Exploring Chaplains' Lived Experience Concerning Mental Health Stigma and Suicidal Thoughts in the Military Context

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Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Science

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2024

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APPROVED BY:

Dr. William Townsend, Committee Chair

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Abstract

The empirical inquiry at the heart of this qualitative phenomenological research revolves around the identification of mental health stigma and suicidal ideation within the military context. This study delves into the lived experiences of military chaplains as they interact with service members grappling with thoughts of suicide and dealing with the associated mental health stigma. By examining the viewpoints of United States Army chaplains, we aim to gain a deeper insight into the perceived mental health stigma and its consequences for service members who are contending with suicidal thoughts. Chaplains' unique viewpoints will contribute to an enriched comprehension of mental health stigma and the effective utilization of mental health interventions. This research focused on nine United States Army chaplains who have served on active duty as the data source collected and analyzed. This research endeavor aims to provide empirical insights and potential strategies for addressing the perceived mental health stigma within the military context, as reported by military chaplains. The gathered data will advance our understanding of mental health stigma and suicidal ideation. Military personnel often encounter feelings of detachment, solitude, purposelessness, and suicidal ideation upon their return from combat or separation from service. Early intervention and treatment are pivotal in alleviating these challenges. The individual interaction of military chaplains will provide an insider's viewpoint on the perceived mental health stigma occurring within the military. This newfound knowledge holds promise for reducing the incidences of suicide within the military community and fostering greater utilization of mental health support.

Keywords: suicide prevention, Unites States military service members, mental health stigma, military chaplains.

Copyright Page

Dedication

I dedicate the dissertation to two exceptional women who have been my unwavering support pillars throughout this arduous journey. I sincerely appreciate both of you for your unending love, encouragement, and sacrifices. Your presence in my life has made all the difference, and this dissertation stands as a testament to the unwavering support of a devoted mother and a loving wife.

To my mother, who selflessly nurtured and guided me from the earliest days of my life, your unwavering belief in my abilities, endless encouragement, and sacrifices have shaped me into the person I am today. Your unconditional love and the values you instilled in me have been the guiding light that pushed me forward during the darkest moments of this academic pursuit.

To my beloved wife, who stood by my side with boundless patience, understanding, and unyielding support, your love has been the rock that supported me during this research and academic endeavor. You are my source of inspiration and joy.

Acknowledgments

Completing this dissertation would not have been possible without the generous support, guidance, and encouragement of numerous individuals who contributed to my journey. This dissertation reflects the collective effort and motivation of all those who have touched my life in numerous ways.

My Committee Chair, Dr. William Townsend, and Committee Member, Dr. Seigel Bartley, thank you for your invaluable expertise, mentorship, and unwavering support throughout the research process. Your insightful feedback and constructive criticism have been instrumental in shaping this dissertation. To the faculty members and mentors at Liberty University for creating an intellectually stimulating and nurturing environment that allowed me to grow both as a researcher and an individual. Your passion for knowledge and dedication to education has been genuinely inspiring. I sincerely thank all the participants and respondents who graciously volunteered their time and expertise for this research. Your contributions have enriched this study and have made a meaningful impact on the findings.

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List of Abbreviations

Adverse Childhood Experiences (ACEs)

Department of Defense (DoD)

Interview Protocol Refinement (IPR)

Interpretive Phenomenological Analysis (IPA)

Mental Health (MH)

Moral Injury (MI)

Military Service Members (MSM)

Mental Health Stigma (MHS)

Post-Traumatic Stress Disorder (PTSD)

Potentially Morally Injurious Events (PMIEs)

Substance use disorder (SUD)

Suicidal Ideations (SI)

Veterans Affairs (VA)

Chapter One: Introduction

Overview

The escalating suicide rate within the military demands urgent attention and a deeper comprehension of the factors influencing the inclination to seek assistance for suicidal thoughts and the stigma connected to MH. Analyzing these dynamics could enhance the utilization of mental resources and mitigate the prevalence of suicide among military personnel. The insight gained from this research could help increase mental resource utilization and reduce the suicide rate within the military context. Suicidal ideation, defined by the DSM-5-TR, is when a person experiences persistent thoughts of death, with or without a detailed plan to die, or a suicide attempt (American Psychiatric Association, 2022).

The literature focused on limitations found with current suicide prevention strategies and the failure to fully explore the perceived stigma associated with seeking mental treatment (Shim & Rust, 2013). Approximately 20 veterans committed suicide daily, and the suicide rate in 2016 was 31.1 for every 100,000 people, 1.5 times greater than the United States general population (Bahraini et al., 2019). MHS leads to damaging consequences for individuals with mental disorders (Shrivastava et al., 2012). This stigma is a significant public health problem that adds to the decline in addressing mental health-related issues (Shim & Rust, 2013). Individuals need help when avoiding mental treatment as this behavior increases negative consequences, prejudice, and discriminatory beliefs the general public holds (Wright et al., 2009). Stigmatization created by labeling, bias, and prejudice raises the perception of underlying negative beliefs of a group (Hinshaw, 2007). Stigmatizing individuals harms social relations and increases fear of mental problems (Hinshaw, 2007). The current literature is limited concerning

the perceived MHS and its impact when seeking help for suicidal ideations in the military establishment.

Chapter One establishes the foundational framework for exploring MHS within the military. Specifically, this chapter centers on military chaplains' insights and real-life encounters as they navigate the complex terrain of SI and MHS within the military context. Chaplains are typically the first to respond when service members experience emotional and mental crises (Ramchand et al., 2016). Chaplains fulfill the mental needs of military service members (MSM) with total confidentiality, which is critical to fully understanding and reducing the barriers associated with the stigma connected with mental treatment (Besterman-Dahan et al., 2012). The three questions utilized in this research were foundational in guiding the researcher and providing motivation for this study. The problem and purpose statements and critical research data outlined the significance of MHS and suicidal ideations.

This research examined the MHS and the impact of seeking help with suicidal ideations. The connection between stigma and seeking treatment for mental issues raises the importance of identifying processes that can lower such problems (Wright et al., 2009). The MHS has been recognized as the main reason only a small percentage of service members with psychological challenges seek help from mental professionals (Kim et al., 2011). A more comprehensive examination of why service members do not seek mental treatment is needed (Kim et al.).

Background

Over the past two decades, researchers have identified and studied the considerable risk to United States MSM regarding suicide (Bjork et al., 2022). Active-duty MSM are at a higher risk than Reserve and National Guard MSM(Bjork et al.). Suicide claimed more lives than AIDS, automobile accidents, and influenza combined and, in 2019, ranked the tenth cause of death in

the United States (Centers for Disease Control and Prevention, 2019). In 2021, military veterans were at a 50% higher risk when not actively utilizing medical and mental resources (Bjork et al.; Bullman & Schneiderman, 2021). The United States population comprises 7.6% veterans and, within that population, account for 14% of adult suicides (Ruiz et al., 2022). Veterans experience 22.2% of completed suicides in the United States (Hilberg et al., 2019). Roughly 20 veterans commit suicide daily, indicating a substantial public health crisis and the need to understand the MHS (Bahraini et al., 2019).

The MHS is mutually experienced by the general population, causing people to disconnect, delaying the treatment of mental illness, and causing social and economic challenges (Shrivastava et al., 2012). Suicide impacts communities, individuals, and families while generating a considerable financial burden, costing taxpayers over $100 billion (Shepard et al., 2016). In 2012, the economic burden for a single suicide death was estimated to cost $1.3 million, and suicide attempts alone cost over $93.5 billion, with missed income and productivity (Bahraini et al., 2019). Research indicates an increased risk for individuals with prior suicide attempts, significant mental issues, adverse life events, and access to lethal means (Clancy, 2018). According to the guidelines established in 2018 between the Department of Defense (DoD) and Veteran Affairs Medical Center, both agencies will combine suicide prevention strategies and treatment guidelines. This 2018 DoD/VA guideline focused on complex case management with behavioral health, medical, and social work models (Veterans Hospital Administration [VHA], 2022).

Situation to Self

A crucial element within phenomenological research involves incorporating the concept of epoché. Epoché refers to suspending judgment, creating a space for introspective self-

awareness. Through this process, researchers can observe the phenomena under study while acknowledging their inability to maintain complete objectivity (Moustakas, 1994). The inspiration for this research project sprang from my extensive background as a 28-year Army veteran and a clinical mental therapist, a role in which I have collaborated closely with fellow veterans at the Veterans Affairs Medication Center. Drawing from my journey, I brought forth preexisting notions and firsthand familiarity with the pervasive MHS, encompassing my perspectives as an individual, a soldier, and a mental professional.

My encounters with the challenges of seeking mental support, aiding military families in coping with a family member's tragic suicide, assisting MSM in moments of crisis amid combat operations, and tending to veterans wrestling with the daunting task of seeking help and grappling with suicidal tendencies have all significantly contributed to the genesis of this endeavor. These experiences have both consoled and affirmed my understanding of the invaluable roles of Chaplains in suicide prevention and their impact on military service members' willingness to seek assistance. Strengthened by my background as a former First Sergeant during combat deployments and my professional identity as a fully licensed clinical mental therapist at the Veterans Affairs (VA), along with my current pursuit of a doctoral degree at Liberty University, I am endowed with diverse vantage points on the matters of MHS and suicidal inclinations within the military and veteran community.

Furthermore, guided by my Christian faith and biblical teachings, my aspiration has consistently aligned with the directive to provide solace to others, drawing from the solace I have received. This endeavor is fueled by my commitment to reassuring veterans facing analogous circumstances that they are not solitary in their battles. In congruence with my Christian worldview, I approach this study with profound sensitivity. I am guided by love and respect in all

participant interactions throughout interviews, cognitive assessments, and the subsequent data analysis process.

Problem Statement

A significant body of research is available concerning the impact of MHS (Blevins, 2019; Clancy, 2018; Ruiz et al., 2022). Similarly, studies have delved into behaviors related to seeking assistance with mental issues (Bjork et al., 2022; Bullman & Schneiderman, 2021; Karras et al., 2022), thoughts of suicide (Ammerman et al., 2021; Faucett, 2021; Schwartz et al., 2021), and the impact of mental issues within the military context (Freeman et al., 2009; Karras et al.; Vogt, 2011). Despite these studies, limited research has been conducted specifically on the lived experiences of military chaplains (Ramchand et al., 2016). This study is grounded in gaining insight into stigma related to mental through the observations and encounters of Army chaplains as they support MSM grappling with thoughts of suicide and impacted by MHS. Uncovering familiar sources and themes is pivotal for diminishing the MHS, a crucial step in curbing suicide rates within the military. A comprehensive understanding of the confines and factors triggering SI is requisite to dismantling perceived MHS (Clancy, 2018).

The literature review uncovered a lack of research that addressed the stigma connected to mental and SI within the military context. This phenomenological exploration sought to amplify understanding by harnessing the perspectives of Army chaplains, thereby illuminating the perceived MHS and thoughts of suicide. The intricate lives of these chaplains, immersed in the military, warrant an enriched comprehension of their encounters within this demographic. The absence of substantial exploration into chaplains' experiences with MHS and SI necessitated this research. Throughout the literature review, merely three empirical studies focused on military chaplain's perspective of the MHS and SI within the military context.

Despite efforts of military leadership and educational interventions, particularly in suicide prevention, available data and resources appear insufficient in addressing MHS and SI in the military (Freeman et al., 2009; Karras et al., 2022; Vogt, 2011). The percentage of completed suicides among veterans in the United States surpasses that of the general population (Monteith et al., 2020). Over the past two decades, suicide rates have surged, persisting despite the 2018 prevention and treatment strategies by the DoD and Veterans Affairs Medical Centers. The veteran population experiences a 50% higher suicide rate than the broader US populace (Bjork et al., 2022). Notably, combat fatalities in Iraq from 2003 to 2017 numbered 4,410, while over 7,300 veterans committed suicide in 2014 (Faucett, 2021). This death rate underscores the greater lethality of suicide compared to combat deaths in Iraq. Prevailing strategies have faltered in curbing suicide rates, mitigating risk factors, and enhancing prevention approaches (Karras et al.).

Addressing and reducing MHS related to SI hinges on comprehending a multitude of perspectives on the crisis. Solutions to the current military suicide crisis are intricate, arising from various contributing factors. The complexity of MHS mandates a personalized and comprehensive approach to fathom the diverse risk elements (Ruiz et al., 2022). Further investigation is imperative to elucidate the correlation between MHS and seeking help with suicidal thoughts. The pervasiveness of mental concerns within the military is evident (Held & Owens, 2013). Research suggests that numerous military members shy away from seeking assistance for mental issues directly tied to combat experiences (Held & Owens, 2013).

Purpose Statement

The purpose of this phenomenological study was to describe the lived experiences of a United States Army chaplain's perspective on MHS and suicidal ideations within the military

context. The researcher collected data from 10-20 chaplains to gather insight and a deeper understanding of MHS and suicidal ideations as they occurred within the military. Military chaplains were selected for this research primarily because they have been excluded from the majority of research (Ramchand et al., 2016). Nevertheless, these professionals are typically the first to respond when service members experience emotional and mental crises (Besterman-Dahan et al., 2012). Chaplains address the mental requirements of MSM in complete confidentiality, a vital aspect in comprehending and diminishing the obstacles linked to the perceived stigma surrounding mental therapy (Besterman-Dahan et al.).

Suicidal inclinations encompass a feeling of burden and the belief that death can bring relief from one's existence, with individuals experiencing themselves as a weight on society, friends, and family (Joiner, 2005). Professionals in the realm of mental hold a pivotal role in responding to crises, advocating for initiatives aimed at preventing suicide, providing training to reduce access to lethal methods, and delivering effective treatments to mitigate suicide rates (Bullman & Schneiderman, 2021). In this pursuit, chaplains offer invaluable perspectives and a unique vantage point on this perceived stigma, enriching the dialogue about the stigmatization of mental health. The inclination toward suicide can intensify when the fear of death subsides and can escalate through repeated exposure to distressing situations or confrontational events (Van Orden et al., 2010). The perception of stigma linked to mental problems often arises from self-imposed beliefs and significantly contributes to the underutilization of treatment services (Shim & Rust, 2013).

The study employed phenomenological research questions and lived experience methodology to address three specific research inquiries concerning the firsthand encounters of chaplains concerning MHS and SI within the military context. The chosen hermeneutical

approach aimed to comprehensively comprehend and elucidate the actual encounters of individuals within a given society. A deeper understanding was accomplished by delving into the fundamental meanings, cultural backdrops, and societal forces that mold individuals' viewpoints and behaviors in their day-to-day existence (Heppner et al., 2016). Employing hermeneutical phenomenology, the researcher interpreted and contemplated pivotal themes that emerge from lived experiences (Creswell & Poth, 2018).

Qualitative research plays a crucial role in comprehending the intricacies of individuals by delving into participant's personal views and insights (Heppner et al., 2016). The primary objective of the research was to extract significance from shared and real-life encounters, thereby nurturing a more profound insight into human experience. This process involved examining diverse perspectives using semi-structured interviews, field notes, surveys, observations, and data analyses to generate valuable insights (Heppner et al., 2016). Within the context of this study, lived experiences were primarily characterized by military chaplains with a history of aiding service members dealing with suicidal thoughts, coupled with a deep understanding of the military environment.

Significance of the Study

This study has the potential to enhance our knowledge and provide a more profound comprehension of the MHS and its influence on seeking assistance for SI within the military. Additionally, the study offered valuable insights into the military's approach to addressing MHS. Military chaplains' roles in suicide prevention are recognized and recommended to be integrated into mental care (Besterman-Dahan et al., 2012). Chaplains met the psychological requirements of MSM in complete confidentiality, which played a vital role in comprehending and reducing the obstacles and perceived stigma linked to seeking assistance from mental experts (Besterman-

Dahan et al.). Mental health treatment can benefit individuals and change how they are impacted by a perceived stigma and the reluctance to seek help from mental professionals (Wright et al., 2009). Understanding the MHS and how it influences the perception of mental treatment in the military is crucial to understanding the hesitancy with MH care and developing interventions to reduce this stigma (Held & Owens, 2013). The significance of the study was evident in the military's suicide rate and the heightened risk when individuals with suicidal thoughts were not participating in treatment. Over the past two decades, there has been a notable rise in suicide rates among the veteran population (Bjork et al., 2022). Over the past two decades, the military community has witnessed a substantial upsurge in suicide rates compared to the broader US population (Bjork et al.). Veterans who do not actively employ VA prevention and treatment services have a 50% greater risk of completed suicide compared to those who utilize VA mental services (Bjork et al.). In the United States, suicide impacts everyone and creates a considerable financial burden, costing taxpayers over $100 billion (Shepard et al., 2016). Enhanced strategies for addressing MHS will benefit military service members. The data gathered through this research assisted the military in directing attention toward solutions, enhancing the utilization of mental treatment, and comprehending approaches rooted in individual perspectives (Corey, 2017). Service members stand to gain from the chaplain's viewpoint, comprehension of stigma, and wisdom from their experiences assisting fellow service members.

Empirically

Exploring the firsthand encounters of chaplains and their perspectives on MHS and thoughts of suicide held importance on multiple levels. The complexity of suicide prevents its attribution to a singular cause; effectively addressing it demands a holistic strategy that encompasses mental practitioners, lawmakers, communities, and individuals (Bjork et al., 2022).

The United States grapples with a notable issue of suicide, leading to a decrease in life expectancy and a 35% surge in mortality rates from 2000 to 2018 (Martínez-Alés et al., 2022). Veterans constitute around 7.6% of the US population but represent 14% of all adult suicides (Ruiz et al., 2022). In 2016, the VA indicated a suicide rate of 31.1% suicide deaths per 100,000 veterans, 1.5% times higher than the non-veteran population (Bahraini et al., 2019). Among male veterans aged 18-34, the suicide rate in 2016 was 40.4% suicide deaths per 100,000 veterans, up from 45 per 100,000 veterans in 2015 (Bahraini et al.). Veterans contribute to 22.2% of all recorded suicides in the United States (Hilberg et al., 2019). The information collected from this research will aid the military in focusing on solutions, improving the utilization of mental treatment, and understanding strategies based on individual viewpoints.

This study was linked to prior research that had examined the impact of MHS (Blevins, 2019; Clancy, 2018; Held & Owens, 2013; Kim et al., 2010, 2011; Lannin et al., 2016; Ruiz et al., 2022; Shim & Rust, 2013), help-seeking behaviors (Bjork et al., 2022; Bullman & Schneiderman, 2021; Gochicoa, 2019; Held & Owens; Karras et al., 2022; Vogel & Wester, 2003), SI(Ammerman et al., 2021; Bjork et al.; Faucett, 2021; Karras et al.; Monteith et al., 2020; Schwartz et al., 2021), and mental challenges within the military context (Freeman et al., 2009; Karras et al.; Vogt, 2011). This research examined the influences of MHS and suicidal ideations within the military and added to the existing body of literature.

Theoretically

This study contributed by exploring stigma towards mental and SI within everyday encounters (Heppner et al., 2016). The research encompassed five central themes: the philosophical standpoint, research inquiries and lived encounters, criterion-based selection, assessment of phenomenological data, and the essence of lived experiences (Heppner et al.,

2016). Research questions were rooted in lived experience to address the chaplain's encounters with MHS and SI within the military. The hermeneutical approach, aiming to comprehend and interpret individuals' lived experiences within a societal context, delved into the underlying meanings, cultural contexts, and societal influences that shape people's perceptions and actions in their daily lives (Heppner et al.).

Practically

This study offered a platform for a previously unheard population to express their experiences concerning the effects of SIand MHS within the military. Researcher focused on an epoché perspective and underlying assumptions and tailored the analytical process to the psychological dimension of the data (Englander & Morley, 2023). The epoché viewpoint enabled experiences to surface within everyday reality for multiple reasons. By suspending assumptions, epoché facilitated a more profound comprehension of participants' experiences, allowing the articulation of those experiences without relying on mere physical descriptions, explanations, stereotypes, or theoretical constructs (Creswell & Poth, 2018). Epoché empowers researchers to perceive the world through the lens of participant experiences (Englander & Morley, 2023). Giorgi's adaptation encompasses the realm of lived experiences, delving into the intricate psychological significance experienced by an individual immersed in everyday life (Giorgi, 2017).

Research Questions

Through a phenomenological approach, questions were developed to deepen our understanding of the perceived stigma around seeking help for SIand mental concerns. The primary goal was to gain direct insights from United States Army chaplains, shedding light on MHS and suicidal ideations in the military context. By mitigating this perceived stigma, Bullman

and Schneiderman (2021) anticipated an increase in the utilization of treatment for mental health-related issues, an enhancement of suicide prevention efforts, a reduction in the use of lethal methods, strengthened safety measures, streamlined prevention initiatives, and ultimately a decrease in the incidence of suicides. Studies suggest that the stigma surrounding mental reduces the likelihood of individuals seeking assistance for mental issues and thoughts of suicide (Lannin et al., 2016). Existing literature highlights shortcomings in current suicide prevention approaches and the insufficient examination of the perceived stigma linked to seeking treatment for mental concerns (Shim & Rust, 2013). The stigmatization of individuals damages social connections and amplifies apprehension related to mental issues (Hinshaw, 2007). In emotional and mental crises among service members, chaplains usually assist MSM in crisis (Ramchand et al., 2016). Chaplains address military service member's mental requirements with complete confidentiality, a vital factor in comprehending and mitigating the obstacles linked to the perceived stigma of MHC (Besterman-Dahan et al., 2012).

Principal Research Questions

This research aimed to collect information and gain insights into the lived experiences of participants within the United States armed forces, specifically focusing on MHS and suicidal ideations.

PRQ1

What is the participants' perspective on their encounters with suicidal ideation and mental health stigma within the military?

PRQ2

How do participants perceive their role in addressing and supporting individuals with suicidal ideations in the military?

Additional Research Questions

The following supplementary research questions were formulated to explore the participants' perspectives regarding the connection between MHS, suicidal ideation, and their responsibilities as military chaplains.

RQ1

How do participants define mental health stigma within the military context?

RQ2

What factors do participants believe contribute to the prevalence of mental health stigma among military personnel?

RQ3

How do participants perceive the impact of mental health stigma on individual willingness to seek help?

RQ4

How do participants describe their existential and spiritual understanding and perspectives regarding mental health stigma and suicidal ideation in the military?

Definitions

The following definitions were used to enhance and clarify the terminology utilized in this study:

1. Adverse Childhood Experiences (ACEs): Experiences with abuse, neglect, and toxic family members, irrespective of combat exposure, are likely to screen positive for mental and behavioral health challenges like depression, PTSD, anger issues, and suicidal ideations (Morgan et al., 2022).
2. Community-Based Outpatient Clinic: Provide basic primary care, mental services, and a wide range of other clinical and diagnostic services (VA, 2022a).

3. Department of Defense (DoD): Categorized as the United States of America's most prominent government agency dating back to pre-Revolutionary times. The primary mission is to provide the military forces needed to deter war and safeguard the country’s security. (DoD, 2019).
4. Interview Protocol Refinement (IPR): The IRP framework can improve interview procedures' reliability and increase the data's quality and importance (Castillo-Montoya, 2016).
5. Interpretive Phenomenological Analysis (IPA): The researcher examines individual narratives equally, moving between important themes while comparing and contrasting themes to create detailed explanations of experiences utilizing open inductive methodology (Pietkiewicz & Smith, 2014).
6. Post-Traumatic Stress Disorder (PTSD): Individuals develop a MH disorder when experiencing or witnessing horrifying or life-threatening events. Indicators often include flashbacks, nightmares, acute levels of anxiety, and uncontrollable thoughts related to the incident (Mayo Clinic, 2022).
7. Potentially Morally Injurious Events (PMIEs): Potentially morally injurious events refer to experiences or situations that have the potential to inflict deep and lasting moral distress or harm on an individual. PMIEs originated from studying the psychological impacts of war and combat on military personnel, particularly concerning their moral beliefs, values, and ethical principles (Levi-Belz et al., 2022).
8. Social and Economic Status: An individual or group's position in society is determined by a mixture of social and economic aspects, such as income, education,

occupation, residence, ethnic origin, and religious background. (American Psychological Association, 2021).

9. Suicide Prevention Team: Works directly with community groups and behavioral health providers to help veterans deal with emotional and mental crises. (VHA, 2022).
10. Veteran Affairs Medical Center is the most extensive integrated healthcare system, serving over 9 million veterans in 1,298 healthcare facilities, 171 medical centers, and 1,113 outpatient sites (VHA, 2022).
11. Veterans Affairs (VA): The VA dates back to the American colonies in function but under different designations: National Home for Disabled Volunteer Soldiers, Veterans Bureau, Bureau of Pensions, War Risk Bureau, and Veterans Administration. The mission is to support and care for those who have served in the United States military, as promised by President Lincoln. (VA, 2022a).

Summary

Statistics indicate that the suicide rate within the military has increased over the last 20 years. Over the past five years, prevention and treatment strategies have not effectively reduced the number of completed suicides. Veterans are at 50% higher risk for suicide than the United States general population (Bjork et al., 2022). Current suicide prevention strategies have a negligible impact on recognizing barriers and reducing risk factors (Karras et al., 2022). The goal of this research was to gain a better understanding of MHS and SI in the military context. Given the complex nature of suicide and the MHS, utilizing a person-centered approach, an integrated approach, and identifying risk factors will offer insight into unforeseen solutions (Ruiz et al., 2022). Research was needed to recognize the connection between the perceived stigma, suicide

deaths, and MHDs, as previous studies have produced inconsistent results (Edwards et al., 2022). This study attempted to understand the stigma associated with mental and SI from a chaplain's perspective. This research contributed additional perspective to the literature and aided future strategies to reduce MHS.

Chapter Two: Literature Review

Overview

This phenomenological investigation intended to offer perspectives from Army Chaplains, shedding light on MHS and suicidal thoughts in the military context. This study aimed to comprehend the significance of the perceived stigma surrounding MH, particularly in the context of suicide prevention. It was imperative to address this stigma to effectively decrease the suicide rate during current and future mental health-related challenges. Recent academic literature, as highlighted by Shrivastava et al. (2012), indicated substantial advancements in the quality and effectiveness of mental interventions in the past five decades. Regrettably, those strides in mental treatment have not effectively lessened the societal stigma attached to mental (Shrivastava et al.). This research endeavor aimed to enhance the comprehension of mental professionals regarding the stigma surrounding mental within the active Army community. Existing literature persists in emphasizing the need to augment individual awareness of psychological challenges, difficulties, and protective elements to refine strategies for preventing suicide (Shrivastava et al.). The literature review aims to delve into how suicide affects the United States military personnel compared to the broader general population, commencing with a comprehensive examination of suicide rates. The literature review addressed indicators of concern, factors contributing to risk such as the influence of early life experiences and exposure to combat, PTSD, substance misuse, coexisting mental conditions, legal complications, socioeconomic standing, available social networks, moral distress, and obstacles encountered in seeking treatment. The concluding segment will offer potential approaches for mitigation and a deeper understanding of the MHS and suicidal ideations.

This research centered around the qualitative phenomenological approach to address two main research questions and three supportive questions, all viewed through the perspective of a United States Army chaplain. This research focused on the MHS and suicidal thoughts in the United States Armed Forces. Data gathering involved semi-structured interview inquiries, field notes, two surveys examining MHS, a concise presentation about MHS, a stigma inventory, and data analysis of transcribed text. This investigation aimed to enhance the comprehension of mental professionals regarding the MHS and prevailing reluctance to seek assistance for suicidal thoughts.

Theoretical Framework

Phenomenological Study

A qualitative approach focused on the chaplain's understanding of the perceived MHS and SI service members encounter in the United States military. During emotional and mental emergencies among service members, chaplains typically assume the primary role in aiding MSM facing crises (Ramchand et al., 2016). Chaplains address the mental needs of MSM while upholding complete confidentiality, a crucial element in understanding and alleviating the barriers associated with the perceived stigma surrounding mental assistance (Besterman-Dahan et al., 2012). To improve suicide prevention strategies, we must fully understand the constraints and risk factors of suicidal ideations and attempts (Clancy, 2018).

Social Constructionism

Social constructionism guides individual worldviews and cultural values by encouraging exploration between reality and cultural conversations (Creswell & Poth, 2018). The social constructionism perspective is compelling, given the unfamiliar cultural backgrounds and worldviews encountered by the military population (Corey, 2017). The not-knowing we

encounter in solution-focused and narrative therapeutic approaches is ideal when working with the diversity of the military population. Chaplains must enter the MSM's world with the idea that the service member is the expert on their own experiences and perceptions. The conversations and dialogue create the meaning of the narrative while the chaplains tell their stories and provide sensitive details about their thoughts (Corey, 2017). Placing more energy toward solutions and understanding those solutions will vary with each person; a mental professional's job is to discover what is working and replicate those concepts (Corey, 2017).

Related Literature

Overview of Suicide in the United States

Suicide is complex and cannot be linked to a single cause; addressing it requires a comprehensive approach involving mental professionals, legislators, communities, and individuals (Bjork et al., 2022). Suicide is a significant problem in the United States, causing a reduction in life expectancy and a 35% increase in death rates between 2000 and 2018 (Martínez-Alés et al., 2022). Suicide rates tend to vary by age and gender. Historically, men have higher suicide rates when compared to women. The veteran population experienced a mild reduction in completed suicides in 2019, primarily in the white population (Martínez-Alés et al.). The 2000 suicide rates in the United States increased significantly, impacting 44 states, all sociodemographic, but predominantly impacted men from 45–64 years old in rural areas (Stone et al., 2018). Suicide rates remained steady and slightly increased within all other racial and ethnic populations (Martínez-Alés et al.). Suicide rates can also vary across racial and ethnic groups, with higher rates observed among specific communities.

The tenth cause of death in the United States is suicide, claiming more lives than AIDS, automobile accidents, and influenza (Centers for Disease Control and Prevention, 2019). Several

risk factors contribute to suicide, including MHDs, substance abuse, previous suicide attempts, family history of suicide, social isolation, access to lethal means, and exposure to the suicidal behaviors of others. Lockdowns, social isolation, economic hardships, and uncertainty may have exacerbated mental issues and increased distress among some individuals. Suicide affects everyone in the United States, from individuals, families, and communities, creating a significant financial strain that costs the American taxpayers over $100 billion with direct and indirect expenditures (Shepard et al., 2016). Suicide attempts cost about $93.5 billion in 2012 based on lost income and productivity, with a $1.3 million estimate for one death (Bahraini et al., 2019).

Overview of Suicide in the US Veteran Population

Suicide within the veteran population has significantly increased over the last two decades (Bjork et al., 2022). Data from the Mortality Data Repository and National Death Index was collected and analyzed through 2016, capturing the considerable risk. Suicide risk among veterans were assessed by comparing suicide rates collectively, by gender, and by unit component (Active duty, Reserve, and National Guard) (Bullman & Schneiderman, 2021). Suicide rates among veterans are 50% higher when compared to veterans actively participating in VA prevention programs (Bjork et al.). Research indicates that both male and female veterans are at a higher risk of suicide than the civilian population (Bjork et al.). Active duty service members are at an increased risk of suicide than Reserve and National Guard veterans, and male veterans are at three times the risk over female veterans (Bjork et al.).

US Veteran Suicide Rates and Statistics

Veterans comprise about 7.6% of the US population, accounting for 14% of all adult suicides (Ruiz et al., 2022). Approximately 20 veterans die by suicide daily with no specific cause identified. Many risk factors have been noted and linked to increased risk, prior suicide

attempts, mental illnesses, life events like divorce, job loss, or death, and the accessibility to lethal means (Clancy, 2018). The VA reported that in 2016, the suicide rate was 31.1% suicide deaths for every 100,000 veterans, 1.5% times higher than the non-veteran population (Bahraini et al., 2019). In 2016, the suicide rate increased with male veterans 18-34 years old at 40.4% suicide deaths per 100,000 veterans and 45 per 100,000 veterans in 2015 (Bahraini et al.).

Suicide in the veteran population is a significant public health crisis. Veterans account for 22.2% of all completed suicides in the United States (Hilberg et al., 2019). Female veterans are the fastest-growing demographic at increased risk for suicide compared to civilians (Gaeddert et al., 2020). Clinical engagements are critical to proving valid findings that guide suicide prevention programs geared toward the female population (Gaeddert et al.). Qualitative interviews indicated that women veterans engage in services more effectively when a therapeutic trust is established, particularly in sensitive areas like suicidality and military sexual trauma (Gaeddert et al.). Significant cross-sectional associations have been found between nightmares and suicidal symptoms (Hilberg et al.). The negative stigma toward psychological issues is a more effective prognosis of suicidal ideations (Hilberg et al.).

Over the last two decades, veteran suicide rates have continued to increase despite efforts by the Veteran Affairs Medical Center and current prevention strategies. Veteran suicide rates are 50% higher than the general United States population (Bjork et al., 2022). From 2003 to 2017, direct combat accounted for 4,410 fatalities in Iraq; in 2014, more than 7,300 veterans committed suicide, making it deadlier than all the combat deaths in Iraq (Faucett, 2021).

Impact of Suicide

Combat operations in Iraq from 2003 to 2017 reported 4,410 fatalities. As of 2014, more than 7,300 veterans committed suicide, making this crisis significantly deadlier than the losses

experienced during combat operations (Faucett, 2021). Only 61% of the Operation Iraqi Freedom and Operation Enduring Freedom veteran population utilize the VA health care system; the other 39% utilize community resources or do not receive health care (Faucett, 2021).

Additional research is needed to evaluate the impact of the interpersonal psychological theory of suicide and self-determination theory to understand more effective ways to focus and develop suicide prevention programs and protective factors (Shue et al., 2020). Veterans revealed suicide attempts to about eight people, with mental professionals as the most helpful and romantic partners the least helpful following a suicide attempt disclosure (Ammerman et al., 2021). Measure the impact of repeated disclosures between mental professionals and friends/family, potentially leading to enhanced gatekeeper-based prevention strategies (Ammerman et al., 2021). Positive reactions during a suicide disclosure are considered practical when a veteran describes their experience (Ammerman et al.).

Suicide Warning Signs and Risk Factors

Increasing access to mental services, promotion of suicide prevention programs, and training in lethal means safety and reductions could aid prevention efforts and help to reduce the risk of veteran suicides (Bullman & Schneiderman, 2021). Veterans utilizing VA health care are twice as likely as non-VA users to use mental services. Telehealth interventions are currently being studied with a primary goal of daily monitoring and early detection of suicide risk (Kasckow et al., 2016). Telehealth utilizes engagement, monitoring, early intervention, support, coaching, and psychoeducation (Kasckow et al.). Their research indicated that telehealth is feasible in monitoring post-discharge suicide risk in the veteran population and substantially influences veterans with a history of suicide attempts. Additional research is needed to assess mental intervention, including medication, verbal therapy, or informal help like faith and

community resources (Nichter et al., 2021). It is critical to fully understand veteran suicide risk factors (Bjork et al., 2022).

Veteran suicide on individual and socioecological risks includes substance use disorders, MHDs, disruptions in life, sexual abuse, access to lethal means, homelessness, legal issues, exposure to combat, and sexual minorities (Ruiz et al., 2022). The relationship between anger and suicide is apparent, even when accounting for other risk factors, such as gender, family history of suicide, and depression (Wilks et al., 2019). Nine predictors of impending suicide risk are: 1) agitation, 2) level of suicidal ideation, 3) somatic worries, 4) anxiety, 5) depression, 6) death, 7) psychiatric diagnoses, 8) history of suicide attempts, and 9) levels of clinical reasoning (Akins, 2019). Current clinical assessment designs to predict SI and suicidal behaviors are inadequate (Franklin et al., 2017).

A significant percentage of veterans who committed suicide contacted the VA healthcare system before their death, resulting in the need for more effective suicide prediction tools and interventions (Kessler et al., 2020). Two-thirds of suicidal individuals contacted the mental system within a year before their death (Kessler et al.). Hospitalization for a psychiatric disorder and emergency department visits for psychiatric-related issues accounted for 30% of the suicides in 2020 (Kessler et al.). One-third of the suicidal individuals were in outpatient treatment centers for mental disorders the month before their death (Kessler et al.). One out of ten veterans who committed suicide visited the emergency department within two months of their death (Laliberte et al., 2021). The risk significantly increased during the preliminary stages of psychosis, with 20% to 40% experiencing suicidal ideations and 5% desiring to die (Pelizza et al., 2020).

Researchers concluded that current suicide prediction tools have little clinical value, and lack the critical information related to effectiveness and focused suicide preventive interventions

(Kessler et al., 2020). Despite standard suicide prevention guidelines, SI and behaviors go unnoticed in the VA emergency room setting based on several factors and barriers with screening, risk assessments, lack of competence, and high workflow requirements (Laliberte et al., 2021). Reduced measures must address the emergency department's risk assessment initiation and follow-up care practices, integrate case review highlights, implement guidelines, and increase formal training (Laliberte et al.).

Childhood Trauma

The harmful impact of Adverse Childhood Experiences (ACEs) has been well-established in psychological research, indicating a significant effect on an individual's mental and behavioral health later in life. A study conducted by Morgan et al. in 2022 highlighted the association between ACEs and mental challenges in veterans, particularly those with multiple ACEs and combat exposure. The risks increased 3–10 times with three or more ACES and combat exposure for both male and female veterans (Morgan et al., 2022). Understanding the relationship between childhood experiences and mental outcomes is crucial in providing appropriate support and intervention for veterans who may have faced adversities early in life. To help mitigate the negative impact of ACEs and combat exposure on veterans' mental well-being and overall quality of life, early detection, and effective treatment are critical. ACEs can include a range of traumatic experiences during childhood, such as physical abuse, emotional abuse, neglect, dysfunctional households, and exposure to violence or substance abuse. When individuals experience multiple ACEs, the cumulative effect can lead to adverse outcomes in adulthood, including higher risks of depression, PTSD, anger issues, and SI.

Veterans subjected to three or more ACEs like abuse, neglect, and toxic family members, irrespective of any combat exposure, are likely to screen positive for mental and behavioral

health challenges like depression, PTSD, anger issues, and SI (Morgan et al., 2022). Research suggests that those with three or more ACEs, in addition to combat exposure, face a much higher risk of mental and behavioral health challenges than those with fewer ACEs or no combat exposure (Morgan et al., 2022). The increased risk is observed in both male and female veterans. It is significant to understand ACEs' potential impact on mental and provide appropriate support and interventions to veterans who have experienced such adversities. Addressing these issues can help improve their well-being and reduce the likelihood of developing severe mental conditions.

Combat Exposure

Service members have a significant challenge to overcome after fully assimilating into the military mindset and experiencing combat. The primary mission of all service members and combat troops is to kill enemy combatants (Freeman et al., 2009). Current studies report that up to one-third of Iraq and Afghanistan combat veterans experience issues with aggression and anger (Moore & Penk, 2011). Combat troops are at increased risk for abnormal irritation, increased aggression, stress-related issues, high blood pressure, relationship conflicts, heart disease, drug and alcohol abuse, SI, and domestic violence, all a direct consequence of war in the combat environment (Moore & Penk). Mental health professionals must answer several important questions concerning combat veterans: medical conditions that could be a contributing factor define individual problems and explore situation-based contributing factors (Moore & Penk).

Complex traumatic exposure is an experience with numerous or continued exposure to traumatic events (Landes et al., 2013). Problematic exposure involves multiple incidences of maltreatment, psychological negligence, neglect, physical abuse, sexual exploitation, and domestic violence. Difficulties are experienced by mental providers when attempting to define

and treat symptoms of PTSD. Childhood traumas could have existed and correlated with additional personality disorders in adulthood (Landes et al., 2013, 2019). Comorbidity is usually a certainty rather than an exception when dealing with veterans and PTSD issues with sleep disorders, substance abuse, and depression disorders (Duax et al., 2013).

Research findings on mental outcomes among male and female veterans exposed to combat can vary across different studies and populations. Research conducted by Morgan et al. (2022) had specific findings for their sample and methodology. Male veterans exposed to combat are considerably more likely to experience problems with depression, PTSD, anger issues, and SI when compared to female veterans (Morgan et al., 2022). The differences in mental outcomes between male and female veterans can result from numerous factors, including biological, social, and psychological factors. These differences can influence how individuals cope with stress and trauma. However, female veterans exposed to combat are more likely to struggle with alcohol use and increased irritability and are ten times more likely to have a problem with PTSD (Morgan et al.). PTSD and other mental issues are severe concerns for veterans, regardless of gender. Both male and female veterans need access to appropriate MHC and resources to provide treatment for their unique needs and challenges.

Research dating back to 1945 indicates that amplified anger levels are associated with combat trauma exposure (Morland et al., 2012). Violence and anger in combat veterans have manifested in property destruction, road rage, domestic violence, and child abuse, impacting the individual, interpersonal relationships, and society (Morland et al.). Multicomponent cognitive behavior therapy and pharmacological treatments are the current formally recognized anger treatment protocols, signifying additional research is needed (Morland et al.). Suicide among combat veterans with PTSD remains a significant concern between the DoD and VA (Hendin,

2014). Vietnam veterans with PTSD are statistically more at risk of dying by suicide than those without PTSD. Veterans face noted mental issues like persistent and severe combat guilt, severe anxiety, survivor guilt, and depression in veterans who attempted suicide (Hendin). Analyses revealed that suicide is typically a time-limited state based on three factors: triggering event, behavioral change, and intense emotional state (Hendin).

Mental Health Diagnosis

Utilizing data and meta-analysis reviews discovers that sleep disorders and disturbances can increase SI over most psychiatric disorders (McCarthy et al., 2022). Utilizing sleep as a single measurement to predict suicide risk is limited (McCarthy et al., 2022). Limiting the differences between suicide and sleep disorder fails to account for other risk factors (McCarthy et al.). Veterans with documented insomnia have a 46.2% increased risk for suicidal attempts versus 12.6% without documented insomnia (Bishop et al., 2018). Veterans with documented sleep-related breathing disorders are at a 5.0% increased risk for suicidal attempts versus 2.5% without documented breathing disorders (Bishop et al.). Veterans with documented nightmare disorder are at a 2.9% increased risk for suicidal attempts versus 0.9% without documented nightmare disorder (Bishop et al.). Findings indicate that sleep disorders place veterans at higher risk for suicidal attempts, and treatment of sleep issues with nonmedication strategies could positively reduce the risk of suicide attempts (Bishop et al.). Co-occurring conditions can increase the risk and direction of suicidal behaviors, impacting treatment and affecting the overall approach a provider uses to manage the risk of suicide (Bahraini et al., 2019).

Schmaal et al. (2020) focused their research on 20-plus years of neuroimaging and SI and behaviors and created transdiagnostic models for SI and behaviors. Increased negative thinking and reduced positive stimulation may facilitate and increase suicidal attempts and behaviors

(Schmaal et al.). Research conducted by Akins in 2019 discusses the potential link between increased agitation and suicide attempts among veterans recently released from inpatient care Akins's research highlights the importance of accurate suicide risk assessments and practical post-care support for veterans. Depression, hopelessness, and negative influences correlated with SI (Schafer et al., 2022). Schmaal et al.'s (2020) research examined the neurobiological underpinnings of suicide and how understanding these alterations could lead to more effective prevention strategies.

History of suicide attempts and other comorbidities are not significantly correlated to increases in SI or attempts (Bjork et al., 2022). Personality disorders increase suicide risk factors significantly; about 30% to 40% at that increased risk have died by suicide, and 40% have attempted suicide (Nelson et al., 2021). Sleep disorders increase the risk of suicidal behaviors and ideations (McCarthy et al., 2022). Additional research is needed to explore the specific comorbidities that increase suicide risks like ADHD, other mood disorders, PTSD, Traumatic Brain Injury history, compounded trauma, and combat exposure (Bjork et al.). Research into personality disorders found that veterans are at increased suicide risk if they encounter significant economic or societal problems, use many health-related services, are unemployed, have a disability, have legal issues, and battle other MHDs (Nelson et al.).

Post-Traumatic Stress Disorder

It is essential to clarify that PTSD can potentially develop after exposure to a traumatic event (Beidel et al., 2011). While direct exposure to or witnessing trauma is a common trigger for PTSD, the etiology of PTSD is not limited to these scenarios (Beidel et al.; Hendin, 2014; Mayo Clinic, 2022). PTSD can develop due to experiencing or witnessing traumatic events like combat, accidents, natural disasters, sexual or physical assault, or any event that severely

threatens a person's safety or well-being (Beidel et al.). PTSD can develop in individuals who have indirectly experienced trauma, such as learning about the traumatic experiences of a loved one, experiencing repeated exposure to distressing details of trauma, or being subjected to ongoing emotional abuse or bullying (Beidel et al.; Mayo Clinic; Wilks et al., 2019). More than two million service members have deployed in support of combat operations throughout Iraq and Afghanistan, with five to seventeen percent of returning service members at increased risk of experiencing PTSD (Peterson et al., 2011). PTSD is usually associated with clinical anguish, social impairment, occupational struggles, reduced quality of life, medical comorbidity, and psychiatric difficulties affecting veterans and their families (Beidel et al.).

Veterans experiencing PTSD or other mental illnesses may raise problems related to veterans' self-stigma and negatively impact post-traumatic growth (Blevins, 2019). Self-stigma, negative post-traumatic growth, and suicide risk increased when veterans felt oppressed and lacked belongingness, which correlates with increased suicide risk (Blevins). Examining protective factors of post-traumatic growth and suicide risk supports the best-fitting model, suggesting that post-traumatic growth could be a positive safeguard against suicide risk (Blevins). The relationship between anger, social support, and SImay vary based on the presence or absence of Major Depressive Disorder and PTSD diagnoses (Wilks et al., 2019).

Spirituality has been recognized as a multi-dimensional concept playing a critical role in treating individuals through traumatic experiences like PTSD (Herbst-Damm & Kulik, 2005). Research has shown that spiritual beliefs, values, and traditions can serve as essential resources in recovery from PTSD and other forms of trauma (Currier et al., 2015). This study highlighted how spirituality can be a crucial factor in addressing the challenges faced by veterans with PTSD. The spiritual teachings, beliefs, and practices that individuals hold can offer a sense of

purpose, meaning, and hope, which are vital components in the healing process. Engaging with spirituality can help veterans find strength, guidance, and comfort during their difficult recovery journey.

Herbst-Damm and Kulik's (2005) research shows that spirituality can enhance coping skills when individuals reflect on and make sense of traumatic events. By providing a support system and a framework for understanding suffering and resilience, spirituality can assist individuals in processing their emotions, making meaning of their experiences, and finding ways to move forward despite their challenges. Spirituality can take various forms, depending on an individual's religious or non-religious beliefs and practices (Currier et al., 2015). For some, it may involve engaging in organized religion; for others, it could be more about personal beliefs, meditation, mindfulness, or connecting with nature (Currier et al.).

Veterans can achieve comfort by seeking a relationship with God, using prayer and meditation to contemplate the traumatic event to navigate the negative symptoms, and helping build positive emotions and support throughout the PTSD struggle (Currier et al., 2015). To achieve true and lasting forgiveness, you must make yourself and the situation right with God (Worthington & Langberg, 2012). According to 1 Corinthians 10:13, "There hath no temptation taken you, but such as is common to man. However, God is faithful, who will not suffer you to be tempted above that ye are able; but will with the temptation also make a way to escape, that ye may be able to bear it." Trust in God; we can manage any situation, trial, and adversity.

Duax et al. (2013) conducted research in 2012 and uncovered that 18% of older adult veterans actively participated in the VA primary care system. Eight percent of those not enrolled reported having PTSD symptoms. Recent analyses conducted on service members returning from combat denote they are at increased risk of suicide, depression, anxiety, anger issues, acute stress

disorder, PTSD, alcohol and substance abuse, family troubles, communication issues, and other serious mental complications (Duax et al.). Statistics indicate that resources are required to diminish the negative impact caused by combat and the dangers of military life (Duax et al.). Educated and knowledgeable mental professionals are needed, along with a cost-effective treatment plan to help support and care for these returning service members (Currier et al., 2015). PTSD has an extraordinarily high comorbidity rate compared to other mental issues, and cost-efficient plans for care should be a priority in public health care (Wangelin & Tuerk, 2014).

Substance Use Disorders

Substance use disorder (SUD) and suicide are two serious public health issues that can often be connected (Kaplan et al., 2014). SUD is when an individual becomes addicted to or dependent on a particular substance, such as drugs or alcohol (Kaplan et al., 2014). SUD can lead to significant physical, psychological, and social consequences for the affected person (Kaplan et al., 2014). Common substances that can lead to SUD include alcohol, opioids, cocaine, methamphetamine, and prescription medications (Conner et al., 2014). The development of SUD is influenced by a combination of genetic, environmental, and behavioral factors (Conner et al.; Wilcox et al., 2004).

A strong association exists between SUD and an increased risk of suicide (Conner et al., 2014). SUD frequently co-occur with MHDs like depression and anxiety (Conner et al.; Wilcox et al., 2004). These disorders can exacerbate hopelessness and despair, increasing the risk of SI and attempts (Conner et al.). Substance use can hinder judgment, increase impulsivity, and risky behaviors that increase suicidal risk. Some individuals may use substances to cope with emotional pain, trauma, or distress. When the effects wear off, the emotional burden may feel overwhelming, leading to suicidal thoughts (Kaplan et al., 2014). Substance use can lead to

social isolation, further exacerbating feelings of loneliness and alienation, which are risk factors for suicide (Kaplan et al., 2014; Wilks et al., 2019). Misusing certain substances, such as opioids or alcohol, can result in accidental overdose, which may not always indicate suicidal intent (Wilcox et al., 2004). However, it can be a significant risk for individuals struggling with substance abuse (Wilcox et al.).

The United States has encountered an enduring plague of opioid overdoses, making it difficult to accurately report suicide rates due to the unknown intent behind lethal overdoses (Martínez-Alés et al., 2022). The substance abuse crisis in the United States has been a significant public health issue for several decades. Opioid use escalated in the early 2000s and was fueled by numerous factors, including improvements in marketing, manufacturing, and product development of opioids (Hadland et al., 2019). The widespread availability and aggressive marketing of opioids contributed to a surge in opioid misuse, addiction, and related adverse outcomes (Martínez-Alés et al.).

Research has shown that opioids have increased suicide rates over the past two decades (Bohnert & Ilgen, 2019). Intentional overdose, where individuals deliberately consume opioids to end their lives, became a concerning issue, with the percentage of suicides involving opioids rising from 0.75% in 2000 to 3.6% in 2017 (Bohnert & Ilgen). It is important to note that the opioid crisis has made it challenging to report suicide rates accurately. The high number of drug overdoses, many of which may be unintentional or accidental, has made it difficult to determine the precise intent behind lethal opioid overdoses. This ambiguity makes it challenging to distinguish between suicides and accidental deaths, leading to complexities in accurately reporting suicide rates (Martínez-Alés et al.).

The opioid crisis is widespread misuse and addiction to prescription and non-prescription opioids, which has led to a significant public health issue in many countries (Centers for Disease Control and Prevention, 2020). The opioid distribution rate was reduced over seven years, ending in 2019 with the lowest over the last 14 years, totaling 46.7 prescriptions for every 100, adding up to over 153 million opioid prescriptions (Centers for Disease Control and Prevention, 2020). Despite these efforts, the sheer volume of opioid prescriptions remains significant in 2020 (Centers for Disease Control and Prevention, 2020).

Addressing SUD and suicide requires comprehensive prevention and treatment strategies (Pew Research Center, 2020). We can reduce the risk linked to mental issues and SI with early detection and treatment for substance use disorders (Conner et al., 2014; Wilcox et al., 2004). Integrating mental screenings into SUD treatment can identify individuals at risk of suicide and provide appropriate care (Conner et al.; Petersen, 2015; Proescher et al., 2020). Utilizing available MHC and addiction treatment are crucial in preventing and addressing substance use issues (Pew Research Center, 2020). Educating communities about the warning signs of suicide and substance abuse can lead to more supportive and compassionate environments (Conner et al., 2014). Reducing the perceived MHS associated with mental and substance abuse can increase individuals' chances of seeking help.

Legal Issues

A significant connection between legal issues and increased suicide attempts has been uncovered (Edwards et al., 2022). The interpersonal theory of suicide implies that a contributing factor to SI can be found with illegal engagement increases, causing a feeling of burdensomeness and social disconnection (Edwards et al., 2022). Veteran suicide risk increases during the days and weeks following an arrest or incarceration, indicating that 20% attempt suicide when

arrested sometime during the year prior (Edwards et al., 2022). Research indicates that older male veterans with antisocial disorders, arrest history, and SUD are about 50% more at risk for suicide than other veterans (Edwards et al.). A connection between suicide risk and legal issues is likely more complex; additional research is needed to understand this inconsistency (Edwards et al.).

The impact of lifetime legal issues associated with PTSD, depression, SI, and suicide attempts when accounting for gender, combat experience, service branch, utilization of MHC, and education is significant when assessing risk level (Holliday et al., 2021). Legal issues appear to be higher in veterans experiencing intensified psychiatric symptoms, increasing the risk of Sis and suicide attempts (Holliday et al.). Additional research is needed to understand better aspects of mental in which veterans experience legal issues, substance use, violence, severe mental disorders, and ethical issues (Holliday et al.). To better understand the relation to mental issues, we need to understand the nature of legal involvement, chronic exposure, crime details, penalizing, environment, and lifetime exposure to the criminal justice system (Holliday et al.).

Social Economical Status

It is essential to recognize the seriousness of suicide and its correlation with social breakdown and socioeconomic hardships. A study by Edwards in 2022 suggests a significant association between suicide and non-suicidal-related hospital visits with these factors. Suicide and non-suicidal-related hospital visits were related to social breakdown and socioeconomic hardship (Edwards et al., 2022). Financial insecurity, housing instability, unemployment, debt, low income, and increased SI can increase the probability of SI.

Research highlights the importance of suicide prevention efforts at the community level, particularly for veterans. Demographic and socioeconomic issues did not substantially impact or

predict veteran suicides. The probability of suicide increases with financial insecurity, housing instability, unemployment, debt, low income, and increased SI (Meltzer et al., 2011). While these factors might play a role in the overall suicide rates in the population, they might not have the same predictive power specifically for veteran suicides. Suicide prevention efforts at the community level are critical for the veteran population as demographic and socioeconomic issues did not substantially impact or predict veteran suicides (Edwards et al., 2022).

Targeted suicide prevention strategies may need to focus on other factors or challenges veterans face. Research emphasizes the need for a comprehensive approach to suicide prevention, considering individual and community-level factors and tailoring interventions to specific populations like veterans with increased risk factors. It is crucial to raise awareness, provide support, and create accessible mental services for those facing financial difficulties, housing instability, unemployment, and other challenges that can impact suicidal thoughts and behaviors.

Access to Resources

Two-thirds of veterans with increased SI are not actively engaged in mental services (Nichter et al., 2021). Only 47% of veterans currently utilize the VA, indicating a significant need to address veterans not receiving health care or obtaining services outside the VA (Ruiz et al., 2022). Improvement needs to focus on increasing access, developing more effective approaches toward veteran suicide, and increasing providers' knowledge of the unique health concerns of the veteran population (Ruiz et al.). Meeting veterans who receive health care is vital in tackling the veteran suicide crisis. All healthcare providers must be prepared to address these issues (Faucett, 2021). Belongingness and burdensomeness are substantially linked to suicide risk among veterans living in rural areas (Compton et al., 2021). Researcher utilized validated

instruments but indicated that based on encountered limitations, additional research should attempt to replicate the results with modalities like self-reporting data and clinical interviews (Compton et al., 2021). Evaluation of interventions and health system methods are needed to prevent suicide (Shiner et al., 2021).

Veterans in rural areas who believe they are a drain on resources, family, and friends are more likely to experience increased risk and SI with intent and a plan (Compton et al., 2021). Researchers focused on descriptive statistics for VA in 2017, studying 6,120,355 VA users, with 32.0% (n=1,955,935) living at a rural address (Shiner et al., 2021). Suicide completion rates are higher for veterans living in rural areas compared to urban areas, with 33.3 vs. 29.1 deaths per 100,000 veterans (Shiner et al., 2021). Veterans living in rural areas experience a higher risk of suicide disparity based on compositional factors like age, gender, and race (Shiner et al.). Additional work is needed to fully understand the related and shared factors with rural veterans before developing a targeted strategy to address suicide problems in rural communities (Shiner et al.).

Social Support

Social support is crucial in veterans' mental and well-being, particularly when mitigating suicide risk. Veterans often face unique challenges after leaving the military, and social support can provide a buffer against stress and psychological difficulties (VA, 2022b). According to interpersonal psychotherapy, individuals who perceive themselves as a burden to others and lack a sense of social connectedness are at higher risk of desiring suicide (Klerman et al., 1996). Younger veterans are at a higher risk for suicide, with one in five veterans reporting SI over two weeks (Nichter et al., 2021). Not all veterans have access to adequate social support, and some

may experience difficulties establishing these connections due to several factors, such as geographical location, social anxiety, or physical limitations (Russell et al., 2019).

Recognizing the importance of social support and creating opportunities for veterans to connect with others can be crucial in addressing suicide risk. A strong social support network can function as an immediate crisis intervention system for distressed veterans, providing timely help and support during challenging times (Petersen, 2015; Proescher et al., 2020). Connecting with others who understand the challenges of military life and transitioning to civilian life can give veterans a sense of purpose and belonging (Pew Research Center, 2020). Camaraderie can positively influence their mental and reduce the risk of suicide.

Perceived social support is found to be uniquely related to SI (Wilks et al., 2019). Social support can impact veteran suicide risk in many ways. A higher perceived social support was protective against SI for veterans with high and low levels of anger (Hawkins et al., 2014). The benefit of social support was more significant for those with low levels of anger, indicating that veterans with anger difficulties may experience reduced social support, making them more vulnerable to suicidal thoughts (Hawkins et al.; Proescher et al., 2020). Individuals with heightened levels of anger and aggression may have more reactive social support networks, which could diminish known protective factors for suicide (Hawkins et al.). Research in civilian samples has shown that the relationship between anger and SI is mediated by thwarted belongingness and perceived burdensomeness (Hawkins et al.). Suicide prevention efforts and interventions that target anger management and social support have effectively treated at-risk veteran populations (Wilks et al.).

Emotional support is impacted by having a solid social support network of family, friends, or fellow veterans who can provide emotional comfort and understanding (Proescher et

al., 2020). Emotional support can be vital in helping veterans cope with feelings of isolation, depression, anxiety, and other mental issues, reducing the risk of suicide (Herbst-Damm & Kulik, 2005). Social activities and supportive relationships can reduce negative feelings and increase the feeling of connection, lessening suicide risk (Proescher et al.). Informational social support can offer valuable information on mental resources, treatment options, and coping strategies (Beard, 2021). Knowledge of social support can empower veterans to seek help and better manage their mental health. Practical support and assistance, such as help with daily tasks or employment opportunities, can alleviate stress, and improve overall well-being (Beard).

Focus groups have identified the need for veterans interested in the type of program that would require some form of connection or reason to participate and engage in program activities after the group concludes (Shue et al., 2020). Veterans discussed the reluctance to participate when the purpose or activities are vague, suggesting that peer outreach could effectively promote the program and help to create buy-in with future participants (Shue et al.). The group experiences highlight the power of shared experience, building intimacy, and the veteran connection (O'Connor et al., 2021). Bonding and recovery within the group treatment strategy are a strength of the suicide prevention group program (O'Connor et al.).

Essential themes with the veteran population following a suicidal crisis focus on the long-term impact of suicide prevention, group therapy, and treatment in an inpatient setting (O'Connor et al., 2021). Mental health professionals, veterans' support organizations, and community outreach programs are critical in identifying veterans at risk of suicide and providing them with the necessary support and resources. Early intervention, open conversations about mental health, and increased awareness can all contribute to reducing veteran suicide rates. A multi-faceted approach could help to address social support, foster connections, and promote open

conversations about mental (Proescher et al.). Understanding these crucial support factors and implementing suitable measures to enhance support can significantly improve veterans' mental well-being and mitigate the effects of moral injury (MI).

Moral Injury

Moral injury can be defined using two different approaches. The first is being betrayed of what is right by a person holding legitimate authority while participating in a perilous situation (Farnsworth et al., 2017). The second definition of MI is failing to stop or witness an act that contravenes deeply held moral beliefs (Farnsworth et al.). Performing or observing killings, extreme violence, or the inability to assist wounded civilians while conducting combat operations are morally detrimental (Held et al., 2018). The consequences of moral injuries are social: increased behavioral issues, substance abuse, social isolation, adverse effects on relationships, and the inability to find meaning in the community (Farnsworth et al.).

Potentially morally injurious events (PMIEs) have been linked to SI and suicidal behavior in veterans (Levi-Belz et al., 2022). PMIEs can significantly challenge an individual's moral beliefs. They can lead to MI, manifesting in numerous negative psychosocial consequences, including PTSD, demoralization, self-handicapping, and suicidal behavior. However, not all individuals who experience PMIEs report SI, suggesting that there may be protective factors that buffer the deleterious effects of PMIEs on mental outcomes (Levi-Belz et al., 2022; Litz et al., 2009). One prospective protective mediator can be found in interpersonal relationships that facilitate accepting support from others (Schwartz et al., 2021). These supportive relationships may help mitigate the harmful psychosocial impact that can surface after exposure to PMIEs.

Research on protective factors for SI among veterans who have experienced PMIEs is still relatively limited. However, some research has been investigating potential mediators, such

as social support, and their role in influencing mental outcomes in this population (Schwartz et al., 2021). Understanding the complex between PMIEs, MI, social support, and their impact on mental is crucial for developing targeted interventions to support veterans struggling with these issues (Kelley et al., 2019).

Researchers conclude that self-disclosure creates a sense of belonging, personal bonding, and support that could reduce suicide risk following an event that potentially impacts a person's morals or beliefs (Levi-Belz et al., 2022). Self-disclosure has been identified as one of the crucial factors in helping veterans heal (Levi-Belz et al.). This healing process helps individual therapy enhance social skills and increase adaptiveness, which could be valuable for veterans struggling with MI (Levi-Belz et al.). Continued research on this topic can help advise helpful strategies for prevention and treatment.

Barriers to Treatment

Military members experience a catch-22 situation when dealing with mental issues based on the idea of being considered average, feeling misunderstood, needing help, and being concerned about being classified as crazy and untrustworthy when they seek help, untimely placing their job at risk (LeFeber & Solorzano, 2019). Secondary information from seven MSM explained similar negative experiences and isolation after being identified as suicidal (LeFeber & Solorzano).

Research conducted with veterans in a rural community indicates a lack of awareness of the veteran suicide crisis, limited discussions centered around suicide, and identification of a community stigma related to suicide (Monteith et al., 2020). Findings imply that focus is needed to reduce the stigmatization in community-based suicide prevention programs, address community misconceptions, increase general knowledge, and increase community awareness to

aid suicide prevention with rural veterans (Monteith et al., 2020). Research uncovered low community readiness, a lack of awareness of the suicide crisis, a lack of resource knowledge, and a general lack of conversation about suicide and the stigma surrounding suicide (Monteith et al.).

Suicide prevention fails to persuade service members to seek treatment and help for SI, indicating a potential problem (Karras et al., 2022). The research discovered worries over self-efficacy, difficulty with the prevention message, psychiatric disorders, difficulty getting an appointment, and other limitations as some barriers to the suicide prevention program and message (Karras et al.). Veterans described current suicide prevention messages as generic and condescending towards them and recommend that a broader message is needed (Karras et al.). Suicide prevention in the military is limited to the medical provider's perspective (LeFeber & Solorzano, 2019). In advertisements and training, veterans are stereotyped as GI Joe and explain that this limited imagery impacted veterans from seeking help (Karras et al., 2022). Female veterans reported they lack inclusion, as most advertisements are focused on young service members in a military uniform, and no older veterans out of uniform (Karras et al.). Messages indicate recovery was improbable, discouraging some veterans from seeking help (Karras et al., 2022). Treatment of depression, anxiety, and PTSD can increase feelings of shame, guilt, and breakdown of trust (Goldstein, 2021). Listening is critical in treating and preventing suicidal attempts (Goldstein). The stigma related to mental treatment comes from the military mindset that weakness, emotions, and vulnerability are too controlled (Goldstein).

Veterans reported a lack of credibility within the suicide prevention messages, suggesting they choose to have suicidal behaviors; this idea causes increased anger and a negative response towards the prevention message (Karras et al., 2022). Overall findings stated that prevention

messages must be evaluated with intended audiences to ensure messages are effectively received (Karras et al.).

Mental Health Stigma

The MHS is a significant problem that affects many people in today's society. Mental health stigma is typically experienced when a person with a mental condition is subjected to prejudicial attitudes, beliefs, and behaviors that can result in discrimination and exclusion from society. Stigmatization is created from labeling, bias, and prejudice that raises the perception of an underlying negative belief of a group (Hinshaw, 2007). Most stigmatized beliefs within society are directed at people with mental illnesses, which increases adverse reactions and social distancing (Hinshaw, 2007). Society perpetuates the MHS that people with mental issues are dangerous and prone to violence (Parcesepe & Cabassa, 2014). The MHS appears to be commonly recognized by society (Corrigan, 2000). Stigmatizing beliefs and actions often vary, but children with depression and adults with substance use disorders are at increased risk of being stigmatized (Parcesepe & Cabassa). Research conducted by Shrivastava in 2012 indicated that stigmatization was expected: 86% of participants concealed their illness; 69% witnessed others expressing offensive things about individuals with mental illnesses; 63% worried about being regarded negatively; and 59% had been treated as incompetent.

Stigmatization of individuals damages social relations and increases fear during its manifestation (Hinshaw, 2007). This negative branding increases the feelings of shame, ineptitude, and social isolation for people struggling with mental illnesses (Parcesepe & Cabassa, 2014). Research directed at society's beliefs, actions, and attitudes toward the MHS stresses the need for future anti-stigma interventions and research (Parcesepe & Cabassa). Terrible events like natural disasters, mass shootings, and acts of violence indicate the need to address the MHS

(Shim & Rust, 2013). Early intervention focusing on mental services could reduce post-combat mental problems and alleviate the need for long-term care (Wright et al., 2009).

Individuals' viewpoint concerning mental treatment impacts the likelihood of seeking help for mental health-related problems (Ajzen & Fischbein, 1980). The MHS affects individual perception toward mental treatment, which is thought to be influenced by other people's views on MHC (Vogel & Wester, 2003). Individuals' attitudes and beliefs toward MHC are indicated as a stronger deterrent to seeking help (Kim et al., 2011). The internal stigma people feel reduces motivation and erodes their positive attitudes toward counseling, eventually reducing positive help-seeking behaviors (Lannin et al., 2016).

Active duty soldiers reported stronger feelings of stigma and organizational barriers to care concerning National Guard military soldiers (Kim et al., 2010). Service members with mental problems are frequently viewed as incapable of incompetence and threatening unit safety (Greene-Shortridge et al., 2007). Mental health problems are relatively widespread within the military population; research indicates many service members are uncomfortable or unwilling to seek help or treatment for combat-related mental problems (Held & Owens, 2013). The MH stigma has been recognized as the main reason only a small percentage of service members with psychological challenges seek help from MH professionals (Kim et al., 2011). Attitudes toward treatment negatively impact treatment-seeking behaviors and indicate the need for a more comprehensive examination of why service members do not seek MH treatment (Kim et al.). Years of continued combat operations and the amount of military personnel experiencing psychological issues are growing and could result in more generations of veterans with MH problems (Litz, 2007).

Stigma Presentation Outline

The MHS creates significant problems that negatively impact today's society. MHS is typically experienced when a person with a MH condition is subjected to prejudicial attitudes, beliefs, and behaviors that can result in discrimination and exclusion from society. Stigmatization is created from labeling, bias, and prejudice that raises the perception of an underlying negative belief of a group (Hinshaw, 2007). Most stigmatized beliefs within society are directed at people with mental illness, which increases adverse reactions and social distancing (Hinshaw).

Society perpetuates the MHS and the idea that people with MH issues are dangerous and prone to violence (Parcesepe & Cabassa, 2014). Mental health problems are relatively widespread within the military population. Research indicates many service members are uncomfortable or unwilling to seek help or treatment for combat-related MH problems (Held & Owens, 2013).

Early intervention focusing on MH services could reduce post-combat MH problems and alleviate the need for long-term care (Wright et al., 2009). To make effective changes, we must first understand the MHS. Research conducted by Shrivastava et al. in 2012 on the MHS indicates:

- 86% of participants concealed their illness.
- 69% witnessed others expressing offensive things about individuals with mental illnesses.
- 63% worried about being regarded negatively.
- 59% had been treated as incompetent.

The General Impact of the Mental Health Stigma

- Damages individuals (Parcesepe & Cabassa, 2014).
- Reduces social relations (Parcesepe & Cabassa).
- Increases fear (Parcesepe & Cabassa).
- Increases feelings of shame (Parcesepe & Cabassa).
- Creates feelings of ineptitude and incompetence (Parcesepe & Cabassa).
- Reduces motivation (Lannin et al., 2016).
- Erodes positive attitudes toward counseling (Lannin et al.).
- Reduces positive help-seeking behaviors (Lannin et al.).
- Stronger deterrent to seeking help from mental health professionals (Kim et al., 2011).

Service Member's Specific Issues

- Active-duty soldiers reported stronger feelings of stigma and organizational barriers to care concerning National Guard soldiers (Kim et al., 2010).
- They are frequently viewed as incapable, incompetent, and threatening unit safety (Greene-Shortridge et al., 2007).
- The main reason is that only a small percentage of service members seek help from MH professionals (Kim et al.).
- Negative attitudes toward treatment can reduce seeking behaviors (Kim et al.).
- Continued combat operations and the amount of military personnel experiencing psychological issues are growing and could result in more generations of veterans with MH problems (Litz, 2007).

Summary

Over the last two decades, the suicide rate in the veteran population has increased substantially (Bjork et al., 2022). To reduce the suicide rate, we must fully understand the perceived MH stigma impacting service members seeking help for SI. Suicide impacts everyone in the United States and creates a significant financial burden on American taxpayers (Shepard et al., 2016). Only 61% of the Operation Iraqi Freedom and Operation Enduring Freedom veterans utilized the VA health care system (Faucett, 2021). Roughly 20 veterans die by suicide daily with no identifiable cause discovered. Army chaplains can help to provide valuable observations, experience, and perspectives on current barriers and potential strategies to reduce the perceived stigma that impacts service members.

Veterans experience many risk factors that create additional barriers to seeking ACEs. like abuse, neglect, and toxic family members, irrespective of any combat exposure, are likely to screen positive for mental and behavioral health challenges like depression, PTSD, anger issues, and Sis (Morgan et al., 2022). Sleep disorders and disturbances can increase SI over most psychiatric disorders (McCarthy et al., 2022). Co-occurring disorders can increase the risk of suicidal behaviors, impact treatment, and negatively impact the risk of suicide (Bahraini et al., 2019). Depression, hopelessness, and negative influences correlated with increased SI (Schafer et al., 2022). Legal issues and increased suicide attempts can significantly increase the risk of SI (Edwards et al., 2022). Lifetime legal issues, PTSD, depression, suicidal ideation, suicide attempts, gender, combat experience, service branch, utilization of MHC, and education impact suicide risk (Holliday et al., 2021). The probability of suicide increases with financial insecurity, housing instability, unemployment, debt, low income, and increased SI (Meltzer et al., 2011).

Younger veterans have a higher risk for suicide, with one in five veterans reporting SI over two weeks (Nichter et al., 2021).

Two-thirds of veterans with increased SI are not actively engaged in MH services (Nichter et al., 2021). Only 47% of veterans currently utilize the VA, indicating a significant need to address veterans not receiving health care or obtaining services outside the VA (Ruiz et al., 2022). Military members experience a catch-22 situation when dealing with MH issues based on the idea of being considered average, feeling misunderstood, needing help, and being concerned about being classified as crazy and untrustworthy when they seek help, untimely placing their job at risk (LeFeber & Solorzano, 2019). The stigma related to MH treatment comes from the military mindset that weakness, emotions, and vulnerability are too controlled (Goldstein, 2021). The MH stigma is a significant problem that affects many people in today's society. Mental health stigma is typically experienced when a person with a MH condition and subjected to prejudicial attitudes, beliefs, and behaviors that can result in discrimination and exclusion from society. Stigmatization is created from labeling, bias, and prejudice that raises the perception of an underlying negative belief of a group (Hinshaw, 2007). Attitudes toward treatment negatively impact treatment-seeking behaviors and indicate the need for a more comprehensive examination of why service members do not seek MH treatment (Kim et al., 2011). Years of continued combat operations and the amount of military personnel experiencing psychological issues are growing and could result in more generations of veterans with MH problems (Litz, 2007).

Chapter Three: Methods

Overview

Research indicates that the stigma toward MS significantly decreases the probability of seeking help for mental problems and suicidal ideations (Lannin et al., 2016). This qualitative study analyzed the perceived stigma of mental and SI in the military from the perspective of military chaplains. Understanding what influences MHS service members experience with SI may help reduce the suicide rate. Service members can face feelings of disconnection, loneliness, isolation, and lack of purpose when returning from combat and reintegrating into civilian life. This research enhanced the current literature on MHS from firsthand accounts. Chapter three focuses on the research design, questions, setting, participants, procedures, investigator's role, data collection procedures, data analysis processes, trustworthiness issues, credibility, dependability, confirmability, transferability, and potential ethical considerations.

Design

Researcher utilized a qualitative approach to reduce the power dynamic found during research with the military population (Creswell & Poth, 2018). This study investigated military chaplains' lived experiences involving MHS and SI with the military. Criterion-based sampling was utilized by selecting participants who met two criteria (Heppner et al., 2016). Participants must have had experience with the phenomenon being researched and be able to articulate their lived encounters (Creswell & Poth). An in-depth look into this phenomenon was necessary to understand the complexity fully, so a quantitative approach was unsuitable (Heppner et al., 2016). Qualitative research helps to understand the complexity of individuals by exploring individual perspectives and understanding (Heppner et al.). This qualitative research aimed to generate meaning from collective and lived experiences to foster a deeper understanding of

human experience. Insight was created by looking at the many viewpoints through numerous strategies like semi-structured conversations, field notes, data analysis, and observations (Heppner et al.).

The phenomenology design comprehensively described the phenomena being studied across everyday experiences (Heppner et al., 2016). Phenomenology research parameters focus on five primary themes: the philosophical perspective, research questions and lived experiences, criterion-based sampling, phenomenological data evaluation, and the spirit of the lived experiences (Heppner et al.). The phenomenological research questions and lived experience approach was utilized to answer three research questions on a chaplain's lived experience regarding MHS and SI with the military. The hermeneutical approach sought to understand and interpret the lived experiences of individuals within a society by examining the underlying meanings, cultural contexts, and societal influences that shape people's perspectives and actions in their everyday lives (Heppner et al.). The researcher used hermeneutical phenomenology to interpret and reflect on essential themes throughout lived experience (Creswell & Poth, 2018).

Researchers should clearly understand the assumptions that influence the research questions. Personal feelings, assumptions, knowledge, and judgments were set aside to facilitate a new and unbiased account of the topic (Creswell & Poth, 2018). Researchers will maintain a solid connection to the topic and balance each section to decode the lived experiences (Creswell & Poth, 2018). Transcendental phenomenology was not be appropriate as researchers remained disconnected and removed their own experiences (Creswell & Poth).

The researcher utilized the fundamental objectives of Interpretive Phenomenological Analysis (IPA) to explore participants' understanding of their experiences (Pietkiewicz & Smith, 2014). The assumption was that participants could interpret their experiences with active

engagement in people, events, and objects and understand people in their lives (Taylor, 1985). To explore participants' understanding of their experiences, IPA utilizes the basic principles of phenomenology, hermeneutics, and ideography, emphasizing precise details (Smith et al., 1995). The IPA researcher examined individual narratives equally, moving between important themes while comparing and contrasting themes (Pietkiewicz & Smith). IPA researchers seek to create detailed explanations of experiences utilizing open inductive methodology to collect and analyze data (Pietkiewicz & Smith). The research utilized HyperRESEARCH software to support qualitative data analysis. HyperRESEARCH provided tools for coding, organizing, and analyzing qualitative data, which was applied to the IPA process.

Research Questions

Numerous recommendations were made to investigate MHS comprehensively. Researchers measured MHS utilizing surveys as the primary measurement tool, missing the opportunity to operationalize the stigma fully (Hinshaw, 2007). Measures of MHS should include more than information about illness, stereotypes, negative attitudes, and behavioral indicators (Hinshaw). Research exploring MHS and seeking help behavior has failed to comprehensively examine the connection with help-seeking behaviors (Vogt, 2011). Additional research concentrating on the attitudes and perceived stigma toward help-seeking behavior across various military units is needed to improve the military's ability to conduct operations (Gochicoa, 2019).

This qualitative phenomenology research addressed the literature gap described by Gochicoa (2019), Hinshaw (2007), and Vogt (2011) by exploring the perceived MHS and Sis that occurred within the military from a chaplain's perspective. Research questions broadly investigate the perceived MHS and SI.

Principal Research Questions

This research aims to collect information and gain insights into participants' lived experiences within the United States Armed Forces, specifically focusing on MHS and suicidal ideations in the military environment.

PRQ1

What is the participants' perspective on their encounters with suicidal ideation and mental health stigma within the military?

PRQ2

How do participants perceive their role in addressing and supporting individuals with suicidal ideations in the military?

Additional Research Questions

The following supplementary research questions were formulated to explore the participants' perspectives regarding the connection between MHS, suicidal ideation, and their responsibilities as military chaplains.

RQ1

How do participants define mental health stigma within the military context?

RQ2

What factors do participants believe contribute to the prevalence of mental health stigma among military personnel?

RQ3

How do participants perceive the impact of mental health stigma on individual willingness to seek help?

RQ4

How do participants describe their existential and spiritual understanding and perspectives regarding mental health stigma and suicidal ideation in the military?

Setting

The qualitative phenomenology research site was a major Army base in New York, comprised of numerous multi-denomination military chaplains. The site was selected based on the diverse population of military chaplains and the vast number of MSM that potentially interacted with the Army Chaplain Corps. Chaplains are usually the first to respond when MSM experience emotional and mental crises (Ramchand et al., 2016). Chaplains provide insight and a unique viewpoint of this perceived stigma. Chaplains fulfill the mental needs of MSM with total confidentiality, which is critical to fully understanding and reducing the barriers associated with the perceived MHS (Besterman-Dahan et al., 2012). For this qualitative phenomenology research, chaplains must have had lived experience helping MSM with SI and a basic understanding of MHS. Provisional approval was received from the temporary and inbound Garrison chaplain on the 12th of June 2023. Deputy Garrison Chaplain has received approval from the local public affairs office and confirmed tentative consent per a phone conversation on the 7th of July 2023.

Coordination and communication were directed to the Deputy Garrison Chaplain to recruit chaplains from the military base in New York. Interested participants received the researcher's contact information. If the researcher fails to gain adequate participants from this location, convenience sampling will be conducted for chaplains outside the approved site. At that point, the researcher will obtain moderator permission from additional sites to recruit participants if this contingency becomes necessary. Pseudonyms were utilized to safeguard confidentiality for each participant and site involved in the study.

Participants

The population for this qualitative phenomenology research included multi-denomination military chaplains. The target population was located within a military base located in the state of New York. This phenomenological study utilized three fundamental conditions for selecting participants. First, participants must be military chaplains. Second, participants must have had experience helping MSM with SI. Third, participants must have been able to communicate their perspectives on the stigma linked to mental and SI in the military. Convenience sampling was utilized based on participant availability and volunteerism. Nonrandom sampling techniques tend to be a weaker sampling method but were necessary considering limitations and population size (Christensen et al., 2015).

The participants for this research focused on nine military chaplains to address the problem statement. Participants varied based on availability and selection regardless of age, race, and gender. The number of participants depended on the complexity of a single case, the depth of individual cases, how the researcher intended to analyze cases, and practical limitations (Pietkiewicz & Smith, 2014). When utilizing a phenomenology hermeneutic approach, less than ten participants are needed if the intensity of data collected is high, and more than thirty participants if the data collected is less intense (Gentles et al., 2015). Generally, phenomenological research requires less than ten interviews to reach data saturation, and no new critical information is discovered (Moser & Korstjens, 2018). In order to aid the researcher in achieving data variation and saturation criteria, approximately nine participants will be utilized.

All participants were required to sign the consent form to participate in this research and fill out the Qualifying Questionnaire (see Appendix D). Interested participants were required to meet all three qualifying criteria to participate in the study: (a) current or former military

chaplain; (b) have interacted with MSM experiencing SI; (c) be willing and able to communicate perspectives related to MHS. At the end of the research, all participants received a (5x10 inch approximate size) custom wood American flag. Each flag was made from reclaimed whiskey barrels and laser engraved with their name and a personal statement thanking them for participating in the research.

Procedures

All required authorization steps were approved and completed before enrolling participants in the research. The Institutional Review Board provided awareness of potential human rights issues and ethical guidelines before conducting research (Heppner et al., 2016). Participants were recruited after receiving signed). Provisional approval was received from the temporary and inbound Garrison Chaplain on the 12th of June 2023. Deputy Garrison Chaplain had received approval from the local public affairs office and confirmed tentative consent per a phone conversation on the 7th of July 2023. Official site permission was obtained from the Garrison Chaplain before submitting the Liberty University IRB application (see Appendix B). The site authorization letter informed the Garrison Chaplain of all information regarding this research proposal, the research process, a copy of the informed consent form, interview questions, stigma training/handout, and self-surveys that were utilized during this research. Recruiting participants from the military base coordinated and initiated communication through the Deputy Garrison Chaplain. Deputy Garrison Chaplain forwarded a letter to participants summarizing the research, process, and requirements (see Appendix C) to all chaplains assigned to the base. The Deputy Garrison Chaplain forwarded contact information to all participants who were interested in participating. Interested participants received the researcher's contact information, information regarding this research, a summary of the process, a copy of the

informed consent form, sample interview questions, stigma training/handout, and an explanation of the self-surveys utilized during this research.

The research was estimated to recruit ten to twenty participants, ensuring data saturation in the event of attrition. The Deputy Garrison Chaplain facilitated the initial contact through official email informing participants of the intended research and the researcher's contact information. After participants were contacted by the researcher directly, the researcher read the Informed Consent form and had the participants sign and return the form through DocuSign. Participants were provided with an electronic copy of the consent form detailing the process, outlining the time commitment required and rights to confidentiality before conducting the interview, with each only being interviewed once. All participants were informed that they had the right to refuse to answer any questions and continue the study; they could also cease participation at any time. Scheduling and coordination for the collection of the Qualifying Questionnaire started after the researcher receives the signed consent form (Appendix D), completion of the Self-Stigma of Seeking Help Scale survey (Appendix G), presentation of the stigma information brief (Appendix H), and when interview would be coordinated. If the researcher failed to gain adequate participants from this location, volunteers recruited from nearby military bases in New York that meet the original participant requirements. The researcher obtained moderator permission from additional sites to recruit participants if this contingency became necessary. Pseudonyms were utilized to safeguard confidentiality for each participant and site involved in the research.

Participants were informed that all interviews would be recorded and transcribed for accuracy. Participants were interviewed once for 60-90 minutes (face-to-face, via Microsoft team meetings, Zoom, or FaceTime) depending on accessibility and availability. Interviews and data

collection continued until saturation occurred or the topic was exhausted, and no new perspectives were presented (Groenewald, 2004). The research utilized the IBM Watson™ Speech Text service to transcribe the audio recording to text. Written transcriptions were validated with participants for data analysis, transparency, and accuracy. Participants reviewed and approved transcriptions; after approval, all transcriptions and digital recordings were destroyed to safeguard participants' privacy and confidentiality.

Role of the Researcher

The primary focus of the researcher under the phenomenological approach can be simplified into one word: describe (Groenewald, 2004). The goal for the researcher in this study was to describe as accurately as possible the phenomenon and remain factual. The researcher functioned as an instrument to collect, analyze, and report data. Phenomenological research aims to gather data on the participant's perspectives and contribute knowledge on the phenomenon (Groenewald). The philosophical concept of epoché is crucial in Husserl's phenomenology, which focuses on the description and analysis of conscious experience (Heppner et al., 2016). In phenomenology, epoché is achieved by suspending or bracketing one's preconceived beliefs, assumptions, and judgments about the world, setting aside preconceptions to approach a phenomenon with a fresh and open perspective (Heppner et al.). Practitioners of phenomenology aim to gain a deeper and more direct understanding of the phenomenon as it is experienced without being influenced by prior beliefs or biases (Heppner et al.). The researcher was an observer without professional or personal relationships with participants.

Researchers must understand that deeply held beliefs and biases can negatively influence research, and steps must be taken to mitigate any potential insertions of bias. Researchers should report any feelings or personal reactions in the methods section and discuss beliefs and the

impact of bias in the limitations section (Heppner et al., 2016). Bias is natural during any research and can be mitigated by having open conversations throughout the research process (Heppner et al.). All interview questions were sent to ten mental professionals for peer review to help limit possible researcher bias. Researcher attempted to avoid data from being rashly categorized into the researcher's bias by writing field notes to help clarify data collection from each interview (Groenewald, 2004). To ensure the recording and observation bias are mitigated during data collection, researcher will follow three basic steps: accept that mistakes can occur, identify, and analyze any mistakes, and implement necessary steps to avoid additional errors (Christensen et al., 2015).

Data Collection

Data quality is paramount in qualitative research, as the reliability and validity of findings largely depend on the quality of the data collected (Creswell & Poth, 2018). To ensure high-quality data, the researcher employed various data collection techniques during interviews, participant observations, field notes, surveys, content analysis, and audio recordings to validate findings. The researcher collected the data to identify and provide an understanding of the everyday experiences of the participants (Creswell & Poth). This research utilized three data sources: two surveys, a post-presentation questionnaire, and a semi-structured interview. The data was collected utilizing ontological philosophical assumptions and phenomenological research methods. Ontological assumption focuses on participants' unique perspectives (Creswell & Poth). Understanding and incorporating a chaplain's perception of MHS and SI can aid future suicide prevention and treatment strategies (Ramchand et al., 2016). A hermeneutic phenology orientation focused data collection on participants' lived experiences and reflected on the nature of the phenomenon (Creswell & Poth).

Recruitment for the study involved contacting a diverse group of military chaplains stationed at a significant Army base in New York. This location was chosen due to its significant population of chaplains from various denominations and its proximity to many military personnel who may engage with them. Recruitment efforts were coordinated by the Deputy Garrison Chaplain, who facilitated communication between potential participants assigned to his current location, chaplains at his past duty assignments, and the researcher. Interested participants were provided with the researcher's contact details and a recruitment email outlining the purpose and procedures of the study. Upon receiving this information, potential participants were asked to complete a screening questionnaire and the informed consent form and return both via email. The researcher then reviewed each questionnaire to ensure that participants had met the criteria to participate in the research. Once eligibility was confirmed, participants were contacted by phone or email to schedule an interview. Before the first interview, all participants signed and returned a consent form via email. Additionally, they were provided with comprehensive information about the research, including an overview of the process, a copy of the informed consent form, sample interview questions, materials on MHS, and an explanation of the self-surveys utilized throughout the study.

Informed Consent

The researcher gained official site authorization before seeking IRB approval from Liberty University. The Garrison Chaplain obtained official site permission (Appendix B). The site authorization letter informed the garrison chaplain of all information regarding this research proposal, the research process, a copy of the informed consent form, interview questions, stigma training/handout, self-stigma survey, and anticipated stigma inventory that were utilized during this research.

The Deputy Garrison Chaplain oversaw communication and coordination with participants. The Deputy Garrison Chaplain sent a comprehensive letter detailing the research, process, and requirements (Appendix C) to all chaplains stationed at the base. Interested individuals received contact details for the researcher, along with information about the research, a process overview, an informed consent form, sample interview questions, stigma training materials, an explanation of the self-stigma survey, and the anticipated stigma inventory used in the research. The Deputy Garrison Chaplain facilitated the initial contact through official email, introducing the participants to the research's purpose and providing the researcher's contact information.

After participants contacted the researcher directly, the researcher read the Informed Consent form and had the participants sign and return the form through DocuSign. The researcher provided participants with a written consent form detailing the process, outlining the time commitment required and rights to confidentiality before conducting the interview, with each only being interviewed once. All participants were informed that they had the right to refuse to answer any questions and continue the study, and that they could terminate participation at any time. Two meetings were scheduled and coordinated after the researcher received the Qualifying Questionnaire (Appendix D) and the signed Informed Consent form (Appendix E).

If the researcher failed to gain adequate participants from this location, volunteers were recruited from nearby military bases in New York that met the participant criteria. The researcher obtained moderator permission from additional sites to recruit participants if necessary. Pseudonyms were utilized to safeguard confidentiality for each participant and the site involved in the study.

Data Collection Procedures

Data collected during all interviews was face-to-face or through an online service like Microsoft team meetings, Zoom, or FaceTime. Before starting each data collection activity, the researcher verified that the Informed Consent form was signed and reminded participants that the interview would be recorded using a digital recorder. To promote consistency for all interviews, the researcher utilized an interview protocol guide (see Appendix N). Data collection utilized field notes during and after the interview, survey, and inventory. Field notes and summarizing were more about how the researcher adjusted his mindset and consciousness to uncover the psychological importance of the data (Englander & Morley, 2023). Pseudonyms were utilized to safeguard the confidentiality of each participant.

First Meeting

The first meeting was conducted via face-to-face or video conference lasting approximately 45 minutes (Introductions 10 minutes; Self-Stigma of Seeking Help Scale survey 5 minutes; presentation on the perceived MHS 15 minutes; complete the Endorsed and Anticipated Stigma Inventory 10 minutes and closing tasks (5 minutes)). The researcher initiated contact with the participants and emphasized that they could retain the freedom to withdraw from the study at any point without facing any adverse outcomes. The researcher built rapport with the participant by providing a brief history of experiences with MHS and the military. The Informed Consent form was reviewed to ensure participants understood what was signed. The researcher explained that qualitative phenomenological research was selected to explore MHS and SI in the military. The researcher collected information for the Demographic Information Questionnaire (see Appendix O), which was utilized to create a Detailed Demographic Information Spreadsheet with Excel (see Appendix J). The researcher added to this information after each participant's

first meeting. The researcher informed the participants what to expect in the second and third meetings. Before ending the meeting, the researcher scheduled the interview approximately one week later.

The first group of data collected was a survey to assess the participant's level of self-stigma utilizing the Self-Stigma of Seeking Help Scale survey (see Appendix G). Participants were given a brief presentation (see Appendix H) on MHS , followed by completion of the Endorsed and Anticipated Stigma Inventory (see Appendix I), allowing participants to expand and reflect on the presentation.

Second Meeting

The second meeting occurred during the semi-structured interviews and was the primary data collection source. The interviews were conducted from 60-90 minutes to help researcher understand individual perceptions, limitations, and hardships. The researcher reiterated to the participants that they could remove themselves from the study MHS, SI, and perspectives on MHS in the military context. The interviews and surveys provided researcher with another layer of information to help uncover themes and a clearer understanding of participants' experiences (Heppner et al., 2016). The researcher informed the participants what to expect in the third meeting. Before ending the meeting, the researcher scheduled the transcription review approximately 1-2 weeks later.

Interviews

The individual interviews were the primary data collection source. Semi-structured interviews provided the structure of the interviews and allowed for more profound responses (Heppner et al., 2016). Researcher collected information utilizing two techniques during interviews: document analyses and observation methods, making this a significant tool for data

collection in phenomenological research (Gill, 2020). Emphasis was placed on guiding the conversation toward participants' perspectives of MHS and SI in the military helped reduce this stigma. Interviews were conducted with three possible formats based on availability (Face 2 Face Microsoft team meetings, Zoom, or FaceTime). The researcher recorded all interviews utilizing a digital recorder. The interviews followed a guide sheet but retained flexibility to follow notable conversations. Guidance protocols provided continuity across all interviews utilizing discovery-orientated strategies (Heppner et al.).

The researcher assessed the interview questions for quality, relevance, and the potential to yield adequate data before the interview. An essential component of the qualitative approach was epistemological reflexivity, meaning how the research questions defined and constrained the information gathered and how the design and technique of analysis affected the data (Pietkiewicz & Smith, 2014). Questions suitable for qualitative research focused on investigating sensory perceptions, thoughts, memories, associations, and individual interpretations (Pietkiewicz & Smith). Questions focused on each participant's lived experience, feelings, beliefs, and views about MHS and SI within the military context. Experienced researchers could effortlessly determine if participants were avoiding issues, questions, and feeling uncomfortable, utilizing essential counseling competencies, and could be an effective tactic during interviews (Pietkiewicz & Smith).

The reliability of interview protocols in qualitative research could have been improved by refining them with the Interview Protocol Refinement (IPR) framework. IRP framework could improve interview procedures' reliability and increase the data's quality and importance (Castillo-Montoya, 2016). IPR framework is a four-step process that (1) aligns interview and research questions, (2) creates inquiry-based discussions, (3) facilitates feedback with interview protocols,

and (4) tests interview questions (Yeong et al., 2018). Interview protocols enhanced the efficiency of interviews while ensuring that the information was collected within the scheduled time (Yeong et al., 2018). Interview protocols helped researchers capture a more vital understanding of the participant's experience and fundamental elements significant to the research (Yeong et al., 2018).

The first phase of the IPR framework aligned interview and research questions by confirming their purpose and ensuring the necessity of questions (Castillo-Montoya, 2016). The alignment of the interview questions in Phase 1 had been checked utilizing a matrix for mapping the interview and research questions (see Appendix L). Phase 2 involved the development of interview questions utilizing expert knowledge, everyday norms, and the general understandability of participants (Castillo-Montoya). Phase two was facilitated by ten MH professionals employed with the VA (see Appendix M). Phase 3 provided feedback on the interview protocol to enhance reliability and trustworthiness by utilizing colleagues or research members to examine the structure, length, writing style, and comprehension (Castillo-Montoya). The guide sheet was utilized to create the interview protocols (see Appendix N). Phase 4 actual interviews assessed in a live simulation; notes were taken on improvements towards conducting the interview, not from the interviewee's thought process comprehension (Castillo-Montoya).

Interview Questions

Interview questions aimed to collect detailed information about the chaplain's perspective on MHS and SI in the military environment. These questions were designed to discover meaning and reflect the lived experience of participants (Willis et al., 2016). The researcher was respectful and empathetic during the interview, as the subject matter could have been sensitive

and emotional (Creswell & Poth, 2018). Additionally, the researcher assured participants of the confidentiality and privacy of their responses (Creswell & Poth).

The hermeneutic phenomenology approach was utilized by qualitative research to understand and interpret participants' lived experiences within a specific phenomenon (Gentles et al., 2015). Researcher attempted to explore the meaning and essence of the participant's experiences and the nature of the phenomenon from their perspective (Creswell & Poth, 2018). Researcher aimed to gather rich, descriptive data from participants about their subjective experiences and interpretations of the phenomenon under study (Creswell & Poth). The researcher used the reflection aspect in hermeneutic phenomenology to gain deeper insights and understanding of the phenomenon and its complexities (Willis et al., 2016). The emphasis was on bracketing preconceived notions and biases to be open to the meanings derived from the participants' experiences (Heppner et al., 2016).

Third Meeting

The third meeting was conducted by email and follow-up calls as required, taking approximately 20 minutes to review and validate the text transcriptions of the interviews. The researcher reiterated that they could remove themselves from the study without consequences. The researcher reminded the participants of the Informed Consent document and reiterated the purpose of this qualitative phenomenological research to explore MHS and SI within the military setting from the chaplain's perspective. Before the meeting, the researcher emailed a copy of the transcriptions to facilitate discussions on discrepancies and allowed participants to clarify any responses. Transcriptions of the interview were emailed to all participants to ensure accuracy and clarification of meaning (Creswell & Poth, 2018). After participants verified transcriptions, the researcher initialed the data analysis process.

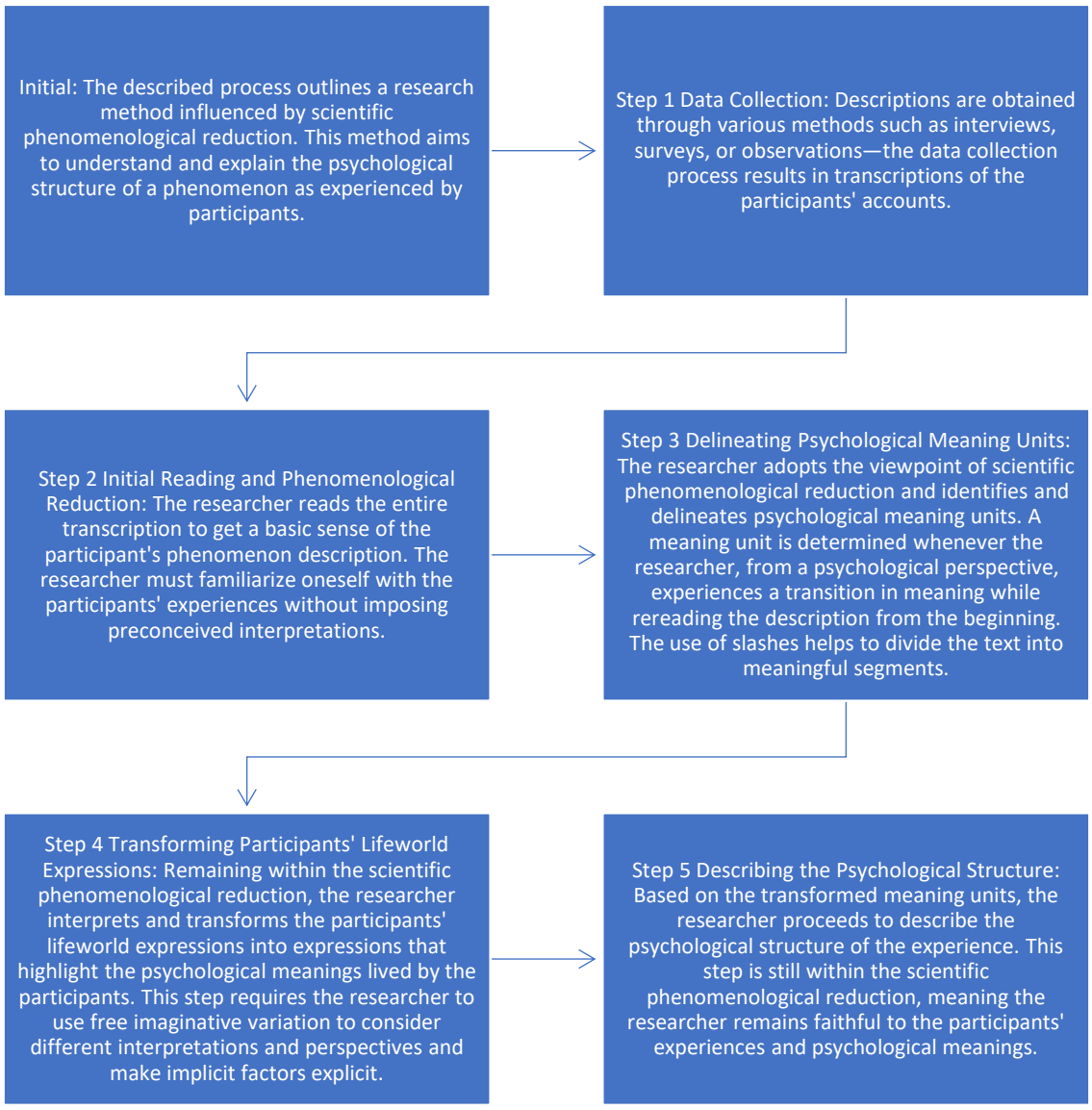
Data Analysis

The problem addressed in this study was understanding the perceived stigma toward MH and SI within the military context. This phenomenological study provided insight from United States Army chaplains on the perceived MHS and SI. This phenomenological study aimed to provide insight from United States Army chaplains into the perceived stigma and SI in the military context. The philosophy guiding this research centered on the understanding that reducing the stigma toward MH early in a military service member's career was critical to reducing the suicide rate. The participants for this study consisted of nine military chaplains who had experience in helping MSM with SI and the stigma associated with MH. Research results uncovered MHS impact in the military and identified problematic areas to aid future suicide reduction policies. When utilizing a phenomenology hermeneutic approach, less than ten participants are needed if the intensity of data collected is high, and more than thirty participants if the data collected is less intense (Gentles et al., 2015). Generally, phenomenological research requires less than ten interviews to reach data saturation, and no new critical information is discovered (Moser & Korstjens, 2018). Approximately nine participants utilized during this research supported data variation and saturation criteria. Data protection and confidentiality procedures were in place before the research began. The researcher limited and managed access to all research data, and the following protocol was implemented. Paper copies of notes, questionnaires, surveys, inventory, and other documentation were secured and effectively restricted from public access (Elsevier, 2021). All paper documents and electronic hardware should be stored in a locked file cabinet (Elsevier, 2021). Names and personal information should be coded with the security key in a separate and locked location. (Elsevier, 2021).

The researcher utilized a five-step data analysis method. This method has been adopted over five decades and is most effective when applied sequentially to the other steps (Englander & Morley, 2023). The five steps have consecutive and non-consecutive elements that create structure and organization while allowing the researcher to move back and forth, revising as new findings and perceptions are introduced (Giorgi, 2017). Once meaningful units are created, the process takes on a back-and-forth motion. These meaning units launch the basic framework for data evaluation, and the process of checking, rechecking, reflecting, and linking the data into patterns begins (Englander & Morley). The researcher assembled the themes presented while analyzing participants' experiences to propose a deeper understanding of MHS and SI in the military context.

Figure 1

Flowchart for Data Analysis (Englander & Morley, 2023)



Initial Reading

Step 1 begins with researcher looking at the whole picture, analyzing all parts of the data, and ends with a new interpretation or understanding of the whole (Englander & Morley, 2023). The initial understanding of the complete description is essential as this understanding aids the researcher in studying the individual parts (Englander & Morley, 2023). This process is not a

hypothesis or conclusion but the start of understanding data. The whole narrative account supplied by the participants will function as the background during analysis. The researcher will review the transcriptions numerous times before beginning the next step (Giorgi, 2017).

Implementing the Phenomenological Viewpoint

Step 2 centers on the phenomenological perspective, a primary characteristic that separates this approach from non-phenomenological qualitative research (Englander & Morley, 2023). Qualitative researchers focus on the epoch and modify the process toward the psychological scope of the data analysis (Englander & Morley, 2023). Time is needed to understand phenomenological research's characteristics fully, and focus is placed on the epoché perspective and assumptions (Englander & Morley, 2023). Epoches' viewpoint lets the experience arise in everyday reality for numerous reasons. Epoche clears the way to understand participants' experiences better and helps define experiences without relying on physical descriptions, explanations, stereotypes, or hypothetical models (Creswell & Poth, 2018). Epoche helps researchers see the world through participant experiences (Englander & Morley, 2023). Giorgi's modification incorporates the area of lived experiences by a particular person engaged in everyday life while extracting psychological meaning (Giorgi, 2017).

Dividing the Data into Smaller Units

Step 3 is inspired by practicality within the phenomenological viewpoint (Englander & Morley, 2023). Within the phenomenological principles, data should be reduced to smaller and more manageable sections, allowing researchers to conduct a more detailed analysis during Step 4 (Englander & Morley, 2023). The data is divided into meaning units ranging from one sentence, paragraph, or page. Not all meaning units are critical to the phenomenon but must be analyzed during Step 4 (Englander & Morley, 2023). The researcher must remain focused on the

epoché perspective and analyze carefully as some meaning units could appear redundant. The researcher will divide the data side-by-side into columns labeled Column 1 (participant description) and Column 2 (phenomenological explanation of psychological meaning). This procedure conveniently manages the analysis process and makes the procedure more transparent for future researchers.

Transforming Daily Expressions into Psychological Meaning

Step 4 emphasizes the connection between Column 1 (participant description) and Column 2 (phenomenological explanation of psychological meaning) (Englander & Morley, 2023). Researchers describe the participants' experiences in general terminology, drawing out the psychological meanings rooted in the everyday depiction (Englander & Morley, 2023). Researchers pursue the meanings within the lived experience for phenomenological analysis while conducting a detailed analysis. Phenomenology is not just notes, summarizing, and condensing meanings but a mindset of psychological meanings drawn from insight (Englander & Morley, 2023). The researcher transforms participants' statements into psychological meanings without adding to what they say. Researchers are not restricted to one column during analysis but should extend the analysis into many stages to demonstrate how levels of generalization are reached.

Restoring to the Whole and Transitioning to the General Structure

Step 5 transitions the data from the smaller meaning units to the whole eidetic analysis to create a new and whole meaning (Englander & Morley, 2023). The researcher will remain within the phenomenological perspective described in steps 1-4, combining the parts into a narrative (Englander & Morley, 2023). The whole meaning structure should be straightforward and feature fundamental parts that hold together. Conclusions will be presented in themes that emphasize the

structure of the phenomenon, stressing their connection to the whole (Englander & Morley, 2023). Other methods present participants' direct quotes but focus on structural and general mean rather than curated raw data (Giorgi, 2017).

Trustworthiness

Trustworthiness in research describes the level of confidence in the methods, data, and analysis of data (Nowell et al., 2017). Trustworthiness in qualitative research is typically described and evaluated by credibility, dependability, transferability, and ethical considerations (Elo et al., 2014). Trustworthiness is correlated with predictable valuation theories where participants share comparable stories that reflect progress and indicate sustainable results (Clare, 2022). Trustworthiness is depicted in qualitative terms outside of average limitations, making it particularly important in qualitative research (Nowell et al., 2017). In qualitative research, the researcher ensures that data analysis utilizes specific and reliable approaches to encourage readers that the findings are worthwhile (Nowell et al., 2017). The researcher will evaluate trustworthiness during all study segments, starting with the preparation phase and ending with reporting the results. The Lived Experience of the chaplains, literature review, and guidance from legitimate textbooks will help create credibility during this research. Confirmability will be demonstrated by researchers' consistency and a continual assessment of potential bias during data analysis. Dependability will be accomplished by providing abundant detail so future researchers can replicate the study. Ethical considerations will be addressed during all phases of research: preparation, data collection, data analysis, and study publishing.

Credibility

To measure and ensure trust, researcher will utilize the technique of contradiction and interpretation. Information collected concerning the chaplain's perspective and experiences will

be compiled into evidence to create a complete and structural understanding of this stigma. This process increases the reliability of the study because researchers will look at recurring behaviors to weigh the evidence. Reflexivity will assess the researcher's self-awareness and accountability of standards and answer if they reflected the participant's authentic experience, if transcriptions are accurate, and if alternative conclusions are identified. Researchers' self-awareness is essential to validate the phenomenological questions and understanding of themes, viewpoints, and experiences.

Dependability and Confirmability

Validation strategies will ensure dependability and confirmability. Descriptions will include a detailed and profound explanation of the chaplain's experiences. Researcher bias will be clarified. Peer review and clinical supervision will be conducted with research data and during the research process. Validating research data is essential to exclude past experiences and biases, thereby creating an avenue to address intricate inquiries and evaluate research methodologies (Creswell & Poth, 2018). It is vital to transparently document data collection processes and methodologies so that others can understand and assess the validity of the data (Creswell & Poth, 2018).

Transferability

To increase transferability and maintain the basic research structure, methods, research descriptions, and data samples will be fully documented, published, and presented with the research findings (Creswell & Poth, 2018). Honest data and results will be published utilizing appropriate and common language (Creswell & Poth, 2018). The researcher will write detailed descriptions of all participants, common themes, and organized themes to aid future researchers in applying this study’s results to future studies.

Ethical Considerations

Ethical issues should be addressed during all phases of research: the preparation phase, while conducting the research, during the data analysis, and in the final stage of publishing the study (Creswell & Poth, 2018). Before starting the research, we will seek approval from Liberty University IRB and Garrison Chaplain, establish professional standards of conduct, and ensure bias based on the research site is mitigated.

All participants will be volunteers and follow appropriate ethical guidelines outlined in professional ethical standards (Creswell & Poth, 2018). Research participants will be informed in writing of the purpose of the study with approved consent forms. Respect will be given based on societal norms, cultural, religious, gender, and other notable or appropriate needs (Creswell & Poth, 2018). Active consent will be obtained by verbal and written agreement utilizing the IRB-approved consent form (Christensen et al., 2015). Informed consent ensures that participants understand and make informed decisions on the study (Christensen et al., 2015).

During the data collection phase, research sites and participants will be respected to build trust and minimize disruptions (Creswell & Poth, 2018). The focus and purpose of this research will be explained to the participants. The research questions will be open-ended to avoid leading the participants, and self-disclosure will be limited to avoid sharing personal ideas (Creswell & Poth, 2018). The data collected will be stored for five years utilizing appropriate security precautions. All information collected will be stored under a double-locked cabinet in the researcher's home to prevent unauthorized access.

While analyzing data, the participant’s privacy will be respected and maintained. Personal bias and viewpoints will be avoided to prevent contrary and skewed findings (Creswell & Poth, 2018). The data will be reported with explicit language and honesty to protect the

participant's identity (Creswell & Poth, 2018). Information and copies of all reports will be shared with stakeholders. The results will be published and available to the general public (Creswell & Poth, 2018). Identified conflicts and any potential profit will be disclosed. The research will begin once approval is obtained from Liberty University's Institutional Review Board.

Summary

This research will center on a qualitative phenomenological approach to explore the perceived MHS and suicidal ideations within the military environment from the chaplain's insight and perspective. Throughout a qualitative study, the researcher will incorporate extensive interviews, observations, and assessments to understand MHS in the military from the lived experiences of military chaplains. This phenomenological study will focus on individuals who share a common experience (i.e., helping MSM with SI and MHS) (Creswell & Poth, 2018). This study will rely on two primary and four secondary research questions to help learn about the impact of MHS and SI in the military.

The philosophy guiding this research is that understanding the MHS towards seeking help for SI is critical in reducing the suicide rate. Military chaplains have unique perspectives as they are typically the first trained professionals to engage with MSM experiencing SI and behaviors. Military chaplains potentially offer insight into the stigma service members experience. Credibility, dependability, transferability, and ethical considerations will be the foundation of research trustworthiness. The data collected will link participants' perspectives and provide insight into the perceived MHS potential in seeking help for suicidal ideations.

The procedure for narrowing down the sampling group for this study will include the following qualifying criteria: participants must be military chaplains, have experience helping

MSM with SI, and be able to communicate their perspectives related to MHS and suicidal ideations in the military. The following methodology during this research will include an introduction call, completing the Qualifying Questionnaire, Self-Stigma of Seeking Help Scale Survey, presentation on the MHS, Endorse and Anticipated Stigma inventory, individual interviews, and validation of transcribed interviews. Indirect observations and field notes will be completed at each interview. Data analysis will utilize inductive and deductive analysis, in-case analysis, cross-case analysis, and open coding. Utilization of these interpretive methods will safeguard validity, accuracy, and integrity when analyzing the results.

Chapter Four: Findings

Overview

This chapter contains detailed findings from the researcher regarding the lived experiences of military chaplains as they interact with service members grappling with thoughts of suicide and dealing with MHS. The questions guiding this research include: What is the participants' perspective on their encounters with SI and MHS within the military? How do participants perceive their role in addressing and supporting individuals with suicidal ideations in the military? How do participants define MHS within the military context? What factors do participants believe contribute to the prevalence of MHS among military personnel? How do participants perceive the impact of MHS on individual willingness to seek help? How do participants describe their existential and spiritual understanding and perspectives regarding MHS and SI in the military? They investigated MHS related to MH and thoughts of suicide in everyday interactions. The five key areas guiding this study are the philosophical perspective, research queries and real-life experiences, criterion-based selection, phenomenological data evaluation, and lived experiences' core (Heppner et al., 2016). The research questions are grounded in lived experiences to address how chaplains encounter MHS and suicidal thoughts in the military.

The existential perspective of Chaplains was described by employing a hermeneutical approach to understand and interpret individuals' lived experiences in a societal context. The study explored the underlying meanings, cultural contexts, and societal influences that shape people's perceptions and behaviors in their daily lives (Heppner et al., 2016).

This chapter presents the results in a narrative format from semi-structured conversations, field notes, data analysis, and observations (Heppner et al., 2016). A five-step data analysis

approach was applied to analyze the data collected. This five-step analysis has been utilized for over five decades and demonstrates optimal effectiveness when applied sequentially to the other stages (Englander & Morley, 2023). The steps encompass consecutive and non-consecutive elements, providing a structured framework that allows the researcher to move flexibly back and forth, making revisions in response to new findings and perspectives as they emerge (Giorgi, 2017). Once meaningful units were established, the process adopted a dynamic, iterative motion. These meaning units served as the foundational structure for data evaluation, initiating a cycle of checking, rechecking, reflecting, and connecting the data into discernible patterns (Englander & Morley, 2023). As the researcher progressed, data was synthesized by identifying themes from the analysis of participants' experiences to contribute to a more profound understanding of MHS and SI within the military context.

Participants

This section introduces nine individuals, each assigned a participant ID number, whose narratives and assessments form the basis of the data for this study. Initially, individual descriptions are presented to delineate the participants' levels of self-stigma when seeking help for mental health-related issues. Subsequently, the descriptions outline participants' external levels and anticipated stigma toward mental health-related matters. It is crucial to note that, despite my attempt to suspend personal judgment or subjectivity in the study, true objectivity in interacting with or observing the participants is unattainable. A copy of the observational protocol (Appendix K) is included to provide transparency. This protocol allows the reader to gain insights into the potential impact of my subjective perspectives and experiences on the research process and the themes developed.

For this study, participants were identified by contacting the Garrison Chaplain at a nearby Army base. The Garrison Chaplain then disseminated the recruitment email to approximately 54 subordinate chaplains and friends. Furthermore, one of the chaplains who initially received the recruitment information shared the email within a Facebook support group called Army Chaplaincy, comprising approximately 1800 chaplains. It is worth noting that this group is not public and is restricted to current and former military chaplains.

The group consisted of nine participants, eight males and one female, all United States Army Chaplains. These individuals met the screening requirements as either current or former Military Chaplains. They had direct experience interacting with service members facing SI and MHS. They were willing to share their perspectives or lived experiences concerning MHS and suicidal ideations within the military. All participants completed the screening questionnaire (Appendix D). Although ten participants volunteered and signed the consent form, only nine ultimately completed the interview. The data collection process, involving interviews, the Self-Stigma of Seeking Help Scale, and the Endorsed and Anticipated Stigma Inventory, took place from December 2023 to February 2024. The data was collected via video conferences, Zoom and Teams, and telephone interviews.

Participants underwent three critical steps in the study process. Initially, they filled out the Self-Stigma of Seeking Help Scale (Appendix H) and received an overview detailing the prevailing information on MHS in the military (Appendix I). They completed the Endorsed and Anticipated Stigma Inventory (Appendix J). Before each interview, participants were briefed that the researcher would assume the role of an information gatherer, not a counselor. A pre-interview test of the recording device was conducted.

Guidance for the interviews was provided using the interview guide (Appendix K) and observation protocol (Appendix S, T, and U). Upon completion of the interviews, transcriptions were generated, and participants were emailed a copy for accuracy verification. Notably, one participant identified one error in the content of the transcriptions, clarifying discrepancies between what was transcribed and what he intended to convey. Corrections were made and duly noted in the finalized transcriptions.

The table below delineates the participants' shared characteristics and unique aspects.

Table 1

Characteristics of Participants

Participant ID	Gender	Ethnicity	Age	Duty Status	Highest Rank	Current or last Active duty Chaplain Position	Education Level
P1	Male	White/Caucasian/European American	55-64	Retired	MAJ	Garrison Family Life Chaplain FORSCOM	MA/MS
P2	Male	White/Caucasian/European American	45-54	Active Duty	LTC	Garrison Deputy Chaplain FORSCOM	EdD/PhD
P3	Male	Asian/Pacific Islander	35-44	Active Duty	MAJ	Division Chaplain TRADOC	MA/MS
P4	Female	African/African American	35-44	Active Duty	CPT	Battalion Chaplain TRADOC	MA/MS
P5	Male	White/Caucasian/European American	45-54	Active Duty	MAJ	Brigade Chaplain FORSCOM	MA/MS
P6	Male	White/Caucasian/European American	45-54	Active Duty	MAJ	Garrison Family Life Chaplain FORSCOM	MA/MS
P7	Male	Asian/Pacific Islander	35-44	Active Duty	CPT	Battalion Chaplain FORSCOM	MA/MS
P8	Male	White/Caucasian/European American	35-44	Active Duty	MAJ	Garrison Deputy Chaplain FORSCOM	EdD/PhD

P9	Male	White/Caucasian/European American	35-44	Active Duty	MAJ	Brigade Chaplain TRADOC	EdD/PhD

P1

P1, a retired Major who served as an Army chaplain, had a diverse military career spanning various positions and duty locations. From serving at the battalion level to becoming a Family Life Chaplain at the garrison level, he has accumulated a wealth of experience. P1 is currently employed by the Department of Veterans Affairs as a chaplain on a MH ward, bringing with him a unique blend of experience from both clinical and non-clinical settings while on active duty and while collaborating with veterans at the VA.

P1 reflected on the challenging nature of his experience with SI and MHS, particularly in light of his positions and responsibilities. This challenge stemmed from his education extending beyond what is required. Despite not needing a therapist's license to fulfill his role as a chaplain, there were instances where he had to delve deeply into complex issues, such as interpreting suicidal gestures or statements. He possesses a deeper understanding of these complexities compared to many chaplains, recognizing nuances in how suicide intersects with other aspects of life. This understanding distinguished him from those without experience counseling individuals dealing with such emotions.

About a decade ago, P1 found himself in a challenging situation shortly after completing his education in the military and obtaining licensing as a therapist. A soldier approached him, expressing the turmoil within their family. The soldier's marriage was crumbling due to the soldier's extramarital behaviors and life choices, placing P1 in an uncomfortable position as he felt unequipped to counsel effectively. Recognizing the importance of providing unwavering support as a chaplain, P1 realized the gravity of his discomfort in this scenario. Complicating

matters further, the soldier held a critical and irreplaceable Military Occupational Specialty, complicating the unit's ability to address the soldier's issues adequately. P1 acknowledged that while it is not always within a chaplain's scope to make people feel better solely, it is imperative to intervene when faced with a suicidal soldier. His duty, in such instances, extends to preventing the soldier from committing suicide or engaging in harmful behaviors.

P1 observed shifts in the military's approach to tackling MHS and suicide prevention, often influenced by political dynamics, particularly the occupant of the White House. According to P1, the priorities the commander-in-chief sets significantly impact the allocation of resources toward strengthening the military and ensuring its readiness to defend the nation. When there is a focus on bolstering military capabilities, funding tends to be directed toward programs addressing MH issues and suicide prevention.

P1 emphasized the importance of maintaining accessible and effective support systems at both individual unit and organizational levels to combat MHS and encourage soldiers to seek help for suicidal thoughts. This approach entails ensuring the availability and functionality of resources supporting MH and well-being within the military community.

P2

P2 currently serves as an active-duty Lieutenant Colonel, fulfilling the role of an Army chaplain at the Garrison level. P2 has guided high-ranking military officers and new recruits in multiple combat operations throughout his career. Operating within a sphere of heightened expectations and stress, P2 is responsible for upholding exemplary standards within the military.

P2 reflected on his experience positively, having aided numerous soldiers grappling with suicidal thoughts. However, he has also experienced the tragic loss of soldiers to suicide. P2's faith played a significant role in his approach, as he believed in free will and individual choice

regarding life and death. P2 perceives his role as equipping individuals with coping mechanisms to navigate life's challenges, striving to exhaust all avenues in assisting struggling soldiers.

P2 observed a stigma surrounding MH within the Army, noting that some soldiers fear repercussions on their security clearance if they seek behavioral health support. This fear, in turn, hindered open communication and trust within the ranks, as individuals withheld information due to concerns about jeopardizing their clearance status and sensitive situations based on position and job requirements.

One of the significant insights P2 has gained from his time in the Army is the role of chaplains in facilitating yearly mandatory training on suicide prevention, ranking among his top three passions as an Army chaplain. P2 finds fulfillment in teaching and facilitating this vital training yet acknowledges that not all chaplains share the same level of motivation due to variations in job responsibilities. Suicide prevention falls under the purview of Army G1, but P2 emphasizes the necessity of leadership engagement across all levels to combat MHS and encourage soldiers to seek assistance.

According to P2, leadership must actively advocate for MH support and encourage soldiers to seek help as a sign of strength rather than weakness. He emphasized the importance of leaders speaking out and reassuring soldiers that accessing resources such as the chaplain team or behavioral health services increases their capabilities as soldiers or warriors. Instead, P2 stressed that it demonstrates courage and determination to address vulnerabilities and cultivate resilience.

P3

P3, a Major currently serving at a training location responsible for training future officers in the United States Army, reflected on his overall positive experience supporting service members grappling with thoughts of suicide and MHS. He highlighted the robust support

systems found through clinical and Non-Commissioned Officer (NCO) channels, which he described as overwhelmingly supportive in nearly all cases. However, he identified two significant issues that frequently come to mind in this realm.

Firstly, he emphasized the concern surrounding MH challenges affecting mission readiness and associated reportable metrics. When critical individuals face personal struggles that impact their performance, P3 stated it could disrupt the brigade's reportable metrics, creating pressure on those in crucial support roles. Secondly, P3 noted the stigma perpetuated through peer-to-peer interactions, often observed within barracks or among colleagues. Service members may hesitate to seek help due to fears of repercussions, such as discharge from the Army, especially if they have dependents and responsibilities outside the military. This stigma, he observed, centers more on the perceived impact of responsibilities rather than concerns about personal judgment from others.

P3 has observed numerous changes in the military's approach to addressing MHS and suicide prevention, mainly through the availability of resources like MFLIC and behavioral health integration. In organizations where these resources are accessible, P3 notes a significant impact on his role as a chaplain. However, he highlighted that not all changes have reached every corner of the military, leading to chaplains still serving as the primary point of contact for MHC. P3 has identified this shift as the most notable change, coupled with concerns about job security. P3 believes that increasing resources will encourage more soldiers to seek help for suicidal ideations at various levels within the military hierarchy.

P3 finds himself in a quandary regarding confidentiality; while he sometimes wishes to be able to break confidentiality when necessary, he fears this could result in them becoming mandated reporters. Similarly, he desires more substantial confidentiality for medical providers

to avoid mandating reporting. Despite the contradictory nature of these wishes, P3 recognizes that both scenarios could improve support for service members facing MH challenges.

P4

P4, a Captain serving as an Army Chaplain training future Army officers, brings a unique perspective to her role, drawing from her civilian experiences before joining the chaplain corps. Despite being the least experienced officer among her peers, she possesses a wealth of knowledge and insight.

In her time collaborating with infantry officers, particularly young lieutenants, P4 has encountered the devastating impact of three suicides over a year and a half. She observed a troubling pattern among male officers in her training environment, noting that many suppress their emotions and refuse to seek help for their MH struggles. P4 described a culture where emotions are dismissed, and individuals are expected to soldier on without processing their grief or seeking support. This approach, she reflected, leads to a cold and callous atmosphere, prioritizing mission completion over the emotional well-being of individuals.

P4 also shared how some soldiers have been more willing to seek MH support outside of instances related to suicide. She recounted an experience with her brigade commander, who shared his MH struggles and medication use in response to the unit's suicides. However, some perceived his delivery as disingenuous despite his intentions to encourage seeking help.

Acknowledging her limitations and relatively short military tenure, P4 expressed confidence in the seriousness with which the chaplain corps addresses MH, particularly in highlighting the benefits of spirituality. She underscored the significance of soldiers proactively managing their self-care and spiritual well-being to bolster themselves and their loved ones. P4 is a vocal advocate for fostering transparency and vulnerability within leadership ranks, asserting

that setting an example of openness can empower soldiers to prioritize their MH and foster personal growth.

P5

P5, an Active Duty Major serving as a brigade-level Army Chaplain, has a wide range of experience spanning from battalion to his current position, where he oversees the training and evaluation of unit chaplains in a simulated combat environment. He emphasized the privileged nature of soldiers' communications with him, highlighting that chaplains are bound by confidentiality and cannot disclose these conversations.

P5 observed that soldiers often come to him with suicidal ideations, which he views as primarily private matters associated with feelings of depression, discouragement, and isolation. He attributes the stigma surrounding MH to a broader societal issue, likening it to the feeling of shame Adam and Eve experienced in the story of the Garden of Eden. P5 suggested that individuals struggling with MH concerns may feel ashamed of their thoughts and emotions, leading them to hide their struggles from others out of fear of judgment or discovery.

P5 reflected on changes within the military's approach to addressing MHS, and suicide prevention, particularly concerning shifts in leadership within the Chaplain Corps. He noted that the previous Chief of Chaplains implemented spiritual readiness training to enhance connections between commanders and chaplains across all levels of command. P5 highlighted the significance of spiritual readiness assessments for soldiers, providing valuable insights into their sense of purpose and meaning.

However, with the departure of the previous Chief of Chaplains, P5 anticipates a change in emphasis on these programs, as they were not initiated under the new leadership. Despite this, P5 believes that engaged leadership remains crucial in effectively supporting soldiers' MH and

well-being. He acknowledges the ongoing challenge of soldiers feeling isolated in their worlds, a phenomenon he imagines has existed throughout history.

P5 emphasized the importance of leadership demonstrating vulnerability and sharing their struggles to create meaningful connections and provide insight into overcoming challenges. He noted that the tendency to put leaders on pedestals can be counterproductive, and leaders who openly acknowledge their difficulties and the steps they have taken to address them can offer valuable support to their subordinates.

P6

P6, a Major currently serving in the Army as a Family Life Chaplain, regards the topic of MH and suicide prevention as sacred and deeply personal. He believes that chaplains are called upon by divine providence, circumstances, and the individuals themselves to be present and provide compassionate listening to soldiers in their moments of hurt and pain. P6 has experienced the loss of three soldiers to suicide from previous units and has conducted memorials to honor their lives. One of these soldiers was someone with whom P6 had developed a friendship and a professional relationship. P6 recognized the importance of building such connections with soldiers, as it fosters an environment of trust and comfort, enabling them to open up about their struggles with suicidal ideation. He emphasized chaplains' critical role in supporting soldiers in these vulnerable moments.

P6 reflected on the numerous conversations he has had with soldiers from various levels and backgrounds about suicidal thoughts, underscoring the importance of his role as a listener and confidence in providing them with the support they need. P6 highlighted a practical advantage of chaplain services compared to behavioral health resources within the military. He noted that chaplains typically offer more immediate availability for soldiers seeking support,

whereas accessing behavioral health services requires scheduling appointments with waiting periods ranging from two to six weeks. This accessibility can be crucial for soldiers in distress, providing them with a prompt avenue for seeking help and support when needed.

P6 emphasized the critical role of good leadership in reducing MHS and supporting service members within the military. He believes that NCOs and officers who exhibit kindness and a genuine concern for the well-being of their soldiers contribute significantly to fostering a supportive environment. P6 underscored the importance of prioritizing people over the mission, emphasizing the value of authentic care and support. He acknowledged the skepticism within the military regarding new campaigns or initiatives aimed at promoting well-being. However, he emphasized that genuine acts of kindness and empathy from leadership can profoundly impact soldiers. P6 shared examples of how supportive NCOs and officers can offer comfort and support to soldiers facing personal challenges, such as relationship issues, by providing a listening ear and offering practical assistance, such as inviting them to their homes.

P6 believes these acts of kindness and empathy are invaluable for soldiers, particularly those who may not have experienced such support in their family or personal lives. He emphasized that feeling heard and supported by their leadership and peers can immensely benefit soldiers, providing them a sense of belonging and security in challenging times.

P6 highlighted the availability of resources like the Shoulder to Shoulder program and the Commander's Guide to Suicide Prevention, which emphasize the importance of reducing stigma surrounding MH issues from various perspectives, including leaders, behavioral health professionals, and chaplains. He noted that these efforts have increased soldiers seeking help, resulting in a heavier counseling workload. P6 believes training leaders to be effective listeners, caring, and empathetic can further enhance soldiers' willingness to seek support. He emphasized

that soldiers often identify their favorite NCOs or officers based on genuine care, attentive listening, and responsiveness to their needs.

P6 suggested that the emotional connection forged between soldiers and their leaders is critical to effective leadership. However, P6 expressed uncertainty about how the Army's recruiting process will identify and select individuals with these essential leadership qualities. It raises a broader question about how the Army can ensure its leaders possess the necessary attributes to support and care for their soldiers effectively.

P6 described his role as a Family Life Chaplain, which includes training other chaplains to effectively care for people, demonstrate compassion, and listen empathetically. He emphasized the importance of leading by example and engaging in co-counseling sessions with fellow chaplains to demonstrate effective counseling techniques. P6 acknowledged that not all chaplains may feel confident in their counseling abilities or may prioritize other aspects of their role, such as preaching or leading worship services, over counseling. Despite this, P6 noted that he remains committed to encouraging and supporting chaplains in improving their counseling skills and recognizing the importance of empathy and compassion in their ministry.

P7

P7, a Captain serving as a chaplain at the battalion level in the United States Army, describes the challenges encountered when soldiers are hesitant to seek help for MH issues. He observed that many soldiers may prefer to keep their struggles to themselves rather than reach out for support. P7 notes that some soldiers may contemplate using behavioral health services as a means to exit the military, particularly if they are considering separation from the military.

P7 reflected on the difficulty of accurately assessing the extent of SI and MHS among soldiers who are reluctant to disclose their struggles. He emphasized the importance of creating a

supportive environment where soldiers feel comfortable opening up about their MH concerns, as this can facilitate early intervention and support. However, P7 acknowledged that achieving this level of trust and openness can be challenging, particularly when soldiers grapple with the decision to remain in the military or pursue civilian life.

P7 highlighted the effectiveness of support and resources provided through chaplaincy involvement in various gatherings such as fellowship and chapel services. He noted that these opportunities for connection and community can be helpful for soldiers struggling with MH issues, as they may tend to isolate themselves during challenging times. P7 acknowledged the Army's efforts in addressing MH concerns, including suicide prevention, through regular discussions during formations and the implementation of various programs. P7 feels room for improvement in fostering compassion and care within the military culture.

As a chaplain, P7's role is impacted by the need to provide compassionate support that may be lacking in other areas of the Army. He believes his role involves filling this gap by offering empathetic listening, support, and guidance to soldiers facing MH challenges. P7 described his role as crucial in providing compassionate care that complements the Army's existing programs and initiatives in addressing MH and suicide prevention.

P7 reflected on many soldiers' fear of seeking help due to concerns about potential repercussions, such as being removed from the Army. He emphasized the importance of creating an environment where seeking help is encouraged and supported, with the assurance that assistance will be provided without punitive consequences.

P7 shared a recent experience involving a captain who experienced significant stress after receiving an unfavorable evaluation from her previous command team. This stress led to her turning to alcohol, resulting in her absence from work. P7 and the Battalion Executive Officer

visited her to offer support, but she was intoxicated. Consequently, she was sent to Substance Use Behavior Counseling and later to the brigade, where she is now facing separation from the Army. P7 highlights the impact of the negative evaluation and mistreatment from her previous command team, particularly noting the additional stressors that come with being at a critical point in her career. He also mentioned the dynamic between female soldiers, noting that they can sometimes be harsher on each other, which may have contributed to the captain's feelings of mistreatment and stress. This example underscored the need for leaders to support and understand soldiers facing challenges rather than resorting to punitive measures. P7 emphasized the importance of creating a supportive environment where soldiers feel empowered to seek help without fear of negative consequences.

P8

P8, a Major serving at the Garrison level as an active duty chaplain, has dedicated himself to improving suicide prevention programs throughout the Army. With nearly 14 years of experience as a chaplain, he has been confronted with soldiers experiencing suicidal ideations from the beginning of his career. Even during his time as a reserve chaplain, he encountered soldiers dealing with the aftermath of suicide, with incidents occurring at a rate of at least two per month.

Reflecting on his experiences, P8 notes that the majority of issues leading to suicidal ideations among soldiers are not combat-related. Instead, he observed that many junior soldiers struggle with essential life skills and coping mechanisms. They often feel ill-prepared to navigate challenges such as financial difficulties, relationship issues, and stress within their units. P8 emphasized that many of these soldiers lack a sense of purpose or direction in life, exacerbating their struggles. In his current position, P8 oversees individuals dealing with suicidal ideations,

and he observes that many of these cases involve young soldiers who feel overwhelmed and helpless in the face of life's challenges. P8 highlighted that their inability to find solutions or coping mechanisms leads them to consider suicide as a way out, as they feel disconnected from any sense of purpose or meaning.

P8 underscored the importance of addressing the underlying issues that contribute to suicidal ideations among soldiers, including providing support, guidance, and resources to help them navigate life's difficulties and find a sense of purpose and belonging. P8 discussed the challenges faced when soldiers cannot cope with basic life necessities and struggles. He noted that there is a tendency to quickly refer these soldiers to behavioral health services, even when the root of the problem may not necessarily be mental health related. Financial difficulties, for example, are often overlooked as the primary issue, leading to a cycle of worsening debt and reliance on behavioral health services without addressing the underlying financial problems.

P8 highlighted the strain this places on the behavioral health system, with appointments becoming increasingly difficult to obtain due to overutilization. He recounted experiencing significant wait times for behavioral health appointments at his previous duty station due to the overwhelming demand for services. To address this issue, P8 emphasized the importance of directing soldiers to the appropriate resources based on their specific needs. He advocates for a more thorough assessment process to determine whether soldiers truly require behavioral health intervention or if they may benefit from assistance in other areas, such as financial counseling or stress management techniques. P8 stated that we can address the root causes of soldiers' struggles; P8 believes that the Army can better allocate resources and provide more effective support, ultimately reducing the strain on the behavioral health system and improving overall soldier well-being.

P8 emphasized the power of sharing success stories and struggles with others to provide support and encouragement. He believes hearing from individuals who have overcome challenges and sought help can inspire others to do the same. At the 10th Mountain Division on Fort Drum, P8 discusses two key initiatives: the Keys to Connection program and the Mountain Cares Program. The Keys to Connection program focuses on helping new service members identify their purpose, determine the path to achieving it, adopt practices that support their goals, and cultivate relationships that sustain them. P8 noted that this program has successfully fostered conversations and supported soldiers across the division.

The Mountain Cares Program, which stands for Critical Assistance and Resources for Environmental Stressors, aims to match soldiers with the appropriate resources based on their needs. By addressing issues at their root and providing preventive measures, P8 believes that the program can effectively support soldiers and prevent crises before they occur. Overall, P8 stressed the importance of addressing purpose and stressors early on, as these factors can significantly impact a soldier's mental well-being and contribute to suicidal ideation. By promoting conversations about purpose and providing targeted support, P8 believes that the Army can better support soldiers and reduce the risk of suicide.

P8 underscored the importance of open conversations within teams and units, emphasizing the need for soldiers to get to know one another and share their experiences with MH and seeking help for suicidal ideations. He compared this to seeking recommendations from friends before purchasing a product, highlighting the value of hearing firsthand accounts of what has worked for others. P8 believes we can foster an environment where soldiers feel comfortable sharing both positive and negative experiences related to mental health; P8 believes that soldiers will be more inclined to seek help when needed. He suggested that hearing from trusted peers

who have utilized behavioral health resources successfully can instill confidence in others to do the same.

Ultimately, P8 believes that creating a culture of openness and trust within teams and units can lead to better utilization of MH resources and improved outcomes for soldiers struggling with suicidal ideations. By sharing experiences and promoting the effectiveness of available resources, soldiers can feel empowered to seek the help they need without fear of judgment or negative repercussions.

P9

P9, a Major serving on Active duty, reflects on the changing nature of encounters with SI throughout his career as a chaplain. At the captain level, typically serving as a battalion chaplain, P9 encountered SI more frequently, particularly among junior soldiers in a younger age range. However, in his current role, which involves training the trainers for both National Guard and Army Reserve units, P9 encounters SI less frequently, as their audience tends to be more senior. This observation highlights the evolving dynamics of MH challenges within different ranks and age groups of the military. While P9 still encounters cases of SI in his current role, the frequency of such encounters has diminished compared to his experiences at the battalion level.

P9 recounted an anecdotal experience highlighting the stigma surrounding MH issues within the military. He recalled a senior major who was grappling with long-term behavioral health issues, including PTSD, and contemplating self-harm. P9's primary concern was the potential impact seeking help might have on their retirement benefits. The soldier felt torn between enduring silently until retirement to ensure financial security versus seeking help and risking his retirement prospects. P9 alleviated some of the major's concerns by discussing the possibility of medical retirement and its financial benefits.

Reflecting on his 14-year career, P9 noted a significant shift in how MHS is perceived and addressed within the military. He recalled a time when SI was often brushed aside or managed informally within units, with soldiers being told to "sleep it off" behind the staff duty desk. However, he described that attitudes have evolved, and there is now a greater understanding of the seriousness of MH issues. Suicide prevention is recognized as a critical priority, with the knowledge that individuals in crisis must be promptly referred to for professional care. This shift represents a meaningful change from earlier years and reflects a growing awareness of addressing MH issues within the military.

P9 emphasized the importance of having behavioral health resources integrated at the unit level, directly under the command of the unit's leadership. He recalled a shift from the previous setup where behavioral health services were centralized and not directly affiliated with specific units. Now, P9 has observed a trend where units have their behavioral health providers who work directly for the commander. This arrangement allows for a closer working relationship between commanders and behavioral health professionals, enabling more proactive and personalized support for soldiers.

Additionally, P9 discussed the concept of triage in behavioral health services, highlighting the need to differentiate between cases requiring licensed providers' expertise and those that other types of support could address. Drawing an analogy to an emergency room, where not all patients need urgent care, P9 suggested that a similar approach could be utilized with behavioral health services in the military. By categorizing and directing individuals to the most appropriate resources based on their needs, the military can optimize available resources and ensure that individuals receive timely and practical support.

P9 advocates for strategic and efficient utilization of behavioral health assets so soldiers are guided to the most suitable resources based on the nature and urgency of their needs. This approach aims to enhance accessibility to support services while alleviating pressure on licensed providers by redirecting fewer complex cases to other forms of assistance.

P9 highlighted the abundance of resources available to soldiers within the military and the DoD. However, it noted that these resources must be more effectively communicated or made visible to service members. He emphasized that while numerous resources exist, many soldiers may need to be made aware of them due to inadequate dissemination of information. P9 shared his experience of discovering available resources only after being in the military for 14 years, indicating that such information may not reach soldiers promptly. He expressed concern that soldiers may feel they have nobody to turn to for help when, in reality, numerous resources are available to support them. The challenge, as P9 sees it, lies in effectively communicating the availability of these resources to soldiers in a manner that goes beyond simply checking a box during in-processing. He suggested a need for a more organized and targeted approach to informing soldiers about available resources, such as categorizing resources based on specialization and regularly updating soldiers on their availability.

Overall, P9 advocates for a more proactive and strategic approach to informing soldiers about the available resources, ensuring that they are aware of the support options available to them when needed.

Results

The primary inquiry guiding this investigation was: What is the participants' perspective on their encounters with SI and MHS within the military? Through their responses to interview inquiries aligned with this research focus, participants unveiled two key themes: First, “Factors

that increase MHS and SI in the Army," correlating with research questions one, three, four, and five. Secondly, “Factors that reduce MHS and SI in the Army” is linked with research questions one, two, and six. Furthermore, in Theme One, subthemes are highlighted: negative impact on the job, position, rank, career, and or authority; lack of unit leadership engagement and support; implicit messaging; lack of resources; feeling like a failure; and substance use. Within Theme Two, subthemes emerge emphasizing resources, chaplain confidentiality, chaplains' presence and proximity of care, relationships and support, chaplains' availability, and listening and empathy.

Self-Stigma of Seeking Help Scale

The Self-Stigma of Seeking Help Scale (SSOSH) evaluates individuals' perceptions and beliefs toward seeking help for MH issues. Developed by researchers Vogel et al. (2007), this scale addresses the complex phenomenon of self-stigma, wherein individuals internalize societal stereotypes and prejudices related to help-seeking behaviors, leading to reluctance or avoidance of seeking necessary MH assistance. SSOSH consists of a well-structured questionnaire encompassing multiple dimensions such as perceived public stigma, self-stigma, and attitudes toward seeking professional help. Participants rated their agreement with various statements, providing a nuanced understanding of their self-stigmatizing beliefs related to MH support. The researcher employed the SSOSH to shed light on the pervasive nature of self-stigma across different demographic groups and cultural contexts. The scale identified the individual risk of avoiding MH services due to internalized stigma by pinpointing specific dimensions of self-stigma, providing the researcher with a more nuanced understanding of the multifaceted challenges these chaplains faced in acknowledging and addressing their MH needs.

The following table presents a summary of participants' overall self-stigma regarding seeking help for MH. The results indicate participants' viewpoints based on a 5-point Likert scale

with the notion that they would encounter problems when seeking assistance for mental health-related issues.

Table 2

Self-Stigma of Seeking Help Scale Results

Participant ID	Total score out of 50	Results 1 = Strongly Disagree 2 = Disagree 3 = Agree and Disagree equally 4 = Agree 5 = Strongly Agree
P1	20 / 10 = 2	2
P2	19 / 10 = 1.9	1.9
P3	16 / 10 = 1.6	1.6
P4	16 / 10 = 1.6	1.6
P5	33 / 10 = 3.3	3.3
P6	19 / 10 = 1.9	1.9
P7	26 / 10 = 2.6	2.6
P8	17 / 10 = 1.7	1.7
P9	33 / 10 = 3.3	3.3

Endorsed and Anticipated Stigma Inventory

The Endorsed and Anticipated Stigma Inventory (EASI) is a self-report assessment tool comprising 40 items distributed across five scales tailored to gauge MH beliefs specifically relevant to military and veteran populations. The primary focus of the inventory was to understand the chaplain's attitudes that influence their willingness to seek MH treatment. Each chaplain rated eight items within the following five scales:

- Beliefs about mental illness (endorsed stigma)
- Beliefs about MH treatment (endorsed stigma)

- Beliefs about treatment seeking (endorsed stigma)
- Concerns about stigma from loved ones (anticipated stigma)
- Concerns about stigma in the workplace (anticipated stigma)

Utilizing a 5-point Likert-type response format (ranging from 1, strongly disagree, to 5, strongly agree), chaplains provide nuanced feedback on their attitudes toward these critical aspects.

As mentioned earlier, the inventory yielded five distinct scale scores, one for each scale. It is important to note that the items within each scale were not aggregated to create a total score, as the scales function independently as stand-alone measures. Flexibility is built into the EASI's administration, allowing users to selectively employ a subset of scales based on their research or clinical needs.

The following table presents a summary of participants' individual beliefs about mental illness. The results indicate participants' feelings based on a 5-point Likert scale with the notion that mental health-related issues are viewed as unfavorable.

Table 3

Endorsed and Anticipated Stigma Inventory Results: Beliefs about Mental Illness

Participant ID	Total score out of 40	Results 1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither Agree nor Disagree 4 = Somewhat Agree 5 = Strongly Agree
P1	17 / 8 = 2.125	2.125
P2	15 / 8 = 1.875	1.875
P3	23 / 8 = 2.875	2.875
P4	13 / 8 = 1.625	1.625
P5	14 / 8 = 1.75	1.75
P6	16 / 8 = 2	2
P7	17 / 8 = 2.125	2.125
P8	12 / 8 = 1.5	1.5
P9	14 / 8 = 1.75	1.75

The table below summarizes participants' personal beliefs regarding MH treatment. The results are based on a 5-point Likert scale with the question that MH treatment is not helpful

Table 4

Endorsed and Anticipated Stigma Inventory Results: Beliefs about Mental Health Treatment

Participant ID	Total score out of 40	Results 1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither Agree nor Disagree 4 = Somewhat Agree 5 = Strongly Agree
P1	20 / 8 = 2.5	2.5
P2	13 / 8 = 1.625	1.625
P3	15 / 8 = 1.875	1.875
P4	19 / 8 = 2.375	2.375
P5	28 / 8 = 3.5	3.5
P6	13 / 8 = 1.625	1.625
P7	23 / 8 = 2.875	2.875
P8	16 / 8 = 2	2
P9	9 / 8 = 1.125	1.125

The subsequent table offers an overview of participants' perspectives on seeking MH treatment. This table highlights participants' feelings based on a 5-point Likert scale, with the idea that MH treatment is not helpful.

Table 5

Endorsed and Anticipated Stigma Inventory Results: Beliefs about Treatment Seeking

Participant ID	Total score out of 40	Results 1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither Agree nor Disagree 4 = Somewhat Agree 5 = Strongly Agree
P1	12 / 8 = 1.5	1.5
P2	13 / 8 = 1.625	1.625
P3	24 / 8 = 3	3
P4	19 / 8 = 2	2
P5	29 / 8 = 3.625	3.625
P6	23 / 8 = 2.875	2.875
P7	23 / 8 = 2.875	2.875
P8	22 / 8 = 2.75	2.75
P9	21 / 8 = 2.625	2.625

The table below summarizes participants' personal beliefs regarding how their family and friends would perceive them if they were aware of their MH challenges. The results indicate participants' level of concern based on a 5-point Likert scale with the belief that family and friends would hold a negative view of mental health-related problems.

Table 6

Endorsed and Anticipated Stigma Inventory Results: Concerns about Stigma from Loved Ones

Participant ID	Total score out of 40	Results 1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither Agree nor Disagree 4 = Somewhat Agree 5 = Strongly Agree
P1	11 / 8 = 1.375	1.375
P2	10 / 8 = 1.25	1.25
P3	10/ 8 = 1.25	1.25
P4	10 / 8 = 1.25	1.25
P5	16 / 8 = 2	2
P6	19 / 8 = 2.375	2.375
P7	14 / 8 = 1.75	1.75
P8	9 / 8 = 1.125	1.125
P9	27 / 8 = 3.375	3.375

The table below outlines participants' perspectives on workplace MHS. It presents respondents' perceptions based on a 5-point Likert scale with the idea that individuals with MH issues would be viewed negatively by coworkers, supervisors, and others in the workplace.

Table 7

Endorsed and Anticipated Stigma Inventory Results: Concerns about Stigma in the Workplace

Participant ID	Total score out of 40	Results 1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither Agree nor Disagree 4 = Somewhat Agree 5 = Strongly Agree
P1	18 / 8 = 2.25	2.25
P2	25 / 8 = 3	3
P3	17 / 8 = 2.125	2.125
P4	36 / 8 = 4.5	4.5
P5	30 / 8 = 3.75	3.75
P6	24 / 8 = 3	3
P7	31 / 8 = 3.875	3.875
P8	N/A	Participant does not wish to answer.
P9	31 / 8 = 3.875	3.875

Theme Development

A methodical and logical coding approach was employed, carefully considering potential biases documented in the research journal. Initial codes were formulated by transitioning from smaller units of meaning to a comprehensive eidetic analysis, aiming to establish a new and holistic understanding (Englander & Morley, 2023). I maintained a phenomenological perspective, amalgamating individual components into a coherent narrative. The resulting structure presented a clear and cohesive framework, intricately interlinked essential components. The thematic presentation of the theme articulated and highlighted the phenomenon's structural

aspects and interconnectedness (Englander & Morley, 2023). Any emerging sub-themes were thoroughly incorporated into the analysis, findings, and interpretation.

Themes

After reading, transcribing, revisiting the transcripts, and reviewing the recordings, I successfully identified and coded repeated words, phrases, perspectives, and topics. Through this analysis, two major themes emerged among the participants. These primary themes are as follows: “Factors that increase MHS and SI in the Army” and “Factors that reduce MHS and SI in the Army.”

Table 8

Thematic Analysis

Emerging Themes	
Theme One	Factors that increase MHS and SI in the Army.
Subtheme	Negative impact on job, position, rank, career, and or authority
Subtheme	Lack of unit leadership engagement and support
Subtheme	Implicit messaging
Subtheme	Lack of resources
Subtheme	Feeling like a failure
Subtheme	Substance use
Theme Two	
	Factors that reduce MHS and SI in the Army.
Subtheme	Resources
Subtheme	Chaplain confidentiality
Subtheme	Chaplains being present and proximity of care
Subtheme	Relationships and support
Subtheme	Chaplains availability
Subtheme	Listening and empathy

Theme One: Factors that Increase MHS and SI in the Army

Military life presents a myriad of challenges, both personal and professional. It often entails prolonged separation from loved ones, heightening emotional strain on relationships. The risk of MI looms large in combat deployments and training regimens, exerting a profound toll on MH. Emotional duress is commonplace when confronting trauma, witnessing violence, or

mourning fallen comrades. Consequently, service members may grapple with MH conditions like PTSD, depression, and anxiety, exacerbated by the rigors of military existence.

P1 highlighted soldiers' concerns about not advancing to higher ranks because they feared their emotional management abilities might be questioned. Officers also grapple with similar anxieties regarding crucial roles vital for their career progression. Additionally, every officer faces the pressure of eventually taking command of a unit. Meanwhile, NCOs worry about fulfilling their duties in leading squads or platoons and securing desirable positions like First Sergeant. This collective drive to reach the next career level often leads individuals to navigate situations without a secure safety net, a challenge further compounded when MH issues are involved.

P2 emphasized that despite their efforts to provide support and resources, the decision to take one's life ultimately rests with the individual. Expressed a perception of having equipped individuals with coping mechanisms and assistance but acknowledged that the ultimate choice lies with the person.

P3 discussed how MH issues can significantly impact mission readiness and the metrics used to assess it, both qualitatively and quantitatively illustrating the domino effect that occurs when a key individual, experiencing legitimate MH challenges, becomes unable to perform their duties, throwing off the metrics for an entire brigade. P3 believes there is a perception that individuals in critical support roles are burdened with the weight of their responsibilities and may face stigma from their peers and superiors. This stigma may manifest as concerns about being perceived as "choosing" to have problems or facing repercussions such as being kicked out of the Army. P3 emphasized that addressing MHS is an ongoing challenge, requiring continuous effort from organizations and individuals alike rather than a one-time solution.

P4 described the difficulty some soldiers face in seeking MH support, leading to a buildup of anger and emotional turmoil, particularly when trying to cope with the loss of friends. P4 noted that only a small percentage of soldiers choose to confront their emotions and honor their fallen comrades. In contrast, others adopt stoicism, pushing aside their grief to focus on the mission. P4 emphasized two main barriers to seeking help: the demanding training schedule, which leaves little time for accessing support services during regular hours, and a perceived disconnect from leadership, which may not prioritize MHC or create an environment conducive to seeking help without stigma. This lack of support can make soldiers feel isolated and hesitant to address their MH needs, fearing it may be seen as a weakness or disloyalty to the Army.

P5 suggested that MH issues are not just a problem within the military but are reflective of broader societal challenges. P5 highlighted a perceived shift away from a belief in spiritual solutions to problems, noting that as society moves away from this perspective, there is an increase in individuals struggling with MHS and issues. P5 acknowledged that while some individuals may feel comfortable confiding in them about suicidal ideations, for many, such thoughts remain private due to feelings of depression, discouragement, and isolation. They explain that disclosing such thoughts can be difficult and often requires extensive conversation, indicating hesitancy among individuals to talk about their struggles, even within the military community.

P6 shared their perspective on the role of a chaplain, viewing it as a sacred and vulnerable position where they are called upon to listen to and support individuals in their times of distress. They believe that chaplains are chosen by a higher power and circumstances to provide solace and comfort to those in need. P6 also addresses the challenges within the military's Embedded Behavioral Health (EBH) program, highlighting the issue of understaffing

and a lack of trained providers. They note that chaplains, while integral to providing support, may not receive sufficient training in counseling, as their primary degree is often a Master of Divinity, with limited counseling coursework available in seminaries. P6 emphasized the importance of helping chaplains understand and tackle the MH needs of service members despite these training limitations.

P7 reflected on the challenges soldiers face in the Army when it comes to admitting to SI or MH issues. They describe a culture where individuals are expected to be solid and challenging, leading to quick judgment and exclusion if they express vulnerability. P7 noted that soldiers seeking help are often labeled weak or accused of shattering their duties rather than being supported. This stigma surrounding MH concerns leads many to keep their struggles to themselves. P7 also mentioned the presence of counterproductive leadership within the Army, where toxic behaviors can further exacerbate the challenges faced by soldiers dealing with MH issues.

P8 offered insights into the unique pressures military members face, noting that while their experiences may not be unique, they often deal with more serious matters than civilians. The constant pressure to excel in defending America's freedoms can foster a "tough man" persona, discouraging individuals from seeking help and admitting to struggles with MH or suicidal ideation. P8 highlighted the importance of recognizing and utilizing available support resources like behavioral health professionals and chaplains. They also touch on counterproductive leadership within the military, where some individuals may attempt to manipulate situations to their advantage, including seeking psychiatric evaluations to be deemed unfit for duty.

P9 observed a shift in the Army where younger soldiers, typically ranging from E-1 to E-4, are increasingly comfortable seeking care for MH concerns. However, they noted that there is still a lingering stigma, particularly among more senior ranks, such as Senior NCOs and field grade officers. These individuals may feel nervous about seeking help due to concerns about confidentiality and how it might impact their careers. P9 highlighted a unique challenge military personnel face, where any aspect of their personal life can potentially affect their career advancement. Unlike civilian professions, where off-duty actions typically have minimal impact on work, military personnel must consider how seeking help may be perceived by superiors and affect their professional trajectory. This concern can lead to hesitation in seeking care, as individuals fear it may be viewed as a weakness or inability to manage higher responsibilities.

Table 9

Number of Participants Who Related the Factors that Increase the Mental Health Stigma and Suicidal Ideations in the Army

Subtheme: Factors that Increase Mental Health Stigma and Suicidal Ideation in the Army										
Subtheme: Negative impact on job, position, rank, career, and or authority	x	x	x	x	x	x	x	x	x	9
Subtheme: Lack of unit leadership engagement and support	x		x	x		x	x	x	x	7
Subtheme: Implicit messaging			x	x	x		x	x	x	6
Subtheme: Lack of resources			x	x	x	x		x	x	6
Subtheme: Feeling like a failure	x		x	x	x	x		x		6
Subtheme: Substance use	x			x	x	x	x	x		6
	P1	P2	P3	P4	P5	P6	P7	P8	P9	Total

Table 10

Frequency Statistic for Participants Indicating the Factors that Increase Mental Health Stigma and Suicidal Ideation in the Army

Subtheme: Factors that increase mental health stigma and suicidal ideation in the Army					
	Total	Min	Max	Mean	Std Dev
Subtheme: Negative impact on job, position, rank, career, and or authority	36	1	6	4	1.732
Subtheme: Lack of unit leadership engagement and support	9	0	3	1	0.866
Subtheme: Implicit messaging	12	0	4	1.333	1.323
Subtheme: Lack of resources	9	0	2	1	0.866
Subtheme: Feeling like a failure	7	0	2	0.778	0.667
Subtheme: Substance use	9	0	3	1	1

Negative Impact on Job, Position, Rank, Career, and/or Authority

P1 described a situation where a soldier with a crucial Military Occupational Specialty (MOS) was causing problems within the unit. However, because of the importance of his skills, they could not afford to lose him. The following reflects a common concern among soldiers of all ranks: the fear of jeopardizing their career progression due to MH issues. Privates worry about promotions, sergeants fear being discharged, and officers are concerned about future job prospects. The stigma surrounding MH problems, especially in higher ranks, can hinder career advancement, making it difficult for individuals to seek help without risking their professional reputation. This stigma can create a barrier to accessing necessary support, particularly for those aiming for long-term military careers.

P2 discussed the persistent stigma around seeking MH support in specific military roles, particularly in intelligence units where security clearances are crucial. Soldiers may fear seeking behavioral health assistance could jeopardize their security clearance and career prospects. This

concern can lead to individuals avoiding necessary support and confiding in chaplains or other sources they perceive as less likely to affect their careers. Despite efforts by the Army to reassure soldiers that seeking MH support will not necessarily impact their careers, there remains a lingering apprehension, especially regarding the potential for medication or treatments that could render them non-deployable. Ultimately, the decision to seek help is personal, influenced by concerns about career advancement and job performance.

P3 stated throughout their career joking about the interchangeable nature of our military roles—whether as an O-4 56A, an O-3, or an O-2, we are all replaceable at the end of the day. While there is truth to that sentiment, as a chaplain, I strive to remind individuals of their inherent worth beyond their assigned roles. There seems to be a qualitative shift in attitudes toward seeking care over one's military journey. Early on, there is often a "suck it up" mentality, dismissing minor ailments. Later in MSM career, nearing retirement, there is a push to maximize VA disability benefits. This shift signals a change in perspective, mirroring my conversations as retirement nears. The perception of MHS intersects with mission readiness, particularly when key individuals struggle but feel pressure to suppress their issues for the sake of their responsibilities. This pressure can stem from within or from peers, emphasizing duties over personal well-being. Ultimately, the stigma seems more linked to perceived obligations than individual concerns about reputation.

P4 recounted a soldier’s reluctance to seek help, describing how the soldier was hesitant and avoided making an appointment for behavioral health. Despite encouragement from others, the soldier was deterred by peers who warned of negative consequences, including potential ridicule or reprimand. This stigma created a sense of humiliation around prioritizing MHC. A prevailing belief was that one must fully commit to infantry duties to be considered a competent

leader. This mindset led many soldiers to believe that if they could not manage their issues independently, they were unfit for their infantry role, further dissuading them from seeking assistance.

P5 recounted a soldier's experience of spiraling into depression, describing how a series of mistakes or perceived failures led to isolation and further self-criticism. The soldier highlighted the circular nature of MHS within the military, where seeking help often leads to expectations of self-sufficiency from MH providers. This lack of clear guidance can compound frustration and helplessness among service members. Moreover, the fear of negative consequences, such as losing security clearance or facing career setbacks, can deter individuals from seeking assistance. The soldier also touched on the fear of repercussions under the Uniform Code of Military Justice, leading some to contemplate drastic measures like suicide as a means to protect their family. This complex interplay of factors underscores the challenges faced by service members in navigating MH support within the military context.

P6 reflected their role as a battalion chaplain within an aviation unit, specifically an Apache unit deployed to Europe. During their rotation, they found themselves as pilots' primary behavioral health officer, as there were limited MH resources available. They observed that pilots, regardless of aircraft type, shared a common concern about being grounded due to MH issues, which could impact their flight time and training objectives. For higher-ranking officers, the fear often revolved around career implications, such as being passed over for command positions if they disclosed MH struggles. Interestingly, P6 noted their hunch that most suicides within the military do not involve officers or warrant officers, although they lacked concrete data to support this observation.

P7 highlighted the reluctance of soldiers to seek help due to fears of negative repercussions, such as being discharged from the Army or facing a lack of trust from their peers. They expressed concerns about the lack of confidentiality in seeking help from behavioral health services, as soldiers may feel exposed and vulnerable if their issues are reported. This fear of repercussions extends to seeking support within their team, as some soldiers think that the Army's emphasis on teamwork does not always translate into genuine support when individuals are in need. P7 emphasized the need for a supportive environment where seeking help is encouraged and met with genuine assistance rather than punishment or dismissal.

P8 recounted an experience from 2012 involving an E-4 specialist who was struggling with combat-related stressors, impacting his sleep and interpersonal relationships. Despite encouragement to seek help from MH services or the VA, the soldier expressed concerns about the impact on his career in the Army. He feared being perceived as weak or worthless for seeking counseling, highlighting the pervasive stigma surrounding MH support in the military. P8 noted similar instances where higher-ranking soldiers, including a Battalion Sergeant Major, hesitated to disclose their struggles for fear of jeopardizing their career advancement opportunities. This fear of repercussions often made soldiers suffer in silence, avoiding the help they needed for fear of professional consequences.

P9 shared a recent anecdote about a senior major struggling with long-term behavioral health issues, including PTSD, and contemplating self-harm. Despite needing help, his primary concern was how seeking assistance might affect his retirement. This fear stemmed from the overarching stigma surrounding MH in the military, where individuals worry that acknowledging their struggles could jeopardize their careers. P9 emphasized that military personnel face unique challenges, as any aspect of their life can potentially affect their career advancement. Unlike

civilian professions, where personal issues typically have minimal impact on job performance, military personnel must constantly consider how their actions may be perceived in the context of their career trajectory. This heightened scrutiny can lead to hesitation in seeking help, as individuals fear being perceived as incapable or unreliable. Additionally, P9 noted that while MH crises may not always be explicitly documented, the language used in performance evaluations can subtly convey negative perceptions about an individual's ability to manage challenges. This crisis highlights the pervasive nature of stigma within the military and the complex decisions individuals must make regarding their MH and career prospects.

Lack of Unit Leadership Engagement and Support

P1 recounted a challenging situation during their second deployment as a chaplain, where they advocated for a soldier's MH but faced resistance from higher-ranking officers. Despite expressing concerns to the platoon sergeant, first sergeant, and company commander about the soldier's unsuitability for deployment due to MH issues, the soldier was deployed and tragically ended up killing civilians. This incident led to friction between P1 and their superiors. P1 highlighted the pressure within the military to document everything, not necessarily for the soldiers' well-being but to protect the chain of command from potential repercussions.

P3 reflected on the ongoing challenge of suicide prevention within the military, describing it as a continuous and ever-evolving task. They recounted a particular incident where a soldier took his own life despite having attended suicide intervention classes. P3 acknowledged the importance of such training but emphasized that the outcome was the same whether the soldier attended the class. This experience underscored the emotional toll of suicide prevention efforts, especially when they involve soldiers with whom they had personally interacted. P3 also discussed perceptions of stigma surrounding MH support, noting that while some soldiers may

view mandatory training as a mere checkbox, others may not perceive any stigma associated with seeking help. They highlighted the value of regular training in reaching individuals who may be struggling, regardless of their perceptions or experiences.

P4 expressed concerns about disparities between officers and non-commissioned officers (NCOs) regarding camaraderie and quality of life. They observed that officers often have more freedom and leisure opportunities than NCOs. P4 attributed this discrepancy to the need for more mentoring and guidance from senior enlisted leaders. Without a Command Sergeant Major (CSM) or similar figure to provide individualized feedback and support to enlisted personnel, P4 felt that the situation for NCOs had deteriorated over time and showed no improvement.

P6 highlighted examples of bad leaders, stating the importance of compassionate and empathetic leadership in reducing MHS and supporting service members. They emphasized that NCOs and officers who prioritize the well-being of their soldiers and demonstrate genuine care can make a significant difference. P6 noted that when soldiers feel understood and supported by their leaders, it can provide a sense of security and belonging, especially for those who may not have experienced such support in their personal lives. They underscored creating an environment where soldiers feel heard and valued, emphasizing compassionate leadership's profound impact on morale and MH within military units.

P7 highlighted the challenges soldiers face in seeking help for MH issues within the Army. They mentioned how individuals expressing SI or MH concerns are often quickly judged as weak or accused of trying to avoid work. This judgmental attitude creates a stigma around seeking help, leading many soldiers to keep their struggles to themselves. P7 recounted an incident where her NCO discouraged a soldier from reaching out for support, who accused her of neglecting responsibilities. They also noted a cultural divide between older soldiers prioritizing

mission above all else and newer soldiers prioritizing personal well-being and enjoyment. This contrast in mindset contributes to the stigma surrounding MH in the military, making it difficult for soldiers to address their struggles without fear of judgment or repercussions openly.

P8 recounted the story of a staff sergeant facing significant challenges in her personal and professional life. She was dealing with divorce, financial issues, and her teenage daughter's gender identity struggles, which left her feeling useless and without purpose. Despite feeling unsupported by her family and leadership, she thought she had reached the end of herself, with no hope for the future. P8 emphasized that individuals experiencing suicidal ideations feel this way due to a lack of purpose or support in their lives.

P9 highlighted the differences in consequences between enlisted soldiers and officers, noting that enlisted soldiers often face immediate disciplinary actions, such as extra duty. In contrast, officers may experience a slower impact on their careers due to mistakes. P9 shares examples of when leadership fails to engage soldiers but recently observed a shift in the Army's culture, noting that there is now more emphasis on taking care of the individual soldier for the soldier's sake rather than solely for the organization's benefit. In comparison, some leaders in the past have expressed concern about the impact on organizational resources over concern for the soldier.

Implicit Messaging

P3 expressed their take on the matter from a theological standpoint, highlighting the complexities surrounding recruitment processes. They noted the discrepancy between the seemingly clear-cut policies and the intricate reality. The extensive list of conditions deemed permanently disqualifying for military service presents a dilemma, with most current service members likely meeting at least one disqualifying criterion. Despite the existence of waiver

authorities, decisions often lean towards accepting around 70% of such cases, raising questions about the true permanence of these disqualifications. This inconsistency between labeling conditions as permanently disqualifying while simultaneously granting waivers prompts reflection on the subjective nature of medical standards. P3 pondered the potential stigma attached to seeking medical assistance and its impact on recruitment and career progression. They considered the tension between honesty about medical needs and the mission-oriented focus of military service, underscoring the relevance of these discussions across various contexts.

P4 highlighted a significant issue regarding the lack of connection between soldiers and their leadership during training. They observed that there is an unspoken expectation for soldiers to prioritize their well-being outside of official duties, which can create a sense of isolation and reluctance to seek help for MH concerns. This dynamic does not foster a supportive environment and may even make soldiers feel like they are letting down the Army by prioritizing their mental health.

P5 sheds light on institutional factors perpetuating MHS within the military, particularly regarding seeking assistance for suicidal thoughts. They pointed out the influence of warrior codes, whether explicitly stated or implicit, which emphasize the expectation to endure any challenge without faltering. This mindset instills a belief that soldiers should be able to oversee any situation independently. Consequently, when individuals struggle, they may internalize inadequacy and self-doubt. P5 also hinted at the absence of experiencing standard basic training, which could further compound these challenges.

P7 emphasized the challenges soldiers face when opening up about MH issues within the Army. They described how individuals who express suicidal thoughts or MH concerns are often quickly judged as weak or deemed as wanting to shirk responsibilities. This judgmental attitude

can lead to soldiers keeping their struggles to themselves out of fear of being ostracized or labeled as lazy. P7 recounted an incident where they spent time talking with a soldier who needed support, only for the soldier to be later criticized by their NCO for supposedly avoiding work. This incident illustrates the pervasive mindset prioritizing work over mental well-being, particularly in specific units like the 92Gs.

Additionally, P7 highlighted the gender dynamics within the Army, noting that female soldiers may face harsh treatment from their peers and superiors. They recounted a specific case where mistreatment led to significant stress for a female soldier, ultimately resulting in her seeking help and getting sober. Despite her efforts to improve, the Army ultimately decided to discharge her, underscoring the challenges soldiers face when navigating MH issues within the military system.

P8 provided insights into the unique challenges faced by military members regarding mental health. They acknowledged that while many experiences may not be exclusive to the military, the gravity of the situations soldiers encounter sets them apart. The constant pressure to excel, coupled with the responsibility of defending national freedoms, fosters a mindset of self-reliance and toughness, which can exacerbate the stigma surrounding MH issues. Moreover, this mentality often discourages individuals from admitting to suicidal thoughts or seeking help. P8 highlighted the importance of recognizing behavioral health professionals and chaplains as valuable team members, akin to training with one's squad, to overcome these challenges. They also emphasized military leaders' distinctive pressures in making life-and-death decisions, underscoring the impact on soldiers' willingness to disclose their struggles or utilize available resources. P8 stressed the critical role of mid-level leaders in shaping the institutional response to MH issues. They noted that the messaging from leadership regarding the value of seeking help

influences how junior members perceive the institution's stance on mental health. Ultimately, P8 emphasized the need for institutional support and effective communication to address the stigma surrounding MH and encourage soldiers to seek assistance when needed.

P9 reflected on the evolution of attitudes towards MH within the Army, noting significant improvements compared to their earlier experiences. They recalled a time when suicide was perceived as a burden on resources and an inconvenience to the organization, with individuals struggling being viewed as needing to "get their crap together." However, P9 observed that such perspectives are no longer tolerated today and would likely result in swift consequences, possibly even removal from command. This shift highlights a positive change in how MH issues are perceived and addressed within the military, signaling progress toward a more supportive and understanding environment.

Lack of Resources

P3 emphasized the critical role of resources, whether it was just themself and the Physician as the sole helping professionals during a deployment or whether they were alone. They stressed the importance of resources, even in a garrison environment, institutional setting, or within any organization's structure. They drew parallels to their experience in a TRADOC environment, where resources were primarily focused on trainees, leaving other populations at a disadvantage. In their current role, resources are dedicated to cadet ministry, engaging with the lives and problems of young adults within a military and college context. However, this leaves a similar level of support needed for such a large population, including staff, faculty, MPs, and medical personnel. The existing support structure could be better, especially considering the dual focus on trainees and support cases. They acknowledged the presence of older, more experienced staff who might require less support but emphasized the need to allocate resources appropriately,

particularly in addressing MH needs. Despite being the closest thing to a MH provider in their setting, they faced challenges due to limited resources and the inexperienced nature of their colleagues on the medical side. They navigated situations where they were the sole provider responsible for making critical decisions regarding soldiers' MH, promising to facilitate access to resources rather than offering a quick fix. Reflecting on experiences in Hawaii and TRADOC, they observed the need for careful language around MH, considering how quickly individuals may be referred for help and the natural inclination to seek respite in challenging situations.

P4 highlighted an essential aspect of their current role: providing soldiers with crucial information and resources regarding MH before they embark on their training. They described how they brief soldiers, sharing personal insights and outlining the potential barriers to seeking MH support. They emphasized the need for soldiers to take charge of their well-being, stressing the importance of building a toolkit for navigating life's challenges. They recounted instances where soldiers approached them with stress-related concerns, sometimes belatedly, despite earlier opportunities for assistance. By normalizing the idea of seeking support from the chaplain, they aimed to foster open dialogue and encourage more soldiers to utilize their services. In one poignant case, P4 recounted counseling a married couple experiencing significant marital issues, including infidelity. Despite their efforts to refer the husband, who was struggling with the complexities of marriage and his Christian faith, to licensed MH professionals, he seemed to view the chaplain as his sole source of support. Tragically, when the situation escalated and his wife expressed the intent to leave him, he lacked the necessary resources and professional guidance, ultimately leading to his suicide. This heartbreaking outcome underscored the critical need for accessible MH resources and highlighted the limitations of relying solely on religious counsel in such complex situations.

P5 discussed the challenges they have faced in assisting service members with MH issues and SI. One significant barrier they highlighted is the backlog of individuals waiting to access MH services. Despite recognizing the need for help by commanders, the resources necessary to meet this demand are lacking. They elaborated on how providers within the military and civilian sectors leave their roles, potentially due to frustration or discouragement with the system. This turnover exacerbates the shortage of available resources for soldiers in need of MH support, creating a cycle of unmet demand and limited access to care.

P6 recounted their experience as battalion chaplains in an aviation unit deployed on rotation to Europe, specifically mentioning their time in Greece, where they served as behavioral health officers for pilots and the entire unit alongside flight surgeons. They discussed encountering barriers in their efforts to support service members with MH issues and suicidal thoughts. One major obstacle they identified was the understaffing of Embedded Behavioral Health (EBH) services, resulting in a shortage of providers and clinicians. Additionally, they noted that chaplains, who often play a supportive role in MH matters, may be undertrained in counseling skills. This deficiency is attributed to the primary educational focus of chaplains being on theological studies, with limited exposure to counseling training during their seminary education.

P8 discussed the strain placed on the behavioral health system due to overloading. They noted that the system is so overwhelming that individuals who genuinely require assistance from behavioral health professionals struggle to secure timely appointments. This bottleneck occurs because resources are utilized by individuals who may not need them, further exacerbating the problem. At one duty station, they encountered significant delays in accessing behavioral health appointments, with some individuals facing wait times of 6 to 12 weeks or even longer. This

backlog underscores the extent to which the system is overutilized and the urgent need for a more efficient allocation of resources to ensure that those in genuine need of support receive timely assistance.

P9 highlighted the issue of availability of MHC, noting that while there may be more levels of care available now compared to 15 years ago, there is also a significantly higher demand for these services. They shared an anecdote from their time at Fort Lewis, where non-emergency behavioral health visits could have a wait time of up to six weeks, leading to ethical dilemmas for providers who needed to prioritize urgent cases. They expressed skepticism about claims of increased provider numbers, suggesting that the rise in appointments may outweigh any increase in staffing. Despite potential improvements in the number of providers, the demand for appointments continues to outpace the available resources, leading to an imbalance in care provision. P9 highlighted their unique challenge in their current location, where no military behavioral health assets are available. This situation exacerbates the availability of care issue, as soldiers must seek MHC from local resources in the civilian community.

Feeling Like a Failure

P1 recounted a profoundly moving encounter involving a young soldier grappling with suicidal ideations and feelings of failure, which occurred before they departed from service. The soldier, aged 19, had enlisted in the Army, seeking a fresh start after facing challenges following high school. P1 noted the signs of distress during their conversation, as the soldier expressed overwhelming feelings of hopelessness, failure, and a profound sense of purposelessness. Recognizing the gravity of the situation, P1 dedicated extensive time to engage with the soldier, investing about two hours in conversation despite the added challenges posed by pandemic safety measures. Despite the physical barriers, P1 remained a steadfast source of support,

endeavoring to establish a meaningful connection with the soldier and offer guidance through their struggles. Ultimately, the soldiers could return to their unit and complete Advanced Individual Training (AIT). P1 took proactive steps to ensure continuity of care by informing the battalion chaplain at the soldier's new posting about their previous discussions and challenges. P1 felt this proactive approach aimed to facilitate ongoing support for soldiers as they transitioned to their unfamiliar environment, underscoring the importance of consistent care and advocacy within the military community.

P3 recalled a profoundly tragic incident involving a lieutenant general who, despite being selected for command, struggled with inadequacy feeling and the impostor syndrome. P3 shared that this General completed suicide in 2016, just two days before he was scheduled for his third star and assumed the position. The circumstances surrounding this General's death highlight the profound impact of MH challenges, even among high-ranking officers. P3 emphasized the tragic nature of the situation and stressed the importance of seeking help with MH concerns within the military, regardless of rank or position. This poignant example serves as a reminder of the significance of destigmatizing MH issues and providing support to those who may be struggling, regardless of their professional achievements or status.

P4 highlighted a specific vulnerable population within the military community: recruits undergoing medical treatment or disciplinary actions, often called "recycles." These individuals may feel a sense of unworthiness and isolation due to their perceived inability to contribute fully to their unit. P4 emphasized that these recruits are at higher risk for MH problems and suicidal ideations. Sharing a poignant example, P4 recounted an incident where a recruit expressed SI after experiencing emotional turmoil triggered by a failure during training. Despite appearing physically fit, the recruit harbored unresolved emotional trauma and felt overwhelmed by the

shame associated with being recycled. Through compassionate dialogue, P4 helped the recruit explore underlying issues, including past relationships and feelings of shame, ultimately identifying the root cause of their distress. By prioritizing understanding and addressing the root cause of SI rather than immediately referring to MH professionals, P4 facilitated a deeper exploration of the recruit's emotional struggles. This approach enabled the recruit to articulate their emotions effectively when seeking help from embedded behavioral health services, avoiding misdiagnosis, and receiving appropriate support. P4's intervention underscores the importance of holistic and empathetic care in addressing MH challenges within the military community.

P5 identified institutional factors within the military culture that contribute to MHS, particularly when seeking help for suicidal ideations. They pointed to the influence of written and unwritten "Warrior codes" that emphasize the expectation that service members persevere and overcome any challenge, regardless of its nature or severity. These codes instill a belief that soldiers should be able to manage any situation independently without showing vulnerability or seeking external support. P5 highlighted how these ingrained beliefs can lead individuals to doubt themselves if they struggle or experience MH issues, as they may feel they are not living up to the perceived standards of military excellence. They emphasized internalizing these expectations, which can result in isolation and reluctance to seek help, as individuals may fear being perceived as weak or inadequate. Ultimately, P5 underscored the need to address and challenge these institutional attitudes and beliefs to create a more supportive environment for service members and increase the likelihood of seeking help for MH issues, including suicidal ideations. They emphasized the importance of recognizing and acknowledging the unique

challenges posed by these cultural factors to effectively address stigma and promote mental well-being within the military community.

P6 shared an example concerning a soldier in their early army career who tragically took his own life. The soldier had faced disciplinary action due to drug involvement, which included potent substances beyond marijuana detected in a urinalysis. Despite being a capable soldier, he grappled with feelings of failure, likely exacerbated by fear of disappointing his father and the repercussions of his actions. P6 emphasized that the soldier's death may have been perceived as a way to escape anticipated negative consequences. In their role, P6 often educates soldiers about the misconception that seeking help for MH concerns means the end of their military career. They emphasize that receiving treatment, including medication or hospital stays, does not equate to career termination. Instead, it signifies addressing stress, anxiety, or safety issues as a necessary step toward mental well-being.

P8 told a story of a staff sergeant they supported who was preparing for retirement but faced numerous challenges. She was divorced, and her teenage child was struggling with gender identity issues, which strained their relationship. Feeling overwhelmed by these changes and life's complexities, she felt worthless to her family due to her divorce and financial struggles. Additionally, she encountered difficulties with leadership in her organization, finding them incompetent. P8 stated that despite having potential support systems, she perceived them as failures and reached a breaking point, devoid of hope and purpose.

Substance Use

P1 recalled, in their role as chaplains in the military, encountering service members grappling with the weight of suicide loss and MHS. Reflecting on their experiences, P1 recalled instances where they provided support to individuals navigating these challenging circumstances.

While one individual sought further assistance, regrettably, updates on the other two remain unknown. P1 learned that one soldier ultimately chose to leave the military due to their struggles. P1 encountered two chaplain assistants who sought help for MH issues, including suicidal ideation. However, upon closer examination, it became apparent that their challenges were intertwined with substance abuse, primarily involving drugs and alcohol. P1 reflected that they seemed to find it easier to articulate thoughts of suicide rather than confront their underlying addiction issues.

P4 recounted their experiences as a chaplain in the military, supporting service members dealing with suicide loss and MHS. One service member, who had been stuck at the identical rank for eight years due to MH issues, anger problems, and alcohol abuse, sought help from P4 after his wife issued an ultimatum. Despite being unfamiliar with chaplain services and expressing reluctance about discussing religion, the service member agreed to meet with P4. P4 initiated weekly sessions, focusing on the service member's needs. Eventually, the service member's marriage was restored, he received a promotion, and he began addressing his alcohol abuse issues within two months.

P5 recounted an emotional encounter with a service member grappling with the stigma of MH issues. The soldier, facing various challenges, including a DUI on the post, was referred to P5 for support. Despite not expressing a current desire to harm herself, the soldier revealed a history of suicide attempts. Over several meetings, they discussed her struggles, and she ultimately lost her position due to complex issues. Although she transitioned to work at a higher level, her MH continued to deteriorate. Tragically, two months after P5 left, the soldier took her own life during a medical separation process. P5 reflected on the situation's complexity, pondering whether feelings of isolation, old habits, or a lack of regular communication with the

brigade chaplain contributed to her decision. The absence of explicit disclosure regarding suicidal intentions made this case particularly challenging for P5.

P6 recounted an incident from their military career involving a soldier who ultimately took his own life. The soldier faced disciplinary action due to drug-related issues, including testing positive for potent substances beyond marijuana. Despite being a capable soldier, the individual grappled with fear from familial expectations and feelings of inadequacy. These factors likely contributed to his reluctance to seek help for his MH struggles, ultimately culminating in tragedy.

P7 recounted two challenging situations involving service members struggling with MH issues. In one instance, a soldier faced personal turmoil when his wife, residing in Africa, chose to distance herself from him and their children, leading him to spiral into drug use and AWOL incidents. Despite efforts to support him, his mental and emotional state continued to deteriorate, even resulting in disruptive behavior while in prison. Another soldier, a captain, experienced significant stress after receiving an unfavorable evaluation from her previous command team. This stress manifested in excessive drinking and absenteeism from work, eventually leading to her being sent for evaluation and subsequently chaptering out of the military. P7 highlighted the impact of harsh treatment from superiors, particularly noting the effect of perceived mistreatment by a female BN XO on the captain's mental well-being.

P8 highlighted that many of the challenges faced by soldiers are not combat-related but rather stem from difficulties adjusting to life and coping with stressors. He emphasized the importance of having a sense of purpose and hope, noting that individuals with suicidal ideations often feel a lack of direction and optimism about the future. From a religious standpoint, he emphasized the significance of a perspective extending beyond the present moment. P8

recounted an encounter with a soldier who was struggling emotionally, likely exacerbated by alcohol consumption, and appeared to be grappling with grief issues. Despite her distress, P8 took the time to provide support and compassion to help her navigate through her difficulties.

Theme Two: Factors that Reduce Mental Health Stigma and Suicidal Ideation in the Army

P1 emphasized the widespread popularity of chaplains, recounting numerous conversations with colonels and lieutenant colonels who acknowledged the confidentiality inherent in chaplaincy roles. They noted a dual perspective: On one hand, the refinement of chaplain positions has streamlined their roles, while on the other, it has created an opportunity to intensify their training. A close associate, an active senior chaplain, oversees a group of approximately 80 chaplains and has devised a comprehensive training regimen. This training includes specialized instruction in areas such as suicide prevention, marital counseling, and fostering better workplace relationships. Leveraging the expertise of various chaplains, he arranges for family life chaplains to address familial issues while ensuring all chaplains are equipped to manage MH crises.

Additionally, he collaborates with military behavioral health specialists to provide targeted education to soldiers in a chapel setting. This approach emphasizes accessibility and practicality in addressing soldiers' needs. Acknowledging the absence of a one-size-fits-all solution, the P1 remains confident in the military's commitment to refine and adapt its support systems continually.

P2 recounted a pivotal moment early in their career involving a soldier attending one evening worship service. Following the service, the soldier engaged in a lengthy conversation, pushing the speaker's mental and physical limits after a taxing day. Recognizing the soldier's distress and potential for self-harm as they attempted to flee, P2, drawing on their background as

a former football player and track coach, instinctively intervened, physically preventing the soldier from leaving. Promptly instructing their religious affairs specialist to contact the military police, P2 ensured the soldier received the necessary assistance. The soldier's emotional release after this intervention underscored timely intervention's significance in crises. P2 emphasized the importance of leadership in encouraging individuals to seek help when needed, whether from chaplains or behavioral health programs. They highlighted that seeking help does not diminish one's standing as a soldier; instead, it demonstrates strength in addressing personal challenges and striving for improvement.

P3 shared several reflections on the complex issue of suicide prevention and intervention within the Army. They emphasized that ownership of this critical matter should not solely rest with the Chaplain Corps but instead be seen as a collaborative effort. Despite this, chaplains often find themselves at the forefront, conducting most training sessions. While it may be preferable for chaplains to lead these sessions rather than less experienced personnel, such as young officers in administrative roles, the ideal scenario would involve resourcing additional support. P3 expressed a paradoxical desire for increased availability of chaplains to provide support while acknowledging the potential drawbacks of mandated reporting. They highlighted a similar tension in their wish for stronger confidentiality protections for medical providers, recognizing that mandatory reporting can sometimes inhibit individuals from seeking help. Ultimately, P3 sees an opportunity for a more open dialogue, akin to the principles of confidentiality in healthcare under HIPAA, where individuals can seek guidance without fear of repercussions from their chain of command.

P4 reflected on their early experiences as a chaplain, noting the stark contrast between their time in the reserves and their subsequent assignment at Fort Benning. In the reserves, they

primarily interacted with mature soldiers who had extensive life experience, which somewhat shielded them from encountering significant issues like SI. However, upon transitioning to a new duty assignment, P4 encountered a different demographic of younger, less experienced officers who lacked a strong sense of identity beyond their military roles. This shift compelled P4 to delve deeper into understanding the various support mechanisms available to soldiers, recognizing the link between physical and MH. They emphasized the importance of adopting an integrated approach, particularly in navigating the complexities of the Army's Health and Fitness (H2F) initiatives. Despite the challenges posed by this transition, P4 embraced the opportunity to advocate for transparency and vulnerability within leadership ranks. Drawing parallels to their upbringing, P4 highlighted the generational cycle of concealing struggles and the detrimental impact it can have on subsequent generations. They urged leadership to share their experiences and challenges, dispelling the illusion of perfection and creating an environment so soldiers feel empowered when seeking guidance and support. By promoting humility and open dialogue, P4 believes leaders can better connect with and support their soldiers through shared experiences and mutual understanding.

P5 discussed their evolving approach to connecting with soldiers and addressing issues like suicide prevention. They emphasized the importance of purposeful engagement and planning their interactions to ensure meaningful conversations with soldiers struggling without realizing it. Drawing from past experiences, P5 highlighted the need for open dialogue and understanding within units, stressing the importance of recognizing shifts in behavior, and reaching out to support one another. In their suicide prevention briefings, P5 advocated for a proactive approach that goes beyond simply discussing the act of suicide. They emphasized the significance of finding purpose and meaning in life, encouraging soldiers to seek fulfillment and navigate

challenges with resilience. P5 underscored the role of engaged leadership in fostering a supportive environment, noting that leaders who disclose their struggles and seek help set a powerful example for their troops. By breaking down the pedestal often placed upon leaders and promoting vulnerability, P5 believes that genuine connections can be formed, leading to more robust support networks and improved well-being among soldiers.

P6 reflected on the consistency of their role as a chaplain, particularly in the context of reducing risky behaviors within their battalion. They highlighted the importance of psychoeducation and suicide prevention classes, as well as building relationships with soldiers to identify those at higher risk. P6 emphasized the need for leaders to discern between soldiers who may need additional support based on their behaviors and circumstances. In their role as a family life chaplain, P6 noted a slight shift in responsibilities due to the absence of a command structure. They described themselves as taking on a more therapeutic role, offering guidance in meetings and training sessions on post. Additionally, P6 highlighted their efforts to train other chaplains in providing compassionate care and improving counseling skills through co-counseling sessions. They acknowledged chaplains' varying strengths and preferences, encouraging them to continuously develop their counseling abilities rather than pigeonholing themselves into specific roles.

P7 shared insights from their experiences interacting with soldiers, emphasizing the importance of increased awareness, and understanding of their struggles. They highlighted the need for creating an environment where soldiers feel safe seeking help without fear of negative repercussions, such as being removed from the Army. Reflecting on a recent encounter with a soldier, P7 recounted the story of a captain who experienced significant stress following a poor evaluation from a previous command team. Coping with this stress by turning to alcohol, the

soldier's situation escalated when she failed to report to work while intoxicated. Despite efforts to support her, including a visit from P7 and the Battalion Executive Officer (XO), the soldier was ultimately referred to Substance Use Behavior Counseling (SUBC) and subsequently faced discharge proceedings. P7 noted the additional stress caused by the perceived mistreatment from a female Battalion XO, illustrating broader dynamics of gender dynamics within the military. This experience highlighted the challenges soldiers face in navigating career milestones and the impact of leadership styles on their well-being.

P8 reflected on their journey of seeking support within the Army, noting a shift from initially relying solely on spiritual guidance to embracing a more collaborative approach involving various resources and expertise. Drawing from their own experiences, P8 highlighted the importance of teamwork and open communication within units, emphasizing the need for soldiers to share positive and negative experiences regarding MH and seeking help. They likened the process of seeking help for MH concerns to consumer behavior, suggesting that individuals are more likely to utilize resources recommended by trusted peers. P8 stressed the significance of creating a culture within teams and units where individuals feel comfortable discussing MH and seeking assistance, ultimately leading to better outcomes and increased utilization of available resources. They emphasized the impact of trusted voices in promoting the acceptance and effectiveness of MH support, countering negative perceptions that seeking help may harm one's career.

P9 reflected on their evolution as chaplains, noting a shift in perspective regarding their role in supporting soldiers within the organization. Initially, they approached soldier issues primarily to protect the organization's interests, often emphasizing soldiers' commitments to their contracts. However, over time, they recognized that the Army may only sometimes be the best fit

for some individuals. The pivotal realization for P9 was understanding that what is best for the soldier can align with what is best for the organization, and these interests need not be mutually exclusive. They emphasized the importance of facilitating transitions out of the Army when it is in the soldier's and the organization's best interest rather than simply deferring problems. P9 also discussed the abundance of resources available to soldiers within the military and DoD but highlighted the challenge of making these resources more visible and accessible. They suggested improved communication and organization of available resources, ensuring that soldiers are aware of and can easily access the support they need. Additionally, P9 proposed a more practical approach to introducing resources to soldiers beyond the initial in-processing stage to ensure sustained awareness and utilization throughout their military careers.

Table 11

Number of Participants Who Related the Factor that Decrease the Mental Health Stigma and Suicidal Ideations in the Army

Subtheme: Factors that Decrease Mental Health Stigma and Suicidal Ideation in the Army										
Subtheme: Resources	x	x	x	x	x	x	x	x	x	9
Subtheme: Chaplain confidentiality	x	x	x	x	x	x	x		x	8
Subtheme: Chaplains being present and proximity of care	x	x	x		x	x	x	x	x	8
Subtheme: Relationships and support	x		x	x	x	x	x	x		7
Subtheme: Chaplains availability	x	x	x		x	x	x		x	7
Subtheme: Listening and empathy	x	x	x		x	x		x		6
	P1	P2	P3	P4	P5	P6	P7	P8	P9	Total

Table 12

Frequency Statistic for Participants Indicating the Factors that Decrease Mental Health Stigma and Suicidal Ideation in the Army

Subtheme: Factors that Decrease Mental Health Stigma and Suicidal Ideation in the Army					
	Total	Min	Max	Mean	Std Dev
Subtheme: Resources	27	1	8	3	2.179
Subtheme: Chaplain confidentiality	20	0	4	2.222	1.202
Subtheme: Chaplains being present and proximity of care	18	0	4	2	1.414
Subtheme: Relationships and support	14	0	4	1.556	1.333
Subtheme: Chaplains availability	15	0	4	1.667	1.323
Subtheme: Listening and empathy	11	0	3	1.222	1.202

Resources

P1 described how the roles of chaplains have been refined, removing some unnecessary aspects. They highlighted a partially positive outcome, noting that there is now a push to enhance chaplains' training and resources. They shared insights from a senior chaplain friend who oversees 80 chaplains, detailing the development of annual training plans. These plans focus on expertise areas such as suicide prevention, marriage counseling, and fostering better work relationships. External resources like family life chaplains and MH professionals are being utilized to address specific needs, with sessions held in chapel settings for soldiers.

P2 underscored the significance of resources available within the military, explicitly mentioning behavioral health services within the surgeon cell. They acknowledged the limitations of chaplaincy in addressing specific MH needs, mainly when medication is necessary due to a chemical imbalance in the brain. P2 emphasized the importance of recognizing when a soldier may require medication in addition to counseling, highlighting the complementary role of behavioral health professionals in providing comprehensive support. This recognition reflects an integrated approach to MHC within the military, ensuring that soldiers can access adequate resources to address their individual MH needs.

P3 emphasized the importance of resources in addressing critical issues like suicide prevention within the Army. They highlighted the need for a collaborative approach, suggesting that suicide prevention should not be solely owned by the Chaplain Corps but rather viewed as a shared responsibility where chaplains serve as resources. P3 noted that while chaplains often end up leading classes on topics like suicide prevention, they expressed a preference for chaplains over less experienced personnel teaching such sensitive subjects. They reflected on the evolving nature of their role in addressing these issues, acknowledging the challenges and complexities involved. This perspective underscores the ongoing adaptation and collaboration when addressing MH issues within the military.

P4 shared stories illustrating the positive impact of resources when dealing with soldiers and MH. They described a situation where they engaged in a lengthy conversation with a soldier experiencing suicidal ideations, ultimately uncovering the root cause of their distress. By delving into the soldier's past and understanding their experiences, P4 was able to provide valuable insight to the embedded behavioral health professionals, resulting in the soldier receiving appropriate support. Reflecting on their experience in the reserves and at Fort Benning, P4

highlighted the differences in maturity and experiences among soldiers. They emphasized the importance of understanding the layers of non-ability to be resilient with MH problems. P4 discussed the power dynamics inherent in referrals, noting that soldiers often equate education and credentials with success and may feel inadequate if they perceive themselves as lacking in these areas. They stressed the importance of recognizing individual soldiers' needs and providing support tailored to their unique circumstances, irrespective of educational background.

P5 highlighted the significance of utilizing resources like behavioral health to address MHS within the military. They emphasized that sometimes soldiers need the intensive support provided by inpatient behavioral health to become receptive to further help and discussion about their MH challenges. P5 also stressed the importance of having knowledgeable and relatable individuals available to provide support, such as military family life consultants. P5 noted that consultants with prior military experience tend to understand soldiers' experiences better and are more effective at connecting with them than those without military backgrounds. Additionally, P5 discussed the effectiveness of programs like military family life consultants (MFLC) in connecting with soldiers. They noted that retired MFLCs with prior military experience tend to understand soldiers' experiences better and can establish connections more quickly than those without military backgrounds. This experience underscores the importance of understanding the context and terminology of military life when providing support to service members.

P6 discussed a situation where they provided support using cognitive behavioral therapy techniques to a soldier who was struggling with feelings of inadequacy. Despite the soldier not being able to access specific resources due to time constraints, P6 was able to offer effective therapy and help alleviate the soldier's suicidal ideations through cognitive restructuring and challenging negative thoughts.

P7 emphasized the importance of support and resources for soldiers, mainly focusing on the role of community and care provided by chaplains. They mentioned organizations like Cadence and events like Strong Bonds as valuable resources for soldiers. Additionally, they highlighted the significance of chaplains continually checking in on soldiers, especially young women who may need additional support. Offering care, checking up on their well-being, and providing treats are small gestures that can make a substantial difference in showing soldiers that they are cared for and supported.

P8 highlighted the crucial role of chaplains in promoting resources for soldiers' well-being. They acknowledged that while some chaplains may have reservations based on personal beliefs, the majority recognize the value of utilizing available resources, including behavioral health services. By promoting these resources at the team and unit levels, chaplains can encourage soldiers to seek help and support, ultimately leading to better outcomes and reducing the MHS.

P9 shared their experiences with resources and supporting soldiers with MH issues, highlighting the Army's increased priority on providing next-level care, including medical and behavioral health support. They emphasized the importance of addressing stigma and ensuring that soldiers receive appropriate care rather than solely relying on chaplains as a solution. They also discussed a shift in how suicide and MH concerns are treated within the Army, noting a greater emphasis on taking such issues seriously and ensuring individuals receive proper care. Additionally, P9 mentioned the importance of optimizing resource allocation, suggesting a more strategic approach to matching soldiers with the appropriate level of care based on their needs. This approach involves recognizing that not all cases require intervention from licensed

behavioral health providers and ensuring that soldiers can access alternative support options when appropriate.

Chaplain Confidentiality

P1 emphasized the importance of non-verbal communication when expressing oneself, especially within the military context. They highlighted the role of chaplains as a safe outlet for soldiers to confide in, even when they cannot speak to anyone else. P1 recounted instances where they used their authority to ensure soldiers sought MH support, acknowledging the challenges individuals face in seeking help due to potential career repercussions, particularly for officers aiming for promotion. They shared a personal experience of discreetly counseling a one-star General for marriage issues, illustrating the need for confidential resources in high-pressure environments. Despite efforts to maintain anonymity, career pressures can still impact individuals' ability to seek help openly.

P2 recounted a poignant story underscoring the importance of confidentiality in chaplaincy and the consequences when it is breached. They described a situation where a soldier, facing severe legal issues, was suspected of being suicidal while incarcerated. Despite Provost Marshall's inquiry, P2 upheld confidentiality, prompting them to assess the soldier's condition based on observations made by the military police. Tragically, the soldier was released under “24-hour buddy watch”, which proved inadequate, leading to the soldier's suicide. This tragic outcome highlighted the critical need for proper assessment and intervention in such cases. P2 reflected on soldiers' tendencies to seek support from chaplains or religious affairs specialists before behavioral health services. They stressed the importance of providing guidance and support while maintaining transparency about the limitations of their role in counseling. P2 emphasized the significance of confidentiality in building trust with soldiers and ensuring they

feel comfortable confiding in chaplains or religious affairs specialists. This reflection underscored chaplains' vital role in supporting and guiding service members while respecting their confidentiality.

P3 shared their perspective on confidentiality within the military context, highlighting the need for a safe space where individuals can share concerns without fear of mandatory reporting. They described a scenario where a commander acknowledged the role of chaplains in addressing underlying issues that may not be immediately apparent. P3 discussed the tension between the military's mission-driven culture, prioritizing metrics and operational readiness, and the need to address MH issues. They emphasized the challenges of balancing confidentiality with the demands of military leadership, expressing a desire to maintain confidentiality while recognizing the need for transparency in certain situations. P3 reflected on their role as chaplains, wishing for the ability to provide candid feedback while also acknowledging the importance of discretion and sensitivity in discussions with military personnel.

P4 shared her perspective on the importance of chaplain confidentiality in fostering trust and openness among soldiers. She noted that the assurance of complete confidentiality distinguishes chaplains from other MH professionals and serves as a crucial factor in soldiers' willingness to seek help. P4 emphasized that without this confidentiality, soldiers may be hesitant to discuss their deepest concerns and struggles, limiting the effectiveness of support services. She highlighted how this confidentiality creates a safe space for soldiers to express themselves without fear of judgment or repercussions. P4 explained that this level of trust enables soldiers to share their innermost thoughts and feelings, allowing for deeper discussions and more effective support. Overall, she stressed the significance of chaplain confidentiality in facilitating meaningful connections and supporting soldiers in need.

P5 discussed the concept of privileged communication in their role as a chaplain, acknowledging that individuals often seek him out for confidential discussions due to this privilege. However, they noted that suicidal ideations are typically intensely private matters, and individuals may struggle to fully disclose their thoughts and feelings even in a confidential setting. P5 reflected on the stigma surrounding MH discussions, noting that while some individuals may disclose thoughts of suicide, many hesitate to do so beyond a certain extent. P5 shared their experiences of having ongoing relationships with individuals who ultimately took their own lives without disclosing their struggles to him, highlighting the complexity of MH discussions. Regarding the efficacy of privileged communication, P5 expressed ambivalence, acknowledging that while some individuals appreciate its confidentiality, others eventually feel comfortable seeking help beyond him. They emphasized the importance of maintaining an open dialogue and being available to support individuals through their MH challenges, regardless of the level of confidentiality involved.

P6 highlighted several reasons soldiers might choose to confide in a chaplain rather than a MH provider. Firstly, there is the issue of confidentiality, where soldiers may feel more comfortable sharing sensitive information with a chaplain due to the assurance of confidentiality. Secondly, there is the established relationship that soldiers may have with their chaplain, which can differ from their relationship with MH providers. The therapeutic relationship with a chaplain may feel more familiar and comfortable to some soldiers. P6 also shared an example from their experience as a chaplain in an AIT battalion, illustrating how soldiers sometimes turn to chaplains for support when they are reluctant to seek help from MH providers due to concerns about being grounded or facing consequences that could impact their training or career progression.

P8 shared an example highlighting the importance of confidentiality in encouraging soldiers to seek help for MH issues. They described a situation where a soldier was hesitant to seek support from behavioral health due to fears of negative consequences on their career and perceived stigma. However, the soldier felt comfortable confiding in the chaplain, knowing their communication would remain confidential. The chaplain provided support and linked the soldier with another family member as an additional resource, with plans to revisit seeking help from behavioral health. This example underscores the role of chaplains in creating a safe space for soldiers to discuss fears of being judged or experiencing repercussions.

P9 highlighted the ongoing stigma surrounding seeking MH support, particularly among senior ranks in the military. While stigma has decreased overall, there is still a noticeable divide between junior and senior soldiers. Senior leaders, including Senior NCOs and field-grade officers, may harbor concerns about how seeking help could impact their careers, leading them to seek confidential support from chaplains or off-post resources. The confidentiality provided by chaplains is crucial in encouraging soldiers to seek help, as it allows soldiers to discuss concerns without fear of repercussions or a paper trail. Additionally, the geographical accessibility of chaplains, who are assigned at every level from battalion command up, plays a significant role in making support more accessible to soldiers, particularly junior ones who may be less familiar with other MH resources. Overall, confidentiality and proximity are seen as critical factors that chaplains offer in supporting soldiers' MH.

Chaplains Being Present and Proximity of Care

P1 shared a compelling anecdote highlighting the vital role of chaplains in providing discreet and supportive counseling services within the military. They recounted an experience counseling a one-star officer for marriage issues, demonstrating the confidentiality and trust

placed in chaplains. Despite the officer's public stature, the confidential counseling sessions facilitated a positive outcome, allowing the couple to address their challenges and move forward. However, P1 noted that despite successfully resolving their marital issues, the officer faced career setbacks and ultimately retired as a one-star general, possibly due to the stressors inherent in their position. P1 underscored the importance of confidential support services and proximity in maintaining mental well-being within the military community.

P2 highlighted the significant role of chaplains within the Intelligence and Security Command, where numerous units report directly to their command and, in turn, report directly to the Department of the Army. P2 emphasized the importance of chaplains holding top-secret clearances within these units, as it allows soldiers and civilians alike to confide in them about sensitive matters. This clearance reassures individuals that they can speak openly about their experiences and challenges, knowing that chaplains have the necessary clearance to manage classified information. This access fosters trust and enables chaplains to provide meaningful support to those under their care within the command structure.

P3 emphasized the importance of proximity of care in addressing MH concerns, citing a specific situation where a soldier exhibited signs of malingering suicidal ideations. Despite skepticism about the soldier's sincerity, P3 committed to providing support and conversation, even if it meant dedicating considerable time each day for months. They acknowledged the limitations of their role as a chaplain, cautioning against a "Savior complex" and stressing the importance of realistic expectations in providing care. P3 highlighted the utility of the ASSIST model, which focuses on ensuring safety and offering support without necessarily solving all problems. While praising the model's effectiveness, they also critiqued the bureaucratic hurdles

associated with its certification process. This reflection underscores the complexities and challenges inherent in providing adequate MH support within the military.

P5 emphasized the importance of being purposeful and intentional in his interactions with soldiers, especially those who may be struggling but may not realize it themselves. They highlighted the need to have a plan and seek out opportunities to help soldiers. By being present in the areas where soldiers gather and by asking pertinent questions about their well-being, P5 aims to create opportunities for support and connection. They described this approach as being where soldiers are, particularly in what P5 referred to as "points of friction," where individuals may be experiencing challenges or difficulties.

P6 discussed the efforts made to reduce the stigma surrounding MH within the military. They mentioned resources like the "Commander's Guide to Suicide Prevention," which addresses stigma reduction from various perspectives, including leaders, behavioral health professionals, and chaplains. P6 noted that soldiers seeking help had increased his counseling workload, indicating a positive trend toward seeking support. P6 emphasized the importance of training leaders to be good listeners, caring, and empathetic. They highlighted that soldiers often admire leaders who demonstrate these qualities and take care of their needs.

P7 emphasized the importance of being present and providing proximity of care, especially for younger soldiers who may face challenges adjusting to military life. They described efforts to connect with soldiers, such as checking in on them, serving food at the dining facility (DEFAC), and participating in fellowship gatherings on post. These actions aim to create a supportive environment and show solidarity with soldiers facing difficulties. The chaplain mentioned their commitment to understanding soldiers' experiences and struggles, which has heightened their awareness and sensitivity when interacting with them. However, they

acknowledged the challenge of reaching out to individuals who may withdraw or isolate themselves when experiencing MH issues and suicidal thoughts.

Regarding practical support and resources, the chaplain suggested involvement in fellowship gatherings and community events to provide social support. However, they also recognized the difficulty in engaging individuals who may be avoiding social interaction due to MH challenges. This highlights the need for tailored approaches to reach and support soldiers who may be experiencing MH difficulties.

P8 highlighted the importance of being present and providing proximity of care in supporting soldiers facing MH challenges. They recounted instances where they engaged in ongoing conversations with individuals, providing counseling and support over time. In one case, they reflected on using a behavioral health model in counseling without necessarily following a specific counseling method. This underscores the adaptability and effectiveness of providing support based on individual needs rather than adhering strictly to a particular approach. Additionally, they described an incident where they intervened to help soldiers in distress, initially calming them down and then facilitating a connection with embedded behavioral health resources for ongoing support. This demonstrates the proactive approach of ensuring individuals receive the appropriate care and follow-up, even if the chaplain needs to be fully aware of all available resources. These examples illustrate the chaplain's commitment to providing compassionate care and support to soldiers, leveraging their presence and accessibility to address MH concerns effectively.

P9 shared examples highlighting the importance of proximity and access to care in supporting soldiers' MH. They emphasized how soldiers often feel more comfortable seeking help from someone they have interacted with in a familiar environment, such as during field

training or in the motor pool. This proximity creates a sense of trust and openness, making individuals more likely to reach out for support. Furthermore, they discussed the advantages of embedded behavioral health teams, where providers are integrated into units and operate at the same level as commanders. This setup allows for more direct and frequent interactions between soldiers, commanders, and behavioral health providers, facilitating better communication, trust-building, and collaboration in addressing MH concerns. Overall, P9 highlighted the significance of proximity and accessibility in ensuring soldiers receive the support they need. It also emphasized integrating behavioral health resources at the unit level to improve MH outcomes.

Relationships and Support

P1 emphasized that while various resources and training are valuable in addressing MHS and suicide prevention, the most impactful interventions involve building relationships, providing counseling, implementing programs, distributing informational materials, fostering buddy-to-buddy interactions, and ensuring support from senior NCOs and officers. P1 recounted a specific experience of being involved in suicide prevention efforts at the Warrior Transition Battalion in Fort Carson, Colorado Springs, where they witnessed the importance of these holistic approaches in addressing suicidality and completing suicides. Ultimately, they stressed the significance of creating a culture where soldiers feel supported and cared for, with readily available MH resources and leadership that prioritizes the well-being of their troops.

P3 underscored the importance of supportive relationships and normalizing discussions about struggles within the military community. They highlighted the need to recognize that everyone faces challenges, and that seeking help is a normal part of life. P3 noted that while routine suffering, such as enduring physical discomfort, is often normalized within the military, MH issues still carry a stigma. They suggested that the organization could become more resilient

and supportive by acknowledging and supporting individuals going through MH challenges. P3 expressed a desire to see a shift towards normalizing conversations about MH, fostering a climate where soldiers feel comfortable seeking help and supporting one another. They believe this shift would make the organization more robust and supportive overall.

P4 discussed the differences observed in how male and female soldiers approach seeking help, particularly regarding SI. They noted that female soldiers often have stronger connections with friends and family who encourage them to seek help, making them more likely to follow through with seeking support. In contrast, male soldiers, especially those in the infantry, may lack strong familial bonds or have experienced familial rejection, making it harder for them to reach out for support. P4 emphasized the importance of combatting the Army's influence on soldiers' identities and helping them discover who they are while in service. P4 shared their journey of dealing with the aftermath of a friend's suicide and how it affected her MH. P4 highlighted the crucial role of chaplains in providing support and guidance during challenging times, underscoring the significance of having a supportive network in times of need.

P5 discussed the importance of building relationships and supporting MH through initiatives like spiritual readiness training. They mentioned that their Chief of Chaplains conducted training sessions aimed at helping commanders and chaplains connect better with individuals at all levels. As part of this effort, they implemented a spiritual readiness assessment for soldiers to gauge their sense of purpose and meaning in life. While acknowledging the impact of these initiatives, P5 also noted the challenges in sustaining such programs, especially with leadership changes. Despite this, he expressed optimism about the progress in helping soldiers connect with resources and support systems outside of themselves, such as God, chaplains, and

other individuals who can assist. They acknowledge that there is still work to be done but believe they are moving in the right direction.

P6 emphasized the significance of relationships in his role as a chaplain, particularly in the context of addressing SI among soldiers. While they did not have prior relationships with the individuals who came to him with suicidal thoughts, he highlighted that he had counseled hundreds of soldiers on such issues over his career. P6 noted that their role had involved efforts to reduce risky behavior within the units he served, including providing psychoeducation and conducting suicide prevention classes. Additionally, they mentioned the importance of building relationships with soldiers, especially those facing high-risk situations like divorce.

P7 highlighted the importance of community support and resources in providing care for soldiers, particularly emphasizing the need for a sense of community, sharing, and spiritual support. They mentioned events like singles and couples gatherings, such as BSRT (Better Opportunities for Single Soldiers) and strong bonds events, as opportunities for soldiers to connect and find support. Additionally, P7 expressed their commitment to checking up on soldiers, especially young ones, and providing care by stopping by and offering treats or simply being present, listing, and offering help. They also mentioned external resources like Cadence, an organization off-post that provides support to soldiers. Overall, P7 emphasized the significance of community and personal support in helping soldiers navigate challenges and find resources to cope with their experiences.

P8 highlighted the importance of directing, supporting, and guiding individuals to the right resources as a suicide prevention measure. Instead of solely focusing on suicidal ideations, they emphasized the need to assess if someone is genuinely suicidal or if they require help in another aspect of their life. They shared a powerful example of a Colonel who sought help from

various sources, including his wife, behavioral health, counseling, and even a supervisor who was a general officer. This Colonel's decision to seek help ultimately led to positive outcomes, contrasting with the tragic fate of the general officer who did not seek help. P8 emphasized the value of individuals sharing their success stories and struggles openly, advocating for transparency and honesty in discussing MH issues. They stressed that hearing about others' positive experiences while seeking help can encourage individuals to utilize available resources and overcome the stigma of seeking support.

Chaplains Availability

P1 recounted an impactful experience demonstrating the importance of chaplains' availability in supporting soldiers' MH. They shared a story about a 19-year-old soldier who was struggling with SI during training at their post. Despite all the challenges posed and risks during the COVID-19 pandemic, P1 spent two hours conversing with the soldier, providing support and guidance. Despite the physical barriers imposed by protective gear, P1 maintained an open and supportive demeanor, ultimately helping the soldier regain stability and return to their unit to complete their training. Recognizing the ongoing need for support, P1 ensured continuity of care by informing the battalion chaplain about the soldier's struggles before their transfer to a new posting. This proactive communication allowed the receiving chaplain to monitor the soldier's well-being and offer continued support. P1 highlighted the importance of maintaining availability and functionality in chaplaincy to support soldiers through their challenges and ensure their overall well-being.

P2 emphasized the critical importance of availability and accessibility in the context of their command, the Intelligence and Security Command. With numerous units reporting directly to them and their direct connection to the Department of the Army, P2 underscored the value of

having chaplains embedded within these units, possessing top-secret clearances. This clearance enables soldiers and civilians within their command structure to confide in chaplains about sensitive issues, knowing they have the necessary clearance to discuss classified matters. P2 highlighted the role of chaplains as a readily available resource within the units, serving as a trusted confidant for individuals facing challenges. They noted that having chaplains in the command structure reassures individuals that they have someone to turn to before seeking help from behavioral health services. This accessibility and presence of chaplains within the unit ministry team are invaluable assets, fostering an environment where soldiers feel comfortable seeking help and support.

P3 highlighted the importance of availability and accessibility in providing support to individuals struggling with MH issues within the military. They shared a personal experience of a soldier expressing SI and the struggle with language surrounding MHC. P3 discussed the challenge of combating stigma while ensuring individuals receive the necessary support and care. They reflected on the dual role of chaplains as caregivers at the tactical level and advisors to commanders at the operational level. P3 emphasized the need for open communication and advocacy for soldiers' well-being, acknowledging the importance of supporting and addressing organizational challenges that may impact MHC within the military.

P5 emphasized the importance of being present and available for soldiers, regardless of the circumstances. He highlighted the significance of building relationships with soldiers during their most challenging times, whether going through an obstacle course or simply being present in their environment. By being accessible and familiar to soldiers, he aims to create an environment where they feel comfortable seeking support without hesitation.

P6 highlighted several reasons soldiers may seek support from chaplains rather than behavioral health providers. Firstly, chaplains often have quicker availability than behavioral health appointments, which sometimes take weeks to schedule. Secondly, chaplains offer confidentiality, allowing soldiers to express their concerns without fear, judgment, or repercussion. Lastly, soldiers may feel more comfortable approaching chaplains due to an established relationship or familiarity, but they may also need to learn the behavioral health officers or providers. This difference in the therapeutic relationship with chaplains compared to MH providers contributes to soldiers' preferences in seeking support.

P7 emphasized the importance of availability as a chaplain, noting that many soldiers may need to learn who their chaplain is when asked. This lack of awareness underscores the need for chaplains to be present and accessible, particularly given the frequent influx of new soldiers. They believe being visible outside of the office environment is crucial for effectively fulfilling their role.

P9 highlighted the importance of care availability in facilitating soldiers' willingness to seek help. They shared instances where soldiers who had previously not sought help with SUD indicating the impact of being present in soldiers' environments. They also discussed the advantage of embedded behavioral health teams, emphasizing the value of familiarity and prior connections in encouraging soldiers to utilize these resources. Additionally, they touched on the increasing demand for MHC and the challenges posed by limited availability, recalling instances where soldiers had to wait several weeks for non-emergency behavioral health appointments. In such cases, they mentioned the ethical dilemma of prioritizing urgent cases to ensure timely access to care.

Listening and Empathy

P1 reflected on the significance of non-verbal communication and empathy in the role of chaplains within the military. They noted that chaplains often serve as a crucial outlet for soldiers who need someone to talk to but may feel unable to confide in others. P1 highlighted the confidential nature of chaplaincy, providing soldiers with a secure space to express their thoughts and emotions. They recounted instances where they used their authority as senior figures to ensure soldiers received the MH support they needed despite the confidentiality of their conversations. P1 emphasized the balance between active listening and exercising authority when necessary to ensure soldiers' well-being.

P2 reflected on the significant role of chaplains and religious affairs specialists in supporting soldiers, noting that many soldiers feel comfortable confiding in them before seeking help from behavioral health services. P2 shared their experience teaching and mentoring religious affairs specialists, emphasizing the importance of clarifying their role as listeners rather than counselors. They stressed the importance of encouraging individuals to seek support from chaplains while maintaining confidentiality. P2 highlighted the vital role of trust, confidentiality, and active listening in fostering a supportive environment where soldiers feel comfortable sharing their concerns and seeking guidance.

P3 discussed the significance of active listening and support at the military's tactical and operational levels. At the tactical level, they emphasized their role as a caregiver, providing a safe space for soldiers to express their concerns and receive non-threatening listening. However, at the operational level, P3's responsibility shifts to advising commanders on organizational issues affecting MH support. They recounted instances of difficult conversations with commanders, where they addressed challenges within the organization and advocated for

improved support structures. P3 highlighted their role as a voice and advocate for soldiers' ability to seek help while also describing the commander's intent towards those individuals who may be struggling. They illustrated their commitment to supporting soldiers by recounting a specific situation involving a soldier expressing suicidal ideation, demonstrating their dedication to providing ongoing support and intervention when needed.

P5 emphasized the importance of empathy and being present for soldiers in challenging situations. By actively engaging with soldiers and facing their struggles alongside them, he aims to demonstrate his support and availability. P5 highlighted the significance of understanding the context and terminology of military life, especially for programs like military family life consultants (MFLC), to effectively connect with soldiers and provide support. Additionally, he mentioned the need to be purposeful in his interactions with soldiers, ensuring he is available to those struggling, even if they are not openly expressing it. This proactive approach allows him to ask meaningful questions and offer support when needed. P5 believes it can be challenging, but God is there and will always listen.

P6 emphasized the crucial role of good leadership in reducing MHS and supporting service members. They highlighted the importance of NCOs and officers who demonstrate kindness and empathy and prioritize the well-being of their soldiers. When leaders genuinely care for their soldiers, it creates a sense of belonging and security, especially for those who may lack such support in their personal lives. This support from leadership can profoundly impact soldiers, providing them with a sense of being heard and valued, which is immensely valuable for their overall well-being.

P8 recounted a challenging situation where they provided support to a soldier experiencing suicidal ideations and struggles with alcohol abuse. Despite their efforts to link her

with resources and provide regular touchpoints, she continued to face difficulties, including long waits in the ER and ongoing struggles with her MH. However, there were signs of improvement through collaborative efforts with behavioral health professionals and the soldier's willingness to engage in coping mechanisms. Ultimately, there was a positive outcome as the soldier's daughter wanted to reconcile, bringing hope for her recovery. P8's story highlights the importance of persistence, collaboration, and empathy in supporting individuals facing MH challenges.

Summary

The chapter explored the experiences of military chaplains in dealing with suicidal thoughts and MHS among service members. It outlines the research questions and methodology, including semi-structured interviews with nine chaplains recruited from a New York Army base. Insights from these chaplains reveal challenges such as soldiers' reluctance to seek help and the impact of leadership on MH issues. The analysis of participant transcripts revealed two significant themes regarding MHS and SI in the Army: "Factors that increase MHS and suicidal ideation" and "Factors that reduce MHS and SI."

Under the first theme, participants described the challenges soldiers face in advancing their careers due to fears that seeking help for MH issues might be perceived as a weakness. Officers and non-commissioned officers (NCOs) worry about fulfilling their duties and securing desirable positions while navigating MH challenges. Some participants emphasized the perception that addressing MH concerns may impact mission readiness metrics, potentially leading to stigma from peers and superiors. Others highlighted the difficulty soldiers face in seeking support due to demanding schedules and perceived disconnect from leadership, leading to feelings of isolation and reluctance to address MH needs.

The second theme focused on efforts to reduce MHS and suicidal ideation. Participants noted the importance of recognizing broader societal challenges contributing to MH issues and emphasized the role of spiritual support in addressing these concerns. Chaplains, viewed as vital sources of support, face challenges within the military's MH system, including understaffing and limited training. Participants also discussed the culture within the Army that discourages vulnerability, leading many soldiers to keep their struggles private. Despite increased comfort among younger soldiers seeking care, lingering stigma remains, particularly among more senior ranks, where concerns about confidentiality and career advancement persist.

Overall, the themes highlight the complex interplay between individual experiences, organizational culture, and broader societal attitudes in shaping attitudes toward MH support in the military.

Chapter Five: Conclusion

Overview

The purpose of this phenomenological study is to articulate the firsthand encounters of a United States Army chaplain regarding MHS and SI within the military context. This chapter highlights the discoveries, discourse, implications, delineations, constraints, and prospects for further investigation. Furthermore, it elucidates how the study's outcomes align with existing research, their potential benefits to stakeholders, and their validation or contradiction of prior literature. Lastly, this section outlines potential avenues for future research inspired by inquiries raised during the study.

Summary of Findings

This phenomenological exploration delved deep into the firsthand experiences of military chaplains engaging with service members, navigating thoughts of suicide, and confronting MHS. The investigation unveiled two overarching themes: "Factors exacerbating MHS and suicidal thoughts within the Army" and "Factors alleviating MHS and SI within the Army." These themes thoroughly addressed the study's primary focus and four supplementary research inquiries. The findings of this inquiry uncovered multiple avenues for prospective research.

Research Questions Addressed

The primary research question in this study was: What is the participants' perspective on their encounters with SI and MHS within the military? Participants shared their insights and experiences concerning their efforts to assist soldiers dealing with SI and the repercussions of MHS. P1 described the experience as predominantly challenging due to the need for education beyond immediate requirements. P8, in their current role, encounters challenges while supervising individuals facing similar obstacles, often stemming from a lack of purpose or life

skills. P4 reflected on their experience as honorable yet difficult, witnessing soldiers navigating trauma and grief. P7 acknowledged the difficulty of supporting service members with suicidal thoughts, many of whom resist seeking help and contemplate leaving the military, presenting a persistent challenge for chaplains. P5 found the experience challenging due to the sensitive nature of disclosing MH concerns.

In contrast, P2 viewed their role as a Chaplain overall positively, having aided numerous soldiers with suicidal thoughts and coping mechanisms. P3 described their experience as supportive, with solid backing from NCO channels. P6 regarded chaplaincy as a sacred duty, seeing themselves as chosen to listen and support those in need. P5 recognized the positive impact of privileged communication despite soldiers' hesitating to share.

P9 emphasized the evolving nature of encounters with SI throughout a chaplain's career, varying with the rank and age range of soldiers served. P2 found solace in providing support and tools, understanding the individual's ultimate autonomy in their decisions. P3 noted challenges arise when MH issues affect mission readiness metrics. P8 highlighted non-combat-related issues among junior soldiers, such as financial and personal struggles. P4 observed resilience and emotional detachment among soldiers facing adversity, with a minority choosing to honor their fallen comrades.

Research Question Two. How do participants perceive their role in addressing and supporting individuals with suicidal ideations in the military?

Participants perceive their role in addressing and supporting individuals with suicidal ideations in the military as multifaceted and challenging, with various perspectives and experiences shaping their approach: Chaplain Qualifications and Training (P1); Humanity and Boundaries (P2); Stigma and Pressure (P3); Impact of Leadership (P4); Role of Chaplaincy (P5);

Sacred and Therapeutic Role (P6); Resistance to Seeking Help (P7); Challenges Faced by Junior Soldiers (P8); and Stigma and Career Concerns (P9). Overall, participants perceive their role as vital in addressing and supporting individuals with suicidal ideations in the military. However, they also acknowledge the complexities, challenges, and systemic issues that impact their effectiveness in this role.

P1 discussed that while not legally mandated, specific qualifications are vital for chaplaincy roles. P1 shared that your average chaplain may lack a comprehensive understanding of the complexities surrounding suicide and its intersections with various aspects of life, unlike those with counseling experience or formal training in emotional support. Finding oneself unable to offer counsel confidently can be disconcerting. It is essential to avoid such situations where one feels incapable of providing meaningful support or engaging in empathetic conversations. P1 believes that chaplains should be equipped to empathize with others and communicate effectively. There were instances where P1 struggled with interactions and felt ineffective in assisting. Occasionally, encounters with individuals grappling with profound struggles can be challenging. However, managing typical cases of suicide or suicidal thoughts is feasible. P1 believes the difficulty arises when deciding to end one's life seems to lack rationality.

Ultimately, P2 emphasized that despite their role, they are still human, and the job comes with challenges. They highlighted the risk of experiencing secondary PTSD, particularly if they feel they have not truly assisted someone or taken their actions personally. It is crucial not to internalize these situations. Instead, there needs to be a recognition of personal boundaries and accountability. At the end of the day, if they have exhausted all efforts to assist, that is where their responsibility ends.

P3 reflected their overall experience, highlighting significant challenges. P3 identified two crucial issues regarding stigma: the impact on mission readiness and the metrics used to gauge it. When a critical individual experiences difficulties, it can disrupt the entire brigade's metrics, even if the reasons are legitimate. P3 shared that there is a sense of pressure or judgment, with some questioning why someone is facing problems at that moment. This pressure might come from both within and outside the unit. The second issue involves peer-to-peer stigma, where individuals fear repercussions if they seek help. There needs to be more concern about how seeking assistance might affect their career or personal life, leading to hesitance in reaching out for support. The stigma often revolves around responsibilities and the potential consequences of seeking help rather than personal perceptions of others.

P4 shared their observations on soldiers seeking MH support beyond issues related to suicide or grief. They attributed this shift in behavior to the openness of their former brigade commander, who candidly discussed his MH struggles and medication during town hall meetings. Despite initial skepticism about the sincerity of his message, more soldiers felt encouraged to seek help after witnessing his transparency. As a result, they started exploring various avenues of MH support, including social workers and psychiatrists, whereas they previously only visited embedded behavioral health psychologists. P4 expressed gratitude for the evolving support systems within the military and their excitement about the progress being made. They emphasized chaplains' confidentiality, highlighting its significance in fostering trust and openness among soldiers. This level of confidentiality, where chaplains cannot disclose information to the President of the United States, creates a safe space for soldiers to share their deepest concerns without fear of repercussion. P4 noted that without this assurance of confidentiality, soldiers might not feel comfortable discussing their most pressing issues. They

emphasized the importance of trust in the chaplain-soldier relationship, as it allows soldiers to share their thoughts and emotions freely, ultimately facilitating deeper conversations and support.

P5 shared their perspective on privileged communication within the context of their role. They acknowledged that while some denominations, like the Catholic Church, prioritize privileged communication for sacred matters, their interactions with soldiers have not observed significant benefits. Occasionally, soldiers may seek assurance of confidentiality, but P5 emphasized the importance of fostering an open dialogue where soldiers feel comfortable seeking help beyond their initial conversation with the chaplain. While they do not have the authority to change policies regarding privileged communication, they prefer maintaining the current approach. However, P5 recognized the value of referring soldiers to behavioral health services when necessary, especially when they require more intensive support than the chaplaincy can provide. They highlighted the limitations of their role in terms of continuous support, joking about the impracticality of being a soldier's constant companion for extended periods. They acknowledged the benefits of inpatient behavioral health care in creating an environment where soldiers can become more receptive to guidance and support. This, in turn, opens up opportunities for further discussions about hope, assistance, and personal growth.

P6 shared their perspective on the sacred and vulnerable nature of the chaplain's role, viewing it as a divine appointment to listen to the hurts and pains of others. They recounted conducting memorials for soldiers lost to suicide, highlighting the importance of relationships in their work. While they did not have a prior relationship with the soldiers they memorialized, they counseled numerous others who struggled with suicidal ideation, drawing from their extensive experience as licensed marriage and family therapists. P6 noted several reasons why soldiers

may choose to confide in a chaplain. Firstly, chaplains typically offer more immediate availability than behavioral health services, where appointments can be delayed for weeks. Secondly, there is the assurance of confidentiality, which soldiers may find reassuring. Lastly, soldiers may feel more comfortable speaking to a chaplain with whom they have an established relationship than a behavioral health officer with whom they may not know. P6 emphasized chaplains' unique therapeutic relationship, distinct from that of MH providers.

P7 described their overall experience supporting service members dealing with suicidal thoughts and MH challenges. They noted that many individuals they encountered in such situations often resist seeking help and prefer to keep their struggles to themselves. Some may even contemplate leaving the military and utilizing behavioral health services to facilitate their exit. P7 observed a recurring pattern among soldiers who struggle to continue their service or separate (ETS) from the military, finding it difficult to open up even to a chaplain. This reticence can make understanding the soldiers' emotional state and needs challenging.

P8 shared their observations regarding the challenges faced by junior soldiers, emphasizing that most of these issues are not related to combat or combat stress. Instead, many young soldiers struggle with essential life skills and coping mechanisms. P8 shares that they often find themselves ill-prepared to manage various life stressors, like financial trouble, relationship problems, or challenges within their military unit. P8 noted that these soldiers frequently lack a sense of purpose in life, exacerbating their struggles. When faced with problems they do not know how to address, their immediate response may be to express thoughts of suicide. This reaction stems from a feeling of helplessness and a belief that they have no control over their circumstances. Without a clear purpose or sense of belonging, they may perceive themselves as burdens to others, further contributing to their despair. In P8's current

role, where they supervise individuals dealing with suicidal ideations, they continue to encounter similar patterns among junior soldiers. Many of these soldiers, typically up to the rank of private first class or specialist, struggle to navigate life's challenges and lack the necessary support systems to help them cope effectively.

P9 discussed their experiences with encountering SI and thoughts throughout their career as a chaplain, noting that the frequency of these encounters has varied based on the rank and age group they were serving. In their earlier roles as a battalion chaplain dealing with junior soldiers, they encountered suicidal thoughts more frequently. However, these encounters with a more senior audience are less common in their current role. Regarding stigma surrounding seeking MHC, P9 observed a decrease in stigma, particularly among younger soldiers and junior enlisted personnel. They noted that it is rare to find a young soldier uncomfortable seeking care within the Army. However, P9 highlighted that there is still some stigma among senior ranks, including senior non-commissioned officers (NCOs) and field-grade officers, who may be hesitant based on potential concerns related to confidentiality and the expressed concern that seeking help for MH issues could be perceived as a weakness, potentially impacting one's career progression in the military. They highlighted a hierarchical system where those who rise in rank may sit on boards determining others' opportunities, possibly influenced by biases against those who seek MH support. The availability of training opportunities like NCO schools is inconsistent, leaving soldiers uncertain about their career advancement. Unlike in the past, where soldiers experiencing MH challenges might be temporarily relieved from duty for respite, now there is a tendency to dismiss them altogether. This approach, while removing individuals from immediate combat, fails to address underlying MH needs and can lead to the loss of valuable personnel.

Additionally, there is concern that some individuals may exploit the system by feigning MH issues to exit service without consequences, undermining the integrity of support systems and benefits available to genuine cases. P9 shared examples of senior officers seeking care with them, as confidentiality is guaranteed, or off-post, where they felt assured of confidentiality. They emphasized the importance of continuing efforts to reduce stigma, particularly among more senior ranks, to encourage those needing help without fear of repercussions.

Research Question Three. How do participants define mental health stigma within the military context?

Participants define MHS within the military context as a pervasive issue with far-reaching consequences. Participants identified the following factors that define MHS in the military: Fear of Security Clearance Impact (P2); Tragic Consequences of Mishandling (P3); Culture of Concealment and Prioritization of Functionality (P3); Reluctance to Seek Support (P4, P5, P7); Accessibility and Confidentiality with Chaplains (P6); Fear of Repercussions and Lack of Coping Skills (P7, P8); and Evolution of Perspective (P9): Some senior personnel still harbor stigma regarding seeking help for MH issues, but there is a growing recognition of the importance of prioritizing soldiers' well-being and facilitating transitions out of the military when necessary. Overall, MHS in the military context manifests in various forms, including fear of repercussions, reluctance to seek support, and a culture of concealment, highlighting the need for systemic changes to promote openness, support, and understanding.

P1 emphasized the importance of thorough documentation in military contexts, noting that it extends beyond ensuring soldiers receive proper care. They highlighted that documentation primarily protects those involved, ensuring a detailed record of mitigating potential liabilities or repercussions in the event of any issues or mishaps.

P2 highlighted the lingering stigma surrounding MH, particularly about security clearances within intelligence roles. Many soldiers fear that seeking behavioral health support could jeopardize their clearance status, leading them to be hesitant or cautious about seeking assistance. This fear may also impact the level of trust and openness between soldiers, as some may refrain from sharing sensitive information with those known to be seeking MH support. P3 recounted a tragic incident highlighting the consequences of misunderstanding and mishandling MH concerns. Despite clear indications of suicidal ideation, the soldier in question was released to their unit and placed under inadequate supervision. Tragically, this resulted in the soldier taking their own life by jumping from a building. This devastating outcome underscores the critical importance of proper assessment, intervention, and support for individuals experiencing MH crises. It serves as a poignant reminder of the real-life consequences of stigma and mismanagement in MH care.

P3 highlighted a pervasive culture of zero defects within specific military environments, where there is pressure to conceal issues and prioritize functionality over well-being. They noted that metrics often focus on tangible outcomes, such as the number of soldiers deployed, without considering their MH status. The emphasis is on meeting deployment quotas regardless of the soldiers' readiness or condition. This approach can lead to individuals being deployed despite struggling with MH issues, ultimately prioritizing operational needs over the welfare of service members.

P4 provided insights from their experience working at the Infantry Basic Officer Leadership Course (BOLC), where they observed a concerning trend of young lieutenants, predominantly male, struggling with MH issues. They noted that, within this demographic, there have been three suicides in the past year and a half. P4 highlighted that many of these soldiers,

particularly males, tend to suppress their emotions and refrain from seeking support, contributing to a culture of emotional avoidance and silence. This reluctance to open up and discuss their feelings may exacerbate their challenges and hinder efforts to provide necessary support and intervention.

P5 recounted an incident involving a soldier from their first unit who expressed suicidal thoughts. After an open discussion, the soldier admitted to contemplating suicide. P5 suggested self-referral to a hospital for a break from stressors, to which the soldier agreed. P5 accompanied them to the hospital, where the soldier disclosed their situation to the doctor. The chain of command was informed of the admission, possibly by the hospital. Reflecting on the experience, P5 acknowledged the challenge of encouraging individuals to disclose MH struggles, mainly due to stigma. They expressed frustration with the cyclical nature of trying to address a problem that is inherently difficult for individuals to confront. This highlights the complex dynamics involved in supporting individuals with MH concerns, especially when stigma and reluctance to disclose are significant barriers.

P6 offered additional insights into why individuals may confide in a chaplain. Firstly, chaplains typically offer more immediate availability than behavioral health providers, where scheduling appointments may take weeks. This accessibility makes chaplains a readily accessible resource for soldiers in need. Secondly, there is the assurance of confidentiality, as chaplains are bound by strict confidentiality rules, which may make soldiers more comfortable sharing sensitive information. Lastly, soldiers may feel a sense of familiarity and trust with their chaplain, as opposed to a behavioral health officer or provider whom they may not know as well. This established relationship can foster a unique therapeutic dynamic distinct from that of MH providers.

P7 expressed concerns about the military's approach to addressing mistakes, noting that the consequences can be severe once an individual makes an error. P7 feels this fear of repercussions may deter soldiers from getting help for mental health-related problems as they worry about potential adverse outcomes. P7 also highlighted a broader issue of soldiers isolating themselves and avoiding social interactions or support, instead preferring to spend time alone in their barracks, engaging in activities like playing video games. This pattern of isolation and reluctance to communicate exacerbates the challenges soldiers face. P7 underscored the need for support that encourages open dialogue and addresses MH concerns without stigma or fear of punishment.

P8 highlighted the issue of soldiers lacking basic coping skills, which leads to an overreliance on behavioral health services for problems that may not necessarily require MH intervention. They noted that some soldiers face financial difficulties at an early age, yet instead of addressing the root cause, they are sent to behavioral health. This overburdens the system, causing delays for those who genuinely require MH support. P8 emphasized the importance of directing soldiers to the appropriate resources that focus on a specific need rather than automatically referring them to behavioral health for every issue. They stressed the need for leaders to assess whether soldiers are truly experiencing suicidal ideations or if they require assistance in other areas, thereby ensuring that MH resources are allocated effectively and efficiently.

P9 expressed their observation that some senior personnel still harbor stigma regarding seeking help for MH issues, fearing potential impacts on their career advancement. However, P9 noted a personal evolution in their perspective over the years. Initially, they prioritized the Army's interests and encouraged soldiers to honor their commitments, even if they struggled.

Over time, they realized that the Army may not be the best fit for everyone and that facilitating a soldier's transition out of the Army could benefit both the individual and the organization. This shift in mindset allowed them to see that prioritizing soldiers' well-being ultimately serves the organization's best interests rather than merely deferring problems for later resolution.

Research Question Four. What factors do participants believe contribute to the prevalence of mental health stigma among military personnel?

Participants believe several factors contribute to the prevalence of MHS among military personnel: Career Concerns and Rank Hierarchies (P1, P2); Recruitment Pressures and Deployment Stressors (P3); Leadership Dynamics and Emotional Suppression (P4); Societal Attitudes and Security Concerns (P5); Judgmental Attitudes and Fear of Ostracization (P7); Unique Pressures of Military Service (P8); and Constant Scrutiny and Fear of Repercussions (P9). Overall, participants identify a complex interplay of systemic, societal, and individual factors that contribute to the prevalence of MHS among military personnel. Addressing these factors requires comprehensive efforts to destigmatize MH, promote open dialogue, and provide accessible support resources within the military context.

P1 outlined soldiers' concerns regarding their career progression, which are often tied to their rank, position, and authority within the military hierarchy. Privates may worry about promotions to higher ranks like Private First Class, while Sergeants are concerned about maintaining their position or advancing further within the enlisted ranks. Officers may fear that their MH struggles could hinder their chances of being selected for key positions or commands crucial for their career advancement. P1 shared that this fear of being perceived as incapable of managing their emotions or responsibilities can create a barrier with mental health-related

treatment, as soldiers worry about the negative impact on their careers and opportunities for advancement.

P2 discussed the phenomenon of soldiers, particularly those of higher ranks, Major or above, feeling hesitant when contemplating if they should get help for MH problems due to the possible negative impact on their career. They may turn to religious affairs specialists as a first point of contact for support. P2 emphasized the importance of training religious affairs specialists to provide support while clarifying their role as non-counselors. Additionally, they noted that soldiers' Military Occupational Specialty (MOS) and the units they are assigned to could influence their willingness to seek help, particularly in classified environments like Military Intelligence, where the stigma surrounding MH may persist. This stigma could impact soldiers' career progression or assignments.

P3 reflected on the challenges within the military recruitment process, drawing from their experience as a former chaplain recruiter. They highlighted the stressors and demands faced by recruits, including suicidal ideation, which can even arise within the recruiting realm itself. P3 recounted an incident where a private, despite concerns raised by a drill sergeant in a handwritten note, was still pushed through the system and graduated, prompting an investigation. This highlights a past emphasis on meeting recruitment quotas that may have compromised standards. Furthermore, P3 discussed additional stressors, such as family separation and the impact of deployments on soldiers and their families. P3 underscored the significance of these factors and their impact on the MHS faced by military personnel.

P4 provided insights into the challenges faced by soldiers in infantry units, particularly concerning leadership dynamics and personal struggles. They observed a tendency among infantry leaders to prioritize mission accomplishment over acknowledging and processing

emotions, creating a culture where soldiers feel compelled to shut off their emotions to fulfill their duties. Additionally, P4 noted that many soldiers lack solid familial bonds, having experienced parental absence, adoption, or familial rejection, which can exacerbate feelings of isolation and contribute to suicidal ideations. Reflecting on their experiences as a chaplain, P4 highlighted differences between their previous service in the reserves and their current assignment at Fort Benning. In the reserves, they primarily interacted with more mature soldiers, such as warrant officers and CID agents, who were better equipped to navigate military life and manage stressors. However, they encountered younger, less experienced soldiers at Fort Benning, including second lieutenants, who often lacked a sense of identity outside the military. In response, P4 emphasized the importance of proactive MH support, providing soldiers with resources and information about seeking help before they face overwhelming challenges. P4 described their efforts to normalize discussions about MH and encourage soldiers to utilize chaplain services. By addressing barriers to seeking MH support and promoting self-advocacy, P4 aims to create a supportive environment where soldiers feel comfortable reaching out for assistance and accessing the necessary resources.

P5 discussed the MHS from a societal perspective, emphasizing the importance of faith-based solutions and suggesting that the lack of spiritual guidance contributes to ongoing struggles with MH. They highlighted the circular nature of seeking help from MH providers without finding satisfactory answers, leading to a sense of frustration and continued stigma. Additionally, P5 acknowledged the unique challenges within the military context, where seeking MH support can impact one's career and security clearance. P5 recognized the necessity of managing access to weapons for individuals experiencing suicidal or homicidal ideations and proposed measures to reduce stigma and provide support for soldiers struggling with mental

health-related issues, particularly in deployed settings. Overall, P5 emphasized the complexity of addressing MHS and the need for multifaceted approaches that consider both societal attitudes and military structures to support individuals experiencing MH challenges effectively.

P6 shared their experience as a battalion chaplain in an aviation unit, mainly focusing on their role during a deployment to Europe and Greece. They mentioned being the primary behavioral health officer for the pilots in their unit, highlighting the stigma associated with seeking MH support among officers, especially concerns about being grounded from flying duties. P6 discussed officers' reluctance to seek help due to fears of appearing weak or the possible negative consequences of sharing activities related to criminal behavior or adultery. P6 emphasized the role of chaplains in providing a subclinical level of care and encouraging soldiers to seek appropriate help when needed. Additionally, P6 recounted a tragic incident involving a soldier who faced disciplinary action and subsequently died by suicide, underscoring the complexities surrounding MH issues in the military context. They stressed the importance of educating soldiers about MH resources and dispelling misconceptions about the potential career implications of seeking help.

P7 shared the story of a soldier from Africa who faced challenges with MH and personal relationships, ultimately leading to drug use and AWOL incidents. In the Naval Consolidated Brig awaiting trial, the soldier's behavior has been erratic, resisting cooperation with the system. P7 emphasized the stigma surrounding MH in the military, where soldiers expressing SI or MH issues are often judged as weak or seeking an excuse to avoid work. This judgmental attitude contributes to soldiers keeping their struggles to themselves instead of seeking help. P7 highlighted the need for a more supportive environment that encourages soldiers to seek assistance without fear of judgment or ostracization.

P8 shared instances of soldiers struggling with MH issues and the challenges they faced in accessing behavioral health resources due to an overloaded system. One example involved a staff sergeant nearing retirement who felt overwhelmed by divorce, financial issues, and challenges with her child's gender identity. Another case involved a soldier who felt pressured to maintain a tough persona and was hesitant to seek help. P8 highlighted the unique pressures faced by military personnel, including the responsibility of defending freedoms and making life-and-death decisions, which contribute to the stigma surrounding MH. P8 eloquently describes the unique challenges military members face, emphasizing that while many experiences may not be unique, the gravity of their situations sets them apart. The pressure to excel and maintain a tough persona, coupled with the responsibility of defending freedoms, creates an environment where seeking help can be stigmatized. However, P8 underscores the importance of recognizing behavioral health professionals, chaplains, and other support resources as integral parts of the team. P8 stated that by acknowledging the role of these professions, soldiers can overcome the stigma surrounding mental health-related problems and access the assistance they need to navigate the complexities of military life.

P9 highlighted a significant challenge unique to military personnel: the constant scrutiny of their actions and behaviors, which can directly impact their careers. Unlike many civilian jobs where personal conduct outside of work has minimal repercussions, military members face the reality that any misstep could affect their career advancement. P9 shared that this pressure can deter soldiers from seeking help for MH issues out of fear and the negative consequences they could face from the military. However, P9 noted that there has been progress in how the military addresses MH, with suicide no longer viewed solely as an inconvenience but as a severe issue requiring support and intervention.

Research Question Five. How do participants perceive the impact of mental health stigma on individual willingness to seek help?

Participants perceive several ways in which MHS impacts individuals' willingness to seek help within the military: Career Concerns and Stigmatization (P1, P2, P4); Resource Allocation and Support Structures (P3, P6); Culture of Stigmatization and Competition (P5, P7, P8); Perceived Expectations and Lack of Support (P8); and Differential Treatment and Considerations (P9): Overall, MHS within the military context significantly impacts individuals' willingness to seek help, with concerns about career implications, resource availability, cultural attitudes, and leadership dynamics playing prominent roles in shaping soldiers' decisions to access MH support services. Addressing these factors requires comprehensive efforts to destigmatize MH, promote a supportive environment, and improve access to MH resources within the military.

P1 expressed concern that seeking help for MH issues could be perceived as a weakness, potentially impacting one's career progression in the military. They highlighted a hierarchical system where those who rise in rank may sit on boards determining others' opportunities, possibly influenced by biases against those who seek MH support. The availability of training opportunities like NCO schools is inconsistent, leaving soldiers uncertain about their career advancement. Unlike in the past, where soldiers experiencing MH challenges might be temporarily relieved from duty for respite, now there is a tendency to dismiss them altogether. This approach, while removing individuals from immediate combat, fails to address underlying MH needs and can lead to the loss of valuable personnel. Additionally, there is concern that some individuals may exploit the system by feigning MH issues to exit service without consequences, undermining the integrity of support systems and benefits available to genuine cases.

P2 emphasized addressing MH concerns despite potential impacts on careers or job responsibilities. They highlighted the role of chaplains in helping individuals understand that seeking help is ultimately for their well-being. P2 encourages soldiers to prioritize their health and well-being, suggesting that delaying seeking help could exacerbate the situation. P2 stated, "My job as a chaplain is to help them realize if it does impact their job, then it could be better for you, and that is what matters; otherwise, if you keep, you know, putting it off and putting it off, it is just going to make it worse on you and your life."

P3 highlighted the challenge of resource allocation, particularly in environments where resources are primarily focused on specific populations, leaving other groups underserved. They emphasized the need for adequate support structures and staff to effectively address the needs of all individuals within the organization. P3 suggested that more than the current resource distribution may be required to meet the demands of the entire population, indicating a need for increased resources and support.

P4 stated, "I highly recommend them, but my peers have told me, you know, that they are yelled at for trying to make an appointment for behavioral health." P4 feels like past soldiers were screwed, not by public humiliation, but it was enough humiliation about trying to take care of yourself, not even just the EBH or social worker. P4 stated that if you are not 100% in for infantry, then you are not qualified to be a leader, and that was the message that disqualified so many of them. P4 shared the message given to soldiers: if I cannot manage this on my own, then you are not supposed to be infantry, and that stopped them from going to get help.

P5 shared that in their experience, the majority of individuals expressing suicidal thoughts are enlisted personnel. However, they also noted an incident where an officer in one of their units took his own life. They observed a tendency among officers and senior enlisted

personnel to hide their struggles, striving to maintain an image of having everything together. P5 mentioned a specific case where issues were known with individuals struggling with SUD indicating a pattern of avoiding addressing problems until they escalate. They highlighted concerns among higher-ranking individuals about the potential consequences of their mistakes, including legal ramifications under the Uniform Code of Military Justice, leading some to contemplate suicide as a way to provide for their families. P5 expressed uncertainty about the right approach to addressing this issue and acknowledged the complexity of distinguishing between officers and enlisted personnel in terms of handling MH challenges.

P6 described their role as a chaplain and highlighted consistent areas of focus, including reducing risky behavior in their battalion and providing psychoeducation to soldiers and commanders, particularly in suicide prevention. They emphasized the importance of helping leaders identify soldiers needing support and advising commanders on how to care for their troops. While their role has remained consistent across different assignments, they noted some differences as a family life chaplain, where they have more of a therapeutic role but still contribute to meetings on the post. P6 also mentioned challenges related to accessing MH services, citing an example of a clinic at Fort Kavas that requires attendance at a cognitive-behavioral therapy class before seeing a provider, likely due to limited resources.

P7 described encountering a culture within the military where soldiers are discouraged from seeking help for MH issues due to a perceived focus on work and mission primarily. They shared instances of soldiers being criticized for expressing personal struggles and emphasized a disconnect between the Army's rhetoric of teamwork and the reality of individual competition, especially among officers. P7 also highlighted experiences with leaders prioritizing personal

advancement over their subordinates' well-being, leading to a toxic work environment. They referred to such leadership as "counterproductive" rather than "toxic."

P8 highlighted an obstacle where junior soldiers may feel they cannot prioritize their MH due to perceived expectations and lack of support from junior leaders. They noted a shift in the Army's messaging regarding MH resources but emphasized the importance of mid-level leaders in fostering a supportive environment. If these leaders do not encourage seeking help, it could negatively impact how junior soldiers perceive the institution's stance on MH.

P9 noted that while they have not observed the worst-case scenario of suicide resulting from reluctance to seek help, they have seen instances where initial hesitancy needed encouragement. They highlighted the diverse levels of flexibility between officers and enlisted soldiers in seeking help, with officers often facing more stringent considerations due to their positions. Additionally, they mentioned encountering SI more frequently among junior soldiers compared to senior audiences.

Research Question Six. How do participants describe their existential and spiritual understanding and perspectives regarding mental health stigma and suicidal ideation in the military?

Participants describe their existential and spiritual understanding regarding MHS and SI in the military in several ways: Chaplain's Role and Spiritual Support (P1, P2, P3, P8); Normalization of MH (P3, P5, P6); Unit-Level Support and Compassionate Leadership (P4, P6, P7, P9); and Proactive Suicide Prevention and Accessible Resources (P4, P5, P9). Overall, participants emphasize the role of spiritual support, normalization of MH discussions, compassionate leadership, and proactive suicide prevention efforts in addressing MHS and SI

within the military. By integrating these perspectives and approaches, participants aim to create supportive environments that prioritize soldiers' well-being and promote help-seeking behaviors.

P1 emphasized that while it is not always the chaplain's role to provide comfort, it is crucial to intervene when faced with a suicidal soldier to prevent them from committing the act. They stressed the importance of relationships, counseling, programs, and interpersonal interactions in addressing MH issues. They also noted a shift in the role of chaplains, highlighting the need for careful presentation and understanding of spiritual aspects in supporting the unit.

P2 highlighted the distinction between chaplain and behavioral health counseling, emphasizing the role of religious beliefs in their approach. They mentioned incorporating prayer into sessions based on the individual's preferences and relying on the guidance of the Holy Spirit. Additionally, they underscored the importance of having a Chaplain section within units, providing soldiers with an alternative resource for support before seeking behavioral health services.

P3 emphasized the importance of normalizing discussions about struggles and seeking help across the spectrum of MH. P3 highlighted the need to address the MHS within the military community. Additionally, they mentioned a shift in their approach from seeing themselves as a savior to understanding their caregiver role and recognizing their limitations in providing support. P3 stated, “ I have gone from here is my opportunity to be the savior to Here is my opportunity to have a conversation and hopefully keep them alive; To allow God to work within their life, to keep them, too, to capture a glimmer of hope, to keep them alive, for now.”

P4 shared the positive impact of their brigade commander's openness about MH struggles, which encouraged more soldiers to seek help without fear of negative consequences.

They noted an increase in soldiers seeking diverse types of MH support, including medication and therapy, with different professionals. They emphasized the importance of creating opportunities for soldiers to seek help in a comfortable environment. They suggested incorporating MH support into the unit's battle rhythm to provide soldiers with dedicated time and space for seeking assistance.

P5 emphasized the importance of being present with soldiers during their struggles and building relationships in challenging times. P5 discussed the need to engage with soldiers and create opportunities for meaningful conversations purposefully. Additionally, P5 advocates for a shift in suicide prevention briefings to focus not only on avoiding suicide but also on finding purpose and meaning in life. P5 stressed the importance of understanding the dynamics of suicide and being proactive in helping others seek assistance.

P6 highlighted the Army's efforts in addressing issues like suicide prevention through various programs and discussions during formations. However, P6 suggested that the Army sometimes lacks compassion and caring, mainly when supporting soldiers seeking help. They share a personal experience involving a captain who faced stress and mistreatment, leading to alcohol use, and ultimately being chaptered out of the Army. This situation underscores the importance of creating an environment where soldiers feel supported and encouraged to seek help without fear of negative consequences.

P7 described how they volunteer to serve food at the DEFAC (Dining Facility) once a week, mainly to support soldiers in the 92G culinary specialist MOS. When asked why they do it, P7 explained that it is about understanding and empathizing with the soldiers' challenges, fostering a sense of camaraderie by "embracing the suck" alongside them. This experience has

heightened P7’s awareness of soldiers' struggles, enhancing their ability to connect with and support them.

P8 reflected on the influential role of chaplains in promoting MH support. They acknowledge that some chaplains may have reservations about behavioral health due to personal beliefs but emphasize the importance of utilizing available resources. P8 highlights the evolution towards a more collaborative approach, recognizing the expertise of others and advocating for teamwork. They stress the value of sharing success stories to encourage others to seek help and destigmatize MH challenges.

P9 discussed the importance of proximity and access to MHC within the military. They highlight the advantages of embedded behavioral health teams, which operate closely with units and are more accessible to soldiers. P9 emphasized the benefits of personal connections and trust-building that come with proximity, allowing for more effective support and communication between soldiers, chaplains, and behavioral health professionals. They suggest that readily available resources at the unit level increase the likelihood of soldiers utilizing them.

Discussion

This section offers insights into how the present study builds upon and enhances existing literature concerning the firsthand experiences of military chaplains as they engage with service members navigating SI and confronting MHS. Through a hermeneutical approach, the study delved into the existential perspective of chaplains, seeking to understand and interpret military chaplains' lived experiences within the broader societal context. The research examined the underlying meanings, cultural contexts, and societal factors influencing service members' perceptions and behaviors related to MHS and SI while serving in the military.

Confirmation of Previous Empirical Literature

This examination of chaplains' experiences reaffirms previous research findings concerning MHS and SI within the military. Service members encounter MHS, and the risk of suicide is influenced by various individual and socioecological factors (Ruiz et al., 2022), including resource limitations (Franklin et al., 2017), inadequate social support (Russell et al., 2019), treatment barriers (LeFeber & Solorzano, 2019), and the effects of MHS (Parcesepe & Cabassa, 2014).

Individual and Socioecological Factors

Ruiz et al. (2022) highlight the multifaceted nature of veteran suicide, attributing it to a plethora of individual and socioecological factors. These factors encompass substance use disorders, MH issues, disruptions in life, experiences of sexual abuse, access to lethal means, homelessness, legal entanglements, exposure to combat, and identification as sexual minorities. Furthermore, Wilks et al. (2019) discovered a notable correlation between anger and suicide, independent of other risk factors such as gender, family suicide history, and depression. Akins (2019) further identified nine predictors signaling impending suicide risk, including agitation, intensity of suicidal thoughts, somatic concerns, anxiety, depression, perception of death, psychiatric diagnoses, history of suicide attempts, and levels of clinical reasoning.

An established connection exists between SUD and heightened suicide risk (Conner et al., 2014), frequently intertwined with depression and anxiety (Conner et al., 2014; Wilcox et al., 2004). These disorders intensify feelings of hopelessness and desperation, heightening the probability of SI and actions (Conner et al., 2014). Substance use compromises judgment amplifies impulsivity and fosters risky behaviors that escalate the risk of suicide. While some individuals may use substances as a form of coping with experiencing emotional distress or

trauma, the subsequent emotional burden upon their wear-off may precipitate overwhelming SI (Kaplan et al., 2014). Additionally, substance misuse can foster social isolation, exacerbating feelings of loneliness and alienation, both significant suicide risk factors (Kaplan et al., 2014; Wilks et al., 2019). Although accidental overdose from substance misuse does not always indicate suicidal intent, it poses a substantial risk for those grappling with substance abuse (Wilcox et al., 2004).

SUD and suicide stand as significant public health concerns, frequently intersecting (Kaplan et al., 2014). SUD entails dependence or addiction to substances like alcohol, opioids, cocaine, methamphetamine, and prescription drugs, resulting in profound physical, psychological, and social repercussions (Kaplan et al., 2014). The onset of SUD is influenced by genetic, environmental, and behavioral factors (Conner et al., 2014; Wilcox et al., 2004). Participants (P1, P4, P5, P6, P7, and P8) underscored the impact of substance use in exacerbating MH issues, impairing daily functioning, exacerbating family problems, and heightening suicidal ideation. For instance, P4 recounted a scenario involving a service member who, grappling with MH challenges, anger issues, and alcohol abuse, sought help after his wife issued an ultimatum.

Resources Limitations

Availability of MH support and suicide prevention programs are paramount, particularly given that a sizable portion of veterans experiencing suicidal thoughts refrain from seeking MH support (Bullman & Schneiderman, 2021; Nichter et al., 2021). Veterans who engage with VA healthcare are twice as likely to access MH services, emphasizing the necessity of effective outreach within this demographic (Ruiz et al., 2022). However, with only 47% of veterans currently utilizing VA services, there is an urgent need to address barriers hindering some veterans from accessing care (Ruiz et al., 2022). Addressing the veteran suicide crisis requires a

concentrated effort to enhance service accessibility, refine suicide prevention strategies, and ensure healthcare providers are prepared to manage the needs of veterans (Faucett, 2021; Ruiz et al., 2022). P3 stressed the need for improved support structures, mainly focusing on trainees and support cases. Additionally, P4 underscored a vital aspect of their current role: furnishing soldiers with essential information and resources regarding MH before their training commences.

While factors like age, gender, and race contribute to suicide risk disparities among rural veterans, further investigation is imperative to grasp and address the underlying factors driving these disparities comprehensively (Shiner et al., 2021). Efforts to prevent suicide in rural areas must acknowledge the challenges and circumstances specific to this population to formulate effective and tailored strategies (Compton et al., 2021; Shiner et al., 2021). P5 recounted the hurdles encountered in assisting service members with MH issues and suicidal thoughts, citing one significant barrier as the backlog of individuals awaiting access to MH services. Similarly, P8 discussed the strain imposed on the behavioral health system due to overwhelming demand, noting that individuals genuinely needing assistance from behavioral health professionals struggle to secure timely appointments. P8 emphasized the importance of guiding soldiers to resources that address specific needs rather than automatically referring them to behavioral health for every issue.

Inadequate Social Support

Preventing suicide among veterans demands a multifaceted approach that addresses individual risk factors, enhances access to MH services, cultivates social support networks, and tackles MHS within both military and civilian communities. Social support emerges as a critical component in the mental well-being of veterans, notably in mitigating suicide risk (VA, 2022b). Post-military service veterans often confront unique challenges, and social support acts as a

pivotal buffer against stress and psychological adversities (Russell et al., 2019). The absence of social connectedness and feelings of burden on others correlate with heightened suicide risk (Klerman et al., 1996). Notably, younger veterans face an elevated risk of suicide, with a sizable portion reporting suicidal thoughts (Nichter et al., 2021).

Recognizing the importance of social support and facilitating avenues for veterans to connect with peers is imperative in addressing suicide risk (Petersen, 2015; Proescher et al., 2020). Robust social support networks can function as immediate crisis intervention mechanisms, offering timely aid during challenging circumstances (Pew Research Center, 2020). Engaging with individuals who comprehend the intricacies of military life fosters a sense of purpose and belonging, positively influencing MH, and reducing suicide risk (Proescher et al., 2020). P8 highlighted the issue of soldiers lacking fundamental coping skills, resulting in an overreliance on behavioral health services for issues that may not necessarily warrant MH intervention.

Perceived social support is closely tied to suicidal ideation, with more excellent perceived support acting as a protective factor (Wilks et al., 2019). Social support can alleviate suicide risk by providing emotional solace, especially for veterans grappling with isolation, depression, and anxiety (Herbst-Damm & Kulik, 2005). Social engagements and supportive relationships nurture a sense of connection and diminish negative emotions, thereby reducing suicide risk (Proescher et al., 2020). Additionally, informational social support equips veterans with valuable resources and coping mechanisms, empowering them to manage their MH (Beard, 2021) effectively. P8 observed that many soldiers, typically up to the rank of private first class or specialist, struggle to navigate life's challenges and lack the support systems to cope effectively.

Treatment Barriers

Predictive models for assessing suicide risk integrate numerous factors such as agitation, suicidal ideation, anxiety, depression, psychiatric diagnoses, and levels of clinical reasoning. However, military personnel often face daunting hurdles when confronting MH issues, fearing potential stigma, job insecurity, and the risk of being labeled as unstable or untrustworthy if they seek help (LeFeber & Solorzano, 2019). This apprehension is echoed by some veterans, who recount negative encounters and feelings of isolation after being identified as suicidal (LeFeber & Solorzano, 2019). P8 emphasized the issue of soldiers lacking fundamental coping skills, leading to an excessive reliance on behavioral health services even for issues that may not necessarily warrant MH intervention. Despite concerted suicide prevention efforts, certain service members hesitate to seek treatment due to barriers like self-efficacy concerns, appointment accessibility challenges, and the perception of generic and patronizing prevention messages (Karras et al., 2022). Veterans express discontent with the current messaging, feeling marginalized or misrepresented, particularly concerning recovery prospects (Karras et al., 2022). MH problems like PTSD, anxiety, and depression can increase feelings of shame and distrust rooted in a military culture that prioritizes stoicism over vulnerability (Goldstein, 2021).

The credibility of suicide prevention messages among veterans is indeed under scrutiny, leading to heightened anger and resistance towards these messages (Karras et al., 2022). Customizing prevention messages to the intended audience and rigorously evaluating their impact is essential to ensure they resonate effectively (Karras et al., 2022). Addressing these challenges and perceptions is pivotal for developing more impactful suicide prevention strategies that genuinely support military personnel in need. P4 illustrated how they engage soldiers by sharing personal insights and outlining potential barriers to seeking MH support. They stressed

the importance of soldiers taking ownership of their well-being and emphasized the value of equipping themselves with tools to navigate life's challenges. P3 sheds light on a prevailing culture of zero defects within specific military environments, where immense pressure exists to conceal issues and prioritize functionality over well-being. P9 noted their observation that some senior personnel still harbor stigma regarding seeking help for MH issues, fearing potential repercussions on their career advancement.

Effect of Mental Health Stigma

The MHS presents a significant barrier to veterans seeking help, perpetuating negative stereotypes, and increasing feelings of shame. This stigma stems from prejudiced attitudes, beliefs, and behaviors, leading to societal discrimination and exclusion (Hinshaw, 2007). Individuals with MH conditions are often unfairly labeled and subjected to bias and prejudice, reinforcing negative perceptions and social distancing (Hinshaw, 2007). Society's tendency to associate mental illness with danger and violence further amplifies stigmatizing beliefs and actions (Parcesepe & Cabassa, 2014). P7 reflected on the challenges soldiers face in the Army regarding admitting to SI or MH issues. They described a culture that expects individuals to be tough and resilient, resulting in swift judgment and exclusion if vulnerability is expressed. P7 noted that soldiers seeking help are frequently branded as weak or accused of neglecting their duties rather than being supported.

Stigmatization leads individuals to conceal their illness, worry about negative perceptions, and fear being treated as incompetent (Shrivastava et al., 2012). Such negative labeling intensifies feelings of shame, inadequacy, and social isolation among those grappling with mental illness (Parcesepe & Cabassa, 2014). Addressing societal beliefs, actions, and attitudes toward MHS is crucial, underscoring the need for anti-stigma interventions and research

(Parcesepe & Cabassa, 2014). P5 suggested that MH issues are not confined to the military but reflect broader societal challenges. They highlighted a perceived shift away from a belief in spiritual solutions to problems, noting that as society moves away from this perspective, there is an increase in individuals struggling with MHS and issues.

The MHS not only influences individuals' perceptions of MH treatment but also affects their likelihood of seeking help for mental health-related issues (Ajzen & Fischbein, 1980). Negative attitudes toward MHC serve as a deterrent to seeking help, diminishing motivation, and eroding positive attitudes toward counseling (Lannin et al., 2016). Military personnel encounter strong feelings related to MHS and organizational barriers to care that impact their willingness to seek treatment for mental health-related issues (Kim et al., 2010). This stigma within the military is fueled by perceptions of incompetence and threats to unit safety, further dissuading service members from seeking assistance (Greene-Shortridge et al., 2007). P4 described the difficulty some soldiers face in seeking MH support, leading to a buildup of anger and emotional turmoil, particularly when trying to cope with the loss of friends. P4 noted that only a small percentage of soldiers choose to confront their emotions and honor their fallen comrades.

Military personnel are hesitant to seek help due to the impact related to MH problems (Held & Owens, 2013). Attitudes toward treatment significantly influence treatment-seeking behaviors, emphasizing the need for a deeper examination of why service members refrain from seeking MH treatment (Kim et al., 2011). With ongoing combat operations and a growing number of military personnel experiencing psychological issues, addressing MHS to ensure that veterans receive support and care is imperative (Litz, 2007). P3 discussed how MH issues can significantly affect mission readiness and the metrics used to assess it, qualitatively and quantitatively illustrating the domino effect that occurs when a key individual experiencing

legitimate MH challenges becomes unable to perform their duties, disrupting the metrics for an entire brigade. P3 believes there is a perception that individuals in critical support roles are burdened with the weight of their responsibilities and may face stigma from their peers and superiors.

Expansion of the Literature

LeFeber and Solorzano (2019) shed light on a catch-22 situation for military personnel concerning MH concerns, where seeking assistance may jeopardize their perceived stability and job security. During this research, nine military chaplains reported witnessing negative experiences and isolation following identification as having MH issues and suicidal tendencies. Monteith et al. (2020) advocate for community-based suicide prevention programs to counter stigmatization and misconceptions and increase awareness, particularly among rural veterans. Their research uncovered low community readiness, limited awareness of the suicide crisis, and a lack of knowledge about available resources. Furthermore, Karras et al. (2022) highlight the inadequacy of current suicide prevention efforts in persuading service members to seek help for suicidal ideation. Barriers include concerns over self-efficacy, difficulties with prevention messages, psychiatric disorders, and logistical obstacles to accessing treatment. Veterans advocate for more inclusive and respectful messaging in suicide prevention efforts.

This study addresses the gap in current research related to the specific reasons behind the stigma surrounding MH and SI among soldiers. Participants in the study identified several factors contributing to this stigma within the Army context. Factors associated the negative impact of MHS in the military affect job security, position, rank, career advancement, and authority (P1, P2, P3, P4, P5, P6, P7, P8, and P9), as well as a lack of accessible resources (P3, P4, P5, P6, P8, and P9), and issues related to substance use (P1, P4, P5, P6, P7, and P9).

Additionally, the research identifies previously undocumented barriers such as inadequate unit leadership engagement and support (P1, P3, P4, P7, P8, and P9), implicit messaging (P3, P4, P5, P7, P8, and P9), and feelings of personal failure (P1, P3, P4, P5, P6, and P8). These findings contribute valuable insights that were not previously addressed in the existing literature on MHS within military contexts.

Individual and Socioecological Factors

Ruiz et al. (2022) propose that various individual and socioecological factors, including substance use disorders, MHDs, life disruptions, experiences of sexual abuse, access to lethal means, homelessness, legal issues, exposure to combat, and identification as sexual minorities, influence veteran suicide. Wilks et al. (2019) discovered a significant correlation between anger and suicide, even after controlling for other risk factors like gender, family history of suicide, and depression. Akins (2019) identified nine predictors of heightened suicide risk, including agitation, intensity of suicidal thoughts, somatic concerns, anxiety, depression, perception of death, psychiatric diagnoses, history of suicide attempts, and levels of clinical reasoning. These findings collectively add to the understanding of suicide risk factors among veterans. P3 provided insight into the reality of MH challenges versus the stress of deployments, highlighting additional stressors that compound the stigma of seeking help for MH issues.

SUD and suicide are significant public health concerns that often intersect (Kaplan et al., 2014). SUD involves dependence or addiction to substances like alcohol, opioids, cocaine, methamphetamine, and prescription medications, leading to significant physical, psychological, and social consequences. There is a strong association between SUD and increased suicide risk, often accompanied by depression and anxiety. Substance use impairs judgment, increases impulsivity, and promotes risky behaviors that escalate suicidal risk. Some individuals may turn

to substances as a coping mechanism for emotional distress or trauma; when the effects dissipate, the emotional burden may lead to overwhelming suicidal thoughts. Substance misuse can also contribute to social isolation, exacerbating feelings of loneliness and alienation, both significant risk factors for suicide. While accidental overdose from substance misuse may not always indicate suicidal intent, it poses a substantial risk for individuals struggling with substance abuse.

Resources Limitations

Improving access to MH resources and suicide prevention programs is paramount, given that a considerable proportion of veterans experiencing suicidal thoughts do not seek MH support. Veterans utilizing VA healthcare are more likely to access MH services, highlighting the importance of effective outreach within this demographic. However, with only 47% of veterans currently utilizing VA services, addressing barriers to care access is imperative. Efforts should prioritize improving service accessibility, refining suicide prevention strategies, and ensuring healthcare providers are adequately equipped to meet veterans' unique needs to tackle the veteran suicide crisis. P3 underscored the critical role of resources, whether working alone or with a physician during deployment.

Rural veterans face specific challenges, with feelings of burdensomeness and lack of belonging significantly linked to heightened suicide risk. Suicide completion rates are notably elevated among rural veterans compared to urban counterparts, emphasizing the necessity for targeted interventions in rural communities. While factors like age, gender, and race contribute to suicide risk variations among rural veterans, additional research is needed to understand and address the underlying determinants of these disparities fully. Suicide prevention efforts in rural areas must acknowledge unique challenges and contexts to develop effective and tailored interventions. P3 emphasized the importance of resource allocation, particularly in addressing

MH needs, while P5 highlighted the understaffing of Embedded Behavioral Health services, resulting in a shortage of providers and clinicians.

Inadequate Social Support

Social support plays a crucial role in veterans' MH and well-being, serving as a buffer against stress and psychological difficulties. P7 highlighted instances where soldiers were discouraged from seeking support from their superiors, underscoring a cultural divide between prioritizing mission and personal well-being. Efforts to prevent suicide among veterans necessitate a comprehensive approach encompassing individual risk factors, access to MH services, social support networks, and combatting MHS. P3 discussed varying perceptions of stigma surrounding MH support among soldiers and emphasized the value of regular training in reaching struggling individuals.

Efforts should focus on facilitating connections among veterans to reduce suicide risk, recognizing the significance of social support. Social solid networks offer timely assistance during crises, instilling purpose and belonging. Perceived social support is associated with lower suicidal ideation, providing emotional comfort and equipping veterans with coping strategies. P4 identified a vulnerable population within the military community undergoing medical treatment or disciplinary actions, experiencing feelings of unworthiness and isolation. P9 shared experiences encountering SI throughout their career as a chaplain, noting variations based on rank and age groups served, with junior soldiers exhibiting higher frequencies of suicidal thoughts.

Treatment Barriers

Predictive models for assessing suicide risk in military personnel incorporate factors like agitation, suicidal ideation, anxiety, depression, psychiatric diagnoses, and clinical reasoning

(LeFeber & Solorzano, 2019). Military members and veterans encounter challenges seeking MH support due to fears of stigma, job insecurity, and concerns about being perceived negatively (LeFeber & Solorzano, 2019). Some express feeling isolated and describe negative experiences after being identified as suicidal. P7 highlights concerns about severe consequences for mistakes, which may deter individuals from seeking help (LeFeber & Solorzano, 2019).

Barriers like self-efficacy concerns and difficulty accessing appointments also contribute to service members' hesitation to seek treatment (Karras et al., 2022). Veterans are dissatisfied with current prevention messaging and feel excluded and misrepresented, especially regarding recovery prospects (Karras et al., 2022). Depression and PTSD may amplify feelings of shame and mistrust, influenced by a military culture valuing stoicism over vulnerability (Goldstein, 2021). P9 reflects on improvements in Army attitudes towards MH, contrasting past views that perceived struggling individuals as needing to "get their act together."

Effect of Mental Health Stigma

The stigma surrounding MH treatment presents a significant obstacle for veterans seeking help, reinforcing negative stereotypes, and fostering feelings of shame and reluctance to seek assistance (Hinshaw, 2007; Parcesepe & Cabassa, 2014). This stigma stems from prejudiced attitudes, beliefs, and behaviors, leading to societal discrimination and exclusion (Hinshaw, 2007). Individuals with MH conditions often encounter labeling and bias, which reinforces negative perceptions and promotes social distancing (Hinshaw, 2007). Moreover, mental illness is often unfairly associated with danger and violence in society, further intensifying stigmatizing beliefs and actions (Parcesepe & Cabassa, 2014).

Stigmatization leads individuals to conceal their illness, worry about negative perceptions, and fear being seen as incompetent (Shrivastava et al., 2012). Such negative

labeling exacerbates feelings of shame, inadequacy, and social isolation among those dealing with mental illness (Parcesepe & Cabassa, 2014). Addressing societal beliefs, actions, and attitudes toward MHS is crucial, emphasizing the necessity for anti-stigma interventions and research (Parcesepe & Cabassa, 2014). Military personnel encounter strong sentiments related to MHS and organizational barriers to care, which impact their willingness to seek treatment for mental health-related issues (Greene-Shortridge et al., 2007; Kim et al., 2010).

P5 expressed frustration with the cyclical nature of trying to address a problem that is inherently difficult for individuals to confront. P5 highlights the complex dynamics involved in supporting individuals with MH concerns, especially when stigma and reluctance to disclose are significant barriers. Military personnel are hesitant to seek help due to the adverse effects of MHS (Held & Owens, 2013). Attitudes toward treatment significantly influence treatment-seeking behaviors, underscoring the need for a thorough examination of why service members refrain from seeking MH treatment (Kim et al., 2011). With ongoing combat operations and a rising number of military personnel experiencing psychological issues, addressing MHS to ensure veterans receive support and care is imperative (Litz, 2007).

P3 expressed their take on the matter from a theological standpoint, highlighting the complexities surrounding recruitment processes and noting the discrepancy between the seemingly clear-cut policies and the intricate reality. P4 highlighted a significant issue regarding the lack of connection between soldiers and their leadership during training. P4 observed that there is an unspoken expectation for soldiers to prioritize their well-being outside of official duties, which can create a sense of isolation and reluctance to seek help for MH concerns. P5 sheds light on institutional factors perpetuating MHS within the military, particularly regarding seeking assistance for suicidal thoughts. P5 pointed out the influence of warrior codes, whether

explicitly stated or implicit, which emphasize the expectation to endure any challenge without faltering.

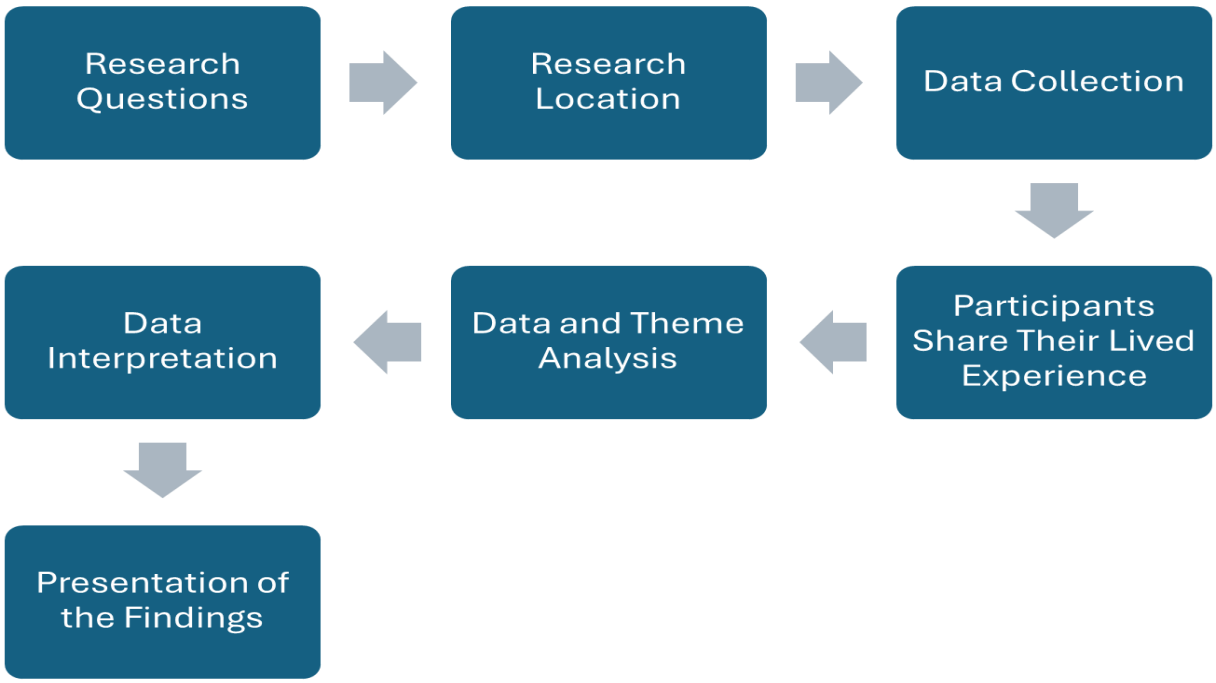
Theoretical Confirmation

This study adopts a Phenomenological approach depicted in Figure 2 (Creswell & Poth, 2018), further enriched by integrating the social constructionism framework illustrated in Figure 3 (Creswell & Poth, 2018). It seeks a profound comprehension of the foundational meanings, cultural contexts, and societal influences shaping individuals' perspectives and behaviors in their daily lives (Heppner et al., 2016). Employing hermeneutical phenomenology, the researcher interprets and contemplates critical themes emerging from lived experiences (Creswell & Poth, 2018).

The study focuses on the perceptions of chaplains regarding MHS and SI among United States military personnel. Chaplains are crucial in supporting individuals facing emotional and MH crises within the military (Ramchand et al., 2016). Recognizing the limitations and risk factors associated with suicidal thoughts and attempts is essential for enhancing suicide prevention strategies (Clancy, 2018). For example, Chaplains address the MH needs of service members while ensuring confidentiality, which is vital for understanding and addressing barriers to seeking MH assistance (Besterman-Dahan et al., 2012).

Figure 2

Generalized Depiction of Phenomenological Research Model

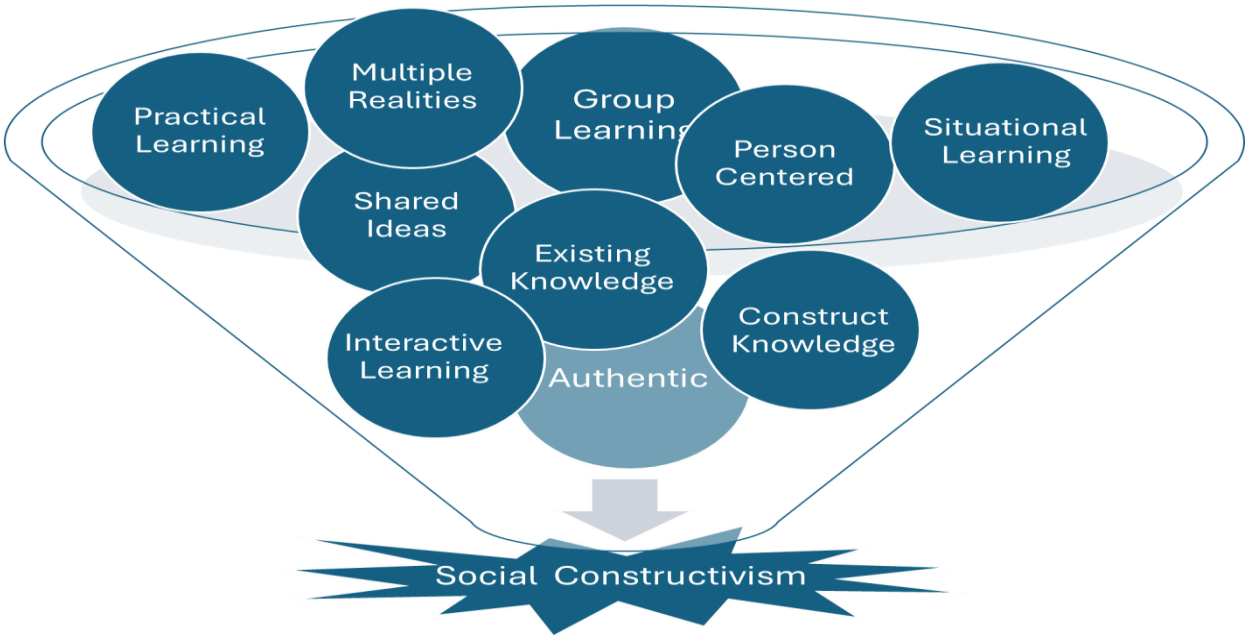


Social constructionism is the guiding framework utilized in this research that encourages exploration between reality and cultural dialogues, shaping individual worldviews and societal values (Creswell & Poth, 2018). Given the military community's diverse cultural backgrounds and perspectives, the social constructionist perspective holds particular significance (Corey, 2017). Embracing the uncertainty inherent in solution-focused and Narrative therapeutic approaches proves beneficial in engaging with the diverse demographic of the military population. Chaplains approach service members with the understanding that they are the authorities on their own experiences and perceptions. Chaplains are tasked with entering the world of MSM with the understanding that each individual is the authority on their own experiences and perceptions. Through conversations and dialogue, meaning is constructed within the narrative, with chaplains sharing their stories and offering sensitive insights into their thoughts (Corey, 2017). It is crucial to recognize that practical approaches will differ for each

person, redirecting focus toward solutions. MH professionals are charged with identifying effective strategies and replicating those concepts (Corey, 2017).

Figure 3

Generalized Depiction of Social Constructionism Framework Model



In the current research, all participants were affected by their interaction with service members while sharing a specific cultural bond only found between them. P8 emphasized the pivotal role of chaplains in advocating for soldiers' well-being by promoting available resources. P8 additionally recognized that while some chaplains may have reservations due to personal beliefs, most acknowledge the importance of utilizing resources like behavioral health services. All participants stressed that by actively promoting these resources within teams and units, chaplains can empower soldiers to seek assistance and aid, thereby improving outcomes and diminishing the stigma linked to MH issues.

Theoretical Expansion

Findings from this research provide important insight into the Social Constructionism theory. Exploring the differences between reality and cultural discussions, shaping individual worldviews and societal values The theory calls for consideration of military chaplains' understanding of the military community's diverse culture and perspectives toward MHS and suicidal ideations and the effect on service members. The present study prompts reflection on chaplain personnel's perceptions, character traits, and beliefs in understating how they navigate MH issues and suicidal ideations. This rationale is based on the study's findings of the factors that increase and decrease MHS and SI in the Army.

The study provides evidence that service members encounter many factors that increase the MHS, most notable: Negative impact on the job, position, rank, career, and or authority; lack of unit leadership engagement and support; implicit messaging, feeling like a failure; and substance use. Military life often entails prolonged separation from loved ones, heightening emotional strain on relationships. The risk of MI looms large in combat deployments and training regimens, exerting a profound toll on MH. Emotional duress is commonplace when confronting trauma, witnessing violence, or mourning fallen comrades. Consequently, service members may grapple with MH conditions like PTSD, depression, and anxiety, exacerbated by the rigors of military existence. Failure to seek help for MH issues promptly can aggravate underlying MH problems. Unaddressed psychological distress can also reduce the strength of the military, and afflicted individuals are unable to resolve their challenges effectively. This research illustrates the need to expand and explore factors that reduce the MHS and SI in the Army.

Participants all noted that focusing efforts to reduce MHS and SI in the Army is critical for both the military and service members' future. Participants noted the importance of

recognizing broader societal challenges contributing to MH issues and emphasized the role of spiritual support in addressing these concerns. Chaplains, viewed as vital sources of support, face challenges within the military's MH system, including understaffing and limited training. Participants also discussed the culture within the Army that discourages vulnerability, leading many soldiers to keep their struggles private. Despite increased comfort among younger soldiers seeking care, lingering stigma remains, particularly among more senior ranks, where concerns about confidentiality and career advancement persist.

This research broadens the theoretical framework for understanding the complex interplay between individual experiences, organizational culture, and broader societal attitudes in shaping attitudes toward MH support in the military.

Implications

The current research implications are based on foundational theories, pre-study empirical findings, and practical applications. Three significant implications are outlined below.

Theoretical Implications

From a theoretical standpoint, the current research underscores the importance of mitigating the adverse effects on military personnel grappling with MH issues and suicidal thoughts. A fundamental aspect of this theoretical framework involves comprehending the stigma surrounding MH and its influence on attitudes toward MH treatment within the military. This understanding is pivotal for addressing the reluctance to seek MH care and for devising interventions aimed at reducing this stigma (Held & Owens, 2013).

Suicide's intricate nature precludes its attribution to a single cause; effectively tackling it necessitates a comprehensive approach involving MH professionals, policymakers, communities, and individuals (Bjork et al., 2022). The present research underscores the necessity of addressing

the obstacles confronting service members in advancing their careers due to concerns that seeking assistance for mental health-related problems is viewed as a weakness and under a negative perspective. Both officers and non-commissioned officers (NCOs) harbor anxieties about fulfilling their responsibilities and securing coveted positions while grappling with MH challenges.

Many participants highlighted the perception that addressing MH issues could impact mission readiness metrics, potentially subjecting them to stigma from peers and superiors. Others emphasized the challenges soldiers encounter in seeking support due to demanding schedules and a perceived disconnect from leadership, which contributes to feelings of isolation and reluctance to address MH needs. This insight is crucial for future research endeavors, as it broadens the scope for understanding the interconnections between these concepts.

Empirical Implications

Empirically, the present research underscores the importance of prioritizing efforts to diminish the stigma surrounding MH issues and suicidal thoughts. Existing literature highlights the crucial role MH professionals play in responding to crises, advocating for suicide prevention initiatives, providing training to reduce access to lethal means, and administering effective treatments to alleviate suicide rates (Bullman & Schneiderman, 2021).

Although various support resources and interventions exist, many military personnel face barriers that limit their access. Evidence suggests that service members encounter numerous factors that contribute to MHS, including adverse effects on job performance, rank, career progression, and authority; inadequate engagement and support from unit leadership; implicit messaging that fosters feelings of inadequacy; and substance use. Participants stressed the significance of acknowledging broader societal challenges that contribute to MH issues and

highlighted the role of spiritual support in addressing these concerns. However, chaplains, perceived as essential sources of support, encounter obstacles within the military's MH system, such as understaffing and insufficient training. Participants identified a culture within the Army that discourages vulnerability, leading many soldiers to conceal their struggles despite younger soldiers showing an increased willingness to seek help; lingering stigma persists, particularly among senior ranks, where concerns regarding confidentiality and career advancement prevail. These findings present opportunities for developing strategies to integrate MH training into chaplaincy roles, thereby enhancing support and bolstering the mental well-being of military personnel.

Practical Implications

From a practical perspective, this research suggests helpful insights for policymakers regarding the availability of MH services to military personnel throughout their careers. The findings highlight challenges service members encounter, both during and after their military service, mainly related to the stigma around MH problems and suicidal ideations. Consequently, there is a pressing need for administrators, leadership, and training programs to prioritize addressing this stigma and enhancing the capabilities of leadership, chaplains, and MH professionals who interact with military personnel to address psychological distress within this population effectively.

This research sheds light on the complexities of the recruitment process and the disparity between policies and the intricate realities service members face. It emphasizes the importance of bolstering the capacity of chaplains to serve as MH providers, which would not only improve the quality of care but also enable them to identify pathways for encouraging reluctant service members to seek assistance. Expanding the reach of available MH resources and ensuring

confidentiality, mainly through resources outside the purview of leadership, is also crucial. This study highlights the negative impact and expectation for service members to prioritize their well-being outside of official duties, which can lead to feelings of isolation and hinder the willingness to seek help for MH concerns. Understanding these limitations and recognizing the critical role of chaplains should be paramount in improving service accessibility, refining suicide prevention strategies, and ensuring leadership is prepared to address the MH needs of service members.

Future efforts should be directed towards reducing MHS and addressing suicidal ideation. It is essential to acknowledge broader societal challenges contributing to MH issues and to recognize the vital role of spiritual support in addressing these concerns. However, it is crucial to address the challenges faced by chaplains within the military's MH system, including understaffing and limited training. Despite progress, there remains a lingering stigma, particularly among senior ranks, necessitating continued efforts to promote a supportive and understanding environment for service members seeking MHC.

Implications for the Military

One of the most critical implications of this research is the urgent need to address the barriers that service members encounter regarding MH issues and suicidal ideations. Leadership should increase efforts to tackle MHS, enhance social support networks, improve access to MH services, and provide targeted interventions for vulnerable populations within the military community. The stigma toward MH issues presents a significant barrier toward seeking help, reinforced by negative stereotypes, and leading to feelings of shame and reluctance to seek assistance. This stigma is rooted in prejudiced attitudes, beliefs, and behaviors, resulting in societal discrimination and exclusion. People with MH conditions often face labeling and bias, further perpetuating negative perceptions and promoting social distancing. Stigmatization leads

individuals to conceal their illness, fear negative perceptions, and worry about being seen as incompetent, intensifying feelings of shame, inadequacy, and social isolation.

Military personnel face strong sentiments of MHS, impacting their willingness to seek treatment. Efforts to address this stigma are hindered by its cyclical nature and individuals' reluctance to confront it. Attitudes toward treatment significantly influence treatment-seeking behaviors, highlighting the need for understanding why service members refrain from seeking help. With the increasing number of military personnel experiencing psychological issues, addressing MHS is crucial to ensure veterans receive support and care.

Addressing MHS within the military involves tackling institutional factors perpetuating stigma and ensuring service members have access to MH support and suicide prevention programs. Barriers to treatment focused on MH and suicidal ideations still exist, necessitating efforts to enhance service accessibility and refine suicide prevention strategies. Improved support structures for trainees and providing essential information and resources regarding MH before training are essential aspects of addressing MHS within the military.

Implications for Family Members and Friends

Efforts to reduce suicide risk among service members should prioritize fostering social connections within the military community. Social support networks offer timely assistance during crises, providing purpose and belonging, and are associated with lower suicidal ideation. Vulnerable populations within the military, such as those undergoing medical treatment or disciplinary actions, may experience feelings of isolation and unworthiness, highlighting the importance of targeted support.

Recognizing the role of social support should focus on enhancing connections and providing emotional solace for service members struggling with isolation, depression, and

anxiety. Supportive relationships and social engagements nurture a sense of belonging and diminish negative emotions, thereby reducing suicide risk. Additionally, informational social support equips service member with valuable resources and coping mechanisms, empowering them to manage their MH effectively. Targeting support efforts towards vulnerable ranks, such as private first class or specialist soldiers, is essential, as they may lack adequate support systems to cope with life's challenges.

Delimitations and Limitations

The boundaries and constraints inherent in research must be identified to ensure a comprehensive understanding of the accuracy and reliability of the research findings. These limitations can serve as valuable pointers for future research endeavors. Presented below are the specific delimitations, primarily focusing on demographics and various design constraints observed in this research.

Delimitations

The study's delimitations represent intentional choices made by the researcher to establish and confine the study's scope. A potential area for improvement in this study is the need for more control over most demographic variables. The sample selection was based solely on meeting the criteria outlined in the qualifying questionnaire the deputy garrison chaplain forwarded. Consequently, most participants were male, likely influenced by the scarcity of female chaplains in the Army. Notably, the research did not control critical demographic factors such as gender, educational level, socioeconomic status, marital status, geographic location, or experience level. This study did not regulate other potentially influential variables, including participant personality type, background, spiritual beliefs, and locus of control. The decision not

to control these demographic characteristics or other variables stemmed from the limited number of available military chaplains, rendering comprehensive control highly challenging.

Limitations

This study explored participants' perspectives on SI and MHS within the military. Consequently, it is essential to acknowledge that conclusions regarding any effects on service members' experiences cannot be reliably drawn, as these perspectives were based on personal observations and experiences. Potential limitations from the lack of consultation with service members directly regarding their experiences with MHS and suicidal ideations, potentially leading to inaccuracies in assessing the impact on participants.

Furthermore, the study's demographic composition presents another limitation. With only one female participant compared to seven males and a skewed distribution across ethnicities, future research could strive for more balanced gender and ethnic representation to better evaluate gender- and ethnicity-related outcomes.

Moreover, the study did not control participants' experience levels, only requiring them to have served as military chaplains. This oversight became evident during the study, as participants with less experience had limited exposure to challenges related to MHS and suicidal ideations, contrasting with those with over a decade of experience, which offered more seasoned perspectives on these issues. This lack of control over participants' experience level influenced the study's findings and warrants consideration in future research designs.

Recommendations

Several recommendations can be made for stakeholders based on the data gathered and the themes developed. The following recommendations could reduce MHS and improve the

well-being of service members and their families. Military leadership would be directed to make changes in the lives of service members dealing with MH issues and suicidal ideations.

Recommendations for the Military

Military leadership must prioritize efforts to address the barriers faced by service members regarding MH issues and suicidal ideations. Increase focus on reducing MHS, enhancing support networks, improving access to resources, and reducing the impact of military careers on seeking help. Socioeconomic factors and barriers such as negative stereotypes, prejudice, and societal discrimination must also be addressed to encourage service members to seek help without fear of stigma or negative repercussions.

Stigmatization leads individuals to hide their MH struggles, intensifying feelings of shame and isolation. Predictive models for assessing suicide risk consider several factors, but military personnel often hesitate to seek help due to fear of stigma and job insecurity. Veterans also report negative encounters and feelings of isolation after seeking help. Despite suicide prevention efforts, some service members still face barriers like self-efficacy concerns and patronizing prevention messages.

Address Barriers to Care. Address the significant challenges in addressing the impact of MH issues on job security, career progression, and personal reputation. Soldiers of all ranks, from privates to officers, fear jeopardizing their careers if they seek help for MH issues due to persistent stigma. This stigma is particularly pronounced in roles requiring security clearances and can lead to individuals avoiding necessary support, fearing repercussions such as being labeled unfit for duty or facing discharge.

Chaplains and behavioral health officers observe a shift in attitudes toward seeking care throughout a military career, from dismissing minor ailments to prioritizing VA disability

benefits near retirement. However, the pressure to prioritize duties over personal well-being persists, fueled by a belief that seeking help implies incompetence in fulfilling infantry roles. Service members' fear of negative consequences, such as losing security clearance or facing career setbacks, further discourages them from seeking assistance. Limited MH resources exacerbate the challenges faced by service members, particularly pilots concerned about being grounded or officers worried about being passed over for command positions. Despite efforts to promote a supportive environment, service members remain reluctant to seek help due to fears of discharge, lack of confidentiality, and perceived lack of genuine peer support.

Even senior officers hesitate to disclose their struggles, fearing repercussions on career advancement opportunities or retirement prospects. The pervasive stigma within the military creates a complex dynamic where individuals must weigh the need for MH support against potential career ramifications. The MH crisis requires comprehensive strategies to destigmatize MH issues and ensure that seeking help is met with genuine support and understanding within the military community.

Reduce Institutional Factors. Leadership within the military must actively confront institutional factors that perpetuate MHS and ensure that service members have access to adequate MH support and suicide prevention programs. Despite efforts to improve access, barriers to treatment for MH issues and suicidal ideations persist, highlighting the need for ongoing enhancements in service accessibility and refinement of suicide prevention strategies. Address MHS by improving support structures for trainees and providing essential information and resources regarding MH before training begins. This proactive approach can help normalize discussions around MH and encourage early intervention.

The cyclical nature of MH issues and individuals' reluctance to confront attitudes toward treatment significantly impact treatment-seeking behaviors. Therefore, it is essential to understand why service members may refrain from seeking help and tailor interventions accordingly. As the number of military personnel experiencing psychological issues continues to rise, addressing MHS becomes even more critical to ensure that service members receive the support and care they need. Foster a culture of openness, understanding, and accessibility surrounding MH to create an environment where service members feel empowered to seek help without fear of stigma or judgment.

Reduce Implicit Messages. The military must address implicit messages that service members encounter, which can perpetuate MHS and hinder help-seeking behaviors. P3 highlighted the complexities of recruitment processes, noting discrepancies between policies and realities, raising questions about the true permanence of disqualifications for medical conditions. The potential stigma attached to seeking medical assistance and its impact on recruitment and career progression. P4 identified a lack of connection between soldiers and leadership during training, leading to isolation and increased MH issues.

Address the challenges service members face when opening up about MH issues within the Army, with judgmental attitudes often leading to isolation and fear of stigma. P8 acknowledged the unique challenges faced by military members, including pressure to excel and self-reliance, fostering stigma around MH issues, stressing the importance of recognizing behavioral health professionals and chaplains as valuable team members, and emphasizing mid-level leaders' role in shaping institutional responses. Addressing these implicit messages and fostering a culture of understanding and support is crucial to encourage service members to seek assistance when needed.

Increase Leadership Engagement. Increasing leadership engagement is crucial for addressing MHS and supporting service members effectively. Military leaders should engage soldiers, emphasize the importance of seeking help, and challenge the culture of concealing MH issues. Some senior personnel still hold a stigma regarding seeking help, highlighting the need for culture change within the military hierarchy.

Leaders must proactively advocate for soldiers' MH, even in challenging situations. P3 highlights the ongoing challenge of suicide prevention, emphasizing the emotional toll on leaders and the importance of regular training in reaching struggling individuals. P4 raises concerns about disparities between officers and NCOs, emphasizing the need for more mentoring and guidance from senior enlisted leaders. P6 emphasizes the role of compassionate leadership in reducing stigma and fostering a supportive environment. P8 underscores the importance of leaders providing support and purpose for soldiers facing personal and professional challenges. P9 highlights the differences in consequences between enlisted soldiers and officers and observes a positive shift in the Army's culture towards prioritizing the individual soldier's well-being. Overall, increasing leadership engagement is essential for creating a culture of support and understanding where service members feel empowered to seek help without fear of judgment or repercussions.

Increase Access to Mental Health Resources. Increasing access to MH resources is crucial for supporting service members' well-being within the military. P2 acknowledged the limitations of chaplaincy in addressing MH needs, emphasizing the importance of recognizing when soldiers may require medication and advocating for a comprehensive approach involving behavioral health professionals. P3 emphasized the collaborative approach needed for suicide prevention, acknowledging chaplains' role as resources, and reflecting on their evolving role in

addressing MH issues. P5 highlighted the effectiveness of utilizing resources like inpatient behavioral health and military family life consultants to address MHS and provide relatable support. P6 discussed providing effective therapy to a soldier struggling with inadequacy despite time constraints, emphasizing the importance of utilizing available resources.

Emphasize the role of community care and highlight the significance of continually checking in on soldiers' well-being. P8 acknowledged the value of utilizing available resources, including behavioral health services, to promote soldiers' well-being and reduce MHS . P9 discussed the Army's increased priority of providing next-level MHC. It emphasized the importance of addressing stigma and matching soldiers with appropriate care based on their needs. Overall, increasing access to MH resources and promoting a comprehensive approach to MHC is essential for supporting service members' well-being within the military.

Increase Chaplains Proximity to Care and Availability. Increasing chaplains' confidentiality, proximity, and availability is vital for supporting soldiers' MH within the military. P1 shared a poignant experience demonstrating the significance of chaplains' availability in providing support to a soldier struggling with SI during training. They emphasized the importance of maintaining continuity of care through proactive communication with other chaplains. P2 underscored the value of having chaplains embedded within units, possessing necessary clearances to discuss sensitive issues, and serving as trusted confidants for soldiers facing challenges. This accessibility fosters an environment where soldiers feel comfortable seeking help. P1 discussed the refinement of chaplain roles, highlighting the development of training plans focused on suicide prevention and relationship counseling, utilizing external resources to address specific needs.

Address the dual role of chaplains as caregivers and advisors, emphasizing the need for open communication and advocacy for soldiers' well-being. P5 stressed the importance of being present and building relationships with service members during challenging times. P6 outlined reasons soldiers may prefer seeking support from chaplains, such as quicker availability, confidentiality, and an established relationship. P7 emphasized the importance of chaplains being visible and accessible, particularly for new soldiers unfamiliar with their chaplains. Finally, P9 discussed the impact of care availability on soldiers' willingness to seek help, emphasizing the value of embedded behavioral health teams and addressing challenges posed by limited availability. Overall, increasing the availability and accessibility of chaplains is essential for ensuring soldiers have the support they need for their mental well-being.

Recommendations for Family Members and Friends

Foster social connections by actively engaging with service members, encouraging them to participate in social activities, and maintaining peer relationships. Social support is crucial in reducing barriers to seeking help and can provide a sense of belonging and purpose.

Provide emotional solace during crises by listening and offering emotional support during challenging times, such as medical treatment, disciplinary actions, financial hardship, or increased substance use. Presence and understanding can alleviate feelings of isolation and unworthiness.

Foster supportive relationships and social engagements to foster a sense of belonging and diminish negative emotions like depression and anxiety. Encourage service members to participate in group activities or connect with peers with similar experiences.

Provide service members with coping mechanisms while offering practical support and resources to help them manage their MH effectively. These coping skills could include information about MH services, coping strategies, and self-care practices.

Target support efforts towards vulnerable ranks. Recognize that some service members, such as private first class or specialist soldiers, may lack adequate support systems to cope with life's challenges. Be proactive in contacting service members to help or connect them with appropriate resources.

By prioritizing social connections, providing emotional support during crises, creating nurturing environments, equipping service members with coping mechanisms, and targeting support efforts towards vulnerable ranks, family members and friends can play a crucial role in supporting service members' MH and reducing suicide risk.

Topics for Future Study

Considering the study's findings, design limitation, and the delimitation in this research, several recommendations for future research have emerged. This recommendation would fill additional gaps in the literature regarding MHS and suicidal ideations in the military. Military chaplains are crucial in supporting service members' MH and well-being. However, several challenges exist within MH research that must be addressed to ensure comprehensive understanding and practical support for service members.

The first recommendation for future research regarding MHS and SI centers around understanding the impact of competing demands service members face. One significant challenge military chaplains face is competing demands, particularly in the context of the military's recruiting crisis. The military may prioritize recruitment efforts over addressing crises within its ranks, potentially neglecting the MH needs of existing service members. This dilemma

highlights the complex balance between recruitment goals and the well-being of current personnel.

The second recommendation involves the impact of changing Societal Views. Another issue arises when individuals seek monetary gain or benefits in the military under pretenses. This deceptive behavior not only undermines the integrity of the military but also perpetuates misconceptions about the institution. Addressing this challenge requires initiatives to educate recruits about the true nature of military service and foster a culture of honesty and integrity.

The third recommendation for future research centers on implied messages projected by leadership and military mindset. The military sends implicit messages to service members regarding MH support, often contradicting its stated policies. Despite disqualifying conditions, service members are led to believe that the military can help them overcome these challenges once enlisted. This discrepancy in messaging can create confusion and disillusionment among service members, hindering their ability to seek appropriate support.

The fourth recommendation for future research would be to focus on specific experience levels in chaplains. In researching military chaplaincy, it is essential to consider participants' experience levels to ensure diverse perspectives are represented. However, this study failed to control participants' experience levels, resulting in varying degrees of exposure to challenges related to MHS and suicidal ideations. Participants with less experience may have had limited exposure to these issues, while those with more experience offered more seasoned perspectives. This lack of control over experience levels influenced the study's findings and highlights the need for more significant consideration in future research designs.

Addressing the challenges within military chaplaincy research requires a multifaceted approach that considers competing demands, societal views, implied messages, and the

experience levels of participants. By acknowledging and addressing these challenges, researchers can better understand the complexities of military chaplaincy and develop more effective strategies to support service members' MH and well-being.

Summary

This study delves into the lived experiences of military chaplains as they navigate encounters with service members grappling with MHS and SI in the military. Through an in-depth investigation, two overarching themes emerged: "Factors exacerbating MHS and suicidal thoughts within the Army" and "Factors alleviating MHS and suicidal thoughts within the Army." These themes comprehensively address the study's primary focus and supplementary research inquiries, shedding light on various phenomena and avenues for further exploration.

Under the first theme, participants illuminated the challenges soldiers encounter in advancing their careers while grappling with MH issues, fearing that seeking help might be perceived as a sign of weakness. Officers and NCOs alike expressed concerns about fulfilling their duties and securing desirable positions amidst MH challenges. Additionally, there was a prevalent perception that addressing MH concerns could impact mission readiness metrics, potentially resulting in stigma from peers and superiors. The demanding schedules and perceived disconnect from leadership also hinder soldiers' ability to seek support, fostering feelings of isolation and reluctance to address their MH needs.

Conversely, the second theme focused on efforts to mitigate MHS and suicidal ideation. Participants emphasized the importance of recognizing broader societal challenges contributing to MH issues and highlighted the role of spiritual support in addressing these concerns. Chaplains, regarded as crucial sources of support, face their own set of challenges within the military's MH system, including understaffing and limited training. Moreover, participants

discussed a prevailing culture within the Army that discourages vulnerability, leading many soldiers to keep their struggles private. Despite a growing comfort among younger soldiers seeking care, persistent stigma remains, particularly among higher-ranking individuals, who harbor concerns about confidentiality and career advancement.

The Implications of this study extend to various stakeholders involved in supporting service members dealing with MH issues and suicidal ideations. Military leadership, MH professionals, military chaplains, peers, and family members all play crucial roles in addressing these challenges. Participants highlighted the perception that addressing MH issues could impact mission readiness metrics, potentially subjecting them to stigma from peers and superiors. Soldiers encounter challenges in seeking support due to demanding schedules and a perceived disconnect from leadership, contributing to feelings of isolation and reluctance to address MH needs. Despite the availability of support resources, many face barriers that limit their access, including adverse effects on job performance, inadequate engagement and support from leadership, implicit messaging fostering feelings of inadequacy, and substance use. Future efforts should focus on reducing MHS , acknowledging broader societal challenges, and recognizing the vital role of spiritual support in addressing these concerns.

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Appendices

Appendix A: IRB Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

November 16, 2023

Eric Victorino
William Townsend

Re: IRB Exemption - IRB-FY23-24-528 EXPLORING CHAPLAINS' LIVED EXPERIENCE CONCERNING MENTAL HEALTH STIGMA AND SUICIDAL THOUGHTS IN THE MILITARY CONTEXT

Dear Eric Victorino, William Townsend,

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).

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your Information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

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, PhD, CIP
Administrative Chair
Research Ethics Office

Appendix B: Permission Request Garrison Chaplain

Letter of Approval for the Garrison Chaplain

Chaplain (MAJ)

Acting Garrison Chaplain,

Address

RE: Request of Study Consent

Dear Ch,

This letter confirms that you have been notified of a research project. It also confirms that you have a brief idea of my study investigating stigma with mental health and SI within the military content from a military chaplain's perspective. I am a postgraduate Behavioral Science major at Liberty University, investigating the summarized topic within your population. My study targets military chaplains as primary participants. Therefore, as the Garrison Chaplain at Fort Drum, I request your review of the interview questions designed for this study. I also request your cooperation and advice on the data within the targeted participants' population. This request letter confirms that I have your permission to contact and recruit study participants from under your command at a date and time convenient to you. It also asserts that I have your support for outreach and coordination and that you will adequately link me with your department. I would only need 2-2.5 hours (divided into three meeting: 1st = 45min, 2nd = 60-90 mins, and 3rd = 20 mins) to interview each participant.

Attached is the consent form for the participants and sample interview questions. Dr. _____ can confirm this study's legitimacy at (xxx) xxx-xxxx or _____@liberty.edu. I am looking forward to collaborating with you throughout my project. Therefore, this consent request meets your approval; please sign, date, and return a copy of this letter as soon as possible. Again, do not hesitate to get in touch through the contact details provided. Thank you for your time and cooperation.

Sincerely,

Eric Victorino

I agree with and consent to the above request

Chaplain (MAJ), USA _____

Acting Garrison Chaplain Date

From: Victorino, Eric
Sent: Monday, June 19, 2023, 1:29:19 PM

To:
Subject: Research request follow up

MAJ ,
I wanted to follow up from our visit last Monday and thank you for your time and consideration. I am still in the proposal process of my dissertation and not officially moving forward until I rece ive approval from Liberty University IRB. I would like to submit proof of conditional support to conduct research with the Fort Drum Chaplain Corp. Basically, I would include an email noting your support with my research proposal. Official consent would be required for me to receive IR B approval. After receiving IRB approval my research could begin. I am estimating at least a cou ple of months before my proposal is approved with Liberty University as I plan to have a couple more revisions and many more corrections.
Please feel free to ask any questions or voice any concerns. Thank you again for your time!
V/r,
Eric Victorino

From: Victorino, Eric
Sent: Thu, Jul 6, 2023, 8:25 AM
To:
Subject: RE: Research request follow up

MAJ ,
Good morning, Sir. I wanted to follow up with my last email and check in to see if you needed more information from me. Thanks again for your time and support. I look forward to hearing from you and moving forward with this research.
Have a blessed day!
V/r,
Eric

From: CH
Sent: Fri 8/11/2023 9:39 AM
To: Victorino, Eric
Subject: Research request follow up

Eric,
My last conversation with CH (MAJ) ____, ____, Deputy Division Chaplain was that we're all good to support your research. We need you to send us the questionnaire.
V/r,
CH

Appendix C: Recruitment Email

Recruitment Email

[Date]

[Recipient]
Chaplain
HEADQUARTERS, UNITED STATES ARMY GARRISON, FORT DRUM
10000 10TH MOUNTAIN DIVISION DRIVE
FORT DRUM, NEW YORK 13602-5046

Dear [Recipient]:

As a postgraduate student in the School of Behavioral Science major, Community Care and Counseling with a focus in Traumatology at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree. The purpose of my research is to collect information and gain insights into the lived experiences of participants, focusing on mental health stigma and suicidal ideations in the military and explore the participants' perspectives regarding the connection between mental health stigma, suicidal ideation, and responsibilities as military chaplains. I am writing to invite eligible participants to join my study.

Participants must be current or former military chaplain and have interacted with MSM experiencing suicide ideations and or mental health stigma. Participants, if willing, will be asked to participate in the following:

- **First meeting** will be conducted face-to-face or via video service taking approximately (45 minutes):
  - Introductions (10 minutes).
  - Complete the Self-Stigma of Seeking Help Scale survey (5 minutes).
  - Receive brief presentation on the perceived mental health stigma (15 minutes).
  - Complete the Endorsed and Anticipated Stigma Inventory (10 minutes).
  - Closing tasks and scheduling the second meeting (5 minutes).
- **Second meeting** will be conducted face-to-face or via video service taking approximately (60-90 minutes):
  - Participate in a semi structured interview.
- **Third meeting** will be conducted face-to-face or via video service taking approximately (20 minutes):
  - Review emailed copy of interview transcript and participant in a follow up call as required to validate the transcripts .

- Participants will be encouraged to express their perspectives on mental health stigma and suicidal ideation within the military context.

It should take approximately 2 to 2.5 hours overall to complete the procedures listed. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please complete the attached Qualifying Questionnaire and return it by email. Contact me at (xxx) xxx-xxxx/xxxxxxxx@liberty.edu for more information, and to schedule an interview.

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of the interview.

Participants will receive a custom wood American flag (5x10 inch approximate size) that the end of this research. Each flag will be made from reclaimed whiskey barrels and laser engraved with their name and a personal statement thanking them for participating in the research.

Sincerely,
-
Eric Victorino

Appendix D: Qualifying Questionnaire

Q1.

Are you a current or former military chaplain?

Q2.

Have you interacted with service member experiencing suicide ideations and or mental health stigma?

Q3.

Are you willing and able to communicate your perspective (Lived Experiences) related to the mental health stigma and suicidal ideations within the military context?

Appendix E: Informed Consent Form

Title of the Project: EXPLORING CHAPLAINS' LIVED EXPERIENCE CONCERNING MENTAL HEALTH STIGMA AND SUICIDAL THOUGHTS IN THE MILITARY CONTEXT

.

Principal Investigator: Eric Victorino, Doctoral Candidate, Community Care and Counseling, Liberty University

Invitation to be part of a Research Study

You are invited to participate in a research study. To be eligible for participation, must be a current or former military chaplain, have interacted with MSM experiencing suicide ideations and or mental health stigma. It is important to note that participation in this research project is entirely voluntary.

Please read the whole form and ask questions prior to deciding whether to participate in this research.

What is the study about, and why is it being done?

The empirical inquiry at the heart of this qualitative phenomenological research involves identifying mental health stigma and suicidal ideation within the military context. This study aims to delve into the lived experiences of military chaplains as they interact with service members grappling with thoughts of suicide and dealing with the associated mental health stigma. Chaplains fulfill the mental health needs of soldiers with total confidentiality, which may be critical to understanding and decreasing the barriers and perceived stigma associated with pursuing help from mental health professionals (Besterman-Dahan et al., 2012).

What happens if you participate in this research?

If you agree to be in this study, I will ask you to complete the following things (the follow list will be applicable to all participants):

- **First meeting** will be conducted face-to-face or via video service taking approximately (45 minutes):
  - Introductions (10 minutes).
  - Complete the Self-Stigma of Seeking Help Scale survey (5 minutes).
  - Receive brief presentation on the perceived mental health stigma (15 minutes).
  - Complete the Endorsed and Anticipated Stigma Inventory (10 minutes).
  - Closing tasks and scheduling the second meeting (5 minutes).

- **Second meeting** will be conducted face-to-face or via video service taking approximately (60-90 minutes):
    - Participate in a semi structured interview that will be audio-recorded.
- **Third meeting** will be conducted face-to-face or via video service taking approximately (20 minutes):
    - Review emailed copy of interview transcript and participant in a follow up call as required to validate the transcripts.
- Participants will be encouraged to express their perspectives on mental health stigma and suicidal ideation within the military context.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from participating in this study.

The benefits of this research will contribute to an enriched comprehension of mental health stigma and suicidal ideation in the military.

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.

I am a mandatory reporter. During this study, if I receive information about child abuse, child neglect, elder abuse, or intent to harm self or others, I will be required to report it to the appropriate authorities.

How will your personal information be protected?

The data collected during this research will be kept private. Published reports will not include any information that will make it possible to identify a subject. All records and data collected will be stored in a secure location, and only the researcher will have access to that information.

- Participant responses will be kept confidential with the utilization of pseudonyms. Interviews will be conducted in a private location so others will not easily overhear the conversation.
- Data will be stored on a password-locked computer. All electronic data will be deleted after three years. Interviews will be recorded and transcribed into text. Recordings will be stored in a password-protected computer for three years and then deleted. Only the researcher will have access to the data.

How will you be compensated for being part of the study?

At the end of the research, all participants will receive an (5x10 inch approximate size) custom wood American flag after this research. Each flag will be made from reclaimed whiskey barrels

and laser engraved with their name and a personal statement thanking them for participating in the research.

Is study participation voluntary?

Participation in this study is voluntary. Your decision will not impact current or future relations with Liberty University or the United States military. If you decide to participate, you are free not to answer any questions or withdraw from the study at any time.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, contact the researcher by email address/phone number listed in this letter. All data collected from you will be destroyed immediately and not included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Eric Victorino. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at (xxx) xxx-xxxx or ____@liberty.edu. You may also contact the researcher's faculty sponsor, Dr. William Townsend, at _____@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 Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted ethically 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 agree 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 of 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 me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

Appendix F: Confidentiality Agreement

During this study: EXPLORING CHAPLAINS' LIVED EXPERIENCE CONCERNING MENTAL HEALTH STIGMA AND SUICIDAL THOUGHTS IN THE MILITARY CONTEXT

1. This researcher will maintain all confidentiality and will not disclose any information to others, including family and friends.

2. This researcher will safeguard confidential information from unauthorized copy, sale, loan, use, or destruction.

3. This researcher's obligation to the client's information will extend beyond the time of the study.

4. This researcher will not violate the confidentiality of this agreement.

This researcher's signature below is an acknowledgment that I have read and agree to adhere to the terms and conditions stated above.

Signature: Date: 27SEP2023

_____ _____

Appendix G: Self-Stigma of Seeking Help Scale (SSOSH)

Adopted from (Vogel et al., 2006)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Appendix H: Stigma Presentation Outline

The mental health stigma creates significant problems that negatively impact today's society. Mental health stigma is typically experienced when a person with a MH condition is subjected to prejudicial attitudes, beliefs, and behaviors that can result in discrimination and exclusion from society. Stigmatization is created from labeling, bias, and prejudice that raises the perception of an underlying negative belief of a group (Hinshaw, 2007). Most stigmatized beliefs within society are directed at people with mental illness, which increases adverse reactions and social distancing (Hinshaw, 2007).

Society perpetuates the MHS , believing that people with MH problems are dangerous and prone to violence (Parcesepe & Cabassa, 2014). Mental health problems are relatively widespread within the military population; research indicates many service members are uncomfortable or willing to seek help or treatment for combat-related MH problems. (Held & Owens, 2013).

Early intervention focusing on MH services could reduce post-combat MH problems and alleviate the need for long-term care (Wright et al., 2009). To make effective changes, we must first understand the MHS . Research conducted by Shrivastava and colleges in 2012 on the MHS indicates:

- 86% of participants concealed their illness.
- 69% witnessed others expressing offensive things about individuals with mental illnesses.
- 63% worried about being regarded negatively.
- 59% had been treated as incompetent.

The general impact of the MHS

- Damages individuals (Parcesepe & Cabassa, 2014).
- Reduces social relations (Parcesepe & Cabassa, 2014).
- Increases fear (Parcesepe & Cabassa, 2014).
- Increases feelings of shame (Parcesepe & Cabassa, 2014).
- Creates feelings of ineptitude and incompetence (Parcesepe & Cabassa, 2014).
- Reduces motivation (Lannin et al., 2016).
- Erodes positive attitudes toward counseling (Lannin et al., 2016).
- Reduces positive help-seeking behaviors (Lannin et al., 2016).
- Stronger deterrent to seeking help from Mental health professionals (Kim et al., 2011).

Service member's specific issues

- Active-duty soldiers reported stronger feelings of stigma and organizational barriers to care concerning National Guard soldiers (Kim et al., 2010).
- They are frequently viewed as incapable, incompetent, and threatening unit safety (Greene-Shortridge et al., 2007).
- The main reason is that only a small percentage of service members seek help from MH professionals (Kim et al., 2011).
- Negative attitudes toward treatment can reduce seeking behaviors (Kim et al., 2011).
- Continued combat operations and the amount of military personnel experiencing psychological issues are growing and could result in more generations of veterans with MH problems (Litz, 2007).

Appendix I: Endorsed and Anticipated Stigma Inventory

Endorsed and Anticipated Stigma Inventory (EASI)

Version date: 2022

Reference: Vogt, D., Di Leone, B. A. L., Wang, J. M., Sayer, N. A., Pineles, S. L. & Litz, B. T. (2014). *The Endorsed and Anticipated Stigma Inventory (EASI)* [Measurement instrument]. Available from https://www.ptsd.va.gov.

URL: https://www.ptsd.va.gov/professional/assessment/functional-other/EASI.asp

Note: This is a fillable form. You may complete it electronically.

Endorsed and Anticipated Stigma Inventory (EASI)

Description

The Endorsed and Anticipated Stigma Inventory is a self-report inventory that consists of 5 stand-alone scales assessing mental health beliefs that may impact willingness to seek mental health treatment.

Scoring and Administration

Each of the 5 scales use a 5-point Likert-type response format: 1 *(strongly disagree)*, 2 *(somewhat disagree)*, 3 *(neither agree nor disagree)*, 4 *(somewhat agree)*, 5 *(strongly agree)*.

Items within each of the 5 scales can be summed to create 5 scale scores. The items should ***not*** be combined to create a total score, as the scales are stand-alone measures.

Users may elect to administer a subset of these scales rather than all 5 scales (e.g., the 3 endorsed stigma scales or the 2 anticipated stigma scales).

ID # _____

EASI

Instructions: Please indicate your agreement with the following set of statements about mental health and mental health treatment. Choose whether you *Strongly disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree,* or *Stongly agree*, and click on the corresponding button to select it. **Please note that you do not have to be currently experiencing, or ever have experienced, a mental health problem to answer these questions.**

Beliefs About Mental Illness

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. People with mental health problems cannot be counted on.	1	2	3	4	5
2. People with mental health problems often use their health problems as an excuse.	1	2	3	4	5
3. Most people with mental health problems are just faking their symptoms.	1	2	3	4	5
4. I don't feel comfortable around people with mental health problems.	1	2	3	4	5
5. It would be difficult to have a normal relationship with someone with mental health problems.	1	2	3	4	5
6. Most people with mental health problems are violent or dangerous.	1	2	3	4	5
7. People with mental health problems require too much attention.	1	2	3	4	5
8. People with mental health problems can't take care of themselves.	1	2	3	4	5

ID # _____

Beliefs About Mental Health Treatment

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. Medications for mental health problems are ineffective.	1	2	3	4	5
2. Mental health treatment just makes things worse.	1	2	3	4	5
3. Mental health providers don't really care about their patients.	1	2	3	4	5
4. Mental health treatment generally does not work.	1	2	3	4	5
5. Therapy/counseling does not really help for mental health problems.	1	2	3	4	5
6. People who seek mental health treatment are often required to undergo treatments they don't want.	1	2	3	4	5
7. Medications for mental health problems have too many negative side effects.	1	2	3	4	5
8. Mental health providers often make inaccurate assumptions about patients based on their group membership (e.g., race, sex, etc.).	1	2	3	4	5

ID # _____

Beliefs About Treatment Seeking

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. A problem would have to be really bad for me to be willing to seek mental health care.	1	2	3	4	5
2. I would feel uncomfortable talking about my problems with a mental health provider.	1	2	3	4	5
3. If I had a mental health problem, I would prefer to deal with it myself rather than to seek treatment.	1	2	3	4	5
4. Most mental health problems can be dealt with without seeking professional help.	1	2	3	4	5
5. Seeing a mental health provider would make me feel weak.	1	2	3	4	5
6. I would think less of myself if I were to seek mental health treatment.	1	2	3	4	5
7. If I were to seek mental health treatment, I would feel stupid for not being able to fix the problem on my own.	1	2	3	4	5
8. I wouldn't want to share personal information with a mental health provider.	1	2	3	4	5

ID # _____

Concerns About Stigma From Loved Ones

If I had a mental health problem and friends and family knew about it, they would . . .

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. …think less of me.	1	2	3	4	5
2. …see me as weak.	1	2	3	4	5
3. …feel uncomfortable around me.	1	2	3	4	5
4. …not want to be around me.	1	2	3	4	5
5. …think I was faking.	1	2	3	4	5
6. …be afraid that I might be violent or dangerous.	1	2	3	4	5
7. …think that I could not be trusted.	1	2	3	4	5
8. …avoid talking to me.	1	2	3	4	5

ID # _____

Concerns About Stigma in the Workplace

If I had a mental health problem and people at work knew about it . . .

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. My coworkers would think I am not capable of doing my job.	1	2	3	4	5
2. People at work would not want to be around me.	1	2	3	4	5
3. My career/job options would be limited.	1	2	3	4	5
4. Coworkers would feel uncomfortable around me.	1	2	3	4	5
5. A Supervisor might give me less desirable work.	1	2	3	4	5
6. A Supervisor might treat me unfairly.	1	2	3	4	5
7. People at work would think I was faking.	1	2	3	4	5
8. Co-workers would avoid talking to me.	1	2	3	4	5

Appendix J: Detailed Demographic Information Spreadsheet

Variables	Frequency	Percent
Gender		
Female		
Male		
I chose not to disclose.		
Ethnicity		
White/Caucasian/European American		
African/African American		
Spanish/Latino		
Asian/Pacific Islander		
Native American		
Middle Eastern		
Multiracial		
Age		
18-24 years		
25-34 years		
35-44 years		
45-54 years		
55-64 years		
64+ years		
Military chaplain		
Yes		
No		
Rank		
1LT		
2LT		
CPT		
MAJ		
LTC		
COL		
Current position		
Battalion Chaplain		
Brigade Chaplain		
Division Chaplain		
Garrison Chaplain		
Other:		
Education Level		
HS		
Some College		
AA Degree/vocational		
BA/BS Degree		
MA/MS Degree		
EdD/PhD		

Appendix K: Interview Protocol

Participant's ID #

- ☐ Greet and thank the participant for assisting in this research project.
- ☐ Explain the purpose of the research project.
- ☐ Review confidentiality and have the participant sign the informed consent form.
- ☐ Address physical comfort and concerns.
- ☐ Explain the purpose of field notes.
- ☐ Record the participant ID number on the field notes.
- ☐ Encourage participants to open up and share their experiences.
- ☐ Explain body language and non-verbal responses are being observed and recorded.
- ☐ Explain that the interview will be recorded and transcribed to ensure accuracy.
- ☐ Start recording, ask interview questions, and follow-up questions as required:

1. Can you describe your overall experience supporting service members who have experienced thoughts of suicide and mental health stigma during your time as a chaplain in the military?
2. Could you share a particularly challenging or memorable encounter with a service member dealing with the stigma of mental health issues?
3. Can you describe a specific situation where you encountered a service member seeking help for suicidal ideations?
4. Based on your interactions in the military, could you share examples of how mental health stigma might influence a service member's decision to disclose suicidal thoughts or emotions?

    How do they express their concerns or fears about seeking help?

5. How do you perceive the mental health stigma affecting service members seeking help for suicidal ideations?
6. Can you describe the role of chaplains in fostering a supportive and stigma-free environment within the military to promote mental well-being?
7. How has your role as a chaplain evolved regarding addressing mental health issues and suicide prevention within the military?
8. What are some unique challenges and stressors that military personnel face regarding mental health stigma and suicidal ideation?
9. Are there any specific barriers or obstacles you have encountered in your efforts to help service members with their mental health and suicidal ideation?
10. Have you encountered situations where the fear of negative repercussions, such as damage to a service member's career or reputation, impacted their willingness to seek help for suicidal ideations?
11. Have you noticed differences in the perception of mental health stigma between enlisted service members and officers when discussing suicidal thoughts?
12. What institutional factors could contribute to the mental health stigma among service members, particularly when seeking help for suicidal ideations?
13. What kind of support or resources are most effective in reducing mental health stigma and supporting service members struggling with mental health stigma and suicidal thoughts?
14. Have you noticed any changes in the military's approach to addressing mental health stigma and suicide prevention recently?

    If so, how have these changes impacted your chaplain role?

15. What can be done at the individual, unit, and organizational levels to reduce mental health stigma and encourage more soldiers to seek help for suicidal ideations?

- Stop the recording and thank the participant for helping in this research.
- Tell the participant that the interview transcript will be made available, and they will have a final opportunity to clarify or add to their responses.

Appendix L: IRP Phase 1 Interview Protocol Matrix

	Background Information	PRQ1: What is the participants' perspective on their encounters with suicidal ideation and the MHS within the military content?	PRQ2: How do participants perceive their role in addressing and supporting individuals with suicidal ideations in the military?	RQ1: How do participants define the MHS within the military content	RQ2: What factors do participants believe contribute to the prevalence of the MHS among military personnel?	RQ3: How do participants perceive the impact of the MHS on individual willingness to seek help?	RQ4: How do participants describe their existential and spiritual understanding and perspectives regarding the MHS and suicidal ideation in the military?
Q1	X		X				X
Q2	X	X					X
Q3	X		X				X
Q4		X	X	X	X	X	
Q5		X	X	X	X		X
Q6		X		X		X	X
Q7		X	X			X	X
Q8	X	X	X	X	X	X	X
Q9	X	X	X	X	X		
Q10	X	X	X	X	X		
Q11	X	X	X	X		X	
Q12		X	X		X		
Q13		X	X		X		
Q14		X	X	X	X	X	X
Q15		X	X		X	X	X

Appendix M: IRP Phase Two

Peer review email conducted on interview questions:

Victorino, Eric

From: Victorino, Eric
Sent: Tuesday, September 5, 2023, 10:32 AM
To:

Cc: Victorino, Eric

Subject: Peer help with my dissertation interview question

I am looking for assistance from a peer perspective, and I would greatly appreciate any help with my dissertation interview questions.

Looking for any input but primarily focused on:

- Questions/statements are free from spelling error(s)
- Do most questions ask participants to describe experiences and feelings?
- Questions are primarily open-ended.
- Questions are written in a non-judgmental manner.
- All questions are needed.
- Questions/statements are concise and Comprehensive.
- Questions/statements are devoid of academic language.
- Questions/statements are easy to understand

Empirical inquiry is at the heart of this qualitative phenomenological research and involves identifying MHS and suicidal ideation within the military context. This study aims to delve into the lived experiences of military chaplains as they interact with service members grappling with thoughts of suicide and dealing with the associated MHS .

1. Can you describe your overall experience in supporting service members who have grappled with thoughts of suicide and mental health stigma during your time as a chaplain in the military?
2. Could you share a particularly challenging or memorable encounter with a service member dealing with the stigma of mental health issues?
3. Can you describe a specific situation where you encountered a soldier seeking help for suicidal ideations?
4. From your interactions with soldiers, could you share examples of how mental health stigma might influence their decision to disclose suicidal thoughts or emotions? How do they express their concerns or fears about seeking help?
5. How do you perceive the mental health stigma affecting soldiers seeking help for suicidal ideations?
6. Can you describe the role of chaplains in fostering a supportive and stigma-free environment within military units to promote mental well-being?

7. How has your role as a chaplain evolved regarding addressing mental health issues and suicide prevention within the military?
8. What unique challenges and stressors do military personnel face regarding mental health stigma and suicidal ideation?
9. Are there any specific barriers or obstacles you have encountered in your efforts to help service members with their mental health and suicidal ideation?
10. Have you encountered situations where the fear of negative repercussions, such as damage to a soldier's career or reputation, impacted their willingness to seek help for suicidal ideations?
11. Have you noticed differences in the perception of mental health stigma between enlisted soldiers and officers when discussing suicidal thoughts?
2
12. What institutional factors could contribute to the mental health stigma among soldiers, particularly when seeking help for suicidal ideations?
13. What kind of support or resources are most effective in reducing mental health stigma and supporting service members struggling with mental health stigma and suicidal thoughts?
14. Have you noticed any changes in the military's approach to addressing mental health stigma and suicide prevention recently?
    If so, how have these changes impacted your chaplain role?
15. What can be done at the individual, unit, and organizational levels to reduce mental health stigma and encourage more soldiers to seek help for suicidal ideations?

Thank you again for any help you could offer!

V/r,
Eric Victorino

Appendix N: IRP Interview Protocol Guide Sheet

Aspects of an Interview Protocol	Yes	No	Feedback for Improvement
Interview Protocol Structure			
Beginning questions are factual.	X		
Key questions are the majority of the questions and are placed between the beginning and end.	X		
Questions at the interview protocol's end are reflective and allow the participants to share closing comments.	X		
A brief script throughout the interview protocol provides smooth transitions between topic areas.	X		
The interviewer closes with expressed gratitude and any intent to stay connected or follow up.	X		
Overall, the interview is organized to promote conversational flow.	X		
Writing of Interview Questions & Statements Questions/statements are free from spelling error(s)			
Only one question is asked at a time.			
Most questions ask participants to describe experiences and feelings.	X		
Questions are primarily open-ended.	X		
Questions are written in a non-judgmental manner.	X		
Length of Interview Protocol			
All questions are needed.	X		

Questions/statements are concise and Comprehensive.	X		
Questions/statements are devoid of academic language.	X		

Appendix O: Demographic Questionnaire

Name:

Email:

Phone Number:

1. What is your gender?

- Female
- Male
- I chose not to disclose.

2. What is your ethnicity?

- White/Caucasian/European American
- African/African American
- Spanish/Latino
- Asian/Pacific Islander
- Native American
- Middle Eastern
- Multiracial

3. What is your age?

- 18-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 64+ years

4. Are you currently serving as a military chaplain?

- Yes
- No

5. What is your rank?

- 1LT
- 2LT
- CPT
- MAJ
- LTC
- COL

6. What is your current position?

- Battalion Chaplain
- Brigade Chaplain
- Division Chaplain
- Garrison Chaplain
- Other:

7. What is your highest level of education?

- HS
- Some College
- AA Degree/vocational
- BA/BS Degree
- MA/MS Degree
- EdD/PhD

Appendix P: SSOSH Approval

From: "Victorino, Eric
Date: Thursday, September 28, 2023, at 7:58 PM
To: "Vogel, David L
Subject: Permissions for use of Measures

Dr. David Vogel,

I am currently pursuing a Doctor of Education in Behavioral Science, specializing in Community Care and Counseling and Traumatology, at Liberty University. My research is centered on the investigation of mental health stigma and suicidal ideation within the military. The cornerstone of this qualitative phenomenological study is the identification of mental health stigma and suicidal ideation within the military context.

The primary goal of my research is to obtain a profound insight into the experiences of military chaplains as they engage with service members grappling with thoughts of suicide and navigate the associated mental health stigma. With this in mind, I am reaching out to respectfully request your permission to utilize your Self-Stigma of Seeking Help Scale (SSOSH) as a valuable resource to support my dissertation.

Thank you for your consideration.

Sincerely,

Eric Victorino

From: "Vogel, David L
Date: Fri 9/29/2023 11:45 AM
To: "Victorino, Eric
Subject: [EXTERNAL] RE: Permissions for use of Measures

Feel free to use the scale in your research.

David

Appendix Q: EASI Approval

From: Victorino, Eric
Sent: Wednesday, September 27, 2023, 6:09 PM
To: Vogt, Dawne
Subject: [EXTERNAL] Permissions for use of Measures

Dr. Dawne Vogt,

I am currently pursuing a Doctor of Education in Behavioral Science, specializing in Community Care and Counseling and Traumatology, at Liberty University. My research is centered on the investigation of mental health stigma and suicidal ideation within the military. The cornerstone of this qualitative phenomenological study is the identification of mental health stigma and suicidal ideation within the military context.

The primary goal of my research is to obtain a profound insight into the experiences of military chaplains as they engage with service members grappling with thoughts of suicide and navigate the associated mental health stigma. With this in mind, I am reaching out to respectfully request your permission to utilize your Endorsed and Anticipated Stigma Inventory (EASI) as a valuable resource to support my dissertation.

Thank you for your consideration.

Sincerely,

Eric Victorino

From: Vogt, Dawne
Sent: Thu 9/28/2023 10:55 AM
To: Victorino, Eric
Subject: [EXTERNAL] RE: Permissions for use of Measures

Yes, you are welcome to use this measure. Good luck with your research!

Best,

Dawne

****

Dawne S. Vogt, PhD

Appendix R: Recruitment Email Follow Up

[Date]

[Recipient]
Chaplain

Dear [Recipient]:

As a postgraduate student in the School of Behavioral Science major, Community Care and Counseling with a focus in Traumatology at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree. The purpose of my research is to collect information and gain insights into the lived experiences of participants, focusing on mental health stigma and suicidal ideations in the military and explore the participants' perspectives regarding the connection between mental health stigma, suicidal ideation, and responsibilities as military chaplains. Two weeks ago, an email was sent to you inviting you to participate in a research study. This follow-up email is being sent to remind you to respond if you would like to participate and have not already done so. The deadline for participation is [Date].

Participants must be current or former military chaplain and have interacted with military service members experiencing suicide ideations and or mental health stigma. Participants, if willing, will be asked to participant in the following:

- **First meeting** will be conducted face-to-face or via video service taking approximately (45 minutes):
  - Introductions (10 minutes).
  - Complete the Self-Stigma of Seeking Help Scale survey (5 minutes).
  - Receive brief presentation on the perceived mental health stigma (15 minutes).
  - Complete the Endorsed and Anticipated Stigma Inventory (10 minutes).
  - Closing tasks and scheduling the second meeting (5 minutes).
- **Second meeting** will be conducted face-to-face or via video service taking approximately (60-90 minutes):
  - Participate in a semi structured interview.
- **Third meeting** will be conducted face-to-face or via video service taking approximately (20 minutes):
  - Review emailed copy of interview transcript and participant in a follow up call as required to validate the transcripts .
- Participants will be encouraged to express their perspectives on mental health stigma and suicidal ideation within the military context.

It should take approximately 2 to 2.5 hours overall to complete the procedures listed. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please complete the attached Qualifying Questionnaire and return it by email. Contact me at (xxx) xxx-xxxx/xxxxx@liberty.edu for more information, and to schedule an interview.

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of the interview.

Participants will receive a custom wood American flag (5x10 inch approximate size) that the end of this research. Each flag will be made from reclaimed whiskey barrels and laser engraved with their name and a personal statement thanking them for participating in the research.

Sincerely,
-
Eric Victorino

Appendix S: Observational Protocol Meeting 1

Activate: First meeting	
Time: Start: End:	
Place:	
Participant ID:	
Descriptive Notes	Reflective Notes
Introductions	
Review consent form	
Self-Stigma of Seeking Help Scale survey	
Presentation on mental health stigma	

Endorsed and Anticipated Stigma Inventory	
Scheduling the second meeting	
Five sense observations	
MSE observations: APPEARANCE: BEHAVIOR: EYE CONTACT: SPEECH: PSYCHOMOTOR CHANGES: AO: MOOD: AFFECT: THOUGHT PROCESS & CONTENT: PERCEPTIONS: INSIGHT & JUDGMENT: SI/HI:	

Appendix T: Observational Protocol Meeting 2

Activate: Second meeting: Semi Structured interview questions	
Time: Start: End:	
Place:	
Participant ID:	
Descriptive Notes	Reflective Notes
Review consent form	
Semi Structured interview questions:	
1. Can you describe your overall experience supporting service members who have experienced thoughts of suicide and mental health stigma during your time as a chaplain in the military?	
2. Could you share a particularly challenging or memorable encounter with a service member dealing with the stigma of mental health issues?	
3. Can you describe a specific situation where you encountered a service member seeking help for suicidal ideations?	
4. Based on your interactions in the military, could you share examples of how mental health stigma might influence a service member's decision to disclose suicidal thoughts or emotions? How do they express their concerns or fears about seeking help?	
5. How do you perceive the mental health stigma affecting service members seeking help for suicidal ideations?	
6. Can you describe the role of chaplains in fostering a supportive and stigma-free environment within the military to promote mental well-being?	

7. How has your role as a chaplain evolved regarding addressing mental health issues and suicide prevention within the military?	
8. What are some unique challenges and stressors that military personnel face regarding mental health stigma and suicidal ideation?	
9. Are there any specific barriers or obstacles you have encountered in your efforts to help service members with their mental health and suicidal ideation?	
10. Have you encountered situations where the fear of negative repercussions, such as damage to a service member's career or reputation, impacted their willingness to seek help for suicidal ideations?	
11. Have you noticed differences in the perception of mental health stigma between enlisted service members and officers when discussing suicidal thoughts?	
12. What institutional factors could contribute to the mental health stigma among service members, particularly when seeking help for suicidal ideations?	
13. What kind of support or resources are most effective in reducing mental health stigma and supporting service members struggling with mental health stigma and suicidal thoughts?	
14. Have you noticed any changes in the military's approach to addressing mental health stigma and suicide prevention recently? If so, how have these changes impacted your chaplain role?	

15. What can be done at the individual, unit, and organizational levels to reduce mental health stigma and encourage more soldiers to seek help for suicidal ideations?	
Five sense observations	
MSE observations: APPEARANCE: BEHAVIOR: EYE CONTACT: SPEECH: PSYCHOMOTOR CHANGES: AO: MOOD: AFFECT: THOUGHT PROCESS & CONTENT: PERCEPTIONS: INSIGHT & JUDGMENT: SI/HI:	
Scheduling the Third meeting	

Appendix U: Observational Protocol Meeting 3

Activate: Third meeting: Transcription review and validation	
Time: Start: End:	
Place:	
Participant ID:	
Descriptive Notes	Reflective Notes
Review consent form	
Transcription review and validation:	
1. Can you describe your overall experience supporting service members who have experienced thoughts of suicide and mental health stigma during your time as a chaplain in the military?	
2. Could you share a particularly challenging or memorable encounter with a service member dealing with the stigma of mental health issues?	
3. Can you describe a specific situation where you encountered a service member seeking help for suicidal ideations?	
4. Based on your interactions in the military, could you share examples of how mental health stigma might influence a service member's decision to disclose suicidal thoughts or emotions? How do they express their concerns or fears about seeking help?	
5. How do you perceive the mental health stigma affecting service members seeking help for suicidal ideations?	
6. Can you describe the role of chaplains in fostering a supportive and stigma-free environment within the military to promote mental well-being?	

7. How has your role as a chaplain evolved regarding addressing mental health issues and suicide prevention within the military?	
8. What are some unique challenges and stressors that military personnel face regarding mental health stigma and suicidal ideation?	
9. Are there any specific barriers or obstacles you have encountered in your efforts to help service members with their mental health and suicidal ideation?	
10. Have you encountered situations where the fear of negative repercussions, such as damage to a service member's career or reputation, impacted their willingness to seek help for suicidal ideations?	
11. Have you noticed differences in the perception of mental health stigma between enlisted service members and officers when discussing suicidal thoughts?	
12. What institutional factors could contribute to the mental health stigma among service members, particularly when seeking help for suicidal ideations?	
13. What kind of support or resources are most effective in reducing mental health stigma and supporting service members struggling with mental health stigma and suicidal thoughts?	
14. Have you noticed any changes in the military's approach to addressing mental health stigma and suicide prevention recently? If so, how have these changes impacted your chaplain role?	

15. What can be done at the individual, unit, and organizational levels to reduce mental health stigma and encourage more soldiers to seek help for suicidal ideations?	
Five sense observations	
MSE observations: APPEARANCE: BEHAVIOR: EYE CONTACT: SPEECH: PSYCHOMOTOR CHANGES: AO: MOOD: AFFECT: THOUGHT PROCESS & CONTENT: PERCEPTIONS: INSIGHT & JUDGMENT: SI/HI:	