup> phase (N = 2084) and the 3<sup>rd</sup> phase (N = 1176). The longitudinal sample was comprised of conscripts who were present in all three of the survey phases (N = 750). General socio-demographic information for both samples is shown in Table 1. The longitudinal sample sizes for EST-Q2 subscales are given in Table 2. Data from female conscripts was excluded from the current analysis due to both the small sample size (1<sup>st</sup> wave:

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<sup>34</sup> Additional stable amount of exemptions from recruitment is amounted to legal reasons, e.g. criminal offences or reaching 28 years of age.

<sup>35</sup> As one group of conscripts was drafted in July and the other in October (with service lengths being respectively 11 and 8 months), the first and second phases of survey were conducted separately and the third jointly, as both groups finish their service together.

N = 24, 3<sup>rd</sup> wave: N = 8) and gender differences related to help-seeking. As there exists a gender gap in mental health service use<sup>36</sup>, special focus is placed on men's emotional states and help-seeking.

**Table 1.** Socio-demographic data from Estonian Conscript Survey 2016

		Cross-sectional sample		Longitudinal sample	
		N	%	N	%
Age group	17–19 years	694	26.2	244	32.8
	20–22 years	1632	61.5	432	58.1
	23–25 years	303	11.4	64	8.6
	26–28 years	24	0.9	4	0.5
Main language at home	Estonian	2214	83.8	612	82.8
	Russian	429	16.2	127	17.2
Highest level of education achieved	Basic education	437	16.5	110	14.8
	Vocational training with a basic education background	230	8.7	53	7.1
	General secondary education	1240	46.7	396	53.2
	Vocational secondary education	550	20.7	135	18.1
	Professional higher education	39	1.5	9	1.2
	Bachelors' degree	149	5.6	39	5.2
	Masters' degree or PhD	8	0.3	2	0.3
Joining conscription	Voluntary, on personal application	970	37.1	309	42.0
	On call-up notice	1643	62.9	426	58.0

<sup>36</sup> **Elise, P.; Verhaeghe, P.; Bracke, P.** 2015. The gender gap in mental health service use. – Social psychiatry and psychiatric epidemiology, Vol. 50, No. 7, pp. 1089–1095.

### 4.3. Measures

#### 4.3.1. EST-Q2

A self-reported emotional state questionnaire (EST-Q2<sup>37, 38</sup>) was administered at three points during the service as a part of a complex overall survey of the conscripts. The subscales of the EST-Q2 covered depression, anxiety, social phobia, panic disorder and agoraphobia, exhaustion and problems with sleep. Every subscale consisted of possible complaints (e.g. feeling sad; inability to relax; waking from sleep too early) to which respondents gave a prevalence value (*Never; Rarely; Sometimes; Often; All the time*). The number of items comprising each of the subscales, the corresponding minimum, and maximum scores and Cronbach's alpha values for reliability<sup>39</sup> are presented in Table 2. A higher score indicates a higher estimate of experienced distress.

**Table 2.** EST-Q2 subscale characteristics and responding longitudinal sample sizes

EST-Q2 subscale	N of items	Score min.	Score max.	Cronbach's $\alpha^a$	N <sup>b</sup>
Depression	8	0	32	0.885	663
Anxiety	6	0	24	0.843	669
Panic disorder and agoraphobia	5	0	20	0.761	680
Social phobia	4	0	16	0.909	681
Exhaustion	4	0	16	0.882	674
Problems with sleep	3	0	12	0.809	683

<sup>a</sup> Based on 1<sup>st</sup> wave of survey

<sup>b</sup> Longitudinal sample size

<sup>37</sup> **Aluoja, A. et al.** 1999. Development and psychometric properties of the Emotional State Questionnaire, a self-report questionnaire for depression and anxiety. – *Nordic Journal of Psychiatry*, Vol. 53, No. 6, pp. 443–449.

<sup>38</sup> **Ööpik, P. et al.** 2006. Screening for depression in primary care. – *Family practice*, Vol. 23, No. 6, pp. 693–698.

<sup>39</sup> Cronbach's alpha values for all three waves of survey were calculated, with  $\alpha$  values mostly rising through waves. The difference was most remarkable on the subscale of panic disorder and agoraphobia scale; with the 3<sup>rd</sup> wave Cronbach's  $\alpha = 0.913$ .

A score of over 11 on the EST-Q2 subscale depression can point to the presence of a mood disorder<sup>40</sup>. Nevertheless, the given scales are not used here as a clinical screening method, but are rather used to evaluate the emotional changes taking place during the length of service. The case prevalence of the depression score will be given to offer comparability with the general population, whereas changes in mean and individual scores are central to the analysis.

The threshold for meaningful change was defined using the Standard Error of Measurement (SEM) proposed by McHorney & Tarlow<sup>41</sup>, which has been determined to be one of the most promising distribution-based methods for evaluating individual changes in health-related quality of life measures<sup>42</sup>. The SEM is calculated using the reliability of the given measure and standard deviation as a baseline.

#### ***4.3.2. Contact with medical help and support services***

Conscripts present during the 3<sup>rd</sup> phase of the assessment were asked to evaluate aspects of their service that ranged from perceived helpfulness of the leaders to specific support services (psychologist, social worker, chaplain). Survey items regarding satisfaction with medical help and specific support services were used to create a series of binary variables that were used to determine the help-seeking rates among conscripts finishing their service.

#### ***4.3.3. Self-evaluated health status***

The self-evaluated health status was assessed in all three phases of the survey. This was done by answering the question “How do you evaluate your health in general?”. Answers were given on a 5-item scale (*Good; Quite Good; Average; Quite Bad; Bad*).

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<sup>40</sup> *Ibid.*, p. 2.

<sup>41</sup> **McHorney, C. A.; Tarlov, A. R.** 1995. Individual-patient monitoring in clinical practice: are available health status surveys adequate? – *Quality of Life Research*, Vol. 4, No. 4, pp. 293–307.

<sup>42</sup> **Wyrwich, K. W.; Wolinsky, F. D.** 2000. Identifying meaningful intra-individual change standards for health-related quality of life measures. – *Journal of evaluation in clinical practice*, Vol. 6, No.1, pp. 44–45.

### 4.4. Data analysis

Data was analysed using the IBM SPSS Statistics version 23 for descriptive statistics and reliability analysis. The general linear model repeated measures procedure was used to evaluate changes in the mean scores between survey waves and between-group one-way ANOVA analysis was used to evaluate differences in EST-Q2 mean scores.

## 5. Results

### 5.1. Changes in emotional states

In both the total and longitudinal samples, depression symptoms became more prevalent during the period of conscription, as is shown in Table 3. Pairwise comparisons using the general linear model repeated measures procedure show the mean difference to be statistically significant when comparing the 1<sup>st</sup> phase scores to the 2<sup>nd</sup> and 3<sup>rd</sup> phase scores ( $p = .001$ ). The difference between the two latter phases is less distinct.

**Table 3. Case prevalence rates and changes in mean scores in EST-Q2 subscale depression**

Wave of survey; point during conscription	Cross-sectional sample		Longitudinal sample	
	%, Case prevalence <sup>a</sup>	Score mean <sup>b</sup>	%, Case prevalence <sup>a</sup>	Score mean <sup>b</sup>
1 <sup>st</sup> wave; first month	34.6 (N=2583)	9.43 (SD=6.82)	32.7 (N=663)	8.89 (SD=6.35)
2 <sup>nd</sup> wave; month 4 or 5	39.0 (N=1824)	10.27 (SD=7.10)	36.0 (N=663)	9.72 (SD=6.97)
3 <sup>rd</sup> wave, 1–2 weeks before end of service	36.1 (N=825)	9.81 (SD=6.87)	37.3 (N=663)	9.80 (SD=6.67)

<sup>a</sup> Case prevalence of depression refers to a subscale score >11, pointing to significant distress.

<sup>b</sup> Subscale minimum value: 0, maximum value: 32.

The main trends in the mean scores by subscales are shown in Table 4. The statistical significance of changes in the mean scores between the survey phases was determined by using the general linear model repeated measures procedure. The relevance of symptoms related to anxiety and the inability to relax showed a slight, although statistically insignificant increase. The prevalence of problems related to panic disorder and agoraphobia rose during

the service. The subscale scores related to social phobia, fatigue, and problems with sleep showed a decline, meaning that the problems related to those aspects of mental health diminished among the conscripts who served the full length of their service.

**Table 4.** Trends in mean scores in EST-Q2 subscales among longitudinal sample

EST-Q2 Subscale and trend	Mean scores by survey waves	Sig. <sup>a</sup> of changes by waves		
		I → II	II → III	I → III
Anxiety: ↑	I. 7.46 (SD= 4.98) II. 7.79 (SD= 5.58) III. 7.90 (SD= 5.62)	.242	1.000	.118
Panic disorder and agoraphobia: ↑	I. 1.14 (SD= 2.08) II. 1.45 (SD= 2.95) III. 1.65 (SD= 5.62)	.018	.391	.000
Social phobia: ↓	I. 3.44 (SD= 3.69) II. 2.91 (SD= 3.57) III. 2.77 (SD= 3.62)	.000	1.000	.000
Exhaustion: ↓	I. 7.00 (SD= 4.58) II. 7.01 (SD= 4.17) III. 6.54 (SD= 4.68)	1.000	.023	.015
Problems with sleep: ↓	I. 4.95 (SD= 3.48) II. 4.80 (SD= 3.68) III. 4.32 (SD= 3.59)	.690	.002	.000

<sup>a</sup> Adjustment for multiple comparisons: Bonferroni

Comparing the scores on the individual level throughout the survey phases shows the overall stability of mental states during conscription. This can be seen in Table 5. To evaluate the changes, the differences between the subject's scores from the three survey phases were calculated pairwise, with negative scores reflecting an increased incidence (and thus, prevalence of symptoms) over time. Stability in scores between measurements is here defined as a change in the score that is less than 1 SEM for the given subscale. That allows us to take into consideration the variability of score ranges due to the subscales being comprised of different numbers of items. It also allows for the evaluation of meaningful changes at the individual level.

**Table 5.** Score stability in EST-Q2 subscale scores between survey waves among longitudinal sample

Subscale	Score increased <sup>a</sup> , %			Remained same, %			Score decreased <sup>a</sup> , %		
	1 <sup>st</sup> vs 2 <sup>nd</sup>	2 <sup>nd</sup> vs 3 <sup>rd</sup>	1 <sup>st</sup> vs 3 <sup>rd</sup>	1 <sup>st</sup> vs 2 <sup>nd</sup>	2 <sup>nd</sup> vs 3 <sup>rd</sup>	1 <sup>st</sup> vs 3 <sup>rd</sup>	1 <sup>st</sup> vs 2 <sup>nd</sup>	2 <sup>nd</sup> vs 3 <sup>rd</sup>	1 <sup>st</sup> vs 3 <sup>rd</sup>
Depression	34.5	30.7	38.8	41.2	38.8	34.1	24.3	30.5	27.1
Anxiety	25.6	28.6	33.8	44.8	43.9	38.1	29.6	27.5	28.1
Panic disorder & agoraphobia	15.4	15.2	17.9	72.5	70.6	68.3	12.1	14.2	13.8
Social phobia	17.5	19.1	17.8	52.7	57.1	49.5	29.8	23.8	32.7
Exhaustion	24.7	20.9	23.0	51.0	52.2	46.4	24.3	26.9	30.6
Problems with sleep	19.4	17.8	19.0	58.2	57.0	52.1	22.4	25.2	28.9

<sup>a</sup> Threshold for meaningful change: an increase or decrease in scores that is bigger than 1 SEM, calculated using the comparison baseline in each subscale.

The subscale of depression showed the highest rate among conscripts whose scores increased throughout the service. Thus, 38.8% of conscripts in the longitudinal sample reported more symptoms of depression in the 3<sup>rd</sup> phase of the survey than were reported in the 1<sup>st</sup>. Whilst the majority of the conscripts' scores remained stable, it is interesting to note that 27.1% of conscripts experienced a decrease of symptoms related to depression throughout the service, with changes being more prominent in the latter part of it.

Stability was most apparent in relation to panic disorder and agoraphobia, as 68.3% of conscripts' scores remained stable from the 1<sup>st</sup> phase of the survey to the last.

The subscale with the biggest rate of conscripts showing decreasing scores was social phobia, as 32.7% of conscripts in the longitudinal sample reported fewer symptoms at the end of the service than they had reported at the beginning.

### 5.2. The link between emotional states in the beginning of service and attrition

The mean scores for the EST-Q2 subscales of depression and anxiety show the average score as being higher among those who left the service prematurely, as compared to the conscripts who served the full length of the service.

One-way, between-groups ANOVA analysis confirmed that the differences in the 1<sup>st</sup> phase depression subscale scores were significant ( $F(1, 2583) = 75.74, p < .001$ ), and showed that the conscripts who left the service prematurely reported more depressive symptoms during the first months ( $M = 12.09, SD = 7.69$ ) as compared to the conscripts who served the full length of service ( $M = 8.94, SD = 6.53$ ). The difference in 1<sup>st</sup> phase anxiety scores was also significant ( $F(1, 2598) = 47.76, p < .001$ ), showing that the group of conscripts who were lost due to attrition reported more anxiety ( $M = 9.46, SD = 5.50$ ) already during the first months, when compared to those who served the full-term ( $M = 7.54, SD = 5.01$ ).

### 5.3. Emotional states' connection with mode of entry to service

The score means for conscripts entering the service voluntarily were lower than for those who were called up to conscript service. One-way between-groups ANOVA analysis was conducted to compare the effect on voluntary application to reported mental distress in the first phase of the survey. The difference in depression subscale scores was significant ( $F(1, 2549) = 34.44; p < .001$ ), showing that the conscripts who applied voluntarily reported fewer symptoms related to depression ( $M = 8.40, SD = 6.47$ ) as compared to the conscripts who had been called up for the service ( $M = 10.03, SD = 6.95$ ). The difference in anxiety subscale scores was significant ( $F(1, 2566) = 42.58, p < .001$ ) with the voluntary conscripts reporting less anxious symptoms ( $M = 6.98, SD = 5.25$ ) than the conscripts who were called up for service ( $M = 8.35, SD = 4.97$ ).

### 5.4. Seeking help

To assess the proportion of conscripts possibly needing or seeking help, we looked at their overall self-evaluated health status together with the EST-Q2 subscale results regarding depression, as is shown in Table 6. Among the conscripts who perceived their health status to be bad or quite bad, 69.6% had a score showing that they suffered from significant mental distress. Among the conscripts who rated their health status to be good, or quite good, 77.6% of the conscripts' reported low depression scores. Among the group of conscripts with a low depression score, 67.4% rated their health status as good, or quite good.

**Table 6.** Self-evaluated general health status by depression subscale scores in 1<sup>st</sup> wave cross-sectional sample

			EST-Q2 Depression Score		Total
			Low <sup>a</sup>	High <sup>a</sup>	
Self-evaluated health status	Good or Quite good	Count	1136	327	1463
		% within group	77.6%	22.4%	100.0%
	Average	Count	493	438	931
		% within group	53.0%	47.0%	100.0%
	Quite bad or Bad	Count	56	128	184
		% within group	30.4%	69.6%	100.0%
Total		Count	1685	893	2578
		% within group	65.4%	34.6%	100.0%

<sup>a</sup>Subscale score of depression >11 designated as high; score ≤11 as low.

Altogether, half of the men (51.0%) who were present during the 3<sup>rd</sup> phase of the assessments reported that they had not had any contact with the specific support services, i.e. they had not met with a psychologist, a social worker or a chaplain during their time in the service. Among the conscripts scoring over the case prevalence threshold for depression in the 1<sup>st</sup> phase of the survey, 45.9% had no contact with any of the specific support services during their conscription period. Interestingly, while over half of conscripts had not been in contact with either of the three specific support services, 39.3% had had contact with all three, as can be seen in Table 7.

According to 3<sup>rd</sup> phase of the survey results, 58.4% of the cross-sectional sample of respondents (N = 802) had not been in contact with a chaplain during their conscription service, while 55.6% reported that they had not been in contact with a psychologist. 53.9% reported themselves as having no contact with a social worker. Rates of no contact for the longitudinal sample (N = 679) were respectively 57.1% with a chaplain and 54.9% with a psychologist, with the rates of contact with a social worker proving to be the same in both samples. On the other hand, only 7.9% of conscripts present in 3<sup>rd</sup> phase of survey reported themselves as having not been in contact with medical help during their service, as shown in Table 7. The respective rate for the longitudinal group was 8.7%.

**Table 7.** Rate of contact with medical help and specific support services according to EST-Q2 depression subscale score among 3<sup>rd</sup> wave cross-sectional sample.

			EST-Q2 Depression score; 1 <sup>st</sup> wave		Total
			Low <sup>a</sup>	High <sup>a</sup>	
Medical help	Contact	Count	485	234	719
		% within group	92.2%	91.8%	92.1%
	No contact	Count	41	21	62
		% within group	7.8%	8.2%	7.9%
Specific support services (psychologist; social worker; chaplain)	Contact with all three	Count	205	102	307
		% within group	39.0%	40.0%	39.3%
	Contact with two	Count	14	14	28
		% within group	2.7%	5.5%	3.6%
	Contact with one	Count	26	22	48
		% within group	4.9%	8.6%	6.1%
	No contact	Count	281	117	398
		% within group	53.4%	45.9%	51.0%
Total		Count	526	255	781

<sup>a</sup> EST-Q2 Depression subscale score >11 designated as high; score ≤11 as low.

As can be seen in Table 8, conscripts perceived the platoon commanders and platoon sergeants to be most supportive agents when needing to resolve problems related to their time in the service, as well as personal problems. Nearly one third of the conscripts regarded the commanders and sergeants to be always, or nearly always helpful. When compared with the military leaders, the three specific support services were perceived as being the least relevant for help-seeking. While less than 8% (N = 744) of the respondents perceived the specific support services (social worker, psychologist, chaplain) as being always, or nearly always helpful, it is important to note that majority of the conscripts did not, in fact, have contact any with them at all.

**Table 8.** Agents of support as perceived by conscripts in 3<sup>rd</sup> wave of survey, cross-sectional sample

Agent of support seen helpful	Always or nearly always (%)	Never (%) <sup>a</sup>
Platoon commander (Rühmaülem)	33.1	21.6
Platoon sergeant (Rühmavanem)	31.1	21.7
Squad commander (Jaoülem)	29.4	29.3
Company CPO (Chief Petty Officer) (Kompanii veebel)	18.6	44.8
Company commander (Kompanii ülem)	18.0	45.4
Spokesperson for conscripts (Ajateenijate esindusmees)	14.6	50.7
Unit commander (Väeosa ülem)	9.8	66.0
Social worker (Sotsiaaltöötaja)	6.9	79.0
Psychologist (Psühholoog)	6.6	79.3
Chaplain (Kaplan)	6.9	80.9

<sup>a</sup>The option "Never" could be chosen regardless of whether or not the respondent had contact with the given agent of support during their service period.

To further examine the perceived helpfulness of special support services among conscripts, Table 8a provides participants' rates that differentiated by their reported contact with the given support service. Conscripts that reported contact with the given services rated them to be helpful more often than conscripts who had not been in contact with the service.

**Table 8a.** Perceived helpfulness of special support services in the 3<sup>rd</sup> phase cross-sectional sample.

<i>Perceived helpfulness in solving problems</i>							
<i>Agent of support</i>	Contact with service		Always or nearly always	Mostly	Occasionally	Never	Total
<i>Social worker</i>	Yes	Count	47	43	41	217	348
		% among conscripts with contact	13.5%	12.4%	11.8%	62.4%	100.0%
	No	Count	6	11	13	390	420
		% among conscripts without contact	1.4%	2.6%	3.1%	92.9%	100.0%
	Total		53	54	54	607	768
			6.9%	7.0%	7.0%	79.0%	100.0%
<i>Psychologist</i>	Yes	Count	43	45	46	202	336
		% among conscripts with contact	12.8%	13.4%	13.7%	60.1%	100.0%
	No	Count	8	8	9	407	432
		% among conscripts without contact	1.9%	1.9%	2.1%	94.2%	100.0%
	Total		51	53	55	609	768
			6.6%	6.9%	7.2%	79.3%	100.0%
<i>Chaplain</i>	Yes	Count	44	40	32	199	315
		% among conscripts with contact	14.0%	12.7%	10.2%	63.2%	100.0%
	No	Count	9	12	10	422	453
		% among conscripts without contact	2.0%	2.6%	2.2%	93.2%	100.0%
	Total		53	52	42	621	768
			6.9%	6.8%	5.5%	80.9%	100.0%

## 6. Discussion

Mental health concerns related to depression increased throughout the conscription among the longitudinal sample, with the case prevalence rising from 32.7% among the 1<sup>st</sup> phase respondents to 37.3% among the 3<sup>rd</sup> phase respondents. This result indicates a significant decrease in the mental well-being of conscripts during the length of service. It also illustrates the exceptional stress experienced during the conscription service, as the prevalence of depression among men in the civilian population in Estonia is estimated to be about 4–6.7%<sup>43,44</sup>. The current data also showed an increase in reported anxiety during conscription, which may be related to the conscripts experiencing problems with adjustment.

Health concerns related to panic disorder and to agoraphobia had a low prevalence, although analysis of the conscript's data in the longitudinal group showed that there was an increase of distress in each of the successive phases of the survey. What is more, nearly a fifth of the conscripts experienced an increase in symptoms related to those problems throughout their time in the service.

The results regarding conscript's feelings of social phobia, problems with sleep and fatigue actually showed a decrease during their time in the conscription service. It may be plausible to attribute these improvements in mental wellbeing to the benefits of military discipline. The continuous routine of addressing superiors, commanding peers and subordinates, and giving situation reports can help familiarize the conscripts, and eventually desensitize them to situations that provoke social anxiety and phobia. The improvement in reported sleep quality could be also be due to the adherence to a strict and physically taxing routine – if the rare opportunity for rest arises, then conscripts fall asleep more easily. Better quality sleep can also help to diminish fatigue. Improvement in these subscales can indicate an adjustment period within the service. It is also important to note that at the beginning of the conscript service, the period of basic training can be more unpredictable, as conscripts are often subject to irregular alarms and drills.

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<sup>43</sup> Kleinberg, A.; Aluoja, A.; Vasar, V. 2010. Point prevalence of major depression in Estonia. Results from the 2006 Estonian Health Survey. – *European Psychiatry*, Vol. 25, No. 8, pp. 485–490.

<sup>44</sup> Aluoja, Anu *et al.* 2004. Symptoms of depression in the Estonian population: prevalence, sociodemographic correlates and social adjustment. – *Journal of affective disorders*, Vol. 78, No. 1, pp. 27–35.

Interestingly, the conscripts who joined the service voluntarily reported fewer symptoms of anxiety and depression as compared to those who entered service after receiving their call-up notice. A possible explanation for this may be due to the perceived control over the situation. A voluntary application provides an opportunity for choosing the time for completing the service, whereas being called up means entering the service on the terms determined by the Defence Resources Agency. Additional promotion for the option of joining the service on one's own application could be beneficial for both parties.

Conscripts who left the service prematurely due to attrition reported more emotional distress already in the beginning of service. They showed more symptoms of depression and anxiety than did their peers, who succeeded in completing their service. Thus, the monitoring of the emotional state of conscripts may provide opportunities for early intervention and referral to the specific support services. Currently, help-seeking from specific support services (psychologist, social worker, chaplain) was relatively scarce, especially in comparison to seeking medical help. 45.9% of conscripts who reported significant distress during the 1<sup>st</sup> phase of the survey did not seek help from a psychologist, a social worker, or a chaplain during their time in the conscription service. As medical support was utilized by nearly all conscripts in the longitudinal sample, it may be beneficial to include routine evaluations of the conscripts' mental health with the medical consultations. Early referral to a specific support service may possibly decrease attrition resulting from mental health problems.

If the stigma related to mental illnesses in the military context is a multifaceted phenomenon, then the attitudes towards psychiatric problems in the mandatory conscription service are even more complex. According to Schei<sup>45</sup>, a psychiatric diagnosis has long been a well-known way to obtain a premature discharge in most military systems, which may explain some of the high prevalence of psychiatric diagnoses among conscripts. Thus, conscripts who seek counsel from a psychologist can sometimes be viewed as a 'simulant' who is seeking "an easy way out". This may decrease the chance of seeking help when mental health support is actually needed. Self-stigma can occur when soldiers with mental health issues convince themselves that they are weak and just want to quit the service. Conscripts might also refrain from seeking help if they plan to apply for a gun permit, as a diagnosis of

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<sup>45</sup> Schei 1994, p. 44.

most mental and behavioural disorders excludes them from obtaining one<sup>46</sup>. Moreover, an institutional stigma might prevent conscripts from seeking help from specific support services. Self-stigma may be a factor in preventing conscripts from reaching out for help, due to the unavoidable disclosure to one's superiors.

Mental health problems are correlated with stigma and with suicide<sup>47</sup>, thus not seeking specific help for mental health problems can have severe consequences. Laukkala *et al.* points out that suicide was one of the leading causes of death among Finnish conscripts during the years 1991–2007, with most of the suicide victims contacting the healthcare services shortly before their suicide due to somatic symptoms, but without expressing suicidal thoughts. A vast majority of the conscripts who committed suicide did not have any recognizable health-related limitations at the beginning of their time in the service.<sup>48</sup> Suicide among Estonian conscripts has steadily declined after 1995, with two cases having taken place over the last decade<sup>49</sup>. Nevertheless, it is important to pay attention to suicide prevention, as the military environment can exacerbate mental health issues due to the presence of multiple stressors, together with access to firearms and the military ethos of self-sufficiency possibly discouraging help-seeking.

There are some likely benefits to raising service members' awareness of mental health problems, as well as making leaders more conscious of mental health problems and encouraging service members to seek help from support services. Platoon commanders, platoon sergeants and squad commanders are seen as the biggest agents of support, and therefore may be able to spot problems early on, and even possibly influence conscripts' attitudes towards help-seeking. One kind of intervention could be the inclusion of psychoeducation

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<sup>46</sup> **Weapons Act**, 13.06.2001, § 36. – RT I 2001, 65, 377, entry into force 31.03.2002, latest redaction RT I, 09.03.2018, 9. <<https://www.riigiteataja.ee/akt/109032018009>> (27.03.2018) **The procedure for medical examinations of applicants for an acquisition permit or a weapons permit, the list of health disorders precluding the issue of a permit, and the requirements for the content and format of a medical certificate**, 21.06.2007, § 2. – RT I 2007, 42, 308, entry into force 01.07.2007, latest redaction RT I, 26.03.2015, 12. <<https://www.riigiteataja.ee/akt/126032015012>>.

<sup>47</sup> **Rüsch, N. et al.** 2014. Does the Stigma of Mental Illness Contribute to Suicidality? – The British Journal of Psychiatry, Vol. 205, No. 4, pp. 257–259.

<sup>48</sup> **Laukkala, T. et al.** 2014. Suicides among Military Conscripts between 1991–2007 in Finland – A Descriptive Replication Study. – Nordic Journal of Psychiatry, Vol. 68, No. 4, pp. 270–274.

<sup>49</sup> From personal correspondence with Andres Siplane, former chief of support centre at Estonian Defence Forces.

for all of the relevant groups (conscripts, service members) and an emphasis on the normativity of emotional distress in a high-stress environment, as well as the efficacy of therapy and early help. As the NATO survey shows, conscripts may be interested in additional resilience training to address stress and feelings of depression – even more so than service members<sup>50</sup>. It has also been found that conscripts who had been in contact with specific support services were more likely to see them as helpful in solving problems, in comparison to conscripts who had not had any personal contact with them. Thus, one way of encouraging help-seeking from specific support services may be to raise awareness of the function and the possibilities of such services in solving service-related and personal problems.

Hom *et al.* have devised an approach that emphasizes the efficacy of evidence based treatments for reducing distress and psychiatric symptoms, while increasing the service members' awareness of the types and severity of symptoms that warrant professional attention. Hom's approach also communicates that self-management often does not sufficiently address mental health problems<sup>51</sup>. Langston *et al.* pointed out the need for long-term anti-stigma programs that take the military culture into account, and that seek ways to reduce the organizational barriers. Organizational policies and programs that are aimed at providing soldiers with mental health support need to be acceptable to both mental health professionals, and more importantly, to those in positions of command.<sup>52</sup>

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In summary, the current analysis of the longitudinal sample of male conscripts showed a rise in the prevalence of symptoms related to depression, anxiety, panic disorder and agoraphobia in the high-stress environment of military conscription. The prevalence of symptoms related to social phobia, fatigue and problems with sleep lessened through the course of service in the given sample.

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<sup>50</sup> **Adler, A. B. et al.** 2013. NATO survey of mental health training in army recruits. – *Military Medicine*, Vol. 178, No.7, p. 765.

<sup>51</sup> **Hom** 2017, p. 63.

<sup>52</sup> **Langston, V.; Gould, M.; Greenberg, N.** 2007. Culture: What Is Its Effect on Stress in the Military? – *Military Medicine*, Vol. 172, No. 9, p. 934.

Conscripts who voluntarily joined the service reported fewer health concerns in relation to depression and anxiety than the conscripts who entered the service via a call-up notice did.

Symptoms of anxiety and depression were related to attrition – with the conscripts who were exempted prematurely reporting more distress already in the early stages of their service, compared to conscripts who had completed their service as planned.

About half of the conscripts in the 3<sup>rd</sup> phase of survey did not report any contact with the specific support services (psychologist, social worker, chaplain) throughout their time in the service. Help was rarely sought, even in the event of problems, as nearly half of the conscripts who had reported significant distress in the 1<sup>st</sup> phase of the survey did not seek assistance from any of the aforementioned services by the time the 3<sup>rd</sup> phase of the survey was administered. Medical help, on the other hand, was sought by a vast majority of conscripts in the longitudinal sample.

Results suggest that conscripts perceive specific support services to be less helpful than military leaders in solving service-related and personal problems. Taking into account the conscripts' contact with the given services, conscripts who had contacted the support services held more favourable views of them, in comparison to the conscripts who had no such contact.

## **7. Limitations and ideas for further research**

The lower levels of anxiety and depression reported in the 1<sup>st</sup> phase of the survey among conscripts who succeeded in completing their services, in contrast to those who left prematurely due to attrition, may be attributable to different causes. It may reflect the possibility that conscripts with better mental health have more endurance throughout service and are more likely to complete it. It may also point to the more determined conscripts reporting fewer mental health problems in the beginning of the service. Also, the longitudinal group's results may be more representative of conscripts who were more motivated to take part in the survey as opposed to their counterparts who were not present in all of the survey phases. In light of these results, the relation between motivation and mental health states warrants further research.

No data was available in regards to the help-seeking behaviours among conscripts who were exempted due to attrition; this is a limitation of the study, as well as an aspect that needs further research. It would be helpful (e.g. for evaluating and/or planning the support services' work) to compare

the help-seeking rates of conscripts who complete their service to the rate of help-seeking among conscripts who had problems severe enough to compel them to leave the service. It is possible that these individuals did actually seek help, but the support received was not enough to alleviate the problems. They also might not have perceived those specific support services as being helpful. The problem also could have been exacerbated by other barriers that discourage conscripts and military personnel from seeking help (e.g. institutional or self-stigma).

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