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PERCEPTIONS OF MENTAL HEALTH SERVICES
AMONG MARINES

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Leslie Marie Belt
Leslie Paul Schellbach

June 2007

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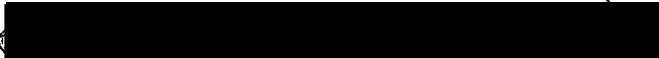
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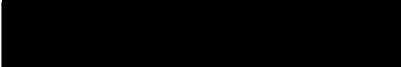
June 2007

Approved by:




Dr. Rosemary McCaslin, Faculty Supervisor
Social Work

6/4/07
Date



Ssgt Wright, USMC 3rd Battalion 7th
Marine Regiment, Remain Behind Element



Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

ABSTRACT

Many troops are being deployed to Iraq and Afghanistan to fight the War on Terrorism. As a result of the stressors of being deployed to a combat situation and the traumatic events encountered, many military personnel return from deployments and struggle with mental health disorders. Few, however, seek the help needed to cope.

Marines make up a large portion of troops being deployed to Iraq and Afghanistan and are faced with dangerous and often life threatening situations. As a result of the dangers they encounter many may develop mental health disorders such as Posttraumatic Stress Disorder; however very few seek treatment. This study focused on the perceptions of Marines toward mental health services. Marines were asked a series of questions to determine what services they knew were available to them, what barriers inhibit them from seeking services, and what would help Marines to feel more comfortable to seek mental health services.

The results found that there is a stigma attached to Marines seeking mental health services although the stigma is not openly acknowledged. It was also found that Marines fear there will be a breach in confidentiality

when services are provided by military officers.

Although, Marines did not openly admit to it there was also evidence that showed they did fear suffering job repercussions.

ACKNOWLEDGMENTS

To my husband Aaron Belt and neighbor Andrea Duke for their support in completion of this project. Also to Patty Schellbach, my wife for her understanding during the compilation of the research project.

DEDICATION

To all the Marine, Airmen, Sailors and Soldiers who
have dedicated their lives to protecting this great
nation.

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CHAPTER ONE

INTRODUCTION

There is recognition that serving in the military can have a detrimental effect on mental health (Perera, Suveendran, & Mariestella, 2004). Military personnel engage in combat operations where they can be exposed to many different traumatic experiences such as, missile attacks, bomb blasts, sniper attacks, and land mines (Perera et al., 2004, p. 396). These types of exposures can put them at risk of death, traumatic experiences, and becoming disabled (Perera et al., 2004). Active duty members of the military face a great deal of stress and the numbers of active duty military personnel that report high levels of anxiety is alarming (McNulty, 2005).

The post 9/11 world created a war on terrorism with base points in Iraq and Afghanistan. Since this war on terrorism, military personnel are deployed to combat situations for extended periods of time. For example, research suggested that, "aircraft carriers have deployed for an average of 7 to 10 months..." (McNulty, 2005, p. 530). After deployments combat veterans often return having experienced exposure to many different physical

and psychological trauma that have been documented from present conflicts to those dating back to the U.S. Civil War (Schneiderman, Lincoln, Helmer, Li, Copeland, Prisco, Wallin, Kang, & Natelson, 2006).

Deployed military personnel have reported being in close proximity of gun or missile fire, and others reported being exposed to nerve agents and other biological warfare chemicals (Schneiderman et al., 2006). Many military personnel reported witnessing death of other American military personnel, enemy forces, or even civilians, and responding to the consequences of chemical attacks (Schneiderman et al., 2006). These exposures could contribute to the development of a mental health disorder. Posttraumatic Stress Disorder is the most common diagnosis given to those who have participated in combat (Schneiderman et al., 2006).

Friedman (2004) wrote about Mr. K, a member of the National Guard, who received his first combat experience when he deployed to the Sunni Triangle in Iraq for twelve months. Mr. K was not evaluated at a psychiatric clinic until several months after his return from Iraq. Mr. K was exposed to many different traumatic events while deployed, including his platoon being heavily shelled and

ambushed, resulting in death or injury to his buddies. Mr. K encountered roadside bombs, and he was aware that he had killed many enemy combatants as well as possibly killing innocent bystanders. "Since returning home he has been anxious, irritable, and on edge most of the time" (Friedman, 2006, ¶ 1). Mr. K is one of the many military personnel that experienced the horrors of combat.

The War on Terrorism not only includes exposure to heinous events but also results in death of U.S. military personnel. "Between March 21, 2003, when the first military death was recorded in Iraq, and March 31, 2006, a total of 2321 deaths occurred to troops in Iraq" (Preston & Buzzell, 2006, The Death Rate of Military Personnel in Iraq ¶ 1). Research also suggested that the rate of death for Marines is more than double that of other branches such as the Army and Air Force.

The exposure to and stress of a combat situation as well as the fear of death would have to have a traumatic impact on military personnel. As a result of their combat experience many military personnel suffer from mental health disorders that need special attention. It is imperative that research be completed to look at the beliefs and attitudes of military personnel toward mental

health services to assure that mental health needs are met appropriately and effectively.

Problem Statement

Research suggested that many military returning from war or combat situations are exposed to traumatic events and as a result develop mental health disorders. Stress is commonly experienced by military personnel and their families (McNulty, 2005). Mental health disorders are often the most prevalent diagnosis for military personnel who have experienced combat (Schneiderman et al., 2006). Even though military personnel are exposed to such traumatic events they are well known for not seeking treatment to help with the psychological burden they carry (Greenburg, Thomas, Iversen, Unwin, Hull, & Wessely, 2003).

Research suggested that "...approximately 6% - 20% of active-duty military personnel meet the clinical criteria for a mental health disorder, with lifetime prevalence estimates of approximately 40%" (Lindstrom et al., 2006, p. 163). This is a significant number of military personnel exhibiting the symptoms of mental health disorders, and a portion of those with mental

health disorders can attribute the disorder to deployments to a combat zone (Lindstrom et al., 2006).

Purpose of the Study

The purpose of this study was to examine the beliefs and attitudes of United States Marines towards mental health services. Its goal was to understand what can be done to make mental health services more effective. The study focused on collecting qualitative data from the Marines stationed at Marine Corps Air Ground Combat Center. The participants were chosen by a strategic random sampling method. The study focused on one Marine Company which contained approximately 250 Marines. Fifteen participants were chosen randomly from this company and were asked to complete the interview process. Participants included any Marine who had been deployed at least one time to Iraq or Afghanistan and was willing to participate. There was no age specifications required in this study, as all Marines were at least eighteen years of age, and the study focused on any concerns about mental health seen by any age Marine. The following people were excluded from the study: any Marine unwilling

to participate, any Marine who had not been deployed, and any Marine related to the researchers.

Marines were chosen as the participants for this study as they make up a majority of the population currently being deployed to Iraq and Afghanistan (Friedman, 2004). Hoge et al. (2004) stated that military personnel do not appear to be seeking services for mental health issues, and this research was designed to uncover the reasoning behind services not being utilized.

The data were collected by an interview process. The interview consisted of fourteen questions in which the Marines were asked to think about the types of services that are available to them. Questions in the interview consisted of asking Marines if they were aware of counseling services, what they felt may be obstacles keeping them from seeking counseling services, and what would make them feel more comfortable seeking counseling services after their return from Iraq and Afghanistan.

This study helped the Marines recognize what services are available to them. It also allowed interventions to be formulated in order to minimize any obstacles they may encounter.

There were minimal concerns about the completion of this research study. Written permission was obtained from the company commander to interview Marines from the 3d Battalion, 7th Marine Regiment (India Company). The Marine Corps did not have a review board, and access was based solely on the willingness of the Marines. The Marines were asked to sign an informed consent agreement and were given the opportunity to ask any questions prior to completing the interview. A list was provided to allow for a strategic random sample to be obtained.

The interviews were conducted at the Catholic Chapel on the Marine Corps Air Ground Combat Center base during regular working hours.

Significance of the Project for Social Work

Combat veterans often face feelings of guilt and shame that may be a result of "... atrocities committed during combat, guilt about surviving combat when others did not, or they may be owing to pervasive problems since returning from combat (e.g., substance dependence, impact of one's anger on family, etc.)" (Gray et al., 2004, p. 327). These feelings can cause marked distress in military personnel and contribute to mental health

disorders. There has been little research of the mental health utilization among military personnel after deployment, and research such as this is imperative to assess the burden of current wars to ensure appropriate mental health services are provided (Hoge et al., 2006). Military personnel are more likely to seek medical treatment than psychiatric treatment (Lamberg, 2004), and understanding the personal implications of seeking mental health services may help to prompt changes to effectively serve the military population.

It is important to understand that "deployment-related stressors have also been shown to affect psychological and physical health both during and after return to the home station" (Adler & Dolan, 2006, p. 93). Mental health problems do not only occur while military personnel are in combat zones; in fact, 61% of military personnel diagnosed with a mental health disorder were not deployed to a combat zone at the time of onset (Perera et al., 2004). Other research suggested that the increase in mental health problems is not evident until three to four months after deployment and, of those diagnosed, more than 60% did not seek mental health treatment (Hoge et al., 2006).

As the war on terrorism continues many military personnel will be deployed and placed in dangerous combat situations. Approximately 700,000 troops were deployed in support of the Persian Gulf War (Schneiderman et al., 2006), and it could be assumed that those numbers would be approximate to the numbers that are deployed to Iraq and Afghanistan. With the high numbers of troops being deployed, and the stressors they endure that could cause mental health disorders it is imperative that their mental health needs be addressed as they return home.

It is important to understand the unique needs of military personnel in regards to mental health services in order to treat them effectively. Understanding their needs will allow the two-thirds who do wish to speak to someone about their experiences after their return (Greenburg et al., 2003) the opportunity to do so.

This research project contributed to social work on three different levels. At the micro level, "clinicians confronted by patients who have had a difficult reentry need to be aware of the complicated nature of readjustment" (Friedman, 2006, Acute Versus Chronic Conditions ¶ 3). This research project looked at the beliefs and attitudes of Marines and contributed to an

understanding of what changes are needed made to make mental health services more effective. Mental health services and social support can have a positive impact on the mental health of military personnel, but only if the support is viewed as positive by the military personnel (Greenburg et al., 2003). This research project will help social workers understand how to create a positive environment and foster a healthy therapeutic relationship with military personnel.

Research suggested that military personnel want to discuss their encounters while in a combat zone and once they return, and that discussing these encounters can in fact be therapeutic (Greenburg et al., 2003). This research project helped social workers understand the barriers military personnel face when seeking mental health services, and allow for change to be made so services may be provided effectively.

On the macro level, this research project helped social workers understand what types of services military personnel are likely to utilize. It is important to understand what types of services are deemed appropriate by military personnel, as "the prevalence of mental health problems related to stress and adjustment

indicates a need to develop field-based service resources to manage and support the affected persons..." (Perera et al., 2004, p. 398). This research project will allow social workers to foster change so the needs of military personnel are met appropriately.

"taking care of the psychological and physical needs of our active duty family members at home will ensure a less stressed service member who will be a better performer in the field. As more military men and women engage in lengthy deployments in support of Operation Iraqi Freedom, we must do all we can to limit their battles to those in the operational setting" (McNulty, 2005, p. 535).

At the policy level this research project fostered knowledge that would allow effective techniques to be created to screen for mental health disorders, and to create programs effective for the special military population. "Little of the existing research is useful in guiding policy with regard to how best to promote access to and the delivery of mental health care to members of the armed services" (Hoge et al., 2004, p. 14).

Last, this research project was significant because as social workers and clinicians have an obligation to

find ways to reach out to military personnel who have experienced trauma regardless of their coping abilities (Dikel et al., 2005).

CHAPTER TWO

LITERATURE REVIEW

The focus of this study was to look at the perceptions of mental health services among Marines. This literature review will focus on the following five domains: military environments, mental health services, absence of trust, and stigma.

Military Environments

When looking at the perceptions of Marines toward mental health services it is important to understand the stressful environment in which they are placed. This stressful environment can lead to the development of mental health disorders at higher rates than the civilian population. Understanding the causes of mental health disorders is imperative before avoidance factors can be addressed. In order to understand the high prevalence of mental health disorders it is important to understand the extreme stressors that military personnel endure as a result of their occupation.

The environment of the military workplace often encompasses many specific stressors that those in a civilian workplace do not encounter (Adler & Dolan,

2006). This could put them at a greater risk for stress related problems which can lead to the development of mental health disorders. One specific stressor military endure is that of deployment. "Combat veterans often return from deployment having experienced a wide range of physical and psychological exposures, symptoms, and medical conditions, (Schneiderman, Lincoln, Helmer, Li, Copeland, Prisco, Wallin, Kang, & Natelson, 2006, p. 577) which ultimately result in the development of mental health disorders.

Military personnel returning from Iraq and Afghanistan often report feeling helpless to change the potentially lethal situations they encounter. Military personnel are often engaged in combat situations where they witness friends being injured or killed. Many report having killed or injured enemy soldiers or possibly innocent civilians. Military personnel have reported being in uncontrollable and unpredictable situations such as being ambushed by enemy soldiers and encountering roadside bombs. They also must endure the aftermath of combat situations in which they are exposed to sounds, sights and smells of dying bodies and the bodies of U.S. allied soldiers, enemy soldiers, and civilians. Often

military must move the remains in an effort to clean up the destruction of combat (Friedman, 2006). The traumatic stressors military personnel endure can lead to the development of mental health disorders and the need for treatment. However, military personnel have a negative perception of mental health services which inhibits them from seeking the treatment they need.

Perera, Suveendran, and Mariestella (2004) stated that actively participating in war situations can lead to a higher prevalence of mental health disorders among military personnel. Perera et al., also state, "Physical and psychological trauma and the subjective experiences of threat to life in such circumstances adversely affect mental health, and often are manifested as unexplained physical complaints" (p. 396).

There are several diagnoses that are prevalent among military personnel. Those diagnoses caused by the stress of serving in the military include "depression and suicidal ideation, adjustment disorder, posttraumatic stress disorder (PTSD), alcohol and drug abuse, and personality difficulties" (Perera et al., 2004, p. 396). Military personnel may need to seek treatment for these issues to help them cope, (Litz & Maguen, 2006).

Posttraumatic Stress Disorder has been most researched and is the most prevalent diagnosis for those returning from combat situations (Friedman, 2004). A report completed by the U.S. Army Surgeon General stated that the top mental health concern affecting at least 10% of soldiers returning from Iraq and Afghanistan is posttraumatic stress disorder (2005b). Posttraumatic Stress Disorder was defined in the Diagnostic and Statistical Manual - III as manifesting symptoms including intrusive thoughts, nightmares, and recollection of the traumatic event, associated with hyperarousal, numbing, and estrangement (McFarlane, 2004). Military personnel who seek treatment after deployment has been reported as low as only 3.4% (McNulty, 2006). A study that focused on the 26,000 U.S. troops deployed to Kosovo and Bosnia for peacekeeping missions reported 13% of those military personnel needed help with Posttraumatic Stress Disorder that was deployment related (Litz & Maguen, 2006). Another study stated that 38% of military personnel diagnosed with a mental health disorder were diagnosed with Posttraumatic Stress Disorder (Schneiderman et al., 2006).

Hoge, Auchterlonie, and Miliken (2006) stated that approximately 19% of all soldiers and Marines returning from the war on terrorism met the criteria for a diagnosis of a mental health disorder. Hoge et al. (2006) compared this with 11.3% of military personnel meeting the criteria for a mental health disorder for previous Iraqi combat operations, and 8.5% for military deployed to other locations. This increase in military personnel developing mental health disorders creates a need to examine the effectiveness of mental health services provided.

The role of women in the military is also increasing, and as a result, the duties they perform are varying greatly. Women may have to work at establishing themselves in jobs which have traditionally been held by men which may put them at a higher risk for developing mental health disorders (Lindstrom, Smith, Wells, Wang, Smith, Reed, Goldfinger, & Ryan, 2006). The increase of women in the military and an increase of those women developing a mental health disorder creates a further urgency to take a look at the perceptions of mental health services among Marines in order to provide appropriate services.

Mental Health Services

As a result of the stressors caused by deployment to combat situations, military personnel develop mental health problems causing the need for mental health services (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). Perceptions of Marines toward the effectiveness of mental health services is important to look at to assure appropriate services are provided. In order to provide effective mental health services to military personnel it is important to understand what services are currently provided and how effective they are in the treatment of mental health disorders. The military provides some mental health services for personnel during and after deployments, but research suggested the effectiveness of these services is questionable. The ineffectiveness of services provided during deployment is only a precursor to the ineffectiveness of treatment once military personnel return home.

One such service provided by the military is the Combat Stress Control Unit. Combat stress control units have been used since 1990 and are comprised of a team of fifteen officers and thirty-three enlisted personnel

(Bacon & Staudenmeier, 2003). The purpose of the Combat Stress Control Unit is to deploy with the troops and provide mental health services while in combat situations (Bacon, et al., 2003). Research on the effectiveness of Combat Stress Control Units found that they often had equipment that was in ill repair, and a lack of knowledge of field and combat psychiatry (Bacon, et al., 2003). Combat Stress Control Units were often ill equipped to provide appropriate and effective mental health services, and members of the Combat Stress Control Units were often deployed with other units, leaving military personnel who had returned home without adequate mental health support (Bacon & Staudenmeier, 2003).

The most prevalent mental health service provided in past wars and that is still used today is the concept of Forward Psychiatry which was developed during World War I for the treatment of shell shock. Most treatment only lasted a short period of time (Jones & Wessely, 2003). Forward Psychiatry focuses on the principles of proximity to battle, immediacy, and expectation of recovery, which ultimately resulted in the acronym PIE (Jones & Wessely, 2003). There have been many claims to the effectiveness of PIE to treat mental health disorders resulting from

serving in combat situations, as well as, to prevent long-term psychiatric disorders. Therefore, PIE remains the most common practice approach (Jones & Wessely, 2003). It is then not surprising that during the Gulf War, with anticipation of a great deal of military personnel affected with mental health problems, PIE would become the primary form of mental health treatment (Jones & Wessely, 2003). The effectiveness of the PIE method, however, is questionable. "During World War II, military psychiatry was a profession under pressure. Aware of its low standing in the medical hierarchy, it needed to prove its worth to a high command that was apparently impressed by figures without inquiring too closely into their accuracy" (Jones & Wessely, 2003, p. 413).

The PIE method also incorporates psychological debriefing, which focuses on the needs of the military as an organization rather than the needs of the individual (Jones & Wessely, 2003). A study completed on the UK military peacekeepers suggested that psychological debriefings are not only ineffective but may prove to be harmful (Greenburg, Thomas, Iversen, Unwin, Hull, & Wessely, 2003). This suggested that outcomes of PIEs effectiveness could have been skewed in order to maintain

credibility. This lack of credible services could have been detrimental to the doctor's career (Jones & Wessely, 2003).

The focus of the PIE method is solely to return military personnel to duty, not to effectively treat the mental health disorder, (Jones & Wessely, 2003). Jones and Wessely, (2003) stated "opponents suggest that PIE treatment is simply an attempt by the military to *conserve the fighting strength*, which is the motto of the US Army Medical Corps" (p. 417). The conservation of this fighting strength only retraumatizes soldiers when they are at their most vulnerable point, and therefore creates a natural response to turn trauma into a chronic disorder (Jones & Wessely, 2003). Studies have shown that 43% of those who had a breakdown and were treated using the PIE method had a second breakdown (Jones & Wessely, 2003). Jones and Wessely, (2003) further stated that only 22% of troops were able to return to active duty, which was reduced to 15% after relapse.

When taking another look at the effectiveness of the PIE method there is a possibility that the reported outcomes tended to exaggerate the effectiveness, and it is necessary to look at whether it is needs of the

individual soldiers that are being met. If Marines perceive mental health services as being ineffective or harmful they are less likely to seek services for the mental health disorders that develop while in combat situations.

While military personnel are in combat situations, not only are the treatments ineffective that are provided, but the measures to assure the mental health well being of military personnel after they return are ineffective. After Vietnam and the exposure of many military personnel to the chemical Agent Orange and the health claims of military personnel returning from the Persian Gulf, a mandate that called for a mental health screening was put into effect in 1997 (Hartman, Wolfson, & Yevich, 2004). There is a great deal of controversy about the effectiveness of this screening and even its existence. Hartman, Wolfson, and Yevich also questioned whether or not this screening was intended to meet the needs of those that it is intended to serve and whether this screening questionnaire was effective in determining mental health concerns. There is only one question dedicated to concerns of mental health. The lack of attention to mental health shows the ineffectiveness of

this screening in treating mental health problems (Hartman et al., 2004).

Treatments for mental health problems for military personnel have commonly focused on the treatment of symptoms, focusing little attention on educating patients on how to maintain their coping abilities (Gray, Elhai, & Frueh, 2004). Along with the focus on treating symptoms, there have often been problems with the inadequate number of professional personnel treating mental health disorders (Holzberg, 1946). There have been concerns that because treatment for military is provided by military, the effectiveness of treatment may be hindered due to the effect that "uniforms could have on open communication and client empowerment..." (Cole, 2006, p. 28).

Other areas influencing the effectiveness of treatment are the multiple roles held by military psychologists. "Military psychologists and psychiatrists frequently face ethical quandaries involving boundary crossings, or extratherapy contact, and multiple relationships," (Johnson, Bacho, Heim, Ralph, 2006, p. 311). Military psychologists and psychiatrists are commissioned officers of the military and are bound to place the mission first (Johnson et al., 2006). This

could hinder the psychologists or psychiatrists from making the treatment of the individual their primary goal, therefore making treatment outcomes ineffective.

Veterans' Affairs is another organization that provides for the mental health needs of military personnel once they return from a combat zone. Studies have shown that physical health needs are easily met for veterans, but their psychiatric disorders may not be so easily met (Lee, Gabriel, & Bale, 2005). The U.S. Department of Veterans' Affairs medical center in Pennsylvania conducted a ninety day study of an inpatient program for the treatment of posttraumatic stress disorder that showed discouraging results (Lee et al., 2005). This study showed that there was a failure rate of 46% for patients with chronic posttraumatic stress disorder. Of those cases that were successful in treatment, few military personnel returned to their level of functioning prior to the combat experience (Lee et al., 2005).

The majority of services that are provided for military personnel when they return from combat situations are provided by mental health centers on the military base (Daley, 1999). Some of the services the

military mental health centers provide are treatment for substance abuse, outpatient therapy, screening and treatment, and consultation services (Daley, 1999). Ineffectiveness of these programs can be caused by lack of funding, focus on short-term and problem focused treatments, as well as the shift of mental health professionals to more administrative positions (Daley, 1999). Efficacy can also be adversely affected by the fact military mental health centers must first and foremost look out for the well being of the military as an organization and not the individual seeking treatment. Often military mental health centers are "seen as a body and fender shop where they are supposed to make soldiers over to return to duty or send them out" (Daley, 1999, p. 125). If military personnel view services as ineffective they are unlikely to seek services in their already vulnerable state.

There is a high prevalence of mental health disorders in veterans as a result of the exposure they received while in combat situations. "More effective methods must be developed to prevent, identify, and treat psychiatric illness, especially alcohol abuse and dependence and PTSD..." (Eisen, et al., 2004, p. 902).

Absence of Trust

Military personnel perceive they are unable to trust those providing mental health services. A sense of trust is crucial in creating an effective therapeutic relationship. It is imperative that a therapist and client create a mutual trust in order for therapy to be effective. An absence of trust can cause military personnel not to seek mental health services they need after returning from a combat situation. Military personnel have trouble believing that the use of mental health services can remain confidential (Friedman, 2004). The absence of trust can play a large role in military personnel not seeking needed services to cope with the mental health problems they endure as a result of exposure to traumatic incidents. The absence of trust can be caused by the lack of appropriate services provided to them. War veterans were seen to have been poorly served by mental health professionals" (McFarlane, 2004, p. 875). This poor service can result in an absence of trust for those being served by mental health professionals, and cause veterans to avoid the much needed services.

Greenburg et al. (2003) stated that there was a significant difference in the well being of military personnel that talked with friends and family as opposed to those that utilized mental health services. Greenburg et al. (2003) also described the successfulness of mental health treatment as being much lower for military personnel that spoke with mental health professionals. This lack of success can also discourage military personnel from establishing a trusting relationship.

This skepticism shows the absence of trust military personnel hold when it comes to seeking mental health services. Research suggested that barriers to seeking mental health care that soldiers reported were the lack of confidence in that care and fear of stigmatization (Litz & Maguen, 2006). This lack of confidence shows the absence of trust toward mental health professionals. Further research is imperative to help repair the relationship between military personnel and mental health professionals.

The military is described as "a hierarchical-based institution with immense organizational power over the individuals that work within its boundaries" (Cole, 2006, p. 30). Members of the military, including military

mental health professionals, are described as being "socialized, often in combative and covert ways, operating in reflexive ways to the custom and practice of the organizational power and structure" (Cole, 2006, p. 30). This would suggest that even military mental health professionals are subject to uphold the military mission (Johnson et al., 2006), rather than foster a healthy therapeutic relationship. This mission first training could create a lack of trust between the client and mental health professional.

Research showed that if military personnel share their experience in a combat zone, they are more likely to talk with spouses or friends rather than their chain of command or medical and welfare services (Greenburg et al., 2003). Litz and Maguen (2006) stated that military personnel who show greater symptoms and who do not seek treatment report they have a lack of confidence in the care they would receive. This showed a lack of trust in the effectiveness of mental health services provided for military personnel, and this lack of trust inhibits them from seeking services that may be much needed.

The multiple roles of military mental health professionals with the military individual client, and

the close knit community the military fosters, may also play a role in maintaining the perception of an absence of trust. There are often personal contacts between provider and client outside of the office (Cole, 2006). Military personnel do not develop a sense of trust with their military mental health professional as a result of these outside contacts.

Unintended Consequences

Fears that seeking mental health treatment may have an adverse affect on one's military career is not uncommon for military personnel (Friedman, 2004). Military personnel commonly stated that concern about the professional cost was a barrier to their seeking mental health services (Litz & Maguen, 2006). Military personnel returning from Iraq and Afghanistan and who showed the most severe symptoms reported they were unlikely to seek treatment for fear it would harm their careers (Friedman, 2004). The demanding positions Marines hold may lead to perceptions that seeking mental health services may result in losing their eligibility to maintain their position in the military service or at the very least may result in relocation to an administrative position.

Studies have shown that mental illness is the leading cause of discharge for military personnel. It is the leading cause for discharge for men and the second leading cause for women (Perera et al., 2004). Friedman (2004) also stated that Marines and soldiers may be able to acknowledge their mental health problems, but were not likely to seek treatment "for fear that a scarlet P could doom their careers" (§ 13). This is similar to the meaning of a scarlet A from literature. Although Friedman did not specify what the P stood for, it could represent a psychiatric discharge, or being labeled psychotic.

Cole (2006) described a case example of a Navy corpsman (Navy medical staff) who sought services for depression, and with little notice the psychologist and corpsman were deployed together for a three month period. The psychologist soon became part of the corpsman's direct chain of command. The corpsman continued to show a decline in performance and the psychologist was required to sign a formal performance counseling form. This resulted in the corpsman terminating services, and his ultimate discharge.

Research looking as far back as 1916 shows that British soldiers diagnosed with shell shock, later to

become known as posttraumatic stress disorder, and were evacuated were unlikely to return to combat units (Jones & Wessely, 2003). Other research showed that although military personnel were retained in the service after treatment, few went back to fighting units. Another study showed that only 30% of troops returned went back to active duty (Jones & Wessely, 2003). This affirmed that even though military personnel may be retained in the services their jobs may be at stake should they seek mental health services. This may be a risk that some military personnel are not willing to take and therefore avoid seeking mental health services. Perera et al. (2004) cited a study that found "...over 50% of those suffering from mental disorders being unfit for military duties" (p. 398).

Command members have also used psychiatric routes as a way to rid their units of military personnel they "regard as unsuitable for missions" (Jones & Wessely, 2003, p. 416). This inappropriate use of power only exacerbates the concern of military personnel being subject to unintended consequences, and therefore leads them not to seek treatment for mental health problems. Research suggested that 54% of military personnel who

screened positive for a mental health disorder, such as posttraumatic stress disorder reported, fears that their unit leadership would see and treat them differently if they were to seek mental health services (The U.S. Army Surgeon General, 2005a).

Stigma

Overlapping with the fears of unintended consequences is the stigma related to military personnel seeking mental health services. The stigma military personnel perceive is not without conviction. Research suggested that a fear of stigmatization limits the number of military personnel who seek treatment for mental health problems (Lindstrom et al., 2006). There is a great concern by military personnel about how they will be seen by peers for seeking help with mental health problems, especially by those military personnel that screen positive for mental health disorders. Veterans that were hospitalized during World War I for shell shock were seen as being inadequate and unstable (Dikel, Engdahl, & Eberly, 2005). Jones and Wessely (2003) talked about the Normandy Campaign where soldiers were viewed as "socially and emotionally immature" (p. 414). Jones and

Wessely, (2003) also discussed how the term "battle exhaustion" was adopted to imply that soldiers could recover from the trauma they endured in combat zones simply by having access to water, food, sleep and stool (p. 413).

The attitude that military personnel with mental health issues are unfit started many years ago and has continued throughout the war on terrorism. Soldiers returning from Iraq and Afghanistan did not seek mental health services, or sought only limited services, for fear of being seen as weak, (U.S. Army Surgeon General, 2005a).

Summary

The research showed that there is a great need to look at the perceptions of mental health services among Marines. The theories of the ineffectiveness of services provided, an absence of trust among those seeking treatment, unintended consequences that military personnel may encounter for seeking treatment and the stigma associated with seeking treatment, all contribute to military personnel not seeking the treatment they need to cope with mental health issues on their return from

combat. Research suggested that, given the ongoing combat operations in Iraq and Afghanistan, mental disorders will continue to be a concern (Hoge et al., 2004). Jones and Wessely, (2003) stated that despite all the efforts to treat mental health problems for military personnel deployed to combat zones, it is unlikely that the elimination of a combat stress reaction is possible. By asking Marines what their perceptions are toward mental health services, appropriate services can be developed to at least effectively treat the stress reactions that cannot be eliminated. The prevalence of stigma throughout the history of war and combat operations has inhibited military personnel from seeking the treatment they need to cope with their mental health disorders. Stigma associated with military personnel seeking mental health treatment must be addressed to allow for the healthy return into a civilized society (Hoge et al., 2004).

CHAPTER THREE

METHODS

Introduction

Chapter Three will cover study design, sampling, data collection and instruments, procedures, protection of human subjects, and data analysis. Fifteen Marines from Marine Corps Air Ground Combat Center in Twenty-nine Palms, California were selected. They were recruited based on combat experience in Iraq and Afghanistan. A list of Marines was obtained by the Company Commander. They were interviewed in a chapel facility during the winter quarter 2007.

Study Design

The purpose of the study was to look at the perceptions of mental health services among U.S. Marines. This study used a qualitative method due to interviews eliciting open ended responses, and the sample was limited to fifteen participants. The study allowed for an in-depth face to face evaluation and analysis. There was no standardized established instrument so questions were based on key themes found in the literature. The researchers hypothesized that participants will give

responses showing that utilizing mental health services will have stigma attached such as being seen as weak by their peers. These Marines may also be looked upon as being inadequate or unstable to peers and superiors alike.

It was also hypothesized that Marines when reporting the need for mental health services may believe that there are unintended consequences such as the participants may lose their eligibility to maintain a position in the military, or will be relocated to an administrative position instead. The participants may also feel that commanders or other superiors will use mental health as a way to rid themselves of military personnel they feel as unsuitable for missions as stated in the literature.

It was also hypothesized that Marines do not trust military psychiatrists. The Marines believe there will be a breach in confidentiality, since the therapist is also subject to military regulations.

Sampling

The sample was recruited from one Marine company of 250 Marines located at the Marine Corps Air Ground combat

Center (MCAGCC) in Twentynine Palms, CA. Fifteen Marines were randomly selected from the company. The participants were at least 18 years of age. Qualifications to be included in the sample are: The Marines must have been deployed for over 6 months to Iraq and Afghanistan to fight the War on Terrorism. Written approval was obtained from the company commander of 3d Battalion, 7th Marine Regiment. The location for the study was in the Catholic Base Chapel which required a reservation request.

Data Collection and Instruments

The interview questions were open-ended. The questions elicited information on the effectiveness of mental health services, the stigma attached to receiving mental health services, the absence of trust associated with mental health services, and unintended consequences that may result in the Marines not seeking mental health services. The data collected focused on the beliefs and attitudes of Marines toward mental health services with the hope of developing appropriate services for Marines. It was also hoped that this research study would prompt further research for the development of services in all branches of the military.

Prior to the interviews the researchers gave a debriefing explaining the rationale of the research and determined the qualifications of the Marines to be interviewed. The Marines also signed a consent form and a debriefing statement was given to them. The interview was stated informally and refreshments were offered to put the Marines at ease for the interview.

Marines were asked: Have you ever been deployed to Iraq and Afghanistan to fight the War on Terrorism? How many times have you been deployed? Were mental health services provided for you while you were in Iraq or Afghanistan? Did you talk to anyone such as family, friends, a counselor, Chaplain, or Commanding Officer in order to cope with the stress of being deployed? Was there any information about mental health covered in your debriefing? Did you feel any authoritative or peer pressures to be less than honest about your feelings in regards to your mental health? If so what were these pressures? How much encouragement was given to seek counseling (mental health) services? Have you utilized counseling (mental health) services? What kind of barriers/obstacles do you feel are keeping you/others from seeking counseling services? Have you experienced

any difficulties in your coping skills (dealing with anger, nightmares, and increased stress levels) since your return? What types of counseling (mental health) services do you feel would be helpful for military personnel returning from Iraq and Afghanistan? What would make you feel more comfortable to seek counseling (mental health) services? What would help lower the negative stigma around military seeking counseling (mental health) services?

Procedures

Questions were asked of the participants on a one-on-one basis. The researchers used an audio recording retrieval method along with note taking. The interview lasted no more than 30 minutes per participant. There was a neutral location for the interview to make the participants comfortable during the process. Comfort levels were monitored throughout the interview process.

Protection of Human Subjects

The participants were given a brief statement on the subject matter of the research project and an informed consent was signed by the participants before the interview began. Participants were notified their

participation was voluntary and they were eligible to leave at any time without penalty. Confidentiality was maintained by coding the data collected by each participant. The data collected was kept in a locked metal box with one of the researchers. All data collected was destroyed after the data analysis was complete. Participants were given access to generalized results of the research study upon completion. A list of counseling services was available should any distress have arose in the Marines. Gift certificates were provided after the completion of each interview to acknowledge the participants time and effort.

Data Analysis

The qualitative narrative streams were analyzed using evaluative software Atlas Ti. Narrative streams were analyzed for coding, thematic content and pattern analysis. Codebooks were developed so that data could be sorted and organized.

Summary

There is little known about the attitudes and beliefs of Marines toward mental health services. The focus of the data was on the beliefs and attitudes of

Marines toward mental health services with the hope of prompting future research for the development of services in all branches of the military.

CHAPTER FOUR

RESULTS

Introduction

This chapter will examine the results of the study. Demographic data will be examined first. A presentation of the issues named by marines will follow this. Then next, will be a review of any themes gleaned by the researchers from the data. The chapter will then conclude with a summary.

Presentation of the Findings

Fifteen US Marines were interviewed at the Catholic Chapel on the Marine Corps Air Ground Combat Center. The demographics were that eleven participants were Lance Corporals between the ages, 20-22. Eight were Caucasian, one was African-American, one was Hispanic and one native-American. Three participants were Caucasian Corporals, ages 20-22. One participant was a Caucasian Sergeant, aged 26.

Ranks held by military members signifies their time of service and their achievement during their military career. The rank of Lance Corporal is granted after finishing boot camp (basic training) and the military

occupational specialty course. The main specialty for a marine is rifleman. A marine can hold another specialty such as supply clerk or mechanic, but always takes pride as a rifleman. Corporal is the first rank towards non-commissioned officer, whose duty is more professional as a leader in their military occupational specialty. The Sergeant and subsequent ranks above have strong leadership skills and train their subordinates.

Question one asked, have you ever been deployed to Iraq and Afghanistan to fight the war on terrorism?

Question two asked, how many times have you been deployed?

All the participants had been deployed to Iraq or Afghanistan to fight the war on terrorism. Two participants had been deployed twice and were now going for a third time. Thirteen participants had been deployed once, now going for a second time.

Question three asked, were mental health services provided for you while you were in Iraq or Afghanistan?

Three participants stated there were no mental health services provided while in Iraq or Afghanistan. Six stated they were told a Chaplain was available if they needed to talk to someone. They also named command

members and a counselor as available. One said, for example:

"They offered us if we needed help or anything we could go talk to the chaplain but it was more on the way back when we were starting to get ready to come back. They said that the chaplain was available and the ways and signs of things and if you needed help with stuff. If you saw someone who was having problems to go and see what would help them out. I got evaluated by the medical officer to see if I had mental problems, but it was more of a screening. They just asked lots of questions."

Six responded with yes, but did not elaborate.

A theme from this question dealt with who was available for the marines on mental health services. The chaplain was seen as the trusted agent when seeking counseling services. The reason is that the chaplain usually accompanies the marines in field exercises and combat. The chaplain theme was predominant in most of the marines interviewed.

Question four asked if they had talked with anyone (counselor, friends, family, commanding officer,

chaplain) to cope with the stress of being deployed to fight the war on terrorism?

Four participants stated they had not talked with anyone about being deployed. Eleven stated they talked with family, close friends from home, and those deployed with them. One said, for example:

"Pretty much just talk to somebody one on one, you're not doing it as a big group, just you going and talk to one person by yourself."

A theme seen here was being with fellow marines one has deployed with. It was more comfortable for the marines to converse with those who shared the same trials and tribulations of combat. One said, for example:

"You talk with your friends who you're with while you're over there, that's pretty much who you talk too you don't really, you don't want to tell your family too much, but you tell them what you're allowed too tell them and then basically just talk with everybody that's there going through it with you".

Question five asked if there was any information about mental health covered in the debriefing?

One participant stated he was debriefed on ways to cope/deal with the stressors of returning from combat. Fourteen stated they were told that mental health services were available. One said, for example:

"They talked about not running from, not avoiding your feelings like to like face your feelings and if you have or if you are having a hard time I guess to seek attention from a counselor or a chaplain or someone like that."

Question six asked if there were any authoritative or peer pressures to be less than honest about their feelings in regards to mental health? If so what were the pressures? All fifteen stated they did not feel any authoritative pressures to be less than honest about their mental health needs.

Question seven asked, how much encouragement was given to seek counseling (mental health) services? Five stated the command did nothing to push mental health services. Ten stated it was encouraged but were told it was up to them to seek the services. One said, for example:

"I'd just say basically kind of what they've been doing just basically pushing the counseling, saying

basically nothing's going to happen to your Marine career, it's not going to hurt your career, basically just keep getting it out there, saying nothing is going to happen it's for your own good, basically just keep pushing it, pushing it, pushing it. Eventually marines will start to catch on, that it's ok to seek something, and it's not just you, you against the world. There's help out there, you just need to either ask someone or just seek it out yourself. I mean that's what your computer is for, just pull it up, something like that."

The theme presented here was encouragement of mental health services. Some felt the command was disinterested in pushing for these services. Others felt encouragement, but to do it on their own time. The chaplain was also an encourager for the marines to seek mental health services.

Question eight asked if they utilized counseling (mental health) services? Nine participants said there was no stigma or encouragement since they did not talk about their experiences. One said, for example:

"Not encouragement, just talk to someone if you have problems. Don't let it build up. Just talk to

somebody about it. Everyone there though pretty much has PTSD. Just talk man to man with someone about it."

Also: "Just the fact we're marines, we're supposed to be tough, we don't want to go pretty much we're just saying we're weak if we go an talk to someone about it because well that's our job that's what we're supposed to do."

One stated that he saw a psychiatrist.

The theme in this question dealt with stigma. Many of the marines feared for their jobs and did not want to be seen as a baby or weakling.

Question nine asked what kind of barriers/obstacles they felt were keeping them/others from seeking counseling services?

As to utilizing mental health services, one participant stated he is going back so he just has to deal with it. One said no one understands so he just has to deal with it. Five said they did not want to be seen as less than capable. Six were unsure of the barriers. Two mentioned training as it keeps them busy.

Question ten asked if they experienced any difficulties in coping skills (dealing with anger,

nightmares and increased stress levels) since their return?

Two participants stated they had less stress since returning because of the fast paced job while deployed. Seven stated they had difficulties with nightmares especially since they were preparing to deploy again soon. One said, for example:

"There has been like nightmares, a lot, just dealing with anxiety, but that was more when I first got back. But the nightmares have picked up more now that I am getting ready to go back. There is not a day that goes by that I don't think about it and certain situations that happened over there and so."

Three said they had no nightmares or problems. One stated he did not know and did not elaborate. One said no nightmares, just some anger:

"Anger wise, I have my outbursts. I don't think it's anything stress wise. That's about it. It was worse at first. I threw my x-box. Slowly got back to normal. I think its combat stress like they talked about before and after we got back. Said after 6-8 months you'd be normal."

One said he had no nightmares, but reported being itchy and that sounds affect him:

"No nightmares I just got itchy and started watching the doors, just like being there, back always up against the wall. Be wary of who comes in the door, stuff like that. But also sounds get to me."

The main themes presented here dealt with some nightmares, but predominantly anger. The nightmares were seen as they were preparing to go back to Iraq. The anger dealt with combat stress or being paranoid of sounds and awareness of the surroundings.

Question eleven asked what types of counseling (mental health) services they felt would be helpful for military personnel returning from Iraq and Afghanistan?

Seven participants stated more outreach and mandatory one on one session to initiate treatment would be helpful for those returning from Iraq or Afghanistan. One said, for example:

"But yeah something like that maybe but like it'd be kind of hard to get people to like go get marines to go to support groups cause maybe they've like say they wouldn't have time or they think they're too busy, maybe so I think this more outreach like you

said, like going to the barracks or maybe having a little meeting or whatever just to like let people know there are counselors and stuff like that."

Three stated having professionals that were closer to the same rank trained. Two participants were indecisive. One stated talking with a chaplain would help. Three stated talking with fellow Marines who were there would help.

The theme from this question mentioned outreach to initiate treatment and professionally trained civilians deployed with units. The marines also mentioned fellow marines with experience.

Question twelve asked what would make them more comfortable to seek counseling (mental health) services?

Four said one on one mandatory session to initiate services would be helpful to be more comfortable with mental health services. Seven stated they would talk to civilians, chaplains or anyone who has been over there. One said, for example:

"It goes back to I just don't like psychiatry. I don't really understand that whole thing with them. I don't like someone telling me how I feel. Also that group thing bugs me. I don't like crowds of

people to talk to. I don't like talking to lots of people, just a few of the guys."

Two stated they would not seek mental health services.

The theme presented here was being comfortable with mental health services being offered. The services would have to be mandatory for treatment options.

Question thirteen asked what would help lower the negative stigma around military seeking counseling (mental health) services?

Seven stated they feared confidentiality would not be kept in reference to negative stigmas on mental health services. One said, for example:

"Yeah more direct access you can just go in and talk to somebody and you don't have to let your chain of command know that's it. That would help. I think that a lot of marines know it should be confidential but you are still in the unit and it is just there, he is wearing the same uniform you are. I think that is kind of a mental thing for marines not being able to talk to someone."

Six stated there are briefs on it. One stated you would have to be with us:

"Well, I guess you would have to be with us to understand all this. Hard to talk with somebody that's never been there."

One stated his unit is pretty open, just be truthful and honest. He said, for example:

"I don't know. Doesn't seem negative. Our unit is pretty open, coping with stuff. Just be honest and truthful. Now if you're malingering we'll know. There's this one guy where his wife cheated on him and he had a complete mental breakdown. We're not going to blame him. It's not his fault. If you didn't see anything and start saying you're traumatized that's another matter. As long as you're being truthful and honest no one should have any troubles. That's the only thing I can think of."

The theme in this question dealt with confidentiality. There was a fear among some marines that confidentiality would be broken. Others felt that if one was truthful and honest then all would be well.

Summary

Chapter Four examined demographics, issues and themes as gleaned from the research. The data collected

from this population indicates a strong need for mental health services to be user friendly. The social worker needs to understand the unique needs of military personnel in regards to mental health services to treat them effectively. It is with the hope that future research will examine the beliefs and attitudes of mental health services for all branches of the armed services.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will focus on a discussion of the data analysis and review whether the data found support the researchers' hypothesis. This chapter will cover the limitations of the study and implications for the social work profession.

Discussion

Before conducting the study the researchers hypothesized that participants in the study would give responses showing that the utilization of mental health services would have a stigma attached such as being seen as weak or less than capable of performing their duties by peers or superior ranking Marines.

The data revealed that nine of the fifteen participants did not feel there was a stigma attached to seeking mental health services and the remaining six feared being seen as weak or crazy, or losing their job should they seek mental health services after their return. These results partially supports that Marines do

feel a stigma attached to seeking mental health services after returning from deployment to Iraq or Afghanistan.

It was interesting however, that although a majority of the Marines interviewed stated they did not feel a stigma attached to seeking mental health services, all fifteen participants stated they did not seek treatment even though they had experienced of symptoms of Posttraumatic Stress Disorder. The lack of Marines seeking treatment supports the hypothesis that there is a stigma attached. More research would be necessary to determine if changing the format of the interview questions would show the hidden stigma of Marines seeking mental health services.

It was also hypothesized that Marines would believe there were unintended consequences such as losing their eligibility to maintain their position in the military or being relocated to an administrative position.

It was found that all fifteen participants felt no authoritative pressures to be less than honest about their mental health needs. It was interesting however, that, when they were asked other questions, the Marines responded in such a way that would lead to the conclusion there were hidden pressures not to seek treatment from

the military command group. For example, one Marine stated that he is a Marine and Marines are supposed to be tough and that he would be weak if he spoke to someone about his experience in Iraq or Afghanistan. This is interesting in that the Marine eluded to the fact that if others saw him as weak he would be incapable of performing his duties as a Marine. Another Marine responded by stating he did not want seeking mental health services to interfere with his training. This lead the researchers to believe that if Marines sought mental health services their training would be placed on hold and without training the Marine is unable to perform his duties. These statements along with the Marines failing to seek mental health services support the hypothesis that if they seek mental health services they will be subject to unintended consequences.

The final hypothesis was that Marines have a lack of trust for military psychiatrists. It was hypothesized that Marines feared there would be breeches in confidentiality, since a military therapist would be subject to military rule and would be forced to uphold the military mission above all else.

The data supported this hypothesis as the Marines failed to seek treatment, expressed a fear of being screened by military medical professionals, and many stated they would feel more comfortable having civilian therapists provide one on one treatment for them after their return from Iraq or Afghanistan. Many Marines stated that although they would prefer to have a civilian therapist providing treatment they would also prefer for them to have been deployed. The Marines believed this would give the therapist a better understanding of the situations they endured while in combat situations.

The data did not directly support each hypothesis, however, after a complete analysis of the data it appears there is a negative stigma attached to seeking mental health services such as being seen as weak. It was also evident that Marines feared being subject to unintended consequences such as losing their job, and a breach of confidentiality by military therapist. Although the Marines did not directly speak about the stigma, unintended consequences, and breaches in confidentiality, it appears that each of the hypothesis is in fact true. More research will be needed to confirm these results.

Limitations

Limitations of this study include a small sample consisting primarily of lower ranking Marines. The sample consisted of Marines only and therefore this study could not be generalized to the entire military population. More research would be needed across branches of military service to have an accurate picture of the entire military population.

Another limitation of this study is that the sample consisted primarily of lower ranking Marines. It would be interesting to see the difference in responses when the sample consisted of enlisted Marines as well as Officers. This limited generalizability to the Marine population in that it can only be utilized for the lower ranking Marines. Officers may have given much different responses to the questions asked.

One final limitation to this study is that the Marines were preparing for another deployment, some for a second time and some for a third time. The study had to be conducted around the Marines' training schedule and preparation for deployment may have skewed the responses the Marines gave in regard to their mental health. Due to the upcoming deployment, Marines may have feared

acknowledging their mental health needs and honestly responding to the questions asked, would hinder their ability to deploy.

Recommendations for Social Work Practice, Policy and Research

The study was intended to prompt future research with the hopes that all military personnel may receive the mental health services they need when returning from any combat situation. More research is needed to identify barriers that prohibit all military personnel from seeking mental health services and what types of programs would be effective in providing successful treatment for those involved in dangerous combat situations.

This study helped the social work profession understand that there is a stigma attached to military seeking mental health services whether it is openly stated or hidden. It helped identify the barriers military members face when seeking mental health services. This study helped social workers to understand what types of services would be most effective when working with military personnel and will help to develop successful treatment styles such as mandatory one on one sessions and outreach programs.

Conclusions

Marines and other military personnel alike are facing more frequent and extended deployments and it is imperative that research be done to improve the mental health services being provided for them after their return. It is urgent that research be conducted to determine what programs will be effective in treating the soldiers and Marines that return from combat situations by lowering stigma, reducing fears of unintended consequences and increasing the trust military personnel have toward mental health professionals.

APPENDIX A
INTERVIEW QUESTIONS

Interview Questions

Have you ever been deployed to Iraq and Afghanistan to fight the War on Terrorism?

How many times have you been deployed?

Were mental health services provided for you while you were in Iraq or Afghanistan?

Did you talk to anyone {counselor, friends, family, Commanding Officer, Chaplin} to cope with the stress of being deployed to fight the War on Terrorism?

Was there any information about mental health covered in your debriefing?

Did you feel any authoritative or peer pressures to be less than honest about your feelings in regards to your mental health?

If so what were these pressures?

How much encouragement was given to seek counseling (mental health) services?

Have you utilized counseling (mental health) services?

What kind of barriers/obstacles do you feel are keeping you/others from seeking counseling services?

Have you experienced any difficulties in your coping skills (dealing with anger, nightmares, and increased stress levels) since your return?

What types of counseling (mental health) services do you feel would be helpful for military personnel returning from Iraq and Afghanistan?

What would make you feel more comfortable to seek counseling (mental health) services?

What would help lower the negative stigma around military seeking counseling (mental health) services?

APPENDIX B
INFORMED CONSENT

Informed Consent

The study in which you are being asked to participate is designed to investigate perceptions of mental health services among Marines. This study is being conducted by Leslie Marie Belt and Leslie Paul Schellbach under the supervision of Dr. McCaslin, Professor of California State University San Bernardino, Masters of Social Work Department. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to respond to several questions regarding perceptions to mental health services. The following questionnaire should take about 20 to 30 minutes to complete. All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion at June 15, 2007 at the following location California State University San Bernardino.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the questionnaire, you will receive a debriefing statement describing the study in more detail and, you will receive a MCX gift card. In order to ensure to validity of the study, we ask that you not discuss this study with other participants. As a result of your participation in this research project you will gain insight to your own mental health needs and knowledge of resources are available to you. This research project involves minimal risks and in the event of distress a referral will be given to you for the base psychiatrist.

If you have any questions or concerns about this study, please feel free to contact Dr. McCaslin at 909-537-5501

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here

Today's date: _____

APPENDIX C
DEBRIEFING STATEMENT

Debriefing Statement

This study you have just completed was designed to investigate the perceptions of mental health services among U.S. Marines. In this study several questions were asked to assess the perceptions of mental health services among U.S. Marines. Perceptions U.S. Marines have toward mental health services can affect whether treatment for mental health disorders is sought. The questions were intended to assess the perceptions U.S. Marines have toward mental health services in order to prompt more research to provide effective and less stigmatized mental health services.

Thank you for your participation and for not discussing the contents of the questions with other Marines. If you have any questions about the study, please feel free to contact Leslie Marie Belt, Leslie Paul Schellbach or Dr. McCaslin at California State University San Bernardino, Social Work Department at 909-537-5501. If you would like to obtain a copy of the group results of this study, please contact the Company Officer of India Company.

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

Assigned Leader: Leslie Belt

Assisted By: Leslie Schellbach

2. Data Entry and Analysis:

Team Effort: Leslie Belt & Leslie Schellbach

3. Writing Report and Presentation of Findings:

a. Introduction and Literature

Assigned Leader: Leslie Belt

Assisted By: Leslie Schellbach

b. Methods

Assigned Leader: Leslie Schellbach

Assisted By: Leslie Belt

c. Results

Team Effort: Leslie Belt & Leslie Schellbach

d. Discussion

Team Effort: Leslie Belt & Leslie Schellbach