

12-2018

# Knowledge of Mental Health Disorders and Resources by Military Personnel

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KNOWLEDGE OF MENTAL HEALTH DISORDERS AND  
RESOURCES BY MILITARY PERSONNEL

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A Thesis  
Presented to  
the Graduate School of  
Clemson University

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Science  
Applied Sociology

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by  
Savanna Taylor  
December 2018

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## ABSTRACT

With more soldiers returning home to the United States than any war era before, there is a need for research to understand military personnel's mental health and how they use resources, like the Veteran's Affairs and non-profit organizations. This study serves to further our understanding about service members' knowledge on this subject. This study adds to the literature by conducting semi-structured interviews with 15 service members who had deployed on either United States military bases or ships, or peace-keeping missions, overseas after 9/11. The interviews were audio-recorded, transcribed, and thoroughly analyzed using a narrative approach. Five important themes emerged from the interviews: prevalence of mental health disorders, knowledge of disorders and resources, barriers to seeking help, types of resources available, and motivations to seek help. Although this study aimed to explicitly understand knowledge, the inductive research process produced four other themes that became pivotal in understanding why active soldiers and veterans were skeptical to seek help.

## KEY WORDS

Military • Knowledge • Resources • Prevalence • Stigma • Mental Health •  
Anxiety • PTSD • Depression

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## LIST OF ABBREVIATIONS

DSM	Diagnostic and Statistical Manual of Mental Disorders
IBM	Integrated Behavior Model
IED	Improvised Explosive Devices
IRB	Institutional Review Board
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
POW	Prisoners of War
PTSD	Post-Traumatic Stress Disorder
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
UWS	Upstate Warrior Solutions
VA	Department of Veteran Affairs

## CHAPTER ONE

### INTRODUCTION

The last day the United States drafted individuals for military service was January 27, 1973 at the close of the Vietnam War. Since then, men and woman have voluntarily joined our country's military in order to willingly fight and defend the homeland and its citizens from outside invasion and terrorism. Although there can be many different reasons for joining the military, be they patriotic, economic, educational, or personal, etc., it is certain that individuals undergo a major transformation after enlistment, during their service, and upon returning to civilian life. Many make this sacrifice with a sense of pride to protect America's freedoms, but often face substantial challenges and problems when they return to civilian life.

Throughout this paper, the term *veteran* will be used to describe any man or woman who has served in the United States armed forces, regardless of deployment, branch, or length of service (Stacer & Solinas-Saunders, 2015). Research suggests that veterans face many problems (e.g. drug and alcohol addiction, entry into jail or prison, trouble finding jobs, homelessness, etc.) that are often tied directly to their service (Beckham, Feldman, & Kirb, 1998; Boscarino, 2006; Dao, 2011; Fontana & Rosenheck, 2005; Hoge, Auchterlonie, & Milliken, 2006; Mares & Rosenheck, 2004; Sederer, 2011; Taft, Vogt, Marshall, Panuzio, & Niles, 2007; Teachman, 2007; Yager, Laufer, & Gallops, 1984). In a study conducted by the United States Army on mental health, one in eight soldiers who served in Iraq reported symptoms of post-traumatic stress disorder (PTSD) while less than half of them sought help (Associated Press, June 30, 2004).

The purpose of this study is to collect information in order to understand the amount of knowledge veterans have on mental health disorders and resources available to remedy those illnesses. The era of military service focused on in this paper will be from September 11, 2001 until present. This era includes military operations Iraqi Freedom (OIF) and Enduring Freedom (OEF), as well as several others.

Although mental health disorders do not only effect service men and women, research indicates that it is extremely prevalent among this population. This study will explore three interrelated themes by investigating veteran's 1) perceived knowledge of mental health disorders, 2) awareness of mental health resources, and 3) access to mental health resources while in the military and upon discharge.

Prior research has explored the extent that mental illnesses afflict our military men and women along with the various treatment resources available (Bedard & Deschênes, 2006; Booth-Kewley, Larson, Highfill-McRoy, Garland, & Gaskin, 2010; Britt, 2000; Bryant, 1979; Freeman & Roca, 2001; Friedman, 2005; Grossman & Siddle, 2000; Hartwell, Jame, Chen, Pinals, Marin, & Smelson, 2014; Kardiner, 1941; McFall, Mackay, & Donovan, 1991; Teachman & Tedrow, 2008). However, very little research has been collected to gauge the knowledge of service men and women to notice the signs and symptoms of mental health disorders or whether they are aware of resources they or their friends and family can utilize to get help once the illness is recognized. This study fills a gap in the literature by conducting semi-structured interviews with 15 veterans who had deployed on either United States military bases or ships, or peace-keeping missions, overseas after 9/11. 16 participants were recruited, although one was excluded for not



fitting the constraints placed on the sample. This study will also explore some other barriers related to seeking help for mental health disorders, once veteran's do have knowledge of certain resources available.

## CHAPTER TWO

### LITERATURE REVIEW

#### Literature on recent American wars prior to 9/11

War has played an important role in human society and culture. The use of violence has become a central way to mitigate differences between conflicting nations, cultures, and groups (i.e., gangs, tribes, etc.) and to deal with corrupt governments. This can be seen in ancient history during Biblical times, among the Romans and Greeks, and many others until present day. Soldiers who enter these conflicts, regardless of era, are exposed to scenes many civilians will never have to come to terms with.

Because of this, many soldiers develop symptoms related to mental illness. Prior to the creation of the Diagnostic and Statistical Manual of Mental Disorders (DSM), doctors were aware of these symptoms although they did not have a medical name for it yet. “Generations before PTSD was diagnosed, doctors used terms such as ‘nervous disease’ in the medical pension files of veterans” (Pizarro, Silver, & Prause, 2006). There is proof of the prevalence of the toll military service takes on individuals in numerous manuscripts and journals from many wars in history including, but not limited to, the Revolutionary War, the Civil War, and both World Wars.

The characteristics of previous war eras are drastically different from the War on Terrorism. One important difference was the number of officers taken as prisoners of war (POW’s). Since World War II, POW’s drew significant amounts of concern about their mental and physical health, due to large amounts of time spent in severe deprivation. Because of this growing concern, research has found that POW’s are unhealthier and are

more likely to die prematurely than non-POW veterans (Bedard & Deschênes, 2006).

“Some research has placed prevalence rates of PTSD for Vietnam veterans at nearly one in three during the first year after returning from combat” (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, 1990). Unfortunately, the torment doesn’t stop immediately upon return from active duty. Schlenger, Kulka, Fairback, Hough, Jordan, & Weiss (1992) found that prevalence rates remained high (approximately 15%) years later.

Some active military and veterans are only diagnosed with a single mental illness. However, it is much more likely that they will have co-morbid disorders, meaning more than one, such as depression and anxiety (Helzer, Robins, & McEvoy, 1987; Kessler, Sonnega, Bromet, Hughes, & Nelson. 1995; Kulka et al., 1990; True, Goldberg, & Eisen, 1988). These disorders and illnesses can affect more than a veteran’s mental health. In addition to developing PTSD, Vietnam veterans were shown to have a high likelihood of developing addiction to alcohol and drugs (Bremner, Southwick, Darnell, & Charney, 1996; Jordan, Schlenger, Hough, Kulka, Weiss, Fairbank, & Marmar, 1991; Kulka et al., 1990; McFall, Mackay, E Donovan, 1991; McGuire, Rosenheck, & Kaspro, 2003; True et al., 1988).

Unfortunately, the individual is not always the only one affected. Interpersonal violence with significant partners has been documented in elevated rates among Vietnam veterans (Beckham, Feldman & Kirby, 1998; Byrne & Riggs, 1996; Jordan, Marmar, Faibank, Schlenger, Kulka, Hough, & Weiss, 1992). When a veteran is subjected to co-occurring problems, it is no wonder the veteran population has high rates of

homelessness. Some studies have found that homelessness is twice as common among the veteran population than the general population (Cunningham, Henry, & Lyons, 2007).

#### Literature post-9/11

Although awareness for mental health has certainly improved since the Vietnam era, much is still unknown by the population about symptoms and the frequency. This knowledge can be empowering and should be taught to a population such as veterans, where the likelihood of developing mental health disorders is high. This could, potentially, increase their likelihood to seek help, although other barriers may be at work. Numerous veterans have enlisted in, and been discharged from, the military during the OIF/OEF era. Even now, many these soldiers are stationed overseas. According to the National Council on Disability (2009), over 1.6 million military service men and women have deployed to both Iraq and Afghanistan in response to OIF/OEF. Furthermore, over 565,000 have deployed more than once. Recent military procedures in Iraq and Afghanistan represent the longest ground combat operations involving American forces since the Vietnam era. Although Vietnam and Korea are thought to be among the bloodiest conflicts for United States military, United States service members who served in the wars in Afghanistan and Iraq faced long and often multiple deployments and a constant risk of injury and death (O'Bryant & Waterhouse, 2007; O'Bryant & Waterhouse, 2008).

As mentioned in a previous section, these tumultuous environments can have a devastating effect on a soldier's psyche. Some soldiers have deployed several times. Many are exposed to traumatic injury and experiences, and more of the wounded have

survived than any previous era (Kang & Hyams, 2005). Depending on military branch and service job, some military personnel experienced high-intensity guerrilla warfare and there was a chronic threat of roadside bombs and improvised explosive devices (IED's) (Friedman, 2005; National Center for Post-Traumatic Stress Disorder (U.S.) & Walter Reed Army Medical Center, 2004). As of April 2018, more than 6,600 soldiers have been killed during OIF and OEF, and nearly 53,000 soldiers have been wounded (<https://www.defense.gov/casualty.pdf>).

Just as research suggested negative health outcomes for Vietnam veterans, research conducted within the past 15 years on the conflicts in Iraq and Afghanistan discovered similar findings. Researchers have reported substantial evidence describing negative effects of combat on the mental health of military personnel since 9/11 (Ahern, Worthen, Masters, Lippman, Ozer, & Moos, 2015; IOM, 2013; Isaacson, Weeks, Pasquina, Webster, Beck, & Bloebaum, 2010; Seal, Bertenthal, Miner, Sen, & Marmar, 2007; Teachman, 2011). The National Defense Council (2009) notes that "an estimated 25-40 percent [of returning veterans] have less visible wounds like psychological and neurological injuries associated with PTSD, anxiety, depression, or traumatic brain injury (TBI), which have been dubbed 'signature injuries' of the Iraq War." The number of troops suffering from head injuries (i.e., TBI) caused by combat is just as alarming as other disorders, like PTSD and anxiety. A recent study found that "20% of all frontline infantry troops suffered from concussions during combat" ("Troops risk", 2006). A research project done by Hoge et al. (2008) found that "15% of the 2,525 army infantry troops surveyed experienced TBI symptoms three to four months after returning to the

states". TBI has also been known to cause symptoms associated with PTSD and anxiety. These symptoms included loss of consciousness, altered mental state, decreased attention, being less motivated, irritability, depression, anxiety, fatigue, headaches, memory loss or disturbance in memory, disrupted sleep, and behavioral problems (Hoge et al., 2008).

In yet another study, approximately 17% of veterans returning from Iraq were diagnosed with a serious mental disorder, two times higher than pre-deployment levels (Hoge et al., 2004). Results from a study done by Seal et al (2007) show that 25% of the OIF/OEF veterans studied received at least one mental illness diagnoses. Of those, 44% received one diagnoses, 29% received two diagnoses, and 27% received three or more diagnoses. Of the 102,632 veterans studied, 13% was diagnosed with PTSD, making it the most common mental disorder diagnoses (Seal et al., 2007).

A crucial part of understanding mental health knowledge among veterans is to combat the growing suicide rate. According to Sederer (2011), the suicide rate among veterans is at a three-decade high. This can be the result of both mental health disorders and a need to relieve the pain these disorders cause. A shocking fact is that more people are dying from suicide than combat among the post 9/11 veteran population (Sederer, 2011).

Just like with the Vietnam veterans, these tumultuous environments and ill effects of the mental health, do not only effect the soldier. Perhaps because of these traumatic experiences, service men and women have said relationships with family members and friends are often disrupted. This, coupled with changes in character by both the service member and their loved ones, often leads to difficulties when it is time to transition

(Elbogen, Johnson, Newton, Straits-Troster, Vasterling, Wagner, & Beckham, 2012; Hoge, McGurk, Thomas, Cox, Engel, & Castro, 2008; Milliken, Auchterlonie, & Hoge, 2007; Teachman, 2007). In addition to the conflict with family and friends, the symptoms associated with combat-related injuries can also lead to anti-social behavior that can draw the attention of the police (e.g., drug use, increased aggression), and may result in arrest and incarceration upon homecoming (Freeman & Roca, 2001; Lasko, Gurvits, Kuhne, Orr, & Pitman, 1999; Sherman, Sautter, Jackson, Lyons, & Han, 2006).

### Life Course Perspective

Life Course Perspective and Homecoming Theory are used as theoretical frameworks for this study. The Life Course Perspective focuses on the importance of time, context, process, and meaning on human development and family life (Bengtson and Allen, 1993). The premise for Life Course Perspective focuses on four main areas: trajectories, pathways, transitions, and turning points. Theoretically, an individual has a set trajectory in life which is determined early in life by several pathways. Pathways are influenced by factors such as parental involvement, social networks, and human agency. Transitions occur when an individual alters the pathway they are on, either by their own choice or outside influence. A *turning point* is defined as a point (i.e., an event or experience) in time which has the potential to alter a person's current life course trajectory (Bengtson and Allen, 1993).

There is growing evidence that military service is linked to a number of subsequent life course outcomes, including education, income, marital status, and health, making joining the military a turning point (Angrist, 1990; 1998; Bennett & McDonald,

2013; MacLean & Elder, 2007; Segal & Segal, 2004; Teachman, 2007a; 2007b; 2008; 2010; Whyman et al., 2011; Wilmoth & London, 2013). Reasons for enlisting in the military can vary from one individual to the next. Research suggests that factors such as “patriotism, propinquity to military installations, family history, and desire for travel and adventure” influence the decision to join the military (Eighmey, 2006; Elder et al., 2010; Kleykamp, 2006; Woodruff et al., 2006). Whatever the reason for enlistment, there is no denying entrance into the military effects a person’s future (e.g., their trajectory).

The reason military involvement is considered such a crucial turning point is explained through research. Much of it suggests that the military is a unique institution that provides individuals with a range of opportunities that are not normally available in a civilian environment. First, the military provides stable employment opportunities and good benefits for young people that are hard to rival (Teachman & Tedrow, 2014). Second, the military provides young recruits with a structured, disciplined life style, and a source of self-esteem and pride (Eighmey, 2006). Bryant (1979) argued that “rigid norms and severe sanctions are dually necessary for members of the military to do things they would not otherwise do and to make the military efficient”. Third, the military offers a sense of social belonging that is not easily attained (Spence et al., 2012). The last component of military life that is difficult to match in a civilian occupation is the opportunity for travel and adventure (Eighmey, 2006; Woodruff et al., 2006).

An argument can be made for the military acting as a positive turning point. This argument is focused on criminal desistance in delinquent youth. It thus appears that successful cessation from crime occurs when proximate causes of crime are affected.



According to Caspi and Moffit (1995) a central component in the desistance process is the "knifing off" (i.e., the removal) of individual delinquents from their immediate environment and creating a potentially new future. "Institutions like the military have this knifing-off potential, as does marriage, although the knifing-off effect of marriage may not be as dramatic" (Laub & Sampson, 2001). Although entering the military may result in criminal desistance for youth, it may serve as a negative turning point upon departure from the military.

Fontana and Rosenheck (2005) found that "pre-military experiences and behavior had the largest effects on post-military antisocial behavior". Still more studies allude to these pre-existing risk factors (i.e., early anti-social behavior and social adversity) which can ultimately affect a veteran's likelihood to become violent (Teachman & Tedrow, 2014; Spence et al., 2012; Bryant 1979). Although evidence supports the connection between pre-existing risk factors and experiences to post-military anti-social behavior and violence, the experiences and traumas experienced while in service can have devastating effects which can follow veterans for their whole lives, beyond their active time in the military. Mental health disorders and symptoms after deployment, such as post-traumatic stress disorder, alcohol and drug misuse, and lack of anger management are often cited as potential facilitators of the link between combat experience and subsequent violence (Eighmey, 2006; Woodruff et al., 2006; Bengtson & Allen, 1993; MacLean & Elder, 2007; Angrist, 1990). Some recent research has even suggested that trauma and combat exposure, coupled with PTSD symptoms, substance abuse, and post deployment adjustment problems, may increase the likelihood of incarceration for

veterans (e.g., supportive of the Violent Veteran Model; McGuire et al., 2003; Saxon et al., 2001; Yager, Laufer, & Gallops, 1984).

Ultimately, the link between military service, combat-related mental health problems (particularly PTSD) and involvement in the criminal justice system remains uncertain, as it appears that other risky behavior, such as drug and alcohol abuse, likely plays an important role (White, Mulvey, Fox, & Choate, 2012). However, an argument can be made that entry into, and exit from, the military can ultimately effect a person's future, sometimes for the better, and other times, for the worse.

### Homecoming Theory

Since 2011, the war has come to an end and the US military presence overseas has been decreasing. More veterans than ever are transitioning back into civilian life and it is crucial to understand and encourage a healthy homecoming transition (Ahern, Worthen, Masters, Lippman, Ozer, & Moos, 2015). Homecoming theory was developed after World War II and identifies the challenges retiring military personnel face when transitioning from military service. Schuetz (1945) claims that the premise for homecoming theory revolves around an individual (in this case, a service member) who is separated from his or her social network by both time and space. Both the service member and those in his or her social network experience varying situations while separated from each other. These unique experiences alter both the military member and the members of his or her social network, which creates a sense of unfamiliarity between both parties upon return by the service member. This unfamiliarity produces shock and

rough waters during homecoming which makes re-establishing connections difficult on both sides.

The separation between family and service members upon enlistment has unmeasurable consequences on mental health, especially during the transition back to civilian life. A related study found that many veterans who showed no signs of mental health disorder symptoms immediately after their return from service were diagnosed with a mental disorder upon rescreening some months later (Milliken, Auchterlonie, & Hoge, 2007). There is evidence that veterans from preceding wars who had complications in the switch to civilian life faced increased risk of long-term problems that include homelessness, and early mortality (Mares & Rosenheck, 2004; Boscarino, 2006; & Schinka, Schinka, Casey, Kaspro, & Bossarte, 2012), indicating that these transition problems are a long-term concern. Recent studies estimate that up to 40% of returning soldiers are in need of treatment for mental health issues (Department of Defense Task Force on Mental Health, 2007), and that many suffer co-occurring disorders (Seal, Bertenthal, Miner, Sen, & Marmar, 2007).

Given the substantial burden of health problems (both physical and mental) in recent Afghanistan and Iraq veterans, the potential for long-term impacts is worrisome and support for the transition process is necessary. While research indicates that a successful transition is critical for veterans' long-term wellbeing, the nature of the transition experience and readjustment needs have not been examined in-depth among Afghanistan and Iraq veterans.

#### Integrated Behavior Model

Using an inductive approach, the Integrated Behavior Model (IBM) began to shape the topics expressed in the interviews. IBM describes five determinants for behavior. A person must be motivated and have knowledge to perform a behavior, and the behavior must be important to the individual. If the first three determinants are met, social norms must align with the behavior and there must be minimal barriers in place making the behavior easy to perform. The last determinant conveys that a behavior will become habitual if the individual carries it out multiple time, reducing the importance for motivation as the first determinant (Montano, & Kasprzyk, 2015).

I anticipated that the themes and concepts put forth in the Life Course Perspective, Homecoming Theory, and Integrated Behavioral Model will be reiterated during the interviews conducted for this research study. In accordance with the Life Course Perspective it is hypothesized that respondents will emphasize the effect joining the military and separation from the military has on their life. Additionally, it is predicted that Homecoming Theory will explain the change a service member experienced while active in the military and how that affected his or her transition to the civilian world. Furthermore, through the inductive process Integrated Behavioral Model became relevant to understand the themes of knowledge, barriers/social norms, and motivations.

CHAPTER THREE  
RESEARCH DESIGN AND METHODS

Recruitment and Ethics

The participants in this study were recruited, in partnership with Upstate Warrior Solutions (UWS), Clemson University Veteran Center, and Clemson Paralympic Soccer. Information about the study was circulated on social media, and a flyer was distributed on Clemson University's campus. The three recruitment partners have agreed to assist in recruitment by locating and contacting potential participants. They sent contact information to me of all interested potential participants. I contacted each potential participant by phone and read them a verbal recruitment script which has been approved by the Clemson University Institutional Review Board (IRB) (see Appendix C: Institutional Review Board Application and Attachments). The recruitment script included information about me and the research study including the topic, the participant's eligibility, structure and length of the interviews, and that the interviews would be audio recorded to ensure full data coverage. The script also included a sentence explaining that their participation is completely voluntary and that, if they choose to, they may withdraw at any time. Upon their acceptance of the recruitment script, an in-person interview was scheduled. If, for some reason, the participant could not meet in-person, a telephone interview option was offered.

On the day of the interviews, participants were given information about the goals and procedures for the project, and were informed about their ability to withdraw at any time without penalty. In-person interviews were completed at UWS. All participants in

this study were provided with the structure and proposed length of time of the interview, my contact information, and informed consent, verbally. The participants also had a chance, prior to starting the interviews, to ask any clarifying questions. The research and verbal consent was approved by Clemson University Institutional Review Board.

### Summary of Methods

For this study, in-depth semi-structured interviews were the primary method of collecting information. I chose to utilize interview techniques because of the sensitive nature of researching mental illness, especially within the veteran population. This technique, as opposed to quantitative methods (except surveys), has shown significant gains when researching sensitive subjects with less than willing populations (McNamara, 1999). Although survey methods can be employed to research for sensitive topics, in-depth interviews are able to reach a deeper understanding of information put forth by participants. Confidential interviews were conducted over several months at UWS. In the event participants cannot meet in-person, a telephone interview was offered.

A guided interview instrument (see Appendix A: Interview Guide), was developed with input from several partners at UWS, as well as research faculty at Clemson University. This guide was followed loosely and the questions that were asked were separated into five sub-sections: 1) background in the military, 2) knowledge of mental health disorders, 3) knowledge of mental health resources prior to enlistment, during enlistment, and after discharge, 4) personal experience with mental health disorders and resources, and 5) demographics. These questions and categories were designed to explore the three main key themes of this research project: 1) knowledge of

mental health disorders, 2) awareness of mental health resources, and 3) access to mental health resources while in the military and upon discharge.

Questions regarding respondent's background in the military asked about the state of enlistment, length of service, length since separation from the military, whether the participant deployed, and if so, where, as well as whether he or she saw combat during their service. The next section, knowledge of mental health disorders, included questions that gauge the participants' perception about receiving help while in the military (e.g. any barriers), their knowledge about specific disorders (i.e. PTSD, anxiety, depression, etc.), and their ability to notice mental disorders in themselves or others. The third section explored the participants' knowledge of resources by directly asking if they knew of any resources or resource centers before they joined the military, during their service, and after they were discharged. The brief section on a participant's personal experience asked them if they have been diagnosed with a mental health disorder, and whether they received treatment and why. The final section included demographic questions regarding age, gender, ethnicity, marital status, student status, religion, and income.

The interview guide was utilized to keep the conversations on topic and maintain a logical flow, but participants were encouraged to complete their thoughts, give examples, and further elaborate before moving to the next question. Several unguided follow-up questions and probes were asked dependent on participant's responses. However, to ensure confidentiality, no identifying information (i.e., names and unique numbers, dates, or geographic identifiers below the state level) were collected using the Safe Harbor method. During the interviews, hand written notes were taken and two types

of audio recording devices (mobile device and personal laptop) were utilized to analyze participant answers.

Upon completion of the interviews, the participants were asked if they had any further information they would like to add and if they would consider participating in any further research. They were given a chance to present comments about the interview structure and questions. If the respondent did not have any further questions, the participants were thanked and given counseling resources should they need it. Once the interviews were finished, the interviews were transcribed verbatim. The audio recordings and transcriptions were kept on a personal mobile device and laptop, respectively. Language processing software (Otter.ai) was used to transcribe recordings and to ensure the quality of the transcripts. Once each transcript was complete, quantifiable military background and demographic information were inputted into quantitative data analysis software (STATA SE 13).

Upon review of the interviews, key themes and characteristics mentioned in each session were noted. A color-coded guide (see Appendix B: Coding Manual) was created to identify and analyze common themes throughout the participant interviews. This work employed a narrative approach utilizing the stories told by interview participants to provide insights about lived experiences. In the analytic process, main narrative themes were generated through the accounts participants gave about their lives. With these themes, this study may create a better understanding of veteran knowledge and experiences as they relate to mental health.

### Sample Characteristics



Sixteen participants were recruited for the study, but one was excluded for not fitting the inclusion criteria, therefore, 15 interviews were utilized in the analysis. The sample included respondents of diverse military backgrounds (see Appendix D: Table 1 – Sample Characteristics). Participants in the sample were active in the Navy, the Marines, the Army, the Army Reserves, the National Guard, and the Air Force. Each enlisted in the states in which they lived which included South Carolina, Florida, Mississippi, Michigan, Illinois, Arkansas, New York, Pennsylvania, Tennessee, and Minnesota, and the majority currently reside in South Carolina. The average number of years the participants served was 9.7 with the shortest time being 3 years, and the longest time being 20 years. The average amount of time since their separation from the military was 3.9 years. Their military grades varied from E4 to E7, and the military rank varies by branch. All participants had a family history of service within the military, although some weren't within two generations; however, some had fathers, brothers, and sisters who enlisted. All participants did deploy during their service, although the locations varied, as well as the amount of combat experienced first-hand.

The demographic characteristics of the participants interviewed did not vary as much as their military background. The average age for the sample was 32.6 years, with the youngest being 25 and the oldest being 48. All participants reported being Caucasian, although one did identify with a Hispanic ethnicity. An overwhelming majority of participants within this study were male and college students, while only 13% (2 out of 15) were female and 20% (3 out of 15) were non-students. Of the participants who were

not current college students, the highest level of education attained was a Bachelor's degree. Half of the participants were married.

## CHAPTER FOUR

### RESULTS

Through the interviews five main themes emerged. The themes included 1) prevalence for mental health disorders, 2) increasing knowledge of disorders and resources once separated from the military, 3) barriers which inhibit access to resources, 4) various types of resources available, and 5) motivations to seek help for mental health disorders.

The first theme that emerged focused on the perceived prevalence of mental health disorders among both active military and retired veterans. While participating in active duty in the military, participants assumed the number of officers with mental health disorders varied and could be higher, dependent on the job an individual performed while serving. A 25-year-old female Navy Petty Officer Third Class stated:

*“It depends on what your job was. In the Navy and Air Force it's not as common because we have a lot of a lot less combat oriented job than say the army or especially Marine Corps. Marine Corps has a lot of PTSD because they're our bullet catchers basically. They're good guys, but they come back with a lot.”*

Many participants, when asked about the likelihood of developing a mental health disorder upon exiting the military, assumed the transition process could make the prevalence higher. A 32-year-old male Navy Petty Officer Second Class stated:

*“You might have a difficult time adjusting back, you know, back to the civilian world. I mean, you know, not to say, I don't know, if they'd be like having a mental issue, they could just be having a hard time adjusting and I mean, that could lead you down a*

*road you know, in your head that could go somewhere bad. So, I think that maybe it could be more prevalent after the military.”*

A second theme revolved around knowledge of mental health disorders and recourses. Results indicated a large majority of participants had little to no perceived knowledge about mental health disorders or mental health resources prior to enlistment. Most agreed that, once enlisted in the military, that knowledge increased slightly. This was in part because of the push by the military organization for military men and women to seek help for mental health symptoms, namely call centers and hotlines. A 30-year-old male Air Force Technical Sergeant described this phenomenon:

*“When you're welcomed into a unit, they give you a card and the card has like every call center on it that you would need you know: drinking, drugs, the battalion phone number. You were required to have it next to your ID card and the entire time I was in the military, you always had your- it was called your call log. If you had an emergency it had like a battalion, it had drugs, it had all the different numbers on there, and then you had to write in your chain of command on it. This is my squad leader, this is my platoon sergeant, this is my first sergeant. Then you'd laminate it and it would be behind your ID card so anytime that you were in uniform, or whatever that was part of your inspections- whether or not you had your card.”*

The third theme that emerged identified barriers which come into play when military personnel do want to seek out help. Some other participants talked extensively of the availability of mental health professionals on military bases overseas, however they witnessed that many soldiers did not utilize these resources. Instead they would visit the base chaplain in an attempt to avoid stigma from their peers and chain of command. A 37-year-old male Air Force Senior Airman states:

*“Yeah, it’s [seeking help] probably a lot harder. I mean, I mean it’s not impossible I know some people who did while we were in, but it’s probably easier outside of the military, I’m sure. Yeah. There’s less stigma.”*

In addition to the stigma associated with seeking help for mental health disorder symptoms, participants were aware that their job could be on the line if they were viewed as “sick” or unable to work efficiently. A 33-year-old male Marine Gunnery Sergeant states:

*“Extremely. It’s [receiving help] extremely difficult, especially in the job I had in the military. It’s extremely taboo because, we lose our job and if you lose your job you pretty much get kicked out.”*

Although there are certainly barriers related to receiving help for mental health disorders for anyone suffering, there can be an argument made about the culture of the military and the creation of more barriers for those who have joined the military. Once a service man or woman transitions to civilian life, the barriers to receiving help shift from those experienced while on active duty. Some participants said that they perceived their knowledge as increasing the most upon discharge from the military, mostly in part because of their participation with non-profit organizations and universities. These new barriers were identified as geographical proximity to resources like the Department of Veterans Affairs (VA) or non-profits, and access to quality mental health counselors. A 32-year-old male National Guard Sergeant states:

*“I mean, I’d like to think it’s easy, but you know at the same time I mean I guess it depends on where you live too, I mean there’s not really a VA on every corner. I mean,*

*we're lucky to have one [close by] and there's some small places [further away]. If one is disconnected from all that I don't think they would really know about it. It's not as easy as it should be."*

A fourth theme dove into the notion that there are varying types of resources available in both the military and civilian world. While actively working in the military, individuals have the option to speak with trained professional. However, as previously alluded to, the stigma associated with using this opportunity kept many from doing so. Another option, which was pushed by both peers and high ranking military, was to see the unit Chaplain. A 26-year-old female Navy Petty Officer Third Class states:

*"Basically, it's like if you feel like you have a problem I think the route you go is more of a Chaplain. Or at least in my experience the chaplains were kind of the ones who did kind of counseling services."*

Another route to utilize while in the military was to speak with higher ranking officials, however this course was not confidential. A 30-year-old male Air Force Staff Sergeant states:

*"It just depended on what route you wanted to go if you wanted it confidential then you can go to the chaplains and the mental health department, but if it was gonna be known through your chain of command you could talk to a supervisor."*

While exiting the military, officers had to undergo a Transition Assistance Program (TAP). However, the majority of the curriculum for these classes were focused on professional development, not mental health resources. A 28-year-old male Army Corporal states:

*“On your way out of the military, you go to classes called TAP. I can't remember what the acronym stands for but everybody getting out of any branch of the military goes to the class and it's kind of a week of them talking about resume building, resources, resources as far as VA healthcare, GI Bill educational benefits. I say it's mainly more targeted for how to apply for jobs and how to convert your skills required in the military to things that private companies would want to hire you for. But it's also, I mean, they spend some time on resources available to you.”*

After transitioning into the civilian population, veterans have few options for resources on mental health outside the VA. There was a perceived notion by all participants that the VA is inept in their ability to care for physical ails, let alone mental disorders. This has led to many not utilizing the counselors within the VA system. A 38-year-old male Air Force Technical Sergeant recounted his struggle:

*“I have attempted multiple times in the past to seek assistance. I have an appointment this week. I've had difficult experiences with it. The last time I sought assistance the psychiatrist continued to miss appointments before dumping me as a patient which left me with a little bit of heartburn about seeking assistance, because I could never get someone to sit down and talk with me. Hopefully that will change with this next experience, but again it's the Veteran's Administration. So that's a whole other crazy situation.”*

The last theme highlighted motivations participants had to seek help. Some had not been diagnosed with a mental illness, but said they felt they would not seek help even if they had been. Others spoke about their families, and felt a push to seek help because they perceived themselves as a threat to their significant others and kids. A 31-year-old male Marines Corporal states:

*“I haven't been diagnosed with a disorder, but I'd be pretty likely to seek help if I was. I've got a couple kids, I don't want to mess them up.”*

These quotes, along with many other interview answers, showcase many issues related to military men and women seeking help for mental health disorders. As a

country, there is little being done to destigmatize mental health disorders within active military to ensure they get help when needed. Also, there are very few institutions that give proper treatment to veterans dealing with mental health disorders. It isn't necessarily a lack of knowledge on the service man or woman's part, but extensive cultural, medical and geographical barriers that keep many from seeking help to live a mentally healthy life after the military.



## CHAPTER FIVE

### CONCLUSIONS AND DISCUSSION

#### Answering the Research Question

The results presented above have serious implications for the culture of the military and the atmosphere surrounding mental health. Although this study aimed to gauge the knowledge that military personnel held in regard to mental health disorders and resources, many other issues influenced the likelihood of service men and women to seek help. Although the United States currently has an all-volunteer military, does not minimize the fact that mental health disorders effect military personnel at a much higher rate than many other populations. Service members are removed from their social support systems, trained in the most demanding ways imaginable, and transferred to unfamiliar locations, far from home. They are required to see and do things many people in the civilian world will never have to do, which takes an unimaginable toll on even the “strongest” soldier.

The training a soldier undergoes before being deployed changes their physical bodies, mental capacity, and emotional state. This practice of rigorous training leaves little room for what they view as weakness, whether it be physical or mental. Many soldiers who are deployed see their peers, commanders, friends, and comrades killed by violent means. Those images can haunt and plague them causing irreversible effects to their mental psyche. The need for counseling is essential, although there are many barriers which stop military personnel from seeking help. These barriers differ from active duty to retirement.

Active duty members of the military face a stigma, when seeking help for mental health conditions, so severe they fear it could affect their career in the military. Many participants alluded to the belief that if a person is medically diagnosed with a mental illness, then they would not be allowed to deploy. One participant even went so far as to say “if you can’t deploy, you are no longer helpful to the military. They won’t want you anymore and they could dismiss you.” Because of this stigma, by not only peers, but their commanding officers, many soldiers are forced to talk with the Chaplain on their base. This is seen as the accepted way of seeking help, regardless of the religion they ascribe to. Often times, the Chaplain does not have proper training and can make things worse for an already stressed military member.

If a service member felt the need to seek help higher than the Chaplain, there were trained counseling services available.; however, many participants relived the fear they felt of being seen walking to or from the counselors’ offices. Many participants felt the military had made huge improvements in establishing official ways to received help for mental health related conditions, but there is still a need to reduce stigma on deployment bases so military personnel can receive trained and sound treatment without fear of being perceived as weak or broken.

Many service members undergo training programs upon retirement from active duty; however, these programs spend an insufficient amount of time educating individuals on mental health disorders and resources. The participants in this study attributed their increased knowledge to becoming involved in universities and non-profits, like UWS. The military spends so much time and effort to change a recruit from a

functioning member of society into a soldier, but focus very little resources on the transition process. One day an individual could be a soldier, in the middle of a fire fight and explosions, and the next they could be sitting in their living room with their kids and wife. The need for a smoother and more complete transition process is necessary to improve service members' perceived capabilities of reintegrating into the civilian world once again.

Upon retirement from the military, veterans have very few options to receive help for mental health disorders. The main source of counseling comes from the VA, and many participants suggested there are severe problems related to the caliber of training psychiatrists have when dealing with individuals with a military background. Many of the psychiatrists do not have the same background as their patients which creates a distrust in the patient that they are not being heard or understood. Also, one participant suggested that counselors do not try to get to the root of the problem, but simply write prescriptions for anxiety or depression without conducting actual counseling sessions. Not only does this effect the occurrence of addiction to drugs and alcohol for veterans, but also creates a significant barrier for seeking help.

An aspect for many individuals that broke down the barriers established for seeking help for mental health disorders, was having social support from family and friends. Being able to come home to a strong network of individuals pushing a veteran to receive help seemed to be the main reason many participants believed they would seek help. Having children in the home was the main concern for participants who had been diagnosed with a mental illness and seemed to overcome the barriers expressed above.

An implication of military service, however, is a loss of social connection with family and friends. Several participants who were deployed numerous times on lengthy deployments, lost contact with wives, girlfriends, children, and friends. This leaves little for social support upon their transition process, and for many participants effected their willingness to seek help for mental illnesses.

These barriers and lack of support for the transition process calls for policy and cultural changes related to mental health for both the military, the VA, and veteran social networks. The de-stigmatization of seeking help from trained counselors, while active in the military, could ensure soldiers receive effective and efficient help for symptoms related to mental health before they start the transition process. If the perception of the VA as incompetent could be changed and the social networks for veterans increased, maybe veterans would also be more likely to seek help.

#### Theoretical Implications

Both Life Course Perspective and Homecoming theory can be used to explain the phenomena which have been explored during these interviews. However, the determinants proposed in IBM became more influential to explain the main themes uncovered by respondents. Although many participants talked about why they joined the military, how their experience changed them while serving, and about their rocky transition process, the determinants (intention, knowledge, barriers, saliency, and consistency) outlined in IBM became prevalent upon analysis of the data gathered during the interviews.

Life Course Perspective involves trajectories, pathways, transitions, and turning points. The portion of Life Course Perspective most prevalent for this study is turning points. Evidence for the military acting as a turning point became evident during the interviews. First, joining the military could be a positive turning point. A 28-year-old male Army Corporal states:

*“I don't really know if there was a primary reason for me. It was a lot of things: to go to college, to experience the world, seeking adventure could be one of the things. I don't want to give you just a cookie cutter answer like “to serve my country”, but I think the primary reason at the time was because I had, you know, not a lot of other options.”*

Second, military service can take a toll on family life and be a negative turning point. A 43-year-old male Army Sergeant First Class states:

*“Well, I'll give you mine. I woke up in a bed afterwards, not understanding what happened. And then I find out I'm getting a divorce so of course depression is immediate. It's like, “wow, not only did I almost die but now I lost my family”, so of course your whole life changed over one day so anybody that says they are not going to be depressed after something like that is smoking crack.”*

Homecoming Theory states that an individual is removed from an environment, and during his or her time away, both he or she and the people left behind, experience different situations which makes both parties unknown to the other. This creates a difficult adjustment process once the two parties are joined again. The component of Homecoming Theory that became evident while analyzing the interview data was how

hard the transition process can be for service members. A 26-year-old female Navy Petty Officer Third Class states:

*“You're living a life in the military, going into basic training, and they make you what they need you to be. And then that's all you know, the structure and that way of life and one day you're in the military and then the next day, you're a civilian again. There's no help in the transition period. There's nothing. It's just like “thanks, have a nice day.”*

IBM touches on features neither the Life Course Perspective nor Homecoming Theory do. IBM describes five elements necessary for a behavior to occur: intention to perform the behavior, knowledge and skill to carry out the behavior, limited environmental constraints and acceptable social norms, the behavior must be significant, and excessive performance of the behavior may make it habitual (Montano, & Kasprzyk, 2015). During the interviews, participants brought up four out of five of the above notions: intention, knowledge, barriers/social norms, and saliency. First, the theory says that a behavior will occur if the individual has the intent and knowledge to perform said behavior. A 30-year-old male Air Force Technical Sergeant states:

*“If I felt like I was having issues I would seek them out. I just don't feel like I need to at this period in my life, but I do know that it's there. I know plenty of resources now that I could go to if I needed.”*

Second, social norms and lack of barriers was touched on. Examples of social norms include stigma and lack of social support. Barriers illustrated in the interviews include medical incompetence, transportation, and geographical access. A 32-year-old male Navy Petty Officer Second Class states:

*“There could be logistical issues, someone might not be close to a facility, that can help them, they might not have transportation, there might be scheduling conflicts. I know, oftentimes with the Veterans Administration, there can be month long gaps between a request for assistance and the actual fulfilling of that request.”*

Lastly, the behavior is likely to occur if it is important to the individual. This came about in the interviews when it came to seeking help because of having close family ties. As discussed previously, having children was an important factor. Another familial tie was having a significant other who showed substantial interest in helping the service member receive help. A 42-year-old male National Guard Staff Sergeant states:

*“My wife has learned my triggers. She sees it in my face when things are not going well for me. She’s even, at home, I have a service dog, and if my service dog is in another room, my wife has gone and gotten her. She gives me a lot of support to deal with my PTSD.”*

#### Limitations and Suggestions for Further Research

This exploratory study provides insights into military personnel’s knowledge of mental health disorders, but is not without limitations. First, interview participants were self-selected. This is important because participants who self-select are inherently different from those who do not participate. Second, participants were recruited through non-profit organizations near a large university and the VA. This is an important limitation, because access to resources are geographically dependent and thus, can influence a participant’s knowledge. Last, although 16 participants were recruited, only 15 were eligible to complete the study. Of the 15 who completed the study, only a small

portion of them were females. This is generally representative of the military population with 14.5% in the active duty forces, and 18% in the reservists and National Guard (CNN, 2013). However, it would be beneficial to compare gendered perceived knowledge of resources and disorders, which would require a larger female sample.

Although the sample was diverse in terms of military background there was very little variability between races or ethnicity. Therefore, it is important to conduct more research on this topic in other areas of the country and with a larger, more diverse sample. Another interesting aspect for further research revolves around the difference between enlisted service members and commissioned officers. The differences between basic training and officer school could reveal interesting information about the inclusion of information about mental health disorders and resources. It will be important for future research to also use other research methods beyond those used in this project, such as focus groups or surveys, to explore the issues identified here in greater detail.

### Conclusion

Many factors effect a military personnel's willingness to seek help regarding mental health disorders. The five that came to light in this study were 1) prevalence for mental health disorders, 2) increasing knowledge of disorders and resources once separated from the military, 3) barriers which inhibit access to resources, 4) various types of resources available, and 5) motivations to seek help for mental health disorders. Although this study sought to understand knowledge related to mental health disorders and resources, it uncovered many other aspects. With the prevalence of these barriers, and the low likelihood that veterans will seek out, and actually receive help, the



possibility that these service men and women will face significant challenges in their transition out of military life is high. Mental health disorders and symptoms can affect them shortly after transitioning or they can continue to affect them for the rest of their life. Regardless of time, there is a high likelihood that the reason these disorders developed is due to the person's participation in the military which is a huge sacrifice to keep our homeland safe.

Further research in each of these areas could be fuel for policy and cultural changes which may help the military population receive treatment and stay healthy, both physically and mentally. It is imperative to give our veterans a fighting chance for success upon returning from deployment. Active military, veterans, and their families need the help of sound research and activism grounded in research to overcome the stigma and barriers to care faced by persons with mental illness. This study attempted to help identify these barriers by learning what knowledge veterans currently have about mental health disorders and resources available.

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## APPENDICES

## Appendix A

### Interview Guide

Veteran Knowledge about Resources for Psycho Social Health  
Semi-Structured Interview Questions  
Savanna Taylor

1. Background in Military
  - a. In what state did you enlist?
    - i. Is it the same state where you live currently?
    - ii. Is it the same state where you lived prior to enlisting?
  - b. Which branch of the military were you in?
  - c. What was your rank?
  - d. How long did you serve?
  - e. How long has it been since your separation from service?
  - f. Do you have any family that served in the military?
  - g. What was your reason for enlisting?
  - h. What role did the military serve for you?
  - i. Have you been deployed/where?
  - j. Were you in combat?
  - k. Did you receive any honors?
2. Knowledge of mental health issues
  - a. How difficult would it be for someone in the military with a mental health problem to seek out help?
  - b. How common do you think mental health problems in the military are? what about among veterans?
  - c. What barriers do you think they may face?
  - d. What services are provided?
  - e. How common do you think PTSD is in the military? among veterans?
  - f. What do you know about PTSD?
  - g. Do you know of any other mental health problems those in the military or veterans may experience?
    - i. What do you know about anxiety disorder?
    - ii. What do you know about depression?
    - iii. What do you know about substance abuse disorder?
  - h. Do you have any knowledge of other mental health disorders?
  - i. Would you be able to recognize symptoms if you or another were exhibiting them?
3. Knowledge of resources before enlisting

- a. Were you aware of the different types of resources before you enlisted?
    - i. Therapy
      - 1. Drug
      - 2. Alcohol
      - 3. Mental health
      - 4. Counseling
    - ii. Service animals
    - iii. Housing
      - 1. Home repair
      - 2. Rental or mortgage payment
    - iv. Family
      - 1. Childcare
      - 2. Transportation
      - 3. Clothing assistance
      - 4. Food resources
    - v. Educational
    - vi. Work/career
      - 1. Federal sector
      - 2. State sector
      - 3. Private sector
      - 4. Apprenticeship programs
    - vii. Medical or legal
      - 1. Eye care
      - 2. Hearing
      - 3. Dental
      - 4. Insurance
  - b. Were you aware of the different resource centers or hotlines before you enlisted?
    - i. UWS
      - 1. How did you encounter
    - ii. SPAN
    - iii. NAMI
    - iv. VA National Center for PTSD
    - v. Military One Source
    - vi. PTSD United
4. Knowledge of resources during active duty

- a. Were you aware of the different types of resources after you enlisted but before you retired?
  - b. Were you aware of the different resource centers or hotlines after you enlisted but before you retired?
  - c. Were you given any resources while active duty?
5. Knowledge of resources now
  - a. Were you given any resource information upon leaving active duty?
  - b. Are you more aware of resources now that you have come home?
6. Have you been diagnosed with a mental health disorder since leaving active duty?
7. How likely are you to actively seek help from these resources or resource centers?
  - a. Why or why not?
8. Demographics
  - a. How old are you?
  - b. What is your racial background?
  - c. What is your gender?
  - d. What religion do you most closely affiliate with?
  - e. What is your income?
  - f. Are you a student?
    - i. If no, what is the highest educational level you have completed?
    - ii. If yes, where do you attend school?
  - g. Are you married?
    - i. If no, do you have a significant other?

Appendix B

Coding Manual

Knowledge of Mental Health Disorders and Resources by Military Personnel  
Coding Manual  
Savanna Taylor

High likelihood of having a mental health disorder for both active and retired military

Knowledge of mental health disorders and resources

Boundaries identified when attempting to seek out help

Particular types of resources available

Likelihood to seek help was dependent

Appendix C

Institutional Review Board (IRB) Application and Attachments



**IRB Exempt Review Application**

Office use only	<b>Protocol Number:</b> [REDACTED]
Approval Date: [REDACTED]	
Exempt Category: B [REDACTED]	

<b>1.</b>	<b>Developmental Approval:</b>	Enter the IRB protocol number if developmental approval was granted for this research study (temporary approval granted by the IRB for funded projects). [REDACTED]
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<b>2.</b>	<b>Research Title:</b>	<b>KNOWLEDGE OF MENTAL HEALTH DISORDERS AND RESOURCES BY MILITARY PERSONNEL</b>
	Enter title used on consent document(s), if different from research title:	
	If class project, include course number and title:	[REDACTED]

<b>3.</b>	<b>Principal Investigator (PI):</b> The PI must be a member of the <a href="#">Clemson faculty or staff</a> . Graduate students may not be the PI if they are conducting the study for their thesis or dissertation. The PI must have completed IRB approved <a href="#">human research protections training</a> . Training will be verified by IRB staff before approval is granted.	
	Name: <b>Dr. Bryan Miller</b>	<input checked="" type="checkbox"/> Faculty <input type="checkbox"/> Staff
	Department: <b>Sociology, Antropology, and Criminal Justice</b>	E-mail: <b>blm2@clemson.edu</b>
	Campus address: [REDACTED]	Phone: <b>912-478-5213</b> Fax: [REDACTED]

<b>4.</b>	<b>Co-Investigator(s):</b> Co-investigators not affiliated with Clemson University need IRB review at their home institution. IRB training recommended for co-investigators involved with exempt studies but not required for IRB approval.	
	Name: <b>Savanna Taylor</b>	E-mail: <b>sbt@g.clemson.edu</b>
	Department: <b>Sociology, Antropology, and Criminal Justice</b>	Phone: <b>8433232719</b>
	<input type="checkbox"/> Faculty <input type="checkbox"/> Staff	<input checked="" type="checkbox"/> Graduate student <input type="checkbox"/> Undergraduate student <input type="checkbox"/> Other. Please specify. [REDACTED]
	Name: [REDACTED]	E-mail: [REDACTED]
	Department: [REDACTED]	Phone: [REDACTED]
	<input type="checkbox"/> Faculty <input type="checkbox"/> Staff	<input type="checkbox"/> Graduate student <input type="checkbox"/> Undergraduate student <input type="checkbox"/> Other. Please specify. [REDACTED]

- 
5. **Research Team Roles:** Describe team member's role on the study, indicating which team member will be responsible for recruiting, obtaining informed consent, and/or collecting data.

**Description:** Savanna Taylor will be responsible for recruiting, obtaining informed consent and collecting data. Dr. Miller will oversee the process and provide guidance.

6. **E-mail Communications:** Enter the name and e-mail address for co-investigator or administrative staff to be copied on all e-mail communications.

Name: <u>Bryan Miller</u>	E-mail: <u>blm2@clermson.edu</u>
Name: <u>Savanna Taylor</u>	E-mail: <u>sbt@clermson.edu</u>

7. **Study Purpose:** Describe the purpose of the study using lay language and avoiding technical terms. IRB members not familiar with the area of research must understand the nature of the research.

**Description:** The purpose of this study is to be able to better understand the gap between military veterans and psychosocial resources. Many veterans who return home do not indulge in the vast resources provided for them to live a healthy and happy life. These resources include, but are not limited to, therapy, service animals, education programs, and family or housing support. Because of this, many veterans do not receive the help they need. This can cause them to suffer from mental illness like PTSD. It can also cause them to suffer from drug or alcohol addiction. Most unfortunate, veterans who do not receive help can end up in the criminal justice system.

8. **Benefits and Sharing of Results:** Describe the potential benefit(s) to the participants and/or society that may be reasonably expected as a result from this study.

**Description:** In order to help veterans who have returned home, a better understanding is needed of why social resources are not being used. Once this is understood, society can start to help a vast majority of veterans to have a happy and healthy life.

Upon conclusion of the study, describe how results will be shared (e.g., academic publication, evaluation report to funder, conference presentation)?

**Description:** This project will be submitted for publication in several sociological journals.

9. **Anticipated Dates or Research:** Enter anticipated start date (may not be prior to IRB approval; may be "upon IRB approval"): upon IRB approval

Anticipated completion date, include time needed for analysis of individually identifiable data: November 30<sup>th</sup>, 2018

10. **Funding Source:** Check all that apply.

- Submitted for internal funding  
 Internally funded  
 Submitted for external funding

Funding source, if applicable (Do not use initials):

Proposal number (PPN) for the Office of Sponsored Programs:

Name of PI on Funding Proposal:

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- Externally funded  
 Funding source, if applicable (Do not use initials): \_\_\_\_\_  
 Proposal number (PPN) for the Office of Sponsored Programs: \_\_\_\_\_  
 Name of PI on Funding Proposal: \_\_\_\_\_
- Intend to seek funding: From whom? \_\_\_\_\_  
 Not funded

11. Support provided by Creative Inquiry Initiative:  Yes  No

12. Other IRB Approvals:

Was this research study approved or is it currently being reviewed by another IRB?  Yes  No

If YES, enter name of institution: \_\_\_\_\_ Determination Date: \_\_\_\_\_

What was their determination?  Approved  Disapproved  Pending

*Include determination notice/letter with IRB packet.*

13. Exempt Review Categories: The Code of Federal Regulations, 45 CFR 46.101, permits research activities in the following six categories to be exempted. Check the relevant exemption category/categories for your study.

The Federal Office of Human Research Protections has developed [Decision Charts](#) to assist with determining whether a particular study falls within one of exemption categories.

Categories of Research Activities Exempt from Continuing Review	
<input type="checkbox"/>	<p><b>B1.</b> Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as:</p> <ul style="list-style-type: none"> <li>a. research on regular and special education instructional strategies, OR</li> <li>b. research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.</li> </ul> <p>NOTE: Survey and interview procedures with minors are exemptible if the activities fall within this category.</p>
<input checked="" type="checkbox"/>	<p><b>B2.</b> Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, UNLESS:</p> <ul style="list-style-type: none"> <li>a. the information obtained is recorded in such a manner that human participants can be identified, directly or through identifiers linked to the participants; AND</li> <li>b. any disclosure of the human participants' responses outside the research could reasonably place the participants at risk of criminal or civil liability or be damaging to the participants' financial standing, employability, or reputation.</li> </ul> <p>NOTE: Survey and interview techniques which include minors are not exempt. Observation of the public behavior of minors, if the researcher is not a participant, is exempt.</p>

<input type="checkbox"/>	<p><b>B3.</b> Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior <b>that is not exempt under Category B2</b>, if:</p> <p>a. the human participants are elected or appointed public officials or candidates for public office, or</p> <p>b. federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.</p>
<input type="checkbox"/>	<p><b>B4.</b> Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that participants cannot be identified directly or through identifiers linked to the participants.</p>
<input type="checkbox"/>	<p><b>B5. NOTE: Please contact the IRB office before selecting this category since use of this exemption must be initiated by the agency head of the federal funder.</b></p> <p>Research and demonstration projects which are conducted by or subject to the approval of appropriate Federal Department or Agency heads, and which are designed to study, evaluate, or otherwise examine:</p> <p>a. public benefit or service programs; or</p> <p>b. procedures for obtaining benefits or services under those programs; or</p> <p>c. possible changes in or alternatives to those programs or procedures; or</p> <p>d. possible changes in methods or levels of payment for benefits or services under those programs.</p>
<input type="checkbox"/>	<p><b>B6.</b> Taste and food quality evaluation and consumer acceptance studies,</p> <p>a. if wholesome foods without additives are consumed, OR</p> <p>b. if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.</p>

**14. If you selected Exempt Category B4, complete questions a through g below:**

- a. Provide a detailed description of the data or specimens and what information will be used.
- b. What is the source of the data or specimens?
- c. Are the data or specimens publicly available without restriction or password? (That is, can the general public obtain the data or specimens? Data are not considered publicly available if access is limited to researchers.)  
 Yes  No   
*If yes, please contact the [IRB staff](#) for consultation. You may not be conducting research involving human subjects as defined in the federal regulations governing research involving human subjects (45 CFR 46.102).*
- d. If the data or specimens are not publicly available, how are you obtaining permission to access these or to use them for research purposes?   
*Please attach a copy of the correspondence or agreement granting you permission.*
- e. How will you receive the data or specimens (e.g., electronic file, access to hard copy records at record-holder's institution, test tube)?
- f. How are the data or specimens identified when they are made available to you?
- 1)  Direct Identifier (e.g., subject name, address, social security number).

- a) Will you record any direct identifiers that are available to you? Yes\*  No
- b) Will you have access to the data from home or office? Yes\*  No
- 2)  Indirect Identifier (e.g., an assigned code that could be used by the investigator or the source providing the data or specimens to identify a subject, such as a pathology tracking number or a tracking code used by the source).
- a) Will you or a team member have access to the data set code key? Yes\*  No
- If you will receive data with indirect identifiers only, please contact the [IRB staff](#) for consultation. You may not be conducting research involving human subjects as defined in the federal regulations governing research involving human subjects (45 CFR 46.102).*
- 3)  No Identifier (i.e., neither the researcher nor the source providing the data or specimens can identify a subject based upon information provided with the data or specimens).
- If it will be impossible for anyone to identify subjects based upon information provided with the data or specimens, you will not be conducting research involving human subjects as defined in the federal regulations governing research involving human subjects (45 CFR 46). Please contact the [IRB staff](#) for confirmation.*
- g. Will any data or specimens be collected from participants after the submission of this application? (Data or specimens are considered to “exist” if ALL the data or specimens to be used for the research have been collected prior to the submission of this application.)
- Yes\*  No

\*Your research does not qualify for exemption from IRB review under Exempt Category B4.

**SKIP TO QUESTION 21 if you are only applying for exemption under Exempt Category B4.**

**15. Study Sample:** (Groups specifically targeted for study)

Describe the participants you plan to recruit and the criteria used in the selection process. Describe any inclusion or exclusion criteria.

**Description:** Military from after 9/11

Age range of participants: 18-65 Projected number of participants: 15

Study sample includes (check all that apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Employees   | <input type="checkbox"/> Students                                      | <input type="checkbox"/> Minors (under 18) <sup>1</sup>                         |
| <input type="checkbox"/> Pregnant women <sup>1</sup>   | <input type="checkbox"/> Fetuses/neonates <sup>1</sup>                 | <input type="checkbox"/> Educationally/economically disadvantaged <sup>1</sup>  |
| <input type="checkbox"/> Minors who are wards of the state, or any other agency, institution, or entity <sup>1</sup> | <input type="checkbox"/> Individuals who are incarcerated <sup>2</sup> | <input type="checkbox"/> Persons incompetent to give valid consent <sup>1</sup> |
| <input type="checkbox"/> DoD personnel   | <input type="checkbox"/> Other-specify: <input type="text"/>           |   |

<sup>1</sup> State necessity for this type of participant:

<sup>2</sup> Research involving prisoners (incarcerated individuals) requires full board review. Please submit the [Full Board Review Application](#) and a Prisoner Research Addendum.

**16. Study Locations:** Check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> Clemson University                                     | <input type="checkbox"/> Other University/College <input type="text"/>              |
| <input type="checkbox"/> School System /Individual Schools <input type="text"/> | <input checked="" type="checkbox"/> Other – specify <u>Upstate Warrior Solution</u> |

You may need school/district permission if participants will be recruited or data will be obtained through schools. Permission may be necessary for sites not affiliated with Clemson University. Contact appropriate office/department and keep documentation on file.

- 17. Recruitment Procedures:** Describe how prospective participants will be contacted/recruited for the study and how contact information will be obtained, include a copy of the recruitment materials in the packet (e.g., advertisements, flyers, oral and/or telephone scripts, cover letters, or follow-up reminders). Participants may not be contacted prior to IRB review.

**Description:** In partnership with Upstate Warrior Solutions, Clemson Paralympic Soccer, and the Clemson Veteran Center, I will contact participants via electronic or oral communications. A follow-up reminder will be sent 1 week after initial contact. See attached recruitment material.

- 18. Participant Incentives:** Will participants receive any incentive or compensation for participating in the study?  Yes  No

If YES, check all that apply and provide requested information.

- Course/extra credit for students (an equivalent alternative to research participation must be provided and described in your informed consent document(s)).
- Gift(s) - describe gift(s) [include value and when gift(s) will be given]: \_\_\_\_\_
- Monetary incentive(s) - describe incentive(s) [include value and when incentive(s) will be given]: \_\_\_\_\_

- 19. Informed Consent:** Describe the informed consent process, include who will obtain consent, when, and how this will be done. Provide a copy of the participants' and/or guardian's [informed consent document\(s\)](#): information letter, online script, and/or oral script.

**Description:** Savanna Taylor will read an oral consent form to the participants. Once they have heard to consent form they will be asked if they want to participate. Upon they're approval they will considered to have given consent to partake in the study.

Will you use concealment (incomplete disclosure) or deception in this study?  Yes  No

If YES, describe concealment or deception and provide rationale below. See guidance regarding [Research Involving Deception or Concealment](#) and provide a copy of the [debriefing form](#).

**Description:** \_\_\_\_\_

**20. Methods and Procedures:**

- a. What data will you collect? Submit copy of data collection instruments/tools for review (i.e., surveys, interview questions).

A semi-structured interview process will be used to collect data. Participants' answers will be audio recorded via an audio recorder to be transcribed at a later time. This will ensure full data coverage.

- b. How will you collect the data?

- In-person contact  Telephone  
 E-Mail  Mail  
 Online/website  Other - specify \_\_\_\_\_

c. Will you audio/video record or photograph participants?  Yes  No

If YES, check all that apply:  Audio  Video  Photographs

If YES, will you use audio, video, or photographs in presentations, publications, and/or training materials?  Yes  No

Refer to [guidance on audio/video and/or photography](#) for more information and what is required in the informed consent document or script.

d. Describe, in detail, your data collection methods and procedures. Describe how data will be obtained and provide information on what sessions will be audio/video recorded and/or photographed.

The participants will be asked a series of semi-structured questions during a single in-person interview that should not last any longer than 30 minutes. I will record the interview and transcribe within 2 weeks of collecting the data.

e. What is the total time (minutes, hours, days) that each participant will spend in the entire study, include follow-up sessions?

30 minutes

**21. Data Management Plan:** Describe what identifiable data you will obtain from the participants and who will have access to the identifiable data. What security measures will you take to protect the confidentiality of the information obtained? Where will the data be stored and how will it be secured? How will identifiers be maintained and when will you destroy the identifiers (i.e., names, audio/video recordings, photographs)?

**Description:** I will not collect any identifiable data other than demographics. All recordings will be transcribed within two weeks of data collection and then will be erased.

## 22. Conflict of Interest Statement/Financial Disclosure:

Could the results of the study provide an actual or potential financial gain to you, a member of your family, or any of the co-investigators, or give the appearance of a potential conflict of interest (COI)? Refer to [Conflict of Interest policy](#) for more information.

No.

Yes

If YES, indicate the status of the COI and/or financial disclosure:

On file with COI office  Will be submitted to COI office

## 23. PI Verification:

I am the PI and have reviewed the IRB research protocol packet (application, recruitment materials, informed consent materials, and data collection instruments/tools). I request review of this research protocol by Clemson University's IRB.

The PI should submit the complete packet to [IRB@clemsun.edu](mailto:IRB@clemsun.edu). Receipt of the application electronically from the PI will qualify the application as a signed electronic submission.

Knowledge of Mental Health Disorders and Resources by Military Personnel  
Verbal Recruitment Script  
Savanna Taylor

Hello - My name is Savanna Taylor and I am a graduate student from the Sociology, Anthropology, and Criminal Justice Department at Clemson University. I'm calling to talk to you about participating in my research study. This is a study about veteran knowledge of psycho-social resources. You're eligible to be in this study because you are a veteran who served in Iraq or Afghanistan. I obtained your contact information from Upstate Warrior Solution.

If you decide to participate in this study, you will be asked a series of semi-structured questions during a single in-person interview that should not last any longer than 30 minutes. I would like to audio/video record your interview and then we'll use the information to ensure full data coverage.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate, we can go ahead and schedule a time for me to meet with you to give you more information. If you need more time to decide if you would like to participate, you may also call or email me with your decision.

Do you have any questions for me [at this time](#)?

If you have any more questions about this process or if you need to contact me about participation, I may be reached at 843-323-2719 or [sbt@g.clemson.edu](mailto:sbt@g.clemson.edu).

Thank you so much.

Knowledge of Mental Health Disorders and Resources by Military Personnel  
Verbal Consent Form  
Savanna Taylor

Please keep in mind that your participation is voluntary. I can supply you with contact information regarding this study upon request. My name is Savanna Taylor, and I am a Clemson graduate student interested in your experience as a Veteran. The research is being conducted to find out the knowledge Veterans have on psycho-social resources. Your participation will only be needed once for a few questions that should last fifteen to thirty minutes.

The information provided will remain strictly confidential and you will not be identified by your answers. You and/or your company's name will not be disclosed in any way. Data will be compiled as a whole with no individual responses tied to your name or any identifying information about you. All information disclosed during the interview will be kept in a secure location. This conversation will be recorded and notes will be taken. You may choose not to answer any question and are not required to answer any questions. You may withdraw from this study at any moment during or after the interview.

Do you have any questions before we get started?

Appendix D

Table 1: Sample Characteristics

<b>Age</b>	<b>Gender</b>	<b>Branch</b>	<b>Rank</b>	<b>Years Served</b>	<b>Years Since Separation</b>
32	Male	Navy	E5	6	3
37	Male	Air Force	E4	5.5	6
31	Male	Marines	E4	4	8
43	Male	Army	E7	20	6
38	Male	Air Force	E6	12.5	4.5
30	Male	Air Force	E5	8	2
25	Female	Navy	E4	4	3
48	Male	Marines	E6	18	5
42	Male	National Guard	E6	20	1.7
26	Female	Navy	E4	10	7
33	Male	Marines	E7	9.5	5
32	Male	National Guard	E5	7	3
28	Male	Army	E5	9	4.5
30	Male	Air Force	E6	12	2
25	Male	National Guard	E4	4	6