# A Literature Review of Stigma and Barriers to Mental Health Care in the U. S. Military

By

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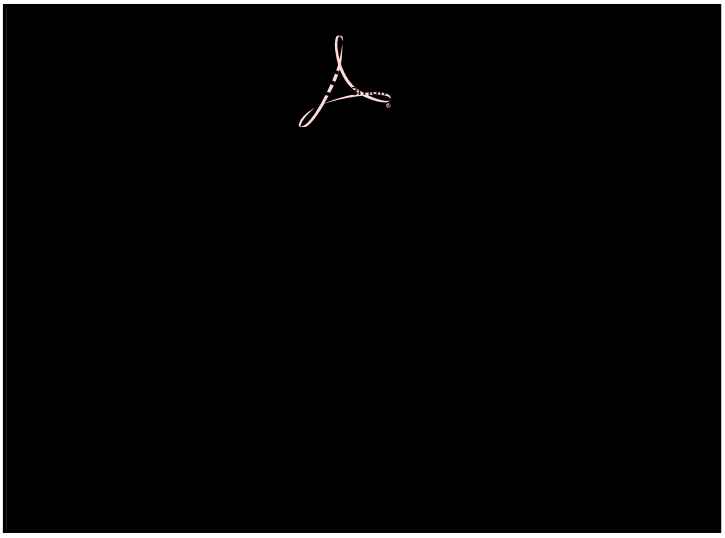

**Abstract**

After 15 years of war and global conflict, the need for psychological health care in the U. S. military has risen exponentially. At military medical treatment facilities, the increased demand for psychological health care has outstripped the mental health resources available, thus creating barriers that hamper the delivery of the effective, timely, and appropriate levels of care provided (Glasmeier, Schultheis, Sassi, Chuvala, Bell, Fay, & Fradino, 2016). Despite the increase in demand for mental health services, Sharp et al. estimated 60% of service members in need of mental health care do not seek care in the military; not because of the availability of services, but primarily because of the stigma associated with mental health care. As a result, stigma is perhaps is the biggest factor that deters service members from initiating mental health care (Sharp et al., 2015). In military culture, seeking care for mental health issues is seen as a weakness with perceived negative career consequences. Service members quickly develop negative beliefs regarding mental health care and as a consequence, those with psychological distress choose not to pursue mental health treatment because of the stigma and perceptions associated with seeking care. The military's pervasive belief in "toughing out" psychological distress and not seeking care for mental health issues results in inadequate mental health treatment of service members arguably creating a serious emerging public health issue.

It has been well established in the literature that stigma associated with mental health care in the military is a predominant barrier to care. Additionally, a common theme that percolates to the surface is that military leadership and organizational climate are predominant contributors to the stigma barrier associated with service

members choosing not to seek mental health care. Leaders tend to judge service members who seek mental health care as broken and often express opinions that the military mission comes before wellness. A more complicated barrier in seeking mental healthcare is the potential negative career consequences on service members. Certain psychological disorders and medical treatment for those conditions can have legitimate repercussions for employment that relate to the ability to accomplish specific missions. Further, some service members perceive that seeking any type of care for general counseling, mental health, or behavioral issues will have similar negative career consequences if leadership becomes aware of their treatment. There is fear that it seeking care will reflect poorly on their performance reports and career (Miggantz, n. d.).

*Keywords:* mental health, stigma, military, barriers

## Table of Contents

## List of Figures

## List of Abbreviations

| | |
|---|---|
| **HLM** | **Hierarchical Linear Modeling** |
| **PTSD** | **Post-Traumatic Stress Disorder** |
| **U. S.** | **United States** |

## Introduction

The purpose of this paper is to conduct a literature review of the existing literature and further examine the root causes of the stigma associated with seeking mental health care in the military. The population under review is limited to members of the United States (U.S.) Military from the 2001 start of combat operations in Afghanistan through global military operations in 2016. It is estimated that between 60-70% of U. S. Military veterans who have been diagnosed with mental health issues do not receive adequate care and follow-up (Sharp et al., 2015). Mental health issues are not treated in the same manner as physical injury or illness. Service members fear the consequences of seeking mental health care that range from concerns about not being promoted, being labeled as lazy, dangerous, undesirable, and not trustworthy, to being discharged from military service. Furthermore, the unintended consequences of not receiving mental health care lead to service members ignoring symptoms and suffering in silence while remaining in combat. This predisposes service members to developing severe depression, post-traumatic stress disorder, and problems with substance abuse (Brown & Bruce, 2016). Based on the existing literature, apprehension to seek mental health care in the military has become a serious public health issue. While much of the literature discusses various causes of stigma and the associated barriers to mental health care, little has been proposed on how leadership in the military use their position and influence to reduce the stigma of mental health treatment and then work within the system to remove the associated barriers to care. The outcome of this systematic review is to recommend leadership strategies to decrease barriers to care for U. S. Military members seeking mental health care.

## Methods

*Search Strategy*

An initial literature search for existing systematic reviews was conducted to determine if a review protocol existed on stigma and barriers to mental health care in the U.S. Military. The search was conducted on October 25, 2016 using PROSPERO, the Cochrane Database of Systematic Reviews, and Campbell Systematic Reviews in order to avoid duplication of the review and help reduce bias in reporting. The key search terms were combined with Boolean operators and included:

1. “barriers to mental health care” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.
2. “barriers to mental health care” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.
3. “PTSD” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.
4. “PTSD” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.
5. “combat stress” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.
6. “combat stress” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

7. “psychological health” OR “mental illness” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

8. “psychological health” AND “mental illness” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

Search results from all three databases noted above yielded only one result. However, this review did not meet the definition of the population under review (Nizam & McCrillis, 2015).

A literature search was then conducted in October 2016. Applicable articles from peer reviewed journals, books, studies, and websites since 2001 were identified through electronic searches on SUMMON, PsycINFO, PUBMED, CINAHL, EMBASE and Sociological Abstract. The key search terms were combined with Boolean operators and included:

1. “barriers to mental health care” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

2. “barriers to mental health care” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

3. “PTSD” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

4. “PTSD” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

5. “combat stress” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

6. “combat stress” AND “U.S. military” AND “armed forces” AND “Marines” AND “Navy” AND “Army” AND “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

7. “psychological health” OR “mental illness” OR “U.S. military” OR “armed forces” OR “Marines” OR “Navy” OR “Army” OR “Air Force” OR “airman” OR “sailor” OR “soldier” OR “service member”.

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This literature search yielded over 3,000 journal articles, books and reports. Duplicate material was then removed and the reference lists of the eligible material was checked for any applicable references material that met the eligibility criteria. Full-text articles, reports were then accessed, and books were accessed to examine the eligibility of the identified materials.

*Inclusion Criteria*

1. Material discussing all branches and member of the U. S. Military and/or;

2. Mental health issues, depression, suicidal ideation, Post-Traumatic Stress Disorder (PTSD), stress, substance abuse, alcohol or drug dependence, work related stress.

3. Barriers to mental health care and/or, stigma, peer pressure, adjustment disorder issues with leadership, concerns with career.

*Exclusion Criteria*

1. Non-members of the U. S. military, civilians, and others.

2. Medical conditions associated with disease, injury, chronic non-mental health conditions, musculoskeletal injuries or disease.

3. Traumatic brain injury.

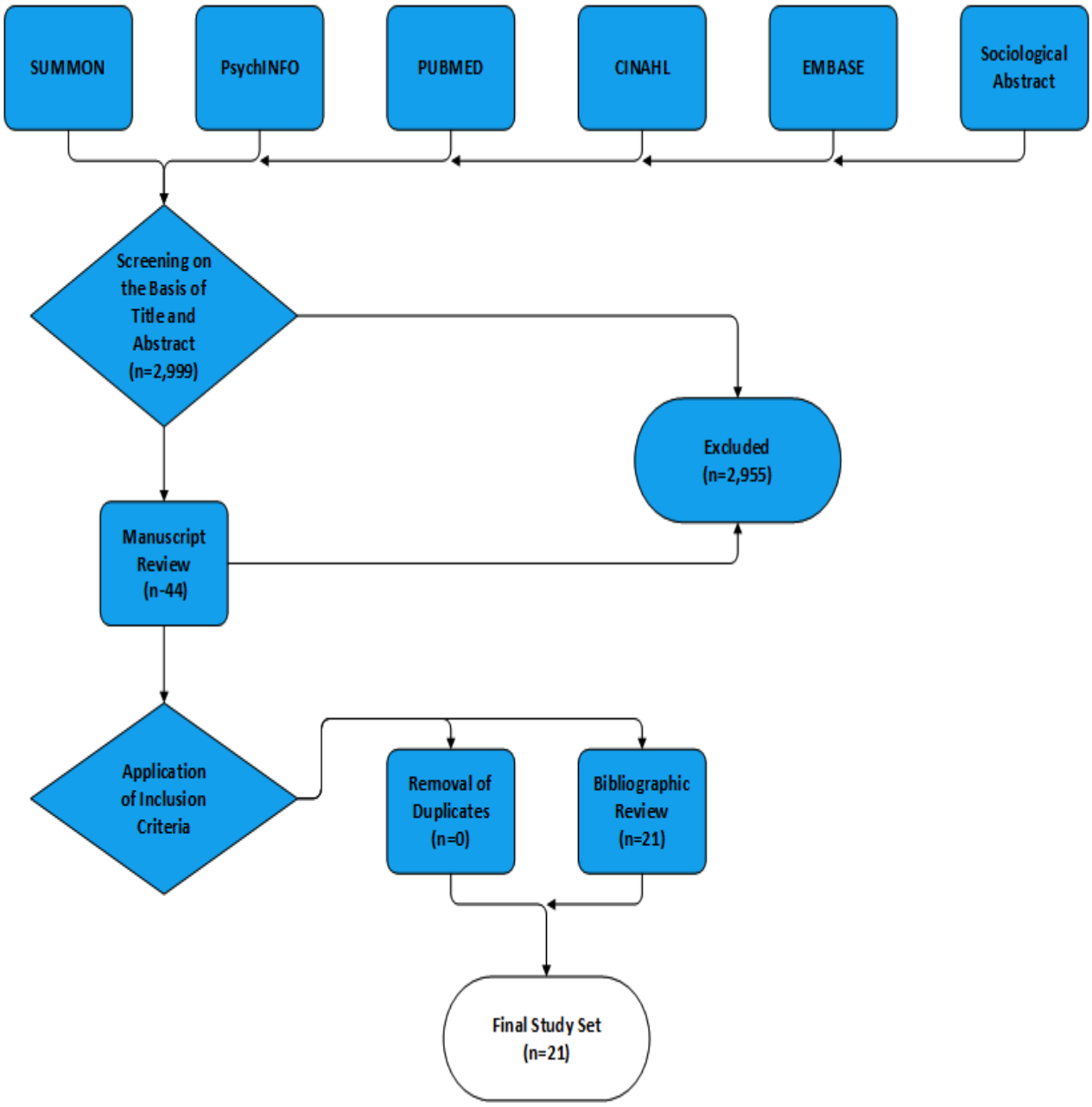
4. Appointment no-shows.

*Literature Selection*

After application of the established inclusion and exclusion criteria, 2,994 articles, two reports, one website, one dissertation, and one book (2,999 resources) were reviewed for eligibility. After all abstracts were reviewed, 2,954 articles and one report were determined to be non-eligible for inclusion. Forty articles, one dissertation, one book, one report, and website (44 resources) met the initial eligibility criteria. Full-text articles, the book, dissertation, report, and website were then accessed for further examination relative to the inclusion eligibility. Out of the 40 articles examined, 23 articles were excluded from further use.

Seventeen articles, one dissertation, one book, one report, and website (21 resources) were eligible based on the inclusion criteria (Figure 1). After review of the references in the 17 articles and dissertation, no further articles were identified for examination. The 17 articles selected for inclusion were then categorized into four main themes that were identified during a detailed review of the literature based on the topic and purpose of this paper.

**Figure 1. Review Process Diagram**



*Themes*

1. Stigma.
2. Leadership.
3. Career consequences.
4. Organizational culture.

Once the articles were categorized, all 17 articles, book, report, and thesis discussed stigma associated with mental health care in the U. S. Military. Of these, eleven discussed the role of leadership as it relates to service members seeking mental health care, four articles discussed the potential negative career consequences for service members who seek mental health care, and three articles discussed the role organizational climate plays in contributing to the stigma associated with service members seeking mental health care. (Appendix 1)

## Results

*Stigma*

There is a myriad of definitions for the stigma associated with mental health care seeking and treatment. In an article by Corrigan, Druss, & Perlick (2014), the authors describe the stigma of mental illness from a social cognitive construct. This two-dimensional model describes the social cognitive constructs associated with stigma and the four types of stigma that impact the individual with a mental health issue (Figure 2).

**Figure 2. Social Cognitive Structural Matrix.**

| | | Public | Self | Label Avoidance | Structural |
|---|---|---|---|---|---|
| **Social Cognitive Structure** | **Stereotypes and Prejudice** | People with mental illness are dangerous, incompetent, to blame for their disorder, unpredictable. | I am dangerous, incompetent, to blame. (Leads to lowered self-esteem and self-efficacy) | I perceive that the public disrespects and discriminates against people with mental illness. | Stereotypes are embodied in laws and other institutions. |
| | **Discrimination** | Therefore, employers will not hire them; landlords will not rent to them, primary care will offer a worse standard of care. | Why try: Someone like me is not worthy or unable to work, live independently, have good health. | I do not want this. I will avoid the label by not seeking out treatment. | Leads to intended and unintended loss of opportunity. |

**Source: Corrigan, Druss & Perlick, 2014.**

By applying this construct to the stigma associated with mental health care in the U. S. Military, we can associate the four themes that resonate in the review of the literature with the social cognitive construct identified by the authors. (Corrigan, Druss, & Perlick, 2014). Figure 3 illustrates the social cognitive constructs as applied in the context of a military organization.

**Figure 3. Social Cognitive Structural Matrix Applied to Military Organizations.**

| | | Public | Self | Label Avoidance | Structural |
|---|---|---|---|---|---|
| **Social Cognitive Structure** | **Stereotypes and Prejudice** | Service members with mental illness are dangerous, malingering; fabricate their disorder, unreliable. | I am ashamed, weak, incompetent, to blame. (Leads to lowered self-esteem and self-efficacy) | I perceive that my peers and leaders disrespect and discriminate against service members with mental illness. | Stereotypes are embodied in military culture and policy. |
| | **Discrimination** | Therefore, leaders will not support them; the organization may discharge them, mental health issues are looked upon differently than physical illness or injury. | Why try: Someone like me is not worthy to serve in the military, I am a broken person. | I do not want this. I will avoid the label by not seeking out treatment. | Leads to intended and unintended loss of employment. |

**Source: Corrigan, Druss & Perlick, 2014.**

McFarling, D'Angelo, Drain, Gibbs, & Rae Olmsted (2011) clearly define stigma in the military as a systemic issue with the root cause seated in the traditions and customs of the armed forces. These beliefs start from initial accession as service members are trained to be physically and mentally tough. As a result, any perceived weakness sets the stage for stigma to be associated with any issue. Stigma, therefore, becomes a major issue in the military as it degrades military readiness of both the unit and individual. In the context of mental health treatment, the stigma associated with seeking care creates a barrier to care. The authors further discuss that it will take a

paradigm shift in beliefs that it is acceptable to ask for help. Additionally, leadership must support an environment that encourages service members to ask for assistance, along with changes in culture and policy (McFarling, D'Angelo, Drain, Gibbs, & Rae Olmsted, 2011).

In 2008, Hoge et al. published a study on mental health problems and barriers to care from combat duty in Iraq and Afghanistan. The study anonymously surveyed 6,201 service members in four combat units and concluded that the group under study was not only at a higher risk for mental health problems but reported that the perception of stigma was the predominant barrier to care to receive mental care treatment. Of the population under study, 65% of the respondents who met the criteria for a mental disorder indicated that by seeking mental health care they would be perceived as weak. Sixty-three percent felt that their leadership would treat them differently, 59% felt that other members in their unit would have less confidence in them, and 50% felt that seeking mental health care would harm their career. The authors concluded that only 23% to 40% of those who met the screening criteria for a mental health disorder sought treatment. These findings indicate that the perception of stigma associated with mental health care by leadership and other service members lead to resistance in seeking care and have serious public health consequences (Hoge et al., 2004).

In a similar study, Kim, Thomas, Wilk, Castro, & Hoge (2010) examined stigma and barriers to care among active duty and National Guard members who were deployed to Iraq or Afghanistan. Using the same five-point stigma scale developed by Hoge in 2004, 1,566 active duty service members and 267 members of the National Guard with mental health problems were given anonymous surveys twelve months after

returning from combat. The survey results revealed that active duty service members reported more stigma as compared to their National Guard counterparts. Among active duty service members surveyed, 40% felt that their leadership would treat them differently, 37% felt that other members in their unit would have less confidence in them, and 31% felt that seeking mental health care would harm their career. In contrast, only 22% of National Guard members felt that their leadership would treat them differently, 20% felt that other members in their unit would have less confidence in them, and 19% felt that seeking mental health care would harm their career. The authors proposed that there are differences in the organizational culture of active duty units versus the National Guard because they are not integrated into the day-to-day lifestyle of active duty service members. Additionally, there may be less fear of leadership having an impact on negative career consequences for National Guard members who seek mental health care, as they are not full-time service members (Kim, Thomas, Wilk, Castro, & Hoge, 2010).

In a paper published by Cornish, Thys, Vogel, & Wade (2014), the authors looked at post-deployment difficulties among military veterans who served in Iraq and Afghanistan. Difficulties included psychological, behavioral, and physical problems. They also looked at barriers to seeking mental health care, specifically stigma and worries about the therapy process. The study was conducted using focus groups with 30 combat veterans of the Iraq and Afghanistan wars, and all four branches of the U. S. Military were represented in the groups. Forty-three percent of the participants in the focus groups indicated that they had sought some form of mental health treatment after deployment. During discussions of barriers to mental health care, stigma resonated with

the participants. The authors categorized the concerns with stigma into two categories, public stigma (the negative reaction by others) and self-stigma (internalizing negative messages). Participants concerns with public stigma included worry that their peers or leaders would find out that they sought out mental health care. They were in fear that receiving care would affect their ability to be promoted, prevent them from going on future deployments, and lost job opportunities. Additionally, participants indicated that the public stigma was internalized (self-stigma), believing that these negative perceptions would be true if they sought mental health care. Participants also revealed that they were ashamed of themselves for seeking care and felt they were less in control of their identity. Cornish et al. concluded that the study was in alignment with the previous findings in the existing literature. Recommendations were offered for barrier-reduction programs that included making information available, methods to facilitate the help-seeking process, and involvement of military leadership (Cornish, Thys, Vogel, & Wade, 2014).

In contrast to other literature reviewed, Quartana et al. (2014), concluded that as the rate of mental health care treatment increased during the Iraq and Afghanistan wars, reported stigma among active duty service member decreased. The authors' extracted data from health-related behavior surveys conducted with active-duty members of the military in 2002, 2005, and 2008 as well as data from land combat study surveys conducted in 2003-2009 and 2011. Respondents to the health-related behavior surveys reported that mental health service utilization increased from 16.1% in 2002 to 28.2% in 2008, reflecting a 75% increase. Mental health related stigma reported a decrease from 48% in 2002 to 35.3% in 2008, an approximate 25% decrease.

Respondents in the land combat study survey report mental health service utilization increased from 19.8% in 2003 to 35.8% in 2011 (80% increase). Mental health related stigma reported a decrease from 77.4% in 2003 to 71.1% in 2011 (8% decrease). The authors conclude that increased utilization of mental health service and a downward trend in reported stigma can be attributed to the effectiveness of an increase in concerns with service members' mental health (Quartana et al., 2014).

*Leadership*

In 2009, Wright et al. published a study that examined how leadership and unit cohesion affected the barriers and stigma of mental health care. The authors suggest that in the military, stigma may be more likely associated with the high demands to maintain unit combat readiness. As a result, seeking mental health care creates a perception of weakness by leadership and peers. The aim of the study was to explore the role of leadership and unit cohesion as it relates to mental health stigma. An anonymous survey of 680 soldiers who served in Iraq was conducted three months after their return from combat. In addition to demographic data and an evaluation of clinical assessment scales of the sample group, a stigma and barriers to care scale was administered. The scale consisted of sixteen items that were measured on a five-point Likert-type scale. Additional scales were administered on leadership behaviors and unit cohesion that were adopted from previous studies. After an analysis of the data, the authors concluded that the participants in the study who scored their leadership highly and reported better unit cohesion, reported a lower perception of stigma and barriers to mental health care (Wright et al., 2009).

In another study conducted by Britt, Wright, & Moore (2012), the authors compared the relationship between positive and negative leadership behaviors with stigma and barriers to mental health care. Participants were all active duty soldiers who recently returned from a 15-month deployment to Afghanistan. A sample size of 1,455 was evaluated on perceived stigma and barriers to mental health care. Additionally, participants rated ten different leadership behaviors of their supervisors and officers utilizing a five-point scale that ranged from “Strongly Disagree” to “Strongly Agree.” The dimensionality of behaviors was determined across three different measurement periods. The association of leadership ratings and perceptions barriers to care and stigma using hierarchical linear modeling (HLM) using SPSS statistical software. The results determined that the behavior of leadership predicted overall stigma and barriers to mental health care over all three measurement periods. The data led the authors to conclude that leadership who demonstrate more positive behaviors are less likely to foster stigma and barriers to mental health care. On the other hand, participants who experienced more negative leadership behavior were more likely to experience stigma and barriers to mental health care (Britt, Wright, & Moore, 2012).

In a two-phase study conducted by Zinzow et al. (2013), these researchers sought to determine the barriers and facilitators of seeking mental health care by active duty service members. During the study, the authors also identified additional barriers to mental health care that included leadership perceptions and the effects of positive leadership. The first phase study group consisted of 78 active duty Army personnel that were divided into three focus groups based on rank. The sample group consisted of both enlisted personnel and officers which were split into four groups. Focus groups

lasted 60-90 minutes and assessed barriers and facilitators of seeking mental health care using a semi-structured interview guide. Questions were open-ended, and content was not limited. The results revealed that both enlisted soldiers and officers identified that leadership has the perception that service members who seek mental health care are malingering and trying to get out of work. As a result, soldiers lack trust of leaders and keep mental health problems to themselves. In phase two of the study, 32 soldiers who were currently in mental health treatment were interviewed individually by a researcher using the same guidelines as the focus groups in phase one. The results in phase two were similar in themes to the first phase regarding concerns about leadership. The authors conclude that the perceptions that leadership hold regarding mental health care and leader behavior are additional barriers to care. They propose that interventions for leaders be developed to reduce barriers and improve unit culture (Zinzow et al., 2013).

In chapter 3 of *Deployment Psychology,* Greenberg & Jones (2011), discuss the role of peers and leaders in optimizing support of mental health care in the military. The authors point out that people who join the military do so with somewhat of an understanding that they will be required to engage in work that is dangerous and will place them in harm's way. These types of duties expose them to the potential of physical injury and death. Unlike many other occupations that involve a high degree of risk, members serving in the military sacrifice a great deal of autonomy and choice. As such, military leadership have a greater level of responsibility in ensuring the physical and mental health than their civilian counterparts. Greenberg and Jones argue that military leaders should through “effective interventions . . . foster an environment in

which peer support flourishes" (Greenberg & Jones, 2011, p. 70). The authors conclude that, based on an abundant body of research, peer support is a key factor that can enhance service member resilience before traumatic events and help prevent the effects of mental health post deployment. As such, military leaders much support these factors rather than act as a barrier (Greenberg & Jones, 2011)

In an article by Greene-Shortridge, Britt & Castro (2007), the authors argue that the primary reason service members do not seek mental health care is due to perceived stigma. The authors reviewed existing literature that discussed the effects of societal stigma, self-stigma, and other factors that have an effect on seeking mental health care such as leadership quality and the presence of a positive unit atmosphere. The model developed illustrates how the various types of stigma prevent service members from seeking mental health care. In additional to the model, the authors propose interventions for stigma reduction in the military. One specific intervention is directed toward military leadership. Greene-Shortridge et al., posit that support from military leadership helping and supporting service members with mental health problems will reduce perceived stigma. Through leadership being involved in a positive manner, those seeking mental health care will do so early and remain an effective member of their unit. The authors additionally suggest that mental health programs and policy be mandated to further support service members with care (Greene-Shortridge, Britt, & Castro, 2007).

Tanielian et al. (2016), conducted a qualitative study of stakeholders in the military medical system to examine possible barriers to mental health care encountered by service members in need of care. The study included six U. S. Army bases to examine the barriers to accessing and using mental health care. Stakeholders included

patients, case managers, and health care providers. The authors interviewed the stakeholders in a series of one-on-one interviews within the parameters of a randomized control trial. Between July 2012 and June 2014, thirty-six patients were selected across the six sites and participated in a maximum of three interviews lasting 30 minutes each. Thirty-one mental health providers were selected to participate by a qualitative study team and were interviewed about their experience providing mental health care in the military health care system. Last, seven case managers participated in two one-hour interviews to discuss their interactions with patients and health care providers. During the interviews, stakeholders raised several institutional attitudes and cultural issues in the military that were barriers to mental health care. Specifically, mental health care is subject to the “will of leadership”. Thirty-nine percent of the patients in the study indicated that leadership attitudes and perceptions about mental health care influence their decision to seek care. Similarly, 39% of health care providers in the study indicated that leadership attitudes and perceptions about mental health care influence their patient's decision to seek care. And last, 86% of case managers in the study indicated that leadership attitudes and perceptions about mental health care influence patient's decision to seek care. The authors conclude that the findings regarding the negative perception of leadership support for mental health care in the U. S. military is a serious concern and recommend that further examination regarding the role of leadership and how they can facilitate rather than impede those seeking mental health care in the military (Tanielian et al., 2016).

*Career Consequences*

In a study conducted by Brown and Bruce (2015), the authors aim to compare the influence of self-stigma, public stigma, and career consequences on service members seeking mental health care. Brown and Bruce posit that “carry worry” is a factor that is independent of self-stigma and public stigma in the context of seeking mental health care that has not been previously studied. The study included 276 participants who were recruited through posts on Craigslist in several cities across the United States. Thirty-eight percent of the study group were active duty members who served in Iraq and Afghanistan. Sixty-two percent were veterans who recently left active duty who also served in Iraq and Afghanistan. Participants were asked to complete self-report measures regarding symptoms of mental health problems, self, stigma, public stigma, and career worry. Participants were then asked to assess their level of willingness to seek mental health treatment. Using confirmatory factor analysis, the authors tested the hypothesis that self-stigma, public stigma, and career worry are factors that are independent. The results of the analysis supported the authors’ hypothesis that stigma, self-stigma, and career worry, while related, are also statistically independent from each other. The results imply that service members may be apprehensive seeking mental health care because of concerns that doing so will harm their military career. The authors conclude that in addition to career worry being a separate factor from self-stigma, and public-stigma in seeking mental health care, career worry is a more persuasive factor for service members not to seek mental health care (Brown & Bruce, 2016).

Bein (2011) conducted a study that assessed the psychological symptoms, self-stigma, and public stigma perceived by U.S. Army National Guard soldiers who returned

from an Iraq deployment. The study was part of a longitudinal study that collected pre and post deployment health surveys starting in December 2008 and concluding in January 2010 after an Iraq deployment. Overall, 2,800 soldier's post-deployment health surveys were processed of which 2,000 were randomly selected for participation. After surveys were completed, 761 were returned and 747 of those qualified for the study. Questionnaires were distributed that asked about previous psychological symptoms, diagnoses, treatment, current symptoms, and concerns regarding deployment. A questionnaire was also administered to gather data on the participant's opinions about mental health illness, treatment, self-stigma, public stigma, and barriers to care. The author found it troubling that study participants were more likely to perceive seeking mental health care as harmful to their career in the military more than mental health care as being seen as a poor decision or not helpful. Moreover, the participants in the study reported that family members would also view seeking mental health care as derogatory for their military career compared to helping mental health problems. Bein suggests that further research is needed to amplify if the perceptions about stigma and career consequences associated with mental health care are in line with what is reported for deployed U.S. Army National Guard soldiers (Bein, 2011).

In the previously reviewed article by Zinzow et al. (2013), the authors identified additional barriers to mental health care involving career consequences. Both enlisted service members and officers expressed concerns that seeking mental health care would harm their career, hinder promotion, results in different treatment by unit members, and potentially lead to discharge (Zinzow et al., 2013).

*Organizational Culture*

Langston, Gould, & Greenberg (2007) published an article that focuses on military culture and how it intensifies mental health problems by creating barriers to care. The authors point out that serving in the military involves exposure to stressful environments and traumatic events. Additionally, the stressors associated with deployments, family separation, and living in austere environments are examined. While culture, in general, has become more open and less critical of mental health care, Langston et al., describe the culture of the military as “prostigmatic”. Military culture supports the idea of not showing weakness and not discussing personal problems, particularly mental health problems. The authors conclude that organizational culture is a significant barrier to mental health care in the military. They state, “Perhaps the real patient is not the individual who has mental health problems but instead is the military culture itself” (Langston, Gould, & Greenberg, 2007, p 70).

In a study by Kim et al. (2011), the authors examined how stigma and negative attitudes affect the utilization of mental health care among soldiers. The authors also point out that previous research indicates that organizational barriers are an additional challenge to service members seeking mental health care in the military. The study collected data from 3,800 active duty U. S. Army soldiers of which, 2,623 indicated that they were deployed to Iraq or Afghanistan. Questionnaires included an assessment of mental health risk, treatment history, and barriers to mental health care. Of the 2,623 respondents to the questionnaires, 881 indicated that they experienced a mental health problem. Of those who reported a mental health problem, 32.9% reported being seen as weak, 31.1% reported that their unit would have less confidence in them, and 28.4% reported that they would not be given time off work for an appointment. The authors

found that items related to stigma in their analysis were associated with negative perceptions of others in response to seeking health care. The authors propose that further research is needed to study the reasons why service members do not seek mental health care and the development of interventions that will remove organizational beliefs and negative attitudes about seeking mental health care (Kim, Britt, Klocko, Riviere, & Adler, 2011).

**Discussion**

As Sharp et al. (2015) point out, approximately 60%-70% of U.S. Military veterans that are in need of mental health care do not seek treatment (Sharp et al., 2015). This is an unfortunate statistic as members of the military work in very stressful environments and are exposed to the trauma of war. Multiple deployments, separation from family members, and austere living conditions add additional stressors that magnify the already tenuous work environment. Arguably, members of the military who are in need of mental health care as a tool to manage these multiple stressors would benefit the most from obtaining care. This topic has been studied extensively and most authors conclude that stigma associated with seeking mental health care in the military is the biggest factor that deters service members from initiating care. As McFarling et al. point out, stigma in the military is a systemic issue that is engendered in a tradition that service members are instilled from initial accession and continues throughout their career (McFarling et al., 2011). While it is important that service members must be conditioned to be physically and mentally strong, the military institution itself has fostered the development of a pervasive belief that any perceived signs of weakness is a negative attribute and quickly becomes a target for criticism and ridicule. Moreover,

mental health issues are only “real” when someone else, such as supervisors or health care providers validate them. As a result, service members with self-identified psychological distress do not want to pursue treatment because of the stigma and perceptions associated with seeking care. This systemic problem with stigma results in service members making a conscious choice not to seek mental care because of the negative consequences of doing so. Hoge et al. conducted a study that examine mental health problems and the barriers to care associated with combat duty in Afghanistan in Iraq. The study findings validate the small percentage of service members who served in combat and self-report a mental health issue, only 23% - 40% sought care. Among the group under study by the authors, a large proportion reported stigma as the main factor that hindered them from seeking mental health care (Hoge et al., 2004). In a similar study, Kim et al. further examined the stigma associated with barriers to seeking mental health care in the military. The authors studied both active duty and National Guard members after serving in Iraq. Interestingly, while stigma was reported in both groups, the percentage of active duty members reporting stigma as a barrier to care was higher than that reported by members of the National Guard. The authors reported that among active duty service members surveyed, 40% felt that their leadership would treat them differently, 37% felt that other members in their unit would have less confidence in them, and 31% felt that seeking mental health care would harm their career. In contrast, only 22% of National Guard members felt that their leadership would treat them differently, 20% felt that other members in their unit would have less confidence in them, and 19% felt that seeking mental health care would harm their career (Kim et al., 2010). The data clearly indicates that while there is stigma reported

as a barrier to seeking mental health, there is a difference in the perception of stigma associated with seeking mental health care between active duty units versus the National Guard. This difference is perhaps associated with the organizational culture of active duty units versus the National Guard because they are not integrated into the day-to-day lifestyle of active duty service members. Additionally, there may be less fear that leadership will have less impact on negative career consequences for National Guard members who seek mental health care, as they are not full-time service members. More importantly, Kim et al. identify three forms of stigma that are a factor in not seeking mental health care. The three forms of stigma that resonate are leadership, loss of confidence by the unit, and career worry such as adverse impact on a military career (Kim et al., 2010).

Leadership, good order, and discipline are the cornerstone of an efficient and effective military unit. The high risk of serious injury and death in the military demand unit cohesion and consequently the maintenance of high levels of combat readiness. These demands place an enormous amount of pressure on leadership, specifically the commanding officer. The commanding officer in any military unit is a unique position in which that individual is held ultimately accountable for unit combat readiness and the safety and well-being of each and every member of the unit. Unfortunately, through a review of the literature, military leadership has been identified as a predominant barrier for service members seeking mental health care. The pressure to maintain combat readiness and not losing a service member due to a medical issue, which degrades readiness, is a driving factor in the stigma associated with mental health care. Unlike physical illness or injury, leaders tend to judge service members who seek mental

health care as weak and broken, often expressing opinions that mission comes before wellness.

Wright et al. (2014) compared the relationship between positive and negative leadership behaviors with stigma and barriers to mental health care. Their results determined that the behavior of leadership predicted overall stigma and barriers to mental health care in that leadership who demonstrated more positive behaviors are less likely to foster stigma and barriers to mental health care. On the other hand, participants who experienced more negative leadership behavior were more likely to experience stigma and barriers to mental health care (Wright, Britt, & Moore, 2014).

Similarly, the study conducted by Zinzow et al. (2013), to determine the barriers and facilitators of seeking mental health care by active duty service members, the authors identified barriers to mental health care that included leadership perceptions and the effects of positive leadership. The results revealed that both enlisted soldiers and officers identified that leadership has the perception that service members who seek mental health care are malingering, trying to get out of work, and viewed as a liability to combat readiness. The consequences of these perceptions and behaviors by leadership led to soldiers lacking trust of their leaders and the tendency to keep mental health problems to themselves and not seek care (Zinzow et al., 2013). The findings of the study clearly support the discussion that perceptions that leadership hold regarding mental health care and leader behavior facilitate stigma and are additional barriers to service members seeking mental health care.

Greene-Shortridge et al. (2007), posit that support from military leadership helping and supporting service members with mental health problems will reduce

perceived stigma. Through leadership being involved in a positive manner, those seeking mental health care will do so early and remain an effective member in their unit (Greene-Shortridge et al., 2007).

In perhaps the most descriptive study reviewed, Tanielian et al. (2016), conducted a qualitative study of stakeholders in the military medical system that examined possible barriers to mental health care encountered by service members in need of care. During the interviews conducted with stakeholders several institutional attitudes and cultural issues in the military were pointed out that were identified as barriers to mental health care. Specifically, stakeholders identified that mental health care is subject to the "will of leadership." The data collected in the study revealed that 39% of the patients interviewed indicated that leadership attitudes and perceptions about mental health care influenced their decision to seek care. Similarly, 39% of healthcare providers interviewed during the study indicated that leadership attitudes and perceptions about mental health care influence their patient's decision to seek care. And lastly, 86% of case managers interviewed in the study indicated that leadership attitudes and perceptions about mental health care influence patient's decision to seek care (Tanielian et al., 2016). The data from the Tanielian study clearly demonstrate that stakeholders involved in mental health treatment for service members perceive that military leadership does not support service members who seek mental health care. The lack of support creates additional stigma that affects a service members' decision to not seek mental health care.

Leadership in the U.S. military is predominately a transactional style of leadership in which orders are given, received, and carried out. Failure to carry out

orders in this type of setting can result in serious consequences that can range from serious injury to death. Just as the methods used to conduct warfare have evolved over time, the methods and styles of leadership required in military organizations have evolved as well. By looking at the various branches within the U. S. Military, numerous cultures and sub-cultures emerge that are influenced by the individual branch of service, warfare component, and occupational specialty. Leading these diverse cultures and sub-cultures within each organization requires leaders who are proficient in their warfare niche or specialty and have the ability to execute a leadership style that can adapt and change with rapid changes in circumstances and environment to enable the organization to perform at a higher level and meet the military mission. The complexity and dynamics in this type of environment requires leaders to focus on mission accomplishment with little margin for error in human dynamics. As such, leadership in the military is arguably a significant factor that contributes to public stigma associated with service members seeking care for mental health issues. The decision to seek care can be influenced in a positive or negative manner based upon perceptions of leadership who support or do not support service members desire to seek care. Based on the significant rate of service members who have self-identified as having mental health issues and do not seek treatment, is a clear indication that the leadership in most military units do not support service members in need of care and seek mental health services. This can be harmful to the service member as they may not be getting the appropriate level of mental health care that is truly need and creates a serious public health issue.

An additional factor that contributes to the barriers in seeking mental healthcare are the potential negative career consequences on service members creating career worry. Certain psychological disorders and medical treatment for those conditions can have legitimate repercussions for continued service in the military that relate to the ability to accomplish specific missions, deploy, handle weapons, and maintain security clearances. As a result, some service members perceive that seeking any type of care for general counseling, mental health, or behavioral issues will have similar negative career consequences if leadership becomes aware of their treatment. There is fear that it seeking care will reflect poorly on their performance reports, affect promotions, or result in discharge.

Several studies reviewed in the literature discuss career worry and its influence on stigma associated with mental health care. An interesting hypotheses advanced Brown and Bruce (2015) propose that “career worry” is a factor that is independent of self-stigma and public stigma in the context of seeking mental health care which has not been previously studied. The authors’ findings imply that service members may be apprehensive in seeking mental health care because of concerns that doing so will harm their military career. Additionally, the authors posit that in addition to career worry being a separate factor from self-stigma, and public-stigma in seeking mental health care, career worry is a more persuasive factor for service members not to seek mental health care (Brown & Bruce, 2016).

In another discussion regarding career worry, Bein (2011) conducted a longitudinal study that assessed the psychological symptoms, self-stigma, and public stigma perceived by U.S. Army National Guard soldiers who returned from an Iraq

deployment. The author found it troubling that study participants were more likely to perceive seeking mental health care as harmful to their career in the military more than mental health care as being seen as a poor decision or not helpful. Moreover, the participants in the study reported that family members would also view seeking mental health care as derogatory for their military career rather than helping mental health problems. While Bein suggests that further research is needed to amplify if the perceptions about stigma and career consequences associated with mental health care, this outcome remains consistent with the finding in similar studies.

Serving in the U. S. Military has also been associated with patriotism, pride, selfless service, and duty to country. As an all-volunteer force, less than 1% of the U. S. population that are qualified, serve in the military. Therefore, entry in the U. S. Military becomes competitive and once members are serving, for most, maintaining their status on active duty is a priority. Career worry is not limited to just mental health issues. Job performance, physical performance and physical and mental health are factors that can affect the ability to serve. Moreover, Zinzow et al. (2013) found that both enlisted service members and officers expressed concerns that seeking mental health care would harm their career, hinder promotion, result in different treatment by unit members, and potentially lead to discharge (Zinzow et al., 2013). Any threats to these factors that could be harmful or seen as derogatory to one's career and potentially lead to discharge, genuinely lead to career worry, and service members try to avoid them to the greatest extent possible.

Finally, the organizational culture in the U.S. military is dramatically different and unlike any other institution. The unique demands of military life place extreme pressure

on service members and their families. The military is grounded in a tradition that has specific rituals and symbolism, and are based on hierarchy and discipline. Members of the military share the same set of beliefs that is based on the understanding that the mission and the unit always comes before the individual. This unique environment that service members work in creates a complex organizational culture that can vary at the individual branch of the military and have subcultures based on the type of unit such as infantry, aviation, surface ship, submarine, etc.

The article published by Langston, Gould, & Greenberg (2007) focuses on military culture and how it intensifies mental health problems by creating barriers to care. The authors point out that serving in the military involves exposure to stressful environments and traumatic events. Additionally, the stressors of associated with deployments, family separation, and living in austere environments. While culture in general has become more open and less critical of mental health care, Langston et. al., describe the culture of the military as “prostigmatic”. Military culture supports the idea of not showing weakness and not discussing personal problems, particularly mental health problems. The authors conclude that organizational culture is a significant barrier to mental health care in the military. The authors summarize the effects of military culture on mental health stating, “Perhaps the real patient is not the individual who has mental health problems but instead is the military culture itself” (Langston et al., 2007).

Kim et al. (2011) add to the discussion of organizational culture and mental health care. They examined how stigma and negative attitudes affect the utilization of mental health care and specifically point out previous research that indicates organizational barriers are an additional challenge to service members seeking mental

health care in the military. In their analysis, the authors found that items related to stigma were associated with negative perceptions among unit members in response to those individuals who sought mental health care. The authors propose that further research is needed to study the reasons why service members do not seek mental health care and the development of interventions that will remove organizational beliefs and negative attitudes about seeking mental health care (Kim et al., 2011).

Organizational culture in the U.S. military as in any other organization is comprised of shared assumptions, values, and beliefs, which govern how people behave in the organizations. These shared values have a strong influence on the people in the organization and dictate how they dress, act, and perform their jobs. Every organization develops and maintains a unique culture, which provides guidelines and boundaries for the behavior of the members of the organization.

**Recommendations**

A paradigm shift in leadership, culture, and policy is needed. First, leadership must understand and accept that mental health care should not be treated any differently than care for a physical disease or illness. They must view individual health in the overall context of “wellness” whether it be physical, mental, or spiritual and that wellness acutely affects morale, readiness, and mission effectiveness—that health is mission critical.

The culture within the organization is rife with stigma regarding mental health care and the negative stigma must be reduced universally throughout the organization starting at the highest levels of leadership. Leadership should be educated from the top

down regarding the difference between mental health care, general counseling, and individual support services. Mandatory blended training for all levels of leadership should be developed and conducted by mental health professionals through face-to face and Internet based training. After initial training is conducted, leaders should be required to complete an annual update thereafter. Once leadership demonstrates understanding, buy-in, and support of mental health care, service members will become less fearful of openly seeking care and will have the ability to build a trusting relationship with leadership. Once stigma barriers start to break down, only then can the process become more transparent and mental health care become “accepted” throughout the organization and process change can be implemented.

Policy in the U. S. Military is significantly different than public policy and law. Policy is decentralized and can be implemented from the top down at the Department of Defense level or it can be established at the individual service level all the way down to the unit level. Unit commanders can implement and enforce additional local policy that is based on previously establish policy issued by a higher authority as long as the unit issued policy meets or exceeds the existing policy. Unit level policy is often issued to address specific local requirements, provide clarification of policy issued by higher authority, or adapt existing policy to specific situations.

Policy regarding mental health care in the U. S. Military should be established by the Department of Defense so that it flows from the top down and applies to all branches and units of the U. S. Military. This policy must ensure that mental health illness and care is treated the same as physical illness or injury. This is the first step in facilitating the elimination of stigma associated with mental health care in the U. S.

Military. Additionally, policy that requires training and education programs for leadership regarding mental health issues that service members face, and how, as leaders, buy-in and support of mental health care is essential for service members under their command to receive the care that they need and desire. This will contribute not only to individual wellness but unit combat readiness as well. Finally, policy to authorize additional funding for U. S. Military to undertake the appropriate access to care and have adequate mental health services are paramount for providing service members comprehensive and quality health care.

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# Appendix

| Stigma and Barriers to Mental Health Care in the U. S. Military<br>Identified Resources by Four Themes | |
|---|---|
| **Stigma**<br>(n=21) | 1. Bein, L. (2011).<br>2. Britt, T. W., Wright, K. M., & Moore, D. (2012).<br>3. Brown, N. B., & Bruce, S. E. (2016).<br>4. Cornish, M. A., Thys, A., Vogel, D. L., & Wade, N. G. (2014).<br>5. Corrigan, P., Druss, B., & Perlick, D. (2014).<br>6. Glasmeier, A., Schultheis, E., Sassi, A., Chuvala, C. L., Bell, A., Fay, J., & Fradino, J. (2016).<br>7. Greenberg, N., & Jones, N. (2011).<br>8. Greene-Shortridge, T. M., Britt, T. W., & Castro, C. A. (2007).<br>9. Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004).<br>10. Kim, P. Y., Britt, T. W., Klocko, R. P., Riviere, L. A., & Adler, A. B. (2011).<br>11. Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., & Hoge, C. W. (2010).<br>12. Langston, V., Gould, M., & Greenberg, N. (2007).<br>13. McFarling, L., D'Angelo, M., Drain, M., Gibbs, D. A., & Rae Olmsted, K. L. (2011).<br>14. Miggantz, E. L. (n.d.).<br>15. Nizam, Mirjam & McCrillis, Aileen. (2015).<br>16. Quartana, P. J., Wilk, J. E., Thomas, J. L., Bray, R. M., Rae Olmsted, K. L., Brown, J. M., & Hoge, C. W. (2014).<br>17. Sharp, M., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015).<br>18. Tanielian, T., Woldetsadik, M. A., Jaycox, L. H., Batka, C., Moen, S., Farmer, C., & Engel, C. C. (2016).<br>19. Wright, K. M., Britt, T. W., & Moore, D. (2014).<br>20. Wright, K. M., Cabrera, O. A., Bliese, P. D., Adler, A. B., Hoge, C. W., & Castro, C. A. (2009).<br>21. Zinzow, H., Britt, T., Pury, C., Raymond, M. A., McFadden, A., & Burnette, C. (2013). |
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