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Perceptions of mental health services for Operation Iraqi Freedom and Operation Enduring Freedom military personnel: A needs assessment

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PERCEPTIONS OF MENTAL HEALTH SERVICES FOR OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM MILITARY PERSONNEL: A NEEDS ASSESSMENT

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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ABSTRACT

The purpose of this study is to assess the mental health needs of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) military personnel. This project will use a qualitative approach in order to evaluate perceptions of mental health services among military spouses and mental health practitioners. This method was chosen because the depth that this study hopes to acquire can only be achieved through qualitative interviews. The responses of the military spouses and practitioners provide reliable insight into the mental health needs of OIF/OEF military personnel because of their close involvement with the population at risk. This project is significant to social work practice because its implications may be used towards the implementation of interventions designed to better address the mental health needs of the growing OIF/OEF military population.

ACKNOWLEDGMENTS

We would like to thank the Veterans Home of California Barstow and Bill Rigole for continued support of this project. Bill, thank you for your mentorship and guidance during our research.

Special thanks to Dr. Tom Davis for your understanding of the importance of this project and providing us the needed direction.

DEDICATION

This project is dedicated to the honorable men and women proudly serving in the United States Armed Forces. We would also like to appreciate the families sustaining their loved ones in the service. Lastly, this is dedicated to our wonderful families who have supported us throughout the research process.

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CHAPTER ONE

INTRODUCTION

News of Operation Iraqi Freedom and Operation Enduring Freedom OIF/OEF, also known as the War on Terror, has flooded the media since the war's initiation in 2001. Thousands of military personnel are deployed to OIF/OEF each month and still thousands more are preparing for deployment. With so many U.S. troops engaging in combat, one thing that is certain is that at the end of the war, America will witness the return of over 700,000 currently active military personnel (Williamson, 2007). Research states that at least one-in-three Iraq veterans, and one-in-nine Afghanistan veterans will have some sort of mental health issue like anxiety, depression, and PTSD (Williamson, 2007). Among these, many will have first hand experiences with war trauma resulting in severe mental health issues in need of professional treatment.

Research dating as far back as World War I has documented that major psychological diagnoses of military personnel returning from war include what are now known as Post Traumatic Stress Disorder (PTSD), Major Depression, and Anxiety Disorder (Williamson, 2007).

Studies show that for those diagnosed with these types of mental disorders, the symptoms stem from the extremely distressing experiences they have out on the battlefield in dealing with bombs exploding, witnessing comrades being injured or killed, killing or hurting others, and living day after day with an unrelenting fear of dying (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2007). The stress produced from such horrifying situations takes an immense toll on the human psyche. It may also negatively affect their physical bodies as well. For those inflicted with PTSD, the lingering effects of memories from their terrible experiences can mean having reoccurring episodes in which they mentally relive their past traumas. The resulting levels of stress manifest themselves in different displays of maladaptive psychological symptoms and pose serious problems for everyday life.

Problem Statement

The problem this study addressed was mental illness among OIF/OEF military personnel returning from war. War-related mental illness has been heavily documented since World War I (Daley, 2000). Although it is known

that mental health issues are common among personnel returning home from war, statistics show that a great deal of those who should be getting mental health services are not seeking or receiving the help they need (Erbes, Westermeyer, Engdahl, & Johnsen, 2007). Current explanations for such findings seem to be tied to several different factors including stigma attached to mental health services and flaws within the systems of mental health services distribution to military personnel (Erbes et al., 2007).

Research by mental health practitioners has suggested that within the military, mental health services are looked down upon (Britt, Greene-Shortridge, & Castro, 2007). There is also a suggested stigma attached to those who seek services. Mental health services perceived by OIF/OEF personnel as a disgraceful, and are viewed only as a solution for those too weak to handle their own personal problems (Britt el at., 2007, Hoge et al., 2004). Those who have been known to utilize such services have attested to being ridiculed and even shunned by their peers; the reason being is that psychological impairment is not being viewed as a serious illness (Britt et al., 2007). If such stigma does exist,

then perhaps soldiers are not seeking out services out of fear of persecution by their peers and even commanding officers (Hoge et al., 2004).

The importance of mental health treatment for these military personnel reaches far beyond just the individuals diagnosed with mental disorders. The psychological problems are often the catalyst to other personal issues such as domestic violence and substance abuse (Alt, 2006). Soldiers returning from war often have difficulties in their personal lives at home, and struggle with social issues such as trouble integrating back into civilian life (Henderson, 2006). The rippling effects of the mental disorders have caused concern from many different people. Not just the OIF/OEF personnel, but their spouses, friends, and relatives share in the concern.

Collective research indicated that mental health practitioners are concerned about service utilization because from their perspective they see the potential for widespread dysfunction and chronic disability if this population is left untreated (Williamson, 2007). A single individual's hardships can impact an entire network of people, and with so many troops at high risk of

developing mental health problems, the psychological repercussions of warfare have the potential of affecting not only the OIF/OEF personnel but also those around them.

More than half a million people will be returning from the War on Terror and issues like mental illness, substance abuse, and domestic violence will definitely take a toll on all of society (Williamson, 2007). It is important to understand service utilization in more depth simply because of its sheer size. Hundreds of thousands of soldiers and their families will be in need of services. A better understanding of this problem is the first step to solving it. If we can understand the barriers keeping personnel from getting mental health services, then we can draw up ways in which to counteract those barriers. A major milestone is to devise interventions that will make mental health service seeking more acceptable for the soldiers and to find ways to improve military mental health services in general (Operation Iraq Freedom Mental Health Advisory Team, 2003, Daley, 2000).

The findings of this study could change social work on a large scale because its implications apply towards

the area of military social work practice, which is predicted to grow exponentially in the near future. This research study has added to the growing body of knowledge surrounding military mental health. In time, we hope to see that more attention and research go towards military mental health treatment, further elaborating on the issues we have addressed. OIF/OEF will bring a heavy workload to the doorstep of social work. If we heed the existing empirical evidence, we have a chance to be prepared for the demands of this ever-growing population.

To understand the barriers that military personnel face regarding mental heath services, we used an alternative angle for data collection. Along with research, we interviewed military spouses and mental health practitioners and conducted a needs assessment based on their knowledge of the mental health needs of military personnel and services available to them. By law and as student researchers, we were not able to directly contact active military personnel in order to conduct our assessment. Through the Veterans Home California, Barstow and a network of military spouses, we obtained significant perceptions of military mental health services from those closest to the mental health issues

of military personnel. Our research question was, "What are the perceptions of military mental health services among spouses and mental health service practitioners?" The independent variable in our design was the group, either spouse or mental health professional, that the interviewee was a part of. The dependent variable was their responses to interviews which we collected and evaluated throughout the progression of the study. The responses from both groups were compared both within each group and between them.

Purpose of the Study

The purpose of this study was to assess the perceptions of mental health services for OIF/OEF military personnel among military spouses and mental health practitioners. The professional and personal knowledge of the mental health practitioners and the military spouses provided valuable information about the effectiveness, availability, strengths, and weaknesses of the military's mental health services. Most importantly the contributions of the spouses and practitioners helped shed light on the mental health needs of the vastly

growing military population of men and women returning from Iraq and Afghanistan.

The global War on Terror has had a significant impact on the prevalence of mental health needs of the military. The increase in combat exposure, severity of injury, longer lengths of deployments and frequent separation from families and support systems have continued to test the mental health readiness of the military. OIF and OEF have produced well over half a million veterans, a number that is continuing to climb. Currently over 700,000 OIF/OEF veterans are eligible for health care through the VA (Williamson, 2007). This immense population of veterans has challenged the current military mental health system. Non-stigmatized mental health services will be paramount in treating this specific military population.

A significant issue addressed in this research study was the prospect that stigma exists in military mental health services. The research showed that stigma has impacted OIF/OEF military personnel in their search for services. According to the literature, military personnel have resisted seeking help because they were afraid of how they would be perceived by their peers and by

leadership (Hoge et al, 2004). There was a fear among OIF/OEF military personnel that if they received mental health services they would be spurned by their comrades and commanding officers as well as blamed for their mental health problems (Britt, Green-Shortridge, & Castro, 2007). Obtaining mental health services has also been perceived by OIF/OEF veterans as a way to ruin a career. There is great fear among combat veterans that obtaining mental health services will put a blemish on their service record and negatively affect their "promotability" (Henderson, 2006). The possibility of stigma could be a formidable obstacle for the military personnel that would benefit from mental health services.

We hypothesized that unique barriers to care and service utilization existed within the current mental health system. We projected that one significant contributing factor was found within the agencies that provide the mental health services to OIF/OEF military personnel. The VA centers, which have provided a bulk of the mental health services, may not have enough trained mental health practitioners to meet this growing population's needs. The OIF Mental Health Advisory Team found that practitioners needed more training in tactics,

techniques and interventions related to combat stress, suicide, early identification, and post-deployment follow-up (MHAT, 2003). Unfortunately 90% of the military psychiatrists, psychologists, and social workers reported no formal training in PTSD treatment, which was the most common mental health problem for military personnel connected to OIF/OEF (Williamson, 2007). Perhaps a lack of necessary finances may have had an effect on the deficiencies in the continued education and training of mental health practitioners previously mentioned. Another aspect we anticipated assessing was the number of workers functioning in the capacity of military mental healthcare practitioners.

Our study also included an assessment of the accessibility of the mental health services offered to OIF/OEF military personnel. The wars in Iraq and Afghanistan are unique in that they have deployed the highest percentage of National Guard units than any wars in U.S. history (Henderson, 2006). National Guard personnel do not live on bases or posts like most full time active duty military personnel. Most live many miles away from the nearest military installation. Mental health services are predominantly offered and advertised

to those living on military installations (Henderson, 2006). We anticipated finding that OIF/OEF men and women serving in the National Guard were without sufficient knowledge or access to mental health services.

Understanding the strengths and weaknesses of military mental health services can be unearthed by speaking to those most closely related to the subject, military spouses and military mental health practitioners. This research study was conducted through qualitative methods. Using narrative analysis provided a unique and insightful collection of responses regarding military mental health services. The mental health practitioners and the military spouses are the two populations that were interviewed. The mental health practitioners offered first hand information about the mental health services that were available and attested to the effectiveness of these services. The military spouses provided valuable information about the mental health wellbeing and needs of the OIF/OEF population. Narrative analysis was used with both of these populations.

Qualitative research is based on interpretative perspective, which states that reality is defined by the

research participants' interpretations of their own realities (Grinnell & Unrau, 2005). The best data source came from our participants, the military spouses and the mental health practitioners that work with current active duty military personnel.

Our data was obtained through interviews with these two specific populations. The interviews were semistructured and focused. Predetermined questions were asked but we had the latitude to explore areas of interest during the interviews. Two different interviews were given, one specific to the military spouses and the other was specific to the mental health practitioners. There was overlap in the content of the questions asked. Our sampling design strategy for obtaining military spouses and mental health practitioners was based on availability sampling and snowball sampling. Based on availability, we contacted military spouses and mental health practitioners. From these contacts, we were referred to other possible participants. We were not concerned with the military branch affiliations, rather the perceptions of the services provided. There was no gender, ethnic, age, or rank status criteria pertaining to the military spouse population. Our sample of mental

health practitioners had to be able to provide mental health services and work specifically with the military population.

Significance of the Project for Social Work

The returning OIF/OEF military population numbers in the hundreds of thousands. These men and women along with their families will seek services, and their mental health needs will be felt throughout the military and civilian mental health service organizations. Social services as well are expected to bare the brunt of this soon-to-be enormous social issue. The military population in is homogenized throughout the nation, states, counties, and communities. They will add mental health issues to those of the millions of veterans from previous wars, bringing a new era of combat related stressors, compounding the need for adequate services.

This study was intended to contribute to the full understanding of the barriers of military mental health services, and the specific needs of the OIF/OEF population. Through identification of current limitations and strengths of services in place, we have contributed to the initial stages of developing plans to

appropriately accommodate for the mental health needs of this growing population.

This study and the many similar studies that have preceded it have helped instigate a more thorough reevaluation of issues surrounding military personnel. The OIF/OEF population is a new and unique group of men and women. Their mental health needs have in some ways mimicked those of past wars, but have also shown significant differences. This study was purposed to encourage social workers to take a look at the effectiveness of the mental health services and take responsibility in providing for the mental health needs of this military population.

This research study falls within the assessment phase of the generalist model. The assessment phase is the analysis of the problem, the person(s), and the ecological context (Hepworth, Rooney, Rooney, Strom-Gottfried, Larsen, 2006). Interviews with the spouses and the mental health providers have assessed the military's mental health services, and have also given insight to precipitating and perpetuating factors to service utilization and underutilization. By interviewing spouses and mental health providers of the OIF/OEF

military population we sought to gain valuable information about mental health service utilization. It is because of the subject's close involvement with the OIF/OEF military personnel that the data produced from this study was a valid depiction of current mental health needs of OIF/OEF personnel.

Our research question, "What are the perceptions of mental health services for OIF/OEF military personnel from the perspective of their spouses and mental health service practitioners?" was the foundation of this needs assessment. Through the interviews and the analysis of the collected data, we assessed military mental health services and help develop a solution for this social issue.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter is a review of the literature which includes empirical data and personal testimonies about military mental health services for the OIF/OEF population. It includes resources outlining common mental illnesses related to military service, the prevalence thereof, existing treatment techniques, and perceptions of mental health care services for OIF/OEF personnel among military spouses and mental health practitioners.

Mental Health Problems of Operation Iraqi Freedom and Operation Enduring Freedom Military Personnel

Military mental health is vital to the readiness and effectiveness of the United States armed forces. Significant previous empirical research has been done in the area of veteran's mental health. Literature is continuing to compile on the mental health issues of the veterans who are involved with the current wars in Iraq and Afghanistan.

In a research article by Hoge, Castro, Messer, McGurk, Cotting, and Koffman (2004) mental health

problems of combat units in Iraq and Afghanistan were studied. Hoge et al. surveyed three Army units and one Marine Corps unit before deployment and three to four months post-deployment. The research found that OIF/OEF veterans had a strong reported correlation between the prevalence of PTSD and combat experiences such as being shot at, handling dead bodies, knowing someone that had died or been injured, or killing enemy combatants (Hoge et al., 2004). What the researchers found was that the increase in combat exposure also increased the likelihood of mental trauma (Hoge et al., 2004). Combat exposure in Iraq was reported more often than in Afghanistan with more than 90% of respondents serving in Iraq experiencing some form of combat (Hoge et al., 2004). Hoge et al. surveyed the military units and found that screening criteria for major depression, PTSD, anxiety, and alcohol misuse was significantly higher among soldiers post-deployment. The research showed a significant difference between duty in Iraq and Afghanistan. 11.2 percent of soldiers having served in Afghanistan experienced criteria for major depression, generalized anxiety, or PTSD, which was significantly lower than the 15.6-17.1 percent of soldiers having served in Iraq (Hoge

et al., 2004). This article provided current data regarding the mental health consequences of combat duty in Iraq and Afghanistan and an overview of the significant mental health problems experienced by OIF/OEF veterans.

The Iraqi Freedom Mental Health Advisory Team (MHAT) found similar statistics as Hoge et al. MHAT's research was conducted to assess and obtain information regarding the mental health problems and well-being of OIF military personnel currently deployed in combat operations.

The study found that 17 percent of OIF military personnel screened positive for traumatic stress, depression, or anxiety and reported impairment in social or occupational functioning (MHAT, 2003). 15 percent of OIF personnel versus 7 percent of OEF personnel screened higher on the traumatic stress scale. Depression and anxiety were almost identical in OIF and OEF military personnel (MHAT, 2003). MHAT found that suicide was a significant mental health concern. The research established that 17 percent of OIF personnel screened positive for suicidal ideation, compared to the 12 percent rate of soldiers screened before deployment (MHAT, 2003).

The MHAT study also looked at demographic information and noncombat stressors related to mental health well-being. What was discovered was that OIF soldiers were more likely to experience mental health problems if they were junior-ranking and active duty (MHAT, 2003). The most frequent noncombat stressors reported were the length of deployment and uncertain redeployment date (MHAT, 2003). Uncertain redeployment dates were significantly connected with the decrease in morale, and screening positive for depression, anxiety, and PTSD (MHAT, 2003). This study provided valuable information regarding mental health problems associated with military personnel during OIF deployment. Stressors experienced while on deployment and military demographics were found to increase the prevalence of mental health problems in the OIF population.

The research article by Grieger, Cozza, Ursano, Hoge, Martinez, Engel, and Wain (2006) studied the rates of PTSD and depression among battle injured soldiers returning from Iraq and Afghanistan. Much like the research done by Hoge et al. and MHAT, Grieger et al. also found increased PTSD rates in the OIF/OEF population. However, Grieger and colleagues looked at the

rates of both PTSD and depression over time, to see how or if mental health problems would manifest themselves in the injured OIF/OEF veteran population.

The research found that one month after injury 4.2 percent met the criteria for PTSD and 4.4 percent met the criteria for depression. At four months 12.2 percent met the criteria for PTSD and 8.9 percent met the criteria for depression. The last survey was given at seven months and 12 percent met the criteria for PTSD and 9.3 percent met the criteria for depression (Grieger et al., 2006). This study showed a pattern of increased mental health problems over time after combat related physical injury. This research was the first to examine the rates of PTSD and depression among injured military personnel returning from combat in Iraq and Afghanistan. The findings were important because they depicted the rates and course of PTSD and depression among OIF/OEF military personnel, and explored their mental health issues in more depth.

An executive summary was conducted by Williamson (2007) in which the severity and multitude of mental health problems occurring in OIF/OEF population was evaluated. While Grieger et al. looked specifically at PTSD and depression, Williamson examined it from a

broader perspective. Williamson discussed PTSD and depression but also provided more information relating to OIF/OEF mental health.

Williamson (2007) noted that mental health problems were already higher than recorded rates of Vietnam veterans, especially PTSD which is the hallmark of OIF/OEF veterans. Research found that one-in-three OIF veterans and one-in-nine OEF veterans will experience a mental health problem like PTSD, depression, or anxiety and a recent survey establish that 38 percent of soldiers, 31 percent of Marines, and 49 percent of National Guardsmen reported psychological problems (Williamson, 2007). Williamson points out that the rise in mental health disorders have also increased co-occurring disorders like alcohol and drug abuse, as well as increased the likelihood of spousal abuse, child abuse, divorce rates, and suicide. These statistics are staggering and suggest that a vast array of mental health problems and co-occurring disorders are plaguing the OIF/OEF population.

Substance abuse and suicide rates have significantly increased since the beginning of OIF/OEF. The Army has had a three-fold increase in substance related incidents,

and suicide rates in Iraq have increased to 16.1 suicides per 100,000 from 11.6 suicides per 100,000 in the OIF/OEF population (Williamson, 2007). This article explores the multitude of mental health problems facing the OIF/OEF population as well as exposing the large population of military personnel manifesting these mental health issues.

Prior research has suggested that PTSD is the most prevalent mental health problem in OIF/OEF military personnel. Riddle, Smith, Corbeil, Engel, Wells, Hoge, Adkins, Zamorski, and Blazer (2007) conducted a longitudinal study and found that alcohol abuse was the most prevalent mental health disorder among the military personnel studied followed by PTSD, major depression, panic syndromes, and other anxiety syndromes.

Williamson (2007) touched on the demographics related to mental health problems. Riddle et al.'s research looked closer at the military demographic information and the correlation with OIF/OEF mental health problems. What was found was that female soldiers were more likely to have higher rates of mental health problems, with the exception of alcohol abuse which was more prevalent in male military personnel (Riddle et al.,

2007). Younger, active duty personnel between the ages of 17-24 were also more likely to have mental health problems (Riddle et al., 2007). This study is valuable in understanding the demographic indicators of mental health problems in the OIF/OEF population as well as validating alcoholism as a significant OIF/OEF mental health issue.

Military Spouse Perspective

The military spouse population is a viable wealth of information about what is it like living life within the military culture. They experience first hand the benefits of military life and also the struggles. The military spouse's perspective provides a vantage point into the services offered to OIF/OEF military members. Literature regarding the military spouse's perception of mental health services is scarce and more research needs to be done on this population in the future.

In a section of the book written by Alt (2006), pertinent spousal perspectives of the mental health services and mental health problems of OIF/OEF military personnel are examined. Using current empirical research Alt (2006), who is a military spouse expounded on the stressors surrounding OIF/OEF military personnel and

families. Alt provided the perspective that violence is a predominant worry among military spouses in regards to their returning soldiers, and that the attitude of the military to provide preventative help is less than desired. Alt (2006) cited data from the Defense Department that showed domestic violence has increased 8 percentage points from 1998 to 13 percentage points in 2004. From the military spouse perspective domestic violence is a manifestation of the stressors endured by OIF/OEF veterans, including PTSD as a major indicator of violence post deployment (Alt, 2006).

Interestingly Alt provided very little information about services aimed specifically for returning OIF/OEF military personnel. Alt explained that services are rarely offered to returning military personnel that have screened positive for combat stress, a factor that increases the prevalence of mental health problems including domestic violence. Alt cites a study done by the U.S. Air Force indicating that four out of five soldiers that screen positive for combat stress are not being referred for treatment (Alt, 2006).

There is also the perception that the military does not want to, "air its dirty laundry" in public because of

fear that it will weaken the military unit (Alt, 2006). Therefore the perception among spouses is that services are not openly made available if it hurts military cohesion and casts a negative light on the military or service members. Alt pointed out that the military is taking steps to enforce mandatory counseling once abuse has occurred (Alt, 2006). However, the opinion is that there continues to be very little preventative services offered to OIF/OEF soldiers returning home. Alt's text is important to understanding the military spouse's perspective of both the preventative services that are made available to the OIF/OEF military population and the barriers that limit service utilization.

Another spousal perspective is explored in a portion of Henderson's text (2006). She focused on the difference of living on and off military installations. Through interviews with spouses, empirical research, and Henderson's experience as a military spouse the perceptions of mental health services is explored between active duty and National Guard OIF/OEF military personnel.

National Guard units make up over 300,000 of the men and women serving in Iraq and Afghanistan (Henderson,

2006). This population is allotted the same mental health services as active duty military personnel; however the perception among military spouses is that National Guard personnel do not receive the same services because they do not live on military installations. Mental health services are not readily available to National Guard service members due to the perceived lack of communication and education about services, availability of providers and services, and lack of social support and assistance (Henderson, 2006). Henderson (2006) interviewed multiple military spouses and found that those living on military installations believed that services were available. Those services included: mental health programs, marriage and family therapy, pastoral counseling, anger management counseling, substance and domestic violence programs, social support groups, and life skills training (Henderson, 2006). Those that lived off post felt isolated and that sufficient services were not accessible. One spouse complained of never getting mailings, flyers, and information pertinent to services related to her service member (Henderson, 2006).

The importance of the research done by Henderson was that she discussed two differing perspectives about the

mental health services provided. Those two perspectives give valuable insight into service underutilization in the military.

Alt and Henderson both describe barriers in obtaining mental health services. Alt explored the perception of stigma related barriers while Henderson discussed the perceived lack of education and communication between those that live on and off military installations. Both women provided two different spousal perspectives that can account for service utilization and underutilization. In another portion of Henderson's text she adds to Alt's perspective of stigma related barriers towards obtaining mental health services.

The military spouse's perspective is that OIF/OEF military personnel are not receiving help for combat related mental health problems because of the fear that obtaining services will be placed on their permanent records and therefore obstruct their careers. Henderson (2006) states that, "discussions with social workers, therapists, psychologists, and psychiatrists become part the service member's medical record, which can be reviewed by his or her commanding officer". From the spousal perspective a military member can lose

advancement in their career, or possibly face scrutiny from their chain of command if services are sought out. This valuable perspective suggests that a stigma does exist between obtaining mental health services and military career advancement.

Mental Health Practitioners' Perspectives

The Mental Health Advisory Team (MHAT) of Operation Iraqi Freedom surveyed more than 750 soldiers serving in Kuwait and Iraq in order to assess stress levels, morale, and the use of mental health services. The team's findings in a report by the Walter Reed Army Institute of Research indicated that the majority of the soldiers reported experiencing low levels of stress while deployed however, 17% of the population screened positive for depression, traumatic stress, or anxiety with co-occurring social/occupational skills (Operation Iraq Freedom Mental Health Advisory Team, 2003). More than half of those surveyed reported having a low or very low personal or group morale. The soldiers who screened positive for depression, traumatic stress, or anxiety stated that barriers to mental health services that are experienced include difficulty in getting to the

behavioral health services site, getting time off of work, not knowing where to go for help, and services not being available (Operation Iraq Freedom Mental Health Advisory Team, 2003). Also, among the OIF soldiers were major concerns over the stigmatization of mental health services. They felt that they would be labeled as weak be their peers, and expressed fear that perhaps they would be somehow penalized by their commanding officers (Operation Iraq Freedom Mental Health Advisory Team, 2003). The article closes with recommendations by the MHAT to address the needs of the soldiers. The team recommended developing outreach programs (physical and educational), reviewing deployment policies, teaching coping skills to soldiers, and starting a peer-monitoring program in which accountability would remain within a soldiers unit. This article is important because its findings support other research also assessing the mental health needs of military personnel. It addresses the needs of soldiers as they express them, through the lens of a mental health assessment team. The insight provided by the surveys and the recommendations made by the team are a useful supplementary resource in treatment development for all OIF/OEF personnel.

The study done by the MHAT team is revolutionary because it was one of the first to be conducted in an active war zone. Its findings differ slightly from most other studies about military mental illness because other studies assess subjects after their return from service. This factor may be significant because statistically the onset of mental illness occurs after returning home. MHAT's findings are still important to this research project because they show that even in an active war zone there is still evidence of mental health service underutilization. Also is provides possible ways in combating the problem.

In congruence with the WRAIR report, an article by Britt, Greene-Shortridge, and Castro (2007) provided statistics, collected by mental health practitioners, on the prevalence of war-related mental disorders such as PTSD and the low percentage of military personnel who actually receive mental health services. The authors define stigma and explain how it impacts military mental health services, resulting in such low utilization rates. This study finds that the societal stigma from the military is often internalized by individuals who then become apprehensive about seeking help for psychological

issues (Britt et al., 2007). Lastly the article suggests that the stigma can be combated through protest and the educational promotion of military-related mental illness (Britt et al., 2007). The article is important because it provides rationale explaining underutilization of military mental health services being the result of stigmatization. Though this may not be the sole issue affecting service utilization, based on the research by professional mental health care providers, it is a major contributor to the social issue.

Like other articles evidencing service under utilization, this study shows that the majority of military personnel who screened positive for mental illness are not getting services. Similar to the MHAT report (Operation Iraq Freedom Mental Health Advisory Team, 2003), this article points to stigmatization as a major obstacle deterring utilization, a common factor indicated in similar types of research. Another significant similarity is the suggestion of implementing programs purposed for educating people about mental illness in order to erase the stigma. These programs would be for the general military population, the public, and those who have been diagnosed with mental illness.

The article by Erbes, Westermeyer, Engdahl, and Johnsen (2007) described a recent study of various levels of mental health service used among military personnel returning from Iraq and Afghanistan. The study looks at a sample of 120 returnees at a Veterans Affairs medical center. They were screened for PTSD and alcohol abuse. Of the population 56 percent of those who were PTSD positive reported previously getting mental health services while only 18 percent of those with alcohol abuse problems reported using services (Erbes et al., 2007). The rationale for these percentages was that the maladaptive symptoms of these disorders lead to physical, economic, and social problems that hindered treatment seeking (Erbes et al., 2007).

This article is important because its findings add to the collection of factors theorized to be stunting the utilization of mental health services in the military. The authors suggest that it is the mental disorders, or at least the maladaptive symptom manifestations thereof, that are keeping those in need from getting necessary treatment.

This study offers a different rationale than the others because it indicates symptoms rather than

environmental problems as a major factor in service underutilization. While other studies look at stigmatization and service delivery systems, Erbes et al. (2007) seek out the more cognitive dysfunctions at work. Though dissimilar, its findings are still a testament to underutilization of services and the notion that it is a multifaceted problem.

Currently Available Mental Health Services

The section in James Daley's book reviewed for the purposes of this research project provides descriptive examples of military mental health services currently available to military service personnel. According to the text, there are many available services in the military mental health system (Daley, 2000). The chapter shows that within the gamut are services such as exposure therapy, cognitive behavioral therapy, psychopharmacology, group therapy, family counseling, substance abuse counseling, psychiatric nursing, and a host of other services addressing the issues of both individuals and groups (Daley, 2000). This book is important because it provides evidence that there are numerous mental health services available. The author

presents the concept that the problem of underutilization is not due to the nonexistence of services, but instead that there are other issues involved.

This text provides a great deal of information about services available but there is not a thorough explanation as to how services are being delivered (in terms of training and manpower) or how they are being advertised. Daley shows what services are out there, but it would be helpful to know more about how they work

Authors Monson, Schnurr, Resick, Friedman, Young-Xu, and Stevens (2006) take a deeper look into the therapeutic services available to military personnel and examine Cognitive Process Therapy and its applications for military veterans suffering from PTSD. CPT is a form of Cognitive Behavioral therapy designed for use with PTSD. The primary means of change are cognitive interventions involving psychoeducation, processing theory, and contextualization of traumatic events and the related emotions. CPT utilizes cognitive and exposure techniques to ultimately get patients to challenge the debilitating beliefs and thoughts about their traumatic experiences in order to change their daily living for the better (Monson et al., 2006).

This article is important because not only does it highlight a form of available therapeutic treatment for military personnel, but also it is a study that examines key maladaptive elements to PTSD. The article does not promote CPT as the only way of treating PTSD but instead suggests that there are other useful treatment alternatives as well.

From other research, it seems that therapies similar to CPT, CBT, and Exposure therapy seem to be consistent forms interventions within military mental health care (Operation Iraq Freedom Mental Health Advisory Team, 2003 & Daley, 2000). This article goes along with others that describe services in saying that no one treatment method works for everyone. It suggests that to treat the population requires that practitioners draw from the numerous means of treatment available, and that therapy is just a single component of treatment.

The article written by the National Center for Post Traumatic Stress Disorder continued on the subject of multidimensional treatment and summarized many aspects of the overall treatment of veterans and active duty personnel delineating guidelines for clinicians on the important focuses of mental health care (National Center

for Post-traumatic Stress Disorder, 2007). Some major considerations on the part of military personnel that the article addressed were concerns of being labeled with mental disorders, confidentiality, and the fear of punitive consequences for seeking mental health services. According to the authors, these are serious issues that have fueled negative perceptions of mental health services. The authors addressed the importance of mental issues tending to more than just the psychological issues, but also to domestic, social, substance abuse, and even employment issues. From a practical perspective, this means that interventions should encompass mental illness education, coping skills, cognitive functioning, and transition into civilian society. This article is important because it shows that from the mental health practitioner's perspective, the needs of the military personnel coming back from the War on Terror are complex and in order for their mental health treatment to be adequate, it must first be acceptable and secondly, comprehensive.

New and innovative services could also help increase mental health service utilization. In July of 2003, the U.S. Army Surgeon General chartered a mental health unit

known as the Operation Iraqi Freedom (OIF) Mental Health Advisory Team (MHAT) to assess the behavioral health issues of soldiers in active combat. This article (MHAT, 2003) reviews MHAT's programs, results, and shortcomings. MHAT functions in several ways. They provide on-sight behavioral health consultation in active war zones, give services to soldiers who need them closer to their unit, brings holding capability closer to the soldier, and improves mental health services for soldiers being evacuated. Overall the MHAT meant to improve military mental health services by bringing services to the soldiers and making delivery faster than ever before. Findings of the article show that units such as MHAT have a high return-to-duty rate (over 95%)(MHAT, 2003). However, even with services being within close proximity, almost half of the soldiers stated they did not know how to obtain services. Only a third of those wanting help, received it (MHAT, 2003). The article is an overview of a newer type of mental health service being made available to military personnel. It is important because the MHAT program is supposed to resolve the inaccessibility barrier to mental health service and improve utilization rates. Though it is evidence of efforts being made, there

are still reports of services being problematic for soldiers. The article sheds light on the ongoing factors impeding service utilization.

Although the type of frontline service addressed is still considerably new, the findings of the MHAT report have a great deal of relativity to other references that discuss the services available. As has been stated before, underutilization is a complex problem with a complex solution. Like the other articles, the MHAT report advocates the same belief in the importance of comprehensive mental health services.

Theories Guiding Conceptualization

The theory of reasoned action (TRA) predicts and attempts to understand an individual's behavior (Fishbein & Ajzen, 1981). TRA explains behavior by focusing on the person's intent, attitude, and subjective norm towards performing a specific behavior. The theory suggests that the behaviors of seeking or avoiding mental health services are a direct reflection of the attitudes and beliefs of service personnel (Abraham & Sheeran, 2003). These in turn become the subjective norm for their spouses.

The perceptions of mental health practitioners are reinforced by their empirical findings. As for the spouse's perceptions, they are validated through TRA as behaviors driven by beliefs, generated by the subjective norms (behaviors) of their military counterparts (Abraham & Sheeran, 2003).

Summary

This chapter covered contemporary military mental health issues including the prevalence of mental illness in the OIF/OEF population, the utilization of mental health services, and perceptions of aforementioned services by military spouses and mental health practitioners. The articles also outlined the needs of OIF/OEF military personnel and provided some recommendations for meeting those needs. The chapter concludes with the integration of the Theory of Reasoned Action which provided guiding rationale validating the perceptions of spouses and practitioners.

CHAPTER THREE

METHODS

Introduction

Chapter Three discussed the steps used in the development of this research project. This chapter specifically outlined the study design of the project and the population in which qualitative data was obtained. In addition, procedures of data collection and analysis were included as well as precautions taken towards the protection of human subjects.

Study Design

The purpose of the study was to assess military mental health services for OIF/OEF population through the perspectives of military spouses and mental health practitioners. The research method that was chosen for the purpose of this study was a qualitative approach utilizing interviews for data collection. The reason we chose a qualitative approach was because the depth that this study hoped to acquire could only be achieved through face to face interviews.

For our interviews, we selected a population of military spouses and mental health practitioners and

implemented a specifically designed standardized instrument. We anticipated that the questions asked would provide detailed insight into the availability, utilization, and effectiveness of military mental health services for the OIF/OEF population. The perceptions of military spouses and practitioners provided valuable firsthand knowledge about the effects of wartime stressors on military personnel.

Three limitations to this research design we identified were that it did not allow for a large population to be sampled, it incorporated opened ended responses that were prone to misinterpretations, and there was potential for interpretive bias on the part of interviewees and interviewers. The human subjects may have been unable to maintain objectivity because of emotional investment or conflicts of interest. However, we were careful in considering these limitations throughout the research process.

The research question studied the perceptions of mental health services for OIF/OEF military personnel among military spouses and mental health practitioners.

Sampling

Data was collected through qualitative interviews with military spouses and mental health practitioners. These two sampling populations accounted for at least thirty qualitative interviews. Our sampling design strategy for obtaining military spouses and mental health practitioners was based on availability sampling and snowball sampling.

The Veteran's Home of California, Barstow provided access to mental health practitioners through availability sampling within the VA system. The population of military spouses was obtained through snowball sampling. We were not concerned with the military branch affiliations, rather the perceptions of the services provided. There were no gender, ethnic, age, or rank status criteria that defined our military spouse population.

Data Collection and Instruments

Data was collected through qualitative interviews both face-to-face and over the telephone. The interviews were used to measure the responses of the military spouses and mental health practitioners. We analyzed

their responses for the purpose of assessing military mental health services.

The responses of the interviewees were the dependent variable of the study and their analysis was a driving factor in the needs assessment. The independent variable was which group, either spouse or practitioner, the interviewee participated in. Both groups were subject to the set of questions found in the research instrument.

The instrument was comprised of predetermined questions developed by the researchers. The set of questions was constructed after analysis of academic literature and empirical research. The validity and reliability of this instrument was unknown.

The interviews were semistructured and focused. Two different interviews were given, one specific to the military spouses and another to the mental health practitioners. Examples of some of the questions are as follows: "What mental health services are available to your spouse?", "How do returning OIF/OEF military personnel get information about mental health services?", "What is your opinion about the mental health needs of returning OIF/OEF military personnel?"

The strength of the qualitative interview was the depth in which attitudes and beliefs of the spouses and practitioners were understood. The weakness of the qualitative instrument was the potential lack of clarity in interpretation on behalf of the interviewers.

Procedure

The data was gathered through telephone and face-to-face interviews with military spouses and mental health practitioners. Human subjects were selected using snow-ball sampling and availability sampling. The interviews were structured using a standardized questionnaire. Initially mental health practitioners at the Veterans Home of California, Barstow were interviewed on site. Those outside of the VHCB, who we were referred to, were interviewed at the location of their discretion or over the telephone. Spouses were interviewed at a location of their discretion or over the telephone.

All interviews were conducted by either one or both of the researchers. Each interviewee was provided an informed consent form and a debriefing statement.

Protection of Human Subjects

To protect the population of active duty military personnel, we focused our sampling population to military spouses and mental health practitioners. To ensure confidentiality we did not place the names or any other identifying information on record. We also provided each interviewee written documents of informed consent and debriefing. For interviewees that participated via telephone, we provided a verbal statement of confidentiality as well as assurance that interviews will not be recorded.

Data Analysis

This study was a qualitative research design utilizing face-to-face and telephone interviews. The data that was obtained through the interviews was processed using Atlas TI software. Narrative streams were coded accordingly by the system provided in Atlas TI.

Summary

In this chapter we discussed the plan we used to develop this research project. This chapter outlined the study design of the project as well as the human subjects population by which qualitative data was obtained. In

addition, procedures of data collection and analysis were outlined as were the precautions necessary in protecting human subjects. Such precautions included an informed consent, debriefing statement, and the protection of confidentiality.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents the qualitative data collected among mental health practitioners and military spouses in regards to their perceptions of military mental health services for the OIF/OEF military population. The findings are organized by prevalent themes that emerged through the interviews with the mental health practitioners and military spouses. Those themes include: perceptions of mental health problems among military personnel, perception of what mental health services are available, what kind of mental health services are being accessed, perceptions of mental health service efficacy, perceived stigma for mental health services, and the perception of mental health service needs within the military mental health system. The data is compiled into graphs, tables, and relevant quotations taken from the narrative interviews.

The following tables and their content represent the qualitative outcomes of this study. These qualitative outcomes are further delineated, interpreted, and

discussed at length in chapter five. The following qualitative outcomes were guided by the fundamental questions of this study: What are the perceptions of mental health needs of OIF and OEF military personnel among military spouses and mental health practitioners. This study was comprised of 26 participants from various locations in the United States.

Presentation of the Findings

Table 1. Perceptions of Mental Health Problems Among Military Personnel (Part 1)

(12 Practitioners)

Mental Health Problem	*Percentage Indicated as Most Prevalent MH Problem*
Post Traumatic Stress Disorder	75%
Readjustment Issues	42%

Practitioner Quotes

- "Adjustment disorders involving relationships and isolation"
- "Psychosocial challenges are more intense and readjustment is more challenging with new vets"

- "More and different trauma exposure, higher suicide rates, domestic violence, alcohol and drugs, and occupational problems increased"
- "If you only look at the disease you don't see the rest"

Table 2. Perceptions of Mental Health Problems Among Military Personnel (Part 2)

(14 Spouses)

Mental Health Problems	*Percentage Indicated as Most Prevalent MH Problem*
Post Traumatic Stress Disorder	43%
Readjustment Issues	21%
Depression	21%

Spouse Quotes

- "PTSD is most prevalent because can't process, emotional loss of friends"
- "They go through so much, it is what they see, and they can't handle and go crazy. It is in their dreams, thoughts, flashbacks; it doesn't stop"

Table 3. Perception of What Mental Health Services Are Available

Practitioners	Spouses
Outpatient Services	On Post Counseling
Civilian Private Mental Health Services	Military One Source
VA Mental Health Services	VA Mental Health Services
PTSD Counseling	Civilian Mental Health Services
Bereavement Services	Frontline Debriefings
Family Counseling	In Theater Counseling
Rehabilitation Services	Family Counseling
Suicide Prevention	Tri-Care Counseling Services
Group Therapy	Individual Counseling
Inpatient Mental Health Services	Chaplain Services
Residential Treatments	On Base Hospital
EMDR	Brochures
Phone Support	Post Deployment Assessments
Military One Source	Life Skills Centers
PDHRA	Sexual Assault Task Force
Peer to Peer Training	Depression Screening
SRPs	Anger Management Services
Post Marriage Enrichment Programs	On Base Psychiatric Services
TBI Treatment	Off Base Psychiatric Services
Grassroots Programs: Give an Hour	Family Advocacy Services
Vet Centers	Transitional Counseling Services
Individual Counseling	
Psychiatric Care	

Table 4. What Kind of Mental Health Services Are Being Accessed

	Practitioners	Spouses
Military/Federal Services	75%	100%
Civilian/Private Services	33%	0%
Total number of participants	n = 12	n = 14

Practitioner Quotes

- "Soldiers very seldom seek services independently. They usually seek by the urging of their spouses, commanding officers, or by their bosses"
- "Go through your commanding officer"

Spouse Quotes

- "Get services through the soldier's initiative"
- "Ask their Sgt. They go to their Sgt. for everything, even personal. They have to go though the chain of command"
- "Referral system is through the military, there is not a referral system for civilian services" "Go through the commanding officer for services available. Access to outside services is limited"

Table 5. Perceptions of Mental Health Service Efficacy

(Part 1)

(Practitioners 12)

Perception of Mental Health Services that Work	Perception of Mental Health Services that Do Not Work
Civilian Counselors	Perceived Non Confidential Services
Medication - Short Term	PTSD Groups
Family Counseling	Fast Paced Services
Individual Therapy	Virtual Reality Techniques
Group Therapy	Flooding Therapy
Marriage Counseling	Vietnam Founded Services
PTSD Counseling (Individual and Groups)	Traditional Psychotherapy
CBT Treatment	All General Mental Health Services
Comprehensive Services	Self-Medication
Peer to Peer Programs	Long Term Medication
Holistic Services	On Base Services
Psychotherapy (Individual and Groups)	Services with Long Wait Times
Proactive Early Intervention	
Traumatic Incident Reduction Techniques	
Chaplain Services	

- "Mental Health services work but are contingent upon the soldier's desire to access and seek out the services"
- "All mental health services work it is just getting the soldier to take advantage of them.

Soldiers have to change their idea of mental health services"

- "They all work somewhat the problem is programs built on Vietnam foundation. There is a need for comprehensive services"

Table 6. Perceptions of Mental Health Service Efficacy (Part 2)

(Spouses 14)

Perception of Mental Health Services that Work	Perception of Mental Health Services that Do Not Work
Family Advocacy Marriage Counseling Civilian Services Confidential Services Pastoral Services After Hour Services Individual Counseling	Civilian Services Military Mental Health Services Suicide Prevention Programs Pre Deployment Briefings Post Deployment Briefings Services from Chain of Command Referrals Military One Source
Perception of Mental Health Services that Work: 23%	
Perception of Mental Health Services that Don't Work: 54%	
Don't Know if Mental Health Services Work or Not: 23%	

- "No mental health services work"
- "Don't think any services work"
- "Afraid to use services"
- "They work if soldier wants to receive help and services don't work if soldier is forced"

Table 7. Perceived Stigma For Mental Health Services

	Practitioners	Spouses
Positive Perception of Mental Health Services	0%	14%
Negative Perception of Mental Health Services	100%	86%
Total # of participants	n = 12	n = 14

Practitioner Quotes

- "Mental health problems aren't trendy in the military"
- "Kiss of death for career in military"
- "If you have a history of mental issues it is hard to advance"

Spouse Quotes

- "No stigma, soldiers actually encourage each other to seek help"

- "No stigma between soldiers and commanding officer, soldiers are compassionate to one another"
- "Lose rank, they are weak, it will ruin careers, and it is put on permanent records. Don't want to chance screwing up their careers"
- "Fear of being discharged or given a desk job; fear of commanding officer"

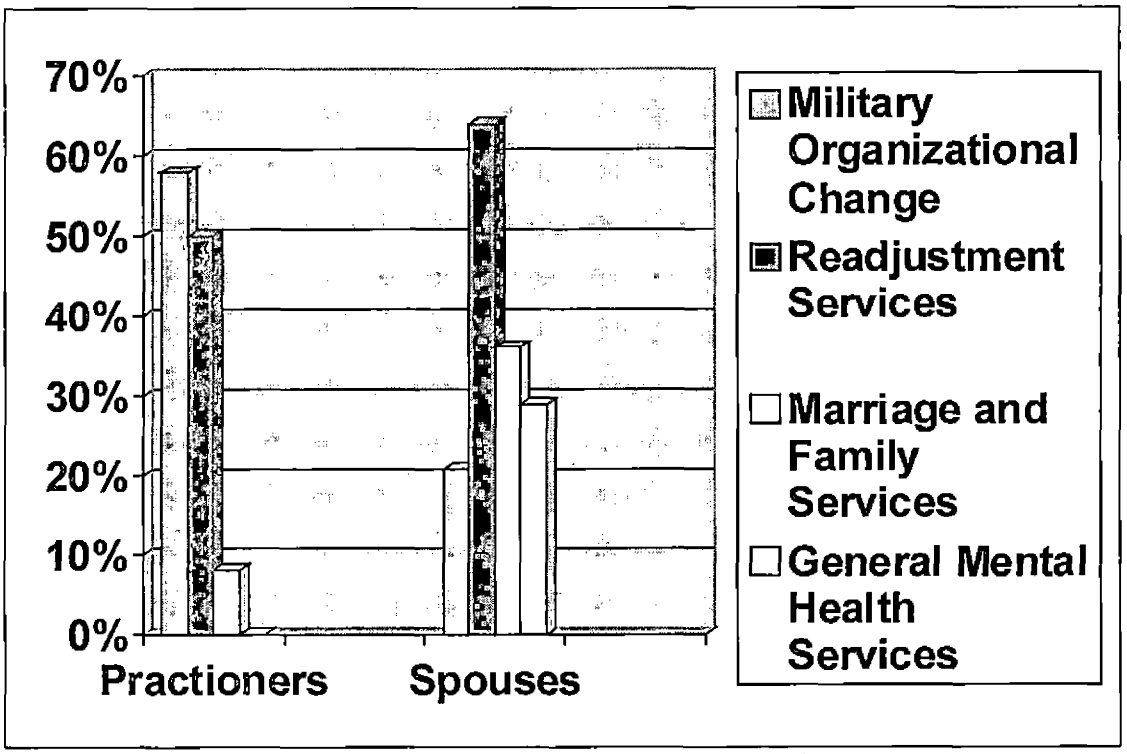

Figure 1. Perception of Needed Services Within the Military Mental Health System

Practitioner Quotes

- "Need to push the point and you need to create awareness, also go to military leadership and convince them mental health services are good for soldiers"
- "Education to reduce the stigma of mental health services is number one
- "Educate from top down and bottom up and families as well"
- "If you only look at the disease you don't see the rest"
- "The most prevalent is resituating, retraining, and going back into society"
- "Job skills training, marriage and family counseling, PTSD counseling, ROP-all need to be available for returning soldiers"
- "Train soldiers to come out of combat"

Spouses Quotes

- "Longer more intense training on specific suicide and depression problems. More focus on a prevention program"

- "Educate soldiers better on what they are going through. So they know they are not the only ones"
- "Mandatory counseling especially marriage counseling"
- "More extended services, offer more services than are already in place"
- "More family friendly services"
- "Readjustment services are needed"
- "Mandatory counseling sessions, especially marriage counseling"

Summary

This chapter addressed the major themes that were predominant in the qualitative data collected from mental health practitioners and military spouses. The themes were an accumulation of the data gathered in the needs assessment regarding the perception of military mental health services for OIF/OEF military personnel.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will elaborate on the findings of our research study that discuss: what mental health problems are prevalent in the OIF/OEF population, what mental health services are available to this population, how do OIF/OEF military personnel access these services, the efficacy of mental health services currently in place, and suggestions of mental health service improvement from military spouses and mental health practitioners. Also, this chapter will outline the limitations to our study and provide recommendations for social work practice, policy, and research.

Discussion

Perceptions of Mental Health Problems among Military Personnel

Based on the data collected from the interviews with both military spouses and mental health practitioners, we found that overall the most mentioned mental health problems by both subject populations were Post Traumatic Stress Disorder (PTSD) and issues related to readjustment

into civilian life. The responses from the mental health practitioners show that 75 percent of those interviewed identified PTSD as the "most prevalent" mental health problem faced by OIF/OEF personnel. 42 percent of the mental health practitioners said that readjustment to civilian life was the most prevalent problem. There was overlap in the percentages due to some of the practitioners regarding both problems as equally prevalent.

In contrast with the mental health practitioners, the military spouses identified not only PTSD and readjustment, they also named depression as a common mental health issue among OIF/OEF personnel. Of the 14 military spouses interviewed, 43 percent reported that PTSD was the most prevalent mental health problem. 21 percent identified readjustment as the most common problem. Lastly, depression was reported most prevalent by 21 percent of the military spouses as well.

Both military spouses and the mental health practitioners connect the mental health problems with the exposure that military personnel get to traumatic wartime events. The data suggests that they have difficulty coping with their experiences when they return to

civilian life. "They go through so much, it is what they see, and they can't handle and go crazy. It is in their dreams, thoughts, flashbacks; it doesn't stop," quoted one of the military spouses.

The data also found that for the OIF/OEF personnel, coming back home and trying to reintegrate into civilian life causes problems because it is difficult for them to transition from deployment back to their homes with their families, relearning to socialize again. Lastly, the third major mental health problem indicated by a significant amount of the military spouses (21 percent) was depression. They said that it is a real issue with OIF/OEF personnel because their experiences in battle are tied to overwhelming emotions that the OIF and OEF personnel often have a hard time communicating. All of these findings are a testament to the severity of specific mental health problems in the lives of the OIF/OEF personnel. They are evidence that a genuine need for mental health services to tackle these issues.

Perception of what Mental Health Services are Available

The two subject groups were able to list numerous mental health services that are currently available to

returning OIF/OEF personnel. The multitude of different services that they mentioned covered a broad spectrum issues commonly faced by military personnel returning from deployment. Some of the services mentioned included psychological counseling services, peer support groups, marriage and family services, group therapy, crisis intervention services, anger management, sexual assault prevention, bereavement services, and spiritual service. Both group's combined knowledge resulted in fairly long list of comprehensive services. Because the practitioners were able to name more services despite their smaller subject group, this suggests that the practitioners have more knowledge of what services are available for the OIF/OEF personnel.

How are Mental Health Services Accessed for Military Personnel

As previously mentioned, many different types of mental health services are available to returning OIF and OEF personnel. Whether it be marital counseling, anger management services, or spiritual counseling, the research shows that the services are in fact in place and available. Further, the data collected also shows that personnel seeking mental health services have options in

regards to where they go to get help. The term "options" in this case refers to the military personnel's choices between whether they get services from military or federal organizations/agencies, or from civilian organizations/agencies. There are discrepancies in the results from the two subject groups.

From the accounts of the mental health practitioners, we see that 75 percent reported that OIF/OEF personnel access mental health services provided by the military or other federal installations. As for civilian mental health services, the practitioners reported that 33 percent of personnel seeking help sought services from agencies and organizations having no direct affiliation with the military or government. So although this data suggests that the military is most likely providing the bulk of mental health services, there are still a considerable number of people going elsewhere for treatment.

On the contrary, the military spouses reported results very different from those gathered from the practitioners. Unanimously, all 16 spouses reported that OIF/OEF personnel receive mental health services exclusively from either military or federal service

providers. Several of the spouses had mentioned that access for these services come from the commanding officers. This information corroborated with that of the practitioners who also said that military mental health services were accessed through the military's chain of command which required those who sought services to approach their commanding officers. For those who sought civilian or private sector services, it was reported that they did so on their own initiative. Whether or not either of the types of services (military or civilian) worked, was up to further investigation.

Perceptions of Mental Health Service Efficacy

The efficacy of the mental health services that are available for OIF/OEF military personnel were differentiated between military spouses and mental health practitioners. The mental health practitioners provided a variety of mental health services that were perceived to "work and not work" for the OIF/OEF military population, while the military spouses' perception of mental health service efficacy was limited.

The data suggests that mental health practitioners had a greater awareness of the multiple services and treatment modalities that are and are not effective in

serving the OIF/OEF military population. For example, some of the effective treatment modalities and services included: Cognitive Behavioral Therapy, civilian mental health services, confidential services, proactive early intervention techniques, and comprehensive holistic services. Some of the mental health services that were not effective included: Flooding Therapy, long-term medication, Vietnam based mental health services, non-confidential services, and services provided on military installations. What the data revealed was that many of the services that were perceived to be effective for the OIF/OEF military population were also perceived to be ineffective. An example of these services included: PTSD group counseling, Psychotherapy both individual and group, and medication treatment. This data suggests that many services and treatment modalities exist for the OIF/OEF population but the perception of efficacy is a determinate if those services are rendered. This data may also imply that the mental health practitioner's own expertise and treatment styles could contribute to the perception of service's efficacy. The data exposed the importance mental health practitioners place on civilian

mental health and confidential services which was congruent with both practitioners and military spouses.

Military spouses perceived that more family centered services were effective. The spouses also perceived civilian and confidential services as beneficial to the OIF/OEF military population. The data reports that military spouses did not perceive most military based services as being effective, these included: general military mental health services, pre and post deployment debriefing, and services provided through the chain of command referrals.

54 percent of the military spouses that participated in this research project had the perception that no mental health services are effective for the OIF/OEF population. This data may imply that the spouses in this study have not had positive experiences with their significant other's access or the delivery of mental health services.

The data suggests that military spouses are unaware of services that are made available to the OIF/OEF military population and therefore is unable to determine the efficacy of the services. 23 percent of the spouses did not know whether mental health services "worked or

did not work". This could imply that they may not have a significant amount of knowledge of services because their significant other has not accessed civilian or military mental health services.

Perception of Mental Health Service Needs within the Military Mental Health System

The interviews with the mental health practitioners and the military spouses provided important data regarding their perceptions of what mental health service changes are needed within the military mental health system. Data shows that mental health practitioners perceived organizational change as the predominate (58 percent) service change need within the military mental health system followed by an increase in readjustment services (50 percent) and marriage and family services (8 percent).

Data showed the mental health service needs within the military mental health system from the perspective of military spouses that included an increase need of readjustment services (64 percent), followed by marriage and family services (36 percent), increase in general mental health services (29 percent), and military organizational change (21 percent).

Limitations

There are several limitations to this needs assessment which must be taken into consideration in relation to the findings of this study. The first is the size of the sample population and what it means in regards to the results of this study being generalized to the greater population. Being that the sample size was only 26 individuals, issues may arise concerning whether or not the findings are applicable on a greater scale.

Another limitation to this research project was the sparse criteria for qualification as a participant in the study. We set no specific criteria for the spouses such as duration married to an OIF/OEF military personnel, residency either on or off-base, or military branch affiliation. Each of these different variables could have greatly impacted the outcome of the research. For example the length of marriage to an OIF/OEF person may correlate with how much knowledge the spouse might have based on exposure to living a military-influenced lifestyle. Also, their amount of knowledge may be relative to where they live whether on-base or off-base. Proximity to services may play a role in what information is available to them. The different branches of the military (e.g. Army,

Marines, Air Force, Navy, or National Guard/Reserves) might also have differences in their individual mental health service systems. Depending on which branch the spouse's significant other was serving in, data regarding mental health services may likely vary from one person to the next.

As for the mental health practitioners, we did not specify what discipline they had to be from in order to participate in the study nor did we specify if they could be civilian practitioners or military personnel themselves. The varying backgrounds of the different disciplines may have resulted in some of the inconsistencies in the study's findings. Perhaps with more specific criteria, the study may have seen different results. Also the element of bias may have played a role due to the fact that some of the practitioners interviewed were military personnel themselves while others were civilians.

The final limitation was that the information gathered from the military spouses and the mental health practitioners was secondary information regarding the circumstances of OIF/OEF personnel. The most absolute and accurate information would most likely come from the

military personnel themselves. There were restrictions denying access to active duty military personnel that we had to follow. We hypothesize that had we been able to interview actual OIF/OEF personnel, our results would have been much more telling, and perhaps more reliable as well.

Recommendations for Social Work Practice, Policy and Research

This study provided perceptions of military mental health service needs for OIF/OEF military personnel. The point of views from both mental health practitioners and military spouses illuminated many important mental health-related issues regarding this particular military population. They identified what they perceived to be serious issues regarding the population in need as well as the delivery system of the services they seek. The information they provided could be valuable to future studies on mental health problems within the military, however the data is not an all-encompassing source of definitive information on this population.

We recommend for the future of social work studies in this area, researchers somehow find a means to conduct a study which will gather information directly from the

military personnel. First hand information from this group about their mental health problems and their issues with mental health services would likely be most reliable, uniform, and accurate.

We also recommend that a more in-depth look into access of the military mental health system be examined. This study could address reasons why OIF/OEF personnel are having difficulty with mental health problems despite services being in place. This study may require a further assessment of the perceived stigma regarding mental heath problems and service seeking. Lastly, the study could take a comparative look at the differences between civilian and military mental heath services.

Our final recommendation for future research would be that it takes an analytical approach on current training policies and education that exists within military leadership. This would be a pertinent issue to explore given the many references in our study to the influence that commanding officers have on those who seek mental health services.

By bringing an observational eye to the upper tiers of military leadership, the results could be highly influential in making any necessary improvements that

will ultimately trickle down to the rest of the military organization.

Conclusions

Mental health needs among OIF/OEF military personnel is a serious social issue complicated by many different human and systematic factors. This needs assessment was able to provide important information regarding the perceptions of military mental health services among military spouses and mental health practitioners. Their concerns centered around: what current mental health problems exist, what services address the problems, the efficacy of the services, and finally what changes should be considered for the future in order to improve mental health services for the OIF/OEF personnel. We concluded that while mental health services for this population exist, improvements are necessary in order to more efficiently address mental health needs and the service delivery system. Whether the problem needs to be addressed at the level of the personnel themselves or at the level of the military organization as a whole, is up to future studies and continued research. We have suggested avenues in which potential studies may direct

themselves in order to add to the body of knowledge surrounding this issue, with the goal of ultimately finding efficient solutions for those in need.

APPENDIX A

QUALITATIVE INSTRUMENT

Qualitative Instrument

Spouses:

1. What mental health services are available to your spouse?
2. What mental health services work or do not work?
3. Do you see a need for mental health services for returning OIF/OEF military personnel?
4. How do returning OIF/OEF military personnel get information about mental health services?
5. How could OIF/OEF military personnel benefit from mental health services?
6. What do you feel is the most prevalent mental health issue faced by OIF/OEF military personnel?
7. Is it difficult for returning OIF/OEF military personnel to obtain mental health services? If so why?
8. Describe what you know about how military personnel obtain mental health services?
9. Is there a perceived stigma in the military regarding mental health services?
10. Are there any changes you would make in the military mental health system?

Mental Health Practitioners:

1. What mental health services are available for returning OIF/OEF military personnel?
2. What mental health services work or do not work?
3. What is your opinion about the mental health needs of returning OIF/OEF military personnel?
4. What do you feel is the most prevalent mental health issue(s) faced by OIF/OEF military personnel?
5. How do mental health services impact returning OIF/OEF military personnel?
6. Is it difficult for OIF/OEF military personnel to obtain mental health services? If so why?
7. Compare and contrast the scope of civilian mental health services with military mental health services?
8. By what means do military personnel most typically obtain your services?
9. Is there a perceived stigma in the military regarding mental health services?
10. Are there any changes you would make in the military mental health system?

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

This study is designed to assess the mental health services for Operation Iraqi Freedom/ Operation Enduring Freedom (OIF/OEF) military personnel. The study is being conducted by Chrystal Long & Jeff Soriano under the supervision of Assistant Professor Tom Davis, PhD, at California State University of San Bernardino. This study has been approved by the Department of Social Work Subcommittee Review Board of California State University, San Bernardino.

In this study you will be asked to respond to questions pertaining to your perception of mental health services for the OIF/OEF population. The interview should take about 15 to 20 minutes to complete. All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. You will remain anonymous and all data will be reported in group form only. You may receive the group results of this study upon completion in September, 2008 at the John M. Pfau Library, located at 5500 University Parkway San Bernardino, CA 92407.

Your participation in this study is completely voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the interview you will receive a debriefing statement describing the study in more detail. There are no foreseeable risks to participants as a result of this study. Participants will benefit from this study through the expansion of their knowledge on the research topic. They will also gain awareness on related issues as a result of this study.

If you have any questions or concerns about this study, please feel free to contact Tom Davis, PhD at (909) 537-3839.

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

Place a check mark here ☐ Today's date: _____

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The study you have just completed was designed to assess the perceptions of military mental health services for OIF/OEF military personnel. This study was a needs assessment of the mental health services that are offered to returning military personnel. Interviews were conducted with both military spouses and mental health practitioners. The responses to research questions were analyzed and compared. The perceptions of both groups of interviewees will provide important information related to the mental health service needs of military personnel. We are most interested in the perceptions of people we hypothesized to be highly involved with the OIF/OEF military population. No forms of deception or coercion were used during the sampling or interview process.

Thank you for your participation and for not discussing the contents of the decision question with other students. If you have any questions about the study, please feel free to contact Chrystal Long or Jeff Soriano or Professor Tom Davis, PhD at (909) 537-3839. If you would like to obtain a copy of the group results of this study, please contact Professor Tom Davis, PhD at (909) 537-3839 at the end of Spring Quarter of 2008.

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ASSIGNED RESPONSIBILITIES PAGE

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

1. Data Collection:

   Team Effort: Chrystal Long & Jeffrey Soriano

2. Data Entry and Analysis:

   Team Effort: Chrystal Long & Jeffrey Soriano

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Chrystal Long & Jeffrey Soriano

   b. Methods

      Team Effort: Chrystal Long & Jeffrey Soriano

   c. Results

      Team Effort: Chrystal Long & Jeffrey Soriano

   d. Discussion

      Team Effort: Chrystal Long & Jeffrey Soriano