A PHENOMENOLOGICAL STUDY EXPLORING THE EXPERIENCES OF ACTIVE-DUTY

SERVICEMEMBERS SEEKING MENTAL HEALTH TREATMENT: HOW MENTAL

HEALTH STIGMA IN THE MILITARY CAN AFFECT HELP-SEEKING BEHAVIOR

by

Philip Clinton Allen

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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APPROVED BY:

Dr. Michael Howard, Ed.D., Committee Chair

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Abstract

The purpose of this phenomenological study was to examine the experiences of active-duty servicemembers regarding mental health stigma and help-seeking behavior. Due to the trauma of intense combat, military servicemembers experience mental health problems at an alarming rate, and despite increased awareness and access to mental health resources, they are still reluctant to seek treatment. This study explored the lived experiences of military servicemembers with an aim to address the following research question: "How do military service members experience overcoming mental health stigma and decide to seek treatment while still on active duty?" Thirteen participants from the United States Army, Air Force, Navy, and Marine Corps were administered interviews inquiring into their experiences with mental health via Zoom and phone. Themes emerged in two categories: "Stigma" and "Overcoming Stigma." The associations of common themes between the two categories that included 50% or more of the 13 participants are presented. The three strongest themes participants recounted as factors that led to deciding to seek mental health services were the realization that professional help is needed to address mental health concerns, personal growth in deciding to seek mental health services and trust in others. Because of the intrinsic motivational nature of these factors, the researcher concluded that overcoming stigma is unteachable. However, there are practical ways to reduce external stigma in the military, including educating military leaders, servicemembers, and family members about mental health and the need for treatment if warranted.

Keywords: stigma, barriers, mental health, military, leadership, service member

Copyright Page

Dedication

To my parents, Bob and Carol, I dedicate this dissertation to you. If not for your unwavering support and belief in me, I would not be where I am today. You have guided me from my very first step and continue to do so with encouraging words and a faith that I can accomplish any goal I set. Although I have made mistakes, you have never stopped loving me and have never stopped trusting that I will find my way. You have exemplified the love of God in everything you have done and have always kept me in your prayers. Whether it was during my time in the military, oversees in Korea and Iraq, or stateside working on my undergraduate, graduate, and now doctorate degree, you have been the rock I lean on in my difficult times. I look to the two of you as an example of the type of person I want to become. I hope I have made you proud and will continue to do so every day of my life. I love you, Mom and Dad.

To my pride and joy, my daughter, Eliana, I also dedicate this dissertation. You have brought me such joy since the day you were born. I am proud to be your father, and I hope I make you proud as well. I have come this far only because of your belief in me and because I want to be a shining example that it is never too late to chase your dreams and accomplish the goals you set. I will always believe in you and do whatever it takes to support you in your dreams. I could not be where I am without your love and encouragement. I love you, Eliana.

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List of Abbreviations

Animal assisted therapy (AAT)

Canadian armed forces (CAF)

Climate Support of Mental Health (CSMH)

Cognitive processing therapy (CPT)

Community-based outpatient clinic (CBOC)

Defender's edge (DEFED)

Department of Defense (DOD)

Department of Veterans Affairs (VA)

Ending Self-Stigma for PTSD (ESS-P)

Eye movement desensitization and reprocessing (EMDR)

Ganz Scale of Identification with Military Culture (GIMC)

Mental health condition (MHC)

Mental health services (MHS)

Military occupational specialty (MOS)

Operation Enduring Freedom (OEF)

Operation Iraqi Freedom (OIF)

Posttraumatic stress disorder (PTSD)

Prolonged exposure (PE)

Sexual violence (SV)

Unit Climate Support of Mental Health (CSMH)

United States (US)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

Overview

There is little consensus among researchers in mental health when discussing how stigma

affects help-seeking behavior (Fox et al., 2018). With the rise in cases of posttraumatic stress

disorder (PTSD) and other mental health disorders related to combat deployments (Bein et al.,

2019), it is essential to explore why military servicemembers seek mental health treatment at

such low rates. It is not for a lack of resources, as availability and effectiveness of mental health

treatment for the military and veterans has greatly improved in recent years (Adler et al., 2015;

Bolton et al., 2004; Ouimette et al., 2011; Rauch et al., 2009; Ready et al., 2008, as cited in Bein

et al., 2019). This access to care and subsequent unwillingness to seek treatment has led to

troubling statistics surrounding the effects of untreated mental health disorders among active-

duty military personnel and veterans.

As of 2019, there were roughly 3.5 million post-9/11 veterans. Whereas many veterans

succeed in reintegrating to civilian life, there are those who have difficulty because of a variety

of problems, often related to mental health. Of those post-9/11 veterans receiving care through

the Department of Veterans Affairs (VA), 57% have a provisional psychiatric diagnosis

(Aronson et al., 2020). If left untreated, post-combat deployment psychiatric issues can lead to

PTSD (20-22%), major depressive disorder (17-24%), and comorbid disorders, such as substance

use disorders (e.g., alcohol abuse 7-27%; Elbogen et al., 2013; Seal et al., 2009; Skidmore &

Roy, 2011, as cited in Bruce & Brown, 2016). Other issues, which are compounded by and often

result from a lack of mental health treatment, include aggressive behavior, risk-taking behavior,

sleep difficulties, somatic symptoms, pain symptoms, and functional impairment (Nassif et al.,

2019). As reported by the World Health Organization (WHO), younger servicemembers exposed

to combat are also at a higher risk of developing PTSD (Walker, 2010), especially those servicemembers younger than 25 years old (Keeling et al., 2018). These statistics underscore the need for further research into how to combat stigma and encourage military servicemembers to seek help for psychiatric-related symptoms and diagnosed disorders.

Whereas there is a substantial amount of research surrounding mental health stigma and the military, it does not address how servicemembers have overcome stigma and chosen to seek help while on active duty. This qualitative study examined the experiences of veterans currently receiving mental health treatment in an outpatient setting. It examined the veterans' stories from the time they identified they were experiencing a mental health issue and how they were able to combat the stigma they experienced and seek help while still on military active duty.

In this chapter, the historical context and social background of military mental health stigma and its effects on help-seeking behavior are presented. Overall, this chapter provides a basis for exploring the phenomenon of military mental health stigma and ways of combating its effects on help-seeking behavior.

Background

Military servicemembers are regularly exposed to hazardous work environments that lead to a high risk for developing mental health problems (Hoge et al., 2004; Hotopf et al., 2006; Sareen et al., 2007, as cited in Gould et al., 2010). Because of this sustained exposure to hazardous work conditions, such as live fire exercises and combat deployments, the United States Government has funded large scale campaigns aimed at increasing mental health awareness and has created greater means of access to obtaining mental health treatment. However, those experiencing mental health-related problems often refuse to seek help (Hoge et al., 2004, as cited in Gould et al., 2010).

This reluctance to seek treatment can often be traced to one or more forms of self-stigma, public stigma, anticipated and internalized stigma, perceived stigma, and other barriers to care, such as leadership and work environment (Fox et al., 2018; Barr et al., 2019; Besterman-Dahan et al., 2013; Krill Williston & Vogt, 2019; Hernandez et al., 2017). A lack of treatment for mental health-related issues leads to an increase in PTSD-related symptoms, suicide (LeardMann et al., 2013; Warner et al., 2011, as cited in Bein et al., 2019), and other psychiatric conditions (Lu et al., 2011; Milliken et al., 2007; Owens et al., 2009; Seal et al., 2009; Wagner et al., 2007, as cited in Bein et al., 2019).

The stigma associated with traumatic combat stress has a long history. According to Nash et al. (2009), documented accounts of traumatic combat stress and what is known today as PTSD can be traced as far back as 2,000 years in Homer's Iliad and Odyssey. Beliefs regarding the cause of this stress have shifted through the years; such stress was labelled as hysteria by the Germans in 1916 and attributed to a pre-existing personal weakness in the afflicted. These notions of pre-existing personal weakness led to the German military not being held responsible for soldiers presenting with combat stress. The government no longer had to pay disability compensation to veterans and did not have to evacuate afflicted soldiers. Soon after, the French, British, and later Americans, followed with almost identical policies.

The term hysteria was not meant to be a neutral descriptive term. Hysteria carried with it a feminine connotation and was meant to be as stigmatizing as possible. This type of stigma led to psychiatric evacuations during wartime falling from 10% during WWII to 3.7% in the Korean war, to barely 1.2% in the Vietnam War. However, this did nothing to curb the long-term disability and help-seeking of veterans following the war. Although language changed and a shift away from hysteria and personal weakness had begun, soldiers still believed they were at fault.

Regardless of the number of times a servicemember was told traumatic stress symptoms were normal, they could not overcome the feeling that anything other than personal weakness was to blame.

Military resilience training teaches that a soldier's inner strength that enables them to enter combat and face adversity will also empower them to overcome any type of stress-related symptoms of readjustment post-deployment (Nash et al., 2009). Incorporation of resiliency training could help prevent some of the associated self-doubt surrounding military servicemembers when faced with adversity.

<div align="center">**Problem Statement**</div>

There is a common stigma among military servicemembers that seeking mental health services (MHS) will cause them to be perceived differently by their leaders. This belief can stem from external reactions to others receiving MHS or from within, as servicemembers may perceive seeking MHS as embarrassing and weak (Warner et al., 2008, as cited in Hernandez et al., 2017). Not receiving MHS while serving on active duty can worsen mental health problems. Untreated traumatic stress can lead to the servicemember experiencing worse symptoms once out of the military, problems later in life (Schnurr et al., 2004, as cited in Campbell et al., 2018), and difficulty reintegrating into civilian life (Brignone et al., 2017).

The problem this study was designed to address is that military servicemembers often do not seek help for mental health issues for fear of retaliation from military leaders, persecution from peers, or a personal belief that they are weak. Lack of active servicemembers seeking treatment can lead to the deployment of servicemembers who have compounding mental health problems, which compromises unit readiness and cohesion. A lack of mental health treatment can also lead to military servicemembers' symptoms worsening upon separation from the

military, causing homelessness, drug and alcohol addiction, incarceration, family violence, and suicide, as well as social isolation, reduced employment, housing, and educational opportunities, discrimination, receipt of inadequate general and mental healthcare, and an increased risk for victimization (Drapalski et al., 2021).

Purpose Statement

The purpose of the phenomenological study was to explore the lived experiences of Operations Iraqi and Enduring Freedom (OIF/OEF) era veterans currently receiving outpatient mental health treatment following discharge from service to better understand the impact of stigma on their decision to seek mental health treatment while on active duty and how they overcame mental health stigma. Much of that research has been conducted using quantitative survey methods, as well as reviews of existing literature. An example is a study conducted by Hernandez et al. (2016) in which, "The CINAHL, PsycARTICLES, PsycINFO, and PubMed databases were used to search for literature related to stigma that service members associate with accessing MHS" (p. 190). The aim was to provide insight into the stigma surrounding help-seeking behavior in the military and possibly provide commanders with a means to alleviate the stigma, making it easier for servicemembers to receive MHS while remaining on active duty or before separating from the military.

Theoretical Framework

Because this study examined the experiences of servicemembers overcoming stigma and seeking MHS while on military active duty status, a hermeneutical phenomenological approach was chosen. There is not much existing literature that examines mental health stigma through a phenomenological lens. This study was grounded in a social constructivist research philosophy. Social constructivists have a strong belief that people can develop meaning through their

perceptions of society and through these perceptions they develop an understanding of the world (Creswell & Poth, 2018). This study relied on the subjective meanings of the participants' experiences: their meaning regarding the stigma of mental health in the military and how they were affected by it. The goal of research using a social constructivism framework is to rely as much as possible on the participants' views (Creswell & Poth, 2018). By interviewing participants that have overcome stigma, a greater understanding of how to combat stigma can be known.

Significance of the Study

The importance of overcoming stigma is a constant theme throughout mental health stigma-related literature. Many researchers have discussed potential paths to overcoming barriers related to mental health access and combatting stigma (Drapalski et al., 2021). According to Drapalski et al. (2021), "Many include psychoeducation to dispel misconceptions about mental illness, cognitive techniques to combat self-stigmatizing thoughts, reinforcement of personal strengths, and practical skills to avoid or address self-stigma" (p. 137). Whereas it is crucial to understand how stigma affects help-seeking behavior, it is also important to study the ways in which individuals have already overcome stigma in their own lives. This study was designed to add to the existing research by providing a unique look into the experiences of individuals who experienced a mental health-related issue following a combat deployment to OEF/OIF, decided to seek treatment on active-duty, and in so doing, were able to overcome military mental health stigma.

Empirical Significance

There is no existing literature specifically describing the experiences of those who have found a way to navigate the impact of stigma and mental health on their careers. This study was

designed to fill that gap. The findings of this phenomenological study contribute to the current literature and understanding of how stigma affects help-seeking behavior of active-duty military servicemembers. Previous studies have focused on multiple types of stigmas and their range of impacts on an individual, yet all stigma types have the same outcome: they create barriers to getting help (Barr et al., 2019; Besterman-Dahan et al., 2013; Hernandez et al., 2017; Krill Williston & Vogt, 2019). By the time a servicemember develops PTSD and other mental health-related symptoms that begin to affect their job performance and home lives, it is often too late to intervene and damage to their careers and families has already been done. A qualitative, phenomenological study allows unique insight into how servicemembers were able to navigate the delicate balance of acknowledging they were experiencing a mental health problem and seeking help while remaining on active duty status in the military.

Theoretical Significance

The unwillingness of many military servicemembers to seek treatment for mental health-related problems because of stigma is a unique phenomenon. The problem continues to exist and has only grown with OEF/OIF. The study drew on social constructivist theory by its use of a hermeneutical approach to phenomenological inquiry to gather the experiences of servicemembers who have lived through combat, mental health repercussions, and sought treatment while under the stressors of military mental health stigma. According to Creswell and Poth (2018), "hermeneutical research . . . describes research as oriented toward lived experience (phenomenology) and interpreting the 'texts' of life" (p. 77). These lived experiences are those shared by the participants during semi-structured interviews, and the 'texts' of life can be interpreted as the stories participants shared with the researcher. The intent of using social constructivism theory and a hermeneutical approach to gain a deeper understanding of the lived

experiences of servicemembers who have sought help while on active duty was to yield new information surrounding this subject. This approach to phenomenological research allowed for the most in-depth gathering of data to highlight ways to combat stigma throughout the military branches of service.

Practical Significance

The military has invested heavily in programs designed to combat stigma and has tried to eliminate barriers to care. However, servicemembers are still refusing to seek treatment at an alarming rate. Of those post-9/11 veterans currently receiving healthcare through the VA, 57% have a provisional psychiatric diagnosis (Aronson et al., 2020); yet nearly 60% of those with a diagnosable mental health disorder do not seek help (Sharp et al., 2015). The findings from this research will aid future military commanders in their approach to mental health and will provide insight into ways to combat stigma throughout the military branches of service. This would aid in supporting the already utilized practices established by the U.S. Department of Defense (DOD). Through examining how previous servicemembers overcame stigma, new approaches to combating stigma may be developed as well.

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Research Questions

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The central research question in this phenomenological study provides an umbrella for all other questions that were asked during the research. It gives a direction for the researcher to follow. The study was designed to address this research question, including the methods used to gather data. The interview protocol, consisting of open-ended questions, was designed to address the central research question and sub-questions. These open-ended questions were designed to lead to deeper thought and experiences being shared by the participants. This method of information gathering is paramount to enriching a qualitative study (Yin, 2018).

Central Question

The central research question of this phenomenological study is as follows: How do active-duty servicemembers describe their experiences of overcoming mental health stigma to seek MHS? Whereas much of the previous research has sought to understand how stigma affects help-seeking behavior (Barr et al., 2019) and barriers to healthcare (Hernandez et al., 2016; Hoge et al., 2006, 2004; Kulesza et al., 2015; Mittal et feal., 2013; Roscoe & Anderson, 2019; Roscoe, 2021), no research exists on how active-duty military personnel overcame stigma to seek mental health treatment. Therefore, this study establishes a platform upon which to build future research.

Sub-Question 1

Sub-Question 1 is as follows: How do active-duty servicemembers describe their experiences with mental health stigma in the military? This sub-question was addressed by giving participants an opportunity to share how they experienced stigma before and after they realized they had a mental health problem.

Sub-Question 2

Sub-Question 2 is as follows: How do active-duty servicemembers describe their decision-making process to seek MHS while navigating mental health stigma in the military? This sub-question was designed to inquire into how servicemembers view the importance of their mental health with regard for their families and careers. This question was addressed by asking participants to share their experience with stigma and their decision to seek mental health treatment.

Sub-Question 3

Sub-Question 3 is as follows: How do active-duty servicemembers describe their experiences of seeking MHS? This question was designed to explore how active-duty servicemembers experience seeking MHS beyond their decision to do so.

Sub-Question 4

Sub-Question 4 is as follows: How do active-duty servicemembers describe the outcome of their decision to seek MHS? This question was addressed by allowing participants an opportunity to share their outcomes pertaining to their decision to seek MHS.

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Situation to Self

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The researcher has been on both sides of mental health stigma. He can say with certainty that mental health stigma is a serious problem. When the researcher first entered the military in 1998, he did not understand what a mental illness or disorder was. The researcher did not grasp the concept that people encounter stressful situations in life that lead to them needing mental health treatment. The researcher was naïve and did not think that a mental health problem was something that could happen to him. He was one of the people that helped to perpetuate the stigma of mental health. When the researcher saw someone in his unit who was struggling and had to see a psychologist, he thought they were weak and did not want them to be in his platoon. He thought this illness was something that could spread to and infect others. It shames him to convey what occurred when that soldier on his unit sought help: servicemembers made fun of him. The military leaders were aware of how the servicemembers felt and of the things they would say, yet they did nothing to dissuade these actions. It was not that they were condoning the behavior; rather, they did nothing to stop it.

It was not until the researcher suffered a traumatic brain injury (TBI) while in Iraq that he became aware of the severity of mental health issues related to trauma and the need to seriously reconsider how it is treated. He did not immediately experience symptoms. Therefore, he did not seek mental health treatment right away. His symptoms became exacerbated several years later. The researcher began to experience anger and impulsivity issues, as well as trouble with concentration. His friends and family saw a change in him, and his leadership became irate at the thought of him wanting to see someone about what was occurring. He eventually decided he needed help and sought care from an Army psychologist. After several weeks of seeking professional help, the psychologist decided it was best for the researcher to not remain in service. The researcher experienced both extremes of mental health stigma and sees a need for change.

Definitions

1. *Anticipated Stigma* – Anticipated stigma has been defined as "beliefs about the extent to which family members, friends and colleagues will stigmatize an individual for experiencing or seeking treatment for a mental health problem" (Corrigan & Rüsch, 2002; Corrigan & Wassel, 2008; Vogt et al., 2013, 2014, as cited in Krill Williston & Vogt, 2019, para. 1).

2. *Intervention* – Intervention is "the act of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)" (Merriam-Webster, 2022, para. 1).

3. *Military servicemember* – A military servicemember is a full-time active-duty member of one of the six military branches (Army, Navy, Air Force, Marine Corps, Coast Guard and Space Force); a reservist on federal active duty, or a member of the National Guard on

federal orders for a period of more than 30 days (U.S. Department of Justice [DOJ], 2022).

4. *OEF/OIF combat era veteran* – An OEF/OIF veteran is any military servicemember that deployed to OEF/OIF or served in a nondeployed support role.

5. *Perceived stigma* – Perceived stigma is any form of stigma that may alter the perception of the individual affected. Perceived stigma includes public stigma, internalized stigma, and structural discrimination (Williamson et al., 2019).

6. *Posttraumatic stress disorder* (PTSD)– PTSD is a mental health disorder that develops following the experience of or witnessing a life-threatening event, such as combat, natural disaster, a car accident, or sexual assault (U.S. Department of the Veterans Affairs [VA], 2022).

7. *Public stigma* –Public stigma is the perception of external prejudices and stereotypes and the endorsement of stereotypes by the public with corresponding discrimination (Skopp et al., 2012).

8. *Reintegration* – Reintegration is the transition from military service to civilian life following discharge from active duty (Romaniuk et al., 2020).

9. *Self-stigma* – Self-stigma is "the internalization of stereotypes among individuals with mental illness" (Reger et al., 2020, para. 1). An example of self-stigma would be, "I am weak and incompetent and don't deserve to wear a military uniform" (Reger et al., 2020, para. 1).

10. *Stigma* – "Stigma is when someone views you in a negative way because you have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype)" (Mayo Clinic, 2022, para. 1).

11. *Veteran* – A veteran is "a former member of the armed forces" (Merriam-Webster, 2022, para. 1)

Summary

To combat mental health stigma in the military, one must understand its effects on help-seeking behavior. Much research exists on how stigma plays a role in a servicemembers' decision to not seek help. However, no research exists on how servicemembers have overcome stigma and decided to seek treatment while on active duty. Regardless of increased awareness of mental health following OEF/OIF, many servicemembers continue to refuse treatment in large part because of the stigma surrounding mental health. This phenomenon can be attributed to feelings about oneself, fear of retaliation from leaders, or fear of destroying one's career. Researchers have studied this phenomenon from a vantage point of eliminating the stigma or making mental health treatment more accessible but have overlooked the methods already being used by active-duty men and women. Once it is known how they have overcome stigma, the DOD can adapt these methods of combating stigma to create programs that work with preexisting strategies.

CHAPTER TWO: REVIEW OF THE LITERATURE

There is a common stigma among military servicemembers that seeking mental health services (MHS) will cause them to be perceived differently by their leaders (Hernandez et al., 2017). This belief can stem from external reactions to others receiving MHS or from within as servicemembers may perceive seeking MHS as embarrassing and reflecting weakness (Warner et al., 2008, as cited in Hernandez et al., 2017). However, not seeking out and receiving MHS while serving on active duty can worsen mental health problems and subsequently lead to problems later in life (Schnurr et al., 2004, as cited in Campbell et al., 2018). Fifty-seven percent of post-9/11 veterans currently receiving healthcare through the VA have a provisional psychiatric diagnosis (Aronson et al., 2020). Of a total of 3,295 post-9/11 veterans, 73% screened positive for a probable anxiety disorder, 69% for PTSD, 57% for alcohol use disorder, and 77% for a minimum of one general medical issue. It can also be difficult for veterans to reintegrate into civilian life because of the traumas they encounter during combat and the lack of adequate mental healthcare while on active duty (Brignone et al., 2017). The high number of veterans developing mental health symptoms and lack of adequate care on active duty highlight the importance of identifying the root causes of stigma, identifying ways to combat stigma, and alleviating barriers to seeking MHS.

Stigma

What is Stigma?

There are many definitions of stigma. However, a broad conception of mental health stigma is that it is multifaceted in nature and encompasses stereotypes and prejudices about those with mental illness, as well as any real or perceived discrimination resulting in unfair treatment (Corrigan et al., 2014, as cited in Reger et al., 2020). Stigma is experienced as perceived negative

attitudes (i.e., perceived stigma) or a change in how individuals are treated in their communities

(i.e., discrimination or enacted stigma; Murray et al., 2018). Goffman (1963, as cited in

Hernandez et al., 2017) identified stigma as a deeply discrediting attribute. Stigma is also known

as a literal or figurative marking. According to Hernandez et al. (2017), stigma is a Greek word

meaning an identifiable mark, brand, or tattoo that is placed on the skin of criminals and slaves

for identification. One can see why stigma is undesirable and how it may account for why so

many may go to great lengths to avoid such labels.

Branding can be a literal mark, or it can take the form of a label (Hernandez et al., 2017).

Military servicemembers have identified these labels as "crazy," "violent," "depressed,"

"distant," "weak," and "unreliable" (Roscoe, 2021). These labels are often internalized and

increase the servicemembers' level of self-stigma. It is important to recognize the strain

reintegration into civilian life can place on a military veteran. Fear of any manner of stigma can

produce an environment ripe with silence and denial about mental health. This atmosphere can

make it increasingly difficult to discuss underlying problems (Roscoe, 2021). Should any stigma

become so great that it prevents a servicemember from seeking help, a multitude of

consequences can ensue. These consequences include, but are not limited to, physical

discomfort, relationship difficulty, reduced self-esteem, isolation, severe depression, and suicide

(Hoge et al., 2006, 2004; West et al., 2011, as cited in Roscoe, 2021).

Types of Stigmas

Stigma is a significant public health concern linked to anxiety, stress, depression, reduced

self-esteem/self-efficacy, reduced delay in seeking care, and lowered care compliance (Frank et

al., 2018). Researchers have sought to understand the influence of various types of stigmas on

the likelihood of seeking MHS for mental health issues.

Self-Stigma

Two of the most common and costly mental health problems that are present with OEF and OIF veterans are PTSD and depression (Bruce, 2010; Kang et al., 2015; Seal et al., 2009, as cited in Barr et al., 2019). One key barrier to veterans of these wars who present with PTSD and depression is self-stigma (Barr et al., 2019). Self-stigma is the internalization of stereotypes among individuals with mental illness. Self-stigma can cause a servicemember to believe they are weak and incompetent and that they do not deserve to wear a military uniform (Reger et al., 2020). Self-stigma is also associated with a lowering of self-esteem and decreasing motivation to seek treatment. This association may be due to people being less likely to seek treatment if they believe their mental illness is their fault (McGuffin et al., 2021). It is evident that veterans suffering from PTSD and depression have low self-esteem and do not seek mental healthcare because of self-stigma.

This desire to not seek treatment is then influenced by the individual's awareness of the societal stigma of mental health and self-stigma (Bein et al., 2019). "I am crazy," and "I am weak" are the two most common internalized stigmas identified in the armed forces (Pury et al., 2014, as cited in Coleman et al., 2017). Other individuals experiencing high levels of stigma may choose not to reveal their mental health treatment, and some may not be aware they have a mental health-related issue, thus they do not seek treatment (Fikretoglu et al., 2008; Osório et al., 2013, as cited in Coleman et al., 2017). To counteract the high levels of stigma, psychoeducation must be used to eliminate negative belief statements.

Bonfils et al. (2018) sought to examine how stigma affects veterans' help-seeking behavior among two groups of veterans: those with PTSD and those with schizophrenia. Bonfils et al. performed their study with veteran volunteers from a single VA facility. The PTSD

population consisted of 46 veterans, and the schizophrenia population consisted of 82 veterans. Three subscales, alienation, stereotype endorsement, and social withdrawal, were used to evaluate the stigma in the two groups. The results showed no significant differences ($\mu \geq 1.5$) between the two PTSD and schizophrenia groups with respect to alienation, stereotype endorsement, and social withdrawal (Bonfils et al., 2018). Corrigan et al. (2006b, as cited in Bonfils et al., 2018) found that stigma becomes problematic not only when an individual is suffering from mental illness and is aware of public stigma but also when the individual begins to identify with the stereotype. This study is valuable because it demonstrates a relationship between stigma, mental health diagnosis, and alienation, which could lead to further complications.

Public Stigma

An individual's decision to seek treatment for mental health concerns is affected by both self-stigma and public stigma (Corrigan, 2004, as cited in Besterman-Dahan et al., 2013). According to Skopp et al. (2012), public stigma is the perception of external prejudices and stereotypes. Further, public stigma is the endorsement of stereotypes by the public with corresponding discrimination. This form of stigma can lead to beliefs like, "Soldiers with PTSD are dangerous and won't be promoted" (Reger et al., 2020). Because public stigma is the societal belief that one is unacceptable, it can lead to individuals believing themselves to be unacceptable by societal standards (self-stigma). This reduction in self-worth will often be compounded by a lack of seeking psychological help (Vogel et al., as cited in Besterman-Dahal et al., 2013).

Kulesza et al. (2015, as cited in Roscoe, 2021) found veterans were less likely to partake in mental health treatment if greater levels of public stigma existed. Therefore, public stigma perceptions influence how military veterans manage stigma and whether they decide to seek help

(Roscoe, 2021). Public stigma often has a direct association with self-stigma. However, compared to self-stigma, the effects of public stigma have less of an effect on help-seeking behavior. This is because past positive experiences with mental health services tend to counteract the impact of the stigma (Skopp et al., 2012).

Anticipated Stigma

Whereas self-stigma may be one of the most prevalent stigmas affecting servicemembers, anticipating how others will perceive their decision to seek treatment can be equally detrimental to help-seeking behavior. "Anticipated stigma refers to beliefs about the extent to which family members, friends and colleagues will stigmatize an individual for experiencing or seeking treatment for a mental health problem" (Corrigan & Rüsch, 2002; Corrigan & Wassel, 2008; Vogt et al., 2013, 2014, as cited in Krill Williston & Vogt, 2019, para. 1). Families, specifically spouses, have considerable influence over military servicemembers. This influence affects servicemembers' morale, wellbeing, motivation, and extends to their willingness to enter mental health treatment. Spouses also support servicemembers during their time in service, throughout deployments, changes in duty station, training, or when the servicemember is injured or becomes ill (Schvey et al., 2021). Veterans suffering from mental illness are more inclined to seek treatment with support from friends, family, or colleagues.

According to Krill Williston and Vogt (2019), anticipated stigma and mental health beliefs are individual-level factors that impede a veterans' use of mental healthcare services. Anticipated stigma is second only to self-stigma in posing the greatest barrier to mental healthcare in the military (Vogt et al., 2014). Mental health beliefs reflect an individual's personal beliefs about mental health problems, treatments, and help-seeking behaviors. Of those surveyed regarding barriers to mental healthcare, between 35% and 65% reported anticipated

stigma as a concern (Krill Williston & Vogt, 2019). Fox et al. (2018) used longitudinal data to confirm that "the relationship between anticipated stigma and use of mental health treatment is mediated by internalized stigma of seeking treatment" (p. 18). Therefore, personal beliefs related to mental health can either deter or assist help-seeking behavior.

Thornicroft et al. (2009, as cited in Quinn et al., 2015) worked with individuals diagnosed with schizophrenia from 27 different countries to examine their experiences of discrimination and anticipated discrimination. The study was conducted in conjunction with a global INDIGO study. Anticipated discrimination was highly correlated (95%) with anticipated stigma. Anticipated discrimination was defined in the study as the fear of future discrimination associated with employment. Anticipated social stigma is fear of revealing one's mental health diagnosis; thus, hindering one's involvement in relationships for fear of rejection (Angermeyer et al., 2004; Cechnicki et al., 2011, as cited in Quinn et al., 2015).

Perceived Stigma

Perceived stigma may have the potential to deter military servicemembers from seeking MHS (Gibbs et al., 2011; Gorman et al., 2011; Hoge et al., 2004; Kim et al., 2011, as cited in Hernandez et al., 2017). Perceptions of stigma are likely to increase when a military servicemember is experiencing a mental health disorder (Britt et al., 2015; Hoge et al., 2004; Kim et al., 2010, 2011, as cited in Hernandez et al., 2017). A recent systematic review and meta-analysis of 15 independent studies of military servicemembers showed that 26 to 44% of participants agreed that mental health stigma prevented them from seeking MHS (Sharp et al., 2015, as cited in Hernandez et al., 2017).

Recent military combat has been shown to increase female veterans' exposure to military sexual trauma and intimate partner violence (Williston et al., 2020). Studies have shown that

24% to 46% of female veterans reported experiencing childhood sexual abuse, and 23 to 33%

reported experiencing sexual assault in the military (Pulverman et al., 2019). Both exposures

increase the chances of developing mental health problems. However, many females do not seek

mental health treatment because of a perceived, and sometimes warranted, lack of ability of some

providers to address gender-specific needs. Some gender-specific differences also exist in how

one perceives stigma. Such differences can be seen in many military cultural norms. These

norms promote masculinity and often devalue femininity. Military culture also assumes females

are not "real combat" veterans. These perceptions germane to military culture may make it

difficult for female veterans to seek and use mental health treatment (Williston et al., 2020).

Other considerations regarding stigma and barriers to treatment include higher workplace

hostility, lower satisfaction toward leaders, coworkers, and job satisfaction (Yamawaki et al.,

2016). To meet the mental health needs of the female military population, there needs to be more

gender specific MHS and providers available.

Society often views all mental illness the same. This view places every mental illness into

the same category with the same consequences in work environments (Elraz, 2018). Military

personnel often fear their mental health will prevent them from receiving promotions or job

placement, and those in the civilian workplace have similar fears (Bruce & Brown, 2016). The

failure to address these issues can aggravate the symptoms and lead to compounding issues,

including but not limited to negative effects on social, emotional, and physical health. Further

complications can include increases in physical pain, decreased energy, reduced productivity,

spending less time with friends and relatives, bouts of unemployment, and possible attempted

suicide (Cohen et al., 2013; Ilgen et al., 2012; Pittman et al., 2012; Ware & Sherbourne, 1992, as

cited in Bruce & Brown, 2016). As with other mental health conditions, one can credit an

individual's reduced capacity to perform with the stress-inducing conditions of work stress, inability to handle workloads, inability to cope while in a work environment, and a failure to possess the required skills for managerial duties (Elraz, 2018). Each mental health condition should be treated individually to alleviate complications in work environments.

Whereas many in leadership positions have frowned on mental health conditions, there are those that advocate for the resilience of someone managing one. Such resilience includes individuals developing unique skills and insights, effective means of managing their conditions, and their ability to cope with stress in the workplace. These individuals are thought to possess special skills because of their need to cope with a mental health condition (Elraz, 2018). With the right treatment and support system, a person with a mental health condition can be a productive member of society.

According to Sharp et al. (2015, as cited in Vidales et al., 2021), nearly 60% of servicemembers in need of MHS do not seek help. They believe mental health carries a mark of dishonor for the one seeking help. This makes servicemembers with mental health issues vulnerable to prejudice and discrimination (Clement et al., 2014, as cited in Vidales et al., 2021). If a servicemember does seek help, they often drop out before completing treatment due to fear of being passed over for a promotion or another negative career impact (Brown & Bruce, 2016; Jennings et al., 2016, as cited in Vidales et al., 2021). Therefore, psychoeducation in eliminating stigma may be needed to increase retention in mental health treatment.

Mental Health Stigma and the Military

Mental health issues are more prevalent in the military than in the public (Judkins et al., 2020). This trend contributes to a servicemember being at greater risk for exposure to traumatic events during combat deployments (Vogt et al., 2014). Active-duty servicemembers and veterans

who have served in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi

Freedom (OIF) in Iraq suffer from many psychiatric issues, including PTSD (20-22%), major

depressive disorder (17-24%), and comorbid disorders, such as substance use disorders (e.g.,

alcohol abuse, ranging from 7-27%; Elbogen et al., 2013; Seal et al., 2009; Skidmore & Roy,

2011, as cited in Bruce & Brown, 2016). In Hitt and Massi Lindsey's (2020) research,

approximately 14% or 300,000 servicemembers returning from combat deployments have PTSD.

According to Judkins et al. (2020), PTSD occurred most frequently in men (81.1%) between the

ages of 20 and 24 (26.6%). Of the total participants with PTSD, 66.6% were married and 67.5%

identified as White. PTSD was represented in the branches by the Army (63.2%), Marine Corps

(13.9%), Navy (11.7%), and Air Force (11.2%; Judkins et al., 2020).

Roughly 60% of servicemembers with a diagnosable mental disorder do not seek any

type of help (Sharp et al., 2015, as cited in Roscoe, 2021). In 2017, 6,139 veterans of the United

States military committed suicide, which is an average of 17 deaths by suicide every day (VA,

2019, as cited in Roscoe, 2021). According to Cerully et al. (2018), servicemembers

experiencing symptoms of mental illness that do not seek help are at higher risk for suicide, sleep

disturbances, intimate partner violence, child maltreatment, difficulty concentrating and

maintaining focus, physical conditions, and less military deployment availability. According to

Frank et al. (2018), mental and physical illnesses can lead to enacted or felt stigma. Studies have

shown that those with mental health conditions are at far greater risk for discrimination and

negative feelings than their counterparts without such conditions.

Mental health stigma has created a significant barrier to seeking help for psychologically

related conditions in the United States (McGuffin et al., 2020). According to Hitt and Massi

Lindsey (2020), less than half of those with diagnosable symptoms seek treatment because of the

stigma associated with mental health.

Goode and Swift (2019) examined mental health stigma among active-duty servicemembers and veterans using an experimental design; the study involved asking them to read a vignette describing veterans with and without a mental health problem and seeking or not seeking mental health help. There was a significant association between mental health concerns and beliefs that others would stigmatize those experiencing mental health problems. Findings also showed that servicemembers held more negative attitudes toward other servicemembers experiencing a mental health problem than those receiving professional psychotherapy. These findings demonstrate that words such as "mental health," "illness," "disorder," and "problem" carry a negative connotation because individuals are not educated on what mental health truly is. The researchers concluded that normalizing mental health is the key to decreasing stigma.

Stigma is generally considered to create the highest barriers to seeking mental healthcare by military populations when employment discrimination is considered. This is because of disclosure/confidentiality concerns among military leadership and mental health professionals (Clement et al., 2015). When reviewing stigma-related research, both the stigma within the military and public stigma have been identified as a barrier to help-seeking behavior (Hernandez et al., 2016; Hoge et al., 2006, 2004; Kulesza et al., 2015; Mittal et al., 2013; Roscoe & Anderson, 2019, as cited in Roscoe, 2021). The potential exists for servicemembers with mental health issues to feel they are working in a hostile work environment.

Fear of military reprisal for seeking help is a great concern among servicemembers (Waitzkin et al., 2018). Waitzkin et al. (2018) found that factors causing servicemembers to fear seeking out military mental health services included fear of reprisal, mistrust of command, insufficient and unresponsive services, cost as a barrier to care, deception, enlistment remorse,

guilt, preexisting disorders, family and household issues, and military sexual trauma. Waitzken et al. documented the frequency of themes of concerns for servicemembers: 93% reported insufficient or unresponsive services, 56% reported fear of reprisal for seeking services, 48% mistrust of command, 22% preexisting mental health disorders, 22% military sexual trauma, and 19% reported cost as a barrier to care (Waitzkin et al., 2018). These results show a disturbing trend in the military.

Stigma is also prevalent in the Canadian Armed Forces (CAF), where mental health issues have risen over the past 10 years (Frank et al., 2018). Gould et al. (2010) followed the redeployment of servicemembers in the Canadian Forces ($N = 5255$) from Afghanistan, showing that as few as 38% to 45% of soldiers scoring above the cut-off for mental health screening had any interest in receiving mental health services, and merely 23% to 40% had sought any form of mental healthcare. The three identifiable reasons for this lack of help-seeking behavior were perceived weakness for seeking help, differential treatment by unit leadership, and fear of a lack of confidence in them by their unit (Gould et al., 2010). This demonstrates that perceived stigma is a global concern.

Research has also shown that a minority of U.K. armed forces servicemembers with mental health problems seek help, and most do not seek any form of psychological support for their conditions (Gould et al., 2008; Jones et al., 2010; Hines et al., 2014; Iverson et al., 2010, as cited in Jones et al., 2018). Studies performed with U.S. and U.K. personnel have demonstrated that mental health stigma, self-reliance, and the worry that seeking help may have a negative effect on one's career have been shown to be significant reasons for not seeking help. Among the existing forms of stigma, several stigmas stand out among military servicemembers: public stigma, internalized stigma (or self-stigma), and structural discrimination. Common themes

among servicemembers include sayings such as "I am weak" or "I am crazy" (Williamson et al., 2019). It is vital to eliminate negative beliefs about the self to combat stigma.

In a study conducted by Pietrzak et al. (2009), OEF-OIF servicemembers who screened positive for PTSD, depression, or an alcohol use disorder endured greater levels of perceived stigma and barriers to mental healthcare when compared to OEF-OIF servicemembers that screened negative for the same issues. Participants for the study were found using the Connecticut OEF-OIF Veterans Needs Survey. A total of 1,050 veterans were eligible to participate in the study, having served between January 1, 2003, and March 1, 2007. Two hundred eighty-five veterans returned questionnaires and were eventually included in the subsequent data. Over 1/4 (26%) of respondents ($n = 66$) reported using MHS during the last 6 months, with 15% of total respondents ($n = 40$) reporting using those services for medication. For those with diagnosed conditions, PTSD was the only significant predictor for stigma and barriers to mental healthcare (Pietrzak et al., 2009).

A further study examining the poor response rate to this survey showed that mental health stigma was a factor in some veterans' willingness to participate (Pietrzak et al., 2015). Of the 1,050 OEF-OIF identified veterans in the Connecticut Department of Veterans Affairs (VA) who were mailed surveys, only 285 replied. That represents a 27% return rate on a survey directly related to their mental health. Also, the respondents tended to be older veterans. Barriers to healthcare were identified as negative beliefs about mental healthcare and unit support (Gould et al., 2010; Pietrzak et al., 2015). Low levels of unit support can have a detrimental effect on the psychological wellbeing of someone with a mental health problem (Pietrzak et al., 2015). Moreover, veterans with military leaders who were educated were more likely to seek help. The authors concluded that educating military leaders, as well as servicemembers and their families,

that combat stress reactions are a normal response to an abnormal situation could reduce stigma and barriers to mental health.

Ganz et al. (2021) conducted two research studies seeking to understand the relationship between military culture and mental health treatment outcomes. Study 1 showed that active-duty soldiers scored higher on the Ganz Scale of Identification with Military Culture (GIMC) than their civilian counterparts for components, such as values of duty, selfless service, honor, and personal courage, but not for the values of loyalty, integrity, and commitment. Study 2 demonstrated that those servicemembers who sought mental health treatment after joining the military reported caring less about the treatment's effects on their careers than those who did not seek treatment. In 2019, 8.4% of the entire Armed Forces screened positive for a mental health disorder. This is alarming because of the supposed "healthy soldier" effect of all recruits being screened for mental health-related issues prior to enlistment (Ganz et al., 2021). Both studies demonstrate that military culture has a strong effect on treatment outcomes.

Seidman et al. (2019) examined the relationship between psychological help-seeking stigma and use of outpatient behavioral health. The study was conducted over a 2-year period and followed active-duty military personnel initially referred for neuropsychological evaluation with symptoms secondary to their histories of mild TBI. The results provide evidence of self-stigma, but not public stigma, regarding the negative effects of help-seeking on future mental healthcare of active-duty servicemembers over 2 years post-treatment (Seidman et al., 2019). Because of military culture, self-stigma levels may not weaken after receiving counseling for a mental health problem as it does in civilian populations (Wade et al., 2011, as cited in Seidman et al., 2019). This sustained level of self-stigma may inhibit an individual from seeking further treatment. Seidman's results indicated that self-stigma is negatively related to treatment-seeking,

whereas public stigma is unrelated to service use. The findings of their study showed that 86% of participating servicemembers sought help and attended multiple sessions within the past year, thus demonstrating psychological concerns. Nevertheless, self-stigma interfered with attendance and contributed to some early dropouts (Seidman et al., 2019). Such findings indicate a need to re-examine military culture and its impact on a servicemembers' desire to remain in treatment.

Factors Affecting Active-Duty Help-Seeking Behavior

Aikins et al. (2020) sought to examine factors affecting the motivation of active-duty Army soldiers seeking behavioral health treatment. The study used the Anderson (1995) behavioral health treatment model to identify the factors, which are predisposing factors, enabling factors, and need factors. The only factor strongly associated with increased treatment motivation and treatment engagement was the presence of PTSD symptoms. According to the study's findings, the greater the severity of PTSD symptoms, the more likely the soldier would be to ask for a behavioral health consult. The researchers found that despite a lack of reduced stigma, those with PTSD will still often seek help (Aikins et al., 2020). This differs from previous research that found that mental health stigma often overrides the desire of the individual to seek treatment.

Keeling et al. (2020) sought to examine whether self-efficacy affects help-seeking behavior. Such findings could have positive implications, such that raising self-efficacy could lower stigma and increase help-seeking behavior. However, Keeling et al. (2020) found that an increase in self-efficacy led to a decrease in the likelihood of a servicemember seeking help for PTSD or depression. Whereas one would think that an increase in PTSD and depressive symptoms would lead to a decrease in treatment-seeking, Keeling et al. (2020) found that PTSD symptom severity and depression symptom severity had a positive main effect on treatment-

seeking behavior and as symptom severity increased the likelihood a servicemember would seek help also increased. This finding supports those of Aikins et al. (2020), in showing that servicemembers with PTSD do seek help in spite of the stigma.

Perceptions of Military Culture and Reintegration

Some aspects of a military servicemembers' experiences can be associated with a higher risk of developing mental disorders and suicidal ideation, whereas others are associated with lower risk. This interaction needs to be examined in relation to positive and negative effects of military service when studying the mental health of veterans (Campbell et al., 2018). The stigma in the military may be due to the military's culture of stoicism, self-reliance, and prioritizing unit needs over individual needs. It may also be because information is shared among military leaders and soldiers fear lack of confidentiality on the part of mental health officials. Military servicemembers fear unit leaders will lose confidence in their ability to perform unit tasks, and they fear having problems and seeking treatment while struggling for career progression (Hernandez et al., 2017). Helping servicemembers to overcome fear of repercussions from seeking mental health services is an issue that will take time, resources, and education.

Reintegration into civilian life is a major concern when evaluating the mental health of a veteran. Trouble adjusting to life following separation from the military is known as identity adjustment (Orazem et al., 2017). A servicemember has been held to military standards and followed military protocol for such a time that they fail to identify as anything other than a military servicemember following separation from active duty. Identity adjustment can lead to the following problems:

- Feeling like one does not belong in civilian society;
- Missing the military's culture and structured lifestyle;

- Holding negative views of civilian society;

- Feeling left behind compared to civilian counterparts due to military service;

- Having difficulty finding meaning in the civilian world. (Orazem et al., 2017, p. 7).

Because of identity adjustment, veterans have stated they often feel alienated or out of sync with their nonveteran civilian counterparts. This alienation can be from strangers, coworkers, friends, and even family. Because of the strain identity adjustment places on relationships, it can intensify already present mental health conditions or cause nonexistent mental health conditions to emerge (Orazem et al., 2017).

Stigma and Military Leadership

Many veterans have reported adjustment problems upon returning from combat deployments. These problems include but are not limited to PTSD-related symptoms, depression, aggressive behavior, risk-taking behavior, alcohol misuse, sleep difficulties, somatic symptoms, pain symptoms, and functional impairment (Nassif et al., 2019). However, only a minority of those reporting such problems seek help. Many servicemembers are not interested in receiving care because they believe it will negatively affect their careers or, perhaps, are not aware of the options for treatment at their disposal. Whatever the reason, the stigma of seeking help or the barriers associated with treatment exist. The stigma reflects the worry of treatment being embarrassing, causing harm to their career, or fellow servicemembers losing confidence in them. The practical barriers to receiving treatment are those operational impediments that cause difficulty accessing care. This could include leadership not allowing time off to attend treatment, not knowing where treatment can be received, or not knowing about treatment (Britt et al., 2012). The perceived stigma of having a disrupted career has caused many servicemembers to deny themselves the care they needed.

There is a common stigma among military servicemembers that seeking MHS will cause them to be perceived differently by their leaders. This belief can stem from observing external reactions to others receiving MHS or from within, as servicemembers may perceive seeking MHS as embarrassing and/or because people are weak (Warner et al., 2008, as cited in Hernandez et al., 2017). Servicemembers with prior deployments to combat operations are significantly more likely to believe their leadership would treat them negatively if they were to access MHS (Hernandez et al., 2017; Campbell et al., 2018). Many of the associated problems can be attributed to perceived stigma about military leadership.

Serving in the military is considered a high-risk job. Employees of high-risk occupations are often exposed to stressors resulting in mental health problems. The culture and expectations of these professions also set a standard for psychological and physical resilience. These expectations can discourage mental health treatment and lead to servicemembers developing coping strategies for mental health problems (Britt et al., 2020). Britt et al.'s (2020) study examined infantry soldier units and the influence of unit climate support of mental health on help-seeking behaviors. Unit climate support of mental health was defined as "a specific element of a team's climate related to the recognition of mental health problems among fellow unit members, the execution of positive behaviors in addressing the problem, and refraining from negative behaviors associated with the problem" (Britt et al., 2020, p. 142). Findings showed that if a soldier is assigned to a unit in which treatment-seeking is encouraged, positive comments about treatment will likely be encouraged, and negative comments will be dissuaded (Britt et al., 2020).

The researchers suggested that one common barrier to care found in many studies of this type is unsupportive military leadership. Soldiers are more likely to report symptoms associated

with mental illness under the command of a supportive leader than a destructive leader (McGuffin et al., 2021). As per Britt et al.'s (2020) findings, unsupportive leadership can be combated with supportive peer networks.

Military culture has fueled mental health stigma and created a judgmental atmosphere in which issues pertaining to mental health are viewed as something the servicemembers should be able to control and where accessing mental healthcare is viewed as demonstrating weakness. Leadership plays a crucial role in a servicemembers' ability to cope with stress, their level of mental health stigma, and their help-seeking behaviors (McGuffin et al., 2021). The support of military leadership is paramount to any productive change.

Whereas there is a belief that military leadership could be at fault for some of the stigma surrounding mental health, other research shows where some leaders have taken an advocacy role for servicemembers and have made it a point to convey that seeking help when it is needed is the right thing to do (Gibbons et al., 2014). However, there is still a reasonable fear that comes with seeking mental health treatment. Gibbons et al. (2014) identified stigma as pervasive, influencing personal identity, psychological health, community, and organization. Military stigma is apparent in the warrior ethos and coupled with a genuine fear of one's career and promotions being jeopardized by seeking and receiving any form of mental health treatment. Therefore, mental health providers see this population as challenging. This fear of leadership retaliation and career suicide could be reduced if a collaborative healthcare approach were adopted. Military servicemembers could be considered a high-risk population that would benefit from a collaborative care model that includes military members and their families. By integrating mental health and primary care, the perception of a mental health diagnosis could become destigmatized (Gibbons et al., 2014).

Much research has been done on the perceived stigma of enlisted soldiers in the military, but there is little research regarding stigma related to leadership. A recent study showed that 20% ($n = 39$) of the total participants ($N = 190$) reported having sought mental health treatment while 76% ($n = 144$) had not (Hamilton et al., 2016). However, 4% ($n = 7$) did not respond. Therefore, even in a survey study, mental health stigma was still present. Also noted was that officers rated self-stigma higher than perceived stigma (Hamilton et al., 2016). This indicates they cared more about what they thought of themselves than what others would think of them. This belief comes from the idea that military culture has labeled those servicemembers that seek help for mental health conditions as weak. It is important to note that many officers within the study held a negative view about seeking help for mental health-related problems because of the influence that officers have on lower ranking servicemembers (Hamilton et al., 2016). It is plausible to believe that such influence would lead to anticipated discrimination and stigma associated with MHS.

While military chaplains do not directly engage in combat, they are exposed to some of the harshest combat environments because they are embedded with combat units. Military chaplains are expected to provide counsel to soldiers in crisis, yet they often do not undergo decompression of their own. A deployed chaplain is often responsible for the spiritual wellbeing of up to 1,500 servicemembers. Their responsibilities range from helping with mental health issues, reintegration post-deployment, recognizing signs of PTSD and suicidality (Army 2012; Bonner et al., 2013, as cited in Besterman-Dahan et al., 2013), providing spiritual support in combat operations, leadership coordination in combat and operational stress control, as well as counseling struggling servicemembers and their families at home and abroad (Abruzzese, 2008, as cited in Beterman-Dahan et al., 2013). There have been instances of military chaplains

experiencing such high levels of burnout that they commit suicide before reaching out for help (Besterman-Dahan et al., 2013). Understanding the struggles of embedded support personnel could help shed light on views of military mental health stigma.

Nonroutine Discharge and Mental Health

Over 28.5% of OEF-OIF veterans who sought care following service in the military were discharged under nonroutine conditions. Among these veterans, over 35% were discharged due to having disabilities. Compared to routinely discharged veterans, those discharged for disabilities presented with mental health issues twice as often. Those presenting for PTSD tended to be discharged twice as often as those not presenting with PTSD (Brignone et al., 2017). PTSD accounts for a large percentage of servicemembers discharged under nonroutine conditions.

There may be an association between veterans who sustained physical injuries and the development of PTSD. There may also be an association between nonroutine discharge and mental illness or behavioral issues that began before military service yet were not identified at service enlistment (Brignone et al., 2017). Brignone et al. (2017) stated, "Differential diagnostic risks between these groups inform critical points of intervention, as these disorders are related to functional limitations and adverse circumstances that contribute to poor community reintegration, including unemployment, decreased social support, medical problems, and criminal justice involvement" (p. 562). Therefore, it may be beneficial to determine the type of discharge and adverse effects following separations from military service.

National Guard vs Active-Duty

There is a disparity between active duty and National Guard soldiers in the reporting of mental illness symptoms. Active-duty servicemembers report greater symptoms associated with mental illness; at 3 months post deployment, 45% active-duty and 33% National Guard tend to

report symptoms; a similar discrepancy is noted at 12 months post-deployment, with 44% active-duty to 35% National Guard members reporting symptoms. However, National Guard soldiers (27%) seek treatment at more than twice the rate of active-duty soldiers (13%). This may be because National Guard servicemembers have greater access to civilian mental health professionals and do not have to worry as much about confidentiality (Kim et al., 2010). Because National Guard servicemembers can seek civilian healthcare, there is less concern about confidentiality.

Little research exists about how different facets of stigma and barriers to care might affect military subgroups. In one Bryan et al. study, Bryan et al. (2020) examined four subgroups of stigma and barriers to care: no stigma or barriers, mild stigma and barriers, moderate stigma and barriers, and high stigma and career concerns. Results showed that more than one of these subgroups showed significant differences concerning demographics, mental health conditions, and mental healthcare utilization. This shows that stigma and barriers to care are likely to be present across multiple subgroups of military servicemembers (Bryan et al., 2020; Sharp et al., 2015; Kim et al., 2010). Although little research has been done, it is, therefore, likely that stigma and barriers to care vary among the subgroups of the military.

Personal and Professional Impact

Britt et al. (2015) conducted a study of military personnel who screened positive for PTSD, received treatment in the past 12 months, but then subsequently dropped out. The researchers sought to understand stigma related to dropping out of treatment and included four types of stigmas: perceived stigma to career, stigma-differential treatment, stigmatizing perceptions of others, and self-stigma from seeking treatment. Results indicated that soldiers who screened positive for or reported having mental health symptoms scored higher on all types of

stigmas. Second, all stigmas were associated with treatment-seeking, but only stigma perceptions of others correlated with soldiers receiving treatment. This means that the soldiers receiving treatment were more concerned with what others thought of them due to their receiving treatment. Also, although they were aware of external stigma, this awareness did not cause dropout rates to increase. Lastly, career, differential, and perception stigmas were associated with dropping out of treatment, but self-stigma from seeking treatment was the only stigma that remained a unique correlate of treatment dropout. This means that dropout rates only increased because of self-stigma.

According to Dondanville et al. (2018), servicemembers tend to believe that, because of the associated stigma, admitting to a psychological problem instead of a medical problem has a greater chance of negatively affecting their career. Dondanville et al. found that after educating the military leaders, the participants' beliefs about the effectiveness of PTSD treatment increased and they had a greater awareness of where they could find treatment for themselves and their subordinates. The study also identified the three most significant barriers to soldiers receiving treatment: soldiers denying they have PTSD, the stigma of having PTSD, and soldiers having difficulty identifying PTSD symptoms.

When military personnel consider seeking treatment for mental health-related conditions, they also consider the effects the treatment will have on their careers. The stigma associated with mental health is often seen as a mark that will distinguish them from other servicemembers. In a study of 6,153 soldiers pre- and post-deployment to OEF-OIF, stigma-related concerns were consistently endorsed as a reason for not seeking help for mental health related conditions (Hoge et al., 2004, as cited in Brown & Bruce, 2016). Whereas 17% to 33% of OEF-OIF servicemembers meet the criteria for issues related to anxiety, alcohol, depression, and

interpersonal relationships, as few as 20% of those diagnosed seek help. These servicemembers would rather risk their mental health than possibly be stigmatized by others within their ranks (Brown & Bruce, 2016). Of these stigma-related concerns, career worry was the strongest predictor of an unwillingness to seek treatment (Brown & Bruce, 2014).

Combating Stigma

To destigmatize mental health issues, the military has attempted to frame mental health as analogous to physical injuries by using terms like *operational stress injury*. In one previous study, perceived stigma was identified as being greater in those with physical and psychiatric illnesses compared to someone with only a psychiatric illness. There was no significant association between mental health and enacted or felt stigma, which indicated that most participants did not associate their mental health with their illness. Moreover, the link between physical health and enacted stigma was stronger in military personnel than civilians. This association remained stronger even after adjusting for differences in sociodemographics, mental health, and severity of disabilities. The differences were greatest when physical health was poor and became closer as physical health improved (Frank et al., 2018). Servicemembers with both physical and psychiatric illnesses may identify a perceived failure as greater.

Britt et al. (2018) examined the effectiveness of unit training designed to boost the support of fellow soldiers for those servicemembers suffering from a mental health disorder. The training raised awareness of the importance of mental health treatment and when to seek treatment. Results showed significant bias toward mental health treatment being less good and less effective when compared with medical treatment. There was no significant difference in the evidence for bias between the soldiers who received the training and those that participated in the survey-only control. All participants who received the training reported favorable results. The

Britt et al. study showed positive preliminary evidence that a training program designed to teach supportive behaviors toward soldiers with mental health problems increases overall supportive behaviors. Whereas the study demonstrated an increase in overall supportive behavior, it did not find strong evidence of increases in the confidence that fellow soldiers would help those with mental health problems seek treatment nor of overall knowledge of mental health issues in the military.

Coleman et al. (2017) suggested that negative words associated with mental health can exacerbate an already fragile state of someone suffering from mental illness, whereas positive language can help to alleviate stigma. One reported method for overcoming stigma is to help individuals realize that negative beliefs about mental health conflicts with any positive changes that could result from seeking treatment. Further, stigma can be reduced through psychoeducation regarding PTSD symptoms at a societal level. Using the words "mad," "crazy," or stating that something is wrong with them carries a negative connotation that does not accurately reflect a mental health problem (Coleman et al., 2017).

Should an active-duty servicemember, veteran, or civilian overcome their initial stigma and seek treatment, it is crucial that there are evidence-based therapies available that can lessen the stigma associated with receiving mental healthcare. Whereas traditional therapies are useful in reducing symptoms associated with mental health conditions, subsequent research indicates that nontraditional approaches may further reduce associated stigma and make the client more receptive to care and more likely to return for future treatments.

Evidence-based Therapies

Prolonged exposure (PE) therapy is a trauma-focused treatment for PTSD that employs psychoeducation to combat mental health stigma (Reger et al., 2020). Although PE was not

initially developed for stigma-related intervention, the psychoeducational aspects of PE may benefit patients and decrease the effects of stigma by offering treatment that contrasts with the patient's negative beliefs, such as being incompetent or weak, which is one of the most prevalent stigmatizing stereotypes among military personnel (Goodwin et al., 2015, as cited in Reger et al., 2020). PE can help military personnel with negative self-stigma.

According to Murray et al. (2018), cognitive processing therapy (CPT) has been used to treat stigma associated with rape and its effects on sexual violence survivors. The most common form of stigma among sexual violence survivors is enacted stigma in husbands abandoning their wives and being shunned by their communities. CPT, an evidence-based psychotherapy designed for rape survivors, includes aspects of psychoeducation and cognitive restructuring. Murray et al. found that group-based CPT led to significant reductions in levels of trauma, depression, anxiety, and functional impairment for sexual violence survivors. Group CPT also yielded positive results on emotional support seeking, membership, and community participation. If group CPT has a significant impact on sexual violence survivors, it is possible group CPT could yield positive results in military servicemembers suffering from mental health stigma-related issues. Group CPT can help address issues through "its focus on cognitive reframing, reducing avoidance of trauma-related cues and social isolation, and specific emphasis on identifying and challenging maladaptive beliefs (such as self-blame and negative beliefs about self and others)" (Murray et al., 2018, para. 5). CPT can help overcome public and self-stigma.

Eye Movement Desensitization and Reprocessing (EMDR)

Whereas EMDR is not considered a new therapy, it is nevertheless seen as nontraditional and not offered by everyone. EMDR is an imaginal exposure therapy, which, in accordance with the adaptive processing model, identifies memories of negative experiences as a cause of mental

health problems (Shapiro & Forrest, 2016). Through EMDR, these memories can be rewritten by incorporating bilateral stimulation while taxing working memory. Bilateral stimulation is induced through eye movements, tapping, or auditory sounds. This method of inducing bilateral stimulation could be considered nontraditional because a retelling of the traumatic event is not needed to perform EMDR. Recall can be done by the client simply imagining the event and holding those memories in their mind. When incorporating bilateral stimulation during memory recall, resources dedicated to the imagery of the traumatic event are limited; thus, the memory becomes less vivid and emotional in future recall (Lenferink et al., 2017).

EMDR is supported by extensive research and is recognized as an effective treatment for trauma by organizations worldwide. In 2002, the Israeli National Council of Mental health identified EMDR as a preferred treatment for trauma victims affected by terrorism. In 2009, the International Society for Traumatic Stress Studies recognized EMDR effectiveness as being supported by research. In 2010, the VA created guidelines that established EMDR in the category of therapies with the highest level of evidence. It was then recommended as a premier treatment for PTSD. According to research, roughly 5 hours of EMDR therapy eliminates PTSD in 84% to 100% of civilians who have experienced traumas like rape, accidents, and disasters. Further research has shown a 77% to 80% elimination of PTSD in civilians with multiple-traumatic experiences with 8 to 12 hours of EMDR (Shapiro & Forrest, 2016).

EMDR combines the physiological and psychological mechanisms of healing, and it is a treatment that has impressed both patients and researchers: patients have reevaluated their views regarding health, healing, and the interaction of the body and mind. EMDR taps into a person's physiological system enabling them to allow their innate healing to take over. Moreover, patients

working through trauma using EMDR come to see their past suffering in relation to their whole

life (Shapiro & Forrest, 2016).

Combat Veterans

EMDR was first used with combat veterans, leading to the development of EMDR's

eight-phase approach. PTSD symptoms associated with combat and those of first responders

share many similarities. The psychological impact of combat has been well researched and

known for many years (Shapiro & Forrest, 2016). According to Shapiro and Forrest (2016), "The

trauma of combat got locked in their nervous system and was triggered almost daily by loud

sounds, recurring dreams, physical pain, and the daily pressures of life" (p. 44). This statement

illustrates the importance of a therapy designed to alleviate the symptoms of PTSD.

EMDR's Eight-Phase Approach

The eight-phase approach integrates aspects of psychodynamic, cognitive, behavioral,

and interactional therapies. The first phase of EMDR is gathering a thorough history of the client

and developing a treatment plan. Phase 2 is preparation. The importance of preparing a client for

EMDR cannot be overemphasized. Establishing trust is one of the most critical aspects of

preparing a client for EMDR. Whereas a client does not need to go into detail about the trauma,

if trust is not established, the client may be unwilling to be truthful about the severity of their

pain. Phase 3 of EMDR is assessment. During this phase, the client and therapist will establish

which areas of the traumatic event to target during treatment (Shapiro & Forrest, 2016).

Phase 4 is desensitization. During this phase, the client focuses on disturbing emotions

and sensations while they are measured on the Subjective Units of Distress (SUD) scale. The

changes to responses are evaluated as treatment progresses and until symptoms are eventually

resolved. Phase 5 of EMDR is installation. This phase requires the client to install positive

beliefs they now have about themselves concerning the traumatic event. These positive beliefs will replace the negative beliefs they have about themselves. The sixth phase is the body scan. The body scan is performed by asking the client to bring the traumatic memory to mind and identify bodily sensations they may be experiencing. These sensations will be noted for further reprocessing. Phase 7 of EMDR is closure. By properly closing a session, the therapist ensures the client leaves in a better state than they entered. The final stage of EMDR treatment is reevaluation. This phase takes place at the beginning of each new session, where the effectiveness of the last session is discussed. In essence, each subsequent session after the first one begins with Phase 8 and ends with Phase 7 (Shapiro & Forrest, 2016).

Animal-Assisted Therapy (AAT)

Another nontraditional therapy that may work for overcoming stigma associated with MHS is AAT. AAT has been widely associated with programs designed to target various pathologies and populations. Numerous studies have focused on the efficacy of AAT when treating dementia, depression, PTSD, and schizophrenia. Outcomes are generally influenced based on the degree of animal interaction (Charry-Sánchez et al., 2018).

The history of AAT can be traced back to Hippocrates prescribing horseback riding to treat insomnia. Further research has identified cases of AAT affecting individuals' heart rate, blood pressure, salivary cortisol, and prolonged survival following a heart attack. Therefore, there is ongoing research to study the efficacy of AAT to treat mental health disorders. Of the current research, dogs and horses are the most common animals used in therapies and it is recommended that both animal and therapist should receive extensive training. AAT can be done individually or in a group setting (Charry-Sánchez et al., 2018).

Psychoeducation

Whereas core therapeutic approaches are crucial for addressing mental health issues and for combating stigma, it is equally important, if not more so in some cases, to provide psychoeducation. It is vital that the client understands what is taking place due to trauma because it decreases internalized and perceived societal stigma. Normalizing viewpoints about mental health (Çapar Çiftçi & Kavak Budak, 2022) is why psychoeducation is often one of the first steps of the treatment process. Reger et al. (2020) noted, that psychoeducation is "a key feature of most . . . approaches . . . [and] involves providing accurate, normalizing, useful information about mental illness and recovery. Myth correction, through teaching facts about mental illness, is a common key component" (para. 2). Educating soldiers about the nature and effectiveness of treatment can go far in encouraging help-seeking behavior. Educating military leaders about the benefits of unit support and its effect on psychological health can also benefit enhanced unit support (Pietrzak et al., 2015). Drapalski et al. (2021) presented a study of a pilot randomized trial evaluating feasibility, acceptability, and preliminary outcomes of the Ending Self-Stigma for PTSD (ESS-P) program. ESS-P is a 9-session group intervention for veterans with diagnosed PTSD. Veterans learn tools and strategies for addressing various stigmas. Drapalski et al.'s results were similar to previous studies regarding the self-reporting of stigma. Servicemembers with diagnosed PTSD reported moderate-to-high levels of self-stigma compared to veterans with other mental health disorders.

This research is crucial because it identifies a potential tool that can be used to minimize the stigma associated with military mental health and treatment-seeking behavior. Symptom reduction was not the goal of the study when administering ESS-P. However, results showed that servicemembers who participated in the pilot program displayed a clinically and statistically

meaningful reduction in depressive symptoms (Drapalski et al., 2021). These findings show that psychoeducation can play a role in improving self-esteem and thus improve overall mental health.

Goode and Swift (2019) examined mental health stigma among active-duty servicemembers and veterans using an experimental design consisting of reading a vignette describing a veteran that did or did not have a mental health problem and did or did not seek psychotherapy. Findings showed that servicemembers held more negative attitudes toward other servicemembers experiencing a mental health problem than those receiving professional psychotherapy. Results showed a significant association between mental health concerns and beliefs that others would stigmatize those experiencing mental health problems. However, there was no significant interaction between mental health experience and treatment-seeking status. These findings demonstrate that words, such as "mental health," "illness," "disorder," and "problem" carry a negative connotation because individuals are not educated on what mental health truly is. The researchers concluded that normalizing mental health is the key to decreasing stigma.

Other Types of Interventions

Although efforts have been made to stem the growing problem of servicemembers seeking mental health treatments, there continues to be a problem with help-seeking behavior. A recent survey shows that only 21% of those screening positive for mental health problems were currently in treatment (Hong et al., 2021). This has caused the military to approach outreach in a different way. Approximately 76% of servicemembers use social media routinely (Hill et al., 2020, as cited in Hong et al., 2021). Social media campaigns have shown an increase in reaching hard-to-reach populations, which have demonstrated a willingness to remain in contact for up to

1 year following campaign exposure. Over 90% of U.S. adults aged 18 to 49 use a smartphone, with 47% using social media 6 or more hours weekly (Pew Research Center, 2019, as cited in Hong et al., 2021). The DOD is hoping that this type of exposure will lead to an increase in help-seeking behavior by reducing the stigma associated with mental health and raising awareness of a problem that affects everyone (Hong et al., 2021). Social media remains a valuable tool in combating stigma and mental health.

Warrior culture in the military values strength, resilience, courage, and personal sacrifice above all else. It is an elitist and superior mindset instilled from basic training throughout one's career. Clinical thinking and training use words such as "illness" and "disorder" when discussing and describing mental health. Therefore, the warrior identity of strength and elitism is at odds with clinical terminology and reinforces the disconnect between servicemembers and mental health professionals (Bryan & Morrow, 2011). Psychoeducation would be valuable in teaching servicemembers that a belief in warrior ethos does not mean sacrificing one's mental health.

The Defender's Edge (DEFED) program was designed and marketed as a performance enhancement program and not a mental health program. The DEFED program was also based on two primary principles:

> SF [Special Forces] personnel are inherently resilient and strong and already possess basic knowledge and skills to maintain psychological health and well-being, and combat should not be viewed as a risk factor but rather as an athletic event requiring high levels of physical and mental fitness and endurance (Bryan & Morrow, 2011).

The program was designed to incorporate skills training modules as educational and practice sessions and mental health integration through an assigned clinical psychologist. This psychologist is a member of the unit and participates in the full spectrum of unit activities. This

makes the psychologist visible and gains the trust of everyone (Bryan & Morrow, 2011). Trust is valuable in establishing newly formed programs and protocols.

The social norms approach is also used to specify messages that correct misperceptions about the prevalence and social approval of mental health behaviors (Hitt & Massi Lindsey, 2020). Identification and treatment of PTSD in its early stages is vital in decreasing comorbid conditions, and therefore it is crucial to reduce stigma in veterans with PTSD. A Dickstein et al. (2010) addressed three stigma-intervention strategies: protest, education, and contact. Protest is any strategy that aims to redress negative attitudes about mental illness. This strategy can be seen in advocacy groups that openly reject the negative portrayal of mental illness in film and television. Education is used to distribute accurate information and to correct misinformation about mental health and to challenge mental illness stereotypes. Contact is performed by engaging with individuals suffering from mental illness that hold implicit or explicit negative stereotypes. Contact is also used as a strategy to challenge their beliefs and reduce social distancing.

Further Research

The participants of a recent study were 94 undergraduate women at a small U.S. liberal arts college. This research is essential because of its positive frame: it is one of the only articles to discuss self-affirmation and values like family, friends, work, and humor as increasing resilience to self-destructive views on mental health. The researchers stated, "Not only does values affirmation increase self-reported state self-compassion above and beyond its effects on general mood, but it makes people treat themselves and others with more kindness" (Glazer et al., 2021, p. 2). The study results showed no association between perceived public stigma and any of the self-compassion measures. The help-seeking propensity subscale of the study was

positively associated with self-kindness and mindfulness (Glazer et al., 2021). The study's findings demonstrate that a positive self-identity and mindfulness can prevent stigma.

Hughes et al.'s (2020) conducted a study using participants from the general population. They sought to understand how psychological distance (the amount of time that has passed since the trauma) affects one's willingness to seek treatment. The results showed that the more time that has passed, the greater the chances are that one will seek treatment because internalized stigma will have been reduced. Although internalized stigma has been shown to act as a barrier to seeking treatment, some individuals seek help despite their concerns (Hughes et al., 2020). Hughes et al. cited past research that supported the conclusion that, "Indeed, individuals with high internalized stigma comprise a significant proportion of those in outpatient treatment (Picco et al., 2016; Ritsher & Phelan, 2004)" para. 3). This shows that stigma may play a role in an individual's help-seeking behavior based on the elapsed time since the occurrence of the traumatic event (Hughes et al., 2020). Thus, according to Hughes et al.'s study, the more time that passes following the trauma, the more likely the individual is to seek treatment.

Summary

Stigma has been identified as a major factor in creating an environment often hostile toward those suffering from mental illness and psychologically related disorders. Whereas many forms exist, stigma can be divided into self-stigma and public, anticipated, or perceived stigma, as well as any combination thereof. Moreover, whereas efforts have been made to destigmatize mental health and advances have been made in creating greater accessibility to mental healthcare, servicemembers are still reluctant to seek mental health treatment. This reluctance has led to a culture of mental health problems going untreated and an increase in mental health-related conditions, such as homelessness, drug and alcohol addiction, incarceration, family

violence, suicide, social isolation, discrimination, and an increased risk for victimization (Drapalski et al., 2021).

Further steps must be taken to address alternate means of combating stigma and reaching those servicemembers who continue to fear retaliation from military leaders and negative impacts to their careers. Whereas it is beneficial to treat the stigma once an individual has asked for help, it is of greater importance to provide psychoeducation related to mental health to address these issues beforehand. Until mental health has been destigmatized and is viewed the same as physical illness, it will be difficult to overcome.

CHAPTER THREE: METHODS

Overview

The purpose of this phenomenological study was to explore the lived experiences of Operations Iraqi (OIF) and Enduring Freedom (OEF) combat-era veterans who sought mental health treatment while on active duty. Their stories were thought to provide valuable insight into how they overcame the stigma of mental health in the military to seek help for their mental health issues. The study was designed to explore the stigma surrounding help-seeking behavior in the military and possibly provide commanders with a means to alleviate the stigma, making it easier for servicemembers to receive MHS while remaining on active duty or before separating from the military. Both interviews and a focus group were the main vehicles of data collection.

Design

This study used a phenomenological approach to qualitative research. Phenomenological research focuses on the commonalities among the research participants and their perceptions of the experienced phenomenon (Creswell & Poth, 2018). Because this study aimed to understand mental health stigma in the military and its effects on help-seeking behavior, a phenomenological study approach was deemed to be an appropriate fit for the study.

Participants

Research participants for this study consisted of 13 veterans currently receiving outpatient MHS. The only criterion for participation was that the servicemember sought MHS while on active duty following a combat deployment to OEF/OIF or a nondeployable support role in OEF/OIF. Therefore no one was excluded based on gender, age, rank at time of seeking MHS, or MOS at the time of seeking MHS.

Setting

Individual Interviews

The study took place in a setting allowing for privacy. Participants could choose the location in which they were interviewed. Locations available to those in Pittsburg, TX were a separate room at the local American Legion Chapter building or a room in the Texarkana VA Clinic or Shreveport VA Hospital. A private Zoom call was also offered to all. The Shreveport VA hospital provides primary medical care and specialty health services, including mental health, women's health services, kidney care, dialysis, dental and vision services, treatment for spinal cord injury, prosthetics, polytrauma care, and more (VA.gov, 2022). The Texarkana clinic is a specialty outpatient clinic primarily serving veterans' mental healthcare needs in northeast TX. It specializes in psychotropic medication management, as well as group and individual therapy. The VA healthcare system has multiple outpatient clinics throughout northeast TX and northwest LA that, with prior approval, may be used to host interviews if they are closer to the participant's home. Because the VA was not used in an official capacity for determining participation in the study, VA IRB approval was not needed.

Focus Group Interviews

The focus group took place over a group videoconference. Some participants wished to not be involved in the live videoconference, yet still wanted to provide feedback about the study. These participants were given questions to answer and return to the researcher via email. This method was primarily for the two participants located overseas at the time of the study. Because of the time difference, they were unable to meet at the same time as the rest of the group.

Research Questions

This study was a hermeneutical phenomenological qualitative study grounded in social constructivist theory.

Central Research Question

How do active-duty servicemembers describe their experiences of overcoming mental health stigma to seek MHS?"

Research Sub-Questions

1. "How do active-duty servicemembers first identify a mental health issue is present?"

2. "How do active-duty servicemembers describe their experiences with mental health stigma in the military?"

3. "How do active-duty servicemembers describe their experiences following their decision to seek MHS?"

4. "How do active-duty servicemembers describe the outcome of their decision to seek MHS?"

Instrumentation

Inclusion Criteria Questionnaire

Criterion sampling was performed through a questionnaire for study qualification. The only criterion for participation was that the servicemember sought MHS while on active duty following a combat deployment to OEF/OIF or a nondeployable support role of OEF/OIF.

Demographic Questionnaire

A demographic questionnaire was administered by the researcher upon speaking with the participant and having them agree to the study.

Individual Interviews

All interviews were semi-structured and used the interview questions as a guide to the gathering of needed information. The questions were designed to achieve the study's goal by eliciting responses regarding those areas deemed most important to the study. These were not yes or no questions, rather they were designed to keep the participant on the relevant topic of mental health stigma in the military. The interview questions are as follows:

1. When did you first identify that you had a mental health problem?

This question was used to identify a timeframe for when the participant first identified he or she had a mental health problem. It allowed for a deeper understanding of what was taking place in the life of the participant when the mental health problem first manifested.

2. How did you react to identifying you had a mental health problem?

This question was designed to explore the mindset of the participants when they first identified a mental health problem existed.

3. How did mental health stigma in the military affect your decision to seek MHS?

This question was designed to allow the participant to share the effects of stigma in their decision-making process and provide valuable insight into ways of overcoming stigma.

4. What steps did you take to negate mental health stigma in the military when you decided to seek MHS?

This question was designed to invite the participant to further explain how they overcame stigma when deciding to seek mental health. It was aimed to gather information on ways participants combat stigma.

5. What effect did your decision to seek MHS have on your career?

This question was designed to allow the participants to evaluate the outcomes of their

decision to seek mental health treatment while on military active duty.

Focus Group

After individual interviews had been completed, a voluntary focus group was held at a scheduled time to discuss the experience of participating in this study, as well as any discussion they wanted to have about their experiences with stigma in the military. The focus group was voluntary and allowed the participants to interact with one another and ask the researcher questions. The focus group was scheduled for 90 minutes in length and began with relevant questions offered by the group leader. After everyone had time to answer the questions, the group was opened for discussion. Interaction and feedback from group members was encouraged.

The focus group began by the researcher asking the volunteers if there was anything related to the interview questions that they would like to add. This took place by asking each question one more time and allowing time for responses. When this was completed, a series of focus group questions were asked. These questions were as follows:

1. "How was your experience with the study?"

2. "How did you feel about the questions being asked?"

3. "Do you have any further information you would like to add or share with the group?"

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Trustworthiness of the Study

</div>

Reflexivity is the process of a researcher conveying their background and how it influences the information gathered in the study. It is also a means of conveying what the researcher hopes to gain from the study (Creswell & Poth, 2018). Reflexivity increases the reliability of the study because the researcher is transparent about the types of influences that could affect the results of the study if they are not made clear before the data are collected and

intentionally managed. The researcher's background indicates he had a personal interest in the topic being discussed. In the case of this study, the background is also a positive attribute because participants could relate to the researcher by knowing the researcher has also experienced the phenomenon of military mental health stigma.

The implementation of good-quality recording devices and transcription of digital files was used throughout data collection and analysis. Transcription is essential to establishing an accurate account of the participants' responses and determining common themes. An audit trail is a method of digital memoing throughout the data collection and data analysis process. Audit trails are essential because they can be retrieved, examined, and used as a validation strategy for documenting the researcher's thoughts throughout the study (Creswell & Poth, 2018). These methods ensure trustworthiness throughout the study.

Procedure

After obtaining approval of Liberty University's Institutional Review Board (Appendix A), the researcher began recruiting participants for the study. These volunteers were found through interaction with veteran members of the American Legion and by networking with other veterans to identify participants. Potential participants contacted this researcher and were screened to determine whether they met the criteria for participation. Once eligibility to participate was established, the researcher forwarded the consent form (Appendix B) and scheduled the participant for the interview. Data were first gathered through a demographic questionnaire filled out by the researcher after speaking with the participant. Interviews were unstructured yet had questions designed to keep the recorded interview aligned with the study (Appendix C). Interviews lasted between 30 and 60 minutes.

Participants who attended the focus group discussed their experiences with military

mental health treatment or discussed the study. Participants who could not attend received

questions through email and returned them to the researcher. This was also the time when

participants received their gift cards to compensate and thank them for their time and willingness

to contribute to the study.

Data Analysis Procedures

Upon completing the interview, the recordings were played back and transcribed

verbatim into written format. Transcribing allows the researcher to read and memo emerging

ideas within participants' interviews. The researcher used identifiable codes, applied said codes,

and reduced codes to themes (Creswell & Poth, 2018). Coding allows the researcher to "make

sense of the text collected from interviews, observations, and documents" (Creswell & Poth,

2018, p. 190). It is vital to build detailed descriptions, apply codes, develop themes, and provide

interpretation without the undue influence of personal views or perspectives (Creswell & Poth,

2018).

CHAPTER FOUR: RESULTS

In this chapter, the results of the study are reported. A description of participant demographic is provided, along with an introduction to individual participants. The researcher will elaborate on themes that emerged during an analysis of responses to the individual interview questions, provide a reflexive self-analysis, and present the findings from the focus group.

Demographics and Participant Introductions

Thirteen OEF/OIF veterans were interviewed as participants in this study. Recruitment for the study proved difficult throughout data collection. Many Vietnam Era veterans were interested in the study but did not meet the criteria of having served post 9/11. Several potential participants were interested in the study but when they were asked about signing a consent form, they became hesitant about signing their name to a document and decided to not schedule an interview. Whatever the reason, the researcher thanked them for their time and respected their wishes to not participate. Because recruitment was taking longer than expected, the researcher spoke with his chair about alternate methods of participant outreach. Despite being informed of possible participants, the American Legion in the researchers' hometown did not have any veterans who met the criteria for the study. However, the post chaplain did know of a retired sergeant major who works with servicemembers suffering from PTSD. Through this individual, a word-of-mouth chain was started that resulted in finding over half of the needed participants for the study. The other half of the participants came from a social media post that garnered positive results.

All participants signed consent forms and completed the interview process through videoconference, via Zoom, or over the phone because of individual residential locations and access to Internet services. Interviews took place during February, March, April, and May of

2023. Demographic information was obtained through a short demographic questionnaire and was also discussed during the beginning of the individual interviews. Ten of the 13 participants lived within the continental United States. At the time of the interview, participants' ages ranged from early 30s to 72-years-old. Demographic information is presented in Table 1. Participants' age at the time of their first mental health visit is used in the table, and these ranged from 20 to 56-years-old. In the end, a diverse range of individuals regarding branch of service, enlisted and commissioned rank, and combat military occupational specialties participated. Participants were from the Army, Air Force, Navy, and Marine Corps.

Table 1

Demographic Information

Pseudonym	Gender	Age at time of MHS in years	Rank at time of MHS	MOS	Branch of Service
Alpha	Male	54	O4 – Major	56A – Chaplain	Army
Bravo	Male	32	E4 – Corporal	68W – Combat Medic	Navy/Army
Charlie	Male	21	E4 – Petty Officer Third Class	ET – Electronics Technician	Navy
Delta	Female	30	E5 – Staff Sergeant	4Y – Dental Assistant	Air Force
Echo	Female	32	E5 – Staff Sergeant	3D – Cyberspace Support	Air Force
Foxtrot	Male	34	CW3 – Chief Warrant Officer 3	153A – Rotary Wing Aviator	Army
Golf	Male	24	E4 – Specialist	35P – Crypto Linguist	Army
Hotel	Male	31	O3 – Captain	13A – Field Artillery Officer	Army
India	Female	23	E4 – Senior Airman	4A – Medical Supply Tech	Air Force
Juliet	Male	30	E7 – Sergeant First Class	33W – Electronic Warfare Maintenance Technician	Army
Kilo	Male	23	E5 – Sergeant	19K – Armor Crewman	Army
Lima	Male	20	E3 – Private First Class	94E – Comms Security and Radio Repair	Army
Mike	Male	34	E7 – Gunnery Sergeant	2336 – Explosive Ordnance Disposal	Marine Corps

Alpha

  Participant "Alpha" is a male who at the time of the interview was 72 years old. He is a

retired U.S. Army Chaplain. Alpha sustained a TBI while deployed to a combat zone, and the

TBI followed five separate concussions. At each hospital, Alpha was treated as though his

condition was more minimal than it was. Eventually the military sought to ignore the injury and

discharge a lieutenant colonel (LTC) with 18 years of service as a failure to conform to military

life. Circumstances changed when Alpha began having seizures because of the TBI. Alpha chose

to share his story to bring awareness that mental health affects every rank, and the military

sometimes tries to ignore it.

Bravo

  Participant "Bravo" was 41-year-old at the time of the study. Bravo's mental health

problems began while he was a combat medic stationed in Germany. He was part of a unit that

oversaw offloading dead bodies as well as severely injured servicemembers to the local hospital.

The more exposure Bravo had to the physical horrors of wartime, the more his mental state

began to deteriorate. Bravo eventually suffered a broken back and neck, which compounded his

mental health problems. Bravo wanted to share his story hoping that others learn from where he

chose poorly and wisely regarding his mental health.

Charlie

  Participant "Charlie" is a male who was 32-years-old at the time of the study. He served

in the U.S. Navy as an electronics technician, and he first noticed signs of mental-health-related

issues in middle school. Charlie has since left the Navy and pursued a career in business

management. At the time of the interview, Charlie was not seeing a mental health professional

but was waiting on his insurance to approve a mental health consult. Charlie agreed to discuss

his experiences because he wished that his leadership in the Navy would have supported him by receiving the care he needed.

Delta

Participant "Delta" is a female who was 52-year-old at the time of the study. She is a retired Air Force master sergeant. Delta spent 20 years in the Air Force as a dental assistant and first sought mental health treatment for her son when he was having difficulty managing his attention deficit and hyperactive disorder (ADHD). She later noticed herself becoming overwhelmed by the constant effects of military life. Delta and her husband were both military servicemembers and they were stationed overseas while raising two children. Delta was also the supervisor of a dental clinic and needed mental health services to teach her some coping methods to better handle the stressors she was facing. Delta wanted to share her story to show that not all stories involving mental health and the military are negative.

Echo

Participant "Echo" is a female who was 56-year-old at the time of the interview. She is a retired Air Force chief master sergeant who worked in cyberspace support. Echo sought mental health services as an E5 junior NCO. Echo was turned away from military MHS. They believed she did not have a mental health problem. Echo sought care through primary care physician, who subsequently prescribed an antidepressant. As her career continued, Echo realized she needed more than medication and sought talk therapy when she was at the rank of E8. Her therapy, which was psychodynamic, lasted for 3 or 4 months, and Echo learned tasks to help her cope with depression. This therapy, combined with a new medication, provided Echo with the care she needed. Her positive experience lasted until she was stationed with the Army at the rank of E9. MHS was highly discouraged in this military unit, and the doctors encouraged Echo to hide the

reason for her medication. The doctors wrote in her records that she was taking her medication for smoking cessation. Echo wanted to share her story to show that experiences can be positive and negative and that, in her experience, the military will go out of its way to avoid labeling something mental health.

Foxtrot

Participant "Foxtrot" is a male who was 52-years-old at the time of the study. He is a retired chief warrant officer 4 (CW4) AH-64D Apache helicopter pilot. Foxtrot first noticed signs of a mental health problem while deployed to Iraq in 2007. Although his best friend saw what was happening, Foxtrot chose to not seek help until 2015, after an incident in Afghanistan where he almost took his own life. Foxtrot confided in his commanding officer what happened with respect to the incident and requested a referral to mental health. Foxtrot said he did this to "check the box" but still elected to not disclose the severity of his situation. Foxtrot stated that he would have gone sooner if he knew how difficult it would be to battle his own mental health and if he had known that he was not alone in feeling the way felt. He stated he realized that mental health problems are more common than anyone thinks. Foxtrot chose to share his story to illustrate the importance of seeking MHS when signs of mental health problems first arise.

Golf

Participant "Golf" is a male who was 39-years-old at the time of his interview. He is a medically retired Army sergeant. He served as a Chinese Mandarin linguist and deployed to Iraq shortly before discharging from the military. Golf recalled becoming aware of feelings of depression, anxiety, and a lack of satisfaction in his life during his early 20s. Upon entering the military and arriving at his first duty station following advanced individual training (AIT), he was given a personal health assessment. The reviewer suggested that Golf speak with a

counselor. This was not a mandate, but Golf saw it as an opportunity to share his feelings. Golf

continued to speak with the counselor before his deployment. His deployment was delayed

because the rear detachment commander of Golf's new unit was receiving information from the

mental health unit and supplying details of his treatment to the unit in Iraq. Golf was motivated

to share his story because it demonstrates that a breach of trust and confidentiality can cause

problems for those seeking help.

Hotel

Participant "Hotel" is a male who was 43-years-old at the time of the study. He is a

lieutenant colonel (LTC) in the U.S. Army, currently on active duty as a foreign affairs officer

(FAO). Hotel first became aware of his mental health problems in 2007 when his wife noticed

anger issues and erratic behavior. Hotel saw a brigade mental health representative that worked

outside of a formal mental health clinic and received information that helped him learn to

recognize stress and anger. Stress and anger eventually led Hotel to develop an eating disorder

that he still struggles with today. Hotel shared many stories involving the stigma of mental health

and how judging someone without knowing all the details can lead one to falsely label someone

with a mental health disorder. Hotel wanted to share his story because it shows that being honest

about a mental health disorder can benefit someone seeking mental health treatment and that

leaders will understand that sometimes they must look beyond what they see on the surface.

India

Participant "India" is a female who was 55-years-old at the time she was interviewed for

this study. She is a retired Air Force master sergeant who worked as a medical supply technician.

India first sought mental health for marriage counseling after her husband had discussed divorce

for several months. She decided to go to marriage counseling without her chain-of-command

knowing. India wanted to keep it quiet because it was a personal matter. After transferring to an overseas unit, her husband filed for divorce, and India became a divorced, single mother in a foreign country. When she brought her concerns to her new supervisor, he asked her if she needed to see a mental health professional. Her supervisor asked this in such a way that India feared seeing that seeing a mental health practitioner at this time would have a negative impact on her career. She decided to not seek out mental healthcare at this time. India wanted to share her story to make people aware that perceptions of mental health from leadership can affect one's decision to get the help they need.

Juliet

Participant "Juliet" is a male who was 45-years-old at the time of the study. He is a sergeant major in the U.S. Army National Guard currently working as an electronic warfare maintenance technician noncommissioned officer in charge (NCOIC). He sought mental health services when he was a sergeant first class (SFC) serving with a unit assigned to Joint Special Operations Command (JSOC). Juliet has deployed several times with the JSOC unit for periods of 4 and 6 months. During this time, his wife was having an affair, which was creating undue stress on Juliet. He decided to speak with a mental health specialist assigned to his unit and discuss ways of coping. Eventually, Juliet was sitting at his home with a pistol placed against his head and decided he needed to speak with a mental health professional again and make changes to his career. Those changes meant leaving JSOC. Juliet wanted to share his story to raise awareness of the necessity of making changes when one sees that their current situation is affecting their mental health.

Kilo

Participant "Kilo" is a male who was 40-year-old at the time of the study. He is an SFC currently serving in the Army National Guard as a human intelligence data collector. Kilo first became aware of his issues with mental health in 2006, after surviving an improvised explosive device (IED) blast in Iraq. Kilo started his military career as a tanker before transitioning to a career in military intelligence. When Kilo deployed as a senior NCO, he was responsible for over 100 soldiers. Kilo experienced the loss of several soldiers due to suicide and their being killed in action. The soldiers dying from suicide began to take a toll on Kilo's mental health. Kilo was already suffering from PTSD and a TBI. Kilo sought out mental healthcare to learn how to cope with these deaths and this resulted in a behavioral health profile that prevented him from advancing in his career. Kilo wanted to share his story to show how leadership can fail soldiers and how even through mental health can sometimes negatively impact a career, it is worth pursuing.

Lima

Participant "Lima" is a male who was 31-years-old at the time of the study. He served in the Army as a communications security and radio repair technician until 2014 when he chose to get out of the military as a specialist. Lima first experienced mental health related symptoms when he blacked out during the run portion of the Army Physical Fitness Test (APFT). Lima was treated by the company medics and then sent to see a primary care physician. The primary care physician determined there was nothing physically wrong with Lima and suggested he see a mental health professional. Several days passed while Lima built up the courage to see the mental health professional. When he did, he was told he had stress- and anxiety-related issues. Lima continued receiving MHS while serving on a base in TX but had trouble when he

transferred duty stations to Korea. His troubles in Korea eventually lead to his spending several days in an inpatient care clinic. Lima wanted to share his story to demonstrate how a supportive chain-of-command can enhance or hinder the care a servicemember receives.

Mike

Participant "Mike" is a male who was age 39 at the time of the study. He is a retired Marine Corps explosive ordnance disposal (EOD) technician who reached the rank of gunnery sergeant. Mike began experiencing problems with his weight late in his career. He was told to seek services at the TBI clinic and check on his testosterone levels because of a TBI he had suffered during a combat deployment. Mike found his levels to be low and began testosterone treatments, as well as counseling. Mike's counselling was interrupted several times because of combat deployments and each time he returned, his mental health had deteriorated further than before the deployment. Mike made the difficult decision to place his mental health before his career. He knew he would be persecuted for his decision, but he knew this was best for him and his family. Mike also wanted to be an example for his fellow Marines, showing that mental health is important. He made a point to protect the Marines below him from any persecution they may face from taking care of their mental health. Mike wanted to share his story to show the importance of making an early decision to seek mental health and not wait until it begins affecting your home life and career.

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Clusters of Meaning

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Upon completion of the participant interviews and conducting bracketing, horizontalization, and clusters of meaning, the researcher identified common themes. This section presents the results of horizontalization and clusters of meaning. Bracketing is setting aside one's personal perspective to avoid biasing the results. Horizontalization is developing data

from the first and second research questions, including significant statements that provide insight in the participants lived experiences, and continuing through data analysis. Clusters of meaning is another name for developing significant statements into themes used in phenomenological research (Creswell & Poth, 2018).

Negative Experiences

A negative experience is described as anything that caused the participant to question their need to seek mental health services while in the military. Each of the following experiences occurred at least once during the 13 interviews.

Personal Struggle

In this code, participants recounted recurring feelings of fighting with oneself regarding the choice to seek or not to seek MHS.

Distrust of Leadership

In this code, participants struggled with distrust of an individual, chain-of-command, or the entire military.

Denial

Participants recounted experiencing denial with respect to their suffering from a mental health disorder.

Initial Negative Experience

Participant discussed being weary of mental health treatment after initially having a negative experience the first time they sought MHS.

Fear of Looking Weak

Participants recounted feelings of being afraid that others would perceive them as weak given that the military teaches that servicemembers are supposed to be resilient and not let things bother them.

Lack of Knowledge about Mental Health Treatment

Participants expressed the fear of seeking MHS because of a lack of knowledge or skewed understanding of what takes place during treatment.

Being Treated Differently

Participants also recalled having the perception of being treated differently than others in their unit.

Betrayal

Participants recounted feeling betrayed by the confidence they placed in another.

Persecuted for Needing Mental Health Treatment

Participants also expressed the feeling or the reality of suffering negative consequences because they were receiving mental health treatment.

Overcoming Stigma

In this study, an experience of overcoming stigma was any event that occurred that made it easier for the participant to choose to seek mental health treatment while in the military. Each of the following experiences occurred at least once during the 13 interviews.

Realization that Professional Help is Needed

Participants understood that the mental health problem they were having was beyond their control, whether through self-realization or being told by another individual.

Personal Growth

Participants also discussed having experiences of personal growth, which they defined as putting aside their fears and apprehensions and realizing that seeking mental health treatment was more important than their reasons for not seeking treatment.

Connecting with Others

They also recounted that they decided to seek mental health treatment through interactions they had with other people.

Coverup

Participants discussed not disclosing the reason for seeking MHS or hiding the fact that they were seeing a mental health professional.

Trust

This theme consisted of placing enough trust in someone that one discusses their mental health problems.

Courage

Participants recounted having the courage to seek MHS without influence from another.

Encouragement

They also discussed receiving encouragement from others to seek MHS.

Addressing the Effects of the Problem and not the Source

Some participants also discussed seeking MHS but not discussing the cause of the mental health problem.

Individual Analyses

Alpha

Alpha's Overall Experience and Contribution to Themes

Participant Alpha suffered multiple head injuries during his time in Iraq. When asked about his first experience with mental health in the military, he recalled,

It was in, uh, let's see. It was in August of 2005. I had been in my fifth or sixth explosion and, um, my sergeant first class came up to me and said, "Sir, you need to go home." I said, "I'm fine. What are you talking about?" He says, "Sir, you need to go home." I again said, "I'm fine. What are you talking about?" He then said, "Sir, what day is it?" "I don't know." "What month is it?" "I don't know." I kept telling him I was fine. So, then our battalion surgeon came by my office, and he saw that I had pictures of my kids and he said, "Are these your kids?" I said, "Yeah." He asked, "What are their names?" (crying) "I don't know." He immediately sent me to neuropsychiatry. We had one in Iraq at the time. He said, "We gotta get you home."

Upon leaving Iraq, the military did not take Alpha's injury seriously until he suffered a stroke approximately 5 days after his latest head trauma. He stated,

When I was brought back the second time I was wounded, and I was medevacked. When I arrived in [REDACTED], I was a moderate traumatic brain injury. That was one step above a mild TBI. When I got to [REDACTED], I was labeled a PTSD patient. When I got to [REDACTED], they walked me into a room, and, um, said, "We're going to discharge you because of your failure to adjust to military life." I was a field-grade officer with 18 years of service.

When Alpha received a promotion to Lieutenant Colonel, the military refused to promote him because he was on medical hold. When asked if he believed this was directly related to his time in MHS, Alpha stated,

> Absolutely! I was promoted to Lieutenant Colonel while I was on medical hold at [REDACTED], and they refused to promote me, because they said, "You cannot be promoted to while you're a patient and on medical hold." The promotion date was prior to the date I went on medical hold or what they called the Wounded Warrior program, and, um, so my promotion was postponed by about a year. That's a lot of active duty pay but that's also, um, time ticking by on your next promotion.

Alpha was also passed over for his promotion to Colonel and discharged from the military 1 day before he would have been a Colonel. He would later be promoted to Colonel in the [REDACTED] State Guard. He recalled,

> I received a 4-year waiver from the Pentagon to stay and counsel because I was working at the resiliency center, and I was working with wounded soldiers in the reset program and reorientation. I had three offices at [REDACTED], and they called me in and said, "We are discharging you." My discharge date was one day before I made Colonel. The base commander called me and another chaplain in, whom I was very close with, and said, "I can only give a promotion to one of you." He told me I had earned it, but he was giving it to my buddy. I think that was directly related to my health issues with mental health.

When Alpha was asked if he believed his time spent receiving MHS from the Wounded Warrior program had anything to do with his not being promoted, he stated,

I think it had a lot to do with my not making Colonel. I also did not get assignments that I should have gotten. I stayed for 5 years with my last commander because he knew me and knew I did a good job. However, I was placed in the Wounded Warrior program for my final year after they told me they were discharging me. I know that even though the Chief of Chaplains gave me a 4-year extension, that, um, I think the medical and mental health issues cut that in two. I had finished all of Command and General Staff College and they still wouldn't promote me.

While at the Wounded Warrior campus, he saw how stigmatizing it was to be there with individuals who were suffering from substance use disorders, and he often felt like people assumed he was an abuser as well. Alpha shared,

The downside of that was, for example, at one time we had 135 soldiers in the Wounded Warrior campus. There were two of us, my assistant and I, that were physically wounded. There were 133 that were there for drug or alcohol problems. There was a huge stigma there that you obviously are an abuser. You're abusing drugs or alcohol. That's what got me. There was that stigma, that you as a person receiving mental health had gotten into trouble, rather than trouble came looking for you and, um, you're trying to fight your way back from it. So, that was a big challenge.

Regardless of the outcomes he endured due to choosing to seek MHS, Alpha said that he would make the same choice again regarding mental health. He expressed the hope that his story would benefit servicemembers and help to destigmatize mental health in the military. Statements from Alpha's interview that highlight the themes of his experience with military mental health stigma are in Table 2.

Table 2

Thematic Abstraction of Alpha's Experience

Theme	Participant Statement
Personal struggle	"I said, 'I'm fine. What are you talking about?' He says, 'Sir, you need to go home.' I again said, 'I'm fine. What are you talking about?' He then said, 'Sir, what day is it?' 'I don't know.' 'What month is it?' 'I don't know.' I kept telling him I was fine."
Distrust of leadership	"Um, chaplain privacy is totally sacrosanct, except within your chain of command of chaplains. So, if I go to a chaplain who is in my chain of command and tell him I'm having a problem relating to the world, I do not have privacy. I'm not guaranteed privacy, so I have to go to a fellow chaplain in another unit or, um, go outside the military."
Denial	"I wouldn't admit that I was having problems in my head, so to speak. I obviously was something that, um, it was just a problem with the pain I had. So, I'd be like saying to myself, 'Look. You're okay. You just haven't been able to sleep. As soon as we can get the pain gone, you'll be okay again.'"
Being treated differently	"When I was brought back the second time I was wounded and I was medevacked; when I arrived in [REDACTED], I was a moderate traumatic brain injury. That was one step above a mild TBI. When I got to [REDACTED], I was labeled a PTSD patient. When I got to [REDACTED], they walked me into a room, and, um, said, 'We're going to discharge you because of your failure to adjust to military life.' I was a field-grade officer with 18 years of service."
	"The base commander called me and another chaplain in, whom I was very close with, and said, 'I can only give a promotion to one of you.' He told me I had earned it, but he was giving it to my buddy. I think that was directly related to my health issues with mental health.
	"That's what got me. There was that stigma, that you as a person receiving mental health had gotten into trouble, rather than trouble came looking for you and, um, you're trying to fight your way back from it. So, that was a big challenge."
Persecuted for needing mental health treatment	"I think it had a lot to do with my not making Colonel. I also did not get assignments that I should have gotten. I had finished all of Command and General Staff College and they still wouldn't promote me."

Steps to Mitigate Stigma

Chaplains are sometimes seen as mental health professionals because they handle many of the emotional and spiritual issues in a military unit. They provide counseling to many servicemembers that do not want to go to MHS. Therefore, this was an unusual situation for Alpha. When asked about how he handled this situation, Alpha recalled,

Well, that's a tricky one. Um, because I was basically seen as a mental health professional myself. So, people were used to seeing me in the department because I was there all the time. I was often called to the psychiatry department. However, they weren't used to seeing me on the other side of the counter, and I wasn't used to being there as well, on the intake side. So, it was, you know, saying, "Okay. I gotta swallow some pride, and also, I have a lot to learn. I can learn through this." I kept thinking, not only is this for me, but I can share this with other people. I think that . . . knowing I can carry this on through my ministry, um, was kind of a motivation.

Alpha also saw his time with MHS services as a chance to grow as a professional. He would learn the counseling techniques that were used to help him and then use them when helping others. He also gained the trust of individuals by having gone through MHS. Alpha recalls,

I had times where it was because people knew I had had troubles, it was hard for them to take me seriously, but other times other people took me very seriously exactly because they knew I had troubles. The more I learned about resilience, and the more I taught it, the higher the trust level went. People would say, 'You've been to hell and back.' I would say, 'Yep.' Especially when I would start seeing guys who were on their third and fourth deployments.

Statements from Alpha's interview that highlight the themes of his experience with overcoming stigma are in Table 3.

Table 3

Thematic Abstraction of Alpha Overcoming Stigma

Theme	Participant Statement
Personal growth	"So, it was, you know, saying, 'Okay. I gotta swallow some pride, and also, I have a lot to learn. I can learn through this.' I kept thinking, not only is this for me, but I can share this with other people. I think that was, knowing I can carry this on through my ministry, um, was kind of a motivation."
Connecting with others	"I had times where it was because people knew I had had troubles, it was hard for them to take me seriously, but other times other people took me very seriously exactly because they knew I had troubles. The more I learned about resilience, and the more I taught it, the higher the trust level went."

Bravo

Bravo's Overall Experience and Contribution to Themes

Participant Bravo began his military career in the U.S. Navy where he first noticed signs of depression from being relegated to spending intended amounts of time in a submarine. He decided to leave the Navy and join the U.S. Army as a combat medic. Bravo's first assignment sent him to [REDACTED], where he was part of a detail responsible for removing dead bodies, as well as severely wounded servicemembers and transporting them to their assigned locations within the airbase. This assignment took a heavy toll on Bravo and eventually caused turmoil in his marriage and family dynamic, leading to his decision to enter counseling. Bravo recalled,

It was 2012, around wintertime. It was right before Christmas. It was a couple of months after I finished offloading the bodies. Actually, more like 6 months to 1 year after that, um, that all of this started happening. Like I said, there was a change in my marriage. I originally went for my marriage, for marriage counseling. Moreso than anybody else

talking to me because I just got salty. I was like, "Whatever. It's just dead bodies. It's not me. I'm six feet above. They're six feet below."

Bravo continued having trouble with mental health and eventually decided to seek help for problems with anger. The civilian mental health professional that saw Bravo tried to find the underlying cause even though Bravo did not understand what was troubling him. He stated,

> The civilian lady that was there tried to identify it with me, and she asked me what she wanted me to do. She asked me if I wanted her to label it what it was, or if I wanted to stay in the military and have my career. She asked me which one I wanted it labeled as and how we would go about dealing with it. I told her, "I want to stay in the military. I know this. This is what I do. I'm proud to serve my country. I'm good at my job." She said, "Okay." I was then labeled as having an adjustment disorder. I was also labeled with depression.

Bravo continued seeing a mental health professional under the guise of marriage counseling for fear of what would happen to him if he was labeled as having a mental health problem. He recalled,

> I thought I was immediately going to be labeled a shitbag because they would pull your weapons card. They would pull you from anything. The secret clearance that I had would be pulled. I wouldn't be allowed in the hospital. I'd be pretty much wrapped up in a I-hug-me jacket in a looney bin. That's pretty much what I thought of it as, for mental health. She tried to help me out because it was my decision if I wanted to stay in and not have any repercussions and not have my clearance taken away. It seems the military gives you an ultimatum of seeing [a] mental health [practitioner] and having your career ruined

or ignoring it and staying in. I also asked the therapist to label it as marriage counseling instead of what it really was.

When asked if his choice to seek help for his mental health had a negative effect on his career, Bravo stated,

Well, by the time I was seeking mental healthcare I had already broken my back and my neck. I was pretty much at the point where I didn't feel like I could trust anyone. I think they just ignored it because I was already getting discharged for my injuries.

When Bravo was asked if would have done anything differently. He stated,

I think I would've done it completely different, so I wouldn't have caused pain to the one's I love. I would've gone in there and been stuck up the counselor's butt saying, "Hey. This is what's going on today. Help me get through this. What do I need to do to get through this? Is there some program you can recommend?"

Statements from Bravo's interview that highlight the themes of his experience with military mental health stigma are presented in Table 4.

Table 4

Thematic Abstraction of Bravo's Experience

Theme	Participant Statement
Personal struggle	"I was in [REDACTED]. I'm loading bodies. Some of them were just mangled; some of them were, you know, still talking and mangled. It just went downhill from there. Then, um, it was really when it started effecting my marriage and my family life that I realized I had anger issues."
Distrust of leadership	"Are you freaking kidding me? There're people over there yelling and screaming about bullshit and you're saying I have a mental health problem. No thank you! You're trying to take away my weapon, my qualifications, my worthwhile to my unit. So, I'm not gonna have that!"
Denial	"I was like, 'Whatever. It's just dead bodies. It's not me. I'm six feet above. They're six feet below.'" "I'm trying to 'Yeah, okay. Okay. I'm not crazy. I haven't shot anybody. I haven't done shit wrong! I just have a shit attitude because I hate dealing with bullshit.' I kind of laughed it off."
Lack of knowledge about mental health treatment	"I thought I was immediately going to be labeled a shitbag because they would pull your weapons card. They would pull you from anything. The secret clearance that I had would be pulled. I wouldn't be allowed in the hospital. I'd be pretty much wrapped up in a I-hug-me jacket in a looney bin. That's pretty much what I thought of it as, for mental health."
Being treated differently	"That's what I thought would happen if I told them, 'Hey look, this is what's been going on.' I thought they would say, 'You have to go to an inpatient facility, we're taking everything from you, you can't see your wife and kids, you can't work in your unit anymore, and you will be a non-useful body to us. Thanks.'"
Betrayal	"Ever since then, relationships have just been almost like, I don't know. It's hard to form a relationship and it's hard to trust somebody. Then when you do trust them . . . it's almost like it's too much for them and they leave. What I've learned is that those that love you, leave you."

Steps to Mitigate Stigma

Bravo chose to address the cause of his mental health issues and instead focus on his anger, depression, and anxiety. He stated,

Well, I didn't talk about the problem. I talked about the anger that came and that my relationship with my kids was in jeopardy. I skirted the problem. I would say, "I'm

having issues with anger. I'm having issues with depression. It feels like my heart is

about to beat out of my chest when I think about certain things."

Bravo wanted to remain in the military but had such a fear of the repercussions he would

face for seeing a mental health professional that he chose to continue counseling by labeling his

sessions as marriage counseling. Bravo stated,

She asked me if I wanted her to label it what it was, or if I wanted to stay in the military

and have my career. She asked me which one I wanted it labeled as and how we would go

about dealing with it. I asked her to label it as marriage counseling instead of what it

really was.

Bravo also sought the guidance of his ombudsman at the base hospital where he worked.

Here he felt he could be open about his problems without fear of repercussion. Bravo recalled,

The ombudsman was in the hospital. She sat me down and cared, and not only that, but

she also gave me a hug. She saw I needed it and that kind of shook me out of this, "Okay,

Doc. What are we doing here?" She said, "Look, human beings were designed to be close

to one another." That dropped my guard, and I wasn't scared she was going after my job.

Bravo's statements highlighting his experience with overcoming stigma are in Table 5.

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Table 5

Thematic Abstraction of Bravo Overcoming Stigma

Theme	Participant Statement
Coverup	"The civilian lady that was there tried to identify it with me, and she asked me what she wanted me to do. She asked me if I wanted her to label it what it was, or if I wanted to stay in the military and have my career. She asked me which one I wanted it labeled as and how we would go about dealing with it. I asked her to label it as marriage counseling instead of what it really was. Nobody's going to look into marriage counseling."
Trust	"The ombudsman was in the hospital. She sat me down and cared, and not only that, but she also gave me a hug. She saw I needed it and that kind of shook me out of this, 'Okay, Doc. What are we doing here?' She said, 'Look, human beings were designed to be close to one another.' That dropped my guard, and I wasn't scared she was going after my job."
Addressing the effects of the problem and not the source	"Well, I didn't talk about the problem. I talked about the anger that came, and that my relationship with my kids was in jeopardy. I skirted the problem. I would say, 'I'm having issues with anger. I'm having issues with depression. It feels like my heart is about to beat out of my chest when I think about certain things.'"

Charlie

Charlie's Overall Experience and Contribution to Themes

When asked about his first sign of mental illness, Charlie stated he experienced intrusive dreams at a young age. "Um, probably back in middle school, so I would say 2003 or 2004." He then provided context: "So, in middle school, that reference included self-harm. I have a few scars from that; physical scars. Um, of course, emotional as well from everything that was going on." Charlie explained how his childhood trauma affected his decision to seek MHS while in the military as follows:

Um, and then, while I was in the military, I noticed some of those same emotions and

feelings were resurfacing because of a similar situation that I was going through and, um,

I could kind of feel those emotions tracing back to that physical harm. I didn't want to do

that, especially being in the service. I had a lot going for me at the time, and I just knew

that I had access to resources and that made it a bit easier to reach out.

Instead of immediately going to seek MHS, Charlie decided to confide in his significant

other. This choice changed his experience with MHS for the worse. Charlie recalled,

> Um, so, the girl I was dating at the time, I told her and I just kinda talked it over with her,
>
> and I realized that it wasn't going to be enough for what I needed. I wasn't getting the
>
> support from her that I could've been getting from a professional.

Charlie wanted to seek MHS but had concerns regarding trust in his supervisors. He said,

"I planned on going sometime in the next few days. I just worried about what I was going to say

to get time off work. I didn't know how my senior chief was going to take hearing about it."

When asked about taking steps to negate the stigma surrounding mental health in the military,

Charlie recalled that he did not have the opportunity to really think about it. He stated,

> That one was kind of forced upon me. I had decided to go and talk to someone, but before
>
> I got the chance to do it, they were knocking on my door. So, I expressed to my
>
> significant other at the time, like, what the dreams were and how often they were
>
> occurring and she kind of said something to her chain of command, who then reported it
>
> to my chain of command, and I was kind of like escorted from my barracks to the mental
>
> health facility.

This betrayal of trust created a further lack of trust in others, as well as the Navy. When

asked if he would make the same choices today, Charlie said, "Um, I mean, given that that was,

you know, 10 to 11 years ago, I think that I would have opted to go on my own before telling

her." At the time of the interview, Charlie continued to struggle with trusting people and hoped

that his continued mental health treatment would allow him to not have negative thoughts and

dreams, and that one day he would have the opportunity to be the supervisor that provides help to someone in need. Statements from Charlie's interview that highlight the themes of his experience with military mental health stigma are in Table 6.

Table 6

Thematic Abstraction of Charlie's Experience

Theme	Participant Statement
Personal struggle	"It was more of a personal perception than anything else."
Distrust of leadership	"I didn't know how my senior chief was going to take hearing about it." "I appreciate that they didn't leave anything to chance. They moved forward with what they perceived to be a threat. However, the way they moved forward was a bit of an aggressive manner."
Fear of looking weak	"My biggest concern before going was how I would be perceived as a leader, as an E-4, to anybody and everybody that was below my ranking that I had oversight to."
Lack of knowledge about mental health treatment	"My only experience with seeing what happens to people in mental health facilities was in the movies and stuff like that. Where, you know, you go, for lack of a better term, people into like the nuthouse, you know? Being put in a straitjacket, and that's just kind of like what I envisioned. I mean, nobody in a semi-decent state of mind would voluntarily opt to go and see, you know, put their foot in the water and see if that's accurate, as to how that's handled and treated. I understand there's different severities to mental health illnesses and stuff like that, but that's not something I was looking forward to at the time."
Being treated differently	"Not being able to go on my own accord, and being forced and escorted out of my barracks, you know, kind of seeing all of the glances and glares through the halls as we were going down, and whatnot, as well as, you know, leaving base in the back of an MP's car…" "I wish they would've talked to me before taking me away. They knew a doctor couldn't see me that night but that I could be seen the next day and they still did what they did. I think maybe they could've isolated me somewhere; they could've, you know, kind of monitored me in the barracks instead of hauling me off, essentially, in the back of a car to go stay the night in the nuthouse. I felt like a criminal."
Betrayal	"The reason I was where I was at was because I confided in somebody and trusted them to maintain that confidentiality that our relationship should've entailed. Instead, she went and told somebody and then it just came back around that way."

Steps to Mitigate Stigma

Charlie stated that he did not take any steps to mitigate the stigma surrounding his mental health issues because he was taken into custody by military police and taken to a psychiatric hospital for overnight observation. Charlie did state that he realized he needed more help than he could receive by confiding in a significant other. Charlie also stated that he realized he would not be of any help to his subordinates if he did not get the help he needed. One can conclude that this meant he pushed past the stigma to decide to get help but that he did not have the opportunity because of the intervention of outside personnel. A statement from Charlie's interview that highlights the theme of his experience with overcoming stigma is in Table 7.

Table 7

Thematic Abstraction of Charlie Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"Um, so, the girl I was dating at the time, I told her and I just kinda talked it over with her and I realized that it wasn't going to be enough for what I needed. I wasn't getting the support from her that I could've been getting from a professional."

Delta

Delta's Overall Experience and Contribution to Themes

Participant Delta first encountered mental health treatment in the military when she received her son's diagnosis of ADHD. She took her son to an on-base mental health provider and together they learned techniques that would benefit their family. Later Delta had feelings of anxiety and depression and sought mental health services to help her cope with her busy life. She recalled,

I thought I was going crazy because there was so much going on in my life and my

anxiety and my depression were really high. I couldn't figure out why. The first therapist

I saw, I explained everything to him, and he was like, "Well you're active-duty military.

You're married to military. You have two children. You're stationed overseas, and you're

a supervisor of a clinic. It's kind of normal for what you're going through. So, I was like,

'Okay. That makes sense.'"

Delta sought therapy again following her husband's return from OTS (Officer Training

School). She stated,

I guess I was jealous of his job and the people he was involved with and those type of

things at work. I then decided I needed to work on this, and it was identified that I had

some codependency issues, and issues with my dad when all of this stuff came up. I have

been in and out of therapy since that time in order to work on myself and to become a

better person.

When asked how she first identified that a potential mental health problem existed, Delta

said,

It was the way I felt. I felt depressed. I felt uneasy, and then my husband at the time had

told me, "You have some problems here. You have some issues you need to kind of look

at. Your self-confidence and self-esteem are really low."

Delta did not have any hesitation regarding her decision to seek MHS. Delta's sister is a

therapist and had the support of her military unit. Delta recalled,

I think my expectations were positive. My sister is a therapist, so I've always had that

thought process that it's helpful for people. I never thought that I would need to have it,

but it makes sense. I didn't have a negative posture on it at all. I think my sister being a

therapist helped me make the decision to go seek help. I did go on base in [REDACTED],

but I think in my career field it wasn't an issue, and no one ever brought it up that it was

an issue.

When asked what impact her decision to seek MHS had on her career and if she would

make the same choice today, Delta said,

If anything, I think it was positive. It made me more confident and surer of myself, that I

could do the things that were being asked of me and get promoted throughout my career.

I feel it was a very positive experience. I would absolutely make the same choices today.

A statement from Delta's interview that highlights the theme of her experience with

military mental health stigma is presented in Table 8.

Table 8

Thematic Abstraction of Delta's Experience

Theme	Participant Statement
Personal struggle	"I guess I was jealous of his job and the people he was involved with and those type of things at work. It was the way I felt. I felt depressed. I felt uneasy, and then my husband at the time had told me, 'You have some problems here. You have some issues you need to kind of look at. Your self-confidence and self-esteem are really low.'"

Steps to Mitigate Stigma

Delta's experience with military mental health was a positive one. Mental health was

encouraged in her unit and Delta's sister was a therapist. Delta also had the support of her

military unit. This support from family and work made it easy for Delta to seek the help she

needed. Therefore, it was natural for Delta to seek MHS, and she did not have to overcome

stigma to make that choice. Statements from Delta's interview that highlight the themes of her

experience with overcoming stigma are in Table 9.

Table 9

Thematic Abstraction of Delta Overcoming Stigma

Theme	Participant Statement
Trust	"I think in my career field it wasn't an issue, and no-one ever brought it up that it was an issue."
Encouragement	"My sister is a therapist, so I've always had that thought process that it's helpful for people. I never thought that I would need to have it, but it makes sense. I didn't have a negative posture on it at all. I think my sister being a therapist helped me make the decision to go seek help."

Echo

Echo's Overall Experience and Contribution to Themes

Participant Echo is a 56-year-old retired Air Force chief master sergeant. She served in the communications field and first experienced problems with her mental health while stationed in [REDACTED]. Echo began feeling that something was wrong and sought help through the mental health facility on [REDACTED] AFB (Air Force Base). At the time of her initial contact with MHS, Echo was an E5/Staff Sergeant. She said,

Well, I just started to feel kind of, not right, kind of, where I didn't want to do anything. I was just kind of depressed, and I sought some mental health treatment. I went over there, and I saw one of their technicians and they basically told me that I didn't need any mental health treatment. I was kind of dismissed. That was my first impression of mental health.

Because Echo did not receive the care she needed at the AFB, she discussed her concerns with her primary care provider, who in turn prescribed her Celexa.

For several years and through several duty stations, Echo never thought to return to MHS because of how she was initially treated. Echo also elected to abstain from treatment because of her rank at the time. She said, "When you're an E5, you're at the whim of everyone else. When

you're an E5, a junior NCO [non-commissioned officer], you're kind of just dismissed." Because

of this, Echo did not seek help until she reached the rank of E8 and was ready to be promoted to

E9. She said, "When you're an E8 going on to E9, you kind of have a little more control and

people will listen to you a little bit more." This gave Echo the courage to seek treatment.

The medication had stopped working and Echo felt she needed something more. This

time Echo had a positive experience with mental health. She recalled,

> The positive at [REDACTED] was I was actually able to get into some counseling and
>
> able to understand some of the way I was feeling. At that point, I was an E8 at the time
>
> and I was starting to put my health above other things. I was gonna give E9 two shots to
>
> test for and then I was gonna be done. So, in my mind I was preparing for retirement, and
>
> I didn't care at the time. I was like, "You know what? I gotta get my mind right, and I
>
> gotta figure out why I'm feeling the way I'm feeling." I just kind of said, "I'm retiring
>
> anyway, so I gotta get this figured out." You know, the psychologist that I saw, she was
>
> good, and I learned some tools I could use to help fight some of the negative, you know,
>
> depressive feelings I was having.

However, this positive experience would not last long. Echo was promoted to E9 and

transferred to a new duty station where she saw how another branch of the military felt about her

taking psychotropic medications. At this time, Echo was an Air Force senior NCO stationed at an

Army base. Echo stated,

> When I got promoted to E9 and I had to go to [REDACTED], that ended. I was pretty
>
> much told right from the get-go, by that doctor when I said, "Yeah. I'm on Wellbutrin for
>
> depression," where he was like, "No. It's smoking cessation." I knew right then and there
>
> that going to mental health was not really gonna be an option where I was at that point. It

was even deterred. You didn't go. We had social workers on our compound where we were at, and it was known that you don't go over there, and you don't go talk to them. It was like, "Wow! Okay." So, I'm feeling down but the doctor who said it was for smoking cessation kept giving me the prescription for the Wellbutrin because he knew I needed it. But he would never identify that it was for major depressive disorder. You just didn't go to mental health there. You did not go to mental health!

Statements from Echo's interview that highlight the themes of her experience with military mental health stigma are in Table 10.

Table 10

Thematic Abstraction of Echo's Experience

Theme	Participant Statement
Personal struggle	"Well, I just started to feel kind of, not right, kind of, where I didn't want to do anything. I was just kind of depressed."
Distrust of leadership	"When you're an E5, you're at the whim of everyone else. When you're an E5, a junior NCO, you're kind of just dismissed."
	"I knew right then and there that going to mental health was not really gonna be an option where I was at that point. It was even deterred. You didn't go. We had social workers on our compound where we were at, and it was known that you don't go over there, and you don't go talk to them."
Initial negative experience	"I went over there, and I saw one of their technicians and they basically told me that I didn't need any mental health treatment. I was kind of dismissed."
	"I first kind of thought, 'What's wrong with me? Why am I having these negative thoughts? Why am I feeling this way?' I just couldn't understand it because when you start to feel like that you analyze your life. You're like, 'I have a good life. I have a good marriage. I have a good job.' Then you try and find something that's the trigger for these feelings, and I didn't have a trigger. So, I couldn't really understand it. That's kind of why I wanted to talk to somebody. Why am I feeling this way? When I was blown off, it was really kind of like a kick in the gut. Like, they're supposed to care, and they don't."
Persecuted for needing mental health treatment	"I have been in commanders calls where they are like, 'If you need help, go and get it,' but they really don't mean it. Those are just the words. Because in the next breath, they're like, 'Well, your clearance can be effected, or you're gonna get discharged.'"
	"You didn't ever advertise that you were going to mental health. I had a TS/SCI [Top Secret/Sensitive Compartmented Information] with a few other identifiers attached to that, and I worked in the intelligence division. You couldn't; it was highly discouraged to go to mental health. Highly discouraged because you could lose your clearance. You're not considered reliable. Now you're considered that there's something wrong with you. Now you need to be watched. So, you didn't advertise that you were going."

Steps to Mitigate Stigma

Echo's experience with mental health began in a disappointing manner. She knew she had a problem and sought MHS. She was turned away after seeing a technician and not a counselor

or psychologist. Echo still felt she needed help, so she spoke with her primary care physician and received Celexa. This was her first step in overcoming stigma.

Echo advanced through the ranks of the Air Force and transferred to many different duty stations. Once she reached the rank of E8, she decided that her mental health was a priority for her. She recalled saying, "You know what? I gotta get my mind right and I gotta figure out why I'm feeling the way I'm feeling." I just kind of said, "I'm retiring anyway, so I gotta get this figured out." Echo chose her mental health over her career. This worked out for her until she began working with the Army as an E9.

Echo arrived at her new duty station with the Army and underwent medical and psychological testing for her new position. The military doctor encouraged her to lie about why she was taking antidepressant medications. Echo recalled the conversation as follows:

> For that job, I had to go through some psychological testing, and even the psychologist picked up that I have depression. They asked me why I was on Wellbutrin, and I said, "Well, I have major depressive disorder." He said, "No. You're taking this for smoking cessation, right?" I remember that. "I said, "Well no. I don't smoke. I quit smoking like 15 years ago." Then he goes, "No. You're taking this for smoking cessation." He knew what was going on, and he actually put that in my record; that I was taking the Wellbutrin for smoking cessation. Nowhere in my records does it say I smoke. They hid it.

Statements from Echo's interview that highlight the themes of her experience with overcoming stigma are presented in Table 11.

Table 11

Thematic Abstraction of Echo Overcoming Stigma

Theme	Participant Statement
Realization that Professional Help is Needed	"Even though the mission was still an important mission, it wasn't, I don't want to say, as serious, but the way I was feeling, I knew I needed to talk to somebody.
Personal Growth	"It was far more important to get to the bottom of the way I was feeling than my clearance at the time."
Coverup	"I really didn't tell anybody that I was going. I just said I had a medical appointment."
	"I was pretty much told right from the get-go, by that doctor when I said, 'Yeah. I'm on Wellbutrin for depression,' where he was like, 'No. It's smoking cessation.' So, I'm feeling down but the doctor who said it was for smoking cessation kept giving me the prescription for the Wellbutrin because he knew I needed it. But he would never identify that it was for major depressive disorder. They hid it. They kind of wrote around things so I wouldn't be disqualified from the job."
Trust	"I worked for a different command at the time. I worked for Headquarters [REDACTED]. Luckily, they didn't really ask any questions. When you just say, 'Hey, I gotta go to medical' and you walk out, they're like, 'Okay.' When you get back, they're like, 'How was your appointment?' 'Okay.' You know? They didn't really ask any questions."
Courage	"I was like, 'You know what? I gotta get my mind right and I gotta figure out why I'm feeling the way I'm feeling.' I just kind of said, 'I'm retiring anyway, so I gotta get this figured out.' When you're an E8 going on to E9, you kind of have a little more control and people will listen to you a little bit more."

Foxtrot

Foxtrot's Overall Experience and Contribution to Themes

Participant Foxtrot first noticed his issues with mental health while he was deployed to Iraq in 2007. He stated, "Early [in] 2007, when I arrived in Iraq, we were doing a 15-month rotation. That was the first time that I had a realization that, um, I had issues." He was not alone in noticing this problem. His best friend at the time also noticed he was becoming more aggressive. Foxtrot recalled,

> My best friend, [REDACTED] noticed. He would say, "Dude! Lighten up." He's awesome, but nobody really said anything specific besides, "[REDACTED], you need to relax." Really it was just my friend that was like, "Dude! You need to step it down a little bit."

Foxtrot chose to keep things to himself and focus on his job. He was an Apache pilot. According to Foxtrot, this job placed an emphasis on not showing any signs of weakness. He said,

> I kept it to myself because I knew it could be a career ender, and you know, you have your Infantry guys and your Artillery guys and your Apache pilot guys and, you know, we have to be strong. You know? We don't want to portray weakness. So, mental health was a weakness.

Foxtrot shared that he had an incident in Afghanistan during one of his combat tours that is undocumented. He wanted to share this incident to show that not receiving help can lead to much greater problems. Foxtrot shared,

> There was an instance that was undocumented. I woke up with a 9-mil in my mouth passed out drunk. No lie. I woke up in my room, in a little plywood box in Afghanistan

with my 9-mil, with the hammer back, in my mouth, and my roommate woke me up. That

was it.

In 2015, after approximately 7 years and attempting to cope with his mental health

problem, Foxtrot chose to confide in his commanding officer who made him a referral to mental

health. Foxtrot shared that he spoke with the counselor but elected to not disclose all of his

thoughts and feelings because he still feared for his career. He stated,

I basically saw a counselor and I talked, and that was kind of it. It wasn't a big

interaction. It was kind of like to check the box. I talked about it with my commander,

and he referred me. I did it, and I went, and I said all the right things. It's like now in this

interview, I can say all the right things, but it's not what's in my head.

When asked if he would make the same choice today, or if he would have sought help

sooner, Foxtrot said, "Probably sooner, yeah, for sure. I would've tried to realize that, uh, the

things that I feel are probably shared by a lot of other servicemembers, I guess. I would've

known that I'm not alone."

Statements from Foxtrot's interview that highlight the themes of his experience with

military mental health stigma are presented in Table 12.

Table 12

Thematic Abstraction of Foxtrot's Experience

Theme	Participant statement
Personal struggle	"I was going through some marital issues. Um, uncontrolled thoughts, anger, um, being so angry at the littlest thing. Like, somebody at the dining facility asking for your ID [identification] card, or something, and they say it in the wrong way and you just snap. You know what I mean? Just little things. It wasn't a giant thing, it was just little things that, uh, made you so angry for no reason. So, I was getting angry for no reason."
Distrust of leadership	"In the military, they put up a good charade of, 'Oh. There's mental health available and there's no repercussions.' But, in reality, there's going to be repercussions."
Fear of looking weak	"I'll be honest, I didn't really seek mental health at that time. Not in those 15-months in Iraq. I didn't seek mental health. I kept it to myself because I knew it could be a career ender, and you know, you have your Infantry guys and your Artillery guys and your Apache pilot guys and, you know, we have to be strong. You know? We don't want to portray weakness. So, mental health was a weakness."
Persecution for needing mental health treatment	"They're not going to be overt, like, you know, like, 'Oh. This guy was an E7 and now he's an E6.' It's nothing like that. It's just like, 'Okay. This guy has an issue, so we're going to kind of put him on the side burner.'"

Steps to Mitigate Stigma

Foxtrot's experience with overcoming stigma began with fear of repercussions. He

decided to wait approximately 7 years before finally seeking help. He had support and

encouragement from his commanding officer and accepted a referral to see a military counselor.

Foxtrot recalled, "I talked about it with my commander, and he referred me." This

encouragement from and trust he had in his commander reinforced Foxtrot's decision to seek

MHS.

However, the effects of stigma were still present. Foxtrot did receive MHS, but he

decided to not reveal the totality of the mental heath issues he was experiencing. He said, "I

basically saw a counselor and I talked, and that was kind of it. It wasn't a big interaction. I was

kind of like to check the box." This was enough to satisfy Foxtrot's experiences at the time.

Statements from Foxtrot's interview that highlight the themes of his experience with

overcoming stigma are presented in Table 13.

Table 13

Thematic Abstraction of Foxtrot Overcoming Stigma

Theme	Participant Statement
Trust	"I talked about it with my commander, and he referred me."
Encouragement	"My best friend, [REDACTED] noticed. He would say, 'Dude! Lighten up.' He's awesome, but nobody really said anything specific besides, '[REDACTED], you need to relax.'"
Addressing the effects of the problem and not the source	"I basically saw a counselor and I talked, and that was kind of it. Um, but again, I didn't talk about it with really anyone when I went. I just couldn't bring myself to talk about it."

Golf

Golf's Overall Experience and Contribution to Themes

Participant Golf first became aware of his mental health issues in his early 20s. Although

he stated he was unable to remember exactly how he reacted to this realization, he did say, "I

don't remember. I could acknowledge it with myself, but, um, you know, I probably called my

mom." When asked what his symptoms were, he stated, "Probably depression, lack of finding

satisfaction in life, and anxiety." At this time in his life, Golf was enlisted in the military and had

apprehensions about seeking mental health treatment. Golf recalled,

I had fears that the unit wasn't going to see going to appointments as a legitimate thing,

or that people would say that I'm shamming. Um, that I didn't have a specific idea of

how, but whatever I told the counselor or psychologist, or whoever I was going to see,

um, that it would, you know, like my privacy, specifically with me being in the military,

my privacy, my HIPAA [Health Insurance Portability and Accountability Act] rights would not be observed by the military. Thus, it would negatively affect my career somehow. But I didn't have a specific fear of how that would manifest.

It would turn out that his fears were justified. Golf experienced a betrayal by his mental health provider and his rear detachment commander. Golf recalled,

Because I ended up going back multiple times and because they ended up delaying my going forward, the major that was the rear detachment commander was feeding all of the stuff that was going on with me forward to the unit in Iraq. I came to find out later that they were all being told I wasn't in Iraq yet because I was some kind of mental case. So, there was already this pre-built-up notion about me. I didn't realize until I got there, but it negatively affected my career in that way. Everybody just assumed that I was going to be worthless to the unit because of this one dude pushing all of my information forward.

Golf was then asked if he would do anything differently if he were to have the knowledge he has today. Golf's statement changed during his answer. He said,

I would have gone to see the mental health people, but I wouldn't have told my unit the nature of my appointments or what I was doing if I could avoid it. I would have just said it was a medical appointment. But I guess they had access to that information anyway. You know what? I would have done it differently! I wouldn't have gone! It sucked arriving somewhere and realizing people had been told all this shit about you that wasn't true, all because some, you know, rear detachment commander was making up whatever story about why I wasn't there yet.

Statements from Golf's interview that highlight the themes of his experience with military mental health stigma are presented in Table 14.

Table 14

Thematic Abstraction of Golf's Experience

Theme	Participant Statement
Personal struggle	"Probably depression, lack of finding satisfaction in life, and anxiety. I don't remember. I could acknowledge it with myself, but, um, you know, I probably called my mom."
Distrust of leadership	"I had fears that the unit wasn't going to see going to appointments as a legitimate thing, or that people would say that I'm shamming."
Initial negative experience	"It sucked arriving somewhere and realizing people had been told all this shit about you that wasn't true all because some, you know, rear detachment commander was making up whatever story about why I wasn't there yet."
Being treated differently	"I went from being a hot-shot soldier to being a shitbag because I had to go to appointments, whether it be for mental health or for my back injury or any of that stuff. I went from good to just an absolute shitbag."
Betrayal	"Because I ended up going back multiple times and because they ended up delaying my going forward, the major that was the rear detachment commander was feeding all of the stuff that was going on with me forward to the unit in Iraq. I came to find out later that they were all being told I wasn't in Iraq yet because I was some kind of mental case."
Persecuted for needing mental health treatment	"SFC [REDACTED] was mocking me in front of the rest of the platoon. If you were not in good standing with someone like SFC [REDACTED], he failed to lead you anymore. I didn't do anything wrong. I did everything that was asked and expected of me. I wasn't a bad soldier. I was a broken soldier. The culture of the Army at that time was a broken soldier is a bad soldier."

Steps to Mitigate Stigma

While Golf did experience apprehension concerning his potential mental health treatment, he stated that he did not need to overcome mental health stigma. Golf stated that he knew it was his choice to seek mental health but that he felt pressured to do so because of his rank and position in the military. When asked about negating stigma to decide to seek MHS, Golf recalled,

I didn't really. I just went. I was told I had to go because of a way I answered a question on a questionnaire that they had us fill out when I got to [REDACTED]. It wasn't so

much that I was told to go but that it was a suggestion. It's a little bit foggy. I know it was

up to me but at the same time when you're junior enlisted, suggestions sometimes feel

like orders. I hadn't even gotten to my unit yet. I was still in the reception process when

someone approached me. They pulled me aside and told me I should make an

appointment with mental health. Based on how everything was going at that time, I

could've just ignored it, and nobody would've said anything to me, but I decided it was

worth looking into.

Statements from Golf's interview that highlight the themes of his experience with

overcoming stigma are presented in Table 15.

Table 15

Thematic Abstraction of Golf Overcoming Stigma

Theme	Participant statement
Realization that professional help is needed	"I was told I had to go because of a way I answered a question on a questionnaire that they had us fill out when I got to [REDACTED]. They pulled me aside and told me I should make an appointment with mental health."
Personal growth	"Based on how everything was going at that time, I could've just ignored it, and nobody would've said anything to me, but I decided it was worth looking into."
Encouragement	"I was still in the reception process when someone approached me. They pulled me aside and told me I should make an appointment with mental health. It wasn't so much that I was told to go but that it was a suggestion."

Hotel

Hotel's Overall Experience and Contribution to Themes

Participant Hotel first became aware of his mental health problems when his wife brought it to his attention in 2010, after he returned from a tour in Iraq. When asked about noticing signs of mental health, Hotel recalled,

I don't know if I did. My wife kind of did, and it took a while to let it sink in. I guess it was early 2010. It was immediately after I returned from my deployment to Iraq. Like everyone, I'm driving all erratic when I come home; a little alert and a little stressed, and my wife is like, "Nah. You don't talk to me like this. You've never talked to me like this before." Some of that was just projection on my part. Then I started to really, really have issues. I was really worried about going to see mental health about it.

Hotel began seeing a brigade mental health representative who worked outside formal mental health settings. This was partly because he did not believe he needed continuous care. Hotel stated, "maybe my case was not debilitating. I didn't need continuous care, but you know, when I really think about it, every time I PCSed [permanent change of station], I kind of checked back in, you know, chain-of-command be damned." Although Hotel did not have the same fears as others with a mental health problem, he was keenly aware of the fear surrounding formal mental health treatment. He recalled,

I know my experience wasn't the same. However, there absolutely was a stigma! There was a fear! People put a real fear into you, but the actual consequences of that, for me anyways, turned out to not be accurate. At least in my case. But I can remember it being accurate in other people's cases, so I don't want to take away from that. It's something that terrified all of us, and we've all heard the stories.

After seeing the brigade mental health representative, known as a military family life consultant (MFLC), Hotel tied his anger and stress to hunger and developed an eating disorder. He stated,

> I was stationed in Germany, and they had these things called an MFLC or a military family life consultant. That was actually really good, but what it led me to do was; they gave me this thing called Hungry, Angry, Lonely, Tired, and, um, it helps you deal with stress. I took that as, "Oh. I'm feeling angry and hungry. Boom! Hungry, angry; they're all the same thing." Then I started eating everything. I just binged. It made me think what had changed about me. I don't know if I ever really got over that. It was just the way I coped.

As stress continued to build in Hotel's life, his MFLC told him he needed to seek help from someone with more experience. He not only heard this from the MFLC, but also from his NCOs. Hotel recalled,

> I was trying my best outside an office job, and it was stressful. There were individual instances of trauma, but I don't think it was any different from any of the others. I certainly didn't feel like I had my Saving Private Ryan moment, and I felt guilty thinking I even needed help. Because I knew somebody who had lost their face. I knew somebody who had lost a leg, and that wasn't fucking me. Why the fuck did I deserve to be back? I also had to set an example for the boys. At that time, Artillery was all boys, and what would that fucking look like? If I could, I had conversations really on the NCO side. They were like, "You need to go do this." The NCOs in my life, the MFLC herself said, "You need a little more help than what I'm giving you."

This is when Hotel decided to seek formal treatment. Hotel decided to seek treatment because he did not see himself remaining in the military. Hotel said, "Fuck it! I'm not going to stay in anyway. They're going to kick me out. Fine! I'll go back to law school or whatever." Hotel spoke to the psychologist but was unsure if anything was ever written in his personnel file at that time. After returning from Afghanistan, Hotel again spoke with the MFLC. He recalled,

> When we got back, they had MFLCs for everybody. I was seeing this person, and I did all that. I kind of kept that up, but to be fair, when I got selected for FAO and moved right out to California, I didn't really follow up on that because one thing led to another that led to another. I PCSed again after that one. It just got forgotten.

Hotel decided if he ever wanted to recover from his mental health, the best thing for him to do was to be honest about it. He took his mental health seriously and led other soldiers to take theirs seriously as well. Hotel stated,

> When I came back in '11 and '12, I had so many boys that needed to go, I sent people to mental health if they had a problem, and to be honest, the same people who suggested I go, I asked them to go too, and they did.

The newfound awareness of the need for mental health became a staple of his leadership, and he continued to advocate for others to seek treatment when needed. Hotel recalled,

> Most of the guys were not hardcore combat, they weren't gun bunnies, they weren't the fire-support guys when they only converted to infantry. This was the case in Afghanistan. [Hotel is referring to the fact that in Afghanistan, he was with normal soldiers, not the "hardcore" guys that are considers special operators, rangers, etc.]. That was actually about the moment when the leadership was like, "It's far better to happen, to let them get evaluated, than to face other issues."

When asked if he would make the same choices today regarding his mental health, Hotel said,

> I think I would've gone sooner. I think I would've gone back. Now that I think about it, yeah, I was too busy, and I wasn't in a place where mental health was available. I got sent to [REDACTED], I got put in grad school without that around, and yet, um, I might've reached out to military one-source or something like that. Having said that, the violence and anger has all but gone away, but I've still never gotten over the eating disorder. Again, if you saw me to this day, I'm about 6' 3" and 220 pounds, but I'm not the skinny guy I used to be, not anymore. I know I would've been there. I would've gone earlier.

At the time of the interview, Hotel was still serving in the Army and still struggling with his eating disorder. Hotel was continuing to be an advocate for mental health and hoped that leaders will learn to evaluate a soldier to find out the root of the problem rather than assume the worst and discharge them from service.

Statements from Hotel's interview that highlight the themes of his experience with military mental health stigma are shown in Table 16.

Table 16

Thematic Abstraction of Hotel's Experience

Theme	Participant Statement
Personal struggle	"Some of that was just projection on my part. Then I started to really, really have issues. I was really worried about going to see mental health about it."
Denial	"There were individual instances of trauma, but I don't think it was any different from any of the others. I certainly didn't feel like I had my Saving Private Ryan moment, and I felt guilt thinking I even needed help. Because I knew somebody who had lost their face. I knew somebody who had lost a leg, and that wasn't me."
Initial negative experience	"I was stationed in Germany, and instead of having those, they had these things called an MFLC or a Military Family Life Consultant. . . .But what it led me to do was; they gave me this thing called Hungry, Angry, Lonely, Tired, and, um, it helps you deal with stress. I took that as, 'Oh. I'm feeling angry and hungry. Boom! Hungry, angry; they're all the same thing.' Then I started eating everything. I just binged."
Fear of looking weak being treated differently	"I also had to set an example for the boys." "I know my experience wasn't the same. However, there absolutely was a stigma! There was a fear! People put a real fear into you."
Persecuted for needing mental health treatment	"In a peace-time Army, a TBI and seeking mental health was fucking huge! I remember people coming up in the officer ranks and senior NCO ranks going and getting a prescription for Zoloft and they were done; you're out! You know? They lost everything; clearance and everything!"

Steps to Mitigate Stigma

Hotel was able to overcome much of the stigma surrounding him at the time by having a supportive home life and a supportive chain-of-command. While much of the military continued to stigmatize mental health treatment, Hotel was able to bypass this effect because of the leadership around him at the time of his mental health problem. Hotel said, "It was known that I went and that I had to tell my battalion commander, and he was like, 'You gotta do what you gotta do.'" Hotel saw the benefit of being a compassionate leader regarding mental health and

continued to lead others in the same way. He stated, "I tried to apply it to my command. Every

step, I've tried to do that."

Statements from Hotel's interview that highlight the themes of his experience with

overcoming stigma are presented in Table 17.

Table 17

Thematic Abstraction of Hotel Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"They were like, 'You need to go do this.' The NCOs in my life, the MFLC herself said, 'You need a little more help than what I'm giving you.'"
Coverup	"I don't know if it ever really got recorded in my files."
Trust	"It was known that I went and that I had to tell my battalion commander, and he was like, 'You gotta do what you gotta do.'"
Courage	"I then went to the Brigade shrink, and I wasn't sure I could do it, and I that time I was like, 'Fuck it! I'm not going to stay in anyway. They're going to kick me out. Fine! I'll go back to law-school or whatever.'"
Encouragement	"They were like, 'You need to go do this.' The NCOs in my life, the MFLC herself said, 'You need a little more help than what I'm giving you.'"
Addressing the Effects of the Problem and not the Source	"What it led me to do was—they gave me this thing called Hungry, Angry, Lonely, Tired, and, um, it helps you deal with stress. I took that as, 'Oh. I'm feeling angry and hungry. Boom! Hungry, angry; they're all the same thing.' Then I started eating everything. I just binged. It was just the way I coped."

India

India's Overall Experience and Contribution to Themes

Participant India first decided she needed to seek MHS after many months of her husband

discussing the idea of divorce. India recalled,

It was in my first marriage, and it was probably seven years into my marriage, um, when

my spouse started talking about divorce. That probably went on for six to eight months

before we decided, as a couple, to say, "Hey, let's go to mental health and see if we can

get some marital counseling." Because, at the time, we both agreed that that was a good idea, to go and get help to see if we could salvage the marriage.

India did not experience any apprehension when deciding to seek MHS for her marriage. She stated, "It wasn't that I was depressed or having anxiety or any of those things. It was just, 'Hey. We need help with our marriage.' We were both agreeable to do that." When asked if her supervisors were aware of her seeking MHS, India replied,

> I don't recall even letting them know that I was going for marriage counseling. It was just, "Hey. I've got an appointment." You know? That kind of thing. I don't think I sent up any flags saying, "Hey. We're going to marriage counseling."

India talked about her experience with witnessing other branches of the military and how they treat their servicemembers regarding mental health and other needs. India stated,

> I do know that the Air Force is just a better quality of life. They seem to be more concerned and go out of their way to help their people in different situations, even outside of mental health. You know? So, I think it's just a better quality of life in the Air Force, and I could see in other services where there is a lot of stigma about a person going to mental health for anything.

India eventually transferred overseas, and her husband decided he wanted the divorce. When India arrived at her new duty station, she spoke with her superintendent about the stress of being a newly divorced single mother in a foreign country and her superintendent asked her if she needed to go see a mental health practitioner. He asked it in such a way that India felt she would jeopardize her career if she said yes. India said,

> He asked me, "Do you need to go to mental health?" He asked it with such a tone that put me off, and I remember telling him, "No. I don't need to go to mental health." He asked it

in such a way that I felt like if I said yes that I needed to go to mental health, that it would somehow be a reflection on me, and maybe on my approval rating. You know? So, I told him no. He was a jerk of a superintendent.

India sensed that this may have had a negative effect on her because she thought she could have used mental health to help her get through this adjustment in her life. India recalled,

I know the second time, when that superintendent asked me, I probably could have used some help with dealing with being divorced and being a single mom in an overseas country. You know? So that probably negatively impacted me that I didn't go and get help because of the way that he asked if I needed to go get help.

When asked if she would make the same choice today regarding her mental health, India replied,

I think I would've made the same choice because it's one thing to have a supervisor that's compassionate and understanding and doesn't give you a tone when they ask you if you need to see mental health and they ask it in a caring way. So, if it was the same superintendent all over again, I would've made the same choice and said, "No. I'm good."

Statements from India's interview that highlight the themes of her experience with military mental health stigma are presented in Table 18.

Table 18

Thematic Abstraction of India's Experience

Theme	Participant Statement
Personal struggle	"It was in my first marriage, and it was probably seven years into my marriage, um, when my spouse started talking about divorce. That probably went on for six to eight months."
Distrust of leadership	"I guess I just didn't want them to know what was going on in my marriage, per se.' It was kind of, uh, more of a private thing."
Fear of looking weak	"That was probably just because there is a bit of a stigma of, 'Hey. These people need help.' I don't know. You don't want to naturally just appear weak in a sense, and going to mental health for stuff, a lot of times there's that stigma that you're weak and you can't handle it, and you have to go get help."
Being treated differently	"Someone is going to think something about you because you had to go to mental health."
Persecuted for needing mental health treatment	"I remember talking to my superintendent, and I don't recall exactly what I said to him, but it must have been something on a personal nature like, 'Hey. I just recently divorced. I'm a single mom. It's a lot.' He asked me, he said, 'Do you need to go to mental health?' He asked it with such a tone that put me off, and I remember telling him, 'No. I don't need to go to mental health.' He asked it in such a way that I felt like if I said yes that I needed to go to mental health that it would somehow be a reflection on me, and maybe on my approval rating."

Steps to Mitigate Stigma

India negated the stigma surrounding mental health in the military by not sharing why she was going to mental health. She told her supervisor that she had an appointment and did not tell them she was going to attend mental health treatment. India said, "I guess I just didn't want them to know what was going on in my marriage, per se. It was kind of, uh, more of a private thing." India thought this was possible because of how the Air Force treats its servicemembers. India expressed the belief that the Air Force has a better quality of life that yields greater results when

individuals seek help for numerous issues. She stated, "They seem to be more concerned and go out of their way to help their people in different situations, even outside of mental health."

Statements from India's interview that highlight the themes of her experience with overcoming stigma are presented in Table 19.

Table 19

Thematic Abstraction of India Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"That probably went on for six to eight months before we decided, as a couple, to say, 'Hey, let's go to mental health and see if we can get some marital counseling.' Because, at the time, we both agreed that that was a good idea, to go and get help to see if we could salvage the marriage."
Personal growth	"It wasn't that I was depressed or having anxiety or any of those things. It was just, 'Hey. We need help with our marriage.' We were both agreeable to do that."
Coverup	"I don't recall even letting them know that I was going for marriage counseling. It was just, "Hey. I've got an appointment." "I guess I just didn't want them to know what was going on in my marriage, per se'. It was kind of, uh, more of a private thing."
Trust	"So, I didn't really have apprehension from anyone at work or anyone in the military about going."

Juliet

Juliet's Overall Experience and Contribution to Themes

Participant Juliet first noticed signs of mental health problems during his time with a unit assigned to JSOC in 2008 while he was participating in multiple deployments to Iraq and Afghanistan, and his wife was having an affair. Juliet's brother had died in Iraq in 2003, and his wife was fearful of his being part of a JSOC unit. Juliet thought his wife had given her blessing, but it began taking a toll on their marriage. Juliet said,

So, we got back from the funeral and everything, and these letters had been waiting for me. They didn't come to my house. They came to the office, and of course I had been out of the office for a while. By the time I got ahold of them, it was almost, I forget, how many days or weeks, or whatever, to the suspense date. So, I was like, "I'm gonna have to make decision on this fast." So, I talked to her and decided to go with what I thought was her blessing. You know? Years later, she was like, "No. I was never into it." That was kind of the reason she gave for our divorce.

Juliet was also under a lot of stress during his early deployments with the unit because of the men that had died during battle. He said,

You know, 2005 and 2006, those were really difficult deployments for [REDACTED], for [REDACTED] squadron, that I was with, in particular. We lost 10 guys in the squadron, which is a lot. It's almost three full teams. You only have three or four teams in a troop. So, it's almost like losing an entire troop out of the assault squadron. It was super difficult!

As Juliet continued his deployments and combat operations, he survived many close calls and yet remained uninjured. He became comfortable with his life in Iraq as he watched his life at home unravel. Juliet said,

By this time, 2007 to 2008ish, and then going through the divorce and everything else, I didn't really want to go home. You know what I mean? I became comfortable, although super angry, I became comfortable in Iraq. I was like, "I know what I'm doing here. I go home, I don't know what the hell is going on. I don't know who's in my house, or what's going on with my kids."

Juliet contemplated taking his own life. He said, "So, um, what obviously made me go to counseling when I got back was, I put a gun to my head. I was like, 'I don't want to leave here, and I'm not getting hurt.'" He watched as his brothers-in-arms died and he remained. He had taken more of a combat-support and supervisory role and was not in as much danger as his brother had been in. Juliet recalled,

> I was doing more staff stuff at that point. I was kind of managing a team that was doing a lot of things across Iraq at the time, but I wasn't going out myself as much. So, I wasn't in danger as much, you know, as I had been than when I was supporting the squadron. So, I was like, "Noone's going to get me, you know, so, I'm gonna get myself."

Juliet thought about his mother and what she had dealt with when his brother had died just 4 years earlier. This caused Juliet to rethink suicide. He said, "I thought about my mom, and I thought about what she had gone through just 4 years before that with my brother and everything and I was like, 'No. I've got to find another way to deal with this.'" This is when Juliet decided to see the unit psychologist. Juliet shared his feelings about the stress of the job and the toll it had taken on his marriage. However, Juliet never mentioned his suicidal ideation. He recalled,

> It was like, "Well, if I talk about suicidal ideation, then I'm gonna get pulled off the team." I wanted help with the situation I was in, but the only thing I had going for me was the team. It was the job. I can't say that because they'll pull me off the team.

Juliet realized he needed to make a change before he took his own life. He decided to leave his JSOC unit and return to the conventional Army. This is when he decided to share his experience with suicidal ideation with the unit mental health professional. Juliet said,

I didn't tell anybody about that until the end, when I knew I was going to leave

[REDACTED]. I got the exit interview and that's when I told the psych; at that point, I

was like, "Yeah. I thought about this a couple of times, but I never said anything because

I knew immediately you would've taken me off the team, and that's all I had. That was

the one thing that kept me going." I don't know what I would've done if I didn't have that

to kind of ground myself and sink my teeth into at the time.

Juliet recognized that his job with the JSOC unit was creating many of the problems in

his life, but it was also the only thing keeping him from taking his own life. When asked how he

felt when he decided to seek MHS, Juliet said,

I guess I was a little bit nervous about how it was going to go but also relieved at the

time. Because you're like, "I've made a decision what to do with this, and it's not going

to be painting the wall red with my handgun." I think I remember feeling a little bit of

relief because I'd made a decision and I've got a path in front of me now. Somebody is

going to help guide me through this.

When asked how the decision to seek mental health affected his career, Juliet realized

that it was the right decision to make because of what the alternate would have been. He stated,

I don't think it negatively impacted my career. I mean, it changed the trajectory of my

career. At that point in time, the stigma of going or actually going through the mental

health stuff and talking to the counselor, other than it slowed down my career trajectory

because I changed a lot of the things I was doing, and not because I went to mental

health.

Juliet knew he had no other choice than to seek help or take his own life. He said, "I looked at it like, 'I'm kind of in a corner here, and if I'm not going to go this route then there's only one option left and that is to raise the white flag and get some help.'"

Statements from Juliet's interview that highlight the themes of his experience with military mental health stigma are presented in Table 20.

Table 20

Thematic Abstraction of Juliet's Experience

Theme	Participant statement
Personal struggle	"It was about 2008 when I was going through my first divorce. I don't know if you know, you might know, that my younger brother was killed in Iraq in 2003. That was a big change for everybody."
	"So, although I didn't know what was going on at the time, I probably had some sort of symptoms and trauma starting right around then, surrounding my brother's death."
	"We lost 10 guys in the squadron, which is a lot. . . . It was super difficult!"
	"I became comfortable, although super angry, I became comfortable in Iraq. I was like, 'I know what I'm doing here. I go home, I don't know what the hell is going on. I don't know who's in my house or what's going on with my kids.' So, . . . I put a gun to my head. I was like, 'I don't want to leave here, and I'm not getting hurt.' So, I was like, 'Noone's going to get me, you know, so, I'm gonna get myself.'"
Distrust of leadership	"I never told them about putting the gun to my head, because I knew if I did, they're gonna take my guns away. That would have been it."
Denial	"So, I kinda had a built-in scapegoat already. I mean, it wasn't the traumas of combat. I didn't have to look weak to anybody. It was this external factor of my wife that I had that was causing the problems. Years later I realized that that's not 100% the case. But you've gotta kinda unpack that stuff. At that time, I was like, 'It's not me, man. It's her. So, I'm going to see the doc because I'm messed up over it.'"
Fear of looking weak	"I didn't have to look weak to anybody."
Persecuted for needing mental health treatment	"It was like, 'Well, if I talk about suicidal ideations, then I'm gonna get pulled off the team.' I wanted help with the situation I was in, but the only thing I had going for me was the team. It was the job. I can't say that because they'll pull me off the team."

Steps to Mitigate Stigma

Juliet sought mental health services after placing a pistol to his head and contemplating taking his own life. His first reaction was to think of his mother and what she had gone through when his brother was killed in Iraq 4 years earlier. He decided he needed to seek help then. However, he dealt with this feeling several more times. When asked how he eventually overcame the stigma of having a mental health crisis and having these thoughts he said,

> It was like, "Alright. If I'm not going to do this for the sake of my mother, I gotta do something, or I'll be right back here tomorrow." It wasn't so much overcoming it, as it was making a decision to fight through it.

While the problems in Juliet's marriage were real, he was able to use those problems as a cover to seek help for the feelings he was having at his job. He said,

> So, I kinda had a built-in scapegoat already. I mean, it wasn't the traumas of combat. I didn't have to look weak to anybody. It was this external factor of my wife that I had that was causing the problems. Years later I realized that that's not 100% the case. But you've gotta kind of unpack that stuff. At that time, I was like, "It's not me, man. It's her. So, I'm going to see the doc because I'm messed up over it."

This allowed Juliet to enter mental health without raising a red flag in his career in the JSOC unit. However, when he decided to leave that unit and return to the conventional Army, Juliet developed the courage to share his story during his exit interview. He said,

> I got the exit interview and that's when I told the psych, at that point, I was like, "Yeah. I thought about this a couple of times, but I never said anything because I knew immediately you would've taken me off the team, and that's all I had. That was the one thing that kept me going."

Statements from Juliet's interview that highlight the themes of his experience with overcoming stigma are in Table 21.

Table 21

Thematic Abstraction of Juliet Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"No. I've got to find another way to deal with this."
Personal growth	"Then I thought about my mom, and I thought about what she had gone through just 4 years before that with my brother and everything and I was like, "No. I've got to find another way to deal with this."
Connecting with others	"I think I remember feeling a little bit of relief because I'd made a decision and I've got a path in front of me now. Somebody is going to help guide me through this."
Coverup	"So, um, I put it away and went back to work, and when I got home, I went, and I talked to the doc. You know? [REDACTED] has psych on staff. I talked to the guys on staff there, um, told them what was going on as far as the stress of the marriage, the breakup, all that kind of stuff, um, but never told them about that incident. I never told them about putting the gun to my head, because I knew if I did, they're gonna take my guns away. That would have been it. That was the job." "It was like, 'Well, if I talk about suicidal ideation, then I'm gonna get pulled off the team.' I wanted help with the situation I was in, but the only thing I had going for me was the team. It was the job. I can't say that because they'll pull me off the team. Right or wrong, I don't know."
Courage	"I didn't tell anybody about that until the end when I knew I was going to leave [REDACTED]."
Addressing the effects of the problem and not the source	"It was this external factor of my wife that I had that was causing the problems. Years later I realized that that's not 100% the case. But you've gotta kinda unpack that stuff. At that time, I was like, "It's not me, man. It's her. So, I'm going to see the doc because I'm messed up over it."

Kilo

Kilo's Overall Experience and Contribution to Themes

Participant Kilo first began experiencing signs of a mental health problem in 2006 after suffering injuries from an IED. Kilo had to be medevacked from Iraq and suffered a TBI, shrapnel-related injuries, and PTSD. He sought treatment involving counseling and returned to duty. It was 17 years later when Kilo was again in Iraq that one of his soldiers committed suicide and the unit leadership tried to make light of the serious incident. Kilo recalled,

> This last deployment I was on, I had one of my, uh, one of my soldiers commit suicide, and it was—the way the command handled it was just like deconstructed and they just wanted to—leading up to it, it could've been prevented, but they just ignored a lot of things, and then they were trying to discredit the entire thing and act like it never happened, sweep it from the newspapers, really just counterproductive.

Kilo entered counseling when he returned from his deployment. As he entered the behavioral health program, it triggered a temporary profile with a nondeployable status. Kilo had no physical limitations to his profile, but his command only viewed it as a temporary profile. This caused Kilo to be rejected from attending any professional military education programs (PMEs) like the master leader course (MLC) which was needed for promotion to master sergeant (MSG). Kilo was already an MSG and was interviewing for a sergeant major position. Upon review of his record, the promotion board noticed that he had not attended the MLC and that his promotion was erroneous. Kilo stated,

> The person that was on that board called me and said, "Hey. I need to tell you that you got erroneously promoted." I was like, "How did I get erroneously promoted?" "Well, you were supposed to have the Master Leaders Course to get your E8, and you don't have

it." So, I didn't have to pay the money back, but they scheduled me for the course so I

could keep the rank. I was cool with that, but I'm a behavioral health treatment program

so I've got a deployment limiting condition, zero physical limitations, so I can't deploy.

Kilo's command submitted paperwork to attend the MLC, but he was flagged for having

a temporary profile. Although he had no physical limitations and the Army regulations stated he

could attend because his temporary profile was deployment-related, his first sergeant (1SG)

pulled him from the course and later reduced him in rank to an SFC. Kilo recalled,

She talked to our G3 about it, and the only thing said was that I had a temporary profile

and could I attend a school. She didn't add any specificity to it, and so I got pulled from

the course the day prior. Then, 15 days later from that, I got an email from iPERMS

[military human resources] that was a request for reduction in rank, and then another

week from that, I was reduced. So, now I'm a SFC again when I was promotable ahead of

my peers on the SGM track, and now I'm below my peers.

Kilo has shared his story with other soldiers since going through this reduction. He could

see how his experience was affecting others regarding seeking MHS. He said,

My story and my issues have started coming to light more and more towards my soldiers

and people I'm dealing with, uh, and they're like, "Why would we want to come forward

if something like that happens and it bites us in the ass?"

At the time of the interview, Kilo was continuing to have difficulties related to PTSD

because of counterproductive leadership that lead to his injury and a string of suicides in his unit

during a single deployment. Regarding his injury, Kilo recalled,

One of my biggest constraints with PTSD is counterproductive leadership. Because the

last time I got blown up in Iraq, I told my 1SG that I need[ed] to take my driver off our

truck. I was like, "He's a liability. He's not listening to me. He's not maintaining our truck right. He's gonna get us hurt, killed, something." We had gone through 10 other blasts without a problem, but he wasn't listening.

Although Kilo was aware of the risk of this soldier remaining on the truck during missions, Kilo's 1SG would not listen. Kilo said,

That 1SG was like, "Well, we need the numbers out on the patrols and he's a qualified driver. You have just one more mission before you're off. We'll take care of it after the mission." I was like, "But after the mission, I need him off the truck. I can't trust him. When trust is broken, it's difficult to fix. Outside the wire is not where you fix trust immediately. You need to work on it inside the wire in a safe environment." So, that mission we saw the IED kind of like normal, and he could've swerved to the right and gotten our truck completely around it, and he swerved to the left and centered that blast on my door. I soaked up every bit of it.

Kilo stated that he continued to work to recover from the effects of this incident, but he also had trouble with what he saw as a possible cause of suicide in his unit. Kilo said,

That 1SGs actions became toxic because when you identified the issues that were wrong, he just let it happen, and ultimately it got people hurt. It could've got people killed. I lost 13 people on that mission to suicide, which we shouldn't have. So, everything traces back to that. It's just raw, and I can't work through it.

Kilo continued to express remorse for the loss of one of his soldiers. He recognized that these deaths had taken a toll on his mental health. He recalled,

Then, I guess he didn't work through his evils because he committed suicide, and uh, it was – of all the people I thought it should have been, um, I should've known it would've

been him. I should've given him more attention because I knew his past, and I didn't. I

feel even worse because me and my company commander that I had at the time, asked

him to go on this deployment. He wasn't told. We needed a crypto linguist to work with

the Inherent Resolve team, and he was like, "Yeah. I'll follow you anywhere." I never

knew he would follow me to his own death . . . . So, after so long losing battle buddies to

suicide and losing friends to suicide, uh, that I grew up with and family, I'm crushed. So,

after that, I knew I had a problem.

When asked how he reacted to the realization that he needed to seek professional

treatment for his mental health, Kilo said, "So, I was in denial. I was like, 'I'm gonna be able to

work through this. I'm gonna tough and just get over it.'" He thought about seeking help outside

of his unit, but other agencies were booked for several months, and Kilo did not feel comfortable

with group therapy. He said, "I didn't feel comfortable with group therapy, so I didn't try that at

all." Kilo was still hurting and looking for a way to learn to cope with his feelings. He had begun

reliving the events that began with the explosion in 2006. He finally found a counselor that

helped. Kilo stated,

> I never thought that you could relive experiences like all this, like people have said, and
>
> like movies say, but Good Lord, it's crazy! So, uh, I denied all of that until I got back.
>
> Once I started working with this counselor that works with the Texas Military
>
> Department, I'm moving forward and it's good. But it's still raw and difficult. I was in
>
> denial at first.

Kilo had already spoken about how his choice to attend a behavioral health program

initiated a temporary profile that caused him to be reduced in rank. However, when asked if he

would still make the same choice to attend mental health, Kilo responded,

Yes. I would definitely still get help. It's not predictable that I would've gone into this

situation with this counterproductive leader. But the other effects of me not getting

counseling, the impatient attitude, the aggression, the irritability, the lack of sleep and

constant fatigue— I don't think my wife and my family would've totally understood it if,

um, if I hadn't started the counseling and been more open with them. So, I 110% would

go to counseling again.

Kilo wanted to share his story to show that even when things begin to pile up and it

seems impossible to see a way out, it is never too late to seek mental health help. It is also

important to prioritize one's health over what one thinks may be causing harm.

Statements from Kilo's interview that highlight the themes of his experience with military

mental health stigma are presented in Table 22.

Table 22

Thematic Abstraction of Kilo's Experience

Theme	Participant Statement
Personal struggle	"I got medevacked from Iraq in 2006 for—we got hit by an IED, and I just absorbed it the wrong way, I guess. I've got shrapnel in me, and I've had a TBI. So, that's where I first started experiencing PTSD and TBI."
	"I lost 13 people on that mission to suicide which we shouldn't have. So, everything traces back to that. It's just raw and I can't work through it."
Distrust of leadership	"This counterproductive leader is screwing everybody and not taking the stigma and her position seriously."
	"My story and my issues have started coming to light more and more towards my soldiers and people I'm dealing with, uh, and they're like, 'Why would we want to come forward [to mental health] if something like that happens and it bites us in the ass?'"
Denial	"My problem with the TBI is, I didn't—I kinda just rode through it because I wanted to stay in the military. I just said, 'I'm good. Let's do this. I'm gonna go back fit for duty, and if I need to address any of this stuff later on, I will.' I didn't [know] for God knows how long."
	"I never thought that you could relive experiences like all this, like people have said, and like movies say, but good Lord, it's crazy! So, uh, I denied all of that until I got back."
Initial negative experience	"I worked with the vet center and those vet center programs. Some of those counselors are great and some of them aren't, and it's like I got paired up with the wrong counselors both times."
Fear of looking weak	"I did my best to not show that I was falling apart in front of soldiers because it really affected them."
Being treated differently	"The goal is to work through the PTSD, and expect the best, not the worst. This 1SG and this command just treated me like I'm broken and incapable."
	"I'm trying to get the master leaders course and the biggest thing is me saying, "I can still do it and I'm not broken. Stop treating me like this."
Persecuted for needing mental health treatment	"Then, 15 days later from that, I got an email from iPERMS [military human resources] that was a request for reduction in rank, and then another week from that, I was reduced. So, now I'm a SFC again when I was promotable ahead of my peers on the SGM track, and now I'm below my peers."

Steps to Mitigate Stigma

Kilo was in denial about his PTSD for a long time. He eventually sought treatment outside of his military unit. Kilo has worked through his stigma by connecting with other soldiers and people that ask about his experience. He stated,

So, I'm open with everybody. I go to these Yellow Ribbon events, and I keep in contact with my soldiers. We still have this signal chat group, this signal app up, and we all keep in touch still. If they ask how I'm doing, I'm upfront and honest with them. I'm like, "It's difficult. I'm good, good enough. I'm working through this counseling and I'm glad I'm doing it." I think the biggest thing I'm doing to negate the stigma is saying, "Do it. It feels good."

Because many of the problems associated with Kilo's mental health problems were a result of counterproductive leadership, Kilo made it a point to be a competent leader to those soldiers placed in his care. This was not only a positive example for the soldiers, but it was also therapeutic for Kilo.

Statements from Kilo's interview that highlight the themes of his experience with overcoming stigma are presented in Table 23.

Table 23

Thematic Abstraction of Kilo Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"So, after so long losing battle buddies to suicide and losing friends to suicide, uh, that I grew up with and family, I'm crushed. So, after that, I knew I had a problem."
Personal growth	"That's what I would tell all my soldiers beneath me, but to the O5s and O6s and SGMs, I would be like, 'Hey. This is the situation. I need help. Let's work through it. Let's counter the stigma.'"
Connecting with others	"I'm still fighting through it and I'm still trying to do what is right. I'm keeping my head up and I have no problem telling soldiers I'm in counseling."
	"So, I'm open with everybody…and I keep in contact with my soldiers. We still have this signal chat group, this signal app up and we all keep in touch still. If they ask how I'm doing, I'm upfront and honest with them. I'm like, 'It's difficult. I'm good, good enough. I'm working through this counseling and I'm glad I'm doing it.'"
Coverup	"I've got a counseling team when I get home. I just wanna get home."

Lima

Lima's Overall Experience and Contribution to Themes

Participant Lima first experienced signs of a mental health problem during an APFT run. He blacked out close to the finish line and was treated by unit medical personnel. The medics took him to see a primary care physician. He recalled speaking with the physician as follows,

> I said, "I don't know what it is. I'm running and I'm doing fine and then I start feeling a tightness in my chest.' Then I said, 'They made me the unit armorer as a PFC. I didn't want to be the unit armorer and sometimes I'm there and I have stuff I have to do for my section. I have stuff I have to do for the arms room, and I get told everything is a priority. So, whenever I'm sitting in the arms room by myself, there's sometimes where I start to feel like it's hard to breathe, I need to sit down because I'm feeling lightheaded."

After administering him some tests, the primary care physician told him that he was physically healthy and that he should see a mental health professional because he was exhibiting signs of stress and anxiety attacks. Lima was reluctant to speak to his chain-of-command because he did not know how they would react to him needing to see a mental health professional. He recalled,

> So, then she told me how I would go about seeing mental health . . . . It was also that whole thing of, "How do I take this up to my unit? How do I tell my unit, 'Hey, I want to go see mental health. I feel like I'm having anxiety and stress issues.'" It's not something that's easy and it's not something that's easy to bring up to your chain-of-command . . . . So, I took probably about 3 or 4 days going back and forth on whether or not I was going to go to mental health or whether or not I was going to try and handle the issue myself.

Lima knew there would be changes in how he was viewed if he made a decision to seek MHS. He said, "But I was like, 'How is that going to look if I go there? How is my chain-of-command going to look at me?' Because of course they would know if I went to mental health."

Lima did seek MHS and was doing well in therapy session at [REDACTED]. He had the support of his immediate chain-of-command and that made it easier for him to attend sessions, take his prescribed medications, and receive the help he needed. This all changed when he transferred to [REDACTED]. Lima recalled,

> Then, when I went to [REDACTED] and I was going through everything with my ex-wife, I had some physical issues as well and then, um, started having some trouble sleeping. So, I went back to mental health while I was there, and whenever I was dealing with all of that and at one point, I was considering all ways to get out of the Army, I had my warrant officer come up to me over and tell me that I didn't care about the Army, and

I didn't appreciate what the Army had given me. That was another one of those times where I was like, "Am I doing the wrong thing? Am I doing the wrong thing by trying to get out for my family? Am I doing the wrong thing getting mental health?"

Lima decided he still needed to seek MHS after having trouble sleeping. He made himself an appointment and immediately had trouble with leadership in his unit. Lima said, "They basically tried to make it seem like I was using behavioral health to get out of things." This compounded the stress and anxiety Lima was feeling. While dealing with the changes of a new, overseas duty station, Lima began having marital issues; at the same time, he changed medications and was prescribed Ambien. The Ambien worked for a short time, and then Lima began having sleep problems once again. The night of his argument with his wife, Lima took five Ambien and started having thoughts of suicide. Lima recalled,

So, I got in an argument with my ex-wife and all I could think about was killing myself. So, I went to the CQ [charge of quarters] desk and I'll never forget the look on this poor privates' face who's first duty station is Korea and he's on CQ. I said, "I need you to call someone." He goes, "I don't know if I can do that, and you're not supposed to be out of your room." It was like 3 in the morning, and you're supposed to be in your room at 1 in Korea. I looked at him and I said, "I'm gonna hurt myself. I need you to call someone." So, he freaked out because the sergeant was checking the arms room and he goes, "Sit down. Sit down right here." So, I sat down and kinda held it together. The sergeant came back and kinda had that look like, "What the fuck is this guy doing?" So, the private is like, "Hey. We need to call someone. He's going to hurt himself." The sergeant was then like, "Have you hurt yourself?" I was like, "No." He goes, "Are you okay?" I say, "I don't know."

Lima was transported by ambulance to a hospital in [REDACTED] where he was placed under suicide watch. As time passed, the Ambien began wearing off and Lima became aware of what he had said and done. Lima apologized and told the hospital personnel he was not a threat to himself or anyone else. He said, "I'm sorry. I was on Ambien. I don't feel like hurting myself. I don't know what came over me. I got into an argument with my wife and I'm feeling better now." This was not enough to gain his release. Lima was involuntarily admitted to the hospital psychiatric ward until he could speak with a doctor.

After speaking with a mental health professional and explaining what had happened, the doctor told Lima he did not think he was a danger to himself. He changed his sleep medication and advised Lima that he could go home but that it may be beneficial to remain in the hospital for a few days to continue to talk with someone about what was happening in his life. At this time, Lima's NCOIC and OIC had come to see him in the hospital. His NCOIC was caring and asked how he was feeling. His OIC wanted nothing to do with him because he believed he was a danger. Lima recalled, "My warrant officer seems more like he's concerned about his career and keeping me out of the way because obviously there's something wrong with me." Lima knew he would now be under the radar because he was hospitalized. He said, "Now that I've had this done, I feel like anything I do wrong is going to be magnified 10-fold because I was in the hospital."

Lima continued to feel different because he was no longer allowed to use a weapon. He could not go to the range with his unit. He felt ostracized by his chain-of-command and his fellow soldiers because he was not allowed to participate in weapons qualifications, and he used to be the armorer. He recalled,

It's kind of weird to be on that side of things because when I was the armorer, the chain-of-command would give me a list for people who were like "hey they can't have a weapon." I didn't know why, but I knew if they were on that list, they were either homicidal, suicidal, or some sort of risk. I knew that the armorer for our unit had something like that and was told, "Hey. If [REDACTED] tries to get a weapon, he can't get one."

Lima continued to be treated like an outcast by his unit until his decision to leave the military. When asked if he would make the same decision regarding his choice to seek MHS, he replied, "I would not make the same choice to take the Ambien. If I was still suicidal without the Ambien, it would have been a difficult decision, but I feel like I would do the same thing."

Statements from Lima's interview that highlight the themes of his experience with military mental health stigma are presented in Table 24.

Table 24

Thematic Abstraction of Lima's Experience

Theme	Participant Statement
Personal struggle	"I said, 'I don't know what it is. I'm running and I'm doing fine and then I start feeling a tightness in my chest.' Then I said, 'They made me the unit armorer as a PFC…So, whenever I'm sitting in the arms room by myself, there's sometimes where I start to feel like it's hard to breathe, I need to sit down because I'm feeling lightheaded.'"
	"…I was like, 'Am I doing the wrong thing? Am I doing the wrong thing by trying to get out for my family? Am I doing the wrong thing getting mental health?'"
	"So, I got in an argument with my ex-wife and all I could think about was killing myself."
Distrust of leadership	"It's not something that's easy and it's not something that's easy to bring up to your chain-of-command."
	"That's the big thing – even once you go, it's hard to communicate with them without feeling like you're gonna say something wrong and get in trouble."
Denial	"What's wrong with me? That was the first thing I thought. I thought, 'What's wrong with me?' Because I said, 'How could it be psychological if I'm blacking out? How could it be psychological if it's something I feel in my chest? How could it be something wrong with my brain?'"
Fear of looking weak	"For me it's not easy for me to open up. It's gotten a lot easier over the years, especially with my current wife. But back then it was like, 'I'm a man! I'm a soldier! I'm supposed to be on lock with all this.'"
Being treated differently	"Because of course, as soon as I said I was going to behavioral health, all the questions started coming like, 'Oh my God! Are you suicidal? Do we have to put you on suicide watch? Are we going to have to be on weapons restrictions?' I was like, 'No I'm not. I'm not suicidal. I'm not homicidal. I don't plan on doing anything crazy. It's just stress and anxiety.' I had to tell them that for them to kind of relax a little bit…"
	"My warrant officer seems more like he's concerned about his career and keeping me out of the way because obviously there's something wrong with me."
	"Now that I've had this done, I feel like anything I do wrong it's going to be magnified ten-fold because I was in the hospital."
Betrayal	"I also knew he was a lot closer with everyone in the unit because I was the new guy. So, I'm pretty sure he probably told people that I can't draw a weapon and that's why I'm getting looks."
Persecuted for needing mental health treatment	"It was like, 'I'm not suicidal. 50mg of Ambien messed me up. I got in an argument with my wife. I recognized I was feeling something that was not me and I got help. Now I'm being punished for it.'"

Steps to Mitigate Stigma

Lima overcame his stigma by first realizing he could not control his stress and anxiety on his own. He knew he would need someone to help him learn ways to work through his mental health issues. He said,

> I was thinking that if it is something mental, if it is something that I can get over, I'm going to need help. Because, as I was sitting there in the dark, I started to have that tightness in my chest again, and I realized that I didn't think it was something that I could handle on my own.

Lima was apprehensive about talking to his chain-of-command regarding his need for MHS, but eventually he gained the courage by speaking to a veteran he knew outside of the military. Lima recalled,

> I talked to someone that I know from my personal life that was a veteran, um, and they had a lot of issues that they didn't start getting help with until years after they got out. They were kind of the first person to tell me, "Hey. If you have something going on, there's no weakness in going in. I wish I would've known that whenever I was in, and there's people that understand that."

Statements from Lima's interview that highlight the themes of his experience with overcoming stigma are shown in Table 25.

Table 25

Thematic Abstraction of Lima Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"I was thinking that if it is something mental, if it is something that I can get over, I'm going to need help. Because, as I was sitting there in the dark, I started to have that tightness in my chest again and I realized that I didn't think it was something that I could handle on my own."
Personal growth	"I know that when you kill yourself it might seem like a good decision at the time, but there's no going back on that. There's no going back on killing yourself, and you leave behind a lot of people."
Encouragement	"So, the PA heard that and said, 'It sounds like you're having stress or anxiety attacks. I recommend you go see mental health.'"
	"I talked to someone that I know from my personal life that was a veteran, um, and they had a lot of issues that they didn't start getting help with until years after they got out. They were kind of the first person to tell me, 'Hey. If you have something going on, there's no weakness in going in. I wish I would've known that whenever I was in, and there's people that understand that.'"
	"My NCOIC checked on me and saw how I was doing. He told me I could call him if I needed anything."

Mike

Mike's Overall Experience and Contribution to Themes

Participant Mike first noticed signs of mental health problems near the end of his military career. During the last 5 years of his career, he began having difficulties with his weight. This led him to eventually being tested for testosterone levels at his local TBI clinic. Fluctuations in testosterone levels are common among victims of TBI (Ashley, 2020). Mike recalled,

I went in and got all the labs done for that. The Marine Corps started putting me on the

fat kid program. Then it came out that there were significant medical issues here. I mean

amongst the fact that somebody my age should have had a testosterone level of

somewhere between 600 and 700, and the highest number I put up was 82. Long story short, apparently if you get blown up enough, your endocrine system will shut off.

Low levels of testosterone resulting from a TBI were having an adverse effect not only on Mike's weight, but also on his mood. Mike said, "It kind of seemed like I was tired all the time. I was angry and just hated everybody and everything, or [was] just miserable and felt like crap. I felt like my head was stuck in peanut butter." Following his first testosterone shot, Mike noticed an immediate improvement. He said, "The first testosterone shot I got, it was the day before my daughter's ninth birthday, and the following day was the best day I had had for as long as I could remember."

Shortly after his testosterone treatment began, Mike was again deployed to a combat zone. During this time and upon returning home, Mike began to see how things had deteriorated before his treatment had begun. He said, "kind of like peeling back layers of fog, and then coming home from deployment and looking at how shitty things were. It was just kind of an eye-opener to how bad things were." Mike believed his actions had been self-destructive and that he was now fighting severe anxiety and depression. He said,

> In some ways I was fighting severe anxiety and depression and, um, forget trying to sleep at night between nightmares and everything else. It really came down to the fact that, um, had I not gone to the TBI clinic, I'd probably be dead now. It had gotten to that point where, um, I had struggled with suicide one other time in my life, and fortunately I didn't do it, but I knew what it felt like when you were that close to actually doing it. I started to feel like that again, and it wasn't a route I wanted to go down.

This is when Mike realized he needed to do something to combat his declining mental health. He sought MHS at his local TBI clinic. He was working through a TBI workshop for 2

months, and was doing well, before he was again deployed. When he returned, he felt like he was

in a worse place than when he had left. He recalled, "Right after I got back, it just got worse, and

everything blew apart. I literally called them and said, 'I need to be seen. I'm not in good shape.'

I spent 2-1/2 years at that place."

When asked how he overcame stigma and sought this type of mental health treatment,

Mike said, "I kind of stopped giving a shit about what everybody else thought." This created

tension with him and his chain-of-command, particularly his platoon commander. There were

times when Mike had to put himself first. He said,

> I mean, that still didn't stop some of the bullshit from people that are your boss and when
>
> you're gone all the time, they're like, "You need to be doing this." Then you're like, "No.
>
> I really don't give a shit about you right now. I'm going to take care of me." That caused
>
> some issues.

During this period, Mike received a tremendous amount of support from the Marines he

was in charge of. He said,

> I came back from a doctor's appointment at the TBI clinic, and my entire section looked
>
> at me and they're like, "Dude, you're not okay." I was just like, "Well there's a lot of shit
>
> I gotta get done." "No. You don't understand. You are not okay, and you don't need to be
>
> here." My entire section, which was comprised of sergeants and staff sergeants literally
>
> took me to my truck and told me, "You have had our back for a really long time. It is time
>
> to let us do what you have trained us to do." To me, that was a very profound moment.

The situation with his platoon commander continued to deteriorate, and Mike knew he

needed to transfer to a different unit if he was to continue his mental health treatment. His master

gunnery sergeant knew what type of Marine he was and moved him to a base team. Mike recalled,

> So, I got put into the base team, which was probably the best place I've ever worked at. I did as much as I could, but I was also given the opportunity to kind of fix me to include going through surgery and everything else.

When asked if his decision to seek mental health had a negative effect on his career, Mike replied,

> I was toward the end of my career anyway. For me, I already knew I wasn't going to get promoted again, even before I got that adverse FITREP. There is a possibility I could have kept going had it not been for that adverse FITREP, which also being on light LIMDU, I didn't get selected to master sergeant, so I had service limitations. In some ways that was probably a blessing in disguise. Because had I not had that and got selected, I would have kept going ,and I probably would have fucked myself up more physically and not dealt with what I needed to mentally and probably would be towards the end of a fairly ugly divorce.

When asked if he would make the same choices today regarding his decision to seek MHS, Mike replied,

> Nope! No, I wouldn't have. Because I made a decision to suffer in silence and not do anything for the better part of 15 years, almost 17. Last month was my 17-year wedding anniversary. I never thought it would ever get that far, and I still don't know whether or not I'll make it to 18. What I can say is my wife and I, for the last 3 months, have slept in the same room more than we have in the last 2 years. I mean, a lot of it I did because I wanted to save me and my family. If I had the opportunity to do it again, I probably

would try to fix what was wrong whenever it became a problem instead of hiding it and denying it for so many years.

Statements from Mike's interview that highlight the themes of his experience with military mental health stigma are presented in Table 26.

Table 26

Thematic Abstraction of Mike's Experience

Theme	Participant Statement
Personal struggle	"It kind of seemed like I was tired all the time. I was angry and just hated everybody and everything, or just miserable and felt like crap. I felt like my head was stuck in peanut butter."
	"In some ways I was fighting severe anxiety and depression and, um, forget trying to sleep at night between nightmares and everything else… I had struggled with suicide one other time in my life, and fortunately I didn't do it, but I knew what it felt like when you were that close to actually doing it. I started to feel like that again…"
Distrust of leadership	"I mean, that still didn't stop some of the bullshit from people that are your boss and when you're gone all the time, they're like, "You need to be doing this." Then you're like, "No. I really don't give a shit about you right now. I'm going to take care of me." That caused some issues."
	"I was kind of a giant shit umbrella for the guys that were under me. They didn't really realize how much so until after I left, which is why the platoon pretty much openly revolted against the platoon commander. Especially once they found out his parting gift to me was an adverse FITREP. So, I mean, it was extremely toxic platoon leadership and I kind of just stopped giving a shit about him and was like, 'I've given the Marine Corps almost 20 years of my life. It's time for me to fix myself so I can at least not blow my brains out two years after I get out.'"
Being treated differently	"Because it was one of those where if I don't stop getting fucked with by this platoon commander, I'm gonna get court martialed and he's probably going to be an invalid."
Persecuted for needing mental health treatment	"I was kind of where I knew I was getting a shitty FITREP and about the only thing that platoon commander was gonna do to hurt me with it is if he rolled it up and poked me in the eye. That's kind of a liberating feeling."

Steps to Mitigate Stigma

Mike was returning from a combat deployment when he began fighting severe anxiety and depression. His wife had moved out of the house, and he looked back on the last few years and realized how bad things had become. Mike recalled,

> I kind of came to the realization that my time in the military was vastly ending, and if I wanted to survive outside of the military function, I was going to have to do something because the path I was on, that was not it and that wasn't going to happen.

Mike deployed several more times over the next few years, and each time he returned from a deployment where he did not receive mental health treatment, his mental state was worse. He knew he needed to do something to receive the continued care he required. Mike was experiencing feelings associated with suicidal ideations. He knew the TBI clinic was a way to save his life. He said,

> It really came down to the fact that, um, had I not gone to the TBI clinic, I'd probably be dead now. It had gotten to that point where, um, I had struggled with suicide one other time in my life, and fortunately I didn't do it, but I knew what it felt like when you were that close to actually doing it. I started to feel like that again and it wasn't a route I wanted to go down.

Mike was battling with his platoon commander about attending his therapy sessions and this was creating tension in his unit. He had the courage to stand up for himself and place his mental health first. Mike said,

> I kind of stopped giving a shit about what everybody else thought . . . I mean, that still didn't stop some of the bullshit from people that are your boss and when you're gone all

the time, they're like, "You need to be doing this." Then you're like, "No. I really don't give a shit about you right now. I'm going to take care of me."

Although the situation with his platoon commander did not improve, he trusted his master gunnery sergeant enough to ask to be transferred to another unit to remain in treatment and so he would not get in trouble with his chain-of-command. Mike recalled, "I was fortunate enough to work for a Master Guns [master gunnery sergeant] who knew me long enough to know that when I told him I needed to go somewhere else to finish out, he sent me there." Mike took this opportunity to not only fix himself but also be an example for other Marines. He said,

> Initially I did it for myself and for my family. However, one of the things that I made it a point to do, because I knew there were other people in my platoon and in my section that had their own struggles with mental health; some of it combat-related, some of it not. I made it a point for my section to know if you need help to take care of something.

Mike decided that his mental health was more important than trying to remain in the military. He had already come to grips with his inevitable retirement and was now solely focused on his mental health. He recalled, "I've given the Marine Corps almost 20 years of my life. It's time for me to fix myself so I can at least not blow my brains out 2 years after I get out."

Statements from Mike's interview that highlight the themes of his experience with overcoming stigma are shown in Table 27.

Table 27

Thematic Abstraction of Mike Overcoming Stigma

Theme	Participant Statement
Realization that professional help is needed	"I kind of came to the realization that my time in the military was vastly ending, and if I wanted to survive outside of the military function, I was going to have to do something because the path I was on, that was not it and that wasn't going to happen."
Personal growth	"It really came down to the fact that, um, had I not gone to the TBI clinic, I'd probably be dead now. It had gotten to that point where, um, I had struggled with suicide one other time in my life, and fortunately I didn't do it, but I knew what it felt like when you were that close to actually doing it. I started to feel like that again and it wasn't a route I wanted to go down."
Connecting with others	"Initially I did it for myself and for my family. However, one of the things that I made it a point to do, because I knew there were other people in my platoon and in my section that had their own struggles with mental health; some of it combat-related, some of it not. I made it a point for my section to know if you need help to take care of something."
Trust	"When I was at one command and I was fortunate enough to work for a Master Guns [Master Gunnery Sergeant] who knew me long enough to know that when I told him I needed to go somewhere else to finish out, he sent me there."
Courage	"I kind of stopped giving a shit about what everybody else thought…I mean, that still didn't stop some of the bullshit from people that are your boss and when you're gone all the time, they're like, 'You need to be doing this.' Then you're like, 'No. I really don't give a shit about you right now. I'm going to take care of me.'"
Encouragement	"I came back from a doctor's appointment at the TBI clinic, and my entire section looked at me and they're like, 'Dude. You're not okay.' I was just like, 'Well there's a lot of shit I gotta get done.' 'No. You don't understand. You are not okay, and you don't need to be here.' My entire section which was comprised of sergeants and staff sergeants literally took me to my truck and told me, 'You have had our back for a really long time. It is time to let us do what you have trained us to do… To me, that was a very profound moment.'"

Group Analysis

After completing an individual analysis, in which themes were identified regarding experience with stigma and overcoming stigma within each case, the researcher conducted a group analysis to identify common themes among participants. In this section, the findings of the group analysis will be provided, including a description of each theme that emerged. Tables 28 and 29 presents the participants who had experiences that were documented within the negative themes within "Stigma," whereas Tables 30 and 31 provide a visual representation of whether the participant experienced the theme of "Overcoming Stigma."

Experience with Stigma

The researcher identified common themes among participants relating to their experiences with stigma in the military. The following themes had a negative impact on the participants' decision to seek mental health treatment while serving in the military. The negative themes enhanced military mental health stigma. Table 28 and 29 present the participants who were included in each of these themes of negative experiences with stigma.

Table 28

Participants' Negative Experiences with Stigma by Theme (Alpha – Foxtrot)

Theme	Alpha	Bravo	Charlie	Delta	Echo	Foxtrot
Personal struggle	X	X	X	X	X	X
Distrust of leadership	X	X	X		X	X
Denial	X	X				
Initial negative experience					X	
Fear of looking weak			X			X
Lack of knowledge about mental health treatment		X	X			
Being treated differently	X	X	X			
Betrayal		X	X			
Persecuted for needing mental health treatment	X				X	X

Table 29

Participants' Negative Experiences with Stigma by Theme (Golf – Mike)

Theme	Golf	Hotel	Juliet	India	Kilo	Lima	Mike
Personal struggle	X	X	X	X	X	X	X
Distrust of leadership	X		X	X	X	X	X
Denial		X		X	X	X	
Initial negative experience	X	X			X		
Fear of looking weak		X	X	X	X	X	
Lack of knowledge about mental health treatment					X		
Being treated differently	X	X	X		X	X	X
Betrayal	X					X	X
Persecuted for needing mental health treatment	X	X	X	X	X	X	X

Personal Struggle

All participants experienced personal struggles leading up to their realization that they had a mental health problem that needed attention. These personal struggles ranged from marital issues, feelings of depression, anxiety, and lack of satisfaction in life to flashbacks, nightmares, substance use problems, and guilt. Part of the reason servicemembers experience personal struggles is because of the cynicism they have developed during their time in the military, which conflicted with morals. "Cynicism – characterized as a generally negative worldview that considers others as untrustworthy, deceitful, and selfish – is an important barrier to healthcare for OEF/OIF/OND veterans" (Arbisi et al., 2013; Barefoot et al, 1989, as cited in Smith et al., 2018, p. 17). While cynicism creates barriers, optimism fosters a positive environment in which veterans are protected and have support for hopelessness and suicidal ideations (Bryan et al., 2013, as cited in Smith et al., 2018). To help servicemembers overcome personal struggles, cynicism must be replaced with optimism.

Distrust of Leadership

Distrust of leadership was experienced by 11 out of 13 participants. This distrust could be lack of trust regarding a single individual, unit chain-of-command, or the branch of service they were serving in. Whatever the cause of this distrust, it created an environment that made it difficult for the participant to engage in seeking mental health treatment. Military culture has bolstered mental health stigma and fostered a judgmental atmosphere of personal weakness as something the servicemembers should have under control. Military leadership plays a vital role in a servicemembers' ability to cope with stress, their level of mental health stigma, and their help-seeking behaviors (McGuffin et al., 2021). The attitude of military leadership regarding mental health has fostered this distrust because leadership actions often do not correlate with their words. Similar stories were shared throughout the study, identifying instances of leadership distrust.

Denial

An initial denial regarding the existence of personal mental health problems was reported by six out of 13 participants. The fewer number of participants in this theme illustrates that while denial is an important aspect of struggling to accept that a mental health issue is present, it is not as significant as other themes. In this study, denial took the form of not being aware of the difficulties one may be experiencing, or it was denying to others there was a problem. Fear of stigma can generate an environment in which denying one's mental health seems best. However, this atmosphere can make it increasingly difficult to discuss the root of many mental health problems (Roscoe, 2021). Participant Bravo stated, "For the longest time, I felt ostracized and even with the little computer questionnaire . . . I lied the first couple of times and said everything was fine." Participant Hotel accepted that he had experienced trauma but denied that it was any

more significant than what anyone else had experienced. This indicated that he did want to accept that trauma had a negative effect on him. He stated he felt guilty for even needing help.

Initial Negative Experience

An initial negative experience with mental health treatment was reported by four out of 13 participants. This created a barrier to treatment and made it difficult for them to choose treatment in the future. Participant Echo was turned away by a mental health technician during her initial visit to MHS. She said, "I went over there, and I saw one of their technicians and they basically told me that I didn't need any mental health treatment. I was kind of dismissed." Participant Golf was betrayed by his mental health provider during his initial experience with MHS. His provider relayed what they were discussing to his incoming unit in Iraq. As mental health professionals, we have only one chance to make a first impression with new clients.

Fear of Looking Weak

A fear of looking weak in front of other people was reported by seven out of 13 participants. Other people were family, friends, fellow servicemembers, or their leaders. Warner et al. (2008, as cited in Hernandez et al., 2017) discussed the belief that receiving MHS would cause servicemembers to appear weak to their fellow servicemembers. Fear of looking weak became a strong enough factor that it kept them from initially seeking mental health services. Participants voiced this fear no matter their rank, from lower enlisted to senior enlisted. Participant Charlie, as a specialist in the Army, said, "My biggest concern before going [to MHS] was how I would be perceived as a leader . . . and everybody that was below my ranking that I had oversight to." Participant Foxtrot, as a CW4 Apache pilot, said, "We don't want to portray weakness. So, mental health was a weakness." These quotes illustrate that it can affect anyone.

Lack of Knowledge about Mental Health Treatment

Hesitance to seek MHS because they either were unaware of what took place during mental health treatment, or they had misperceptions of what happens in mental health treatment was reported by three out of 13 participants. Participant Charlie said, "My only experience with seeing what happens to people in mental health facilities was in the movies . . . people in like the nuthouse . . . being put in a straitjacket, and that's just kind of like what I envisioned." Whereas only three of 13 participants identified a lack of knowledge about mental health as being a barrier to seeking treatment, it is something to be aware of when working to destigmatize mental health.

Being Treated Differently

Instances of differential treatment by military leadership, fellow servicemembers, and sometimes family members were reported by nine out of 13 participants. The fear of being treated differently is a common barrier to help-seeking behavior for military servicemembers often resulting in prejudice and discrimination (Clement et al., 2014, as cited in Vidales et al., 2021). Participant India said, "Someone is going to think something about you because you had to go to mental health." The fear of differential treatment is real and was prominent in this study.

Betrayal

Betrayal by someone in whom they placed trust was reported by five out of 13 participants. This betrayal came after confiding in the individual about their mental health concerns. Betrayal can come from a friend, family member, colleague, or even a mental health professional. Participant Charlie confided in his girlfriend after making his decision to go seek MHS. She broke his trust and spoke to her military chain-of-command, resulting in Charlie being taken out of his barracks by military police and placed in an inpatient mental health facility. Participant Golf's trust in his mental health provider was broken when his personal information

and mental health condition was reported to his incoming unit in Iraq. Stories like these cause problems for individuals looking to seek MHS. These instances also make it difficult for the individual to trust in the future and can potentially lead to them not seeking further MHS.

Persecuted for Needing Mental Health Treatment

A form of persecution for needing mental health treatment was reported by 10 out of 13 participants. Because of differential treatment, servicemembers who choose to seek help often drop out before completing treatment for fear persecution and a negative impact on their career (Brown & Bruce, 2016; Jennings et al., 2016, as cited in Vidales et al., 2021). There is a connection between the fear of differential treatment, distrust of leadership, and persecution for needing mental health treatment. While leaders say they want to help their servicemembers, the results of this study show their actions to be contrary when servicemember seek MHS. Participant Kilo sated, "Then, 15 days later from that, I got an email from iPERMS that was a request for reduction in rank." Participant Alpha said, "I think it had a lot to do with my not making Colonel." Stories of persecution by military leaders were expressed by 77% of participants.

Experience with Overcoming Stigma

The researcher identified common themes among participants relating to their experiences with overcoming stigma. The following themes had a positive impact on the participants ability to overcome stigma and make the decision to seek mental health treatment while serving in the military. Table 30 and 31 show participant involvement by theme regarding experiences of overcoming stigma.

Realization that Professional Help is Needed

The realization that professional help is needed was reported as a contributing factor in 9 of 13 participants' decision to seek MHS by. These participants were more likely to place their need for help above any fear once they came to the realization that they needed professional help. Whereas this did not eliminate the fear, it appeared to provide an avenue for the servicemember to choose help. Participant Charlie stated, "I realized that it wasn't going to be enough for what I needed. I wasn't getting the support from her that I could've been getting from a professional." Participant Juliet said, "No. I've got to find another way to deal with this." Statements like these were common throughout the study and illustrate that more often than not, it takes realizing that one needs help before one seeks help.

Personal Growth

Personal growth was reported by nine of the 13 participants as a contributing factor in their decision to seek MHS. In instances of personal growth, servicemembers in this study put their mental health above their careers. Participant Echo stated, "It was far more important to get to the bottom of the way I was feeling than my clearance at the time." The data yielded statements like this throughout the study, showing that personal growth often accompanies one in accepting that professional help is needed to address mental health problems.

Connecting with Others

Connecting with others was reported as a contributing factor in four of 13 participants' decision to seek MHS. Whereas some participants did report this as a reason for their decision to seek mental health, it was seen more often as something that was a result of receiving mental health treatment. Participant Alpha stated,

One of the best things for me was to talk to people who had been there and had gone

through challenges and who shared those with folks. We did some workshops for people

redeploying and it was for people who had been wounded or psychiatrically, mentally

wounded and we did these retreats and soldiers were invited to come with their spouses.

People shared what they had been through and what mental health had done . . . It was

the sharing that, I think, was absolutely phenomenal for realizing you're not alone.

Participant Kilo stated, "I'm keeping my head up and I have no problem telling soldiers

I'm in counseling." Participant Mike expressed his interest in counseling derived from a concern

for himself and his family. However, after beginning treatment and seeing positive results, he

stated, "I knew there were other people in my platoon and in my section that had their own

struggles with mental health . . . . I made it a point for my section to know if you need help to

take care of it." The data showed statements like these were common after receiving mental

health treatment.

Coverup

Covering up why they were seeking MHS was reported as a contributing factor in six out

of 13 participants' decision to seek MHS. Over half of those that reported distrust in their leaders

also reported concealing their true reasons for seeking MHS. Participant Bravo stated, "She

asked me if I wanted her to label it what it was . . . . I asked her to label it marriage counseling

instead of what it really was." Participant Echo also stated, "I really didn't tell anybody that I

was going. I just said I had a medical appointment." The data show that the idea of concealing

one's reason for seeking MHS is to avoid differential treatment or persecution.

Trust

For seven out of 13 participants, trusting others was a contributing factor in their decision to seek MHS. The data in this study show that trust was important to over half of the participants when making their decision to seek MHS. Trust can be placed in family, friends, other servicemembers, and even in leadership and the healthcare system. In Participant Echo's case, she was lucky to have leadership that trusted her to take care of herself with her appointments. This allowed Echo to trust that they would not question where and why she was leaving work for an appointment. Participant Bravo had lost trust in his chain-of-command regarding his need for MHS. However, when he went to his local ombudsman, she made him feel comfortable enough for him to trust her with honest feelings. This allowed Bravo to seek MHS without fear of repercussions. Participant Hotel was able to speak with his battalion commander and receive his blessing to continue receiving treatment. Participant Alpha said, "If it hadn't been somebody I trusted, I might not have been willing to take the next step." The accounts of these participants show that when trust is fostered, seeking MHS is much easier for servicemembers.

Courage

Personal courage was reported as a contributing factor in four of 13 participants' decision to seek MHS. Whereas a little over 30% of the total participants expressed courage as a contributing factor, the theme nevertheless demonstrates how courage can be used to overcome stigma. Participants' accounts show that courage is needed when faced with a toxic work environment regarding mental health and when faced with certain prejudice toward mental health. Participant Hotel was able to gain the courage to seek services after he knew he was leaving the service. He did not care about the repercussions of seeking MHS. However, he later learned that his command was supportive, and he did remain in the military. Participant Juliet

was weary of revealing his mental state until he made up his mind to leave JSOC. He then developed the courage to speak truthfully about how he had been feeling. Participant Mike knew he needed to focus on his mental health and developed the courage to stand up to his platoon commander regarding differential treatment. He later spoke to his master gunnery sergeant and asked to be transferred to a unit conducive to his need to work on his mental health. The stories shared in this study regarding courage were all similar and show a need to overcome toxic leadership and toxic work environments regarding their stance on MHS.

Encouragement

Encouragement from others was reported as a contributing factor in six of 13 participants' decision to seek MHS. Nearly 50% of participants reported receiving encouragement from others as a reason for seeking MHS. Participant Hotel stated, "They were like, 'You need to go do this.' The NCOs in my life, the MFLC herself said, 'You need a little more help than what I'm giving you.'" Participant Lima received encouragement from his physician's assistant, as well as a veteran friend who told him there was no weakness in seeking MHS. After a short stay in an inpatient mental health hospital, Lima also received encouragement from his NCOIC. Whereas courage is needed in toxic environments, these participant narratives show that encouragement can bolster someone's courage to finally seek MHS.

Addressing the Effects of the Problem and not the Source

Addressing the effects of the problem and not the source was reported as a contributing factor to their decision to seek MHS by four participants or over 30% of total participants ($N =$ 13). By addressing their anxiety, depression, or other mental health condition, these participants were able to seek MHS but chose to avoid discussing why they were having these symptoms.

Whereas choosing not to discuss the cause of their symptoms was a form of avoidance, they did eventually choose to address the underlying problem.

Association Between Negative Experiences and Overcoming Stigma

The researcher examined the relationships between the themes contained within "Stigma" and "Overcoming Stigma," and the results of the analysis showed positive associations between these two categories of themes. Not all elements of negative experiences and overcoming stigma overlapped, but examining those that do offers a unique insight into what occurs when an individual is faced with the stigma of mental health and decides to seek MHS.

Regarding the themes that overlapped between these two categories, all participants discussed experiencing a personal struggle upon realizing they had a mental health problem. There were also positive interactions between the theme *Personal struggle* (in the "Stigma" category) and *Personal growth,* and *Trust* (in the "Overcoming Stigma" category). The remaining five themes of "Overcoming Stigma" had an association of less than or equal to 50% with "Stigma" themes and are not reported. Three out of four of the associations between *Personal struggle, Distrust of leadership, Being treated differently,* and *Persecution for needing mental health treatment* and *Trust* were under 50%. However, this researcher thought it was important to show this relationship. *Realization that Professional Help is Needed* and *Distrust of Leadership* were strongly correlated as well.

Whereas results regarding affiliation with branch of service is important, this researcher did not report any results because of lack of branch representation. In this study, participants are represented by Army (54%, $N = 7$), Marine Corps (8%, $N = 1$), Navy (15%, $N = 2$), and Air Force (23%, $N = 3$). Therefore, any data regarding affiliation with branch of service would not be an adequate representation of the reality of mental health stigma in each branch.

Personal Struggle and Realization that Professional Help is Needed

Figure 1 presents the association among participants of the themes *Personal struggle* and

Realization that professional help is needed.

Figure 1

Association Between Personal Struggle and Realization that Professional Help is Needed

Participant	Personal struggle	Realization that professional help is needed
Alpha	X	
Bravo	X	
Charlie	X	X
Delta	X	
Echo	X	X
Foxtrot	X	
Golf	X	X
Hotel	X	X
India	X	X
Juliet	X	X
Kilo	X	X
Lima	X	X
Mike	X	X

Sixty-nine percent of participants who had a personal struggle with mental health stigma

reported the realization that professional help is needed as one of the reasons for overcoming

mental health stigma and deciding to seek MHS. Statements from participant Echo illustrate the

importance of realizing one potentially needing professional help in overcoming personal

struggles. Regarding personal struggle, Echo said, "Well, I just started to feel kind of, not right,

where I didn't want to do anything. I was just kind of depressed." Regarding the need for

professional help, Echo said, "Even though the mission was still an important mission, it wasn't,

I don't want to say, as serious, but the way I was feeling, I knew I needed to talk to somebody."

This shows that Echo was struggling with depression and knew well enough to seek help.

Personal Struggle and Personal Growth

Figure 2 shows the association between *Personal struggle* and *Personal growth*.

Figure 2

Association Between Personal Struggle and Personal Growth

Participant	Personal struggle	Personal growth
Alpha	X	X
Bravo	X	
Charlie	X	
Delta	X	
Echo	X	X
Foxtrot	X	
Golf	X	X
Hotel	X	X
India	X	X
Juliet	X	X
Kilo	X	X
Lima	X	X
Mike	X	X

Sixty-nine percent of participants who had a personal struggle with mental health stigma reported personal growth as one of the reasons they were able to overcome mental health stigma and seek MHS. Statements from participant Alpha illustrate the importance of personal growth in overcoming personal struggles. Regarding personal struggle, participant Alpha said,

I said, "I'm fine. What are you talking about?" He says, "Sir, you need to go home." I again said, "I'm fine. What are you talking about?" He then said, "Sir, what day is it?" "I don't know." "What month is it?" "I don't know." I kept telling him I was fine.

Regarding personal growth, Alpha said, "I gotta swallow some pride, and also, I have a lot to learn." This association shows that Alpha realized he was having difficulties with his memory and could learn from seeking MHS.

Personal Struggle and Trust

Figure 3 shows the association between the themes of *Personal struggle* and *Trust.*

Figure 3

Association Between Personal Struggle and Trust

Participant	Personal Struggle	Trust
Alpha	X	
Bravo	X	X
Charlie	X	
Delta	X	X
Echo	X	X
Foxtrot	X	X
Golf	X	
Hotel	X	X
India	X	X
Juliet	X	
Kilo	X	
Lima	X	
Mike	X	X

Fifty-four percent of participants who had a personal struggle with mental health stigma reported the development of trust as one of the reasons for overcoming mental health stigma and deciding to seek MHS. Statements from participant Foxtrot illustrate the importance of trust in overcoming personal struggles. Regarding personal struggle, Foxtrot said,

I was going through some marital issues. Um, uncontrolled thoughts, anger, um, being so angry at the littlest thing. Like, somebody at the dining facility asking for your ID [identification] card, or something, and they say it in the wrong way and you just snap. You know what I mean? Just little things. It wasn't a giant thing, it was just little things that, uh, made you so angry for no reason. So, I was getting angry for no reason. Regarding trust, Foxtrot said, "I talked about it with my commander, and he referred me." Whereas Foxtrot did not speak immediately to his commander when the symptoms arose,

he did develop enough thrust in his commander to later reveal the state of his mental health.

Distrust of Leadership and Realization that Professional Help is Needed

Figure 4 presents the participants whose statements contributed to the theme, *Distrust of leadership* and those that contributed to the theme, *Realization that Professional help is needed*.

Figure 4

Association Between Distrust of Leadership and Realization that Professional Help is Needed

Participant	Distrust of leadership	Realization that professional help is needed
Alpha	X	
Bravo	X	
Charlie	X	X
Delta		
Echo	X	X
Foxtrot	X	
Golf	X	X
Hotel		X
India	X	X
Juliet	X	X
Kilo	X	X
Lima	X	X
Mike	X	X

Seventy-two percent of participants who endorsed the theme *Distrust of leadership* reported *Realization that professional help is needed* as one of the reasons for overcoming mental health stigma and deciding to seek MHS. Statements from participant India illustrate the importance of realizing one needs professional help in overcoming distrust of leadership. Regarding distrust of leadership, India said, "I guess I just didn't want them to know what was going on in my marriage, per se'. It was kind of, uh, more of a private thing." Regarding needing professional help, India said,

That probably went on for six to eight months before we decided, as a couple, to say,

"Hey, let's go to mental health and see if we can get some marital counseling." Because,

at the time, we both agreed that that was a good idea, to go and get help to see if we could

salvage the marriage.

These statements illustrate that India knew she and her husband needed marriage

counseling through MHS, but that she did not feel comfortable sharing this with her unit

leadership.

Distrust of Leadership and Personal Growth

Figure 5 presents the association between *Distrust of leadership* and *Personal growth*.

Figure 5

Association Between Distrust of Leadership and Personal Growth

Participant	Distrust of Leadership	Personal Growth
Alpha	X	X
Bravo	X	
Charlie	X	
Delta		
Echo	X	X
Foxtrot	X	
Golf	X	X
Hotel		X
India	X	X
Juliet	X	X
Kilo	X	X
Lima	X	X
Mike	X	X

Seventy-three percent of participants that had distrust of leadership reported personal

growth as one of the reasons they were able to overcome mental health stigma and seek MHS.

Statements from Juliet illustrate the importance of personal growth in overcoming distrust of

leadership. Regarding distrust of leadership, Juliet said, "I never told them about putting a gun to

my head, because I knew if I did, they're gonna take my guns away. That would have been it."

Regarding personal growth, Juliet said, "Then I thought about my mom, and I thought about

what she had gone through just four years before that with my brother and everything and I was

like, "No. I've got to find another way to deal with this."

Juliet was contemplating suicide but knew he could not speak about it with his command

because he would lose access to his firearms and thus lose his job. However, he knew if he did

not get help that he may commit suicide. He chose to not put his mother through the loss of

another child and instead chose to speak with MHS upon leaving JSOC. Stories of people not

trusting command and eventually choosing MHS were common in this study.

Distrust of Leadership and Trust

In Figure 6, associations between themes of "Stigma," *Distrust of Leadership* and

"Overcoming Stigma," namely, *Trust,* are shown. Forty-five percent of participants that had

distrust of leadership reported the development of trust as one of the reasons for overcoming

mental health stigma and deciding to seek MHS.

Figure 6

Association Between Distrust of Leadership and Trust

Participant	Distrust of Leadership	Trust
Alpha	X	
Bravo	X	X
Charlie	X	
Delta		X
Echo	X	X
Foxtrot	X	X
Golf	X	
Hotel		X
India	X	X
Juliet	X	
Kilo	X	
Lima	X	
Mike	X	X

While this interaction includes below 50% of total participants ($N = 13$), this researcher thought it important to discuss. Statements from participant Mike illustrate the importance of trust in overcoming distrust in leadership. Regarding distrust of leadership, Mike said, "I mean, that still didn't stop some of the bullshit from people that are your boss and when you're gone all the time, they're like, "You need to be doing this . . . That caused some issues." Regarding trust, Mike said, "When I was at one command and I was fortunate enough to work for a Master Guns [master gunnery sergeant] who knew me long enough to know that when I told him I needed to go somewhere else to finish out, he sent me there." Stories of trust in overcoming stigma were common in the study.

Being Treated Differently and Realization that Professional Help is Needed

Figure 7 shows the associations between *Being treated differently*, which is a theme in the "Stigma" category, and *Realization that professional help is needed*, in the "Overcoming Stigma" category.

Figure 7

Association Between Being Treated Differently and Realization that Professional Help is Needed

Participant	Being Treated Differently	Realization that Professional Help is Needed
Alpha	X	
Bravo	X	
Charlie	X	X
Delta		
Echo		X
Foxtrot		
Golf	X	X
Hotel	X	X
India	X	X
Juliet		X
Kilo	X	X
Lima	X	X
Mike	X	X

Seventy-eight percent of participants experienced differential treatment reported that realizing that professional help was needed was one of the reasons they were able to overcome mental health stigma and seek MHS. Statements from participant Lima illustrate how realizing one needs professional help is vital in helping servicemen overcome the stigma of differential treatment. Regarding differential treatment, Lima said,

Because of course, as soon as I said I was going to behavioral health, all the questions started coming like, "Oh my God! Are you suicidal? Do we have to put you on suicide watch? Are we going to have to be on weapons restrictions?" I was like, "No I'm not. I'm not suicidal. I'm not homicidal. I don't plan on doing anything crazy. It's just stress and anxiety."

Regarding the need for professional help, Lima said, "I was thinking that if it is something mental, if it is something that I can get over, I'm going to need help . . . I realized that I didn't think it was something that I could handle on my own." Over three-quarters of participants experiencing differential treatment have similar stories.

Being Treated Differently and Personal Growth

Figure 8 shows the associations between Being treated differently, a theme from "Stigma," and Personal growth, a theme from "Overcoming Stigma." Seventy-eight percent of participants who experienced differential treatment reported personal growth as one of the reasons for overcoming mental health stigma and deciding to seek MHS.

Figure 8

Association Between Being Treated Differently and Personal Growth

Participant	Being Treated Differently	Personal Growth
Alpha	X	X
Bravo	X	
Charlie	X	
Delta		
Echo		X
Foxtrot		
Golf	X	X
Hotel	X	X
India	X	X
Juliet		X
Kilo	X	X
Lima	X	X
Mike	X	X

Statements from participant Kilo illustrate the importance of personal growth in overcoming the stigma of differential treatment. Regarding differential treatment, Kilo said,

> The goal is to work through the PTSD, and expect the best, not the worst. This 1SG and this command just treated me like I'm broken and incapable and the biggest thing is me saying, "I can still do it and I'm not broken. Stop treating me like this."

Regarding personal growth, Kilo said, "That's what I would tell all my soldiers beneath me, but to the O5s and O6s and SGMs, I would be like, 'Hey. This is the situation. I need help.

Let's work through it. Let's counter the stigma.'" Over three-quarters of participants experiencing differential treatment have similar stories.

Being Treated Differently and Trust

In Figure 9, the association between *Being treated differently* and *Trust* are shown. Forty-four percent of participants who experienced differential treatment reported the development of trust as one of the reasons for overcoming mental health stigma and deciding to seek MHS.

Figure 9

Association Between Being Treated Differently and Trust

Participant	Being Treated Differently	Trust
Alpha	X	
Bravo	X	X
Charlie	X	
Delta		X
Echo		X
Foxtrot		X
Golf	X	
Hotel	X	X
India	X	X
Juliet		
Kilo	X	
Lima	X	
Mike	X	X

While this interaction is below 50%, this researcher thought it important to discuss. Statements from participant Bravo illustrate the importance of trust in overcoming the stigma of differential treatment. Regarding differential treatment, Bravo said,

> That's what I thought would happen if I told them, 'Hey look, this is what's been going on." I thought they would say, "You have to go to an inpatient facility, we're taking everything from you, you can't see your wife and kids, you can't work in your unit anymore, and you will be a non-useful body to us. Thanks."

Regarding trust, Bravo said,

The ombudsman was in the hospital. She sat me down and cared, and not only that, but

she also gave me a hug. She saw I needed it and that kind of shook me out of this, "Okay,

Doc. What are we doing here?" She said, "Look, human beings were designed to be close

to one another." That dropped my guard, and I wasn't scared she was going after my job.

Whether it is a fear of differential treatment or an act of being treated differently, trust is

an important factor to overcome the stigma.

Persecuted for Needing Mental Health Treatment and Realization that Professional Help is Needed

Figure 10 shows the association between the "Stigma" theme of, *Persecuted for needing*

mental health treatment and the "Overcoming Stigma" theme of, *Realization that professional*

help is needed. Eighty percent of participants that experienced persecution for needing mental

health treatment reported realizing that professional help is needed as one of the reasons for

overcoming mental health stigma and deciding to seek MHS.

Figure 10

Association Between Persecuted for Needing Mental Health Treatment and Realization that

Professional Help is Needed

Participant	Persecuted for Needing Mental Health Treatment	Realization that Professional Help is Needed
Alpha	X	
Bravo		
Charlie		X
Delta		
Echo	X	X
Foxtrot	X	
Golf	X	X
Hotel	X	X
India	X	X
Juliet	X	X
Kilo	X	X
Lima	X	X
Mike	X	X

Statements from participant Mike illustrate the importance of realizing one needs

professional help in overcoming the stigma of persecution for needing mental health treatment.

Regarding persecution for needing mental health treatment, Mike said, "I was kind of where I

knew I was getting a shitty FITREP and about the only thing that platoon commander was gonna

do to hurt me with it is if he rolled it up and poked me in the eye. That's kind of a liberating

feeling." Regarding needing professional help, Mike said,

> I kind of came to the realization that my time in the military was vastly ending, and if I
>
> wanted to survive outside of the military function, I was going to have to do something
>
> because the path I was on, that was not it and that wasn't going to happen.

> Over three-quarters of those that identified persecution for needing MHS have similar

stories.

Persecuted for Needing Mental Health Treatment and Personal Growth

In Figure 11, themes between *Persecuted for needing mental health treatment* and

Personal growth are presented.

Figure 11

Association Between Persecuted for Needing Mental Health and Personal Growth

Participant	Persecuted for Needing Mental Health Treatment	Personal Growth
Alpha	X	X
Bravo		
Charlie		
Delta		
Echo	X	X
Foxtrot	X	
Golf	X	X
Hotel	X	X
India	X	X
Juliet	X	X
Kilo	X	X
Lima	X	X
Mike	X	X

Ninety percent of participants that experienced persecution for needing mental health

treatment reported personal growth as one of the reasons for overcoming mental health stigma

and deciding to seek MHS. Statements from participant Echo illustrate the importance of

personal growth in overcoming the stigma persecution for needing mental health treatment.

Regarding persecution for needing mental health treatment, Echo said,

> You didn't ever advertise that you were going to mental health. I had a TS/SCI [Top
>
> Secret/Sensitive Compartmented Information] with a few other identifiers attached to
>
> that…You couldn't; it was highly discouraged to go to mental health. Highly discouraged
>
> because you could lose your clearance…So, you didn't advertise that you were going.

Regarding personal growth, Echo said. "It was far more important to get to the bottom of the way I was feeling than my clearance at the time." Almost all of those that experienced persecution for needing MHS reported personal growth as a decision to seek MHS and had similar stories.

Persecuted for Needing Mental Health Treatment and Trust

Figure 12 shows the association between the theme, *Persecuted for needing mental health treatment,* in the "Stigma" category and *Trust* in the "Overcoming Stigma" category. Fifty percent of participants that experienced persecution for needing mental health treatment reported trust as one of the reasons for overcoming mental health stigma and deciding to seek MHS.

Figure 12

Association Between Persecuted for Needing Mental Health Treatment and Trust

Participant	Persecuted for needing mental health treatment	Trust
Alpha	X	
Bravo		X
Charlie		
Delta		X
Echo	X	X
Foxtrot	X	X
Golf	X	
Hotel	X	X
India	X	X
Juliet	X	
Kilo	X	
Lima	X	
Mike	X	X

India's statements are a good example of this interaction. Regarding persecution for needing mental health treatment, India said,

I remember talking to my superintendent, and I don't recall exactly what I said to him, but it must have been something on a personal nature like, "Hey. I just recently divorced.

I'm a single mom. It's a lot." He asked me, he said, "Do you need to go to mental

health?" He asked it with such a tone that put me off, and I remember telling him, "No. I

don't need to go to mental health." He asked it in such a way that I felt like if I said yes

that I needed to go to mental health that it would somehow be a reflection on me, and

maybe on my approval rating.

Regarding trust, India said, "So, I didn't really have apprehension from anyone at work or

anyone in the military about going." India had trust in her military leaders at her first duty station

and had no fear of going to MHS. Whereas her superintendent at her overseas assignment made

her fearful about seeking MHS, and she chose not to go, stories of trust as being important in

overcoming mental health stigma were common throughout the study.

Focus Group Analysis

The focus group took place following the completion of all interviews. This researcher

invited all participants to the focus group, but it was not mandatory. Four of 13 participants were

present at the Zoom call and three others answered the focus group questions through email. The

call began with the researcher thanking each participant for their time and interest in the focus

group. The researcher then asked the participants to speak about their experiences in the study.

All participants said they enjoyed the study and that it provided them with an opportunity to

evaluate their past experiences of acknowledging when they first identified they had a problem

with mental health. They also thought the study was important because it brought to light what

servicemembers go through when dealing with mental health issues while in the military.

Participant Delta shared,

If this study had been out there prior to and seeing what we need for the military member

while they're active duty versus how we can repair the veteran as they retire, separate,

whatever the case may be, um, my big push was, "If we can help you in the military, we can keep you from committing suicide as a veteran." It breaks my heart to have to see and do the repair work in the end. If we were to do a better job while we're active-duty— being able to debrief, being able to process, and give you the coping skills as you need them, and as you're processing with your families and those types of things, we wouldn't have the suicide rate we have now as veterans.

Participant Lima responded through email. He commented, "My experience was good. I felt that it was an important study and that there is a possibility of helping others with how mental health in the military is approached." Participant Bravo said he was proud to be a part of this study because it made him realize that even though servicemembers are angry, they do not need to let that define them. He said,

> It's funny how you think you're alright and it doesn't affect me, but it does, um, to the point where, you know, you kind of take it out on those you love. So, this study definitely helped me realize that and process that and realize the military is something I did and I'm very proud of my service. However, there is a responsibility on all of us to make it better for, not necessarily ourselves, but the next generation that comes through.

Participant Mike responded, "Overall, my experience with the study was positive. Considering my personal experiences with seeking mental health while in the military, I do truly hope that this study bares [sic] fruit. Even if it only helps one person, it was worthwhile." There were no negative comments regarding the participants' experiences with the study. Participant Golf responded through email and said, "My experience with the study was a positive one. It was really the first time I got to speak about this stuff which I think in the end was therapeutic in themselves."

Next, the participants were asked what they thought about each interview question, beginning with Question 1. Question 1 asked participants to recall when they first identified they had a mental health problem. Participant Charlie answered first. He said, "Instead of saying problem, I would have used concern or challenge, something that is, I don't want to say more sensitive, but essentially that's what it is." He raised awareness of the stigma that is associated with words that carry a negative connotation. When I use the word problem, disorder, or issue, those words can trigger adverse responses in people and immediately put them on defense. Participant Alpha agreed with Charlie and stated, "I agree with that totally. When somebody raises that, you immediately get defensive. It's very easy to say, 'I'm fine.'" There were no further responses nor discussion regarding this question.

Question 2 asked participants how they reacted when they identified they had a mental health problem. Participant Bravo was the first to respond. He thought the question was good but thought it would be wise to ask if it was self-realization or if it was identified by someone else. He reflected on his own experience and how several of his fellow servicemembers told him he needed help. He said, "It was a number of people saying, 'Hey, look. You're dealing with a lot dude, and there's nothing wrong with you but you need to go get some help. So, maybe talk to somebody.'" Participant Alpha agreed with Bravo and interjected that this was also his experience and that he believed most people experience denial and do not accept that they have a problem until someone else identifies it and forces them to confront it. Participants Charlie and Delta did not respond to this question.

Question 3 asked the participants what steps they took to negate stigma and make the decision to seek MHS. Participant Bravo was the first to respond. He thought it was a good question but also thought it would be beneficial to ask if someone felt proud of seeking help or if

they felt ostracized for seeking help. He mentioned that he felt ostracized when he chose to seek help. His would ask, "How has the view of many people in your command climate changed toward you after seeking mental help?" The conversation became about seeking help with therapists that were trusted and how it would be beneficial for the military to allow active-duty servicemembers to seek outside (civilian) mental health resources rather than relying on those within their local units. Participants Charlie, Alpha, and Delta agreed with Bravo and did not have anything else to add regarding the question.

Question 4 asked the participants what effect their decision to seek mental health had on their career. Participant Bravo was again the first to respond. He said, "It was very important because it did highly impact everything in terms of your career. I think it was very important. I would have caveated with, you know, in what way did you notice it affected your career." This researcher reminded Bravo that the way in which the decision affected one's career came out in the discussion. Participant Alpha agreed with Bravo and shared how his decision led to his promotion being postponed by more than 1 year. Alpha believed his career was negatively affected by his decision to seek MHS. Participant Charlie spoke next. He said,

> For me, I don't think it really affected mine all too well. My occurrence was early on in my military career. It was during A-school. So, I knew I was going to be shifting commands after my A-school completion. I was hoping that stuff wouldn't carry over with me. Which it didn't. The question itself was good though.

> There were no further responses nor discussion regarding this question.

Questions 5 and 6 were not part of the original research questions and were developed while speaking with participant Alpha during the first interview of the study. Question 5 asked the participants to ponder their decision to seek mental health and if they would make the same

decision today. Participant Bravo responded first, "Yes. I completely agree. That actually shows mental growth and maturity. Knowing that we had these experiences, how do you look back on them and heal from them? So, I do think that's a very important question to ask." Alpha agreed on the importance of the question because it allowed people to look back on where they were and how far they have come. Participant Delta shared her opinion and experience. She said,

I do believe this is a very important question. Like everyone was saying, looking back, hindsight is 20/20 and if we could do differently, I don't think I would have made a decision other than what I had made because of the growth I have had since I was able to do that.

There were no further responses nor discussion regarding this question.

Question 6 asked the participants what they would say to military leadership regarding how mental health is viewed in the military. Participant Alpha thought it was a good question. Participant Bravo responded further by saying,

It is a very good question. Um, because it is from somebody who has been there, done that, so to speak. Everybody always wants to tell their attacker, aggressor, or whomever it is that's the person who hurt them, how they made them feel. I think that's kind of also helped with closure as well.

Participant Delta was the next to speak. She felt it was an important question but also wanted to share insight into how it could change military culture. She shared,

I feel that we would have a healthier military force if we were able to have an outlet in order to be able to get the help and get the coping skills so that way you can be a better person and become a better soldier and become a better military member, a family member, a commander, all those different things. So, if one of the things I say is if you

don't realize the benefit that you can have if you remove the stigma because you are

proactively, instead of reactively dealing with situations.

The remainder of the discussion regarding this question was a review of what was said to

military leadership by everyone during the initial interviews. Participant Golf, Lima, and Mike

responded through email and gave one response to all questions. Golf said, "I felt the questions

asked were appropriate and I'm eager to see what conclusions are drawn from the information

that is collected and furthermore if this can be used to help inspire positive changes in the

military." Lima said, "I felt that the questions were good, although a little hard to answer because

it was tough to relive events. It brought up feelings and emotions from the past." Mike said, "I

believe the questions that were asked were more than reasonable. I believe they served their

purpose to guide a conversation that allowed for the expansion of subjects relating to the study

that the servicemember may feel strongly about."

The researcher concluded the focus group by asking if there were any questions that the

participants wished were asked during the interview process. Participant Bravo would have

asked, "Since you've identified, or since you actually started going through mental health, how

many people around you have you noticed that could've possibly benefited from mental health?"

Bravo spoke about him being able to see other personnel in his unit who were struggling with

mental health issues and would keep quiet and drink at night, attempting to suppress their

feelings. Participant Alpha would have liked to have questions asked about what triggers an

individual experiencing a mental health problem may have and what modalities have worked for

treating a mental health problem. While these were good questions, the researcher spoke about

how they were better fitted for another study.

The focus group ended by allowing the participants to speak with each other about how they felt about the study or to ask one another any questions they may have. No personal questions were asked, and the participants maintained the topics relates to the study. This researcher concluded that the focus group was successful in providing insight into what was done correctly and what could have been added to make it more beneficial to the participants.

Reflexive Self-Analysis

The bracketing recommendations of Ahern (1999) were followed prior to, during, and after data collection and analysis. The researcher acknowledged his own experiences with mental health stigma in the military, and how those experiences may be a source of bias about how servicemembers with mental health problems are treated on active duty. Attempting to reduce bias and remain neutral is a crucial aspect to any research study. Therefore, the researcher noted his thoughts and feelings when reacting to interviews. The researcher discussed these feelings and thoughts with his personal counselor and his dissertation chair.

Summary

The researcher collected data through interviews and a focus group. The data of 13 participants were analyzed to explore common themes regarding their negative experiences with stigma regarding mental health in the military and their abilities to overcome mental health stigma and choose to seek mental health services. Following the completion of all interviews and the transcription of each interview, the researcher analyzed the data and identified themes where commonalities occurred between participants with respect to statements regarding their negative experiences with mental health stigma and their ability to overcome mental health stigma. The three strongest themes that portrayed ways in which participants were able to overcome stigma and choose to seek MHS were *Realization help was needed, Personal growth,* and *Trust.* Chapter

Five provides a summary of this study, steps military servicemembers can take to overcome stigma in deciding to seek MHS, participants' advice for military leaders, limitations of the study, implications for active-duty servicemembers, veterans, military leaders, and civilians, and ideas for future research.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

The purpose of this study was to explore the lived experiences of OEF/OIF veterans and how they overcame the stigma of mental health in the military. A surprisingly diverse sample of 13 participants were recruited, representing the Army (54%, $n = 7$), Marine Corps (8%, $n = 1$), Navy (15%, $n = 2$), and Air Force (23%, $n = 3$). The make-up of participants was not surprising given the prevalence of PTSD among the armed forces. PTSD is represented in the branches by the Army (63.2%), Marine Corps (13.9%), Navy (11.7%), and Air Force (11.2%; Judkins et al., 2020). Participants also ranged in rank from lower enlisted to senior enlisted and senior commissioned officers, as well as a warrant officer. The sample was also comprised of 10 males and three females. This variety of participants shows that mental health stigma does not discriminate based on gender, rank, miliary occupational specialty (MOS), or branch of service. The researcher was pleasantly surprised by the willingness of the participants to speak openly about their experiences and feelings regarding mental health in the military.

Two categories of themes emerged from responses to the individual interview questions, "Stigma" and "Overcoming Stigma." Participants recounted nine aspects of stigma they encountered: *Personal struggle* ($n = 13$), *Distrust of leadership* ($n = 11$), *Persecuted for needing mental health treatment* ($n = 10$), *Being treated differently* ($n = 9$), *Fear of looking weak* ($n = 7$), *Denial* ($n = 6$), *Betrayal* ($n = 5$), *Individual negative experience* ($n = 4$), and *Lack of knowledge about mental health* ($n = 3$). Themes in "Overcoming Stigma" were *Realization that professional help is needed* ($n = 9$), *Personal growth* ($n = 8$), *Trust* ($n = 7$), *Encouragement* ($n = 6$), *Coverup* ($n = 6$), *Courage* ($n = 4$), *Addressing the effects of the problem and the source* ($n = 4$), and *Connecting with others* ($n = 3$).

With respect to overcoming stigma, it should be noted that the strongest themes, which yielded commonalities among greater than 50% of participants, were the *Realization that professional help is needed, Personal growth, and Trust.* These themes involving overcoming stigma reflect an intrinsic motivation on the part of the participants. It appears from these findings that the method that an individual uses to overcome stigma is developed by their past experiences and their morals and values. Regarding overcoming stigma, the desire to seek help in the face of real consequences to their career must develop organically within the participant. Whereas one individual may choose to deceive their superiors to overcome the stigma, another may choose to be honest and accept whatever outcome follows. The personal nature of how stigma affects an individual and how one should overcome stigma cannot be taught, because it would carry the risk of imposing one's values and belief system on another. This researcher concluded from these findings that stigma is too personal to find common teachable themes of how an individual overcomes that stigma. However, there are many practical ways stigma can be reduced in the military.

Discussion

There is little to no research on teaching servicemembers how to overcome stigma. Researchers have explored factors affecting help-seeking behavior (Aikins et al., 2020; Anderson, 1995; Keling et al., 2020), perceptions of military culture and reintegration (Campbell et al., 2018; Orazem et al., 2017), and stigma and leadership (Hernandez et al., 2017; Campbell et al., 2018; Britt et al., 2020). This study contributes to the existing literature as there were previously no known research studies exploring methods used by servicemembers to overcome stigma. This study further contributes to the existing literature by providing insight into what servicemembers were experiencing before, during, and after identifying they had a mental health

problem, how it affected them, and what they did to overcome the stigma surrounding their decision to seek MHS. Participants were detailed in their responses to the interview questions. Additionally, participants provided detailed responses to what they believe needs to change about military culture and leadership regarding leadership views of mental health treatment in the military. The results of this study also contribute to the existing literature because it focuses solely on post-9/11 servicemembers and includes four of the six branches of the military. This section will elaborate on the common themes of realizing professional help is needed, personal growth, and trust.

Steps to Mitigate Stigma in Decision to Seek MHS

The data showed three of eight factors to overcoming military mental health stigma were shared by more than 50% of the participants. Because these common factors are intrinsic, the researcher has determined these cannot be taught regarding overcoming stigma and must be developed organically through life experiences. Military leaders, unit personnel, and mental health professionals can be made aware of the importance of these factors and be instructed how to make it easier to foster the necessary situations to allow these factors to develop, but teaching one to realize they need professional help, teaching one to grow as a person, and to trust others is not something the military can mandate.

Realization that Professional Help is Needed

Ten participants reported the realization that professional help is needed was a contributing factor in their ability to overcome mental health stigma and make a choice to seek MHS. This realization could be from self-awareness or from another person telling them that help was needed. Many factors can contribute to one realizing that they need professional help. When analyzing the statements from each participant, the data showed seven participants had

self-realization whereas three were told by others that they needed professional help. Participants Charlie, Echo, India, Juliet, Kilo, Lima, and Mike all became aware that they needed to seek mental health. Charlie knew he was not getting enough support from his girlfriend after confiding in her. Echo knew she had waited long enough, and her mental health needed to be a priority. India and her husband knew they needed to seek counseling if they were to save their marriage. Juliet knew he would soon be dead if he did not get help. Kilo had lost battle buddies and family to suicide, and he knew it was affecting him. He decided he needed help. Lima was uncertain what was happening to him but knew if it was something psychological, he could not handle it by himself. Mike would soon be retiring from the military, and he had seen what happened to some of his friends who did not get help. He decided he needed to fix what was wrong before leaving the military. These participants saw something they would not be able fix alone. They made the decision to get professional help.

Participants Alpha, Golf, and Hotel realized they needed help after someone identified they were acting differently. Participant Alpha was having difficulty remembering what day it was, what month it was, and the names of his children. He did not realize he needed professional help until someone asked him these questions, which forced him to face the severity of his mental state. Participant Golf was flagged by his answers on a questionnaire. He was then pulled aside and told it was best that he see a mental health professional. He said it was his choice, but he felt the way they approached him made him feel it was important. Participant Hotel was told by his NCOs and his local MFLC that he needed more help than they could provide.

Whereas realizing that professional help is needed cannot be taught, teaching others to see the warning signs of someone in a mental health crisis can be taught. Signs, such as sadness, anger, and apathy often accompany someone battling a mental health problem. People in the

military can be taught to look for someone cancelling plans, speaking more negatively about themselves, or becoming more agitated about things that used to not bother them. It is important to observe changes in sleep patterns, cognitive difficulty, and self-care (Juby & Tartakovsky, 2022). Training on how to identify a potential mental health crisis and how to approach someone that may need help is something the military can employ to combat the stigma of mental health in the military.

Personal Growth

Nine participants reported personal growth as a contributing factor in their ability to overcome mental health stigma and make a choice to seek MHS. The stories of participants Alpha, Echo, Golf, Hotel, India, Juliet, Kilo, Lima, and Mike align with wanting wellness in their lives rather than living in fear of what may occur. Alpha knew he needed to put aside his pride and realize that MHS could teach him how to be stronger. He also knew he could help other soldiers once he received the help he needed. Echo placed her mental health above the importance of her clearance. Golf knew it was best not to ignore what was happening and to seek answers. Hotel saw how mental health problems were occurring more often and knew it was something he needed to confront. India wanted to save her marriage. Juliet thought of what his mother had gone through when his brother was killed in combat. He did not want her to go through that again if he committed suicide. He knew he needed to find another way to deal with his mental health. Kilo was acting as an example for soldiers beneath him. He was also being honest with his officers so they could help him counter the stigma. Lima knew there was no coming back from suicide, and he did not want to hurt those left behind. Mike knew the TBI clinic saved his life. He now realized that the Marine Corps had taken 20 years of his life, and it was time to take care of himself.

Whereas personal growth to directly overcome stigma cannot be taught, it is possible to help servicemembers develop self-direction and personal responsibility. By doing so, one can identify areas of weakness. By fostering self-direction and personal responsibility, which can take many forms, one can experience personal growth despite their resistance to making changes. They may also seek opportunities to experience personal growth. This may be accomplished through programs that teach wellness. Studies have identified wellness as "a life orientation toward optimal health and realizing one's maximum potential" (Dunn, 1977; Myers et al., 2000, as cited in Weigold et al., 2020, para. 1). By teaching servicemembers to identify areas of their lives that would benefit from wellness, they can become stronger and less susceptible to internal and external stigma regarding their mental health.

Trust

Seven participants reported the development of trust as a contributing factor in their ability to overcome mental health stigma and make a choice to seek MHS. The importance of trust psychologically can be seen as far back as the first stage of Erikson's eight stages of psychological development. From infancy to 18 months of age, children learn to see others as trustworthy or develop an innate distrust of their environment (APA, 2023). Therefore, it is reasonable that trust is at the root of whether someone is willing to be vulnerable with another about their mental health.

Stories from participants Bravo, Delta, Echo, Foxtrot, Hotel, India, and Mike illustrate how trust is congruent with vulnerability. Bravo did not trust his chain of command because of how he was being treated for mentioning he wanted to seek mental health treatment. He then spoke to his local ombudsman and was made to feel comfortable enough to speak about his mental state. Bravo said, "She sat me down and cared, and not only that, but she also gave me a

hug. She saw I needed it and that kind of shook me out of this." Delta was made comfortable by those around her. No one in her unit saw mental health as an issue. Her sister was also a therapist, and Delta was aware of what took place during sessions. Echo had a chain of command that did not ask questions about going to appointments. She felt free enough to go seek mental health help without fear of repercussions. Foxtrot had a commander who was supportive and referred him to mental health. Hotel had the same experience as Foxtrot. Hotel's commander told him to do what he had to do to take care of himself. India also had a supportive chain-of-command with her stateside unit. She was able to get the help she needed for her marriage. Mike was having difficulties with his platoon commander regarding his need for mental health treatment. Luckily, he trusted his master gunnery sergeant enough to ask to be transferred to another unit where he could focus solely on his mental health before retiring from the Marine Corps. These stories demonstrate how trust can make the decision to seek MHS much easier for an individual battling a mental health problem and feeling overwhelmed by the stigma surrounding mental health in the military.

Implications

There are several implications for active-duty servicemembers, veterans, military leadership, and civilians. These implications include awareness and education on mental health stigma in the military for active-duty servicemembers, as well as awareness and outreach for veterans regarding mental health services. Further implications include education on the effect of military leadership on servicemembers regarding mental health, and how mental health stigma in the military correlates with civilian jobs.

Implications for Active-Duty Servicemembers

Servicemembers are advised to be aware of the stigma surrounding military mental health. As stigma can take many forms, it is vital that servicemembers know how each affects an individual. Although combat rotations are all but concluded in today's active-duty military, the number of mental health problems are still increasing with the reports of servicemembers suffering from psychiatric disorders and alcohol use disorders being more prevalent than in the general population (Ayer et al., 2022). Unit cohesion is taught from basic training, and there is often a strong bond that is formed between servicemembers. However, when an individual is suffering from a mental health problem, they can often feel ostracized. The bond they once felt from being a part of a unit can be broken. A servicemember can then feel they have no support from their leadership or their peers. Therefore, low levels of unit support can have a detrimental effect on the psychological wellbeing of someone with a mental health problem (Pietrzak et al., 2015).

Unit cohesion and psychoeducation about mental health should be paramount to newly enlisted soldiers and newly commissioned officers. Awareness about how mental health stigma affects servicemembers and how support from fellow servicemembers can foster positive environments for treating mental health should become quarterly programs in the military. More education is needed about treatment as well. Participant Charlie said, "My only experience with seeing what happens to people in mental health facilities was in the movies . . . people in like the nuthouse . . . being put in a straitjacket, and that's just kind of like what I envisioned." The participants held this stereotype, which is commonly associated with inpatient mental health facilities, and education about what occurs in inpatient facilities can lead to a decrease in myths about mental health and an increase in help-seeking behavior (McCleary-Gaddy & Scales, 2019).

Implications for Veterans

Many veterans have already experienced the stigma of mental health in the military. As they transition to civilian life, they may be struggling to receive the mental health treatment they need. They may be unaware of how to get the help they need and may be suffering from a mental health crisis. The stigma of mental health has caused many veterans to leave the military without receiving any form of mental health treatment, and many have been separated from the military because of a mental health problem.

The VA has many programs available for veterans seeking mental health treatment. The VA offers programs and services to treat anxiety, bipolar disorder, depression, effects of TBI, military sexual trauma, PTSD, schizophrenia, substance use, suicidal ideations, and tobacco use. These programs are offered and tailored for servicemembers transitioning from active duty to civilian life, veterans seeking support, women veterans, LGBTQ+ veterans, family members or friends, older veterans, healthcare providers, and college faculty members (VA, 2023).

Veterans suffering from mental health often struggle with mental health stigma even after being separated from the military. This interaction needs to be examined in relation to positive and negative effects of military service when studying the mental health of veterans (Campbell et al., 2018). Steps should be taken to help veterans reintegrate into civilian life and ease the stigma surrounding their mental health.

Implications for Military Leadership

This study identified distrust in military leadership as a barrier to seeking mental health treatment while in the military. This is because of disclosure/confidentiality concerns among military leadership and mental health professionals (Clement et al., 2015). This is also because of differential treatment by military leadership and a fear of repercussion and persecution for

needing mental health treatment. While military leaders at the highest levels have expressed a desire to foster an environment that is conducive to the mental wellness of their soldiers, the actions of leaders at unit levels contradict what is being said. India's story is a good example of the profound influence of military leadership in posing a barrier to servicemen getting the help they need. Whereas India was able to get the help she needed for her marriage because she had a supportive chain-of-command with her stateside unit, this changed when she was divorced and overseas. She was fearful of her superintendent and made the decision to deny her need for mental health treatment. India did not again seek MHS until she was separated from the military.

This researcher was able to contact U.S. Army General (Retired) David H. Petraeus and ask him about leadership and mental health in the military. General Petraeus served in the United States Army for 37 years. He was the commander of all coalition forces in Iraq from February 2007 to September 2008, commander of International Security Assistance Force (ISAF) and commander of U.S. Forces – Afghanistan (USFOC-A) from July 2010 to July 2011. He later served as the director of the central intelligence agency (CIA). First, when asked about his time in command and the importance of soldiers seeking mental health services, he replied,

> It was very important; that said, so were numerous other actions related to health services, e.g., seeking medical attention for wounds/injuries, seeking counseling for marital issues, seeking assistance with alcohol and drug-related issues. As you will appreciate, a commander seeks to emphasize a host of actions, and this was just one of many (D. Petraeus, personal communication, April 10, 2023).

Next, when asked about leaders viewing a soldier's need for mental health services as generating a red flag and hindering their ability to perform military duties, he replied, "It depended on how serious the issue was" (D. Petraeus, personal communication, April 10, 2023).

Lastly, when asked if he believed there needs to be a change in the way military leaders at all levels approach mental health, he replied,

> I think there has been an evolution on this issue; however, it is, at the end of the day, a very challenging one—because, undeniably, some mental health issues that a soldier might bring to leader's and/or medical attention can be so serious that they affect the individual's ability to perform his or her missions and meeting their responsibilities. That is the inescapable tension that is present (D. Petraeus, personal communication, April 10, 2023).

General Petraeus' remarks convey an understanding from top leadership that mental health is an important subject for military leaders at the highest levels. However, there seems to be a disconnect between what the military wants to implement and what is taught or acted on in lower-level units. The stories that have been shared in this study show that the stigma of mental health and the repercussions for seeking mental health are still present. General Petraeus acknowledged that each case should be taken seriously and, depending on the severity of the mental health issue, should be treated accordingly. General Petraeus' remarks also shed light on a belief that mental health should be viewed much like any other issue for which a servicemember needs help (e.g., medical problems, marriage, and financial counseling). If people approach mental health with the same willingness to provide needed aid as is done in other problem areas, there may be a breakthrough to initiate the destigmatization of mental health.

Participants' Advice for Military Leaders

This researcher asked each participant what they would say to military leadership regarding changes to the approach to mental health in the military. One can always think of what

could be said if given the chance. This researcher wanted to know what the participants who have lived through these experiences would say. The following is a collection of their words:

Alpha. When asked what he would say to military leaders about changing the way they view and treat mental health, Alpha replied,

> I think there needs to be more training and trust in chaplains to address things safely.
>
> They need to implement more ASIST [Applied Suicide Intervention Skills Training]
>
> training. More training for squad leaders to take issues seriously and compassionately.
>
> There needs to be a code system to alert leadership of an issue without an overreaction.
>
> One example is, I could tell my commander that I have a soldier or family with an issue. I
>
> need MP backup, a combat stress officer, a safe meeting room, a secure phone line or
>
> whatever, and my CDR [commander] or CSM [commander sergeant major] trusted me. I
>
> remember a 2 am conversation with my CDR, less than 20 words, but we went to our
>
> designated spots, barracks, ER, squad room, or whatever with our tasks and
>
> communications plan. These things always happen at 2 am. Another one happened after
>
> midnight and required waking up a two-star general. We trusted our team. When I told
>
> the CDR we had an issue, everyone stepped in: security, legal, medical, psych, and all of
>
> them.

Bravo. When asked what he would say to military leaders about changing the way they view and treat mental health, Bravo replied,

> I honestly think it should not be a bureaucrat-run situation. This needs to be soldier-led.
>
> Um, we've got enough love that we would die for one another. This needs to be a soldier-
>
> led, soldier-organized situation. You need to look at things that work, like AA [alcoholics
>
> anonymous], and programs like that. Get guys together that can go through a program

and be strong not only for themselves but for their buddies on their left and right. Don't throw this under the rug. You wonder why, when you get out of the military, you're either successful at not getting caught or you're a criminal? It's because you have so much mental health stuff going on from the military. They don't realize that 1 month of paid vacation you can't afford. So, and then to take it seriously—take it seriously! It's going to affect future generations. I mean, look at the kids. America's been at war since our founding. Finally, how many generations later, our children have mental health issues because their parents had mental health issues, and their parents had mental health issues. What is the common denominator? War.

Charlie. When asked what he would say to military leaders about changing the way they view and treat mental health, Charlie replied,

Um, I mean, like I said, that was 10 to 11 years ago, and I do appreciate their approach, in hindsight. I appreciate that they didn't leave anything to chance. They moved forward with what they perceived to be a threat. However, the way they moved forward was a bit of an aggressive manner. I wish they would've talked to me before taking me away. They knew a doctor couldn't see me that night but that I could be seen the next day and they still did what they did. I think maybe they could've isolated me somewhere, they could've, you know, kind of monitored me in the barracks instead of hauling me off, essentially, in the back of a car to go stay the night in the nuthouse. I felt like a criminal. That's the only time I've ever seen the back seat of an officer's vehicle and there's not much space back there for one. Two, you're essentially in a cage. There's the mesh on the windows and there's that separating barrier between you and the front seat. I think that had more of an effect on me than the rest of it. If had gone right away or if I had not told

my significant other, I could have saved myself from the trauma of what the Navy did to me.

Delta. When asked what she would say to military leaders about changing the way they view and treat mental health, Delta replied,

I think it should be proactive instead of reactive. I think that there should be an annual mental health screening the same as there is an annual dental screening because it can potentially prevent some things from happening. There shouldn't be the stigma that mental health is going to cause me to lose my clearance or lose my weapon, and they're not going to think anything good of me. I think that stigma needs to be taken away to be able to allow these individuals to have this opportunity. I feel that if veterans had had something like that during that timeframe to not make them feel like they're a burden and not competent, then things would have looked different for them. I believe not all of them would be where they are right now, struggling with the aftermath of being discharged, kicked out, or retired for other reasons. Now all of this is in their face, and they don't know what to do with it. Now their quality of life is kind of low. Now they must deal with everything. If we have preventive measures in place, and not the typical post-deployment one where they give everyone a short spiel, and then they're gone, we can show them how to reintegrate with their families because that is a huge issue as well. I know this because I've sat on the other side as a military spouse. If they would have had preventive measures in place to handle PTSD and the like, then I think it would've been different.

Echo. When asked what she would say to military leaders about changing the way they view and treat mental health, Echo replied,

It needs to be more of a focus and not necessarily just saying the words. I have been in commanders calls where they are like, "If you need help, go and get it," but they really don't mean it. Those are just the words. Because in the next breath, they're like, "Well, your clearance can be affected, or you're gonna get discharged." So on and so forth. There needs to be actual action taken to make sure that mental health is not stigmatized. So, if an airman or soldier or seaman comes up to you as a supervisor and says, "I've got some bad feelings. I need to get some help," you can do everything you can to make sure that troop is saved or seen. Because you don't want suicide to be the next option. It could end up with, "I have these bad feelings and I can't go see somebody so let me just do the bad thing." It just needs to have more of a focus and be accepted, and there needs to be no negative consequences for people to go and seek help.

Foxtrot. When asked what he would say to military leaders about changing the way they view and treat mental health, Foxtrot replied,

I would say to continue what they're doing. Just be open and honest and have no repercussions for somebody that has any kind of thoughts. You know? If you have thoughts of danger or suicide, really anything, it's not a game-changer for an individual. It doesn't matter your rank. If you're an E1, CW5, or an O6, it cuts across all ranks that the Pentagon just must understand that they have to take care of their people, one way or another. There's such a huge divorce rate in the military now that it's astonishing. We're in the spotlight of DOD with something like divorce rate, so how do we cope with that? I think it would be beneficial to DOD to recognize something like that. Like, they have

these huge divorce rates and you're hiring Type-1A guys, you know, Navy SEALs, Army

Rangers, Apache Pilots. You know? It's not me talking. You can look at the statistics.

Huge statistics of divorce, and violence, and all this stuff that happens. Also, 22 suicides

a day from veterans. It kills me. Here's the thing. You can't send people to war for 10 or

15 years and not expect mental health problems. The 99% of veterans, even if they're

homeless or whatever, they're not gonna cause harm to anyone. But that 1% or half a

percent, that does something wrong, it's all over CNN and then people are saying,

"Veterans are fucked up!" It's like, what the fuck?

Golf. When asked what he would say to military leaders about changing the way they

view and treat mental health, Golf replied,

It starts at a cultural level. I talk about SFC [REDACTED] in that he was a great military

leader, but also a horrible military leader because he didn't support people who were

going through things or had things going on that, you know, took away from normal unit

activities. I went from being a hot-shot soldier to being a shitbag because I had to go to

appointments, whether it be for mental health or for my back injury or any of that stuff. I

went from good to just an absolute shitbag. SFC [REDACTED] was mocking me in front

of the rest of the platoon. If you were not in good standing with someone like SFC

[REDACTED], he failed to lead you anymore. I didn't do anything wrong. I did

everything that was asked and expected of me. I wasn't a bad soldier. I was a broken

soldier. The culture of the Army at that time was a broken soldier is a bad soldier. It's

going to require a culture shift. It will take getting leaders that can create some form of

equity among soldiers regardless of their status.

Hotel. When asked what he would say to military leaders about changing the way they view and treat mental health, Hotel replied,

Today, I would say that it's very clear that leadership wants the stigma to be gone, but that as the trauma of war is lost, and when you look out and don't see any combat patches anymore, that stigma is coming back because they don't understand it. All a senior leader can do is make a statement and hope a junior leader can implement it, and that's a problem. You can't let up. You've got to act like it's 2009 again. We're not prepared for war time, and we don't have the resources. I think the same thing is happening with mental health, and it's only going to get worse. Also, these servicemembers that normally don't see combat are going to see combat. The people that never set foot on the boats are going to set foot on the boats and it's going to be unbelievable. The only way it's going to get fixed in the Army is to start at the top. It would be better if it could start at the bottom, but that's just not how the system is built.

India. When asked what she would say to military leaders about changing the way they view and treat mental health, India replied,

It always starts at the top, and they have to be the example. If you never hear about anyone in your chain-of-command going and seeing mental health, why would anyone else go? Because it's usually viewed as a mark on your record. So, to me, your chain-of-command, they have to be the example, and it doesn't matter who you are and what rank you are, we all struggle with things in life at different times in our life. But if younger, junior-ranking people don't ever see any higher-ranking people talking about, "Hey. I'm going to go to mental health today because I'm struggling with some stuff, and I need to talk to someone about it"—if the upper echelons aren't going to do that, it's going to have

a negative impact for your younger, junior-ranking people. They aren't going to do it because they think that somehow their performance, um, reports are going to be affected by them going and seeking help for whatever the reason is.

Juliet. When asked what he would say to military leaders about changing the way they view and treat mental health, Juliet replied,

I don't know. That's tough. I think the policies and everything that are in place now, and the way I have seen this actioned by leaders around me, I think we're doing the right thing. I think we're doing a really good job of it. I guess we still have further to go. I mean, you've still got guys that are on duty, or veterans committing suicide at alarming rates every day, but I don't think it's the same as it was in 2007 and 2008 when we were going through it. It was probably better than it was in the '80s and '90s when our parents were possibly serving and that kind of thing. I think we're on the right trajectory. I did not have one of those terrible experiences that some guys talk about, where they were pressured not to do it. What I've seen as a leader now, in the formations I'm in, um, it could be happening. Nobody tells the sergeant major everything, but I don't see it. It seems to be working. It's probably a stay-the-course type of message.

Kilo. When asked what he would say to military leaders about changing the way they view and treat mental health, Kilo replied,

It takes intestinal fortitude. You need to understand yourself. You need some self-awareness and emotional intelligence. You need to understand that not everybody has the same, and issues are going to impact everybody differently. So, to give it one cookie cutter answer and act like every soldier is broken because of it, you can't do that. Just like some soldiers twist their ankles and they can keep moving, some people get counseling,

or some people don't get counseling. Some people have significant events and keep moving and some can't. You gotta be serious about it. You can't be biased. Leadership should not be biased toward anything. It's up to us to encourage whatever the issue is to get resolved and work forward. We don't work in the past, we go forward, and that's the way we need to look. We need to look at the soldier that's getting counseling and not see the soldier that's in counseling right now, we need the soldier that's 10 years from now. That's what we want to see. So, we need to support the soldier to get through counseling, get through the programs or whatever they're into the best of their ability. As leaders it's our job to take care of them.

Lima. When asked what he would say to military leaders about changing the way they view and treat mental health, Lima replied,

Just because someone needs help, that doesn't make them a bad soldier. It's not a weakness. It's something that you can help to fortify. If you show your soldiers you care, that can go a long way. Because I know, for me, with [REDACTED] and my immediate NCOs at [REDACTED], the fact that I could tell that they cared, and not just about mental health, but us as people, it went a long way. It made me feel comfortable to open up to them. It made me feel like I was an important part of the team. Whereas, with the leadership in [REDACTED] and with my warrant officer, I felt like with him, it didn't matter either way. With him, it was a burden to have a soldier in your unit need mental health help. It was a burden to have a soldier in your unit that had physical problems.

Mike. When asked what he would say to military leaders about changing the way they view and treat mental health, Mike replied,

With regards to my experiences with mental health, the problem isn't necessarily at the institutional level. All the big wigs and all the higher ups, battalion commanders, pentagon nerds, all these people, they all quote-unquote beat that drum of mental health being important. Whether they actually believe it or not, I don't know. To me, that's the first problem. They need to actually believe in it. But then you've got all this male bravado bullshit on if you have mental health problems, you're weak or whatever. It's like, I've seen some of the scariest people I've known on the battlefield have to take a knee because they had seen and done too much. They need to actually foster it from the beginning. I mean, we don't throw away a seven-ton or a HMMWV [high mobility multipurpose wheeled vehicle] because it breaks an axle or blows a fuse. Why do we treat people like that? I mean, we've come a long way the last 10 years as a military, but we still have a lot of shit-talking at the lower levels. The people that have actually been there and done that and have the scars to prove it, they need to be taken more seriously. If you don't evolve, you're gonna continue to have more kids committing suicide and you're going to be stuck wondering why. That's where leadership fails. They don't take the time to figure out the why. We foster a culture in the military where you are not entitled to the why. You are entitled to do what you're told. If you teach them the why, sometimes that does better and empowers them.

Research has shown that military leaders can prevent someone from seeking help, as well as be an encouragement for someone to get the help they need. If a soldier is assigned to a unit where treatment-seeking is encouraged, it is likely they will choose to seek help (Britt et al.,

2020). Likewise, soldiers are more likely to report symptoms associated with mental illness under the command of a supportive leader than a destructive leader (McGuffin et al., 2021). Setting the example that mental health is not a weakness and is something to be addressed starts with military leaders, both in the officer and non-commissioned officer corps.

Implications for Civilians

Mental health stigma is not unique to military service. The view of individuals in the military and civilian sector often places every mental illness into the same category. This view is consequential regardless of work environment (Elraz, 2018). The civilian workplace may be very similar to military personnel in terms of civilians also fearing their mental health will prevent them from receiving promotions or job placement. This researcher had the opportunity to interview a retired Naval aviator that now flies as a commercial pilot for American Airlines. He did not wish to be one of the participants for the formal study but did wish to share his story.

Anonymous Naval Aviator/American Airlines Pilot

"Anonymous" is a 44-year-old retired Naval aviator. Anonymous retired as an O5 Commander in the United States Navy. He flew P3 aircraft in support of OIF. His primary mission was ISR [Intelligence, Surveillance, and Reconnaissance], as well as many missions supporting overseas drug interdiction and anti-piracy. Regarding his exit from the military, Anonymous said, "I joined the reserves after my active-duty commitment, and I retired as a Commander. I worked my way up through the reserves and was a commanding officer. I was an O6 select, and I elected to retire instead of continuing." Following his departure from the military, Anonymous flew as a contract pilot in support of OEF. He was part of Task Force [REDACTED] and then flew in support of JSOC. This included ISR for [REDACTED] and assets on the ground.

Anonymous did not experience mental health problems but was aware of problems with some of those he worked with. He recalls,

You know, being in P3s, there actually was this one dude. He was, uh, I can't remember if he was, he was basically air crew. He worked in the back but he self-reported for PTSD and I remember, I read about it in some periodical magazine that the Navy publishes. His career as a P3 crewman was over . . . he self-reported for PTSD I think they said, "You can't be aircrew anymore. You can't be a flier."

Anonymous went further saying, "We all knew, as pilots or even navigators, if you mentioned anything about mental health, your career's over as a flier. 100%." Anonymous was then asked how his crew and other aviators handled this, knowing they could not speak about mental health. He replied, "A lot of people are going to be drinkers. That's the one medication we can get away with that isn't tracked, that the doctors don't document and that doesn't get you pulled from flying status." This was also mentioned by participant Foxtrot, an Army aviator.

Anonymous now flies for American Airlines and says the civilian sector is trying to move away from the stigma of mental health. He says,

Apparently on the civilian side, they're trying to get away from that. They're trying to make it a more hospitable environment and say, "Hey. If you divulge that you have these issues, yeah, you're going to get downed, but it's not necessarily a career killer. You can, potentially, ostensibly, get back to flying status." It's not just PTSD. It's . . . depression and mental health in general. But there's still quite a bit of distrust from the pilot cadre to accept that that's a fact.

Anonymous mentions that the civilian sector of aviation is trying to provide a path back to flying for those suffering from mental health problems. However, he says, "As soon as you

mention mental health, all kinds of sirens start going off. Especially if you mention the word

depression. That's a showstopper." He continued,

> That's the thing—even now in civilian aviation, the way they present is like, "Well yeah.
> We're immediately going to stop you and pull your tickets. However, just because you
> say that doesn't mean that you can't get them back." That's what they're trying to say. Of
> course, they'll say, "We have these one or two success stories." Clearly there's a lot
> fucking more people that have this issue that divulge this issue that never come back. So,
> that's the stigma. Even in civilian aviation, people don't talk about that.

These statements by Anonymous show that the stigma of mental health is not limited to

the military. People in civilian aviation struggle with the same types of stigmas. They exhibit

personal struggles, distrust of leadership, coverup, and many other themes that were identified

during this study. Whereas mental health stigma is more prevalent in the military than the

civilian sector (Judkins et al., 2020), it is still a concern for all employers.

Christian Worldview

As Christians, we believe our body is a holy temple and the Holy Spirit lives within us.

We believe this because 1 Corinthians 6:19-20 in the Bible says, "Do you not know that your

body is a temple of the Holy Spirit within you, whom you have from God? You are not your

own, for you were bought with a price. So, glorify God in your body" (*New King James Version*

Study Bible, 1798/1997). To glorify God, Christians want the body to be as healthy as possible.

The holistic approach to health is to heal the body, mind, and spirit (Raheim & Lu, 2014).

Further, according to Van Nieuw Amerongen-Meeuse et al. (2021), "A holistic approach

correlates with interest for the individual, including his or her R/S [religious and spiritual]

identity, and involves assessment of beliefs that may shape the person and assessment of how

one copes and struggles with illness" (para. 1). This holistic approach is taken by many

Christians.

When something is wrong with the body, an individual will seek help from a medical

doctor. The doctor will examine the patient and make a diagnosis. The doctor will then prescribe

a treatment plan for the patient to follow. This treatment plan could include medications, physical

therapy, or any number of options to treat the physical ailment. The same can be said about

spiritual struggles. As Christians, we pray to God to protect us from spiritual harm, and we attend

church and read our Bibles to feed our spirit through fellowship with other Christians and

through studying the word of God. If we are having a spiritual struggle and we feel we need help,

we go to our spiritual leader, whether that be a pastor, priest, rabbi, or other leader, for guidance

and help in the matter. There should be no difference in seeking help with mental health

problems. Mental health professionals are trained to aid the mind in the same way medical

doctors and spiritual leaders help the body and spirit, respectively. The mental health

professional will speak with the patient, take a detailed history, test, if needed, for diagnostic

relevance, and make a diagnosis. The mental health professional will then develop a treatment

plan that could or could not include medication and a course of action for therapeutic

interventions.

The three common themes found in this study correlate with a Christian worldview

through the Christian belief that individuals cannot fix mental health problems on their own. A

Christian may turn to God first for healing, but then they also seek the properly needed

professional for the problem they are facing. Personal growth is paramount in Christianity.

Christians are constantly wanting to grow spiritually and be a greater example to those around

them. This need to grow can be seen in 2 Peter 3:18. "But grow in the grace and knowledge of

our Lord and Savior Jesus Christ. To him be the glory both now and to the day of eternity.

Amen" (*New King James Version Study Bible*, 1798/1997). Christians want to be the example for

those looking to something greater than themselves. Trust is another facet of Christianity.

Christians place their trust in God and in one another. The scripture teaches us to trust. Proverbs

3:5 states, "Trust in the Lord with all your heart, and do not lean on your own understanding"

(*New King James Version Study Bible*, 1798/1997). Catholic Christians trust their priests to hear

their confessions. Christians often trust one another with prayer requests and confide in them

when they experience difficult times. Therefore, the common themes of realizing that

professional help is needed, personal growth, and trust align will with a Christian worldview.

Limitations

This study was not without limitations. When reviewing the findings of this study,

consideration should be given to these limitations. Limitations include number of participants,

gender, branch of service, and era of service.

Because of the nature of the research, the number of participants was limited to 12. A

13th participant was added because of his branch of service. As participants were found, it

became apparent that there were more volunteers from the Army than other branches. This could

be because nearly 50% of veterans are from the Army. According to the VA (n.d.), "about

50[%] . . . of all veterans served in the Army, almost 25[%] . . . in the Navy, 20[%] . . . in the Air

Force, 10[%] . . . in the Marine Corps, and slightly more than 1[%] . . . in the Coast Guard"

(para. 3). This study was also limited by the ratio of male to female participants. This ratio can be

attributed to the demographics of male to females in the military. According to the U.S.

Department of Labor (2023), women make up 10% of all veterans in the United States. Females

accounted for 23% of participants in this study. Branch of service was also a limitation in this

study. Participants represented the Army (54%, $n = 7$), Marine Corps (8%, $n = 1$), Navy (15%, $n = 2$), and Air Force (23%, $n = 3$). The post-9/11 era was used as a qualifying criterion for this study. This researcher chose post-9/11 to exclude veterans from prior combat campaigns, such as World War II, the Korean War, the Vietnam War, and Operations Desert Storm and Desert Shield. This was done to limit the influence of the confounding variable of being in a particular war (i.e., with unique conditions unique to that war) on experience of stigma in the military. Moreover, this researcher thought the stories of post-9/11 veterans would be more congruent with current research surrounding military mental health stigma.

Recommendations for Future Research

Previous research examined stigma among National Guard and Reserve soldiers (Kim et al., 2010) and stigma effects on active-duty servicemembers (Sharp et al., 2015, as cited in Roscoe, 2021; Frank et al., 2018; Gould et al., 2008; Jones et al., 2010; Hines et al., 2014; Iverson et al., 2010, as cited in Jones et al., 2018; Williamson et al., 2019). It is vital to eliminate negative beliefs about the self to combat stigma. More data can be gathered to combat stigma by pursuing future research.

Negative First Impressions on Return Rate of Mental Health Patients

In this study, four out of 13 servicemembers reported a negative experience during their first interaction with MHS. Whereas this may not seem to be a significant number for this study, it does represent 30% of participants and illustrates the frequency at which people in the military may encounter negative first impressions. Negative first impressions can influence whether mental health patients return and may be a study worth pursuing. We, as mental health professionals, like any other person or profession, only have one chance for a first impression. How many clients do not return for treatment because of how they were treated or their

perceptions of their provider during their first session? This can be influenced by how we speak, how the office staff treat the client, or even by creating a negative environment through the use of the wrong therapeutic intervention. I recommend a future study to explore this topic further.

Chaplains as First-line Intervention

Participant Alpha is a retired Army Chaplain. His work with active-duty servicemembers and veterans highlights the importance of military chaplains in providing mental health support outside of formal mental health treatment. A deployed chaplain is often responsible for the spiritual wellbeing of up to 1,500 servicemembers. Their responsibilities range from helping with mental health issues, reintegration post-deployment, recognizing signs of PTSD and suicidality (Army 2012; Bonner et al., 2013, as cited in Besterman-Dahan et al., 2013), spiritual support in combat operations, leadership coordination in combat and operational stress control, as well as counseling struggling servicemembers and their families at home and abroad (Abruzzese, 2008, as cited in Beterman-Dahan et al., 2013). Future research focusing on the efficacy of chaplains as first-line intervention in a mental health crisis could yield positive results toward alleviating the fear of being vulnerable with military leadership regarding one's mental health.

Chaplains do not always interject religion into every conversation. They can provide guidance on numerous subjects and have similar confidentiality as mental health therapists. According to Carey et al. (2018, as cited in Layson et al., 2022), chaplains have been internationally acknowledged for their broad utility in providing public services to communities and organizations, acting as communication facilitators, providing advocacy, exhibiting multicompetence in diverse skills, providing economic benefits through spiritual care interventions, alleviate personnel conflicts, expediting decision making, and reducing stress and

staff absenteeism. The benefit from further research on chaplains can provide great insight and yield positive results that could change the paradigm of how units treat those in mental distress.

Early Intervention and Psychological Debriefing for Special Operations

Several participants in this study worked with military special operations units. A common theme among the stories shared by these participants was the lack of trust they had in sharing their mental health concerns with their leadership for fear they would no longer be able to be a part of the unit, or they would lose access to their firearms and clearances. Special operations unit personnel operate at extreme levels of stress and intense combat often spanning many consecutive months (Cooper et al., 2020). Whereas their training ensures special operations servicemembers are adequately qualified and prepared for such instances, research has shown that such extreme stress and combat takes a toll on one's mental health. Their concerns may be underreported because of the unique risks they take, and their resilience combined with unit support outside of formal mental healthcare (Osório et al, 2013, as cited in Russell et al., 2017). A study on early intervention and psychological debriefing following direct engagement in combat operations could yield a worthwhile future direction for research that may help to reduce the stigma of mental health in combat operations.

Conclusion

The purpose of this study was to examine the experiences of OEF/OIF active-duty servicemembers overcoming mental health stigma and deciding to seek mental health treatment while on active duty. The following themes relating to mental health stigma in the military emerged through data analysis: *Personal struggle, Distrust of leadership, Persecuted for needing mental health treatment, Being treated differently, Fear of looking weak, Denial, Betrayal, Individual negative experience,* and *Lack of knowledge about mental health*. Overall, the

findings of this study show that stigma remains prevalent across the military and clearly affects individuals in different ways, and that finding ways to combat the stigma at the source should be the focus of future research. The following themes in overcoming stigma reported by greater than 50% were identified through data analysis: the *Realization that professional help is needed, Personal growth,* and *Trust*. Even though these forms of overcoming stigma cannot be taught, it is vital that military leaders, servicemembers, and family members receive mental health education in an attempt to reduce the debilitating effects of stigma in the military. ..

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Appendix A

Institutional Review Board Approval

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

February 17, 2023

Philip Allen
Michael Howard

Re: IRB Exemption - IRB-FY22-23-737 A Phenomenological Study Exploring the Experiences of Active-Duty Service Members Seeking Mental Health Treatment: How Mental Health Stigma in the Military Can Affect Help-Seeking Behavior

Dear Philip Allen, Michael Howard,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B

Consent Form

Title of the Project: A Phenomenological Study Exploring the Experiences of Active-Duty Service Members Seeking Mental Health Services: How Mental Health Stigma in The Military Can Affect Help-Seeking Behavior

Principal Investigator: Philip C. Allen, M.A., Department of Community Care and Counseling, School of Behavioral Sciences, Liberty University, Lynchburg, Virginia

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 years of age or older, must have served in one of the six branches of the military, deployed to a combat zone, or had been in support of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF), identified they were experiencing a mental health problem, and must have sought treatment while on active duty. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to understand the impact stigma has on a combat veterans' decision to seek mental health treatment while on active duty. The answers to these questions will provide insight into the stigma surrounding help-seeking behavior in the military and possibly provide commanders with a means to alleviate the stigma, making it easier for servicemembers to receive MHS while remaining on active duty or before separating from the military.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Participate in a one-hour interview with the researcher. The interview will take place in a private room at either a VA hospital, VA clinic, or over videoconference, whichever is more convenient for the participant. All interviews will be recorded and transcribed for accuracy purposes. Pseudonyms will be used to protect participant privacy.
2. Journal your experiences with seeking mental health services while on active duty. Also, journal your experiences with this study. Participants will have approximately 30 days from the time of their initial interview until the journals are expected to be returned to the interviewer for review. If you choose to provide a copy of your journal, the entries will be used for further data analysis. All entries will be scrubbed for any personal identifiers, and pseudonyms will be used to protect participant privacy.

3. Participate in a voluntary focus group at the end of the study. The focus group will be provided to allow participants to discuss their experiences with the study and ask any questions of the researcher. The focus group will last approximately two hours and will be audio recorded.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include:

*   Raising awareness of the effects military mental health stigma has on active-duty service members' help-seeking behavior.
*   Potential to discover patterns in the help-seeking behavior of active-duty service members experiencing the effects of military mental health stigma.
*   Raising awareness of the effects of long-term mental health treatment following the identification of mental health issues stemming from combat deployments.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of re-exposure to the trauma. Every effort will be made to ensure this does not occur. Questions will be asked about seeking mental health and will not lead to questions about the trauma. The participant will know they have the power to end the interview at any time.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.
*   Participant responses will be kept confidential by replacing names with pseudonyms.
*   Any access to the data will be limited and not used for any purposes outside of this research study. All data will be password-protected on a computer, and all hardcopy records will be stored in a locked filing cabinet. After three years, all digital data will be deleted, and all hardcopy records will be burned.
*   If being interviewed at the hospital or one of the clinics, the interview will occur in a private room. If the interview takes place over a video-conference platform like Zoom, the meeting will be private, free of distractions, and at a time away from other individuals.
*   Confidentiality cannot be guaranteed in focus group settings. Because the focus group will occur with other participants, it is up to each individual to ensure their privacy and not communicate about what is discussed with anyone outside the group.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study. Upon completing all requested tasks (interview, journal, and focus group), participants will receive a $75 Visa Gift Card. The gift card will be handed to the participant at the end of the focus group. Because the focus group is voluntary, scaling gift cards will be given for stages of the study. If a participant only wishes to participate in the interview, they will be given a $25 gift card. Interview and journaling will result in a $50 gift card and $75 for all three stages of the study. If a participant wishes, they can receive their gift card through email.

Is study participation voluntary?

Participation in this study is voluntary. Your decision to participate will not affect your current or future relations with Liberty University, the Department of Veterans Affairs, or any community outpatient clinic you may be attending. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please inform the researcher at the contact information provided in the next paragraph that you wish to discontinue your participation prior to your scheduled interview. Should you decide after your interview that you do not wish to be included in the study, you will still receive compensation for your time, but your responses will not be recorded or included in the study. Should you choose to withdraw, data collected from you, apart from focus group data, will be destroyed immediately and will not be included in this study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Philip C. Allen. You may ask any questions you have now. If you have questions later, you are encouraged to contact him at pallen31@liberty.edu. You may also contact the researcher's faculty chair, Dr. Michael Howard, at mdhoward@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record/video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

Appendix C

Interview Questions/Guide

Icebreaker: The interview will begin with a broad icebreaker to help the interviewee feel safe and enter the flow of the conversation.

1. When did you first identify that you had a mental health problem?

2. How did you react to identifying you had a mental health problem?

3. What steps did you take to negate mental health stigma in the military when you decided to seek MHS?

4. How did mental health stigma in the military affect your decision to seek MHS?

5. What effect did your decision to seek MHS have on your career?