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# The role of military leadership in servicemembers' perceptions of mental health treatment

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# ABSTRACT

The purpose of this mixed methods study was to examine how combat veterans of Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom believe unit leadership in the military addresses the topic of mental health wellness, and how this may influence their individual perceptions on the issue. The specific research question of the study was, "How do veterans perceive mental health wellness is addressed by unit leadership, and how does this affect their attitudes towards psychological treatment in the military?

A total of 107 servicemembers completed an online survey consisting of 13 Likert scale and four open-ended questions that were used to capture their experiences on the topic. Results found that while servicemembers' perceptions vary greatly as to how mental health is handled by unit leadership, up to 40-50% hold a negative view on the matter. This indicates that many servicemembers are receiving mixed messages about mental health, since the military, at an institutional level, has heightened its efforts in addressing issues related to mental health since the beginning of the Iraq and Afghanistan wars. Results of this study may help explain why, despite these efforts, many servicemembers do not seek mental health treatment and suicide rates in the military remain at an all-time high. These findings have serious implications on future research, social work practice, and military policy.

**THE ROLE OF MILITARY LEADERSHIP IN SERVICEMEMBERS'**

**PERCEPTIONS OF MENTAL HEALTH TREATMENT**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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# CHAPTER I

## Introduction

The United States military operations in Iraq and Afghanistan have put significant strain on military personnel, returning veterans, and families. According to the Bureau of Labor Statistics (2012), over 2.4 million United States servicemembers have deployed at least once since 2001, to one or both theatres of war. Many veterans of these wars are exposed to common combat related stressors that include multiple deployments, combat exposure, physical injuries, posttraumatic stress disorder, and traumatic brain injury. Especially during this time of war, the importance of military mental health cannot be underestimated. The Department of Defense Task Force on Mental Health (2007), for example, found that 38% of Soldiers, 31% of Marines, and 49% of National Guard members report psychological symptoms post-deployment.

These high percentages indicate that it is of extreme importance that mental health treatment be made readily available in an appropriate fashion to all United States military personnel. This is an urgent matter, one of life and death. While less than one percent of Americans are veterans of the Iraq and Afghanistan wars, former servicemembers represent 20 percent of suicides in the United States (Department of Defense, 2011). The Department of Veterans Affairs (2011) highlights this epidemic by reporting that approximately 18 veterans commit suicide each day. This averages out to a veteran taking his or her own life every 80 minutes.

While mental health help is available to servicemembers, multiple studies have shown that many who are in need of assistance avoid seeking care because of their perceptions of psychiatric care in the military and its treatment (Dickstein, Vogt, Handa, & Litz, 2010; Drapalski, Milford, Goldberg, Brown, & Dixon, 2008; Gorman, Blow, Ames, & Reed, 2011; Hoge et al., 2004; Kim, Britt, Klocko, Riviere, & Adler, 2011; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Rae Olmsted et al., 2011). It is quite evident that there is great need for more in-depth research regarding servicemembers' views of mental health and its treatment in the United States military. A more extensive look at the barriers preventing servicemembers from seeking psychological care is necessary.

Data from previous studies have indicated that many servicemembers believe their leadership looks negatively upon those who seek psychological services (Gorman et al., 2011; Hoge et al., 2004; Kim et al., 2010; Kim et al., 2011) indicating there is stigma attached to receiving mental health services. This is problematic, considering evidence exists showing that symptoms of PTSD become more chronic in nature and become more difficult to treat the longer they go unaddressed (Schnurr, Lunney, Sengupta, &Waelde, 2003). The early treatment and identification of mental health symptoms within the military is vital. The purpose of this study is to specifically hone in on how unit leadership may actually be preventing servicemembers from accessing this treatment. The study will provide information as to how servicemembers believe mental health wellness is addressed by unit leadership and explain whether or not they believe this issue is a priority and one that is promoted by those in charge.

As a veteran of the Iraq war, the researcher can recall negative attitudes towards servicemembers who sought professional mental health in the unit he served, feeling as though much of this had to do with the words and actions of the non-commissioned officers who were

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among unit leadership. After a string of suicides occurred on the researcher's base in Iraq, a high-ranking sergeant addressed the matter by shouting at his troops. This sergeant did not encourage them to seek available psychological help on base if needed, and instead referred to the deceased soldiers as "weak" and "selfish" while dismissing the cause and the possibility of mental illness altogether. Unfortunately, this way of military being is not isolated and is still common in military culture despite policy efforts to promote mental health wellness.

With hundreds of thousands of our nation's troops recently having deployed in various warzones, sometimes multiple times, the psychological well being of soldiers is of extreme importance and research needs to be carried out to identify what may be prohibiting soldiers from seeking the critical treatment they may need. It is important for soldiers to feel as though they are supported by the military and its leadership in seeking help, if necessary. Of the literature that exists on military mental health stigma, the majority of it focuses on identifying the wide range of general reasons soldiers have negative attitudes towards psychological treatment.

In this study, an online survey was used to explore how the attitude of unit leadership towards mental health may contribute to the perceptions soldiers have towards treatment. The attitude of unit leadership towards mental health is extremely important for the well being of soldiers. According to a study completed by Kim, Britt, Klocko, Riviere and Adler (2011) in which 10,386 deployed Army soldiers were surveyed, it was found that the most common perceived barrier that kept those from seeking mental health help was the fear they would be treated differently by unit leadership and would be seen as weak. It is important to evaluate how soldiers perceive messages about psychiatric care from their leadership and whether or not the military is practicing what is it preaches in regards to promoting mental health wellness and

reducing its stigma. A more in-depth view is necessary to look at how military leadership may influence soldiers' perceptions of mental health and its treatment.

This thesis is based on a mixed-method research design in which an on-line survey was conducted during the spring of 2012 to capture servicemembers perceptions of leadership's handling of mental health treatment. The thesis is divided into five chapters. The following chapter provides a review of the literature on previous research related to mental health stigma in the military and provides justification for the study and research design. The third chapter details the study's design and the methodological processes carried out. This includes a description of how the survey instrument, which 107 servicemembers completed over the span of a month, was designed. Chapter four presents the study's findings. The demographics of respondents are presented along with descriptive and inferential statistical analysis of the quantitative portion of the survey. Thematic analysis of the open-ended, qualitative section of the survey is also presented in this chapter and connections between the qualitative and quantitative findings are highlighted. The final chapter explores the study's implications for further social work research, clinical practice with servicemembers, and military policy relating to mental health services and treatment.

CHAPTER II

**Literature Review**

The following literature review outlines previous research related to mental health stigma and the role it has played in the United States military throughout its history. The first section presents the concept of stigma and includes the key term's definition. This section discusses how stigma is connected with mental health treatment by viewing the association from a framework rooted in labeling theory. This section also addresses why many individuals consider stigma related to mental health illness to be a barrier in seeking psychological treatment.

The second section focuses on the historic stigmatization of mental health in the military. This section explains how society's stigmatization of mental health treatment has been and continues to be exasperated and magnified by the military culture. This is highlighted through a summary of military culture and history. The literature review's third section spotlights how mental health stigma impacts today's military and the way the issue is currently being addressed by the armed forces. In the final section of the literature review, a synopsis of recent research carried out on mental health among servicemembers is presented.

**Stigma, Labeling Theory, and their Connection to Mental Health**

Illegitimacy, shame, disgrace, and dishonor are terms that share the same meaning as the word stigma according to the Oxford American Thesaurus of Current English (Stigma, 2011b). The Oxford English Dictionary defines stigma as "a mark of disgrace or infamy" (Stigma,

2011c).  Stigma is a label of unwanted association.  In fact, the term stems from the Latin word "stizein" that referred to a tattoo or brand placed on ancient Greek criminals to mark their status of inferiority and identify them in case of escape (Stigma, 2011a).

Erving Goffman, a noted sociologist who spent much of his career teaching at the University of Pennsylvania, was influential in developing the modern definition of stigma.  It was Goffman's work that truly impacted the current use of the concept in the social sciences and its relationship to mental illness.  In his book, *Stigma: Notes on the Management of Spoiled Identity,* Goffman (1963) described those with stigmatized conditions as "deeply discredited in society".

Goffman (1963) saw stigma as a personal characteristic that society viewed negatively and differentiated between three types:  flawed individual character, physical deformity, and membership in an objectionable social group.  He categorized mental illness as the first, stigma associated with "flawed individual character," and considered this type to be one of the most discrediting and socially damaging of all.  In a later work, Goffman (1968) was very critical of the way individuals with mental health issues were treated in psychiatric hospitals.  He felt as though treatment was performed in a stigmatizing way through the nature of psychiatric care.

One way of exploring the link between stigma and mental health illness is by applying labeling theory, which was developed by sociologists in the 1960's, stemming from Goffman's work.  Sociologist Howard Saul Becker (1963) was a key influence in the development of this theory and its rise in popularity in the writing of his book *Outsiders*, which focuses on the belief that when a minority deviates from cultural norms, the majority often labels those in this

subgroup as outsiders and in a negative light.  Those with mental illness, whose behaviors may deviate from cultural norms, are thus vulnerable to marginalization and labeling.

In his work, Becker (1963) describes that the functioning and organization of any society or group depends on social roles, which are constructed sets of formal and informal agreed-upon expectations it has about behaviors.  Becker explains that while an infraction among these agreed-upon rules is considered deviant behavior, this deviance is only the product of norms that are socially constructed.  According to Becker, deviance is not directly related to pathology or associated with any specific type of carried out behavior.  In other words, he felt as though the quality of a deviant act should never be assumed.  Rather, "deviant" should be considered a defined label to describe a social behavior that is only the result of others applying societal rules.

Labeling theory also highlights the social and psychological impact of labels including perceived discrimination, negative self-concept, and poor quality of life.  In 1966, a sociology professor by the name of Thomas J. Scheff (1966) published a book entitled, *Being Mentally Ill*, in which labeling theory was for the first time applied to the term mentally ill.   The basis for this application of labeling theory was the assumption that society generally has negative, cultural stereotypes of those with mental illness.  Because those with psychiatric issues are considered "deviant", Scheff (1966) believed individuals who seek treatment for issues related to mental health face stigmatization that results in rejection and punishment from others when they attempt to return to conventional roles.  This theory may explain why many individuals facing psychological issues choose not to seek mental health treatment and instead hide or minimize their symptoms in an effort to avoid being labeled.  Those who make this choice may very well feel as though the benefits of treatment are not worth the stigma that goes hand-in-hand with becoming a mental health patient.

Research scientist Bruce Link (1989) and colleagues utilized labeling theory as a model and developed a more specific framework for mental illness. Link's modified labeling theory of mental illness examines how stigma affects those with psychological issues. His model reiterates the idea that when individuals are diagnosed with mental illness or simply seek treatment for psychological issues, preconceived thoughts associated with mental illness take on personal meaning and become attached to them. Diagnosed individuals internalize a view of themselves as mentally ill or psychiatric patients. This induces negative feelings of the self, which are related to the idea that those treated for mental illness have already developed conceptions of what others think about those with psychiatric issues long before they become patients themselves (Link & Phelan, 1999a).

For example, a common societal stereotype describes those with mental illness as dangerous and unpredictable. According to Link and Phelan (1999a), such beliefs are amplified and take on a whole new personal level of meaning when diagnostic labels are applied to an individual. It is very common for an individual with mental illness to fearfully anticipate how others are going to react to them based on their diagnosis or label as a psychiatric patient. The mark that goes along with seeking treatment from a mental health professional can be as distressing to an individual as the diagnostic label of psychiatric illness itself (Link & Phelan, 1999a).

This application of labeling theory suggests that seeking psychiatric treatment can possibly add an additional source of stress to the mentally ill and can further impair the way individuals with mental illness cope with and confront the world. Link and Phelan (1999b) propose that many mentally ill individuals suffer as much, if not more from the status of being labeled as they do the mental illness itself. The label can cause strain in their relationships,

feelings of rejection, withdrawing behaviors, and an overall impairment to their ability to function.  The modified labeling theory of mental illness suggests that those with psychiatric issues are harmed by these labels even when there are no direct negative reactions from others (Link & Phelan, 1999b).

Various other studies demonstrate the consequences of placing individuals in the cultural category of mentally ill.   These studies demonstrate that the mental health label damages an individual's material, social, and psychological makeup and leads to feelings of demoralization. As a result, individuals with mental illness often utilize unhealthy defensive behaviors to protect themselves from the feeling of rejection by isolating and withdrawing from social interaction (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989).

Recent literature on stigma is closely related to previous works on labeling theory and is relevant to how mental health and its treatment is viewed in the military. Watson, Corrigan, Larsen, and Sells (2007) note the differences between public stigma and self-stigma related to individuals with mental illness.   These researchers believe that the nature of society creates marked categories of persons, which are negative, erroneous, and devalued.  Stigma is considered to be a prejudice or a negative stereotype. Public stigma is the reaction of the general public toward people with mental illness, whereas self-stigma is the internalization of how the general public portrays people with mental illness and the belief in that portrayal. While the definitions are different, both pertain to mental health stigma in the military.  Public and self-stigma are mutually composed of stereotypes, prejudice, and discrimination, which can influence an individual servicemember's decision to seek mental health treatment (Watson et al., 2007).

**The History of Mental Health Treatment and Stigma in the Military**

The stigma associated with mental illness in the military and the fact that many servicemembers avoid seeking care for psychological conditions is not a new phenomenon. While mental health stigma exists among all populations of society, servicemembers have been particularly susceptible to stigma because of the culture in which they exist. For example, the wartime experience of combat servicemembers makes them much more likely than civilians to develop posttraumatic stress disorder (PTSD) or other stress-related disorders (Nash, Silva, & Litz, 2009). In addition, the importance the military places on group loyalty and individual heroism makes it a culture of "machoism." This is the mentality of most militaries across the world and has influenced the way servicemembers have viewed mental illness within them.

Before World War I, there was a period of time when combat stress casualties were viewed from a less-stigmatized, medical standpoint. For example, those who were unable to adapt to the battlefield during the Civil War were medically diagnosed with labels such as "soldiers' heart," "irritable heart," or "sunstroke" and given what was deemed appropriate treatment at the time (Dean, 1997). In fact, descriptions of PTSD-like symptoms of soldiers date back to ancient literature, which includes Homer's *Iliad* and *Odyssey*, both set during the Trojan War. The ancient Greek tragedian Sophocles tells the story of another Trojan War soldier who takes his own life after committing brutal acts in a dissociative flashback to combat. During these ancient times, these acts were attributed to direct interventions by gods, rather than the symptoms of mental injury or illness (Shay, 1994).

Even during the early years of World War I, "shell shock", or what is known today as PTSD, was not viewed as a mental weakness, but instead attributed entirely to the physical injury

of the brain caused by a soldier's proximity to an explosion (Nash et al., 2009).   These

casualties were generally viewed by society as legitimate and deserving medical treatment and

monetary compensation for disability.  Labels associated with these types of combat injuries

were not stigmatizing because they were viewed as resulting from the trauma of war, rather than

caused by negative personal traits.  However, when these types of casualties were depleting the

treasuries and manpower across the world, attitudes towards those experiencing the effects of

military stress seemed to shift (Lerner, 2003).

To address this crisis, the German Association for Psychiatry convened a special War

Congress in 1916 to determine that stress casualties were not the result of a physical injury, but

rather a pre-existing, individual weakness triggered by a traumatic event.  The War Congress

branded this condition "hysteria", a label that carried with it a sense of shame and at the same

time relieved the government of being responsible for making disability payments (Nash et al.,

2009).  This word was intentionally chosen for its feminizing and stigmatizing properties so that

soldiers would be discouraged from claiming negative symptoms as a result of traumatic

experience (Nash et al., 2009).  This shift in the view of combat stress accomplished its goal as

the rate of wartime psychological casualties over time drastically declined.  The rate in WWII,

for example, was approximately 10% compared to barely 1.2% during the Vietnam War (Nash et

al., 2009).

However, this did not come without cost.  It is well documented that many veterans of the

Vietnam War faced an enormous mental health burden during and after the war, but failed to

seek treatment due to the demedicalized model of combat stress (Nash et al., 2009).  The few

veterans that did seek treatment were generally viewed by the mental health profession as having

neurosis or psychosis unrelated to combat and often diagnosed with illnesses such as

schizophrenia, depression, and alcoholism (Scott, 1990). Mental health professionals made these diagnoses utilizing diagnostic nomenclature that did not acknowledge combat trauma (Scott, 1990). At the time, there was not even protocol for psychiatrists at Veterans Affairs Medical Centers to collect military histories of mental health patients (Scott, 1990). The nature of war was minimized and the focus of treatment was what veterans considered to be personal weakness.

For some in the in the mental health profession, the demedicalized model was very problematic. A number of clinicians felt as though war neurosis needed to be officially recognized for the appropriate diagnosis and treatment of disturbed veterans to take place. This led to the formation of a grassroots movement made up of psychiatrists and veterans, who organized to raise awareness about the mental health challenges and stress-related symptoms many veterans face in the readjustment process due to traumatic events experienced in combat.

Heading this effort were Robert Jay Lifton and Chaim Shatan, both former military psychiatrists who served in the Korean and Vietnam Wars respectively, and worked tirelessly to get PTSD recognized by the Diagnostic and Statistical Manual for Mental Disorders (DSM). Lifton was also a leading scholar of the Holocaust and linked similarities between posttraumatic symptoms experienced by survivors of concentration camps to those experienced by combat veterans (Scott, 1990). Lifton and Shatan were among many psychiatrists who viewed the stress-related symptoms Vietnam veterans faced to be brain-based and normal responses to the abnormal situations of combat. Through the input of numerous focus groups and a research-backed task force that also analyzed the psychological impact of non-combat trauma, Lifton and Shatan gained an increasing amount of public support in their efforts (Scott, 1990).

Social movements during the 1970's unrelated to the war also played a role in bringing public awareness about the psychological impact of traumatic events. For example, the women's movement raised knowledge about the emotional toll of sexual and physical trauma, and the societal impact this was having on a greater level (Friedman, Keane & Resick, 2007). Finally in 1980, the American Psychiatric Association published the DSM-III and outlined the new diagnosis of PTSD which described the symptoms of combat (and non-combat trauma) stress in a normalizing manner (Nash et al., 2009). This was a major development for those treating PTSD and especially for the patients they cared for.

Three years later, the National Vietnam Veterans' Readjustment Study (NVVRS) was carried out as part of a congressional mandate to investigate the prevalence of PTSD among Vietnam veterans (Kulka et. al, 1990). Data from the NVVRS is still often used by researchers as its sample is arguably the most representative group of Vietnam veterans studied to date (Kulka et. al, 1990). The study estimated lifetime prevalence of PTSD among 30.9% of male and 22.5% of female Vietnam veterans, rates that are significantly and substantially higher than the rates for Vietnam era non-veterans (Schlenger, Kulka, Fairbank, & Hough, 1992).

**Today's Military Culture and its Approach to Mental Health Wellness**

Today, recruits of the United States Armed Forces receive the message that mental health illness is unacceptable in the military right from the start of their enlistment or induction process. Potential recruits soon learn through pre-screening questionnaires completed at the recruiter's office that history of mental health illness and treatment generally bars an individual from joining the military. Thus, through this policy, the military communicates that mental illness is incompatible with being a soldier.

All branches of the Armed Forces adopt the Department of the Army's *Standards of Medical Fitness* (2011b) in determining whether or not recruits are physically and mentally fit for military duty. This regulation outlines physical and mental health standards that must be met for enlistment, appointment, and induction into the military. A section of this regulation is dedicated to describing multiple psychiatric and behavioral disorders that disqualify a recruit from joining the armed forces.

Mental health screening tools used by the military include review of educational achievement, cognitive testing, and a standard psychiatric evaluation (Cardona & Ritchie, 2007). The latter screens recruits for current or history of disqualifying mental illnesses outlined in the regulation which include, but are not limited to psychotic disorders, mood disorders to include major depression and bipolar, adjustment disorders, personality disorders, and anxiety disorders (Department of the Army, 2011b).

Servicemembers who are diagnosed with a non-preexisting mental health disorder while actively serving in the military are not automatically disqualified from continuing their duty. While active servicemembers are technically held to the same physical and mental fitness standards mentioned above, the military is generally not as rigid when it comes to retaining versus discharging servicemembers based on medical conditions. A servicemember with a mental disorder, or any medical issue for that matter, is discharged only when a medical evaluation board of active duty physicians deems that he or she is unable to perform military duties because of the condition. The medical evaluation board process is often initiated when a commander believes a member of the unit is unable to perform assigned military duties and refers the servicemember to a medical treatment facility (Department of the Army, 2011a).

However, statistics gathered on military medical discharges illustrate a vast discrepancy between the number of servicemembers released for mental health reasons and those discharged for other medical issues.  For example, Hoge et. al (2002) found that servicemembers hospitalized for a mental disorder were more than four times as likely to be separated from the military within six months compared to those hospitalized for other medical conditions.  Nearly 50% of servicemembers hospitalized for a mental health reason were subsequently discharged within this time frame compared to only 12% of those hospitalized for other medical conditions.

According to the Army, the number of soldiers discharged solely because of a mental disorder increased 64 percent from 2005 to 2009.   Over 1,200 Army soldiers received a medical discharge due to mental illness in 2005 compared to 745 four years earlier (Zoroya, 2010).  The increase in number of mental health discharges was even more drastic when considering soldiers who were separated for a combination of psychiatric and physical health reasons.  In 2009, over 3,800 soldiers among this category were discharged compared to 1,397 in 2005.  This marked a 174 percent increase (Zoroya, 2010).

For the 1.4 million servicemembers who currently serve in the active component military, issues related to mental health disorders are the leading cause of hospitalization among men.  For women, they are the second leading cause of hospitalization, following issues related to pregnancy (Armed Forces Health Surveillance Center, 2010).  Each year, approximately six percent of servicemembers are treated at least once for an issue related to a mental health diagnosis (Wilson, Messer & Hoge, 2009).  This statistic does not take into account the vast number of undiagnosed servicemembers who suffer from mental health issues, yet avoid treatment altogether for a variety of reasons.  The figure in and of itself, however, demonstrates

the importance of continuously evaluating how mental health treatment is approached in the military.

Despite the fact that current views on combat stress and PTSD do not blame the individual, it still appears that there are barriers to mental health treatment in the military based on recent statistics regarding suicides among servicemembers. One does not have to look farther than the current military suicide epidemic to recognize the need for critical analysis of the way mental health treatment is provided and also perceived in the service. The suicide rate among active duty military personnel has increased annually for the past six years and for the first time since the Vietnam War, the rate is higher than that of the civilian population. Army officials now calculate 22 military suicides for 100,000 soldiers (Classen & Knox, 2011).

The most recent statistics indicate that this trend is not slowing down. According to the Department of Defense (2012a), the Army reported 27 potential suicides among the branch's actively serving soldiers for the month of April. A total of 95 potential suicides have been reported in 2012 (January-April). Two hundred eighty-two Army soldiers were confirmed to have taken their own lives in 2011. Suicide is currently the second leading cause of death in both the Marine Corps, and also among young, enlisted men in the Army. It is also consistently among the top three causes of death in the Navy (Classen & Knox, 2011).

In response to this epidemic, the military, as an institution, has increasingly heightened its effort in reducing mental health stigma and educating servicemembers about the possible psychological effects of combat. On the macro level, for example, the military has consulted with the American Psychiatric Association (2012) in its ongoing development of the next version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and has recommended

deleting a current criterion for PTSD in the existing DSM which requires a person's response to a traumatic event to involve fear, helplessness, and horror (Abramson, 2012). For a servicemember, these are obviously stigmatizing adjectives when it comes to describing one's response to a combat situation that may prevent a servicemember from seeking help.

Over the past few years, military-wide efforts backed by the Department of Defense have surfaced to combat this stigma related to mental health treatment. The Real Warrior Campaign is one of these initiatives. Launched in May of 2009, the goal of this program is to "promote help-seeking behavior among servicemembers and veterans with invisible wounds and encourage them to increase their awareness and use of resources" (Real Warriors Campaign, 2011). According to the campaign, this is done through outreach and partnerships, print materials, media outreach, an interactive website, and social media.

In addition, policy has been implemented that mandates training programs to educate servicemembers about PTSD before, during, and after deployment. For example, Resilience Training (formerly known as Battlemind Training) was developed by the Walter Reed Army Institute of Research (WRAIR) and was mandated in 2007 by the Department of Defense as a required piece of the deployment training cycle (Adler, Castro, & McGurk, 2009). This education takes place in standard, classroom format as part of the mobilization and demobilization process. Servicemembers are presented with computer slides and video clips, which instruct them to look for signs of mental illness and urge them to seek help during a deployment, if necessary. Servicemembers are also reminded of mental health resources that are available to assist in times of need such as leadership, chaplain services, and combat stress clinics, if available on post.

Resiliency training teaches servicemembers that "inner strength" is needed to get through the adverse situations experienced in war. However, a common critique of this training is that as a result, servicemembers generally imply that a lack of this resilience is the result of mental deficit or weakness (Nash et al., 2009). Because the military culture is dominated by stereotypical masculinity, seeking mental health treatment has historically been viewed as the opposite as being "mentally tough". According to Tanielian and Jacox (2008), the military promotes mental toughness and as a cultural norm, servicemembers are expected to master stress without difficulty. They are expected to rely on inner strength and self-reliance in order to shake off injury and illness. While society's civilian population places stigma on mental health, it is evident that military culture heightens this view among servicemembers.

As far as mental health screening measures, the Army launched a program known as Comprehensive Soldier Fitness (CSF) in 2009, which is strategy that aims to assist soldiers to thrive at a cognitive and behavioral level while serving during a time of war. CSF is a skill-training program that focuses on the physical, emotional, social, family, and spiritual components of a soldier's life. As part of this training, it is mandatory for soldiers to annually complete a Global Assessment Tool, which is an online, 15 minute questionnaire that assesses an individual's strength in these five areas. Confidential results from the 105 question survey are generated, which are used for self-awareness purposes only. Soldiers can use these results to assess their mental health well-being. CSF makes available optional training, to include online modules that focus on the five life dimensions mentioned (United States Army, 2012b).

Since March 2005, the Department of Defense has mandated mobilizing servicemembers to complete pre- and post-deployment health assessment screenings, which place specific emphasis on mental health concerns (Deployment Health Clinical Center, 2012a). These

screenings are at the core of the military's effort to assess mental health wellness among its servicemembers. The Post-Deployment Health Assessment (PDHA) is completed by servicemembers within a month of leaving their theater of operation and assesses servicemembers for physical and behavioral health concerns associated with deployment. Servicemembers complete the Post-Deployment Health Reassessment (PDHRA), an instrument that measures for the same issues a second time, within a window of 90 to 180 days after a servicemember has returned home from combat (DHCC, 2012b). These screenings are then reviewed by health care providers who meet with the servicemembers confidentially to discuss results of the self-assessments.

Outside of these efforts, however, there is no standardized approach to addressing mental health treatment within actual combat units. While some units may support and follow the messages outlined in the efforts described above, it is also possible that the implicit and explicit messages servicemembers receive from their units and direct leadership may contradict these efforts. This means that servicemembers are receiving varying messages, some of which may reinforce the stigma of mental health treatment in the military.

This was highlighted in the Department of Defense (DoD) Task Force on Mental Health report to the Secretary of Defense. In 2007, the task force was assigned the job of providing an assessment of, and recommendations for improving the efficacy of mental health services provided to servicemembers. The task force concluded that, "Leaders are insufficiently trained in matters related to psychological health and need to be knowledgeable about building resiliency, recognizing and responding appropriately to distress and illness, and collaborating with helping agencies to support servicemembers" (DoD Task Force on Mental Health, 2007, p.19). The task force recommended for military leadership of all levels and branches to receive

mandated training on psychological health through the development and implementation of a DoD-wide curriculum. However, this curriculum has not been developed or implemented by the military to date.

Leadership training resources, such as the Department of the Army's *Combat and Operational Stress Control Manual for Leaders and Soldiers* (2009) are certainly made available in today's military. However, the amount of non-mandated training leaders receive on mental health or any topic for that matter, is at the discretion of the unit's commander who is ultimately accountable for all that the unit does or fails to do. The commander also has authority to curtail access to certain resources if he or she feels as though it detrimentally affects mission accomplishment (Department of the Army, 2011a). Because of this the quality of mental health training leaders receive from one unit to another is not uniform. One could assume that a medical unit's focus on mental health would be much different than that of an infantry unit. Yet, the same gap in training could very well hold true even when comparing two different units in the same military occupational specialty.

Commanders also decide how individual military units respond to potentially traumatizing events. While the Army outlines a flexible set of interventions that specifically focus on stress management for units and individual soldiers, it is the commander who ultimately decides how a unit responds (United States Army, 2012a). In response to traumatic events, one of the most common interventions utilized by the Army is critical event debriefing, which is facilitated by a trained military mental health clinician from an outside combat stress unit. A designated leader within the unit also helps to lead the debriefing. The debriefing allows for discussion and a space for soldiers to process trauma and their feelings associated with it. However, the main goal of the debriefing is to quickly restore unit cohesion and readiness to

return to action through clarifying the event that actually happened (United States, Army, 2012a).

Multiple efforts have been described in this section as to how the military is currently working to address mental health wellness and accessibility to treatment.  However, statistics were provided in this section that indicates that issues related to mental health continue to plague the military.  It is not surprising that in the US Soldier's Creed, a standard in which all United States Army personnel are required to live, "mental toughness" is mentioned and considered of extreme importance (United States Army, 2012d).  Recently as an institution, the military has carried out anti-stigma and mental health outreach efforts with the following core message:  "It's okay to leave your group and get help when you are having problems" (Bryan & Morrow, 2011).  This is clearly at odds-end with another part of the Soldier's Creed, in which troops recite, "I will never leave a fallen comrade."  It is evident that soldiers are receiving mixed messages regarding mental health in the military.

**Perceptions of Iraq and Afghanistan Veterans on Mental Health Treatment**

In 2008, the RAND Corporation's Center for Military Mental Health Research conducted a study to estimate the prevalence of PTSD among servicemembers who had deployed to Iraq or Afghanistan.  Among the 1,938 servicemembers who completed a PTSD checklist, 13.8% were estimated to meet DSM criteria for the disorder (Tanielian & Jaycox, 2008).  If this estimate is applied to the 2.4 million servicemembers who have deployed to one or both theatres of war, the number of those suffering from PTSD post-combat amounts to approximately 331,200.

While only a snapshot of the magnitude of mental health issues faced by today's military, this figure alone demonstrates the critical need for ongoing critique as to how psychological

wellness is addressed by the military. The input of those who have served themselves should weigh most heavily when carrying out this assessment. After all, it has been reported that only between 23 to 40% of active duty Army soldiers returning from deployment with a mental health problem receive professional help and that only 13 to 27% of National Guard soldiers seek treatment (Hoge et al., 2004; Kim et al., 2011; Walker, 2010). These statistics demonstrate that a large number of soldiers are clearly not getting the help they need.

According to several recent quantitative research studies that assessed barriers to military mental health care, many who have deployed to Iraq and Afghanistan agree that unit leadership treats those who seek mental health treatment differently (Hoge et al., 2004; Kim et al., 2011; Kim et al., 2010; Gorman et al., 2011). The first study to assess barriers to mental health care among veterans of the country's most recent combat operations was conducted about a year after the US invasion of Iraq. In this study, members of four combat infantry units (three Army units and One Marine Corps unit) were surveyed. Some were administered the survey before their deployment, while the majority completed it three to four months after their return from combat duty.

Out of 637 veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, Afghanistan) who met screening criteria in this study for a mental disorder (PTSD, depression, anxiety, or alcohol misuse), 63% responded indicating that they were concerned about unit leadership treating them differently in seeking psychological treatment (Hoge et. al, 2004). The other perceived barriers most common among those who screened positive for a mental disorder included concern about being seen as weak by others (65%), having members in the unit lose confidence in them for seeking help (59%), having difficulty getting time off from work (55%) and being blamed by leadership for the problem (50%). Those who screened

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positive for mental disorder were twice more likely to report concern about possible stigmatization and other barriers to seeking mental health treatment than those who did not.

In related studies that followed, soldiers' concerns about how they would be viewed by unit leadership was the most common perceived barrier in seeking mental health treatment (Kim et al., 2011; Kim et al., 2010). For example, 34 percent of the 881 OIF and OEF active duty Army personnel who reported mental health problems in a 2011 study agreed or strongly agreed that unit leadership would treat them differently if they sought mental health care. This study's sample collected data from 2,623 soldiers from brigade combat teams stationed in the southern United States (Kim et al., 2011). Respondents indicated the same most common barriers outlined in the previous study mentioned. Other notable perceived barriers to seeking psychiatric care included mistrust in mental health professionals, embarrassment, fear that it would harm their military career, and concern that it would affect their security clearance.

A 2010 study on military mental health stigma specific to OIF veterans yielded similar results; the most commonly perceived barrier to treatment among those with mental health problems in this study was again their concerns about how they would be treated by unit leadership in seeking it. This study looked at 2,520 Active Duty and National Guard Army soldiers who were positively screened for a mental health problem, which included major depressive disorder, severe anxiety symptoms or PTSD. Soldiers were also considered to be a positive screen if they reported frequent aggressive behaviors or if they reported overall problems related to relationships, distress, or alcohol at a moderate or severe level. When screened three months after they had returned from Iraq, 37% of those responded positive for a mental problem indicated that they were concerned about how they would be treated by unit leadership if they sought mental health treatment. Again, the other frequently perceived barriers

included concern about being viewed as weak by others, having others lose confidence in them, being blamed by leaders for their problem, and fear that seeking help would harm their career (Kim et al. 2010).

Gorman et al. (2011) also conducted perceived treatment barriers surveying a much smaller sample of 332 Army National Guard soldiers. These soldiers were recruited in the Midwest at reintegration workshops 45-90 days after their return home from Iraq or Afghanistan. This study screened participants for PTSD, depression, suicidal ideation, and hazardous alcohol use. Forty percent of participants screened for one or more of these mental health problems. Again, leadership concerns were among the top of the list when it came to highlighting significant barriers to seeking mental health treatment. Among those who screened positive for at least one mental health problem, 28% reported that they believe they would be treated differently by unit leaders for seeking psychological care and 20% reported that leaders would blame them for their problem. Other top barriers included concern about being seen as weak (31%), worry about members of the unit losing confidence in them (29%), fear that their military career would be harmed (25%), and embarrassment (24%).

These studies highlight the stigma that exists in the military regarding mental health and may partly explain why many servicemembers with psychological problems do not seek treatment. It is important to note that all of the mentioned research conducted on servicemembers' perceived barriers to mental health care is based on Army heavy samples. While the Army is the largest military component that has deployed the majority of servicemembers to Iraq and Afghanistan, mental health treatment is an issue that needs to be addressed and analyzed across all branches.

Also, women are drastically underrepresented in the samples used. In 2011, women made up 14% of the Army Active Duty, 15% of the Army National Guard, and 23% of the Army Reserves (United States Army, 2012). However, they only make up 1% (Hoge et. al, 2004), 4% (Kim et. al, 2010), 9% (Kim et. al, 2011), and 15% (Gorman et al., 2011) of the studies discussed. Women play an enormous role in today's combat operations. Because of this, it is extremely important for research to analyze how the military addresses the mental health needs of women.

**Current Study**

Despite military efforts to reduce mental health stigma, many veterans of past and present wars who experience psychological symptoms today avoid treatment which has led to a mental health crisis that the military cannot seem to resolve. Additionally, the historical treatment of mental health issues in the military and acknowledging their relationship to combat stress has contributed to this crisis as it is only within the past 30 years that the diagnosis of PTSD has been codified in the DSM. Based on the existing, albeit limited research, the top barriers to seeking treatment appear to be concerns as to how one seeking help would be viewed and treated by others, including leadership, and worry about how accessing care could negatively affect an individual's military career. Clearly, stigma is influencing treatment seeking behaviors despite military-wide efforts to combat it. The current study hopes to add to the existing literature by specifically asking servicemembers about the role leadership plays in the stigma that surrounds mental health treatment in the military. The study will hone in on the specific ways in which leadership communicates messages and addresses mental health.

The main research question the study asks, "How do veterans perceive mental health wellness is address by unit leadership, and how does this affect their attitudes towards psychological treatment in the military?  It is hoped that by exploring this barrier, a better understanding will develop as to how unit leadership in the military implicitly and explicitly addresses the topic of mental health, and why soldiers often report leadership as a treatment barrier.

CHAPTER III

**Methodology**

The purpose of this mixed methods study was to closely examine how servicemembers believe their unit leadership addresses the topic of mental health wellness and how this may influence their perceptions on the issue. These perceptions can greatly impact how likely a servicemember accesses needed mental health care. The specific research question of this study was, "How do servicemembers perceive mental health wellness is addressed by their unit leadership and how does this affect their attitudes towards psychological care?"

Previous studies on this topic have taken a much broader approach by identifying views of leadership as one factor among several that influence soldiers' perceptions of mental health and its treatment in the United States military. This study looked at the specific ways in which leadership communicates messages about mental health. The instrument used in the study was designed to pinpoint the specific implicit and explicit messages soldiers are internalizing from their leaders regarding mental health care. The study also aimed to identify what actions unit leadership may or may not be partaking in to communicate this message. This information is important in assessing why many soldiers in past studies have reported that they feel as though their leadership views mental health negatively, thus creating a significant barrier for soldiers to pursue treatment.

While standard reliability or validity tests were not carried out on the survey instrument, it was reviewed by three current servicemembers prior to implementation. This was to ensure

that directions and questions were comprehensible.  Because the servicemembers' feedback

confirmed that the instrument was easily understood, there were no changes made to the survey

after its review.

Both quantitative and qualitative data were collected through survey questioning that

focused specifically on the experiences soldiers have had with their unit leadership regarding

mental health in the military and how they may have influenced the way they approach and think

about the topic.  The research design allowed for participants to respond anonymously, which

was important given the sensitive nature of this topic with veterans.

The mixed methods design was selected for the study in order to utilize the strengths of

both methodologies.  The multi-layered approach was selected to overcome the limitations of a

single design and provide comprehensive research.  Previous studies on stigma associated with

military mental health care have utilized a strictly quantitative approach.  These studies

effectively identified issues relating to leadership as one of the most commonly perceived

barriers to seeking mental health treatment, among several.  The purpose of designing an

instrument with a quantitative component was to measure servicemembers' perceptions in the

same way that previous studies had done so, but this time focusing solely on barriers to mental

health treatment related to leadership.

A qualitative component was included in the instrument's design to allow

servicemembers to reflect upon their time in the military and provide anecdotal illustration of

how mental health is addressed by unit leadership.  The survey's open-ended questions allowed

servicemembers to use their own words and personal experience to bring to life their perceptions

as to how mental health wellness is addressed by military unit leadership. The benefit of the

research design is to provide findings that include concrete examples of barriers and suggestions for improvements that can assist with shaping programs and policies that may reduce the barriers and stigma related to seeking mental health treatment.

The remainder of this chapter maps out in detail the research methodology from beginning to end.  This in-depth description is broken down into the following sections: sampling and recruitment, ethics and safeguards, survey participation, data collection, and data analysis.

## Sampling and Recruitment

The sample population (N=107) for this study included any past or present United States servicemembers who are veterans of Operation Iraqi Freedom (OIF), Operation New Dawn (OND), and/or Operation Enduring Freedom (OEF).  The online survey collected information from United States military veterans who served one or more combat tours of duty overseas in support of these operations.  Exclusion criteria included those servicemembers without any overseas combat experience in support of OIF, OND, or OEF.  The study collected data through an internet-based survey website called Surveymonkey, and was set up to disqualify those who did not meet the required inclusion criteria (see Appendix D).

A non-probability purposive, snowball sampling methodology was used to recruit volunteers to participate via the social networking site, Facebook (see Appendices F and G). Recruitment was carried out utilizing a flier (see Appendix B) that was disseminated via the social networking site linking participants to the Surveymonkey questionnaire, in which participants were asked to give informed consent, answered screening questions, and then directed to the survey if they consent.  Those who agreed to the consent form advanced to the

two required screening questions: *Are you a past or present soldier of the United States Military?; Have you served or are you serving a deployment in a combat zone overseas in support of Operation Iraqi Freedom, Operation New Dawn, or Operation Enduring Freedom?* Those who did not agree to the terms of the consent form or did not meet eligibility criteria were thanked for their interest and encouraged to contact the researcher with any questions about the study or requirements for participation. At the end of the survey, participants were asked to share the questionnaire link via Facebook with other individuals who met the criteria for participation.

The process for recruitment was carried out as follows. An invitation and link was posted on the researcher's Facebook profile to the Surveymonkey questionnaire. The researcher then invited other members in his Facebook network to assist with recruitment by asking them to copy and post the survey link onto their Facebook profiles. This allowed for the sample to snowball, increasing the pool of participants for the study. It is important to note that this recruitment method classifies the study as utilizing a sampling of convenience.

**Ethics and Safeguards**

This study was designed and carried out in a manner that took measures to ensure ethical research. This section will outline measures that were taken, which met Human Subjects Review Board of the Smith College School for Social Work standards.

**Risks of participation. As a combat veteran the researcher was well equipped to anticipate the risks associated with this survey.** Participants may have experienced many strong feelings in responding to the survey and discussing military mental health in the open-ended questions. Since all participants were combat veterans, the survey may have brought up

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memories of traumatic events in which psychological treatment was sought or simply thought about.  Participants may have become uncomfortable in sharing their thoughts about these events.  Additionally, participants may have had difficulty discussing leadership's response to these matters, as soldiers very rarely have the opportunity to assess their leadership.  It is instead most often the leadership that does the evaluating.  Participants were provided with a list of mental health referral sources (See Appendix E) upon completion of the questionnaire in case they wished to seek support or talk further about these matters.

**Benefits of participation.**  Participants were not paid for their involvement in this study.  However, involvement in the study may have provided participants with non-monetary benefits.  For example, the study may have prompted participants to reflect upon their own perceptions of mental health treatment in the military and analyze how the topic is viewed by unit leadership.  As a result of the study, participants may have gained new insight as to what ultimately affects their thoughts on mental health treatment in the military and may now be able to better identify factors that may influence and relate to their way of thinking.  By taking part in the study, participants provided information that the military could potentially utilize and benefit from in restructuring the way it addresses mental health in a way that more appropriately assists the well-being of its soldiers.

**Voluntary nature of participation.**  Participation in this study was voluntary and participants were informed that they could end the survey early and opt out of it at any time before submitting.   Also, with the exception of the initial rule-out questions that indentified whether or not a participant could take part in the study, participants had the choice of skipping any question that they did not wish to answer.  However, it is important to note that it was impossible to withdraw a participant's survey after it was submitted, due to the anonymous

nature of participation. In other words, it was not possible to recall a participant's responses as these were impossible to link to a particular participant.

**Informed consent procedures.** Before participation, servicemembers were required to indicate agreement with an electronic consent form that provided an overview of the study. Servicemembers were also provided with a link to an external consent form document for printing purposes. A copy of the Informed Consent can be found in Appendix C and is discussed in further detail in the Data Collection section of this chapter.

**Precautions taken to safeguard confidential and identifiable information.** Safeguards were taken to maintain the anonymity and confidentiality of survey participants. The survey did not ask any personal identifying information. In the survey instructions and informed consent (See Appendix C), participants were explicitly advised to avoid providing any identifying information in their narrative answer to the survey's open-ended questions. This ensured participants' anonymity.

Participants' anonymity was also maintained by configuring SurveyMonkey.com's settings so that participants could access the survey and answer questions without identifying information being recorded. For example, answers were gathered without the tracking or saving of names, e-mail addresses, or IP addresses. Surveymonkey's Secure Sockets Layer (SSL) encryption option was enabled so that respondent information was protected "using both server authentication and data encryption, ensuring that user data was safe, secure, and available only to authorized persons as it moved along communication pathways between the respondent's computer and SurveyMonkey servers" (SurveyMonkey, 2011).

Code numbers were generated by SurveyMonkey and were associated with participant responses.  Those that had access to this data for analysis included the researcher, research advisor, and statistical consultant from Smith College.  Any identifying information that participants mistakenly include in their narrative answer were removed by the researcher and kept confidential.

Upon completion of the study, data was stored electronically on encrypted, password-protected media so that the researcher was the only individual able to access it.  This data will be kept secure for three years as required by Federal regulations.  After that time, the data will be destroyed or continued to be kept secure as long as the researcher needs the data for research purposes.  When no longer needed, the data will be destroyed.

**Human subjects review board.**  The design of this study was approved by the Human Subjects Review Board of the Smith College School for Social Work on February 20, 2012 (See Appendix A), ensuring that all materials meet federal and college standards for protection of human subjects.

**Data Collection**

Utilizing the Surveymonkey questionnaire, data collection took place from February 23, 2012 until March 22, 2012.  Participants who accessed the study's Surveymonkey link were directly connected to an informed consent form (See Appendix C) and fully advised of the research design and study as well as the potential risks associated with the survey, the benefits associated with the survey and all efforts taken to ensure their anonymity.  There was also a document version of the informed consent letter linked to the survey so that a participant could

open it for printing or reference purposes. The list of mental health references was also included in this document.

Once participants reviewed the informed consent letter, they indicated their consent electronically. Respondents who indicated electronic consent by marking a box labeled "I agree" were reminded they were free to print out and keep a copy of the Informed Consent if they would like. They then proceeded to the first screening question of the actual survey. Those who marked a box that indicated "I DO NOT agree" were routed to a screen informing them that they were ineligible to participate. Because this study was intended to interview adults who are English-speaking and at least 18 years old, it was not necessary to obtain parental or guardian consents, or to provide a copy of translated forms. Participants who met the inclusion criteria then advanced to the body of the survey (See Appendix D), which was broken up into three sections and took approximately 10-15 minutes to complete. The first section focused on demographics, asking participants questions about themselves and their military service. This data was collected in order to compare survey participants on multiple variables. The demographics collected were as follows: age, race or ethnicity, gender, highest level of education, years served in the military, number of overseas combat deployments in support of OIF and/or OND, number of total months deployed overseas in support of OIF and/or OND, number of overseas combat deployments in support of OEF, number of total months deployed overseas in support of OEF, branch of service most recently deployed with, type of unit most recently deployed with, highest rank held during most recent deployment, highest rank held during military career, current military status, and military occupation.

The second section consisted of a Likert scale questionnaire in which participants provided descriptive data by indicating their level of agreement to thirteen statements related to

how unit leadership and the military addresses mental health. This quantitative component of the instrument measured servicemembers' perceptions as to how supportive leadership was of mental health treatment, how effective leadership was in reducing stigma related to mental health, how well leadership was at assessing the psychological well-being of servicemembers, and how confident they were that leadership would ensure confidentiality to a servicemember seeking mental health services. This section additionally collected data on participants' perceptions as to how well the military addresses mental health overall and also gathered information about participants' personal attitudes towards mental health treatment and wellness.

The survey's final section concluded with four, separate, open-ended questions that allowed for participants to share in detail their personal experience as to how psychological health was addressed in the military by their leadership. The questions in this section were as follows: *Describe the messages you received about mental health from your unit leadership; Explain how your unit leadership addressed the psychological well-being of soldiers responding to stressful periods and trauma that occurred during deployment; If you were to have a direct conversation with your unit leadership about how mental health wellness and treatment should be addressed in the military, what would you tell them?; Have your views on the way mental health treatment and wellness is addressed by the military changed as a result of your service and/or deployment(s)? If so, explain.*

**Survey Participation**

Out of the one hundred thirty-eight participants started the survey, two did not agree to the informed consent and were dismissed. An additional 18 participants were disqualified for not meeting screening criteria: 14 for not being a past or present soldier of the United States

military, and four for not having deployed to a combat zone overseas in support of Operation Iraqi Freedom, Operation New Dawn, or Operation Enduring Freedom.  Twelve participants who met screening criteria did not answer any questions beyond demographics.  These participants were dismissed and not included in survey analysis.  This resulted in a sample of 107 remaining participants.

All but one of the study's 107 participants answered each of the thirteen, quantitative questions entirely.  This participant answered 12 of the 13 questions, skipping the last one in section.  The response in section III, which consisted of the four open-response questions, was not as strong.  The first and second open-response questions both had 73 participants respond. The third and fourth open-response questions had 70 and 71 respondents respectively.

**Data Analysis**

Data collected from the Surveymonkey was exported to a Microsoft Excel file and reviewed.  Any identifiable information found in open-ended responses was deleted.  Analysis of this mixed-methods survey was divided into three parts.  The survey's sample was analyzed demographically using descriptive statistics.  Marjorie Postal, Research Analyst for Smith College School for Social Work, provided analysis support for all quantitative data in this study and ran frequencies for each of its demographic questions utilizing statistical tools in Excel. Information from this analysis was to demographically describe the survey's sample population.

The same method was carried out in analysis of the second section two, which was comprised of thirteen Likert scale questions.  For example, mean scores were calculated to compare, contrast, and further analyze how participants responded to the questions.  In addition, responses to each question were divided into three categories:  1) Strongly Agree/Agree, 2)

Neutral, and 3) Strongly Disagree/Agree. Percentages were calculated to indicate what fraction of the study's sample fell into each of these categories.

Inferential statistics that looked at relationships between demographic characteristics and Likert responses were also generated. This was achieved by running One-way ANOVA with Bonferroni Post-Hoc Tests and also T-Tests that determined whether or not variations among the following demographics resulted in any significant patterns: gender, rank, unit type (active duty vs. guard/reserve), number of deployments, and military occupation. Spearman Rho correlations were also run to determine if the rank of participants influenced how they perceive mental health is addressed by military leadership.

The survey's final section, which consisted of qualitative data, was analyzed using categorizing strategies. Reading through each set of open-ended responses and then designating them into certain classifications allowed for the qualitative data to be reduced and quantified. The section's first open-ended question was as follows: *Describe the messages you received about mental health from your unit leadership.* Each response to this question was categorized into one of the three following groups: 1) A message was received 2) A message was not received 3) Unknown. The "unknown" category was created for responses that did not fit into either of the first two classifications. Responses that fell into the first category were broken done into one of three further classifications: 1) Positive message 2) Negative message 3) Unknown

The section's second question was as follows: *Explain how your unit leadership addressed the psychological well-being of servicemembers in responding to stressful periods and trauma that occurred during deployment(s).* Responses to this question were categorized in a similar manner and grouped into the following classifications: 1) Leadership did address the

psychological well-being of servicemembers in response to stressful periods and trauma. 2) Leadership *did not* address the psychological well-being of servicemembers in response to stressful periods and trauma. 3) Unknown.  The responses from the first classification were grouped further into the following classifications:  1) Positively addressed. 2) Negatively addressed. 3) Unknown.

Analysis of the fourth and final question of the survey resembled that of the first two, which is why it is being addressed out of order.  Question four asked, "*Have your views on the way mental health treatment and wellness is addressed by the military changed as a result of your service and/or deployment?  If so, explain.*"  Responses were grouped into the following categories:  1) Yes. 2) No. 3) Unknown.  Responses that were grouped into the first category were broken down further into the following classifications:  1) Positive change. 2) Negative change. 3) Unknown.

The responses to the third question in this section were coded in a more complex manner. This question asked, "*If you were to have a direct conversation with your unit leadership about how mental health wellness and treatment should be addressed in the military, what would you tell them?*"  For this analysis, each response was read multiple times and assigned one or more categories based on its interpreted theme.  The coding process consisted of continuously drafting and revising themes until only a few emerged.  One theme was "keep up the good work" in which responses complimenting the military's efforts towards mental health treatment were categorized.  The second theme of "say nothing" was developed to capture responses that explicitly stated they would not say anything to their unit leadership regarding this matter.  Other responses fell into the remaining themes: reduce stigma, make mental health wellness more of a priority (including better training and more accessibility), and ensure confidentiality.

The following chapter will discuss the study's finding.  The chapter is broken down into three sections, the first which outlines demographics of survey participants.  The second section provides results to thirteen Likert scale questions.  Qualitative findings from four open-ended questions are provided in the chapter's last section.  Multiple tables are provided throughout the chapter to capture these results.

CHAPTER III

**Findings**

The purpose of this mixed methods study is to provide information as to how

servicemembers perceive mental health wellness is addressed by unit leadership. In the first

section of this chapter, the study's sample of 107 servicemembers is described in terms of

demographics. The section that follows includes descriptive and inferential analyses of

servicemembers' responses to a series of 13 Likert scale questions. These quantitative questions

were designed to measure servicemembers' perceptions of how mental health treatment is

handled by the military. Eight of these questions directly focus on servicemembers' perceptions

of unit leadership's handling of this issue. The chapter's final section presents findings from the

survey's qualitative portion, which consists of four open-ended questions that servicemembers

responded to in written form. An analysis is included that describes themes that emerged from

servicemembers' responses.

**Demographic Data**

**Age**. Among all participants, ages ranged from 21 to 56-years-old. When categorized

into five groups, the largest (N=34) was the 26-30 range which made up 33.0% of the sample,

followed by the 31-35 age group (N=35) that made up 24.3%. A total of 18.4% servicemembers

(N=19) classified into the 36-40 age group, followed by 10.7% who fell into the 21-25 range

(N=11). The sample was made up of 8.7% servicemembers (N=9) aged 46 or older, while 4.9%

were aged 41-45 (N=5).

**Gender.**  The majority of survey participants were male (N=89), who made up 83.2% of the sample.  Women (N=18) rounded out the remaining 16.8% of the sample.

**Race and Ethnicity.** The majority of the sample, 82.2%, identified as being White (N=88).  A total of 11.2% of the sample identified as Hispanic (N=12), making this grouping the sample's second largest representation.  Servicemembers who identified as Native American (N=3) made up 2.8% of the sample, while 1.9% selected "Other" (N=2) in identifying their race/ethnicity.  The African American and Asian/Native Hawaiian/Pacific Islander groupings each made up 0.9% of the sample as both were represented by one servicemember.

**Education.**  Servicemembers were asked to indicate their highest level of education completed.  In terms of academic degrees, those with at least some college (N=38) represented 35.5%, the largest representative group in the sample.  Servicemembers with bachelor's degrees (N=30) represented the second largest group at 28.0%.  Fourteen percent of servicemembers (N=15) indicated they had obtained an Associate's degree as their highest level of schooling, followed by 12.1% (N=13) who acknowledged no education past high school.  The Master's degree grouping made up of 8.4% (N=9) of the sample.   One servicemember (0.9%) identified as having a Doctorate level of education, while an additional servicemember (0.9%) completed a professional degree (JD, MD).

**Branch of military service.**  Sensitive to the fact that some servicemembers switch branches during their military careers, survey participants were asked to identify with the branch of service that they *most recently* deployed with.  The majority of the servicemembers who took part in the survey were Army soldiers (N=86) who made up 80.4% of the sample.  Marines

(N=11) represented 10.3% of the sample, followed by 6.5% servicemembers who most recently deployed with the Air Force (N=7) and 2.8% in the Navy (N=3). The Coast Guard was an additional military branch indicated on the survey's demographic section, but not represented in the sample.

**Unit Type.** Servicemembers were asked to indicate if they most recently deployed with an active duty, National Guard, or reserve unit. Active duty servicemembers (N=65) made up the majority of the sample at 61.3%. Reserve (N=24) and National Guard servicemembers (N-17) made up 22.6% and 16.0% of the sample respectively.

**Current status in the military.** Servicemembers were asked to indicate their current status in the military. Approximately half the sample had been discharged from the military and the other half were still serving on active duty or in the reserve or guard. A total of 54.2% of servicemembers (N=58) indicated they were discharged from the military. Presently serving National Guard and Reserve servicemembers (N=22) made up 20.6% of the sample and 14% of participants (N=15) identified as active duty. Rounding out the sample were the 11.2% servicemembers who were not actively serving, but currently fulfilling their military obligation in Individual Ready Reserve (IRR) status (N=12).

**Years in the U.S. military.** Out of five identified groupings, respondents who indicated they had 6-10 years of military service group (N=42) was the largest and represented 40.1% of the sample. Next, the "five or less years" group (N=29) represented 27.9% of the sample, and the 11-15 years of service group (N=15) comprised 14.4%. Twelve servicemembers in the 16-20 years of service group made up 11.5% of the sample size. The smallest identified representative group consisted of servicemembers who had more than 20 years of military service. This group

(N=6) made up 5.8% of the study's sample.

**Highest rank held during most recent deployment.** Servicemembers were asked to write in the highest rank they held during their most recent deployment. Military ranks are broken into three groups: enlisted (E1-E9), warrant officer (W1-W5), and commissioned officer (O1-O11). The following enlisted ranks were not represented in the sample: E-1, E-2, E-9. No servicemembers identified as having served their most recent deployment as an O-1 and the sample did not have any representation of officers above the rank of O-4. Warrant officers were absent from the sample altogether. Overall, 87.9% of the sample were enlisted (N=94) during their most recent deployment and 12.1% identified as commissioned officers (N=13). The majority of sample was servicemembers who held ranks of E-4 and E-5 during their most recent deployment. E-4 is the highest of the junior enlisted ranks (E1-E4), while E-5 is the lowest of the non-commissioned officer (NCO) ranks (E5-E9). This demographic information is outlined in Table 1.

Table 1.

*Highest Rank of Servicemembers During Most Recent Deployment (N= 107)*

| Rank | Frequency | Valid Percent |
|------|-----------|---------------|
| E-3 | 4 | 3.7 |
| E-4 | 38 | 35.5 |
| E-5 | 35 | 32.7 |
| E-6 | 11 | 10.3 |
| E-7 | 5 | 4.7 |
| E-8 | 1 | 0.9 |
| O-2 | 2 | 1.9 |
| O-3 | 9 | 8.4 |
| O-4 | 2 | 1.9 |
| | 107 | 100 |

**Highest rank held during military service.** Servicemembers were asked to write in the highest rank they held during their military career. The following enlisted ranks were not represented in the sample: E-1, E-2, E-9. No servicemembers identified as an O-2 and again, the sample did not have any representation of officers above the rank of O-4. The sample remained absent of warrant officer participation. While responses to this demographic question indicated that many servicemembers had progressed in rank since their most recent deployment, the breakdown between enlisted and commissioned officer servicemembers remained the same with the former group representing 87.9% of the sample (N=94) and the latter (N=13) making up 12.1%. This data is illustrated in Table 2.

Table 2.

*Highest Rank of Servicemembers During Military Career (N= 107)*

| Rank | Frequency | Valid Percent |
|------|-----------|---------------|
| E-3 | 1 | 0.9 |
| E-4 | 30 | 28.0 |
| E-5 | 36 | 33.6 |
| E-6 | 16 | 15.0 |
| E-7 | 8 | 7.5 |
| E-8 | 1 | 0.9 |
| O-1 | 1 | 0.9 |
| O-3 | 8 | 7.5 |
| O-4 | 6 | 5.6 |
| | 107 | 100 |

**Military occupation.** Servicemembers were asked to indicate which military occupation category best described the duties of their most recent deployment. The majority of the sample was made up participants in combat roles (combat arms, special forces/special ops, and combat support) meaning that many of these servicemembers were on the frontlines and involved in direct tactical land combat. It is important to note that some would argue that non-combat

military occupations carry with them a lesser degree of deployment-related stress. The

breakdown of participants' military occupations is outlined in Table 3.

Table 3.

*Military Occupation Held by Servicemembers During Most Recent Deployment (N=107)*

| Occupation | Frequency | Valid Percent |
|---|---|---|
| Combat Arms | 39 | 36.4 |
| Combat Support | 24 | 22.4 |
| Medical Support | 12 | 11.2 |
| Logistical Support | 11 | 10.3 |
| Special Forces/Special Ops | 6 | 5.6 |
| Military Intelligence | 6 | 5.6 |
| Service Support | 6 | 5.6 |
| Aviation | 3 | 2.8 |
| | 107 | 100.0 |

**Number of deployments and months spent deployed in support of OIF/OND.**

Servicemembers were asked to indicate the number of overseas deployments they served in

support of OIF/OND. A total of 93.5% of the sample indicated that they were OIF/OND

veterans (N=97). The majority had been deployed once (57%) and had spent a total of 7-12

months deployed in support of OIF/OND (43.9%). It is important to note that while only ten

servicemembers indicated that they had not deployed in support of OIF/OND, 12 answered that

they spent 0 months in support of OIF/OND. Data regarding number of OIF/OND deployments

and months spent in support of these operations is outlined in Table 4 and Table 5.

Table 4.

*Number of OIF/OND Deployments by Servicemembers (N=107)*

| # of Deployments | Frequency | Valid Percent |
|---|---|---|
| 0 | 10 | 9.3 |
| 1 | 61 | 57.0 |
| 2 | 25 | 23.4 |
| 3 | 7 | 6.5 |
| 4 | 1 | 0.9 |
| 5 | 1 | 0.9 |
| > 5 | 2 | 1.9 |
| | 107 | 100.0 |

Mean: 1.47

Table 5.

*Number of Total Months Spent by Servicemembers in Support of OIF/OND (N=107)*

| Total Months | Frequency | Valid Percent |
|---|---|---|
| 0 | 12 | 11.2 |
| 1-6 | 4 | 3.7 |
| 7-12 | 47 | 43.9 |
| 13-18 | 21 | 19.6 |
| 19-24 | 11 | 10.3 |
| > 24 | 12 | 11.2 |
| | 107 | 100.0 |

Mean: 14.10

**Number of deployments and months spent deployed in support of OEF.**

Servicemembers were asked to indicate the number of overseas deployments they served in support of OEF. Forty-three percent of the sample (N=46) indicated that they were veterans of OEF, most of whom deployed once. Out of the OEF veterans who participated, 78.3% indicated that they had deployed in support of this operation for a total of 7-12 months. It is important to note that while only 61 servicemembers indicated that they had not deployed in support of OIF/OND, 62 answered that they spent 0 months in support of OEF. Data regarding number of OEF deployments and months spent in support of these operations is outlined in Tables 6 and 7.

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Table 6.

*Number of OEF Deployments by Servicemembers (N= 107)*

| # of Deployments | Frequency | Valid Percent |
|---|---|---|
| 0 | 61 | 57.0 |
| 1 | 36 | 33.6 |
| 2 | 5 | 4.7 |
| 3 | 4 | 3.7 |
| 4 | 1 | 0.9 |
| | 107 | 100.0 |

Mean: 0.58

Table 7.

*Number of Total Months Spent by Servicemembers in Support OEF (N= 107)*

| Total Months | Frequency | Valid Percent |
|---|---|---|
| 0 | 62 | 57.9 |
| 1-6 | 9 | 8.4 |
| 7-12 | 25 | 23.4 |
| 13-18 | 6 | 5.6 |
| 19-24 | 4 | 3.7 |
| > 24 | 1 | 0.9 |
| | 107 | 100.0 |

Mean: 14.10

**Number of redeployed servicemembers in support of the Iraq and Afghanistan operations.** Table 8 illustrates the number of servicemembers in the study's sample that have deployed more than once. The sample contained a proportionate number of servicemembers who had been deployed once (45%) compared to those who had been deployed more than once (55%).

Table 8.

*Total Number of Iraq/Afghanistan Deployments by Servicemembers (N= 107)*

| Number of Deployments | Frequency | Valid Percent |
|---|---|---|
| 1 | 48 | 44.9 |
| >1 | 59 | 55.1 |
| | 107 | 100.0 |

**Limitations of Sample**

According to the Department of Defense (2012b), Army soldiers make up 49.8% of the entire military. Air Force personnel make up 22.4% of the military followed by 17.1% of Navy servicemembers. Marines round out the last 10.7%. Servicemembers in the Coast Guard are not represented in these statistics, as the branch falls under the Department of Homeland Security.

It is important to note that this study's sample disproportionately represented the target population in terms of the military branches. For example, 80.4% of the survey's participants were Army soldiers, leaving the remaining military branches underrepresented. Also lacking in representation were African-American servicemembers, who make up 16.2% of the military population, yet made up only 0.9 of this study's sample. White servicemembers make up 71.8% of the military, but represented 82.2% of the survey's sample. The quantity of White participants led to a lack of representation of minority servicemembers.

**Responses to Likert Scale Questions Addressing Military Mental Health**

Servicemembers were asked to respond to 13 Likert scale questions, which measured their perceptions of how mental health treatment is addressed by the military. Each item was measured on a 5-point scale (1, strongly disagree, to 5, strongly agree).

**Servicemembers' personal awareness and attitude toward mental health treatment.**

Two of the Likert scale questions were designed to measure the servicemembers' individual

attitudes towards military mental health. The majority of the sample reported that they were

aware of mental health services and viewed seeking mental health treatment as a positive action.

As illustrated in table x, fifty-nine percent (N=63) of respondents either strongly agreed (N=30

or 28.0%) or agreed (N=33 or 30.8%) with the statement, "I was aware of mental health services

during my deployment." It is notable that 29 % of servicemembers (N=31) strongly disagreed

(N=14 or 13.1%) or disagreed (N=17 or 15.9%) with this statement. Some of these

servicemembers may have been deployed at early stages of the Iraq and Afghanistan wars, prior

to the military's increased efforts to promote mental health awareness. Thirteen servicemembers

(12.1%) remained neutral to this statement.

The majority of the survey's sample (N=79 or 73.8%) answered that they strongly agreed

(N=43 or 40.2%) or agreed (N=36 or 33.6%) that they would view a fellow servicemember

seeking mental health treatment as positive action. Six servicemembers (5.6%) strongly

disagreed (N=4 or 3.7%) or disagreed (N=2 or 1.9%) with this view. Thirty-six servicemembers

(33.6%) were neutral to this statement. Results for these two questions are outlined in table 9.

Table 9

*Servicemembers' Level of Agreement to Questionnaire Items Related to Personal Awareness and Attitude Toward Mental Health Treatment (N= 107)*

| Item | Valid Percent | | | | |
|---|---|---|---|---|---|
| | SD | D | N | A | SA |
| I was aware of available mental health services during my deployment. | 13.1 | 15.9 | 12.1 | 30.8 | 28.0 |
| I would view a servicemember seeking mental health treatment as positive action. | 3.7 | 1.9 | 20.6 | 33.6 | 40.2 |

**View of leadership's handling of mental health.** Exploring the servicemembers'

perceptions of unit leadership and the way that they address mental health issues is the core of

this study. Because of this, eight Likert scale questions were designed to measure perceptions of

unit leadership. Results for these eight questions are presented below in table 10.

Table 10.

*Servicemembers' Level of Agreement to Questionnaire Items Related to Leadership's Handling*
*of Mental Health (N=107)*

| Item | Valid Percent | | | | |
|---|---|---|---|---|---|
| | SD | D | N | A | SA |
| Unit leadership would treat a servicemember seeking assistance for mental health differently. | 8.4 | 13.1 | 23.4 | 35.5 | 19.6 |
| The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma. | 22.4 | 29.0 | 20.6 | 12.1 | 15.9 |
| My leadership was consistent with the military's effort to reducing negative feelings associated with mental health treatment. | 27.1 | 23.4 | 24.3 | 17.8 | 7.5 |
| My leadership effectively assessed the mental health wellness of its troops. | 28.0 | 20.6 | 26.2 | 15.9 | 9.3 |
| Unit leadership discussed with servicemembers how the stress of a deployment affects mental health. | 22.4 | 26.2 | 20.6 | 23.4 | 7.5 |
| My leadership supported the use of mental health services during my deployment. | 19.6 | 28.0 | 17.8 | 18.7 | 15.9 |
| My leadership would view a servicemember seeking mental health treatment as positive action. | 15.0 | 24.3 | 38.3 | 13.1 | 9.3 |
| Unit leadership would ensure confidentiality to a servicemember seeking mental health services | 15.0 | 21.5 | 29.0 | 22.4 | 12.1 |

When asked to reflect upon how seeking mental health assistance might affect their

working relationship with unit leadership, the majority of servicemembers (N=59 or 55.1%)

strongly agreed (N=21 or 19.6%) or agreed (N=38 or 35.5%) with the following statement:

"Unit leadership would treat a servicemember seeking assistance for mental health differently."

In contrast, twenty-three servicemembers (21.5%) either strongly disagreed (N=9 or 8.4%) or

disagreed (N=14 or 13.1%), while 25 (23.4%) remained neutral on the statement. The results of

the remaining Likert scale questions on unit leadership are described below in descending order based on servicemembers' level of disagreement with the statements.

Just over half of servicemembers (51.4%) either strongly disagreed (N=24 or 22.4%) or disagreed (N=31 or 29.0%) with the statement, "The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma. Twenty-eight percent of servicemembers (N=30) had an opposite view and strongly agreed (N=17 or 15.9%) or agreed (N=13 or 12.1%) that mental health services were encouraged by unit leadership. Rounding out the responses were the 20.6% of servicemembers (N=22) who answered, "neutral".

The next unit leadership statement dealt with stigma and read, "My leadership was consistent with the military's effort to reducing negative feelings associated with mental health treatment." Again, just over half (N=58 or 50.5%) of the servicemembers strongly disagreed (N=29 or 27.1%) or disagreed (N=25 or 23.4%) with the accuracy of this statement. Twenty-seven servicemembers (25.2%) felt as though leadership is consistent in this effort with 7.5% (N=8) strongly agreeing and 17.8% (N=19) agreeing. Twenty-six servicemembers (24.3%) were neutral to the statement.

Servicemembers were asked how well unit leadership monitors its troops in terms of mental health. Responding to the statement, "My leadership effectively assessed the mental health wellness of its troops," almost half of servicemembers (N=52 or 48.6%) strongly disagreed (N=30 or 28%) or disagreed (N=22 or 20.6%). Twenty-seven servicemembers (25.2%) felt as though leadership did affectively assess their troops with ten (9.3%) strongly

agreeing and 17 (15.9%) agreeing.  Twenty-eight servicemembers (26.2%) had no opinion on the statement, answering "neutral".

When responding to the statement, "Unit leadership discussed with servicemembers how the stress of a deployment affects mental health," just under half (48.6%) either strongly disagreed (N=24 or 22.4%) or disagreed (N=28 or 26.2%).  In contrast, 33 servicemembers (30.8%) strongly agreed (N=8 or 7.5%) or agreed (N=25 or 23.4%) to this statement.  Twenty-two servicemembers (20.6%) answered "neutral" to this question.

The next statement focusing on servicemembers' perceptions about how issues related to mental health are addressed by unit leadership was posed as follows:  "My leadership supported the use of mental health services during my deployment."  Fifty-one servicemembers (47.7%) either strongly disagreed (N=21 or 19.6%) or disagreed (N=30 or 28.0%) with this statement.  Thirty-seven servicemembers (34.6%) strongly agreed (N=17 or 15.9%) or agreed (N=20 or 18.7%) that mental health services were supported by unit leadership during deployment.  Nineteen servicemembers (N=17.8%) responded to the statement in a neutral manner.

The next unit leadership statement was posed, "My leadership would view a servicemember seeking mental health treatment as positive action."  Forty-two servicemembers (39.3%) strongly disagreed (N=16 or 15.0%) or disagreed (N=26 or 24.3%) with this statement.  Only twenty-four servicemembers (22.4%) strongly agreed (N=10 or 9.3%) or agreed (N=14 or 13.1%) that leadership would look upon a servicemember getting help for a psychological issue as positive action.  This low total is in stark contrast to the majority of servicemembers who stated they personally had a favorable view of mental health treatment.  As stated in the previous

section, 63 servicemembers (59%) strongly agreed (N=30 or 28%) or agreed (N-33 or 30.8%) with the statement, "I would view a servicemember seeking mental health as positive action.

Finally, 49 servicemembers (36.5%) either strongly disagreed (N=16 or 15.0%) or disagreed (N=23 or 21.5%) with the statement, "Unit leadership would ensure confidentiality to a servicemember seeking mental health services. On the contrary, 37 servicemembers strongly agreed (N=13 or 12.1%) or agreed (N=24 or 22.4%). Thirty-one servicemembers (29.0%) answered neutrally to the question.

The results discussed in this section show while servicemembers range in their perceptions about how mental health is addressed by unit leadership, a large portion feel negatively about the way their leaders address issues related to mental health. Aside from the first Likert-scale question discussed in this section, the percentage of servicemembers who strongly agreed or agreed with the positively stated items about unit leadership ranged from 22.4% to 34.6%. On the other hand, the percentage of those assessed unit leadership's handling of negatively by strongly disagreeing or disagreeing with these same statements ranged from 39.3% to 51.4%.

**View of military's handling of mental health.** Three Likert-scale questions were dedicated to assessing servicemembers' perceptions of how the military, as an institution, addresses issues relating to mental health. Results for these questions are presented in Table 11. The first statement on the military's handling of mental health read as follows: "The military provided me with sufficient training on the effects of combat on mental health." Forty-nine servicemembers (45.8%) strongly disagreed (N=23 or 21.5%) or disagreed (N=26 or 24.3%) with this statement. Thirty-one servicemembers (29.0%) either strongly agreed (N=8 or 7.5%) or

agreed (N=23 or 21.5%) that they were provided with sufficient training by the military. Twenty-seven servicemembers (25.2%) indicated "neutral" as a response.

The majority of servicemembers (N=59 or 55.1%) indicated some level disagreement to the statement, "The military does enough to educate and inform servicemembers about mental health wellness." Twenty servicemembers (18.7%) strongly disagreed with this statement, while 39 (36.4%) disagreed. Thirty-one servicemembers (29.0%) either strongly agreed (N=8 or 7.5%) or agreed (N=23 or 21.5%) that the military's mental health efforts are enough in terms of educating and informing. Twenty-seven servicemembers (25.2%) answered "neutral" to this statement.

The Real Warriors Campaign is an initiative launched by the Department of Defense to promote help-seeking behavior among servicemembers and veterans. However, servicemembers' responses to this survey question indicate that many are not aware of the outreach program. Ninety-three servicemembers (87.7%) strongly disagreed (N=61 or 57.5%) or disagreed (N=32 or 30.2%) with the statement, "I am familiar with the Real Warriors Campaign." Only six servicemembers (5.6%) strongly agreed (N=4 or 3.7%) or agreed (N=2 or 1.9%) that they were familiar with this military effort.

These results are similar to those in the previous section, indicating that servicemembers do not view the military as handling issues related mental health any more favorably. This is despite many military-wide efforts that have been implemented since the beginning of the Iraq and Afghanistan wars to improve the way it handles issues related to mental health. The fact that only 5.7% of servicemembers indicated that they are familiar with the one of the military's main

mental health outreach efforts, the "Real Warriors Campaign," indicates that most of its intended audience is not receiving the message.

Table 11.

*Servicemembers' Level of Agreement to Questionnaire Items Related to the Military's Handling of Mental Health (N= 107)*

| | Valid Percent | | | | |
|---|---|---|---|---|---|
| Item | SD | D | N | A | SA |
| I am familiar with the Department of Defense's "Real Warriors Campaign".* | 57.5 | 30.2 | 6.6 | 1.9 | 3.8 |
| The military does enough to educate and inform servicemembers about mental health wellness. | 18.7 | 36.4 | 15.9 | 22.4 | 6.5 |
| The military provided me with sufficient training on the effects of combat on mental health. | 21.5 | 24.3 | 25.2 | 21.5 | 7.5 |

*Note. *Question thirteen was answered by 106 servicemembers.*

**Inferential Statistics**

Inferential statistics were used to analyze how servicemembers of different demographic groups responded to specific Likert scale questions in relation to others. Hypotheses were tested by running One-Way ANOVA with Bonferroni Post-Hoc Tests and also T-Tests that determined whether or not variations existed among demographic groups. Spearman Rho correlations were also run to analyze relationships among variables. The hypotheses, tests run, and results found are outlined below.

**Hypothesis I: Servicemembers of higher ranks more favorably assess how the military and unit leadership addresses mental health wellness.** Three methods were carried out to test this hypothesis. First, servicemembers were placed into the following four groups, depending on their rank: junior enlisted (E-3, E-4), non-commissioned officers (E-5, E-6), senior non-commissioned officers (E-7, E-8), and commissioned officers (O-1, O-3, O-4).

Oneway Anovas were run to determine if there were differences among these groups in the mean score responses to a variety of Likert scale questions concerning how mental health is addressed by unit leadership and the military.  A significant difference ($F_{(3.103)}=3.326$. $P=-.023$) was found in the statement, "Unit leadership would ensure confidentiality to a servicemember seeking mental health services."  A Bonferroni post hoc test was then run to determine which groups were significantly different.  The test showed the commissioned officer group had a significantly higher mean score (m=3.60) than that of the enlisted group (m=2.52), suggesting more agreement with the statement.  There were no significant differences in any of the other variables.  These results are outlined in Table 12.

Table 12.

*Bonferri Method Comparison of Four Rank Groups' Level of Agreement to the Statement, "Unit leadership would ensure confidentiality to a servicemember seeking mental health services." (N= 107)*

Multiple Comparisons

Dependent Variable
Mean Confidentiality Score; Bonferroni

| (I) Mode | (J) Mode | Mean Difference (I-J) | Std. Error | Sig. | 95% Confidence Interval Lower Bound | 95% Confidence Interval Upper Bound |
|---|---|---|---|---|---|---|
| Junior Enlisted | NCO | -.426 | .272 | .724 | -1.16 | .31 |
| | Senior NCO | -.928 | .454 | .262 | -2.15 | .29 |
| | Commissioned Officer | -1.084* | .378 | .030 | -2.10 | -.07 |
| Non-Commmisioned Officer (NCO) | Junior Enlisted | .426 | .272 | .724 | -.31 | 1.16 |
| | Senior NCO | -.502 | .433 | 1.000 | -1.67 | .66 |
| | Comissioned Officer | -.658 | .352 | .386 | -1.60 | .29 |
| Senior Non-Commisioned Officer | Junior Enlisted | .928 | .454 | .262 | -.29 | 2.15 |
| | NCO | .502 | .433 | 1.000 | -.66 | 1.67 |
| | Commissioned Officer | -.156 | .506 | 1.000 | -1.52 | 1.21 |
| Commissioned Officer | Junior Enlisted | 1.084* | .378 | .030 | .07 | 2.10 |
| | NCO | .658 | .352 | .386 | -.29 | 1.60 |
| | Senior NCO | .156 | .506 | 1.000 | -1.21 | 1.52 |

*Note.* *The mean difference is significant at the 0.05 level.

In the second method, servicemembers were grouped into two categories, one consisting of junior enlisted and non-commissioned officers while the other comprised of senior non-

commissioned officers and commissioned officers.  T-tests were run to see if there were differences in the two groups regarding how they responded to Likert scale questions related to their perceptions as to how mental health is addressed by unit leadership and the military.  A significant difference (t(105)=-2.247, p=-.027, two-tailed)  was found in how the two groups responded to the statement, "My leadership supported the use of mental health services during my deployment."  The junior enlisted/non-commissioned officer group had a lower mean response (m=2.67) than that of the senior non-commissioned officer/commissioned officer group (m=3.38) suggesting less agreement with the statement.

There was also a significant difference (t(105)=-2.458, p=.016, two-tailed) in how the two groups responded to the statement, "The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma."  The junior enlisted/non-commissioned officer group had a lower mean response (m=2.53) than that of the senior non-commissioned officer/commissioned officer group (m=3.29) suggesting less agreement with the statement.

Next, a significant difference (t(105)=2.720, p=.008, two-tailed) was found in how the two groups responded to the statement, "Unit leadership would ensure confidentiality to a servicemember seeking mental health services."  The junior enlisted/non-commissioned officer group had a lower mean response (m=2.78) than that of the senior non-commissioned officer/commissioned officer group (m=3.54) suggesting less agreement with the statement. Results are outlined in Table 13.

Table 13.

*Responses of Junior Enlisted/NCOs (N=83) vs. Senior NCOs/Commissioned Officers (N=24)*

| Likert Scale Question | Rank Group | Mean | t(105) | p |
|---|---|---|---|---|
| My leadership supported the use of mental health services. | Junior Enlisted/NCO | 2.67 | | |
| | Senior NCO/Officer | 3.38 | -2.247 | .027 |
| The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma | Junior Enlisted/NCO | 2.53 | | |
| | Senior NCO/Officer | 3.29 | -2.458 | .016 |
| My leadership effectively assessed the mental health wellness of its troops | Junior Enlisted/NCO | 2.57 | | |
| | Senior NCO/Officer | 2.63 | -.194 | .847 |
| My leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment | Junior Enlisted/NCO | 2.47 | | |
| | Senior NCO/Officer | 2.83 | -1.240 | .218 |
| The military provided me with sufficient training on the effects of combat on mental health. | Junior Enlisted/NCO | 2.71 | | |
| | Senior NCO/Officer | 2.63 | .298 | .767 |
| The military does enough to educate and inform servicemembers about mental health wellness. | Junior Enlisted/NCO | 2.60 | | |
| | Senior NCO/Officer | 2.67 | -.228 | .820 |
| Unit leadership would ensure confidentiality to a soldier seeking mental health services. | Junior Enlisted/NCO | 2.78 | | |
| | Senior NCO/Officer | 3.54 | -2.720 | .008 |
| Unit leadership discussed with servicemembers how the stress of a deployment affects mental health. | Junior Enlisted/NCO | 2.65 | | |
| | Senior NCO/Officer | 2.75 | -.338 | .736 |
| My leadership would view a servicemember seeking mental health treatment as positive action. | Junior Enlisted/NCO | 2.67 | | |
| | Senior NCO/Officer | 3.13 | -1.715 | .089 |

*Note. Significant differences in mean scores are indicated in **bold** print.*

Finally, Spearman rho correlations were run to determine if there was a relationship between servicemembers' rank and how they perceive mental health is addressed by unit leadership and the military. There was a significant, very weak, positive correlation between servicemembers' ranks and their agreement with the statements, "My leadership supported the use of mental health services during my deployment" (rho=.197, p=.042, two-tailed) and "The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma" (rho=.193, p=.046, two tailed). The correlation indicates that as rank goes up, so does agreement that the military and unit leadership is making positive strides in addressing mental health issues. There was also a significant, weak, positive correlation between

servicemembers' rank and the statement, "Unit leadership would ensure confidentiality to a servicemember seeking mental health services" (rho=.226, p=.019, two-tailed).  There were no other significant correlations between servicemembers' rank and any of the other Likert scale questions.

**Hypothesis II:  National Guard/reserve servicemembers perceptions as to how mental health issues are addressed by unit leadership and the military are more favorable than those of active duty units.**  This hypothesis was based on the thinking that servicemembers in active duty units are more immersed in a military culture that has historically contributed to mental health stigma than counterparts in the National Guard or reserves who normally perform military duties on a part-time basis.  T-tests were run to determine if there was a difference in how servicemembers responded to the Likert scale questions depending upon their unit type.  No significant differences were found in any of the variables.  Results from analysis are provided in Table 14.

Table 14.

*Responses of Active Duty (N=65) vs. National Guard/Reserves (N=41)*

| Likert Scale Question | Unit Type | Mean | t(105) | p |
|---|---|---|---|---|
| My leadership supported the use of mental health services. | Active Duty | 2.83 | | |
| | Guard/Reserve | 2.85 | -.083 | .934 |
| The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma | Active Duty | 2.82 | | |
| | Guard/Reserve | 2.54 | 1.018 | .311 |
| My leadership effectively assessed the mental health wellness of its troops | Active Duty | 2.71 | | |
| | Guard/Reserve | 2.39 | 1.219 | .225 |
| My leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment | Active Duty | 2.62 | | |
| | Guard/Reserve | 2.46 | .597 | .552 |
| The military provided me with sufficient training on the effects of combat on mental health. | Active Duty | 2.65 | | |
| | Guard/Reserve | 2.78 | -.540 | .590 |
| The military does enough to educate and inform servicemembers about mental health wellness. | Active Duty | 2.57 | | |
| | Guard/Reserve | 2.71 | -.568 | .571 |
| Unit leadership would ensure confidentiality to a soldier seeking mental health services. | Active Duty | 2.94 | | |
| | Guard/Reserve | 2.98 | -.149 | .882 |
| Unit leadership discussed with servicemembers how the stress of a deployment affects mental health. | Active Duty | 2.77 | | |
| | Guard/Reserve | 2.54 | .919 | .360 |
| My leadership would view a servicemember seeking mental health treatment as positive action. | Active Duty | 2.71 | | |
| | Guard/Reserve | 2.88 | -.742 | .460 |

*Note. Significant differences in mean scores are indicated in* **bold** *print.*

**Hypothesis III:  Servicemembers who have deployed more than once perceive efforts made by unit leadership and the military regarding mental health wellness more favorably than those who have deployed one time.**   This hypothesis was based on the theory that experienced servicemembers are more likely to have recognized the military's increased efforts in effectively addressing mental health since the beginning of the Iraq and Afghanistan wars. Those with multiple deployments have had more than one significant benchmark over the course of their military careers to compare how mental health in the military is handled.

T-tests were run to determine if there was a difference between how servicemembers with one deployment and those who had deployed multiple times responded to Likert scale questions related to how unit leadership and the military addresses mental health compared to those who have deployed multiple times.   A significant difference between the two groups was found among several of the statements, confirming the hypothesis that those with more than one deployment view military mental health more favorably.  Servicemembers with more than one deployment were more likely to agree that the use of mental health was encouraged by unit leadership (t(105)=-2.572, p=.011, two-tailed), that leadership made efforts to reduce negative feelings associated with mental health treatment (t(105)=-2.452, p=.017, two-tailed), that the military does enough to educate and inform about mental health wellness

(t(105)=-2.226, p=.028, two-tailed), that leadership discussed the effects of combat stress (t(105)=-2.404, p=.018, two-tailed) and that leadership would view servicemembers seeking health as a positive action (t(105)=-2.477, p=.015, two-tailed).  These findings are outlined in Table 15.

Table 15.

*Responses of Servicemembers who Deployed Once (N=48) vs. More than Once (N=59)*

| Likert Scale Question | # of Times Deployed | Mean | t(105) | p |
|---|---|---|---|---|
| My leadership supported the use of mental health services. | 1 | 2.58 | | |
| | >1 | 3.03 | -1.707 | .091 |
| The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma | 1 | **2.33** | | |
| | >1 | **3.00** | **-2.572** | **.011** |
| My leadership effectively assessed the mental health wellness of its troops | 1 | 2.38 | | |
| | >1 | 2.75 | -1.471 | .144 |
| My leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment | 1 | **2.23** | | |
| | >1 | **2.81** | **-2.425** | **.017** |
| The military provided me with sufficient training on the effects of combat on mental health. | 1 | 2.52 | | |
| | >1 | 2.83 | -1.289 | .200 |
| The military does enough to educate and inform servicemembers about mental health wellness. | 1 | **2.33** | | |
| | >1 | **2.85** | **-2.226** | **.028** |
| Unit leadership would ensure confidentiality to a soldier seeking mental health services. | 1 | 2.75 | | |
| | >1 | 3.12 | -1.540 | .126 |
| Unit leadership discussed with servicemembers how the stress of a deployment affects mental health. | 1 | **2.35** | | |
| | >1 | **2.93** | **-2.404** | **.018** |
| My leadership would view a servicemember seeking mental health treatment as positive action. | 1 | **2.48** | | |
| | >1 | **3.02** | **-2.477** | **.015** |

*Note. Significant differences in mean scores are indicated in* **bold** *print.*

**Hypothesis IV: Servicemembers with combat arms military occupations perceive efforts by unit leadership and the military regarding mental health wellness less favorably than those of non-combat occupations.** The basis of this theory was that because the mission of infantry units is direct combat, the nature of their job promotes an atmosphere that is even more resistant than that of other military occupations in changing the way it has historically dealt with issues related to mental health. However, T-tests run found no significant differences in the way servicemembers of combat arms military occupations responded to Likert scale questions. Results can be reviewed in Table 16.

Table 16.

Responses of Servicemembers in Combat Arms Units (N=45) vs. Non-Combat Arms Units (N=62)

| Likert Scale Question | Occupation | Mean | t(105) | p |
|---|---|---|---|---|
| My leadership supported the use of mental health services. | Combat | 2.76 | | |
| | Non-Combat | 2.89 | -.488 | .626 |
| The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma | Combat | 2.76 | | |
| | Non-Combat | 2.66 | .350 | .727 |
| My leadership effectively assessed the mental health wellness of its troops | Combat | 2.71 | | |
| | Non-Combat | 2.48 | .889 | .376 |
| My leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment | Combat | 2.58 | | |
| | Non-Combat | 2.53 | .182 | .856 |
| The military provided me with sufficient training on the effects of combat on mental health. | Combat | 2.71 | | |
| | Non-Combat | 2.68 | .138 | .890 |
| The military does enough to educate and inform servicemembers about mental health wellness. | Combat | 2.64 | | |
| | Non-Combat | 2.60 | .200 | .842 |
| Unit leadership would ensure confidentiality to a soldier seeking mental health services. | Combat | 3.04 | | |
| | Non-Combat | 2.89 | .647 | .519 |
| Unit leadership discussed with servicemembers how the stress of a deployment affects mental health. | Combat | 2.82 | | |
| | Non-Combat | 2.56 | 1.041 | .300 |
| My leadership would view a servicemember seeking mental health treatment as positive action. | Combat | 2.69 | | |
| | Non-Combat | 2.84 | -.667 | .506 |
| Note. Significant differences in mean scores are indicated in **bold** print. | | | | |

**Hypothesis V:  There is a difference between males and females feel as to how they feel issues relating to mental health are addressed by unit leadership and the military.** T-tests were run to determine if a servicemember's gender influenced their perceptions as to how mental health wellness is addressed in the military.  No significant differences between males and females were found in any of the variables.  However, it is important to note that females accounted for only 18 of the 107 servicemembers who participated in the study.  This discrepancy significantly weakened the value of the analysis.  Results are outlined in Table 17.

Table 17.

Table 17.

*Responses of Males (N=89) vs. Females (N=18)*

| Likert Scale Question | Gender | Mean | t(105) | p |
|---|---|---|---|---|
| My leadership supported the use of mental health services. | Male | 2.83 | | |
| | Female | 2.83 | .400 | .996 |
| The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma | Male | 2.69 | | |
| | Female | 2.78 | 1.194 | .795 |
| My leadership effectively assessed the mental health wellness of its troops | Male | 2.62 | | |
| | Female | 2.39 | .038 | .499 |
| My leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment | Male | 2.56 | | |
| | Female | 2.50 | .523 | .851 |
| The military provided me with sufficient training on the effects of combat on mental health. | Male | 2.67 | | |
| | Female | 2.78 | .290 | .748 |
| The military does enough to educate and inform servicemembers about mental health wellness. | Male | 2.64 | | |
| | Female | 2.50 | .206 | .656 |
| Unit leadership would ensure confidentiality to a soldier seeking mental health services. | Male | 2.94 | | |
| | Female | 3.00 | .002 | .862 |
| Unit leadership discussed with servicemembers how the stress of a deployment affects mental health. | Male | 2.72 | | |
| | Female | 2.44 | 1.784 | .403 |
| My leadership would view a servicemember seeking mental health treatment as positive action. | Male | 2.79 | | |
| | Female | 2.72 | .436 | .829 |
| *Note. Significant differences in mean scores are indicated in **bold** print.* | | | | |

**Hypothesis VI:  Servicemembers of the Army and the Marine Corps view efforts by unit leadership and the military in addressing mental health less favorably than those of the Air Force and Navy.**  This hypothesis could not be tested due to lack of representation from all military branches.

**Responses to Open-Ended Questions**

Servicemembers were asked to respond to four open-ended questions in written form. Qualitative analysis was carried out by coding responses into categories based on themes that emerged.  This section is broken into four sections to highlight findings from each separate,

open-ended question. Major themes that transpired from responses to each question are discussed and direct quotations from servicemembers' are included to give vivid examples of each.

**Describe the messages you received about mental health from your unit leadership.**
Seventy-three servicemembers responded to the first open-ended question. Responses were analyzed, thematically coded, and initially categorized into the following three, main categories: A positive message was received, a negative message was received, or a neutral message was received. Responses were broken down further and subcategorized within these three classifications. Many servicemembers answered this question, and the open-ended questions that follow, in a manner that generated multiple themes. Therefore, it was possible for some responses to fall into more than one category or subcategory.

*A positive message was received.* In describing the messages they received from unit leadership regarding mental health, eighteen servicemembers (24.7%) responded with written content that included a positive theme.

*Leadership was supportive of issues related to mental health and encouraged treatment.* The majority of responses that discussed receiving a positive message from leadership described an environment in which leadership was supportive of mental health treatment and its use was encouraged. Some servicemembers specifically used words such as "support" and encouragement" when addressing the question. For example, one servicemember wrote, "Command and leadership channels encouraged soldiers of my unit to seek services available from medical and chaplaincy professionals and ensured that all members of the unit were able to recognize the effects of combat stress". Another servicemember stated, "Leadership was

supportive of mental health awareness within the organization and encouraged soldiers to seek the help they thought they needed within reason."

*Leadership made mental health services available.*  Responses that spoke of leadership (N=8) discussing available mental health resources, such as services provided by medics, chaplains, and combat stress units, were also grouped into the "positive message" category.  One such response was as follows:  "Specific announcements were made by leadership when certain services were available on our post, like when dedicated combat stress personnel came to visit."  Another servicemember wrote that leadership said, "If we had mental health problems, we were to talk to the doc."

*Leadership sent mixed messages about mental health.*  Other responses discussed receiving mixed messages and were grouped into both the positive and negative message categories.  In one such response, a servicemember discussed receiving messages from leadership at the beginning of his military career that reinforced stigma, but also spoke of how this improved over time.  He stated,

> When I first entered the service there was stigma, like if you sought mental health
> assistance there was something wrong with you.  Now that OIF and OEF have been going
> on for awhile, the idea of mental health after a deployment has been normalized and there
> is little or no stigma.

Another servicemember discussed that while some of his unit leadership seemed to be supportive to those seeking help, while others being unsupportive.  "Some of our leadership left an impression that you were weak if you sought help, but other leaders who had previous combat experience knew what was what," he stated.    The following response was grouped into both

categories, also interpreted as having a mixed message: "Get mental health help if you need it, but you are NOT getting out of here."

*A **negative message was received**.* The responses of 46 servicemembers (63%) contained content regarding negatively themed messages they received from unit leadership about mental health. Because the military's handling of mental health is so important for multiple reasons, many of which have been outlined, responses that explicitly stated that they received little or no message regarding mental health from unit leadership were grouped into this category. This theme, along with the following two emerged from analyzing servicemembers' responses: leadership discouraged servicemembers from accessing mental health treatment leadership and leadership viewed those seeking mental health treatment unfavorably. These themes are discussed further below.

*Little or no message was received from unit leadership about mental health.* Out of servicemembers' responses that contained a negative theme, 18 (39.1%) mentioned how little mental health was addressed in their military experience, if at all. Examples of such responses include: "I do not recall any messages given or said to me about mental health", "All of the messages I received were about physical health, nothing about mental health", "Other than in mobilization training, I don't think mental health was mentioned the whole time we were deployed", and "I cannot recall mental health ever being discussed in any way; I feel it was something that was swept under the rug."

*Unit leadership discouraged servicemembers from accessing mental health treatment.* The responses of fourteen servicemembers (30.4% of responses with a negative message) indicated that leaders relayed the message that troops should not access mental health care.

"Seeking mental health treatment is highly discouraged by leadership and its attitude is reflected by subordinates," a servicemember stated. Some servicemembers went further, saying they were actually ordered by leadership to avoid seeking treatment. "I was told that I couldn't go to appointments due to unit activities and was never allowed to make them up," one servicemember wrote. "Don't go to treatment. It is a waste of time and takes away from the mission," another servicemember added. An additional servicemember discussed being told by leadership to refrain from speaking of certain issues at a scheduled mental health appointment. He said, "I went to mental health to be cleared for my second and third deployments and was told each time not to tell them how I really felt so that I could deploy."

Other servicemembers explained unit leadership as outlining consequences that would occur for seeking mental health treatment. These responses were also interpreted as having relayed discouraging messages about mental health to services. Two servicemembers spoke of leaders who advised that seeking mental health would negatively affect their careers. "If you seek mental health, you will be chaptered out (discharged) of the service shortly after," one servicemember wrote. Another servicemember stated that leadership warned him, "If you seek mental health you will be chaptered out shortly after."

Four servicemembers suggested that leadership made those who sought mental health treatment feel as though they were putting themselves ahead of their duty. One servicemember explained that he perceived leadership as relaying the message, "Seeking treatment takes away from the mission." Another servicemember stated, "Unit leadership made soldiers seeking mental health treatment aware that were causing a shortage." An additional servicemember stated that those seeking treatment were told, " Suck it up and continue to do your job. If you are

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out of sector because of that there is someone else that will pick up your weight and someone else will get killed."

The "suck it up" mentality was a message a few servicemembers discussed. "Shake it off; Cowboy up," and "Just do your job; You're fine," are examples of such messages servicemembers reported as having received from unit leadership regarding mental health. An additional servicemember attributed the negative message he received from leadership to the culture of his branch of service. He said, "The standard Marine mindset is to suck it up. This seems less a specific leadership issue and more of a Marine Corps culture issue."

*Unit leadership looked unfavorably upon servicemembers seeking mental health treatment.* A total of 40.1% of responses (N=20) grouped into the "negative message" category contained thematic content in which servicemembers felt as though leadership viewed those seeking treatment differently. One servicemember wrote, "I feel that my leadership looked down at somebody that wanted help. They usually thought they were trying to get out of work." Another added, "The command looked at me differently because I had to go to mental health for PTSD after my first tour of duty in Iraq." An additional servicemember explained, "They would remove a man from the watch rotation if there were mental health concerns, and then send him to specialized mental health services, but the person was then looked differently within the command."

The word, "weak" came up in half of the responses that described the unfavorable way leadership viewed those who sought mental health treatment. The following are examples of such: "Admitting to anything that was a weakness was to become weak. Weakness was mocked by unit leadership until it was suppressed and, hidden until it was forgotten", "If you would say

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that you needed to see someone about an issue, you were considered weak", and "If you sought out any help for mental or physical illness, you were labeled as weak and malingering."

A handful of servicemembers explained that their leaders openly mocked those who accessed treatment for psychiatric issues. The following is an example of one such narrative:

> A soldier in my unit went to the chaplain to discuss his situation, and was harassed for it. Leadership would say things to this soldier like, "Hey sergeant. Take care of this paperwork. Wait, is that too much? Do you need to talk to the chaplain first? I don't want to stress you out."

*A neutral message was received.* Fourteen servicemembers (35.6%) mentioned in their responses that unit leadership had provided them with mental health briefings and trainings. Because these efforts were not described in a positive or negative manner, the content was classified into this separate, neutral category. Examples of such responses include, "We were briefed by leadership at monthly safety briefings", "We received in-house classes by leadership and the chaplain", and "Classes were given before, during, and after deployment for which signs to look for in yourself and others around you."

**Explain how your unit leadership addressed the psychological well-being of servicemembers in responding to stressful periods and trauma that occurred during deployment(s).** A total of seventy-three servicemembers responded to the second open-ended question. Responses were initially categorized into two main categories: Unit leadership addressed the psychological well-being of servicemembers in responding to stressful periods and trauma and unit leadership *did not* address the psychological well-being of servicemembers in responding to stressful periods and trauma. Seven servicemembers (9.6%) indicated that

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question was not applicable to them, as they did not experience combat stress or trauma. Responses in the two categories mention were broken down further and subcategorized within each of these two classifications.

***Unit leadership addressed the psychological well-being of servicemembers in responding to stressful periods and trauma that occurred during deployment(s).*** Content derived from 57.5% of servicemembers' responses (N=42) indicated that unit leadership addressed the psychological well-being of servicemembers responding to stressful incidents in one way or another. Within this category, responses are divided into three subcategories depending on how the psychological well-being of servicemembers was addressed by leadership: positively, negatively, or in a neutral manner. Responses to this question will be discussed further within the subheadings below.

*The psychological well-being of servicemembers was addressed positively.* A total of 30.1% (N=22) of servicemembers who responded to the second open-response question indicated that they believed unit leadership effectively addressed combat stress and trauma. The responses had an overarching theme of leadership support in handling stressful incidents. Twelve servicemembers described leaders as encouraging their troops to access a variety of mental health resources if needed. "By and large, leadership was supportive and soldiers seeking help were encouraged to do so," one servicemember noted. "They were responsive when people exhibited stress and offered assistance," commented another.

Seven servicemembers discussed leaders that encouraged troops to talk about a traumatic event after it occurred. Four of these responses described elements of the critical event debriefing intervention often utilized by the Army, where outside mental health providers are

accessed to help units emotionally process an incident. One servicemember highlighted such a debriefing by commenting,

> Stressful events were re-capped at an appropriate pause in action, when soldiers could safely decompress and vent about their recent missions and experiences. Often, chaplains and social workers were present during the platoon/company team-time, which set the stage and built trust between unit members before services were required.

Another servicemember explained, "Everytime my platoon or company had someone killed in action, the brigade psychologist and battalion chaplain would be flown out to our base to provide some form of counseling."

Four servicemembers spoke of classes that leaders were given to help them effectively respond to trauma and combat stress among their troops. "During sergeant's time, soldiers were given classes on how to assist one another during stressful times and also recognize stress levels amongst troops," a servicemember noted.

*The psychological well-being of servicemembers was addressed negatively.* The responses of 18 servicemembers (24.7%) contained content that described leadership as addressing incidents related to combat stress and trauma in a negative manner. More than half of these responses indicated that leadership addressed the psychological well-being of their troops after these incidents by telling them that they needed to "tough it out" or "suck it up".

A servicemember explained, "If it was noticeable that a particular individual was having trouble with their mental health after an incident, it is my opinion that leadership would look the other way or tell them to toughen up." Another servicemember reported, "Leadership told us to ignore it and not to talk about it." An additional servicemember added,

There were several instances that I personally witnessed in which soldiers experienced

mental health disturbances but when they reported their symptoms, their officers and

NCOS had given a number of dismissive responses ranging from "stop faking" to suck it

up.

Other servicemembers commented on leadership's skepticism of those requesting mental

health services after a traumatic event. One servicemember explained that he received the

following message from his leadership after a stressful incident: "If you're faking it, then you're

going to be labeled a bad soldier so either deal with it or take a chance at looking like you're

faking." Referring to those who accessed mental health treatment, another servicemember

wrote, "They were treated skeptically, as if they were dodging duty."

Some servicemembers reported being verbally abused by higher-ups after a traumatic

event occurred. "If anything, severe psychological trauma was made worse by leadership by

chastising, punishing, verbally abusing, and openly mocking soldiers," said one servicemember.

Another added, "When some soldiers openly mocked those having issues, command did nothing

to stop it."

*The psychological well-being of servicemembers was addressed in a neutral manner.*

Five servicemembers responded to the open-response question speaking only to the fact that unit

leadership granted troops time off from conducting missions after a stressful incident, usually a

day. Because this was not interpreted as either positive or negative action, a separate, neutral

category was created for these responses.

***Unit leadership did not address the psychological well-being of servicemembers in responding to stressful periods and trauma that occurred during deployment(s).*** A total of 32.9% of servicemembers (N=24) explicitly stated in their responses that leaders did not address their troop's psychological well-being response to combat stress and trauma. Most of these responses stated this without elaboration. However, a few had more to share about their leadership's lack of response with some writing about specific incidents in which no action was taken. For example, one servicemember explained, "We had a woman in our unit who was raped in Kuwait before we entered Iraq, and nothing was talked about." Another wrote, "We lost our leader by a sniper right next to us, and no one talked about it." An additional servicemember added,

> After a death that impacted the whole unit, no extra counseling was brought in. Soldiers were expected to continue the mission without a unit brief or discussion to ensure that all soldiers were still mission ready. This was a failure on the unit that caused PTSD effects in a lot of soldiers now dealing with the loss.

"We were left on our own to discover our own programs," another servicemember noted.

**If you were to have a direct conversation with your unit leadership about how mental health wellness and treatment should be addressed in the military, what would you tell them?** Seventy servicemembers responded to the third open-response question. The content of responses were analyzed, thematically coded, and classified into the categories described below.

***Reduce stigma.*** Thirteen servicemembers (18.6%) explained that stigma attached to military mental health needs to be more effectively addressed by leadership. Some

servicemembers gave examples as to how leadership magnifies this stigma related to military mental health. "Soldiers who seek help are alienated, ridiculed, and made to seem worthless for trying to get better and do their job. This needs to stop, yesterday!" a servicemember stated.

*Training needs to be improved.* Twenty-one servicemembers (30.0%) discussed that mental health training needs to be improved. Some responses alluded to the idea that leaders need to be better equipped at recognizing the effects combat stress has on their troops. Other responses suggested that it is the military's responsibility to better train all servicemembers on this issue. "Training needs to be more real and personal than a briefing or PowerPoint on suicide awareness," one servicemember commented.

*Mental health issues must be taken more seriously.* Eleven servicemembers (15.7%) suggested that if they were able to have a direct conversation with unit leadership about mental health wellness, they would emphasize how important the matter is in the military. One servicemember said, "There is a time to be strident about petty things like uniform standards, and there is as time to understand that people have larger and more pressing concerns upstairs. Err on the side of the latter."

*Mental health resources need to be more accessible.* Thirteen servicemembers (18.6%) wanted to let leadership know that mental health resources need to be more available. "Allow soldiers to seek the help they need. Overall, it will improve their readiness," one servicemember stated. "Soldiers showing severe signs of mental trauma should be given a chance to speak with a mental health professional, not just given time away from the mission dwelling on the issues bothering them," another servicemember added. Five of these responses suggested making mental health treatment mandatory for all servicemembers. The following is one such response:

"I would suggest that one-on-one time with a psychologist be a regularly scheduled occurrence, like dental work. That way, everyone is looked at and spoken with frequently."

*Confidentiality needs to be better maintained.* Five servicemembers (7.1%) addressed the topic of confidentiality in their responses. "Find a way to keep it totally off the books," one servicemember wrote. "It should be 100% confidential," another servicemember added. "If someone appears disheartened or depressed, reiterate services that are available, but not in such an obvious way," an additional servicemember commented.

*Keep up the good work.* Five servicemembers (7.1%) said they would tell their leadership that their handling of mental health services was sufficient. "We had great leadership and had an open-door policy. I was completely satisfied with the available help," wrote one servicemember. "I would tell them that I think their system and process is adequate for assessing and treating those who need help," added another.

*I would not tell them anything.* Eleven servicemembers (15.7%) said they would not say anything if given the opportunity to have a conversation with unit leadership about mental health. One servicemember explained why he would keep quiet: "I'm pretty sure anything I would have to say would fall upon deaf ears. The military is a traditionalist, conservative enterprise which operates within marginalized confines. Change doesn't come from policy. Change comes slowly via new generational attitudes."

**Have your views on the way mental health treatment and wellness is addressed by the military changed as a result of your service and/or deployment? If so, explain.**
Seventy-one servicemembers responded to the final open-ended question.    Content from responses were initially categorized into the following two groups: My view has changed and

my view *has not* changed.  Responses in the former category were broken down into two subcategories:  My view has changed positively and my view has changed negatively.

The responses of ten servicemembers (14.1%) were not coded into either group because they did not directly answer the question.  Therefore, they did not fall into either category.  For example, some of these responses were by servicemembers who were unsure if their view had changed without elaboration.  "I don't know, I have not been in the military since 2004," one servicemember said.  Other responses were general statements about military mental health, some positive and some negative.  " I got the help that I needed, because I knew it was there," said one servicemember.   Another servicemember was not quite as satisfied.  "I don't think the military's approach to this issue is adequate.  It is almost handled in a 'check the block' kind of way."   An additional servicemember used the space to give the military some further advise on the way it handles issues related to mental health.  "Mental health really needs to start weeding out the people who are looking for a disability check and help people such as myself who have PTSD."

**My view has changed.**  Thirty-seven servicemembers (52.1%) indicated that their view on the way mental health treatment and wellness is addressed by the military has changed.  A total of 45.9% of these responses (N=17) indicated positive change, while 54.1% (N=20) discussed negative change.

*My views have changed positively.*  Eleven servicemembers indicated that their outlook on military mental health has shifted positively as a result of overall improvements that have been made.  One servicemember explained, "In the beginning (2004-2006) there was no support, but now because of the media and the outcries of veterans, there have been positive changes.

Now, there is a much better support element set up for returning vets." "I have seen an increase in awareness at all levels since my first deployment and remain impressed with the resources and effort that have been directed to provide help," added another. Another servicemember stated, "The military has now made it a priority to address some of the issues that our men and women in uniform are facing after combat."

Six servicemembers discussed that their view on military mental health has changed for the better because of positive results they received from treatment. One servicemember reported,

> While I was in, I very much fell into the 'suck it up' mindset. I maintained that for about five years after I got out. I had seen combat and thought I could handle my own head. That mindset cost me a lot. I spent years unnecessarily angry and frustrated. I was unable to express or understand myself and lost my wife because of it. I truly wish I had appreciated mental health treatment from the get go.

*My views have changed negatively.* Thirteen servicemembers wrote that they had expected more in the way the military addresses mental health treatment and wellness. Their responses suggest that their experiences have shaped an opinion that the military is inefficient in handling mental health issues. One servicemember wrote,

> I thought the military would do more for mental concerns. The military seems to publicly display their efforts to help physically disabled veterans, which is wonderful, but how about also working harder on the less obvious disabilities that people return home with?

"I learned that mental health is put at the very bottom of the pre-deployment checklist," another servicemember added. An additional servicemember said, "I thought it was okay before I deployed. Now I realize that the mental health care of troops post-deployment is pitiful."

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Some servicemembers explained that their experiences have made them feel as though the military "does not care" about their mental health needs as individuals. "Yes, my views have changed. I've learned that the military does not care about the individual," explained one servicemember." "It's all about the numbers. Command doesn't care about how wacked out a soldier is as long as the unit is full manned," another added.

Two servicemembers wrote about a negative change in view due to their lack of faith in military mental health care providers. One servicemember wrote,

> I do not feel that any psychologist can help me deal with what I have seen or been through. They are not interested in helping me to deal with things and get to the root of the problem. Therefore, I do not seek counseling.

Two additional servicemembers discussed that their view on how the military addresses mental health issues has been tainted by the actions of some of those they serve with. One servicemember wrote,

> Many soldiers go to mental health to get out of some kind of trouble they are in (drug-related, spousal abuse, etc.) by pleading PTSD to lessen their punishment. Others are trying to score some kind of benefit. Many just use the system to their advantage.

"Many veterans seek mental health help for money incentives. Because the military rewards those who claim mental health problems, there are false claims," another servicemember added.

**My view *has not* changed.** The majority of the 24 servicemembers who stated that their views have not changed did so without elaboration. "I believe the military has always been guarded on this topic, and my deployment has not changed this belief," said one servicemember.

Results from this study indicate that servicemembers vary greatly in the way they perceive mental health is addressed by unit leadership and the military. Some highlight improvement since the beginning of the Iraq and Afghanistan wars in the way the military addresses issues related to mental health. However, 40-50% of servicemembers in this study indicated that they have a negative view in how these matters are addressed and the efforts that have been made. The following chapter will provide reflection on these results, and discuss implications of these findings on further research, clinical practice, and military policy. Limitations of the research will also be discussed.

CHAPTER V

**Discussion**

While previous research has been carried out on stigma associated with mental health in the Armed Forces, this study is the first known to specifically explore the role unit leadership plays in servicemembers' perceptions of psychiatric wellness and treatment. Despite military-wide efforts to reduce stigma, earlier quantitative research conducted on perceived barriers to mental health services concluded that many servicemembers feel as though they would be treated differently by leadership in accessing care (Hoge et al., 2004; Kim et al., 2011; Kim et al., 2010; Gorman et al., 2011). The aim of this study was to investigate the reason why servicemembers have this opinion and to better understand the implicit and explicit messages troops are receiving from their leaders about mental health wellness.

This chapter will first summarize the main findings of the study and compare results to previous research, making connections to studies discussed in the literature review. Next, the study's limitations will be highlighted and suggestions for further research will be made. Finally, implications for clinical practice as well as policy implications will be discussed.

**Summary of Major Findings**

The major findings reported in this study are related to the following overarching theme: many servicemembers have negative perceptions as to how military leadership handles mental health issues. For example, the study found that while the majority of those in the military

(73.8%) would view a fellow servicemember seeking mental health treatment as positive action, less than a quarter of those surveyed (22.4%) believe leadership would hold the same favorable stance towards an individual accessing care.  Becker's (1963) belief that those who deviate from cultural norms are labeled in a negative light may explain why leaders are sending a disapproving message to those that who seek treatment instead of adhering to the historic "suck it up" mentality of the military culture.

Over half of the study participants (55.1%) feel that unit leadership would treat a servicemember seeking mental health services differently. These findings support previous research that has established servicemembers' concerns about unit leadership as a significant barrier in their access to care (Hoge et al., 2004; Kim et al., 2011; Kim et al., 2010; Gorman et al., 2011).  This phenomenon could be explained by Scheff's take on the labeling theory, which was discussed in the literature review.  Scheff (1966) believed that individuals who seek treatment for issues related to mental health face stigmatization that results in rejection and punishment from others when they attempt to return to conventional roles.  Applying Scheff's theory to these findings, the conventional role would equate to the military duties a servicemember would return back to under superiors who would treat him or her differently for accessing mental health care.

Prior studies on military mental health stigma have not analyzed why unit leadership is one of the top perceived barriers in accessing treatment among servicemembers.  They have only identified it as such.  The purpose of this research was to analyze why this perception of unit leadership exists.  The results of this study show that just over half of servicemembers (50.5%) believe the military's efforts of destigmatizing mental health have not trickled down to the actions of its leaders.  Because of this, many servicemembers feel as though the leaders who are

directly responsible for them reinforce stigma and a negative message surrounding mental health. For example, 36.4% of servicemembers indicated that they were not certain unit leadership would ensure confidentiality to an individual seeking mental health services.

Results from this study indicate that it is not only a perceived lack of support of mental health services among leadership that is a barrier, but it is also leadership's skills in educating and training servicemembers and assessing mental health wellness that is a barrier. The negative messages many servicemembers are receiving from those in charge may explain why over half of those surveyed (51.4%) indicated that mental health services were not encouraged by unit leadership. The quantitative section of the questionnaire contained a similar Likert scale question that posed the statement, "My leadership supported the use of mental health services during my deployment," in which 47.7% servicemembers either strongly disagreed or disagreed. In addition, almost half of those surveyed (48.6%) felt as though unit leadership provided them with insufficient training on the effects of combat stress. The same percentage evaluated military leaders as inadequate in assessing the mental health wellness of their troops.

Despite the military's increase of awareness efforts since the beginning of the Iraq and Afghanistan wars, servicemembers did not rate the military's handling of mental health any better. A total of 45.8% of servicemembers stated that the military provided them with insufficient training on the effects of combat on mental health. The majority of those (55.1%) surveyed also indicated that the military does not do enough to educate and inform servicemembers about mental health wellness. As discussed in the literature, the Department of Defense's Real Warriors Campaign is one of the military's leading efforts in combating stigma attached to mental health. However, an alarmingly small number of servicemembers (5.6%) in this survey stated they were familiar with the program.

In examining specific hypotheses, the study found that differences existed in perceptions of leadership based on rank and number of deployments. For example, commissioned officers were much more likely than those of junior enlisted ranks to agree with the statement, "Unit leadership would ensure confidentiality to a servicemember seeking mental health services. Senior non-commissioned officers and officers were more apt to agree that leadership supported the use of mental health services, the utilization of mental health services was encouraged by unit leadership and unit leadership would ensure confidentiality to a servicemember seeking mental health services. Separate analyses to measure relationships in the data found positive correlations between servicemembers' ranks and their agreement with these statements, indicating that as rank goes up, so does agreement that the military and unit leadership is making positive strides in addressing mental health issues. This may be explained by the fact that higher ranking servicemembers have more responsibility for the mental health of their subordinates and therefore would be more likely to assess themselves in a positive light.

Analysis of the data also supported the hypothesis that servicemembers who have experienced multiple deployments have a more favorable view in how unit leadership and the military addresses issues related to mental health than those who have deployed once. Those deployed more than once were more likely to agree that the utilization of mental heath services was encouraged by unit leadership; leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment; the military does enough to educate and inform servicemembers about mental health; leadership discussed with servicemembers how the stress of a deployment affects mental health; and, leadership would view a servicemember seeking mental health treatment as positive action. This could be explained by the theory that those with more than one deployment are more likely to recognize the military's increased

efforts in effectively addressing mental health because these servicemembers have multiple ,significant benchmarks over the course of their careers to compare how it was handled.

In the final part of this study, servicemembers' shared their own personal experiences as to how psychological health was addressed by their leaders and the military through written responses to four open-ended questions. While this qualitative data was not provided by all servicemembers who participated in the study, the data that was collected was valuable in supplementing the Likert scale responses with vivid, personal narratives of experiences with military mental health, some of which were included in the previous chapter.

Servicemembers were asked to discuss the messages they received from unit leadership about mental health. Sixty-three percent of their responses contained content regarding negatively themed messages which supports the quantitative results mentioned above. These negative messages fell under the following themes: 1) Little or no message regarding mental health was received from unit leadership. 2) Leadership discouraged servicemembers from accessing mental health treatment. 3) Leadership viewed those seeking mental health treatment unfavorably. In contrast, 24.7% of servicemembers provided responses with content describing positively themed messages. These responses discussed an environment in which leaders were supportive of mental health and illustrated the fact the experiences among servicemembers are not consistent.

In explaining how unit leadership addressed the psychological well-being of its troops after stressful periods and trauma that occurred while being deployed, 32.9% of servicemembers explicitly stated in their responses that leaders were unresponsive in addressing issues related to mental health. An additional 24.7% indicated leadership carried out measures that were

considered negative.  The majority of these responses indicated that leaders reinforced a "tough it out" or "suck it up" message after combat stress and trauma were experienced by servicemembers.  Others described an environment where leaders reacted to traumatic events by verbally abusing the servicemembers underneath them.  Additional servicemembers spoke of leaders who were often skeptical of those seeking mental health treatment after a traumatic event, questioning them if they were trying to avoid the mission.  This highlights the finding that some leaders are not effectively assessing the mental health well-being of their troops and are unable to distinguish between legitimate combat stress and manipulation of the system.  This finding again ties back to the labeling theory.  Goffman (1963) described those with stigmatized as being deeply discredited in society.  Many servicemembers in this study reported that their mental health symptoms were "discredited" by unit leadership and were they were labeled as malingerers and manipulators of the system.   A total of 30.1% of servicemembers had a contrasting view and indicated that leadership's response to combat stress and trauma was positive and effective.  These servicemembers discussed leaders who encouraged troops to access treatment and created a safe space to talk about emotions related to the stress and trauma of combat.

The study also allowed servicemembers space to discuss what they would want unit leadership to know about the way mental health wellness and treatment should be addressed in the military. The main themes that emerged from servicemembers' responses were suggestions about how mental health issues could be handled better by unit leadership.  Servicemembers would like to see unit leadership take the following actions: 1) Reduce stigma 2) Improve training 3) Take mental health issues more seriously 4) Make mental health resources more accessible 5) Maintain better confidentiality.  The issues that servicemembers spoke of parallel

findings from the quantitative data which indicate stigma and mental health training are matters that need to be addressed among military leadership,

Finally, servicemembers were asked to explain whether or not their attitudes about how mental health is addressed by the military have changed as a result of their experiences in the Armed Forces. Out of the 52.1% of servicemembers who indicated that their view had changed, 54.1% stated that their view on the topic has worsened, while 45.9% indicated an improved outlook. Many servicemembers who discussed a negative change in view stated that their experiences led to their opinion that the military is inefficient in handling mental health issues. Others discussed incidents that guided them to the personal conclusion that the military does not care about the individual servicemember. On the contrary, some servicemembers indicated that the military has made positive progress in addressing mental health over the course of their military careers. Some spoke about their attitudes changing for the better because of positive results they personally experienced in accessing military mental health care. This reiterates the finding that attitudes are not universal among servicemembers in regards to how issues related to mental health are handled by the military.

**Limitations of the Study**

It is important to consider the limitations of this study when interpreting its findings, as the study's design had a number of them. For example, participants were recruited through a method of convenience that consisted of a non-probability purposive, snowball sampling methodology ,which significantly weakens generalizability. Results gathered from the 107 servicemembers who participated in the study are not necessarily representative of the over 2.4 million veterans of the Iraq and Afghanistan wars. Recruitment was primarily carried out by the

researcher via Facebook which in and of itself is a limitation since those without internet access or an account to the social networking website were much less likely to hear about the study.

In addition, the researcher was much more networked with those who have served with the Army than with any of the other military branches. The researcher's request for Facebook users to assist in recruitment efforts most likely generated even more participation from Army veterans. While the study was open to servicemembers of all branches of the Armed Forces, the sample was very heavily composed of those in the Army. The lack of representation from the various military branches and other demographics, limited the amount of analysis that could be carried out. A larger sample population would improve diversity and result in larger representation from servicemembers of various demographic subgroups. This would significantly enhance and increase research opportunities.

It is also important to note the limitations of the survey instrument, which was designed by the researcher. Reliability and validity were not established by any formal means. The anonymous and impersonal nature of the survey did not allow the researcher to ask servicemembers follow-up questions or check for their understanding of the questionnaire. The study's design did not allow for analysis of why many servicemembers chose not participate in the qualitative portion. The written format of the study's qualitative portion was limiting because it did not allow the researcher to seek clarification in servicemembers' responses. The researcher was left to interpret the meaning of various written responses and develop a coding strategy, both of which were very subjective.

While every effort was made to ensure objectivity in the research process, it is important to consider biases of the researcher. The researcher is an Army veteran of the Iraq war and is

aware of his personal biases that may have influenced his approach to the study. Therefore, the researcher conducted this research within the military community of which he identifies as a member. The researcher's personal perceptions of how unit leadership often addressed mental health negatively during his military career inspired his interest in the research topic. While the goal this study was to capture the experiences of other servicemembers regarding this important matter, it is possible that the researcher's experiences may have influenced the way the study was designed and how its findings were interpreted. In an effort to reduce bias, servicemembers' anonymous responses to open-response questions were discussed with a non-military colleague during qualitative analysis.

**Implications for Social Work Research, Clinical Practice and Policy**

The study of stigma associated with military mental health is very scarce. Based on the findings of this particular study and limited research that has proceeded it, there are many recommendations as to how knowledge related to the subject matter could be expanded. As stated in previous chapters, the purpose of this research was to hone in on unit leadership, a perceived barrier to mental health care among several identified by servicemembers in previous studies (Hoge et al., 2004; Kim et al., 2011; Kim et al., 2010; Gorman et al., 2011). Studies that specifically look in-depth at the other perceived barriers to accessing mental health, similar to the way this research looked at unit leadership, are needed.

As far as further research to expand on unit leadership as a perceived barrier to mental health care, studies should be conducted that address limitations discussed in this research. These studies should be designed in a manner that allow for increased sample size and better representation of demographic groups. This would allow for results to be more generalizable of

the population in which the research intends to study.  More qualitative research also needs to be conducted on servicemembers perceptions of how mental health is addressed in the military.  Studies that utilize face-to-face interviewing would provide more extensive feedback on the matter, compared to this study's written format.

The implications this study has on clinical social work are quite evident.  Social workers are at the frontlines when it comes to helping veterans cope with combat-related stress and trauma.  In fact, the Veteran's Health Administration is the nation's largest single employer of social workers.  The findings of this study show that many servicemembers are resistant to mental health treatment because of negative implicit and explicit messages they have from the military.  Stigma associated with mental health treatment in the military is very prevalent and because of this, social workers need to be prepared for the possible reluctant and untrusting attitudes some servicemembers have towards the treatment process.  Professionals in the field need to be able to provide a safe environment where confidentiality is ensured.  They need to be part of the dialogue as to how to effectively address stigma associated with accessing psychological care and also be involved with the mental health training of servicemembers, especially unit leaders.  Finally, social workers need to be equipped in creatively outreaching to servicemembers who may have received an entirely different message regarding mental health through their military experience.  Social workers could be ideal individuals to help train leadership and the military about assessing mental health issues.

The results of this study have huge implications on military policy related to mental health issues as well.  The military needs to reevaluate the way it addresses mental health from the bottom up.  While outreach efforts made by the military at an institutional level are a positive measure, their objective is lost when the actions and words of those with boots on the ground are

not consistent with them.  It is clear that many servicemembers are being relayed a stigmatizing message about mental health from those directly responsible for them.  This creates or maintains a culture that may be negating efforts made by the military at a higher level to raise awareness for mental health concerns and encourage troops to access treatment.  Access to mental health care needs to be increased and issues related to confidentiality should be better maintained.  Some survey participants in this study suggested making periodic mental health appointments for all servicemembers a requirement.  This proposal may be worth investigating.   Also, better training needs to be provided to not only unit leaders, but to all members of the Armed Forces.  This education should be carried out in a proactive manner, so that servicemembers are aware of the possible effects of combat stress and trauma prior to entering the combat zone.  It is important to note that servicemembers who described a supportive mental health environment were represented in this study as well.  Future research on these servicemembers would gather important information about what their unit leadership is doing differently.  This data could be used to shift military policy on mental health.

**Conclusion**

The findings of this study suggest that while servicemembers hold a wide range of views on how issues related to mental health are handled by unit leadership and the military the majority feel as though they are addressed negatively by those in command.  The fact that many servicemembers hold this view about those in charge may help explain why the military still struggles with addressing mental health concerns, and contends with suicide rates that remain at an all-time high despite a number of heightened outreach and awareness efforts.  Many servicemembers report that their leaders are relaying negative messages about mental health, which are perhaps negating efforts being made by the military at a higher level.  Especially at a

time of war, the importance of evaluating and improving the way the military addresses issues related to mental health are of utmost concern.  Results of this study indicate that the military needs to consider restructure the way it addresses mental health so that leaders are promoting an atmosphere where the importance of mental health wellness is not underestimated. Our nation owes this to the servicemembers who have put boots on the ground so that they getting the help they need before, during, and after combat.

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Appendix A

Human Subjects Approval Letter

**SMITH COLLEGE**

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950    F (413) 585-7994

February 20, 2012

Peter Farley

Dear Peter,

You did a very nice job on the revisions and your project is now approved. Your responses were thoughtful as well as professional.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project!

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Kate Didden, Research Advisor

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Recruitment Flyer

# Are You a Veteran of the OIF/OEF or OND?

If so, please consider taking part in this 15 minute survey that will provide important information in ensuring soldiers receive the mental health support that they deserve.

My name is Peter Farley and I am an OIF Veteran and graduate student at Smith College School for Social Work. I am conducting research on how soldiers perceive mental health treatment is addressed by the military and unit leadership.

Data gathered through online survey will support my Masters thesis research on this important and understudied topic.

To be eligible to participate, you must have at least one combat deployment overseas in support of Operation Iraqi Freedom, Operation New Dawn or Operation Enduring Freedom.

If you are interested in participating in the survey, please follow the link:

https://www.surveymonkey.com/s/K938QK7

Please forward the link to this invitation to anyone you know who meets the requirements to complete this study.

Appendix C

Informed Consent


Dear Study Participant,

I am an OIF veteran and Master's student at Smith College School for Social Work carrying out a research study that explores servicemember's view of mental health treatment in the military. The purpose of this study is to gain deeper understanding about how servicemembers believe unit leadership addresses psychological treatment and how this may influence the attitudes of soldiers towards psychological wellness. This study will look at the way mental health is viewed by servicemembers, and how the messages received from military leadership may or may not contribute to the way you feel about psychological treatment. Data collected will be used in writing my Master of Social Work (MSW) thesis and may additionally be used in professional presentations and publications.

As a combat veteran who has deployed overseas in support of either Operation Iraqi Freedom/Operation New Dawn or Operation Enduring Freedom, you are being asked to participate in an online survey. Please do not participate in this study if you are a servicemember without an overseas combat deployment in support of OIF/OND and/or OEF. This survey will take approximately 15-30 minutes and is designed in a way that allows for your complete anonymity. The collected data will not include identifying information.

This online survey consists of four sections, the first which will ask two screening questions. If your answers to these screening questions confirm that you are eligible to participate in this study, you will proceed to the second section of the survey which will ask brief, demographic questions about you and your military service. In the third section, you will provide descriptive data by indicating your level of agreement to a series of statements related to psychological treatment in the military. The survey will conclude with four, separate, open-ended questions that will allow for you to share in detail your own personal experience as to how psychological health has been addressed in the military by your leadership.

By completing this study, you will be providing important information that could be used to help the military improve way that it takes care of servicemembers' mental health. On a personal level, your participation may give you new insight as to what ultimately affects your thoughts on psychological treatment in the military. As a result, you may be able to better identify factors that may influence and relate to your way of thinking. It is important to understand that you may experience strong feelings in discussing military mental health. The survey may bring up memories of traumatic events in which psychological treatment was sought or simply thought

about. You may become uncomfortable in sharing your thoughts about these events. Additionally, you may have difficulty discussing your leadership's response to these matters, as servicemembers very rarely have the opportunity to assess their leadership. It is instead most often the leadership that does the evaluating. You will be provided with a list of mental health referral sources upon completion of the questionnaire in case you wish to seek support or talk further about these matters. Compensation will not be provided to you for participating.

Your anonymity and confidentiality will be protected in survey participation. The survey will not ask you for any personal identifying information. Any identifying data that is accidentally included will be deleted for your protection. This will ensure your anonymity and confidentiality to me. Your anonymity will be maintained by configuring SurveyMonkey.com's settings so that you can access the survey and answer questions without identifying information being recorded. In addition to myself, those who will have access to the submitted data will include my research advisor and possibly additional faculty and staff of Smith College School for Social Work. Upon completion of the study, data will be stored electronically on encrypted, password-protected media so I will be the only individual able to access it. This data will be kept secure for three years as required by Federal regulations. After that time, the data will be destroyed or continue to be kept secured as long as I need the data for research purposes. When no longer needed, the data will be destroyed.

Participation in this study is voluntary and you may end the survey early and opt out of it at anytime before submitting. There is no penalty for withdrawal from the study. Also, after the initial screening questions that identify whether or not you are eligible take part in the study, you will have the choice of skipping any question that they do not wish to answer. However, it is important to note that it is impossible to withdraw your survey responses after the survey has been submitted, due to the anonymous nature of participation. In other words, it is not possible to recall a your responses after they are submitted, as these are impossible to link you individually.

Should you have any concerns about your rights or about any aspect of the study, you are encouraged to call me at **(personal information deleted by Laura H. Wyman, 11/30/12)** or e-mail me at **(personal information deleted by Laura H. Wyman, 11/30/12).** You can also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. Thank you for your participation in this study. Please keep a copy of this form for your records.

**YOUR ELECTRONIC CONSENT INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Survey Instrument

**Screening Questions**

Are you a past or present servicemember of the United States Military?

- Yes
- No

Have you served or are you serving a deployment in a combat zone overseas in support of Operation Iraqi Freedom, Operation New Dawn, or Operation Enduring Freedom?

- Yes
- No

**Part I: Demographics: The following questions ask about yourself and your military service.**

What is your age?

What is your race or ethnicity?

- White
- Black or African American
- Asian, Native Hawaiian, or other Pacific Islander
- Hispanic, Latino, or Spanish Origin
- Native American
- Other Race
-

What is your gender?

- Male
- Female

What is your highest level of education?

- Less than High School
- High School or GED
- Some College
- 2 Year College Degree (Associate's)
- 4 Year College Degree (Bachelor's)
- Master's Degree
- Doctoral Degree
- Professional Degree (JD, MD)

What is the total amount of combined time you have served in the United States military on Active Duty and/or as an Active Reservist (excluding Individual Ready Reserve time)?

How many overseas combat deployments have you served in support of Operation Iraqi Freedom and/or Operation New Dawn? (If none, write 0)

How many total months were you deployed overseas in support of Operation Iraqi Freedom and/or Operation New Dawn? (If none, write 0)

How many overseas combat deployments have you served in support of Operation Enduring Freedom? (If none, write 0)

How many total months were you deployed overseas in support of Operation Enduring Freedom? (If none, write 0)

What branch of the Armed Services did you most recently deploy with?

- Air Force
- Army
- Coast Guard
- Marine Corps
- Navy

What type of unit did you most recently deploy with?

- Active Duty Unit
- National Guard
- Reserve Unit

What was the highest rank you held during your most recent deployment?

What is the highest rank you have held during your career in the United States military?

What is your current military status?

- Active Duty
- Active National Guard (actively drilling)
- Discharged
- Full-time Active Guard Reserve (AGR)
- Individual Ready Reserve (IRR)
- Selected Reserve (actively drilling)

What best describes your military occupation or duties you have mostly been assigned to during your most recent deployment?

- Aviation
- Chaplain services
- Combat arms
- Combat support
- Legal services
- Logistical support
- Medical support
- Military intelligence
- Service support
- Special forces
- Special operations

**Part II: The following section asks for you to rate your level of agreement or disagreement on a series of statements about how unit leadership and the military addresses mental health. Please indicate your level of agreement or disagreement with the following statements (strongly agree, agree, neutral, disagree, strongly disagree):**

I was aware of available mental health services during my deployment.

My leadership supported the use of mental health services during my deployment.

The utilization of mental health services was encouraged by unit leadership to deal with deployment related stress and trauma.

My leadership effectively assessed the mental health wellness of its troops.

My leadership was consistent in the military's effort to reducing negative feelings associated with mental health treatment.

Unit leadership would treat a servicemember seeking assistance for mental health differently.

The military provided me with sufficient training on the effects of combat on mental health.

The military does enough to educate and inform servicemembers about mental health wellness.

Unit leadership would ensure confidentiality to a servicemember seeking mental health services.

Unit leadership discussed with servicemembers how the stress of a deployment affects mental health.

I would view a servicemember seeking mental health treatment as positive action.

My leadership would view a servicemember seeking mental health treatment as positive action.

I am familiar with the Department of Defense's "Real Warriors Campaign".

**Part III: The following open-ended questions ask you to share your opinions and experiences about how unit leadership and the military addresses mental health by typing your answers in the space provided. Please refrain from using names when answering these questions.**

Describe the messages you received about mental health from your unit leadership.

Explain how your unit leadership addressed the mental well-being of servicemembers in responding to stressful periods and trauma that occurred during deployment(s).

If you were to have a direct conversation with your unit leadership about how mental health wellness and treatment should be addressed in the military, what would you tell them?

Have your views on the way mental health treatment and wellness is addressed by the military changed as a result of your service and/or deployment? If so, explain.

Appendix E

Referral List for Participants

If you need additional support or someone to talk to after completing this survey, please refer to the following list of contacts:

Military One Source

1-800-342-9647

http://www.militaryonesource.com/MOS/About/CounselingServices.aspx

Veteran Affairs

http://www.mentalhealth.va.gov/gethelp.asp

Veterans Crisis Line

1-800-273-8255

http://suicidepreventionlifeline.org/Veterans/Default.aspx

Appendix F

Facebook Page Recruitment Post


Are you a veteran of Operation Iraqi Freedom (OIF), Operation New Dawn (OND), (OIF) or Operation Enduring Freedom (OEF)?  If so, please complete this short online survey, which seeks your input about how mental health treatment is addressed in the military.  Your feedback is important in working towards ensuring that those who sacrifice for our freedom receive the mental health support that they deserve.  Your responses will be completely confidential.  No name will be associated with your responses.

Appendix G

Message to Facebook Network Requesting Assistance for Study Recruitment

As many of you are aware, I am a graduate student at Smith College School for Social Work and a veteran of Operation Iraqi Freedom. As part of my graduation requirement, I am conducting research on mental health treatment and wellness among veterans of the wars in Iraq and Afghanistan. My study examines how servicemembers perceive unit leadership addresses mental health treatment. I am recruiting all of my study participants through Facebook social networking, so I am asking for your help in expanding my recruitment efforts. Please refer to the survey link that I have posted on my profile and click "Share" to post the same link onto your profile. This study specifically aims to identify how servicemembers perceive unit leadership addresses mental health treatment. Your assistance with recruitment will help to make my study better and work towards ensuring that those who sacrifice for our freedom receive the mental health support that they deserve. Thank you so much for your help and please message me with any questions.