

IDENTIFYING THE INITIAL MENTAL HEALTH MESSAGES OF ARMY ROTC
STUDENTS AND EXPLORING THEIR CONNECTION TO MENTAL HEALTH STIGMA
AND HELP-SEEKING BEHAVIORS

by

KRISTOPHER GREGORY HALL
B.A. St. Augustine's College, 2005
M.A. Seton Hall University, 2008
Ed.S. Seton Hall University, 2009

A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the College of Education and Human Performance
at the University of Central Florida
Orlando, Florida

Summer Term
2014

Major Professor: W. Bryce Hagedorn

ABSTRACT

Mental health stigma among military service members has been recognized as a significant barrier to mental health treatment as researchers (Greenberg, Langston, & Gould, 2007; Greene-Shortridge, Britt, & Castro, 2007; Hoge et al., 2004; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009) have concluded that military service members are reluctant to engage in help seeking behaviors to avoid negative labeling in the form of stereotyping. Additionally, links have been made between leadership and stigma, acknowledging that military service members are more likely to seek mental health treatment if they perceive that their leadership is supportive (Britt, Wright, & Moore, 2012; Hoge et al., 2004; Wright et al., 2009). Each of the aforementioned authors has advocated for an increased attention on those military service members with mental health issues by offering new programs and providing leadership support. The military has attempted to address both of these suggestions with the introduction of resilience training and increased screening for mental health issues. Unfortunately, despite such interventions, prevalence rates for diagnoses such as PTSD remain at high levels. A reason for this may be due to a lack of attention to the origins of the messages that future leaders receive regarding mental health.

The purpose of this study was to investigate the thoughts, feelings, and beliefs of US Army ROTC students and the possible presence of mental health stigma at their level of military involvement (i.e. pre-commission). The author sought to understand how biases against mental health are formed at one of the earliest points of cultural indoctrination within the military structure. This dissertation will contain an overview of the identified mental health beliefs of US Army ROTC students at a large southern university. How these beliefs relate to mental health stigma and help seeking behaviors will also be explored.

If my dumb ass can get a PhD, anyone can.
-Anthony Warrick, PhD

ACKNOWLEDGMENTS

I'm guessing the best way to do this would be to go chronologically, working backwards. First, I need to thank God for bringing me to this point. There have been days, nights, weeks, and months where only consistent prayer and thanksgiving has got me through. I know that I could not have done this without some divine intervention and I owe all of my past, present, and future success to Him.

Next, I would like to thank my amazing committee. Drs. Carolyn Walker-Hopp, S. Kent Butler, and Sejal Barden have made this a challenging, eye opening, and worthwhile learning experience. Thank you to my chair, Dr. W. Bryce Hagedorn for being supportive and open every step of the way. You took something that filled me with anxiety and kept me calm in rough waters.

Thank you to my Dirties, my cohort, thank you for being a friend. I have learned so much from being with you during this process and I could not have done it without you. I pray for your continued success and thank you for supporting me and learning to accept me for me while helping me grow into a better person. A very special thank you also to the cohorts above and below me, your support, guidance, and friendship helped keep me afloat.

To the Holmes Scholars, your support over these three years has been amazing. It is my sincere hope that the bonds I've formed with you are for a lifetime and that you emerge from your programs ready to take on the world. Thank you for everything.

Thank you to the Hudson County Child Abuse Prevention Center for giving me my start in counseling. I went from a novice masters student taking online classes to a confident counselor thanks to your support. The foundations of my counseling experience were built

thanks to you allowing me to work in so many areas and the experience could not be replaced by anything.

To my NJ/NY crew: Erin, Krystal, Tameka, Johnique, Aliann, Damien, and Sam, you are beyond appreciated. Thank you for allowing me into your lives and continuing to keep me in your hearts beyond distance and time.

There are no words to express the appreciation I have for Robert A. J. Hill, who has been a true friend and confidant from our first meeting. You have made yourself available to me in almost every way I've needed and I could not be more thankful to God for your presence. You have been, and I hope that you will continue to be, a positive influence in my life.

Thank you to "The Serve," especially Sheldon White and his wife Jen, you have helped make my life transitions so much easier with laughter and fellowship. Sheldon and Jen, you've treated me like family for the three years I've been here and you have no idea how much that means to me. I pray that God will continue to bless your amazing hearts.

Speaking of the Nupes, I need to show appreciation to my chapter, Gamma Omicron. Thank you for accepting me as I am and giving me so much joy since Fall 2001. Contact with you was my refuge during this process and you've managed to inject laughter into days where I really wanted to cry.

There are too many of you to name, so I won't name anyone but thank you to my St. Aug family, each and every one of you. Your well wishes, texts, Facebook posts, and congratulatory messages during this time meant the world to me. I came to college alone and left with a family that has supported me for over a decade. I love you all.

An immense thank you to the Addison family who took me in as a college freshman and helped me to develop into an adult during my time in North Carolina. You have my undying

gratitude for your generosity and love throughout the various stages of my life. You were there for my first post high-school graduation and you're in my heart as I go into my last.

Thank you to the UMBC Classic Upward Bound program for exposing me to experiences and universities outside of my immediate comfort zone. I was already on my way to something great, but your help made it that much greater. Think, edit, speak has never left me.

A sincere thank you to my family and friends of family who are again too immense to name. You have watched me grow from a little boy to what I am now. Through hardships and happiness, your presence in my life has made me into who I am and I have taken you with me everywhere I've gone.

Mary G. and Sam Hall. I love you with every part of me and I thank God that at least one of my sharecropping grandparents is alive to see their legacy come to fruition. When I think of my success, I think about it in context of where you've come from and I thank God for allowing him to use me if it means that you get to see things beyond what you had dreamed.

Finally, I need to thank my parents Carroll Wilson-Holmes, Miki Holmes, George Hall, and Lenora Hall. Thank you for teaching me that just because you did your best doesn't mean it was the best that you could do. Thank you for instilling a standard of excellence from day one and putting education at the forefront of my life. I would not be where I am if not for your love and support. Sometimes things don't work out the way we plan, they work out better.

To anyone I forgot; please blame it on the head and not my heart. I just wrote a damn dissertation.

TABLE OF CONTENTS

LIST OF TABLES	xiv
CHAPTER I.....	1
Overview	1
Service Members and Mental Health Statistics.....	2
Overall Mental Health Prevalence.....	3
Specific Illnesses	5
Negative Coping Strategies	7
Current Approaches to Mental Health Treatment and Prevention	10
Mental Health and Treatment Engagement.....	12
Theoretical Framework	15
The Common Sense Model for Illness Representation	15
Alternative Frameworks Considered	17
Statement of the Problem	18
Purpose of the Study	20
Research Questions	21
Definition of Terms.....	21
Rationale for the Research Approach.....	22
Significance of the Study	25
Summary	26
Organization of the Study	26
CHAPTER II.....	28

Introduction	28
Mental Health Belief Systems.....	29
Culture and Belief Systems	30
Specific Diagnoses and Belief Systems.....	32
Service Members’ Mental Health Belief Systems.....	33
Mental Health Belief Systems Outcome Studies.....	35
Summary.....	39
Mental Health Stigma.....	39
Overview	39
Overall Stigma.....	42
Stigma Outside the US	53
Stigma and Leadership	57
Summary.....	60
Help-Seeking Attitudes and Behaviors	61
Masculine Culture and Help-Seeking.....	61
Masculinity and the Military	63
Male Gender Roles, Service Members, and Help-Seeking	66
Help-Seeking and the Military.	69
Summary.....	78
CHAPTER III	79
Methodology	79
Introduction	79

Purpose of the Study	79
Research Question.....	80
Question Formulation	80
Guiding Research Questions	81
Research Design.....	83
Rationale for Research Design	84
Sampling Procedures.....	86
Research Site	86
Participants	87
Instrumentation and Qualitative Research Protocols	90
Data Collection	90
Interview Questions.....	93
Data Analysis.....	95
Validity and Verification Strategies	101
Summary	104
CHAPTER IV	105
Introduction	105
Participants	105
Verification of the Results.....	106
Data Analysis	107
Organization of the Data.....	107

Theoretical Framework.....	108
Thematic Analysis	109
Findings.....	112
Research Question One	112
Thoughts about Mental Health.....	113
Education	114
Contact.....	117
Mind/Body Connection	122
Summary.....	123
Feelings about Mental Health	124
Negative Emotional Outcomes	124
Emotional Adjustment.....	127
Summary.....	129
Beliefs about Mental Health.....	130
Illness Identification	131
Stress Related Factors.....	133
Interpersonal Issues	138
Acceptance.....	139
Treatment Options	142
Civilian vs. Military Expectations	148
Duration	150
Interpersonal Impact	152

Intrapersonal Impact	156
Summary	158
Military Culture.....	160
Intrinsic Factors	161
Extrinsic Factors	164
Summary.....	167
Summary	168
CHAPTER V	169
Introduction	169
Limitations	170
The Common Sense Model of Illness Representation	171
Thoughts about Mental Health.....	172
Mental Health Knowledge Attainment.....	172
Feelings about Mental Health	175
Emotional Reactions to Mental Health.....	175
Beliefs about Mental Health.....	177
Diagnosis Identification.....	177
Causes of Mental Illness.....	180
Mental Health Treatment.....	182
Duration of Mental Illness.....	188
Consequences of Mental Health Issues	189
Stigma, Help-Seeking, and Culture	192

Summary	196
Implications	198
Prevention Improvement	198
Treatment Protocol Development.....	200
Officer Preparation	200
Development for the Field of Counseling	201
Community Education.....	202
Implications for Future Research	203
Conclusion.....	205
APPENDIX A: PERMISSION LETTER	207
APPENDIX B: RECRUITMENT LETTER.....	209
APPENDIX C: IRB ADDENDUM 1	211
APPENDIX D: MEMOS	213
APPENDIX E: ORIGINAL IRB	234
APPENDIX F: INTERVIEW PROTOCOL.....	236
APPENDIX G: OBSERVATION GUIDE	240
APPENDIX H: DEMOGRAPHICS SHEET.....	243
APPENDIX I: IRB ADDENDUM 2 & 3	245
APPENDIX J: MEMBER CHECKING PROTOCOL.....	248
APPENDIX K: POSITIONALITY STATEMENT.....	253
APPENDIX L: TRANSCRIPTS.....	256
APPENDIX M: CODING SHEETS.....	354

REFERENCES 493

LIST OF TABLES

Table 1- Participant Demographics – ROTC Students	106
Table 2 – Major Themes and Codes	111
Table 3 - Thoughts about Mental Health	114
Table 4 – Feelings about Mental Health	124
Table 5 – Beliefs about Mental Health	130
Table 6 – Military Culture	161

CHAPTER I

Overview

The September 11th attacks have resulted in an increased military presence in the Middle East (Tan, 2009), which have led to longer tours of duty and increased combat exposure due to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) (Walker, 2010). During these conflicts 71-86% of service members report being involved in live combat while 55-57% of service members report handling human remains, scenarios which have resulted in service members experiencing higher incidences of mental health issues as compared to service members of previous wars (Hoge et al., 2004). While service members acknowledge mental health issues (e.g., Post Traumatic Stress Disorder; PTSD), seeking treatment for mental health issues are often viewed with skepticism, lowering help-seeking behaviors (Gibbs, Rae Olmstead, Brown, & Clinton-Sherrod, 2011). Such skepticism stems from a set of beliefs known as mental health stigma (Corrigan, 2004). Mental health stigma has been identified as a barrier to seeking mental health services, which can lead military personnel to shun help for their concerns in order to avoid deleterious career impacts and negative perceptions from fellow service members (Hoge et al., 2004).

The Department of Defense attempted to address mental health stigma through resilience training (Zinzow, Britt, McFadden, Burnette & Gillispie, 2012) including Battlemind and Comprehensive Soldier Fitness (CSF) with the intention of improving help-seeking behaviors. Whereas there has been some success, there is a notable lack of empirical studies that investigate the original sources of mental health stigma for the military population. It is important to understand the original sources of mental health stigma as the knowledge can aid in developing

effective intervention techniques and points where interventions should take place. Current interventions generally take place pre and post deployment; however, interventions may be more effective at earlier points of military training. These interventions have been put in place to combat stigma without understanding the origins of beliefs about mental health and mental health treatment. It is important to understand the core mental health beliefs of this population, at the earliest point of cultural indoctrination, in order to ascertain a better understanding of the development of mental health stigma and help-seeking behaviors, which will allow for the development of interventions that are culturally specific and timely to the service member population.

Prior to investigating the mental health beliefs of service members, it is important to understand the enormity of the mental health issues within the military population. This Chapter will detail prevalent mental health issues of service members and will include comparisons of mental health prevalence rates before and after 9/11. This will be followed by the conceptual framework which will guide the study, a statement of the problem regarding mental health belief systems and the military, the purpose of the study and related research questions, and then a definition of terms to be used throughout the study. The methodology for the study will also be provided as well as some potential implications, limitations and delimitations. The author will conclude with the organization of the proposed Chapters to be presented.

Service Members and Mental Health Statistics

Americans experience a myriad of stressful events which may affect coping. Those with proper resilience are able to adapt to these stressful situations while others may experience mental health issues (Morgan & Bibb, 2011). In order to understand prevalence, agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsor efforts

which catalog mental illness within the U.S. Other government agencies, including the Department of Defense (DoD), also collect data but specifically focus on military populations to understand prevalence rates and to inform treatment. The prevalence rates collected by the DoD are important to the current investigation as it will provide detail regarding the severity of mental health issues within the military population, confirming the necessity of the interventions which have been put in place for this population. Additionally, the author will contextualize the severity of the mental health prevalence as the information will be compared to civilian rates and pre and post OIF/OEF engagements, highlighting the lack of help-seeking behaviors by service members due to stigmatic beliefs. The following section details the prevalent mental health issues within military populations and will specifically address PTSD, depression, substance abuse, and suicide.

Overall Mental Health Prevalence

General Mental Health Prevalence. The Department of Veterans Affairs collects data on all service members who engage in treatment at one of their various centers nationwide. Approximately 2,333,972 service members have been deployed to Iraq, Afghanistan, or both between the September 11th attacks and August 30, 2011 (Martinez & Bingham, 2011). The current Healthcare Utilization Report (2013) includes data from all those who have participated in Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn between October 1, 2001 and March 31, 2012. Of those surveyed, it was found that 508,410 (54.4%) of those receiving some form of VA services were diagnosed with a mental disorder. From this statistic, one can conclude that more than half of those who seek VA services require some form of mental health care. Based on the statistics provided by Martinez and Bingham (2012) and the Healthcare Utilization Report (2013), it can be inferred that approximately 21% of all those

serving in the military post 9/11 were diagnosed with a mental disorder. In relation to help-seeking behaviors, Seal et al. (2010) found that between April 1, 2002 and March 31, 2008, out of 84,972 OIF/OEF veterans who received a new mental health diagnosis, 56,586 (66.1%) returned for follow-up treatment. While this number may seem high, it should be noted that service members must undergo psychiatric screening pre and post deployment, meaning that they are more likely to be assessed for mental illness and will have knowledge of any issues. However, one can still see that 1/3 of this population is being redeployed without seeking treatment where they are exposed to unique stressors such as live combat (Hoge et al., 2004). Given that more than a quarter of new cases within the Seal et al. (2010) study did not engage in help-seeking, mental health stigma should be noted as a possible barrier to treatment. Despite differences in data collection techniques and time spans, one can see from the results that service members are more likely to be diagnosed with mental illness, with a significant portion avoiding help-seeking possibly due to mental health stigma. This mental health stigma calls into question the cultural environment that service members are exposed to as cultural influences are reflective of beliefs regarding illness (Diefenbach & Leventhal, 1996). Therefore, it is important to investigate the mental health beliefs of service members to begin to create a picture of their cultural environment and how this affects mental health stigma.

While both civilian and military populations experience mental illness, the military gives focus to certain diagnoses. Hoge et al. (2004) analyzed several factors including mental health status using Soldiers and Marines pre and post deployment to Iraq and Afghanistan. This study is seen as one of the hallmark studies regarding the psychological effects of combat within the OIF/OEF population and has been cited 2,244 times since being published. Whereas the authors originally included the mental health diagnoses of; a) Post-Traumatic Stress Disorder (PTSD), b)

Major Depressive Disorder (MDD), and c) Generalized Anxiety Disorder (GAD); most studies have focused on PTSD and MDD as GAD is sometimes comorbid with PTSD and less prevalent than MDD (Seal et al., 2010). Hoge et al. (2004) also included misuse of alcohol, as this has been cited as a reaction to negative coping (Khantzian, 1985). Though not a focus of Hoge et al., suicide has also been identified as a psychological issue within the military (Garamone, 2014) with incidences increasing post OIF/OEF. Therefore, the author will also present statistical information regarding the differences in the rates of these four disorders pre and post 9/11.

Specific Illnesses

Post-Traumatic Stress Disorder. For service members, increased deployment times and exposure to combat have been found as likely contributors to PTSD, which is prevalent within military populations (Riggs & Semeranian, 2012). Currently, statistics regarding the number of service members diagnosed with PTSD prior to OIF/OEF are scant; however, there is research which details hospitalizations for the disorder prior to this period and through these campaigns. Between 2000 and 2012, 159,107 active duty service members experienced 192,317 mental disorder hospitalizations with a 192% increase of PTSD hospitalizations between 2006 and 2012 (*Summary of Hospitalizations*, 2013). However, between 1990 and 1999, only 1,380 service members were hospitalized for PTSD, marking a drastic increase in PTSD during OIF/OEF. Following OIF/OEF, the government began to give more attention to incidence rates of PTSD in service members following research detailing increases in prevalence (Hoge et al., 2004; Hoge, Auchterlione, & Milliken, 2006; Milliken, Auchterlione, & Hoge, 2007; Richardson, Frueh, & Acierno, 2010) resulting in increased mental health screenings and diagnoses of mental health disorders. Hoge, Auchterlione, and Milliken (2006) conducted a study using Soldiers and Marines returning from Iraq and Afghanistan and found that 4.9-9.8% ($N=16,318$) of service

members screened positive for PTSD. Seal et al. (2010) observed that out of 84,772 participants receiving new diagnoses from the VA, 58.2% of these participants received a diagnosis for PTSD with 23.5% of that population receiving an isolated PTSD diagnosis with no comorbid disorders. Overall, since 2002, approximately 274,319 (29.3%) out of 934,264 OEF/OIF/OND veterans have sought treatment for PTSD according to the VA Healthcare Utilization Report (2012). The aforementioned authors demonstrate that PTSD is a prevalent issue with as many as half of the participants in some studies experiencing the disorder. However, since 2002, approximately only a quarter of service members have engaged in help-seeking for the disorder, possibly due to mental health beliefs based on cultural norms and stigmatic beliefs in the military.

Service members have culturally specific factors which may contribute to and exacerbate mental health issues. Exposure to higher levels of violence (Hoge et al., 2004) is a possible contributor to the PTSD diagnosis, creating a cultural environment where service members are more susceptible to stressors. With this in mind, understanding the mental health belief systems of service members, possibly at earlier stages, may help in reducing symptomology through earlier interventions. While PTSD may be the most prevalent of disorders affecting the military, other mental health issues are also of concern for the DoD.

Depression. Within the military population, 192 (32%) out of a sample of 602 Gulf War veterans were diagnosed with current or lifetime MDD between 1999 and 2002 (VA Healthcare Utilization Report, 2012). Additionally, MDD can be seen as a major mental health issue prior to 9/11, affecting more than a quarter of the sample. Whereas 11,264 service members were hospitalized with the same disorder between 1990 and 1999 (Hoge et al., 2002), 216,768 service members received a diagnosis of MDD between 2001 and 2013 (VA Healthcare Utilization

Report, 2012). Seal et al. (2010) further reported that 42.3% of service members ($n = 84,772$) diagnosed for the first time obtained diagnoses of depression between 2002 and 2008. It must be noted that direct comparison of these statistics is difficult due to variances in data collection times and methods as the SAMHSA only covers a year while the VA Healthcare Utilization Report covers somewhat above a decade. However, one can conclude that a significant portion of the military has been diagnosed and hospitalized with MDD both prior to and after 9/11 and that MDD is a growing diagnosis within this population.

When combined with the comorbid disorder of PTSD, MDD can present a tangible issue for service member preparedness (Schmitz et al., 2012). Despite the resources available, service members are reluctant to engage in treatment seeking behaviors for these issues due to stigma (Hoge et al., 2004). Given that stigma is linked to Mental Health Belief Systems (MHBS), which is directly influenced by cultural beliefs (Ward & Besson, 2012), an investigation into these beliefs would be prudent for this population. Additionally, the lack of treatment seeking behaviors may leave service members susceptible to negative coping strategies including suicide and substance abuse.

Negative Coping Strategies

Substance Abuse. Although alcohol abuse is not approved by Army standards (*Prohibited and Regulated Activities*, 2009) service members present with low, but significant diagnoses for alcohol issues. Between 1990 and 1999, 60,590 (1%) service members ($N = 4,815,864$) were hospitalized for an alcohol dependence disorder (Hoge et al., 2002). Similarly, post 9/11, 62,476 veterans were diagnosed with alcohol dependence syndrome between 2001 and 2013 (Veterans Affairs Healthcare Utilization Report, 2012). Despite being lower in prevalence

than PTSD and depression, a significant amount of service members still experience issues with alcohol with a low number of service members actively engaging in treatment.

The statistics presented are important to note because as stated above, alcohol abuse is often comorbid with PTSD, depression, and suicide (Bray et al., 2010), issues which directly affect the service member population. While there has not been a marked increase pre and post OIF/OEF alcohol dependence, the statistics are worth noting as the Army considers alcohol abuse inconsistent with their standards (*Prohibited and Regulated Activities*, 2009). Furthermore, research has demonstrated that service members feel that help-seeking for issues with alcohol are less stigmatizing than help-seeking for issues with mental health due to the stigmatic beliefs attached to mental health treatment (Gibbs, Rae Olmstead, Brown, & Clinton-Sherrod, 2011). Despite this, the SAMHSA (2010) report shows that a very low number of service members seek treatment for their issues with alcohol. This behavior may be attributed to the service member's beliefs about mental health and the culture of help-seeking that is perpetuated within this population.

Suicide. While not a diagnosable disorder, suicide is worth addressing as it is a possible, and highly undesirable, outcome for those with mental health issues. Formerly, suicide risk rates for service members were lower than the general civilian populations (Kang & Bullman, 2008); however, there has been increased reports of suicides within military populations with a roughly 50% increase in suicides between 2001 and 2008 (Ramchand, Acosta, Burns, Jaycox, & Pernin 2011). Prior to 2002, suicides within all branches of the military were decreasing, but after this period, rates rose within each branch (Allen, Cross & Swanner, 2005) with suicide rates rising from 10.3 per 100,000 in 2001 to 15.8 per 100,000 in 2008. SAMHSA (2010) reports that 4.6% of military personnel ($N = 28,456$) considered suicide within the year 2008 while 3.3% did not

consider suicide within that year, but have considered it since joining service. Ireland, Kress, and Frost (2012) analyzed data collected from the mental health examinations of 576,502 newly enlisted service members between the years of 2003 and 2006. The authors found that within that time, 1,454 of this population presented with suicide ideation during initial screenings through TRICARE. The authors also reported that 999 of the same population of service members attempted suicide or engaged in self-injurious behaviors prior to enlistment. Suicide ideation prior to enlistment is important to note as these feelings may affect the development of MHBS before joining the military. These individuals may have a different view of help-seeking due to their experiences with previous mental health issues, as they may have had contact with mental health professionals or have higher levels of psychoeducation. Finally, between the initial assessments in 2003 and a 2008 follow-up, 266 service members died by suicide (Ireland, Kress, & Frost, 2012). Authors Hyman, Ireland, Frost, and Cottrell (2012) looked specifically at suicide incidence rates and found that between two data collection dates, 2005 and 2008, there was an increase in suicide incidence rates in each branch of the military. According to latest reports, suicide rates within the Army were 20.2 per 100,000 (*Army Health Promotion*, 2011), slightly higher than the rates of the military overall with the Army National Guard above the Army at 31 per 100,000 (Griffith, 2012). From the reported statistics, one can see that there has been a marked increase in suicide within the military, justifying prevention efforts. As a possible outcome for mental health issues, suicide should be given continued attention by researchers and government agencies.

Using the presented statistics, one can determine that there have been increases in mental health symptomology since the beginning of OIF/OEF. Service members are being affected by their time in service, giving rise to instances of PTSD, depression, and the symptoms of these

disorders, substance abuse and suicide. Several researchers, to be discussed at length in Chapter two, have attempted to understand the link between these increased rates and treatment seeking. Researchers (Britt, 2000; Hoge et al., 2004) who have created seminal works have determined that mental health stigma is a significant barrier to help-seeking behaviors, even though few studies exist that investigate the cultural implications of armed forces membership and how this affects MHBS. These cultural understandings are important as they give insight into how MHBS are formed (Ward & Besson, 2012) and therefore, how stigmatic beliefs are developed. Therefore, it is imperative that researchers begin to investigate MHBS to understand the cultural underpinnings of stigma. However, prior to the investigation, it is helpful to note the resilience training initiatives put in place by the DoD to help decrease mental health stigma and increase help-seeking behaviors.

Current Approaches to Mental Health Treatment and Prevention

The increase in mental health diagnoses, suicides, and alcohol dependences have been a concerning issue for the DoD. It is important for the DoD to ensure that service members are at optimal performance to participate in various missions as each service member who is unable to participate in missions due to mental health issues leads to losses in manpower (Nash, Krantz, Stein, Westphal, & Litz, 2011). It is estimated that between 2001 and 2011, healthcare costs for the military rose 167% (Zoroya, 2011) with portions of the increase due to mental health issues as a result of increased deployments (Adams, Camarillo, Lewis & McNish, 2010). To ensure service members are mentally fit for duty, the DoD instituted resilience training initiatives, such as those found in the US Army, to increase mental health awareness and increase service member functioning.

The DoD has primarily used two curriculum for resilience training in the US Army. Sustainment Resilience Training (SRT; formerly Battlemind), was established in 2006 and used psychoeducation and group cohesion to build resilience in service members, their families, and civilians. SRT was eventually replaced in favor of Comprehensive Soldier Fitness (CSF) in 2010 which included elements of SRT but added testing throughout the program to assess the participants' needs and tailor the program accordingly. Through these programs, the DoD has sought to earnestly address mental health issues by equipping service members with the necessary skills to cope with the realities of combat.

There has been some success with resilience training but the issues these programs were meant to address, stigma and help-seeking, are still factors within this population. Researchers (Adler et al., 2011; Castro, Hoge, & Cox, 2006; Harms et al., 2013; Lester et al., 2011) have demonstrated the effectiveness of both Battlemind and CSF regarding reduction in mental health stigma. However, resilience was found to decline as deployment progressed (Carr et al., 2013), suggesting that mental health stigma may reappear as service members endure combat. Additionally, stigma and decreased help-seeking still remain a factor (Blais & Renshaw, 2013, Kehle et al., 2013, Price, 2011) despite concurrent resilience training. Therefore, it is prudent to investigate the mental health belief systems of this population to understand potential sources of their beliefs on mental health stigma and help-seeking.

Whereas the DoD has sought to curb mental health issues through the institution of resilience training, service members are still reluctant to engage in needed services (Iverson, 2005). Mental health stigma within this population has been identified as a possible barrier to seeking treatment (Hoge et al., 2004), resulting in service members possibly participating in combat while having a diagnosed mental health issue. The following section will detail previous

examinations of mental health stigma and help-seeking behaviors within the service member population.

Mental Health and Treatment Engagement

The rises in mental health illness diagnosis rates have demonstrated there is a need for service members' increased usage of mental health treatment. However, researchers (Hoge, Auchterlonie, & Miliken, 2006; Hoge, Castro, et al., 2004) have found that although service members have been diagnosed with mental health illnesses, they are not likely to receive or complete treatment due to avoidance of mental health services. One of the reasons cited for this lack of engagement is mental health stigma. It is important to note the chronological history and seminal works regarding mental health stigma research within the military. To begin, Britt (2000) found that service members were reluctant to engage in mental health treatment when asked to engage mental health professionals in front of other service members. Using the work of Britt, Hoge et al. (2004) developed questionnaire materials which assessed mental health stigma in military populations. Hoge et al. (2004) concluded that service members involved in OIF/OEF were reluctant to engage in mental health treatment due to fear of anticipated mental health stigma including judgment from leadership and peers and possible career hindrance. Finally, researchers have found that anticipated stigma is higher for those with mental health issues than those with substance abuse issues (Gibbs, Rae Olmstead, Brown & Clinton-Sherrod, 2011) and that anticipated stigma exists in service member populations outside the US (Gould et al., 2010; Iversen et al., 2011). The studies conducted by Britt (2000) and Hoge et al. (2004) informed most of the subsequent studies regarding mental health stigma with "stigma" being addressed in different ways. At this time, it is important to describe the types of stigma before addressing their impact on help-seeking behaviors.

Public stigma is the manifestation of cultural belief systems based on stereotypes and prejudices about a particular population (Corrigan, 2004). While this is the classification for overall stigma, stigma can also be broken into several categories based on the perspective of those affected. For example, *anticipated stigma* refers to the belief that one will be devalued or discredited by the community due to a stigmatizing label (Earnshaw & Chaudoir, 2009; Earnshaw & Quinn, 2012; Markowitz, 1998), likely affecting those who are not yet a member of the discredited group. However, *self-stigma*, likely affects those who may be members of the discredited group but have not divulged their status. Self-stigmas are internalized beliefs or prejudice regarding group membership which results in lowered self-esteem, self-efficacy, and self-deprecation (Markowitz, 1998; Perlick et al., 2001; Corrigan, Larson, & Ruesch, 2009; Livingston & Boyd, 2010). It is important to note here again that cultural beliefs are a significant determinant of beliefs regarding illness (Diefenbach & Leventhal, 1996). Therefore, if the culture of a population holds negative beliefs regarding mental illness, those beliefs are likely to create negative stigmas in reference to those with mental health issues. These negative stigmas are likely to decrease help-seeking behaviors as those with mental illnesses will want to avoid the stigmatic label.

Using these definitions, one can surmise that service members may avoid help-seeking for mental illness to avoid being ostracized from the primary group. Public stigma regarding service members' mental health beliefs may then become self-stigma as those who may need treatment internalize the negative beliefs regarding treatment seeking. This internalization creates anticipated stigma, as service members now believe that they will be judged and labeled if it is discovered that they have a mental health issue. These three factors create a venue where service members may recognize they have a mental health issue, but choose not to engage in

help-seeking to remain part of the larger group. Understanding these levels of stigma is important to investigate what cultural influences help to create overall mental health beliefs. Once the belief systems are known, it may be easier to combat stigma from the source through development of culturally specific programs and treatment protocols.

Based on the presented research, one can conclude that mental health stigma is a barrier to treatment within the service member population. Further research has linked mental health stigma to help-seeking behaviors, solidifying the assertion that those who receive a mental health diagnosis are reluctant to seek treatment. Warner, Appenzeller, Mullen, Warner and Greiger (2008) found that nearly 30% of service members were reluctant to seek treatment for a perceived or diagnosed mental health condition post deployment. Additionally, those who hold negative attitudes regarding mental health are less likely to seek treatment for prevalent service member diagnoses such as PTSD (Kehle et al., 2010). Finally, when directly related to mental health stigma, Blais and Renshaw (2013) have found that those who self-stigmatize regarding mental health are less likely to seek treatment.

From the overall information presented, one can conclude that there is a significant contingent of service members who are being diagnosed with serious mental illnesses but will not engage in services due to a reluctance to engage in help-seeking behaviors. When the treatment barrier of stigma is included, it can be surmised that those who fear the consequences of mental health stigma are less likely to seek treatment for fear of revealing their disease. While research in mental health stigma and resulting treatment-seeking behaviors has been firmly established, the sources of the stigmatic beliefs have not been sufficiently investigated. Therefore, it is important to note the roots of stigma through investigation of mental health belief systems as they are directly related to treatment seeking behaviors, which reduces the number of

service members ready to fight. For example, what are service members' beliefs about mental health prior to their enlistment? Additionally, how do these beliefs affect their current thoughts regarding mental health and help-seeking? Understanding the service member's MHBS and therefore, the roots of mental health stigma, will give researchers a baseline in knowing when and how to appropriately intervene regarding treatment. CSF is a start, but there may be other instances, for example pre-active duty, where the DoD can combat stigma and promote treatment seeking.

Theoretical Framework

The Common Sense Model for Illness Representation

To analyze overall beliefs about mental health, the conceptual framework used for this study was the Common Sense Model of illness representation (CSM) created by Diefenbach and Leventhal (1996). The authors of CSM see the individual as a problem solver who when dealing with an illness, will react based on the perceived severity and the emotional impact of the illness. The three central tenets of the model are a) the individual is an active problem solver seeking to understand and test hypotheses about their symptoms and the symptoms' relevance through media and interpersonal messages creating an illness representation; b) the illness representation is the central cognitive model which guides coping and treatment options for the perceived or diagnosed illness and; c) illness representations are specific to the individual and may not fit with medical facts (Diefenbach & Leventhal, 1996). Taken together, one can conclude that the individual creates a personalized picture of illness based on personal experience and socialization which include media and interpersonal communications that dictates how the individual responds to symptoms. Each individual reaches their definition of illness in the same fashion but their perspectives will be different due to personally experienced phenomena.

Individuals create their illness representations based on five attributes described by Diefenbach and Leventhal (1996): identity, timeline, cause, cure/controllability, and consequences. During the development of the Illness Perceptions Questionnaire, researchers Moss-Morris et al. (2001) added illness coherence and emotional representation to the CSM as factors which determine health beliefs. *Identity* refers to the label and the individual's ideas about an illness based on symptomology. *Timeline* identifies whether the illness is acute, chronic, or cyclic. *Cause* extends the definition of the illness by noting when and how the symptoms began. *Cure/Controllability* is the individual's perceived ability to alleviate the symptomology through personal or professional intervention. *Consequences* refer to the individual's beliefs regarding anticipated outcomes as a result of the illness. Finally, *illness coherence* details what an individual thinks about the illness while *emotional representation* is the emotional impact or response to the illness. These seven attributes combine to create a profile regarding the specific illness or phenomena. For this study, data analysis included a priori coding which used the aforementioned attributes as preliminary code groups during the analysis of the interviews. Collected data was matched to the attributes to create a profile of this population's overall beliefs of mental health.

The primary researcher used CSM to create a profile of the participants' thoughts, feelings, and beliefs regarding mental health. The constructs outlined in Chapter two (mental health stigma and help-seeking) were also addressed through the interview questions and drawn from the participants' responses. While the cited research has shown that beliefs about mental health and mental health stigma affect the help-seeking behaviors of active duty military, the current investigation presented an overall picture regarding the phenomena of mental health

within the US ROTC population while understanding if and how stigma and help-seeking is connected to these overall beliefs.

Alternative Frameworks Considered

To investigate the origins of mental health belief systems in service members, this study used the Common Sense Model of illness representation (CSM) as presented by Diefenbach and Leventhal (1996) as a theoretical framework, however, other options were considered prior to beginning research. The primary researcher also considered the Health Belief Model outlined by Rosenstock (1990). According to the model, those who believe that they are susceptible to a condition are also aware of the possible outcomes of their condition. Therefore the individual will attempt to reduce susceptibility to the condition through preventative care or care post-illness, with the benefits outweighing the costs (Rosenstock, 1990). The difference between the Health Belief Model and the CSM is that the Health Belief Model is more an explanation of behaviors related to illness. The model gives more focus to actions and outcomes than to beliefs. The intent of this investigation was to understand the mental health beliefs of ROTC students which may link to behaviors such as stigma and help-seeking. The Health Belief Model may have been more appropriate if the investigation focused on the results of stigma instead of the sources, focusing more on behaviors than beliefs. The purpose of this study was to understand the possible roots of behaviors through understanding beliefs. Therefore, it would not have been possible to achieve the goal of understanding beliefs using a model which analyzes behaviors. As this study was primarily focused on the origins of mental health stigma through the analysis of mental health beliefs, the CSM was the most fitting choice.

The Common Sense Model was used as the purpose of the model was more applicable to the current investigation. Diefenbach and Leventhal (1996) asserted that the individual reacts to

perceived illness based on cognitive and emotional schemas built from previous experiences and socialization, which can also be defined as cultural beliefs. Based on the model, individuals are problem solvers seeking to test hypotheses about their illnesses based on symptomology and previous cognitive models. Taken together, these models (illness representations) dictate how an individual views illness and treats illness, which may or may not align with medical fact (Diefenbach & Leventhal, 1996). For the purposes of this study, CSM was used to conceptualize how service members view mental illness and subsequent help-seeking. This model is more useful for this study as it allows the researcher to capture an overview of service members' beliefs as opposed to only behaviors. This is important as the aforementioned research has demonstrated that beliefs (stigma) drive behaviors (help-seeking), therefore making beliefs the best phenomena to investigate. Through phenomenological investigation, this study sought to understand the thoughts, feelings, and beliefs of participants in regards to mental health. This information was analyzed through the lens of CSM, creating an illness representation of mental health for the target population.

Statement of the Problem

Military researchers (Britt, 2000; Hoge et al., 2004) have suggested participants who screened positively for mental health issues may have avoided help seeking due to established cultural norms and fear of possible backlash linked to self-stigmatization. Langston, Gould, and Greenberg (2007) stated that the stress related elements of the military environment exacerbated mental health issues by promoting stigma among its members. This member promoted stigma is linked with cultural values where service members believe they will be seen as weak due to experiencing emotional stress (Greene-Shortridge, Britt, & Castro, 2007; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Mental health issues can affect job performance as

service members may not be able to perform their required duties, which in turn can cause service members to view others (and themselves) as broken, unreliable, or useless (Gibbs, Rae Olmstead, Brown, & Clinton-Sherrod, 2011).

Researchers (Greenberg, et al., 2007; Greene-Shortridge, et al., 2007; Hoge et al., 2004; Pietrzak, et al., 2009) have all recognized stigma as a significant barrier to mental health treatment as service members are reluctant to engage in help-seeking behaviors to avoid labeling. Additionally, each of these authors has advocated for increased support for those with mental health issues in the form of new programs and leadership support. The military has attempted to address both of these suggestions with the introduction of resilience training and increased screening for mental health issues (Bowles & Bates, 2010; Morgan & Bibb, 2011); however, these interventions have focused on the end result of decreasing stigma and increasing treatment engagement without assessing the reasons why the stigma exists, nor the origins of the stigmatic thinking. Additionally, the seminal pieces by Britt (2000), and Hoge et al. (2004), which have served as the basis of numerous other studies regarding mental health stigma have only identified that stigma exists without identifying the belief systems which underlie stigmatic beliefs (Vogt, 2011). Researchers (Britt, Wright, & Moore, 2012; Gould et al., 2010; Iversen et al., 2011; Kim, Britt, Klocko, Riviere, & Adler, 2011; Rae Olmstead et al., 2011; Wright et al., 2009) used the questions developed by Hoge et al. (2004), based on questions found in the Britt (2000) study. Moustakas (1994) asserted that research into phenomena begin with a qualitative investigation to understand the participant's experience. Britt completed a mixed-methods study regarding stigma in the military workplace, however, the qualitative results were marginalized in favor of quantitative results. Additionally, as mentioned by Vogt (2011), Britt's study proved the existence of stigma without investigating the belief systems which create stigmatic thinking.

While the work of Britt (2000) and Hoge et al. (2004) have been integral to understanding mental health stigma and barriers to mental health treatment in service member populations, more work still must be done to understand the sources of said stigma. Understanding the MHBS will create another viewpoint to mental health stigma, enhancing the work that has been previously completed. Learning the MHBS of this population, and ROTC students in particular (given their status as pre-service members), will give insight into how future officers view mental health and thus inform the MHBS of the soldiers they will one day lead. The results of this study may be used to help inform the development of another intervention point to reduce future stigma and increase help-seeking.

Purpose of the Study

Unfortunately, although the military is making an effort to remove stigma from mental health issues, prevalence rates are still at high levels. A reason for this may be due to a lack of attention to service members' mental health belief systems. Previous literature has addressed the existence of stigmatization but has not addressed where this stigmatization originates or how stereotypes are developed (Vogt, 2011).

The purpose of this study was to discover the belief systems of US Army ROTC members regarding mental health to understand the sources of mental health stigma. Supporting this purpose, Vogt (2011) suggested that further research regarding mental health belief systems should be conducted using sub-groups of service members to ascertain differences between these groups. For the purposes of this study, US Army ROTC members were used in order to assess belief systems at one of the earliest stages of cultural indoctrination. This population is important as commissioned ROTC members become officers in the US Army, where their MHBS will affect enlisted members. Knowing the MHBS of this population may help to identify an early

intervention point where efforts to decrease stigma and increase help-seeking behaviors could be implemented. However, without knowing the MHBS of this population, one cannot begin to understand the best ways to target mental health stigma as the origins of their beliefs (which inform stigma) are yet unknown. Using the results of this study, the author created an illness representation of the mental health belief systems of US Army ROTC students. This illness representation gave insight into how US Army ROTC students view mental health during the early immersion stages of military life. The results demonstrate how previous influences and military influences create a view of mental health at a time where military ideas are still new.

Research Questions

Previous research has revealed much using quantitative assessments; however, there are questions which are best answered through qualitative review. Based on a review of the literature, the focus of this study will be guided by the following research questions:

1. What are US Army ROTC students' thoughts, feelings, and beliefs about behavioral health?
2. What themes emerge from the ROTC students' mental health belief systems that can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members?

There will be a further explanation of the research questions included in Chapter 3.

Definition of Terms

The following terms are defined as they will be applied to the proposed study.

Stigma is defined as cognitive, emotional, and behavioral aspects of a given label which are demonstrated as stereotypes, prejudice, and discrimination (Werner, Corrigan, Ditchman, & Sokol, 2012).

Anticipated stigma is the belief that others will react negatively if help-seeking behaviors are made known (Blais & Renshaw, 2013).

Self-stigma is an internal devaluation based on the perceptions of others regarding the individual's label (Corrigan et al., 2012).

Help-seeking will be defined as seeking either formal or informal services for specific ailments or illnesses (Barker, 2007) due to the focus on initial contact with help-seeking services.

Mental Health Belief Systems are overall conceptions of mental health held by an individual. Belief systems may be a) culturally rooted; b) cross-generational; c) socially transcendent; and d) contain elements of Eurocentric conceptions of mental health (Olmstead & Smith, 1980).

Rationale for the Research Approach

This study employed a qualitative research design, specifically hermeneutic phenomenology. Phenomenology is the study of the lifeworld with the aim of gaining a deeper understanding of daily experiences (van Manen, 1990). Research objectives were achieved through the use of semi-structured interviews and member checking using current US Army ROTC students. Research materials also included observation forms completed by process observers, memos completed by the primary researcher, and consultation with experts in the field of study.

While there has been much informative research regarding stigma and mental health in the military, there are certain protocols which should be followed in the development of any body of research. Gall, Gall, and Borg (2007) outlined a process for research which includes a

phenomenological inquiry, the development of a grounded theory, instrument development and examination, and experimentation. This process is supported by Moustakas (1994) who recommended a phenomenological investigation when beginning research on a new topic. In order to understand human life, knowledge must be generated to break down its complexity (van Manen, 1990) necessitating phenomenological inquiry into the MHBS of Army ROTC students. While it is not a requirement that researchers follow this process, educational texts such as the aforementioned citation urge this process to strengthen the basis of research. The research regarding mental health stigma in military populations has created a strong body of literature, but there has not been a strong qualitative foundation, particularly as it relates to the origins of stigma.

The lack of research protocol does not invalidate all of the literature regarding mental health stigma and the military but it does mean that the current literature should be further evaluated. Rosen and Corcoran (1978) were among the first to study mental health stigma within military populations, however, this study is not widely used as the basis of succeeding literature possibly due to its age. Britt (2000) was the first to analyze mental health stigma within Army populations, and his work was the basis for the stigma questionnaire created by Hoge et al. (2004). Britt's study used civilian literature to create his assessment without completing a qualitative evaluation of the military workplace. The author therefore generalized the "workplace" while designing questions for the study without giving special attention to the dynamics of the service member's environment, resulting in a culturally inaccurate assessment.

Britt's work has had lasting influence over the measurement of mental health stigma within military populations. Hoge et al. (2004) then used Britt's (2000) assessment as the basis for their stigma questionnaire, a seminal work in military mental health stigma research. Hoge et

al.'s stigma questionnaire may have thus had some flaws as it was based on in Britt's (2000) work and it also did not complete a qualitative assessment of the military workplace at the time. OIF/OEF likely caused changes in beliefs regarding mental health but these views and the atmosphere of the workplace have not been taken into account. The findings and questionnaires used by Hoge have been cited and used in several studies on mental health stigma in the military population, creating a body of literature based on research that would have benefited from a phenomenological investigation. Since the questionnaire designed by Hoge and all subsequent studies using this questionnaire have been based on questions that were not specified to the population it is now important to investigate MHBS in order to understand mental health stigma within the context of today's cultural dynamics. The best way to achieve this understanding is through qualitative analysis.

A qualitative evaluation of service members is necessary for several reasons. The first is to assess the current landscape of beliefs about mental health in pre-service leaders and how they relate to the established constructs of stigma and help-seeking behaviors. This is necessary as there have been links to mental health stigma, help-seeking, and leadership, giving importance to a study of pre-service leadership (Britt, Wright, & Moore, 2012; Hoge et al., 2004; Wright et al., 2009). Secondly, it is important to answer the question of how mental health messages are being established within service member populations to determine the sources of the stereotypes regarding mental health. Again, seminal research (Britt, 2000, Hoge et al., 2004) has established the presence of stigma but there has been limited investigation regarding the sources of stigmatic beliefs. Understanding the current landscape of beliefs and how beliefs are established will give insight into the beliefs of those who will work with enlisted service members upon commission. Again, these students may become officers upon program completion, where their MHBS will

influence enlisted members. Therefore, it is important to understand their beliefs at this early stage to understand what types of beliefs will be carried to enlisted members who may need mental health treatment. Due to the age of the Britt (2000) study, the lack of emphasis on qualitative information, and its focus on active duty instead of early stage service members, it is time to re-evaluate the mental health beliefs of the pre-service member population to create a more timely and accurate picture of the phenomena. In order to understand the experiences of those within this population in regards to mental health stigma, a qualitative approach is the most appropriate for this research study.

There are certain cautions in using any research design. Specific to qualitative, the primary researcher sought to reduce bias by including methods for rigor and trustworthiness introduced by Creswell (2013) and Carlson (2010). Bias reduction methods involved including auditors at several points of the research process namely during the design of the research methodology, research, and interview questions. External auditors were also used during data collection and analysis. Additionally, the primary researcher included methods which introduce researcher transparency such as a positionality statement. Additional measures for rigor and trustworthiness will be fully explained in Chapter three.

Significance of the Study

Primarily, the knowledge gained from this study can be used to inform future research into this population. This was the first study to investigate the Mental Health Belief Systems of pre-service leaders in the form of ROTC students. The results of this study uncovered many beliefs regarding mental health including causes for mental health issues within the military population, preferred methods for treatment, and early stigmatic beliefs. The results of this study

should be used to inform further research, as there were many questions which still bear investigation based on the information presented.

Summary

Post September 11, 2001, the military has been engaged in several combat scenarios in the Middle East. These combat engagements have resulted in increased deployments, separation from loved ones, and exposure to violence, all of which have been linked to increases in mental health issues. Although the DoD has instituted resilience training in an attempt to stem some of these mental health issues, there are still high incidences of mental health diagnoses in the form of PTSD and depression in addition to negative coping strategies such as suicide and alcohol abuse. Stigma toward help-seeking behaviors has been linked to a lack of mental health treatment within this population, but the origins of these factors have yet to be discovered. Therefore, it is important to investigate the MHBS of US ROTC students as their roles as future leaders will directly impact stigma and help-seeking within the enlisted population.

Organization of the Study

Chapter one discussed the prevalence of mental health issues within US military populations with prominent issues including PTSD, depression, and suicide. A statement of the problem explained how the initial mental health messages contributing to mental health stigma have not been studied in previous literature. Next, there was a defense of the research approach and a presentation of the overarching research questions. Finally, a significance of the research was described along with a definition of terms.

A review of the literature in relation the issue of mental health in the military will be provided in Chapter two. Specifically, the constructs of mental health belief systems, mental

health stigma, and help-seeking behaviors will be presented in more depth. Additionally, relevant research associated with these constructs with a specific focus on the military population will be explored.

The research methodology for investigating the initial messages that US Army ROTC members receive regarding mental health will be presented in Chapter three. The Chapter will also include the interview questions that will be used during the study and the process used to formulate these questions based on the research questions. Finally, Chapter three will include research protocols and data analysis procedures including steps to ensure rigor and trustworthiness. Results of the research and data analysis will be presented in Chapter four. Finally, conclusions and implications for the research data will be presented in Chapter five.

CHAPTER II

Introduction

The purpose of this study is to understand the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. This population is important because those who are commissioned in the Army during the ROTC program will become officers upon graduation, serving in leadership positions. As will be presented in in this Chapter, leadership is connected to stigma and help-seeking behaviors, making it important to understand ROTC student's views on mental health and those who may need treatment. Therefore, it is important to investigate ROTC students' mental health belief systems as they give insight to the possible presence of stigma and thoughts on help-seeking.

As presented in Chapter one, the Department of Defense (DoD) has given increased attention to the mental health concerns of service members as a result of rising mental health diagnoses. Service members have been diagnosed with PTSD and depression but are not engaging in needed treatment which the DoD has attempted to address through increased, branch specific, emphasis on resilience training. However, prevalence rates for mental health have still increased, with mental health stigma identified as a contributing factor to treatment avoidance (Hoge et al., 2004). This reluctance to engage treatment suggests that more must be done to investigate the roots of mental health stigma within sub-populations of the military.

Stigma is borne from cultural beliefs about mental health (Corrigan, 2004), therefore, it is important to understand the cultural beliefs of a population to ascertain their overall beliefs about mental health and possible links to stigmatic thoughts. To this end, it would be prudent to understand the cultural beliefs of US Army ROTC members, specifically, their overall mental health belief systems, to understand their relationship to mental health stigma and possible help-

seeking behaviors. The following Chapter will give an overview of mental health belief systems, mental health stigma, and help-seeking beliefs and behaviors of the service member population, primarily active duty Soldiers. The Chapter will conclude with a summary of the presented research and a rationale for the current investigation.

Mental Health Belief Systems

Overall Mental Health Belief Systems (MHBS) have been conceptualized as beliefs about the character and competence of individuals with mental health issues and one's level of comfort in interacting with them (Vogt et al., 2013). Belief systems can also be classified as an attitude, opinion, stereotype or ideology (Olmstead & Smith, 1980), suggesting that each of these terms is interchangeable in the literature and measure respondents' thoughts regarding the phenomena. Overall MHBS determine an individuals' thoughts about mental illness and possible reactions to themselves or others who have mental illness. One's beliefs regarding mental illness will determine their beliefs regarding the validity of an illness treatment necessity. Therefore, it is important to understand belief systems as they are indicative of factors including treatment adherence, clinical outcomes, and help seeking behavior (Edlund et al., 2008).

It should be noted that MHBS are neither positive nor negative and the stereotypes created may not have a negative connotation (Olmstead & Smith, 1980); however, when MHBS are viewed negatively, mental health stigma becomes a factor in research (Ward & Heidrich, 2009; Vogt et al, 2013). This is important to note as the cognitive schemas created by mental health beliefs inform stereotypes regarding the mentally ill, which then inform the stigmatic beliefs individuals hold regarding the mentally ill (Corrigan, 2004). If behaviors of the mentally ill are continually seen as negative due to MHBS, these views may contribute to anticipated and self-stigma. Help-seeking behaviors would therefore be lowered as views regarding overall

mental health or illness will be seen as negative. Given this information, it is important to note when negative relationships exist between MHBS and stigma those with mental health issues may not feel comfortable acknowledging mental health issues or realize their own biases regarding mental health, therefore affecting the individual's willingness to seek treatment (Vogt, 2011).

As noted above, cultural beliefs are indicators of mental health stigma (Corrigan, 2004) which can be understood through investigating MHBS. Therefore, it is necessary to understand how culture impacts MHBS to give insight to views on mental health stigma and help-seeking behaviors of specific population. The following section will detail culture's impact on overall MHBS and beliefs about specific illnesses. The section will continue with an overview of the research regarding service members' MHBS and a summary of the presented literature.

Culture and Belief Systems

Mental health belief systems have a strong cultural component, as the beliefs of those in the individual's community have a significant effect on how individuals perceive mental illness. Olmstead and Smith (1980) conceptualized MHBS as deep seeded, cultural beliefs regarding mental health which are cross-generational, transcend social structure, and have commonalities with European conceptions. Further, these beliefs are informed by influences including socialization and cultural norms (Diefenbach & Leventhal, 1996; Scheff, 1966) that when taken together, suggest that individuals form MHBS through consistent, transcendental cultural messages that are reinforced through interaction with others.

Through cultural interaction and generational reinforcement, MHBS are created and eventually solidified. Scheff (1966) found that MHBS formation began as early as childhood and are continually reaffirmed through social interaction where eventually, teenagers adopt the

MHBS of adults as they matriculate through adolescence (Olmstead & Smith, 1980). Through these cultural influences and interactions, individuals form cognitive schemas of mental illness including beliefs about what mental illness looks like, opinions of those who are mentally ill, symptom description, and treatment seeking behaviors (Parham 2002; Sue & Sue, 2003). In summary, MHBS are formed early through cultural interaction and determine how individuals perceive mental illness and treatment. One can assume that different cultures will have different views on mental health, which warrants a discussion on how cultural membership changes MHBS.

Based on cultural membership, individuals have different conceptualizations of the concept of mental health and those who have mental health issues. Using race as a cultural group, researchers have found that African Americans associate mental health with shame and embarrassment with these factors being applicable the individual with the illness and the family of the individual with mental illness (Thompson-Sanders et al., 2004). Regarding location, differences have been found between urban and rural populations with those in urban settings having more positive attitudes about mental health services than rural dwellers (Hayslip, Maiden, Thomison, & Temple, 2010). Differences in age include older adults viewing mental illness as a personal failure or spiritual deficiency (Lebowitz & Niedereche, 1992), and the belief that they will be labeled as crazy or placed in a mental institution or nursing home if mental health issues are revealed (Cole et al., 2009). Finally, in terms of gender, researchers (Fischer & Manstead, 2000) assert that women are more socialized to express mental health symptoms more than males due to cultural expectations. Further, Sigmon et al. (2005) found that women reported greater attention to and fear of mental health issues than men. It can be seen from these studies that different aspects of culture such as race, location, age, and gender affect overall MHBS including

how individuals react to and are affected by mental illness. However, in addition to culture, specific illness has also been found as a factor affecting MHBS.

Specific Diagnoses and Belief Systems

Outside of overall MHBS, individuals may have belief systems regarding specific diagnoses, changing beliefs regarding the causes of mental illness and help-seeking behaviors. For example, individuals are less accepting of those diagnosed with depression versus schizophrenia and believe that childhood issues (Schomerus, Matschinger, & Angermeyer, 2013) and psychosocial stress (Angermeyer et al., 2013; Munizza et al., 2013) are the sources of depression. Regarding help-seeking, respondents felt that seeing one's general practitioner or a mental health specialist was the best method for alleviating this illness (Angermeyer et al., 2013; Munizza et al., 2013). Respondents of studies related to PTSD were able to identify the symptoms of the disease (Reavley & Jorm, 2011) and believed the illness is caused by a traumatic event, physical pain/impairment from an injury or environmental factors (Wong, Kennedy, Marshall, & Gaillot, 2010). Regarding help-seeking, individuals believe that religion, avoidance of negative thoughts, and family members (Greenberg, Gould, Langston & Brayne, 2009; Wong et al., 2010) and family members were the best resources for symptom alleviation. Based on the differences in identification, causes, cures of PTSD and depression, one can surmise that MHBS change based on the specific illnesses.

While not a diagnoses, there are also differences in individuals' MHBS of mental health issue outcomes. When questioned about suicide, respondents shared beliefs that were positive in connotation and felt that suicide was preventable with optimism being important component to treatment (Norheim, Grimholt, & Ekeberg, 2013). Additionally, those with suicide ideation or attempts are more likely to seek treatment than those with a mental health issue but no suicidal

issues (Pagura, Fotti, Katz, & Sereen, 2009) suggesting that suicide is viewed less negatively than mental health issues. Taken together, one can surmise that beliefs differ regarding suicide, with individuals attributing more stigma to mental health issues than those who have issues with suicide.

Based on the illness type or, in the case of suicide, coping strategy individuals hold different beliefs regarding cause and cure. As stated above, the cultural beliefs of a population determine the overall MHBS of individuals and these can change as one specifies the illness. The information presented above show that beliefs of mental health issues common to the military (PTSD, depression, and suicide), change depending on the illness in civilian populations. At this point, it is prudent to shift from civilian perspectives and discuss service members' overall MHBS, as the military is the primary population of investigation for the current investigation.

Service Members' Mental Health Belief Systems

Expression of symptomology is determinant on the culture to which one belongs (Diefenbach & Leventhal, 1996), which suggests that the culture of the military has an effect on how MHBS are shared within the population. The membership of the military exists within a "culture of masculinity," supported by a Combat Masculine-Warrior (CMW) paradigm (Dunivin, 1994). Within the CMW paradigm, the traditional model of a service member includes masculine views and norms (Dunivin, 1994) which emphasizes traits such as bravery, courage, impassivity and hardness while deemphasizing behaviors such as overt displays of emotion (Wessely, 2006). The CMW, combined with cultural expectations due to MHBS, would suggest that service members are not encouraged to express issues regarding mental illness, despite anti-stigma programming.

Military culture has an underlying tone of male normalcy and female deficiency, causing anyone who behaves in a manner outside of masculine norms to be met with negative evaluation (Tavris, 1992). Therefore, those who may show “weakness” through expressing symptomology or help-seeking are viewed negatively in light of what is expected and accepted behavior of a service member. Changing the MHBS of service members through programming should influence negative beliefs regarding mental health as Cole et al. (2009) found, to this end, the DoD has attempted to change the culture informing MHBS through the psychoeducation components of its resilience training efforts. However, the dominant culture of the military dictates that service members display a certain amount of “emotional toughness,” competence, and confidence which may contribute to mental health stigma (Nash, Silva, & Litz, 2009; Sayer et al., 2009). Therefore, it is important to investigate the culture of the military, and in the case of this study, the ROTC, to understand the beliefs which inform MHBS. Through analysis, one can possibly understand the cultural views of the population regarding negative views of mental health, stigma, and help-seeking to begin strategizing ways to counteract these negative factors.

Besides gender, the narrative of MHBS also changes with time and exposure to those with certain illnesses (Diefenbach & Leventhal, 1996). As cultures gain more exposure to those with mental illness and as specific illnesses become more understood, MHBS adapt to the current cultural beliefs. Examples of this phenomenon can be seen in the development of how PTSD is understood in the military population. Lack of knowledge regarding PTSD at the service provider and societal level created a barrier to care for Vietnam veterans (Sayer et al., 2009), resulting in lower instances of treatment seeking in Vietnam veterans (Hoge et al., 2004; Kulika et al., 1990). After 9/11, PTSD has become a more recognized and diagnosed treatment

(Hoge et al., 2004), contributing to the development of treatment protocols and psychoeducation (Castro, Hoge, & Cox, 2006).

This decision to include psychoeducation is important to note as knowledge and exposure changed the MHBS of those with PTSD. When thinking of ROTC, their MHBS will change as they are exposed to more experiences with service members with mental health issues. As they spend more time in service, they are also likely to absorb the cultural messages of more seasoned service members, adopting the MHBS of those around them. Therefore, it is important to understand the MHBS of ROTC members prior to exposure to the enlisted culture to understand their thoughts regarding stigma and help-seeking. There have been investigations regarding service member's MHBS in various aspects, giving a picture of their thoughts of mental illness.

Mental Health Belief Systems Outcome Studies

To date, there have been few studies conducted using US Army Soldiers and no studies using US Army ROTC students detailing the overall MHBS of either population. The US Army is the primary focus of this study due to its relative size as compared to the other branches of the military, with almost twice the number of service members than all other branches (United States Department of Defense, 2013). Therefore, the current investigation will use the US Army as the target population in the belief that research done with these participants has the chance to affect the most individuals and has the greatest number of possible participants. More specifically, the current investigation uses US Army ROTC students to investigate mental health stigma and help seeking behaviors.

Although there have not been studies regarding overall MHBS and the US Army, other authors (Rosen & Corcoran, 1978) have focused on other branches including the US Air Force. These studies address belief systems through mental health stigma, treatment seeking, or a

specific illness such as PTSD (Vogt, 2011) as opposed to overall beliefs. Additionally, those that did give attention to mental health beliefs only did so using few questions and overall beliefs were not the primary intent of the study (Vogt, 2011).

Other branches of the military have investigated overall MHBS, however, the research is out of date. Despite this, it is prudent to mention these studies as they are the only ones available which investigate overall MHBS within the military. The earliest study regarding MHBS of service members was conducted by Rosen and Corocoran (1978) using members of the US Air Force (USAF), which investigated the overall MHBS of active duty USAF officers ($n = 455$) and compared these to the overall MHBS of active duty USAF mental health professionals ($n = 40$). Using survey design, participants were asked to complete the Opinions About Mental Illness Scale (OMI; Cohen & Struening 1962) which assesses overall mental health beliefs and divides them into five categories including authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. The participants were also asked to complete a demographics sheet which detailed age, sex, length of military service, flying status, occupational designation, rank, and years of education after high school. The authors found that those with four or less years of education following high school viewed the mentally ill more paternalistically and overall, officers were less likely to assume a kindly, paternalistic approach than mental health professionals (Rosen & Corocoran, 1978). Additionally, there were significant differences found in OMI scores between officers and mental health professionals regarding authoritarianism, benevolence, mental hygiene ideology, and social restrictiveness. The authors state that the officer group was “much more authoritarian in approach, viewed the mentally ill as a much greater threat to society, and were much less likely to view mental illness as an illness like any other” (Rosen & Corocoran, 1978, p. 571-572). However, when viewed

without comparison, the authors found the officers overall high in benevolent attitudes and low in authoritarian, socially restrictive beliefs.

Before interpreting the results of this article, a few limitations should be reviewed. To begin, attitudes may have shifted regarding mental health due to the relative age of the study and an update would be beneficial as climates within the military have shifted. Additionally, the study focused on members of the USAF and may not be generalizable to those of other branches of the military as article presented the MHBS of USAF officers and compared them to USAF mental health professionals. It can be inferred from the results that overall, officers believe that the mentally ill should be afforded the proper treatment and are not a danger to those around them. However, when compared to mental health professionals, officers appear less benevolent and perceive the mentally ill as a danger to society. This would suggest that while officers see the mentally ill as a population that deserves care, they are less equipped than mental health professionals in how to show compassion to those who are mentally ill. In regards to the current investigation, it is important to know the MHBS of service members as it gives credence to stigmatization and treatment seeking behaviors. Those who believe that the mentally ill deserve proper care may be less likely to hold stigmatic beliefs regarding those who are mentally ill within their ranks and may support them in treatment seeking. Specifically regarding ROTC students, as they will eventually become officers upon graduation, this study gives insight into the views of those who will lead enlisted members. The authors found that officers were protective of those with mental illness but held more stigmatic beliefs than mental health professionals. Therefore, it may be prudent to understand overall MHBS from an earlier point of cultural exposure, such as the ROTC, to assess beliefs about mental health stigma help-seeking behaviors.

Several studies have attempted to assess MHBS in the service member population but have had success in varying degrees. Vogt (2011) completed a meta-analysis investigating those who have investigated the MHBS of the service member population. Of the 15 studies gathered, Vogt found that only two qualitatively assessed personal beliefs regarding mental health. However, neither of these studies investigated overall beliefs and instead focused on beliefs regarding specific illnesses. Edlund et al (2008) investigated beliefs about depression and treatment adherence while Lysaker, Tsai, Yanos, and Roe (2008) investigated self-esteem as it relates to beliefs about mental health (using a measure for stigma) in patients with schizophrenia. While these studies are important to the body of knowledge, it is difficult to understand overall MHBS through investigation of specific illnesses. The previous studies have shown that beliefs regarding specific mental illnesses can change depending on the beliefs, therefore, it is difficult to assess overall mental health using beliefs for specific illnesses. Therefore, it is necessary to begin phenomenological investigation into the overall MHBS of the military population to supplement the quantitative work that has been completed.

The lack of qualitative studies regarding overall mental health beliefs as gathered by Vogt highlights the need for more research in this area. Qualitative investigation gives researchers the opportunity to explore the lived experiences of a population (Creswell, 2013), which yields a different picture of a phenomena than quantitative studies. Important studies such as Hoge et al. (2004) highlight that important conclusions can be made from quantitative research, however, this may not be the best place to start with ROTC students as the phenomena regarding stigma and help-seeking is not yet understood within this population. Qualitative investigation may be the best place to start with ROTC students as it is important to first have a complete understanding of the phenomena as it relates to a population before assessing it

quantitatively (Moustakas, 1994). To this end, the current investigation will use phenomenological qualitative methodology to investigate the MHBS of US Army ROTC students to learn more about their views of mental health, mental health stigma, and help-seeking behaviors.

Summary

This section introduced both overall MHBS and MHBS based on specific illnesses. Both of these concepts include individuals' thoughts and beliefs regarding mental illness which determine how symptomology and treatment are viewed. It should also be noted that these beliefs are influenced by culture and changes depending on the beliefs of the group. Regarding the military, strong masculine cultural beliefs mean that sharing and admitting to mental illness is seen as a weakness. Therefore, service members are likely to carry stigmatic beliefs regarding mental health treatment and less likely to engage in help-seeking behaviors. Officers believe that those with mental illness deserve treatment but are less informed about mental health than mental health practitioners. Therefore, this study is important as understanding the MHBS of ROTC students, future officers, can give insight into stigmatic beliefs that may be held at an early stage of the military career and how they are initially developed. Prior to this, there needs to be discussion on the definition of mental health stigma and its current prevalence in the service member population.

Mental Health Stigma

Overview

While it is often necessary to engage in regular mental health treatment after diagnosis, researchers (Deane & Todd, 1996; Kelly & Achter, 1995; Sirey et al., 2001) have identified

mental health stigma as a hindrance to treatment engagement and adherence. Mental health stigma exists internally and externally (Corrigan, 2004; Ritsher & Phelan, 2004) and their relationship can affect treatment seeking. Internal mental health stigma, or *self-stigma*, causes individuals to internalize negative messages or prejudices regarding mental health resulting in lowered self-esteem and self-efficacy (Markowitz, 1998; Perlick et al., 2001; Corrigan et al., 2009; Livingston & Boyd, 2010), also possibly reducing treatment seeking behavior. Internal stigma also includes *anticipated stigma*, where individuals avoid divulging information due to the belief membership in a stigmatic group will cause them to be discredited (Earnshaw & Chaudoir, 2009; Earnshaw & Quinn, 2012; Markowitz, 1998).

Conversely, *external stigma* includes negative beliefs and attitudes held by a cultural group regarding a sub-group. These attitudes are based on stereotypes and encompass the larger group's beliefs using specific attributes of the sub-group (Corrigan, 2004). External and internal stigma is related as external stigma is used to inform internal (self) stigma. This can be seen in the avoidance of help-seeking in military populations. In military populations, researchers (Hoge et al., 2004) have linked anticipated stigma to avoidance in help seeking after being diagnosed with a mental illness (Hoge et al., 2004). This avoidance occurs as those with issues may wish to keep their mental health status a secret (Corrigan, 2004). It is possible that service member's self-stigma is a result of messages received from external stigma, resulting in anticipated stigma and avoidance of help seeking.

Combined, both external and internal stigma can be seen as a deterrent to help-seeking as individuals fear marginalization from the primary group (Langston, Gould, & Greenberg, 2007). Perceived ostracization causes those with mental health issues internalize the negative beliefs of the main group, therefore reducing help-seeking in efforts to avoid negative labeling. This is

important to note as the military strongly promotes a group culture (Langston, Gould, & Greenberg, 2007), creating a necessity for belongingness to the primary group.

The process of stigma development includes a continuum beginning with observation and ending with observable behavior. Stigma can be defined as negative and erroneous attitudes about a person based in prejudice or negative stereotype (Corrigan & Penn, 1999). Goffman (1963) stated that stigma can be “deeply discrediting” (p.3) and stigmatized individuals have been defined as “deviant, flawed, limited, spoiled, or generally undesirable” (Jones et al., 1984 p. 6). These negative labels alienate those who are stigmatized from overall society, creating a feeling of exclusiveness that individuals will attempt to avoid. In regards to the military, it is prudent to avoid negative labeling as the structure of the military, including acceptance and job promotion, is dependent on the opinion of fellow service members and commanding officers (Baldwin, 1996). Therefore, any behavior which may alienate oneself from the primary group is to be avoided. Given this definition of stigma, it is also important to know how stigma is developed within populations.

Development of stigma can be attributed to a process where thoughts and beliefs about a marginalized population develop into widely accepted stereotypes and end in observed treatment of stigmatized individuals. Corrigan (2004) detailed previous research which described how the observable manifestations of mental health issues (i.e. decreased social skills and poor personal appearance) creates initial images of how individuals perceive those with mental illness, which contributes to a cultural view of the disease. These initial images create stereotypes which are used to judge those within the stigmatized group. Prejudiced individuals then endorse negative stereotypes and negative emotional reactions which can lead to discrimination, the behavioral response to the aforementioned emotional reactions. Self-stigmatization results from attempts to

avoid discrimination from others while those with concealable stigmas (i.e. sexual orientation, faith) will seek to avoid discrimination by denying group status, thereby avoiding the stigmatizing labels which may occur (Corrigan, 2004; Corrigan & Matthews, 2003). However, by dissociating themselves from the stigmatizing group, the individuals may avoid help seeking (i.e. mental health treatment) in fear of attaining a stigmatizing label. The aforementioned progression details how mental health stigma is formed from perceptions and develops into discrimination, the observable outcome of stigmatic thinking. Once these ideas have manifested, they exist externally, shared by the population, or internally, specific to those who may have a mental health illness. The following section will detail the perceived sources of mental health stigma and its effects on help seeking behaviors within the military populations, primarily the US Army.

Overall Stigma

There have been two seminal studies which investigated beliefs of service members regarding overall stigma. In the first of these, Britt (2000) examined how public and private screening for mental and physical health affected mental health stigma using Soldiers (Study 1, $n = 738$; Study 2, $n = 531$) returning from Bosnia using data from two studies. Participants completed a voluntary, anonymous survey following a health screening which consisted of culturally specific psychoeducation and medical education along with an overall health and psychological questionnaire. The first study measured stigmatization when completing medical or psychological questions while the second study measured perceived stigma associated with admitting psychological or medical issues. Measures for the study included the Post-Traumatic Stress Disorder Symptom Checklist (Foa, Riggs, Dancu, & Rothbaum, 1993), the Zung Depression Scale (Zung, 1965), and the Cage alcohol screening test (Escobar, Espi, & Canteras,

1995; Mayfield, McLeod, & Hall, 1974). Participants who scored above cutoff scores were then required to speak to either a mental health or medical professional. Service members who were screened with their units were required to stand in line while waiting to be seen by the necessary professional while service members who were screened alone did not have to do so.

Britt (2000) found several results at the conclusion of this study, the first of these being a significant difference in admitting a psychological problem versus a medical problem, with the psychological problem being more stigmatizing. 61% ($n= 531$) participants agreed or strongly agreed that admitting to a psychological problem would harm their career and 45% ($n= 531$) agreed or strongly agreed that admitting to a psychological problem would cause coworkers to spend less time around them. Additionally, participants believed that it was more stigmatizing to complete a mental health questionnaire versus a medical questionnaire. When given a medical and psychological referral, participants were less likely to follow through on the psychological referral. Participants were also less likely to follow through with treatment when given a psychological referral alone. Britt also revealed that those who scored above cutoff on the psychological questionnaire were more concerned about stigma than those who scored below cutoff. Furthermore, participants who scored above cutoff, when surveyed with their units, reported more concerns about stigmatization than those who were screened alone and were more uncomfortable discussing psychological responses with their unit present than those that were screened alone. Conversely, participants who scored below cutoff were more likely to see a psychological questionnaire and homegoing/reunion briefing as beneficial. In summation, one can conclude from these results that service members felt that mental health issues were more stigmatizing than medical issues and felt more comfortable admitting mental health issues when not in the presence of their unit. This finding speaks to both anticipated and public stigma as the

participants' reluctance to be included in the stigmatized group meant that they had absorbed the negative views of their peers, anticipating that they would be viewed negatively if knowledge of their mental health issues were made public.

Whereas, this study was one of the first to analyze mental health stigma in the military with the results setting the precedent for many studies to follow, several limitations were present in this research. Issues of generalization arise due to the sole use of Army participants and the high number of enlisted (sample 1 = 85%, sample 2 = 82%) service members, meaning that officers are less represented and any results are skewed towards the enlisted population. This is an issue due to the lack of a representative sample of both enlisted members and officers, reducing generalization. There were also issues regarding the development of the stigmatization questionnaires. The authors likened the military environment to the typical "workplace" setting using established research based on the civilian workplace but did not detail how the military workplace may be different. Therefore, the questions used in the survey may not have been culturally specific and could have altered results. Additionally, the Kosovo operation used for this research was a peace keeping mission instead of a mission with a higher amount of combat. Had the authors conducted this study during a more combat intensive theatre, which may have increased the amount of reported mental health concerns, there may have been different conclusions. Lastly, there was an observation period conducted sometime during the study which was not well explained in the manuscript. The authors mentioned a few qualitative conclusions in the rationale but did not include this information in the results section. A companion section or article detailing this qualitative portion of the study would have benefited the overall results as it would have given an added dimension to the overall study. Including the qualitative results of the

study would have given context to the quantitative results, possibly affecting later research based on this investigation.

Limitations notwithstanding, Britt's (2000) study has several implications for the current research as this study was the first to observe the admission of mental illness as a stigmatizing event for military populations. Service members felt more stigmatization in being tested for and admitting to mental health problems than to medical problems. Also, the stigma is increased when the service member's status was identified in public, suggesting that public knowledge of mental health issues is to be avoided. However, the author observed that, "Apparently, the benefits of confiding in a therapist outweighed the negative effects of a stigma in assessing the beneficialness of the psychological components of screening (Britt, 2000, p. 1612)," regarding participants who scored above cutoff on psychological measurements. This finding suggests that receiving help for mental health issues was more important than anticipated stigma and those participants recognized the importance of help-seeking to alleviate symptomology. There is a culture within the military which stigmatizes those with mental health issues as the service members believed that being a part of this group would be negative (Hoge et al., 2004). The current study is important for investigating if early stigmatizing beliefs are present, as they may filter to the enlisted member population. By understanding the MHBS of pre-service leadership, the results of this study may give insight to if negative beliefs are present early in one's military career, negative beliefs which may filter to enlisted members. This may allow for early interventions to reduce mental health stigma and therefore increase help-seeking behaviors.

A limitation of the previous study included the use of participants who engaged in a peace keeping mission instead of live combat. Hoge et al. (2004), however, examined the overall mental health of service members returning from Operation Iraqi Freedom (OIF) and Operation

Enduring Freedom (OEF), meaning this population experienced live combat, resulting in possible increased exposure to variables which would lead to mental health issues and therefore a need for help-seeking. This study was one of the first to examine a large sample of service members during this war effort and assess their mental health status. The sample included predeployment ($n = 2,530$) and postdeployment ($n = 3,671$) service members from one army unit and one marine unit in the infantry division. Participants were given surveys both pre and post deployment after recruitment briefings which were assembled by the unit leader. Service members completed the Patient Health Questionnaire (PRIME-MD; Spitzer, Kronke, & Williams, 1999), the National Center for PTSD Checklist of the Department of Veterans Affairs (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993), and a 2-item alcohol screening instrument (Brown, Leonard, Saunders, & Papasouliotis, 2001). Respondents also completed a researcher generated survey with questions regarding experiences with stress, emotional problems, alcohol, and family including severity for each. Mental health usage and barriers to care, particularly stigma, were measured based on questions Britt (2000) developed regarding mental health stigma.

After data analysis, Hoge et al. (2004) found that participants who screened positive for mental health issues were twice as likely to report fear of stigmatization. Particularly, 50% of positive screening participants felt that a mental health diagnosis would be career harming, 59% felt that their unit members would lose confidence in them, 63% feared repercussions from leadership, 51% felt that their commanding officers would blame them for the issue, and 65% believed they would be seen as weak. Overall, respondents who met criteria for mental health issues were more likely to report anticipated stigma than those who did not meet the criteria for a mental health issue.

Hoge et al.'s (2004) study had a few limitations which must be addressed. The authors surveyed several Army units pre and post deployment while only one Marine unit was used and only screened postdeployment. Due to the varying duties of each branch, the participants may have been exposed to different types of stressors, creating potentially skewed results in some participants. Additionally, participants remained anonymous during the data collection phase. Although the authors collected data from the same brigade for a portion of the sample, the later mixture of brigades and lack of member tracking suggests that while there is change pre and post deployment, it is unknown how this change affects service members individually. Additionally, the questions regarding stigma were adapted from the Britt (2000) study which were not based on the military work environment but civilian literature, meaning that the measure used was not culturally specific and could have yielded different results.

Despite these limitations, Hoge et al. (2004) confirmed the work of Britt (2000), demonstrating that anticipated mental health stigma is present within service member populations. The findings are relevant to this study as it can be observed that those who have mental health issues are more likely to experience perceived stigma, meaning that there are cultural beliefs which create a negative perception of those with mental illness. As a result, the stigmatizing label should be avoided by hiding mental health issues and avoiding help-seeking behaviors or face repercussions due to exposure. Additionally, these service members feel that they will be scrutinized and demeaned by their peers and superior officers, making them less likely to seek treatment to avoid the stereotypes of being associated with the stigmatized group. The stigmatizing beliefs of this population are seen as a significant barrier to treatment, meaning that service members are less likely to engage in help-seeking when stigmatizing views are present. Therefore, it is important to investigate the development of stigmatic beliefs as service

members anticipate backlash from commanding officers (i.e. ROTC students) which reduces help-seeking. This investigation will help to uncover if these beliefs are valid and how future leaders are informed about mental health care.

Other authors have found instances of stigmatic thinking in the military population without directly assessing the phenomena. For example, Gibbs, Rae Olmstead, Brown, and Clinton-Sherrod (2011) explored how perceptions, which inform belief systems, of substance abuse and mental health illness affected treatment seeking behavior. Using a qualitative design, the authors conducted a series of 48 focus groups gathered from six army installations ($N = 270$). Populations included those who were currently seeking treatment for mental health and convenience sampling was used for those who were not in treatment. The authors used six overall guiding questions and a subset of questions based on the participant's treatment conditions including substance abuse, mental health, or no treatment.

The results of the Gibbs et al. (2011) study yielded several results. Preliminary coding was completed using the research questions and a topic guide while final coding was completed using NVivo8 software. The original coding structure was reviewed and refined after the first three focus groups, with the refined structure being used during throughout the study and during theme development. Overall, the authors observed that those engaged in mental health treatment were more likely to describe negative attitudes from peers and commanders. Additionally, enlisted members were more likely to describe negative attitudes regarding mental health than non-commissioned officers (NCO) or officers. Results of this study are similar to the questions posed by Hoge et al. (2004) regarding stigma and barriers to care. Gibbs et al. (2011) reported that participants doubted the combat readiness and leadership abilities of those who admitted to mental health issues. These beliefs are supported by this study as NCOs were more likely to keep

their mental health issues hidden than enlisted members. The authors found that stigma regarding mental health was more prevalent when those with mental health issues acknowledge the issue as this is a sign that the issues have become overwhelming. Those with mental health issues described themselves as “broken,” “unreliable,” or “useless.” Participants agreed that mental health issues were prevalent for most service members but help-seeking was what causes stigmatization. Additionally, mental health issues are legitimized based on deployment status, as those who seek treatment after combat are seen as more legitimate.

The Gibbs et al. (2011) study had some limitations which affect the reliability of the results. The results are not as generalizable due to the inherent nature of the qualitative design. Additionally, the choice of focus groups as the primary interview method may have affected results due to social desirability, as participants may have responded differently if interviewed alone. Despite these limitations, the study has several links to the current investigation. Gibbs et al. (2011) has been one of the few to qualitatively investigate stigma, finding the construct as a barrier to treatment within this population and highlighting the need for more qualitative research in this area. Additionally, mental health stigma was found to exist within both enlisted and officer level service members, suggesting that mental health messages are shared regardless of rank. The study also highlights the cyclical nature of mental health stigma within this population. The fear of stigmatization is recognized regardless of rank, contributing to lowered treatment seeking behavior. However, lower ranking members prefer when officers are open regarding their mental health which may increase treatment seeking behavior within enlisted members. Concurrently, both levels of membership feel that their leadership abilities will be questioned if their mental health status is exposed. This cycle creates a culture where all those who need mental health treatment will not seek services for fear of anticipated stigma. This study

demonstrates the importance of understanding the MHBS of ROTC students, as they will one day become officers after completing the ROTC program. Analysis of the cultural beliefs ROTC members will give insight into and the presence of stigma at an early stage of their military careers to see if early intervention efforts are necessary.

Similar to the Gibbs et al. (2011) study, Rae Olmstead et al. (2011) observed the perceived anticipated stigma of those in different stages of treatment by comparing participants in and out of treatment for mental health issues. The authors used convenience sampling to gather soldiers from two installations ($N = 1,436$) with participants receiving mental health treatment ($n = 388$), treatment for substance abuse ($n = 12$), or both ($n = 70$), while 966 participants were not in treatment of any kind. Treatment was determined using a two question survey asking participants if they received treatment and for what purpose. Barriers to treatment and stigma were determined using questions developed by Hoge et al. (2004) with both mental health and substance abuse being given individual consideration during questioning.

Regarding results, Rae Olmstead et al. (2011) found that those who received any treatment in the 12 months prior to the study reported significantly higher perceptions of stigma than those who received no treatment after controlling for gender and pay grade. Additionally, those who received only mental health treatment reported significantly higher mental health treatment stigma than those who received no treatment. Lastly, participants who received only substance abuse treatment reported higher mental health treatment stigma than both those who received no treatment and those who received mental health treatment. Two major conclusions can be drawn from this research, the first of these being that those in treatment for any behavioral health issue experience anticipated stigma. The second conclusion is that treatment for mental

health is seen as more damaging than substance abuse treatment in regards to behavioral health issues.

A major limitation to the Rae Olmstead et al. (2011) study included a disproportionate number of members in each of the treatment groups, which may have affected the regression results. However, outside of this limitation, this study has relevance to the current research as Rae Olmstead et al. (2011) have demonstrated that stigma exists based on treatment status. Therefore, it can be assumed that there is a cultural belief surrounding mental health treatment, creating a public stigma which behavioral health issues are seen as worse than substance abuse issues. Understanding the culture of early service members and the presence of stigma may give insight into these differences. The current research has not addressed the reasons for this stigma nor why substance abuse treatment is seen as less severe than mental health treatment and it is for these reasons that the foundations of mental health stigma in military populations need to be investigated.

Directly measuring stigmatic thinking, Kim, Britt, Klocko, Riviere, and Adler (2011) examined negative attitudes regarding mental health issues and their effects on treatment seeking behavior. The authors used an anonymous sample of soldiers ($N = 2,623$) six months postdeployment from Iraq or Afghanistan who were recruited during large briefings. To assess for barriers to care, the authors used items developed by Hoge et al. (2004), Britt (2009), and Mackenzie et al. (2004). For mental health diagnoses, the Patient Health Questionnaire (PHQ; Spitzer, Kroenke, & Williams, 1999) was to measure depression, while anxiety was measured by the Generalized Anxiety Disorder-7 (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) and PTSD was measured using PTSD Checklist (PCL; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers, Litz, Herman, Huska, & Keane, 1993). A single, author created, item

was used to assess treatment utilization within the last three months and a single question was adapted from Hoge et al. (2004) and Kim et al. (2010) to measure behavioral and interpersonal problems. Finally, aggression was measured using three items from an assessment created by Killgore et al. (2008).

Kim et al. (2011) found seven stigmatic items related to barriers to care and six items related to negative attitudes towards treatment. Those reporting mental health issues ($n = 881$) were up to twice as likely to report barriers to care as those who did not report mental health issues ($n = 1737$). Less trust from unit members, changes in how they are viewed by leadership, and being seen as weak were among the highest responses of barriers to care related to stigma. Although not statistically significant, it should be noted that those with mental health issues who received care were more likely to report anticipated stigma than those who did not receive care. The authors also found an inverse relationship between negative attitudes towards treatment and treatment utilization with rises in negative attitudes marking decreased utilization.

The aforementioned investigation had a few limitations which should be addressed. The first of these is the use of correlational research design which means that causality cannot be determined based on the results. Additionally, the authors used one data collection period choosing to engage participants six months post deployment. Results may have been more robust with data collection closer to and/or further away from postdeployment. Despite limitations, this study has implications for the current research as results demonstrated that negative attitudes towards treatment seeking decrease service utilization. Additionally, public knowledge of mental health status is seen as a stigmatizing event, suggesting that treatment seeking would be damaging if service members' help-seeking is made known to others. Understanding what ROTC members believe about those with mental health issues will give insight into the possible

existence of stigma at one of the earliest stages of cultural indoctrination. The current investigation may answer questions regarding the sources of the negative attitudes, the reluctance of treatment seeking due to stigmatization, and why the exposure of mental health status is seen as stigmatizing by analyzing if individuals hold stigmatic beliefs upon entering service.

From the studies presented, one can see that overall mental health stigma is a prevalent issue within the service member population, particularly the US Army. There is a cultural belief that mental illness within this population is not acceptable, causing service members to attempt to avoid mental illness labels. Additionally, service members believe that a mental illness is more damaging than substance abuse, suggesting that there is a belief that mental illness is to be avoided at all costs. An investigation into the MHBS and the culture of ROTC students may give insight into the presence and development of stigma and their beliefs regarding help-seeking behavior. While mental health stigma may be seen as a culturally isolated phenomena being primarily in the US, overall stigma regarding mental health treatment is universal and can be found in other cultures as well.

Stigma Outside the US

Mental health stigma is not limited to the US armed forces. Gould et al. (2010) examined stigma as a barrier to treatment across an international sample. Participants included service members from the US ($n = 2,241$), United Kingdom ($n = 4713$), Australia ($n = 163$), New Zealand ($n = 97$), and Canada ($n = 5255$) in re-deployment or immediate postdeployment. The authors compiled military research data from countries that participated in the Technical Cooperation Program (TTCP) Technical Panel 13 (TP13). Participants completed the stigma and barriers to care questions developed by Hoge et al. (2004) and psychological questionnaires.

The authors found that respondents from the US, UK, and Canada who exceeded cut-off screening scores for mental health diagnoses were more likely to perceive anticipated stigma. Conversely, those in New Zealand who scored below the cut-off score were more likely to perceive anticipated stigma. Stigma was a greater concern than the barriers to care variables across all populations. The primary concern for all participants was that they would be marginalized by leadership, would be seen as weak, and/or their career would be damaged.

There were several limitations which must be taken into consideration regarding this study. Data collection procedures were not consistent across all populations which may have influenced results. Primarily, the countries did not have equal response rates meaning that an equal proportion from each population was not represented. New Zealand and Canada were the only countries without anonymous populations while Canada also did not participate in mental health status questionnaires. Therefore, the data from the Canadian population could have affected the results of the study. Additionally, the mental health questionnaires differed across populations meaning that while participants may have met the necessary criteria, the criteria may have been different based on the measure used.

Despite the presented limitations, the results of the study are relevant to the current investigation as the authors have found that mental health stigma is not an isolated occurrence. One can also assert that service members are receiving similar messages about mental health across borders and excursions. The warrior culture of the military is prevalent regardless of nationality and may speak to the masculine cultural norms within the system. Investigating the MHBS of ROTC members will give insight into if these masculine cultural norms exist at the beginning stages of military influence and if these norms contribute to stigmatic beliefs.

Therefore, it is important to analyze the culture of the military to understand the origins of these messages to inform future practice and interventions.

Iversen et al. (2011) investigated barriers to mental health care in the UK armed forces. Using stratified sampling, the authors used participants ($N = 821$) from an existing study (Hotopf et al., 2006) agreeing for follow up and divided them by deployment history, regular/reserve status, and mental health status. Participants completed the Patient Health Questionnaire (PHQ; Spitzer, Kroenke, & Williams, 1999), and 4 items from the Primary Care PTSD (Prins, Krimerling, Cameron, Oumiette, Shaw, Thraikill, Sheikh, & Gusman, 1999). Perceived needs and health service use were measured using a modified version of the Client Services Receipt Inventory (Chisholm, Knapp, Knudsen, Amaddeo, Gaité, van Wijngaarden, 2000) and barriers to care were measured by expanding questions developed by Hoge et al (2004).

The authors found that the most common barriers to care were stigmatic beliefs related to treatment seeking. Service members recognized stigmatizing beliefs as a barrier to care regarding mental health care overall and mental health care providers. Participants felt they would experience decreased trust and possible judgment from leadership and that mental health issues would be career damaging, causing them to be seen as weak (Iversen et al., 2011). Service members were also likely to report that they didn't believe that their visits would be confidential. Although the authors categorized this barrier as an "attitude" regarding mental health, it can also be seen as a belief system resulting in stigma, as the finding suggests that participants anticipate stigma if their mental health treatment is made public. Finally, the authors found stigmatic beliefs based on those in treatment and those not in treatment for mental health issues. Participants with depression were more likely to report that they would be blamed for their issues and be seen as weak by others. Participants with alcohol issues reported that they felt decreased

trust, confidentiality issues, and that they would think less of someone receiving help for mental health issues. Finally, participants with PTSD reported embarrassment as a barrier to care and that they would be blamed by the leadership for their issues.

This study was limited as it used modified questionnaires to assess participants which may have affected the validity and reliability of the instruments, each of which was not reported. Additionally, the participants were those who agreed to a follow up from a previous study and gathering new participants for this investigation may have yielded different results. However, this study has implications for the current investigation as the authors were able to demonstrate anticipated stigmatic beliefs as a barrier to care. These stigmatizing beliefs were consistent across diagnoses and active duty/veteran status. Additionally, it should be noted that those in treatment for alcohol issues felt that mental health treatment would be stigmatizing, similar to the results found by Rae Olmstead et al. (2011). Again, one can see that these issues surrounding stigma are pervasive regardless of nationality, suggesting shared mental health beliefs within military culture. The current investigation is necessary to understand a possible basis of mental health stigma as it has been found to be prevalent internationally.

The studies presented give insight into the prevalence of mental health stigma outside of the US. One can conclude that the cultural development of mental health stigma is shared, and that the warrior culture of service members is pervasive regardless of nationality. While the current investigation will not be able to determine if the cultural beliefs are found in international participants, it will be able to give insight into how the warrior culture relates to mental health stigma at one of the earliest stages of cultural indoctrination. As ROTC members will become officers, and leaders, it is important to understand their MHBS and the possible development of stigma as these will likely impact the soldiers they will one day lead.

Stigma and Leadership

Leadership has also been identified as a predictor of stigma with researchers observing links between beliefs regarding stigma and help-seeking. Wright et al. (2009) investigated leadership, unit cohesion and their relationship to perceived mental health stigma and barriers to care. Six hundred eighty soldiers were given surveys three months postcombat after a 15 month deployment to Iraq. A combat arms battalion ($N = 739$) from another study (Wright et al. 2007) was included in the study to assess the factor structure of the barriers to treatment questionnaire. Stigma and barriers to care were measured using the questions developed by Hoge et al. (2004), depression and anxiety was measured using the Patient Health Questionnaire (PHQ; Spitzer, Kroenke, & Williams, 1999) and PTSD was measured using the Post-Traumatic Stress Disorder Checklist (PCL; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Finally four items from other scales were adapted to measure leadership (Castro, Adler, & Bienvenu, 1998; Thomas & Bliese, 2004) and unit cohesion was assessed using three questions adapted from items created by Podsakoff and McKenzie (1994).

Wright et al. (2009) used structural equation modeling to assess the factors of cohesion, leadership, and barriers to care finding that the model was a good fit for the assessed factors and that these factors were related to mental health stigma. Additionally, there were interaction effects between leadership and cohesion in predicting stigma, which the authors believed indicated higher levels of unit cohesion and leadership with lowered scores on stigma measures. Even after controlling for mental health status, the interaction effect did not change. It can be inferred from the results of this study that stigma is reduced due to factors in leadership and unit cohesion and that participants in this study may feel more comfortable disclosing their mental health status knowing that they will not be stigmatized for doing so.

The study had a major limitation with the authors shortening the leadership and unit cohesion scales for easier administration, which may have compromised how the scales are interpreted beyond their original design. However, this study has relevance to the current investigation as it demonstrates that leadership and unit cohesion are key factors in mental health stigma. Service members in this group with mental health issues may feel more supported due to higher unit cohesion and stronger belief in leadership, therefore lowering their perceptions of anticipated stigma. Again, ROTC members will be officers upon commission, meaning that understanding these students MHBS will be crucial in understanding how future leaders will influence enlisted members' help-seeking behaviors. Additionally, military culture includes a high degree of group mentality which necessitates that service members be responsible for each other's well-being. Understanding how much of group cohesion is present at the beginning of the military career may give insight into the levels of cultural indoctrination found within this population. The current study will investigate cultural experiences of ROTC students which may contribute to MHBS`.

Britt, Wright, and Moore (2012) examined leadership behaviors as predictors of stigma and possible barriers to mental health treatment. The sample included randomly selected active duty soldiers ($N = 1,455$) from a single brigade. The soldiers were selected based on their participation in a previous study by the authors and were surveyed after a 15 months postdeployment to Afghanistan, completing surveys at two, three, and four months postdeployment. Stigma and barriers to treatment were measured using questions developed by Hoge et al. (2004) and NCO and officer leadership were measured using a scale validated in previous research conducted by Castro, Adler and Bienvenu (1998) and Wright et al. (2009).

After data analysis, the authors found that stigma was related to perceived treatment barriers at all three points of measurement. Additionally, NCO behaviors were predictive of overall stigma and were related to stigma within participants (Britt, Wright, & Moore, 2012). Specifically negative/destructive leader behaviors were more strongly linked to stigma, whereas positive/constructive leader behaviors were more strongly linked to practical barriers (i.e. transportation). After examining within-person (level 1) and between-person (level 2) data, the authors found that both positive and negative behaviors were predictive of stigma over time in both levels with higher ratings of negative NCO behaviors and lower ratings of positive NCO behaviors associated with higher reports of stigma. Finally, results from the models tested revealed higher levels of stigma during the months where higher levels of negative NCO and lower levels of positive NCO behaviors were reported.

Although the study yielded several results, there were also several limitations. Attrition was an issue for this study as participant numbers dropped after each assessment where 42% percent of the sample (n = 608) completed only one assessment, 37% of the sample (n = 537) completed two of the assessments, and 21% of the sample (n = 310) completed all three assessments. Additionally, the study used convenience sampling, meaning that no longitudinal relationships can be assessed regarding this population as they were not tracked across time. The authors did not assess for mental health prior to testing, therefore, the results do not reflect if anticipated stigma is higher or lower based on current mental health status. Finally, the authors reported the validity and reliability for the measurements used in the current study but did not demonstrate validity and reliability in previous studies, meaning the results may have been unique to this study based on the instruments used. Outside of these limitations, this study has links to the current investigation as it demonstrates that leadership is a strong predictor of

anticipated stigma. The messages regarding mental health received from commanding officers are important to the anticipated stigma of enlisted service members as those who felt that their unit leaders would be supportive were less likely to report feelings of anticipated stigma.

Investigating the MHBS of ROTC students would help researchers to know how they feel about those with mental health issues prior to exposure to active duty service members. Early work with this population (i.e. the point of this research study) may result in creating officers who are more supportive to those with mental health issues, corresponding with the results of this study which suggest that fostering a sense of trust regarding mental health may lower anticipated stigma and increase treatment seeking behaviors.

Of the many results found in the Hoge et al. (2004) study, one of these also pertained to stigma and leadership. The authors found that participants saw stigmatic thinking by superiors as a barrier to treatment, believing that they would be judged harshly if they engaged in help-seeking. When service members feel that they will not be stigmatized for their decision to help-seek for mental health issues, it can be surmised that they will be more likely to seek treatment. Therefore, this study is important as it will give insight into the views of future officers whose leadership style will determine comfortability in seeking treatment.

Summary

The aforementioned studies demonstrate that perceived mental health stigma is a prevalent issue within the military and a barrier to treatment seeking behavior. Participants in these studies believed that they would experience stigma based on exposure of mental health status, suggesting that it is necessary to hide one's mental health status, therefore reducing treatment seeking behaviors. Additionally, stigma is dependent on the reasons for treatment seeking with participants reporting increased perceived stigma for mental health issues versus medical or

substance abuse issues. Perceived mental health stigma has also been found to exist at all ranks, however, stigma is reduced when there are incidences of high unit cohesion, suggesting that when service members feel supported by unit members and leadership, there may be increased incidences of treatment seeking. These studies are important to the current investigation as the researchers have revealed that perceived mental health stigma is prevalent but have not investigated the reasons for this stigma. The results of the studies demonstrate that perceived stigma exists based on such factors as rank and reason for treatment, but none has demonstrated where the perceived stigma originated or how it was perpetuated throughout the ranks. The current investigation is necessary in order to discover the possible origins of the messages received regarding mental health, understand how stigma begins, and how the negative beliefs are spread.

Help-Seeking Attitudes and Behaviors

Masculine Culture and Help-Seeking

The results of the previous studies help to outline the connection between mental health stigma and help-seeking, however, stigma alone may not be the sole factor in reduced help-seeking behaviors. Expected behaviors regarding masculinity may also be a factor in reduced help-seeking as service members are expected to adhere to stereotyped gender roles due to the culture of the military. The following sections will detail studies which investigate the help seeking attitudes of service members regarding mental health counseling. This section will be followed by studies which investigate Male Gender Role Conflict (MGRC) and its association with mental health treatment seeking in service members. The section will conclude with a summary of the articles presented and their importance to the current study.

Gender and Help-Seeking. Help-seeking behaviors and attitudes have been found to differ based on gender with North American men being half as likely to seek counseling services as women (Wills & DePaulo, 1991) and reduced instances of help-seeking for diagnoses such as depression and anxiety (Kessler, Brown, & Broman, 1981; Tudiver & Talbot, 1999). It has been theorized that socialization and male values are contributors to reduced help-seeking behaviors and attitudes. Schemas of masculine ideology are developed in childhood through examples such as superheroes, bullies, military veterans, athletes, and celebrities (Good & Robertson, 2010). These views are internalized and reaffirmed as the child develops, creating expectations of what is expected of gender. During psychological crisis, males must decide when it is necessary to deviate from traditional ideologies or compartmentalize their issues (Good et al. 2006; Hammer & Good, 2010), with psychological help-seeking being an antithesis of role expectations (Good, Dell, & Mintz, 1989). Characteristics including acknowledgement of personal problems, self-disclosure, tolerance of personal vulnerability and emotional awareness are beneficial for counseling but do not fit socialized gender expectations (Eisler & Blalock, 1991; Good, Gilbert, & Scher, 1990; O'Neil, 1981). Men may believe that it is more beneficial to address issues on their own as therapists could possibly be ineffective, resulting in a loss of autonomy and feelings of weakness due to help seeking (Good & Robertson, 2010). Therefore, researchers have found that those who hold to traditional masculine roles are less likely to seek help for mental issues such as depression (Good & Wood, 1995). Additionally, Berger et al. (2005) found that help-seeking was more closely related to traditional masculine ideology than Male Gender Role Conflict (MGRC); however MGRC has developed as an area for research regarding psychological help seeking.

MGRC has been found to be a barrier to psychological help seeking as those who score higher on measures for the construct have been found to be less likely to exhibit help seeking behaviors (Good, Dell, & Mintz, 1989; Good & Wood, 1995; Robertson & Fitzgerald, 1992; Wisch & Mahalick, 1995). MGRC arises when males are expected to operate outside of traditional masculine ideals, causing conflict regarding how to break norms or seek services. Men who break norms and exhibit role deviant behavior experience condemnation, negativity, objectification and homophobic aspersions (Kunkel & Neilsen, 1998). MGRC includes factors where masculine behaviors which do not fit into the gender role are seen as feminine and homosexual. As a result, those with high MGRC may avoid entering therapy as they equate emotional closeness to homosexuality (O'Neil, Helms, Gable, David, & Wrightsman, 1986) and experience negative attitudes towards therapy (Komiya & Eells, 2001). Robinson and Fitzgerald (1992) found that college men with greater MGRC were less likely to engage in traditional, face to face counseling, but were more willing to attend workshops or seminars. MGRC regarding psychological help seeking has also been found across ethnicity (Neighbors, Musick, & Williams, 1998), class (Hogetts & Chamberlain, 2002), and nationality (Lane & Addis, 2005; Shin, 2002; Solberg, Ritsma, Davis, & Tata, 1994).

Masculinity and the Military

Those in the military are seen as a heightened view of the definition of masculinity (Good & Robertson, 2010). Service members are trained to be mentally and physically strong, expectations which are reinforced in recruitment slogans and stigmatic beliefs regarding mental health counseling (McFarling, D'Angelo, Drain, Gibbs & Rae Olmstead, 2011) and basic training. The traits outlined in MGRC are counter to the strength based training that service members receive during basic training. The goal of basic training is transformation, creating an

environment where service members create a new identity counter to civilian orientations (Petrovich, 2012). Service members are encouraged to sublimate physical and emotional inadequacy or be met with derision while traits such as aggression and endurance are rewarded (Higate, 2003; Sherman, 2005). Therefore, it can be theorized that those who engage in vulnerability and emotional awareness, important for counseling (Eisler & Blalock, 1991; Good, Gilbert, & Scher, 1990; O'Neil, 1981), would be marginalized due to these behaviors being seen as outside of MGRC and service member training. As all of these emotional behaviors run counter to the culture cultivated during military training, it can be surmised that anyone who displays these behaviors would be stigmatized and refrain from help seeking. Those who have been diagnosed with mental health issues may feel MGRC as they must decide to conform to culture or seek help for their illnesses.

Traditional Male Gender Identity and Help-Seeking. Civilian literature has shown that men are less likely to seek professional help than women (Addis & Mahalik, 2003; Husaini, Moore, & Cain, 1994; McKay, Rutherford, Cacciola, & Kabasakalian-McKay, 1996) and are more likely to have negative attitudes towards psychological help (Leong & Zachar, 1999). A possible reason for these beliefs is adherence to traditional male gender identity. Berger et al. (2005) has conceptualized traditional male gender identity as avoidance of femininity, rejection of homosexuals, and increases in aggression, self-reliance, achievement status, and restrictive emotionality. These characteristics are developed through interactions with culture, society, family, and working environment (O'Neil, Helms, Gable, David, & Wrightsman, 1986). Traditional roles are threatened when individuals choose to adhere rigidly to role expectations instead of engaging in help-seeking behaviors, causing gender role conflict (O'Neil, Good, & Holmes, 1995).

The culture of masculinity as defined by traditional male gender identity norms have been shown to affect treatment seeking behaviors in civilian populations (Berger et al., 2005; Lane & Addis, 2005). Research consistently demonstrates that men are less likely to seek psychological treatment than women for mental health issues (Addis & Mahalik, 2003; Husaini, Moore, & Cain, 1994; McKay, Rutherford, Cacciola, & Kabasakalian-McKay, 1996). Additionally, help-seeking behaviors have been found to be mediated by the construct of masculinity where researchers (Kessler, Brown, & Broman, 1981; Tudiver & Talbot, 1999) have found that men are less likely to seek treatment for mental health issues such as anxiety and depression. Taken together, one can surmise that even after being diagnosed with a mental illness, men will be less likely to seek some form of treatment.

Gender role identity, a precursor of MGRC, has also been found to contribute to help seeking behaviors. Lane and Addis (2005) observed that males who have stronger gender identity scores were less likely to seek mental health treatment. From these results, one can conclude that strongly held beliefs of what it means to be “masculine” or a “man” can impede mental health treatment. The gender makeup of the armed forces is primarily male with 465,787 males compared to 75,507 females (*Demographics: Profile of the Military Community*, 2012) therefore, studies conducted with military populations reflect this proportion with higher numbers of males serving as participants. As the military promotes a strong culture of masculinity, it is therefore important to analyze how MGRC affects help-seeking in the service member population. The following section will detail help seeking behaviors based on gender, role identity, and membership in the armed forces.

Male Gender Roles, Service Members, and Help-Seeking

Newly emerging in literature, authors have begun to investigate the role of MGRC in regards to help-seeking in the service member population. Price (2011) conducted dissertation research investigating the relationship between attitudes towards help-seeking, actual help-seeking and traditional masculine identity in combat exposed military personnel. The study consisted of 82 males from all branches of the military. Each participant completed a series of web-based measurements including the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004), the Male Role Norms Inventory – Revised (MRNI-R; Levant & Fischer, 1998; Levant et al., 1992), the Stressful Life Events Screening Questionnaire (SLEQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998), the Post Traumatic Checklist-Civilian (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993), and the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001).

Price (2011) found that psychological openness, help-seeking propensity, and indifference to stigma were all significant predictors in the model with psychological openness having the greatest negative association with masculine identity. The results of this research suggest that those who identify strongly with traditional masculine characteristics are more likely to be affected by stigmatizing attitudes regarding mental health care and are less likely to seek help for mental health issues. The study included several limitations which affect generalizability. The primarily white, Christian male population means that the results of this study may only apply to that population. Additionally, the sample included all military branches with combat experience; however, the largest proportions of the sample were Navy personnel with only half experiencing land-based war zone combat. It is unknown if the participant's

adherence to traditional masculinity ideals differed between service branches, nor how the type of combat may change help seeking behaviors.

Outside of these limitations, the study demonstrates that gender identification is a mediating factor for help seeking behaviors. The study is relevant to the current study as it suggests there needs to be an investigation regarding if the culture of masculinity exists at an early stage of military cultural indoctrination. Understanding the MHBS of ROTC students will give insight into if masculine cues inform mental health beliefs which then inform stigma. By analyzing the presence and development of stigma, researchers can investigate different intervention points for reducing stigma and increasing help-seeking behaviors.

Fleming (2012) conducted dissertation research analyzing relationships between attitudes towards help-seeking behavior and gender role identification. The author used two samples for this research study, the first consisting of active duty combat veterans from all branches of the military ($n = 56$) and the second consisting of any combat veteran ($n = 113$). Both samples were exclusively male. Participants completed an online survey including the Distress Disclosure Index (DDI; Kahn & Hessling, 2001) and the Gender Role Conflict Scale (GRCS; O'Neil et al., 1986). The author found significant results in both samples observing that those with higher scores on the GRCS were less likely to seek mental health treatment. However, the frequencies for these correlations were lower for the veteran sample than for the active duty sample. This research suggests that while gender identification is a mediating factor is for help-seeking behavior, those who are still serving may be more influenced by gender identity when help-seeking than those who have retired.

The major limitations of this study are reflected in the choice and implementation of the instrumentation. The author used only one question to measure mental health help-seeking as

opposed to other existing measures. This question consisted of a “Yes” or “No” response which was not validated against any other measure. Therefore, the results do not reflect if there is a spectrum of help-seeking behavior, nor if the measure for this construct is valid. Additionally, the author removed the “Restrictive affectionate behavior between men” section of the GRCS due to attrition from the first sample after participants shared they were uncomfortable with these questions. Omitting this section means that both samples did not complete the same assessment and the measurements of gender identification were not assessed equally with both populations. Despite these limitations, the results of the study suggested that gender role identification was a significant predictor of mental health help-seeking behavior in military personnel. Again, this study is important to the current investigation in that it points to the need for determining the presence of a culture masculinity in the ROTC and, if present, how the culture is related to mental health treatment.

The reviewed have demonstrated that gender role conflict has a direct relationship to treatment seeking behavior for mental health concerns: those who adhere tightly to traditional male roles are less likely to seek treatment, possibly due to anticipated perceived stigma. It can be concluded that anticipated stigma from fellow service members due to breaking gender norms is more important than treatment seeking for prevalent mental illnesses. The culture instilled within service members is in direct conflict with behaviors which are the most beneficial in counseling, resulting in difficult choices when faced with the need for services. The conflict has been shown here to reduce treatment seeking but research has not qualitatively investigated the origins of these ideas regarding masculinity in early service members. The current study will investigate the origins of the role of traditional male gender stereotypes and their perpetuation

throughout the earlier enlistees. The culture of stigma regarding help seeking and MGRC must also be investigated to discover their origins in treatment seeking behaviors.

Help-Seeking and the Military.

Outside of addressing MGRC directly, other authors have attempted to understand help-seeking using various qualitative and quantitative measures. Stecker, Fortney, Hamilton, and Ajzen (2007) used qualitative inquiry to understand the MHBS in regards to treatment seeking behavior of those serving in the US National Guard ($N = 20$). Using the Theory of Planned Behavior (TPB; Ajzen, 1991) as a theoretical framework, the authors investigated the behaviors of Guardsmen seeking mental health treatment from a physician or mental health professional within one year postdeployment to Iraq. Participants completed the Mini International Neuropsychiatric Interview (MINI; Sheehan, et al., 1998) which was used as a screening device. Those who screened positive for at least one of the target disorders (depression, panic disorder, generalized anxiety disorder, PTSD, and alcohol abuse) were selected to take part in the study. Semistructured phone interviews were recorded and conducted by the primary investigator. Questions were open ended and meant to elicit answers pertaining to the behavioral beliefs of the participants based on the components of the TPB. Participants were asked about advantages and disadvantages to seeking mental health treatment, to describe those who may support or discourage treatment seeking behaviors, and factors which may facilitate or hinder treatment seeking.

Regarding data analysis, interviews were transcribed and checked by the participants for completeness and accuracy. Three interviewers, separately and jointly, then analyzed the transcriptions to identify the commonly held beliefs using line-by-line analysis to ensure each theme would be recognized. After coding, each code was categorized using the TPB as a guide.

The authors found that “getting better” was a primary motivator for seeking mental health treatment, specifically symptom improvement and the ability to return to “normal,” which includes daily functioning. Psychoeducation was also presented as a theme with participants feeling an advantage to treatment seeking would be the ability to better understand their symptoms. Stigma was seen as a disadvantage to treatment seeking with participants believing that they would receive negative labels and experience negative career impact if they sought mental health treatment and getting help would be an impediment to an immediate return home. However, most respondents felt they would be supported by “everyone” including the military in their decision to seek treatment while some felt these same parties would not want them to see a mental health professional and that treatment seeking was discouraged by some officers with the threat of career hindrance.

The study should be viewed in light of a few limitations. Due to the chosen methodology, qualitative inquiry, the results of this study cannot be generalized to other populations. Also, due to using phone interviews to collect data, the authors may have missed several nonverbal cues which could have added to the richness of the qualitative description. Additionally, the authors did not interview participants without a mental health issue. It is possible that these respondents may have felt differently about treatment seeking than those who are currently experiencing mental illness. Finally, the authors did not delineate whether the National Guard members were active duty or retired. This may have influenced their beliefs on treatment seeking as those who were retired may have had less worry about stigma and career advancement and therefore would be more willing to engage in treatment seeking. Outside of these limitations, the study was informative as the authors found that those who have mental illness were willing to seek treatment in efforts to return to equilibrium and functioning prior to their diagnosis. While most

felt they would be supported in treatment by both family and commanding officers, some felt that they would be stigmatized and unsupported in their efforts to seek treatment. This study is important to the current investigation as it is one of the few studies to qualitatively describe the treatment seeking behaviors of service members. The study helps to outline the dichotomous nature of treatment seeking as service members believe treatment seeking would be beneficial, however, fear of stigma, reprisal, and lack of support are also inhibiting factors. Knowing this, it is now important to investigate the thoughts and experiences of early service members as their beliefs regarding mental health and help-seeking will possibly be carried through into their military careers. Early knowledge of these beliefs can give insight into how future commanding officers view help-seeking and therefore how they may view enlisted members who engage in help-seeking.

Another study by Warner, Appenzeller, Mullen, Warner, and Greiger (2008) examined help-seeking attitudes among Soldiers ($N = 2,678$) postdeployment. The authors analyzed implementation strategies, perceived barriers to treatment, and help-seeker characteristics. Participants were given an anonymous, voluntary four part survey developed by the researchers. The parts of the survey included postdeployment screening preferences, care-seeking behaviors, perceived barriers to treatment, and barrier removal strategies.

The authors used demographic information to obtain their results. The authors found that 24.1% ($n = 649$) of participants received some type of treatment, 7.2% ($n = 193$) received care prior to enlistment, 5.7% ($n = 153$) received care predeployment, 11.2% ($n = 300$) received postdeployment treatment, and 20.7% ($n = 536$) of those previously deployed sought treatment postdeployment. Sixty-five point seven percent ($n = 1,760$) of participants were willing to address a perceived or diagnosed mental health condition post-deployment. Finally, respondents

preferred survey or face-to-face interviews versus a full mental health evaluation and were more likely to answer truthfully to physicians and mental health professionals who were from their unit.

This study contained several limitations which compromised the findings. Primarily, the authors did not present previous research to validate the source of the survey questions in three out of the four parts of the questionnaire. The authors did describe using Hoge et al. (2004) to obtain questions regarding barriers to treatment but did not include research for any other construct while the questionnaire overall was not validated against any other existing measure. Additionally, the sample consisted of primarily lower ranking soldiers (E1-E4), therefore, results can only be generalized to this population. Lastly, the authors did not differentiate between the type of mental health issue and length of deployment. Therefore, it cannot be concluded how these factors may affect treatment seeking behaviors. Outside of these limitations, soldiers were willing to seek treatment when a problem existed, whether through their own belief or by diagnosis from a mental health professional. Additionally, the authors did find that service members showed a propensity to seek treatment prior to enlistment, suggesting that views regarding mental health may be more open prior to enlistment. This statement relates to the current investigation as ROTC students may have MHBS which are a mixture of previous experiences with mental health and the cultural cues they have received as a result of their initial exposure to military culture. Therefore, it is important to investigate the MHBS of this population to understand how much of their previous experiences influence their beliefs.

Iversen et al. (2010) examined the treatment seeking behaviors of UK service members ($N = 821$). The authors used stratified sampling, selecting participants from the King's Centre for Military Health Research military health study (Hotopf et al., 2006) who consented to follow-up.

Participants completed the Patient Health Questionnaire (PHQ; Sptizer, Kroenke, & Williams, 1999), the Primary Care PTSD Screen (PC-PTSD; Prins, Kimerling, Cameron, Oumiette, Shaw, & Thraikill, 1999), and a question regarding help-seeking which included medical, mental health, and non-medical professionals. The surveys were conducted by telephone using a two-phase survey technique.

The authors observed that over 80% ($n = 407$) of participants who perceived they had a mental health issue had sought treatment; however, these participants were more likely to use informal sources (family or spouse) than seek professional treatment. Full-time and reserve service members did not differ in terms of help-seeking behaviors though full-time service members with a no rank were more likely to seek treatment. Additionally, help-seeking behaviors were found in Royal Air Force veterans who were diagnosed and medically downgraded. Lastly, of those who perceived they have a mental health issue but are not receiving help, only a small percentage of this group was interested in seeking treatment.

This study was limited due to the telephone interview structure, which may have compromised the responses given by the participants due to possible misunderstandings regarding verbal context. Additionally, the authors did not use a validated questionnaire to ascertain help-seeking behaviors, instead using a question regarding the type of professional they would most likely visit. Regardless of limitations, this study reflects other research which details that those of lower rank are less likely to seek treatment for mental health issues (Gibbs et al., 2011). Additionally, the authors found that females were more likely to seek treatment, confirming gender as a barrier to help-seeking behaviors (Wills & DePaulo, 1991). The study is relevant to the current investigation as it demonstrates a need to understand the MHBS of future

officers, as their beliefs may filter down to enlisted service members. Additionally, the study will give insight into if masculine cultural cues affect MHBS and therefore help-seeking behaviors.

Kehle et al (2010) examined the rates and factors associated with postdeployment treatment seeking behaviors. Participants included U.S. National Guard ($N = 424$) Soldiers who spent an average of 16 months in Iraq. The authors mailed surveys 3-6 months postdeployment to OIF. Each participant was given a \$50 incentive, leading to an 81% response rate. Measures included the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970) Abbreviated version (Fischer & Farina, 1995), the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) and the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The authors also used various sections of other measures to assess factors. Mental health treatment-seeking factors measured using dichotomous variables (Erbes, Westermeyer, Engdahl, & Johnsen, 2007); combat experiences, perceived threat, social support, and stressful life experiences were measured using subscales from the Deployment Risk and Resilience Inventory (DRRI; King, King, & Vogt, 2003); perceived barriers to care were measured using items developed by Hoge et al. (2004). Finally, single, researcher developed items were used to assess overall health, injury in theater, in-theater psychotherapy, medication use, in-theater mental health services, and previous psychotherapy.

The authors found that 34% ($n = 147$) of participants reported receiving some type of mental health care upon returning from OIF with 22.9% ($n = 97$) indicating psychotherapy. Receiving therapy prior to deployment, higher levels of combat and perceived threat, being injured in Iraq, greater PTSD and depressive symptomology, poorer health, greater postdeployment stressors, and more positive attitudes regarding mental health treatment were associated with increased reports of treatment-seeking. Additionally, combat-related injury,

positive attitudes about mental health treatment, and a researcher created Need Factor variable (PTSD symptoms, depression symptoms, current problem, interested in help, need factor score) contributed to help seeking behaviors. Regarding hindrances, self-stigma, reflecting impact of care on self-image and military career and “others” stigma, perceptions about others who seek treatment were related to treatment seeking behavior. Higher negative attitudes about mental health treatment were associated with lower reports of psychotherapy use in relation to questions indicating “mental health doesn’t work.” 51% ($n = 216$) of soldiers who screened positive for PTSD and 40% ($n = 170$) who screened positive for depressive symptoms did not report involvement in mental health treatment.

The study had several limitations which must be addressed. There are generalization issues due to the homogenous sample; specifically Caucasian (90%) U.S. National Guard members. Additionally, the sample was obtained from a single brigade, indicating that results cannot be generalized to National Guard members in other states. The authors’ use of self-report may have skewed results due to the halo-effect, resulting in disingenuous answers. Finally, the author’s use of single, untested items for a number of predictor variables may have affected the study. Outside of these limitations, the results of this study had several implications for the current research. The authors demonstrated that those with positive attitudes about mental health were more likely to seek treatment. Additionally, those who engaged mental health services prior to deployment were more likely to seek treatment postdeployment. A significant amount of participants were willing to engage in treatment seeking when self-perceived need was shown. One of the elements of the Common Sense Model is understanding when it is necessary to seek treatment after recognizing illness. Understanding help-seeking behaviors of ROTC students will

give insight to their feelings on appropriateness on seeking treatment, beliefs that will be passed on to service members in their care.

Blais and Renshaw (2013) measured help-seeking intentions against self-stigma, military and non-military anticipated stigma. The authors investigated possible resources such as military versus family/friends and Medical Doctors (MD)/Advanced Practice Registered Nurses (APRN) versus Mental Health Professionals (MPH). The sample included National Guard and National Guard Reserve combat veterans ($N = 165$) who had been deployed to either Iraq or Afghanistan. Participants were given a packet of surveys including the PTSD Checklist – Military (PTSD-M; Weathers, Litz, Herman, Huska, & Keane, 1993), the Perceived Stigma and Barriers to Care Scale-Stigma Subscale (PSBCS-SS; Britt, 2000), and the General Help-Seeking Questionnaire (GHSQ; Rickwood, Dean, Wilson, & Ciarrochi 2005). Time to complete the packet was approximately 30 minutes and each participant was given \$15 in compensation.

The authors made several conclusions based on the results of this study. Overall, self-stigma was negatively correlated with help-seeking intentions from any mental health source. However, Blais and Renshaw (2013) found that participants were more likely to seek help from a mental health professional than an MD/APRN. Additionally, those who previously sought mental health treatment were more likely to exhibit help-seeking behaviors suggesting that previous engagement with a mental health care professional may reduce stigma. Anticipated enacted stigma from unit leaders was higher than stigma from unit members, and family/friends. Additionally, anticipated enacted stigma from unit members was higher than anticipated enacted stigma from family and friends. The PSBCS-SS was also positively correlated with stigma from each of these sources. These results obtained by the authors support research (Hoge et al., 2004) where service members felt they would be stigmatized by commanding officers as a result of

mental health issues. Finally, the authors completed a latent variable model including the variables self-stigma, anticipated enacted stigma, marital status, post-traumatic stress, history of previous mental health care, and perceived likelihood of redeployment against help-seeking from a medical or mental health professional and found that these factors were related in help-seeking.

The Blais and Renshaw (2013) study had several limitations which affect the generalizability of the results. The sample was very homogenous consisting of primarily white (86.5%), college educated (75.1%), Mormon (68.6%) individuals, possibly due to the location of the study (Salt Lake City, UT). Additionally, a high percentage of participants (63.7%) only experienced one deployment; therefore, it is unknown how help-seeking behaviors may have changed as a result of multiple exposures to combat situations. The authors noted that the cross-sectional design of the study removed the ability to make causal inferences and that the results only lead to conclusions regarding help-seeking intentions, not help-seeking behaviors. Despite these limitations, the authors' conclusions are relevant to this dissertation as they have found that increased stigma results in lowered help-seeking intentions in military personnel. Additionally, the authors found that participants believed they would receive the most stigma from superior officers if they were to seek help for mental health issues. Finally, participants felt they would be stigmatized by others regardless of the type of helping professional.

The studies presented in this section are pertinent to the proposed study. The researchers have proved that service members are willing to seek treatment prior to enlistment but less likely to do so afterwards. The reasons for this change have yet to be investigate and could be answered by the results of this study due to its analysis of early mental health interactions. The authors also found that stigma was directly related to treatment seeking behaviors and that treatment seeking was reduced when more stigma was present or service members felt they would be stigmatized

by superior officers. Additionally, those who were of lower rank were less likely to seek treatment than those who were of higher rank, suggesting career repercussions based on stigma. This study will address the origins of these beliefs and how they are perpetuated through the ranks through analysis of the MHBS of ROTC students. Finally, the studies found that males are less likely than females to seek treatment, suggesting a gender bias regarding beliefs about treatment seeking.

Summary

The aforementioned studies give insight into the issue of how gender affects help-seeking behaviors and also the views of help-seeking within the military population. Service members recognize the need for services but are reluctant to do so due to stigmatic beliefs regarding those who do engage in help-seeking. It is also important to note that leadership is a factor, with even those at high ranks being reluctant to seek treatment. The proposed study will give insight into the MHBS of ROTC students, and as they will be engaging enlisted members, their views and the culture they bring to their military careers will lend useful information to stigma reduction methods.

CHAPTER III

Methodology

Introduction

Qualitative research is often an open and unstructured process, with phenomenological inquiry being seen as a loose set of guidelines which is neither stringent nor completely open to interpretation (van Manen, 1990). For the purposes of this dissertation, a set of stricter guidelines were needed for academic proficiency. This Chapter contains a description of the methodology which will be used to conduct this investigation. The research design to be used in this investigation will include elements of van Manen's (1990) Hermeneutic Phenomenology and analyzed using the Common Sense Model of illness representation (Diefenbach & Leventhal, 1996). The Chapter will begin with a description of the research question and the research design, followed by sampling procedures. Instrumentation and interview protocols will be presented which include the interview questions to be used and data analysis techniques. Finally, the Chapter will conclude with an explanation of validation and verification strategies and a summary of the Chapter.

Purpose of the Study

The purpose of this study was to understand the phenomena regarding the mental health beliefs of US Army ROTC students and how these beliefs relate to mental health stigma and treatment seeking behaviors.

Research Question

Question Formulation

The researcher began researching military mental health prior to the European Branch of the American Counseling Association (EB-ACA) conference in 2012. The EB-ACA conducts a yearly conference focusing on the mental health needs of US Soldiers, their families, and the mental health professionals who serve their needs. When my research began, I was particularly disturbed by the high suicide rates within this population and continuing; I discovered high rates for other mental health issues including depression. Prior to these investigations, the only prevalent mental health issue I was aware of within this population was PTSD. My investigations led to understanding the reasons for these prevalent issues.

Primarily, I was confused about why service members had such high rates of mental illness given the resources that they have at their disposal. For example, there are trained mental health professionals within the military who are available to current service members in addition to the Veterans Affairs which exists to aid service members upon discharge. My research led me to Hoge et al. (2004) and their study on the change in mental health status pre and post deployment to Iraq and Afghanistan. As a smaller portion of their study, the authors addressed mental health stigma as a possible barrier to mental health treatment. Further research confirmed this to be an issue which also affected help-seeking thoughts and behaviors. However, none of the research regarding the service member population addressed the sources of the stigmatic beliefs which were found to exist. It appeared to me that it would be difficult to understand and curb stigma without understanding where it comes from and how it spreads. Therefore, I decided to investigate mental health stigma by addressing it at its earliest stages in the service member

population. My initial thoughts and continued research have led me to the formulation of the primary research question for this investigation.

Guiding Research Questions

As a result of my original inquiry and after investigating published studies, my research question is:

“What are US Army ROTC students’ thoughts, feelings, and beliefs about behavioral health?”

The major components of this question are the words “thoughts,” “feelings,” “beliefs,” and “behavioral health.” Each was chosen as the primary researcher felt they would draw the participant deeper into their psyche regarding the phenomena of mental health. “Thoughts” evokes a surface glance at the phenomena, while “feelings” ask the participant to gauge their emotions, which is generally deeper than a passing thought. Finally, “beliefs” asks them to assess their core values regarding the topic and address the root of their understanding of the phenomena which will hopefully uncover the cultural origins of the beliefs. Additionally, the primary researcher felt that presenting the question in this order, in addition to the order of the interview questions, will evoke a sense of change over time as the interviewer invites the participant to dig deeper regarding the phenomena. Finally, the term “behavioral health” was used in place of “mental health” to be more applicable to the language used within the military system (Castro, Hoge, & Cox, 2006; Orsingher, Lopez, & Rinehart, 2008). The study used ROTC members due to the fact that upon graduation, the students become commissioned officers in the Army. As was demonstrated in Chapter Two, mental health stigma and leadership are linked and therefore the thoughts of those who will become the leaders of those enlisted needs investigation.

Moustakas (1994) presented the aforementioned method of research question formulation to ensure that the question is clear, concise, and concrete. Therefore, I thought it pertinent to also include the words that did not appear in the research question. While my original question included efforts to understand “stigma” and “help-seeking,” I did not want to include these in the research question as I believe it is important to get a full canvas of the participant’s mental health beliefs overall. Questions regarding stigma and help-seeking, the primary constructs from Chapter two, were drawn out using the interview questions. If included in the research question, the question would then become more closed and not conducive to the openness that is inherent to phenomenological research.

The second research question was as follows:

“What themes emerge from the ROTC students’ mental health belief systems that can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members?”

The primary component of this question is the word “theme” which suggests thematic development. The purpose of qualitative investigation is to understand the lived experiences of those being assessed (Creswell, 2013). Through this investigation, the researcher draws together themes which link the common experience of participants. The purpose of this second research question was to draw the thematic relevance from the data found in question one and then to apply these themes to information which will increase the body of knowledge regarding this population. Specifically, themes from the information found in Chapter one will be used to inform prevention efforts to begin analyzing ways to stem stigmatic thinking and increase help-seeking, develop treatment protocols for those who may need treatment at this early stage,

inform counselor educators and future counselors regarding cultural knowledge and best practice for this population, and finally, best ways to discriminate information to those in the community regarding this population.

Research Design

The completed study employed phenomenological qualitative research as its methodology, primarily Hermeneutic Phenomenology (TP). When explaining hermeneutic phenomenology, van Manen (1990) stated that:

To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal (p. 18). This statement suggests that the researcher immerses themselves in the experience of the individual while at the same time, understanding that there will be caveats which may be missed due to the immensity of the phenomena. However, the researcher goes into the exercise of hermeneutic phenomenology with the intention of analysis, knowing that “complete reduction [of the phenomena] is impossible, that full or final descriptions are unattainable (p. 18).”

Any phenomena is experienced uniquely for each person experiencing the event and the researcher looks for meaning and common features between these events (Starks & Trinidad, 2007). For the purposes of this dissertation, the phenomena investigated were the thoughts, feelings, and beliefs of US Army ROTC students regarding mental health. This experienced phenomena was different for each individual and each interview yielded different meanings

relating to the primary question. However, after analysis, the primary researcher found common themes within each narrative which helped to explain the phenomena.

Additionally, this study used qualitative study methods outlined by Creswell (2013) and Glesne (2011) to design the study. Authors have advocated for the use of phenomenological investigation at the beginning of a course of research in order to understand the experiences of the population to be addressed prior to quantitative investigation (Gall, Gall, & Borg, 2007; Moustakas, 1994). At this time, there are very few qualitative investigations which address mental health belief systems within the military and none which address the US Army ROTC, warranting an investigation into the lived experiences of this population as a starting point to building a body of knowledge in this population.

Rationale for Research Design

Phenomenological research can be used to outline the experience of individuals prior to conducting quantitative research with a population whose lived experience has yet to have been explored (Creswell, 2013; Glesne, 2011). Vogt (2011), in a meta-analysis, advocated for a broad assessment of service members' personal beliefs about mental health, particularly the sub-populations within this system. Regarding cultural influences, increased research regarding sub-groups is necessary, as demographics such as differences in age, rank, location, and sex have been found to affect help-seeking behaviors in civilian populations (Iversen et al., 2010; Kehle et al., 2010; Warner, Appenzeller, Mullen, Warner & Greiger, 2008). However, it is currently unknown if or how these demographic factors affect the mental health belief systems of this population. Additionally, out of the three qualitative studies identified by Vogt's (2011) meta-analysis of mental health belief systems, only one qualitative study directly addressed overall mental health belief systems. Previously the only study to broach this topic was conducted by

Rosen and Corocoran (1978) who found that commanding officers in the US Air Force believed that mentally ill individuals deserved care but were less knowledgeable and compassionate than mental health professionals. The need to address sub-populations outlined by Vogt (2011), and lack of research regarding the ROTC population overall, combined with the views of Moustakas (1994) and Gall, Gall, and Borg (2007), supports the necessity of this study. The completed research has addressed a sub-population of the military, added to the body of knowledge regarding mental health belief systems, and introduced the lived experience of an important component of the military structure.

Other methodologies, such as grounded theory, were also considered for this research study, however, phenomenology was the most appropriate based on the data collection and analysis processes and the desired result after data analysis. Data collection and analysis occurs simultaneously in grounded theory research and ends with a theory to explain phenomena based on the results of the interview process (Moustakas, 1994). Phenomenology, however, focuses on how the participant experiences the observed phenomena and generates a portrait of the experience after all data has been collected and analyzed (Moustakas, 1994). Additionally, grounded theory uses participants who have experienced the phenomena where in phenomenology, direct experience with the phenomena is not guaranteed. Although the researcher is interested in mental health stigma and help seeking, the participants in this study may not have experienced either of these phenomena. Creswell (2013) stated that “participants would all have experienced the process, and the development of the theory might help explain practice or provide a framework for further research” (p. 83) in regards to grounded theory research. Therefore, it would not be possible to define the reasons for mental health stigma and reduced help-seeking within this population if they have not developed beliefs regarding these

constructs or had experiences where stigma and reduced help-seeking has been present. The population being sampled in this study may not have experienced mental health stigma due their early status in their military careers and it is not guaranteed they would have participated in mental health services at this time. Future research using participants who have experienced stigma or engaged in help-seeking would qualify for grounded theory. Therefore, instead of an explanation of why the experience occurs, which is the result of grounded theory, phenomenology is only interested in the experience itself and what this means for those experiencing the phenomena. This investigation did not seek to explain stigma and help-seeking through the analysis of mental health belief systems but instead create a portrait of the mental health belief systems of US Army ROTC students and how these beliefs connect to stigma and help seeking.

Sampling Procedures

Research Site

In qualitative research, it is important to conduct interviews in a setting which is comfortable and natural for research participants (Creswell, 2013). For this reason, with the consent of the ROTC program, interviews and member checking sessions were held in the newly constructed classroom building on the campus of a large southern university. The three-story classroom building primarily houses the Army and Navy ROTC programs and has been described as a “major thoroughfare for students and will enhance recruitment efforts” (Ruckmeyer, 2013). Resources for the ROTC programs include recruitment and faculty offices, study areas, conference rooms, storage, and a “Virtual Battlelab” to be to teach map reading, land-navigation, and tactical training. The research site was chosen primarily for convenience of the sample due to proximity of the researcher to the research participants, as both parties share

the same campus. Additionally, due to the size of the university, the researcher was provided with space, the multipurpose room, close to the participants to conduct the interviews, giving the participants a familiar area to participate in the study. The multipurpose room is a large classroom area with several rows of movable desks and no windows. The site provided a semi-private area to conduct the necessary interviews. Although the room was reserved outside students walked through the room on three occasions during interviews, causing issues with confidentiality.

Participants

The study used purposive sampling to obtain a sample which had the specific membership characteristics as outlined by the needs of the study. Regarding specific sampling techniques, the author used homogeneous sampling. This sampling procedure required using participants who have similar traits or characteristics based on membership in a subgroup (Creswell, 2005), namely those from the Army ROTC program. To be included in this study, participants were required to be 1) Students of the university; and 2) Members of the campus US Army ROTC Program. The Army ROTC was used in this study due to its relative size in comparison to the rest of the armed forces. The Defense Manpower Data Center (2013) reports that there are 541,291 Army personnel actively serving, with all other branches reaching less than half this number in membership. If the proportions are reflected in the ROTC population, the higher number of enlisted members means that it is more likely to encounter an Army ROTC member, providing a larger sample base as the ROTC program on campus has approximately 200 members. Finally, the participants of the study were exclusively second year Army ROTC students as this was the only population the author was given access to by LTC Johnson, citing time constraints of third and fourth year students. This restriction was beneficial for the purposes

of this study as the sample of second year students had less exposure to military conditioning, leading to a experiences which were based in more of a mixture of civilian and military beliefs.

It has been suggested that qualitative researchers limit the number of participants used in a study as large numbers of participants may become unwieldy, decreasing the ability of the researcher to provide an in-depth picture of the phenomena (Creswell, 2005). Authors have suggested numbers as low as 1-10 participants to as high as 15-20 participants for phenomenological research (Creswell, 2013; Starks & Trinidad; 2007). Studies similar to the current investigation have used 17 (Ward & Besson, 2012) and 20 (Stecker et al., 2007) participants to understand the phenomena of mental health belief systems. Within the limits of this population, gaining the participants to reach the higher numbers suggested the aforementioned researchers were not possible due to the ROTC student's lack of participation. Efforts were made to increase recruitment numbers using monetary incentives, which increased the number of applicants. However, due to scheduling and participants' time constraints, a final count of eight participants was used for the research study. Using Starks and Trinidad's (2007) rationale, this number was sufficient as the authors suggested that a small amount of participants who have experienced the phenomena is equally as important as a range of different experiences. The participants in this study all had views regarding mental health, signifying that they had experienced the phenomena in some form.

In keeping with the aforementioned suggestions, this study used eight participants which were sufficient to reach saturation. The concept of saturation is rooted in grounded theory research, where a definite number is necessary to define the concept; however, the exact number of participants may vary as the qualitative approach changes (O'Reilly & Parker, 2012). Saturation is achieved when there is no new information generated (Green & Thorogood, 2004)

and there are no new emergent patterns in the data. Therefore, saturation is a marker of the appropriateness of the data and rigid numbers cannot be applied to all cases (O'Reilly & Parker, 2012). Regarding the current study, the researcher felt that beginning with 7-9 participants as suggested by Starks and Trinidad (2007) was all that is necessary to record any emergent themes based on the phenomenological qualitative approach.

The author believes that saturation was achieved through the eight participants used as similarities were found through analysis for themes while the interviews were dissimilar enough to demonstrate individual experiences. For example, during data analysis, participants began to list similar sources for knowledge regarding mental health including classroom instruction and anecdotal evidence. Additionally, when listing specific diagnoses, Post-Traumatic Stress Disorder (PTSD), common to the military community, was mentioned frequently during interviews. However, each participant remembered these events in different ways as there were varying accounts of classroom instruction or listing of additional mental illnesses outside of PTSD. The primary researcher feels that additional interviews may have provided additional accounts of the phenomena but upon analysis, the thematic conclusions would have been the same.

For accessibility purposes, the researcher limited participants to the research university. To find group members, the researcher engaged the campus Army ROTC program, gaining permission from the recruitment officer and Military Studies Department Head (see Appendix A). The parties allotted recruitment to take place during ROTC courses on Tuesdays and Thursdays. At this time, the primary researcher presented the study to the students using a PowerPoint presentation, left them with an explanation of the study (see Appendix B), and asked that they contact the primary researcher to set appointments for participation. One participant

was recruited using this method. A week later, the study explanation was also emailed to the participants through their instructors; however, the researcher also included a \$20 incentive to increase the number of participants (see Appendix C). Appointments were set through email and consisted of coordination of the primary researcher, an observer, the participant, and multipurpose room availability. Overall, 23 participants contacted the researcher for participation and eight participants completed individual interviews.

It should be noted that there were sampling errors which must be mentioned to maintain the integrity of the study. During recruitment, one of the instructors mistakenly offered class credit for completing the research interviews which the primary researcher made every effort to correct. However, one participant completed the interview while under the impression that he would receive of class credit. The primary researcher then spoke with the instructor who sent out another recruitment email which offered class credit. After speaking with the dissertation chair, the primary researcher then asked the instructor to revoke the class credit incentive. Additionally, the primary researcher sent emails to each interested participant stating that class credits would not be offered for participation. Finally, during the informed consent process, all participants were notified that there would be no class credit offered for participation in this study. This process has been noted in the primary researcher's memos which can be found in the appendix (see Appendix D).

Instrumentation and Qualitative Research Protocols

Data Collection

The primary researcher submitted an IRB application prior to the commencement of the study (see Appendix E). All interviews were conducted by the primary researcher. Three second year doctoral students, who had recently completed a qualitative research methods course, and

one recently defended PhD student, served as process observers to assess for consistency and reduce bias through analytic note taking. Van Manen (1990) stated that interviewing needed no special techniques or investigative instruments, however, for the purposes of rigor, the primary researcher used an interview protocol (see Appendix F) to ensure consistency between interviews. The process observers used an observation guide (see Appendix G) to ensure consistency between observations. To protect anonymity, each participant was given a number based on the order of interview (i.e. P1=Participant one). Each participant was read and given an informed consent and told that they were able to remove themselves from the study at any time. They were also informed that there were no health risks associated with this study. Originally, there was to be no compensation for participation in this study, however, as participant numbers were low, the primary researcher introduced a \$25 incentive for participation. Due to ROTC requirements (commissioned students cannot receive gifts above \$20); the incentive was then lowered to \$20. An amendment to the original IRB agreement was submitted to reflect this change. Participants were also asked to complete a brief demographic form which included their age, rank, sex, ethnicity, hometown type (i.e. rural, suburban, urban) and standing in college (i.e. freshman, sophomore, etc.) (see Appendix H).

Interviewing is defined as interactions between the researcher and the participant which elicit participant dispositions which are later used for analysis (Glesne, 2011). The methodology is a commonly used data collection procedure for all qualitative research (Creswell, 2013) suggesting that the method is standard and accepted across qualitative methodologies. Individual interviews were recorded using a voice recorder application on a tablet computer, using the primary data collection method suggested by Creswell (2013). For the purposes of this study, semistructured interviews and the use of an interview protocol were used to elicit dispositions of

US Army ROTC students, particularly their thoughts, feelings, and beliefs about mental health, mental health stigma, and help-seeking behaviors. Each individual interview lasted approximately for 30 minutes. After recording, the interviews were sent offsite to a password protected website for transcription. Each interview was transcribed and sent back to the primary researcher within 2-3 days.

Focus groups were proposed as a data collection method to assess those who may have a shared experience (Creswell, 2005) and to collect multiple perspectives on the same topic (Glesne, 2011). However, due to attrition, member checking was used in lieu of focus groups with IRB permission to reflect this change (see Appendix I). Member checking allows participants to review and check the interpreted data (Carlson, 2010) in order to assess if the interpretation matches the presented experiences (Curtin & Fossey, 2007). Three participants from the individual interviews agreed to serve as member checking with two agreeing to respond by email and the other sitting for a second interview. Creswell (2013) suggested that member checking include interpreted data rather than reviewing transcripts. Therefore, using a modified protocol (see Appendix J), participants were presented with the preliminary themes found during initial data analysis.

Member checking participants were asked their views regarding each theme and asked four additional questions that were unanswered after preliminary data analysis. The participant interview consisted of a 40 minute recorded session. Those who responded by email received the interview protocol were given a week to respond through the same channel. Only one participant out of the two that agreed to participate responded to the email request as the other participant could not be reached after the deadline. Additionally, there was error on the part of the primary researcher as the wrong member checking protocol was sent to the participant responding by

email. Due to this, the participant only responded to the additional four questions and did not comment on the preliminary themes.

Other data collection methods were also employed during other phases of the research process. During all periods of data collection and throughout the research process, the primary researcher kept memos which were used at the data analysis phase. These memos were included as they help to identify any themes which may have emerged during the interview process (Creswell, 2005) and detail the process of research which was again reviewed during data analysis. Process observers were present during the individual interviews and member checking sessions and engaged in taking field notes, thus recording data without direct involvement (Creswell, 2013). The process observers used an observation form adapted by Angrosino (2010) which detailed the events of the interviews including the space, participants, and reactions to questions.

Both memos and field notes were used to record the insights, themes, and ideas during the interview process (Creswell, 2005) and entailed recording that which is beneath the surface of what is seen and heard (Glesne, 2011). This meant that, during the interview process, the researcher and the observer were interested in recording the possible meanings behind the participants' experiences. These memos and field notes included possible themes that may have been hidden from the researcher during the interview process and the observations were later incorporated into the final theme development and narrative.

Interview Questions

Van Manen (1990) stated that phenomenological questions should also be meaning questions which help to understand best practices in certain situations. Interview questions for this investigation were developed using the constructs found in the primary research question and the

constructs as outlined in Chapter two: mental health stigma, and help-seeking behaviors. The interview questions for this study were designed to draw meaning from the thoughts, feelings, and beliefs of the participant's experiences regarding mental health. These factors were important to investigate as they comprise belief systems and can be used to investigate the sources of mental health stigma and the students' beliefs about mental health help seeking. Interview questions were also adapted from studies regarding stigma in the military (Britt, 2000; Hoge et al., 2004) and mental health belief systems of African American men (Ward & Besson, 2012). Hoge et al. (2004) used questions from Britt (2000) to assess how stigma contributes to help seeking behaviors where Ward and Besson (2012) addressed mental health beliefs, stigma, and help-seeking behaviors in African American men using the CSM (Diefenbach & Leventhal, 1996). The current study addressed overall mental health beliefs of US Army ROTC students as well as stigma and help-seeking behaviors. Each of the questions were verified for cultural relevance and ease of understanding by the head of the Military Studies department and two active duty members of the US Army. The questions were also reviewed for clarity by three experts in the field of counselor education and one in the field of curriculum instruction. Semi-structured interview questions for this study included the following:

Culture

What kind of person joins the Army (or the ROTC)?

Thoughts

What comes to mind when you hear the term behavioral health? (or mental health?)

Feelings

What happens to you when you encounter someone with behavioral health issues?

Is there someone in your life who struggles with a behavioral health issue? If so, how has that impacted you?

How do you feel when you encounter a service member with mental health issues?

Beliefs

Have your opinions about behavioral health been influenced? By what?

Have your experiences as an ROTC student influenced your opinions about behavioral health?

What messages about behavioral health have you received as an ROTC student?

Was your idea of behavioral health different before joining the ROTC? How?

Stigma

What are your opinions about someone who goes to see a behavioral health professional (counselor, psychologist, psychiatrist, etc)? Service members?

Help-Seeking

When would it be appropriate to see a behavioral health professional? When would it not be appropriate? What about for service members?

For what issues (current, future) would you personally go see a behavioral health professional?

For service members?

Data Analysis

Data was collected in multiple forms including transcriptions from individual and member checking interviews, field notes from the process observers during the interviews, and memos from the research process. Data analysis was conducted using the process outlined by Creswell (2013). Data was first transcribed into a text document by an outside transcriptionist and then converted to Microsoft Word (Version 15.0.4531.100) where line numbers were added

for visual analysis. Organizing the data using Word aided in ease of readability and note taking during later analysis.

Coding and Theme Development. Coding and theme development was informed by the process outlined by the Ward and Besson (2012) study. The author's coding and theme development occurred in four phases which distills all gathered information into a portrait of the explored phenomena. Coding included both human and computer-aided coding in the form of Dedoose qualitative software (Version 4.5).

The process of coding was broken into three processes contained within four phases. Richards (2005) named descriptive, topic, and thematic coding as different types of coding, each of which was employed for this study. Descriptive coding entailed using the demographic data collected prior to each interview and inputting it into a spreadsheet for later analysis. This process was completed prior to phase one and later input into Dedoose (Version 4.5) with each participant's demographic information being linked to their transcript. Topic coding included allocating passages to topics, which occurred primarily during this phase one. Line by line coding was completed for topic coding, a process which will be explained in later paragraphs. Finally, analytical coding includes interpreting the meaning from the highlighted passages. Analytical coding was ongoing and occurred during phases two and three. The descriptions below will detail the coding and theme development process from phase one to four.

Coding Phases. Phase one consisted of tentative open coding to address any salient emerging dimension as described by the participants. This was achieved through line by line coding as suggested by Glesne (2011) which creates an immersive experience with the data. Richards (2005) outlined directions for coding including selecting relevant material, creating an appropriate category, and filing the category appropriately. During phase one of coding, the

primary researcher selected one of the constructs of the CSM and read each line in a Microsoft Word (Version 15.0.4531.100) transcript for text segments which were relevant to the selected construct. Relevant text segments were highlighted in Microsoft Word (Version 15.0.4531.100) and a word or short phrase was applied to the text segment which identified the segment's main idea. These words and short phrases became the codes which were used for categorization. Additionally, the primary researcher made notes using the "comments" function in Microsoft Word (Version 15.0.4531.100) to record any observations while creating codes.

In relation to theoretical frameworks, Glesne (2011) suggests minimizing the number of constructs during analysis. However due to the use of CSM, and the factors of stigma and help seeking, the researcher used a priori code groups to correspond with the dimensions outlined by the model and the two constructs under investigation. The open coding was repeated for each of the remaining constructs of the CSM, the stigma and help-seeking constructs, and for passages which denoted cultural information. This led to 10 final constructs which were used for analysis. Finally, all highlighted passages were entered into Dedoose (Version 4.5) which was used to for data organization and analysis in later phases.

For this study, the primary researcher used the codes and highlighted passages to extract meaning from the phenomena. Creswell (2013) suggested a tentative code list include no more than 25-30 codes to be reduced with further analysis. The initial code list included 144 individual codes after completing the first analysis using all of the aforementioned constructs. To aid in organization, spreadsheets were created in Microsoft Word (Version 15.0.4531.100) with the seven CSM constructs, stigma, help-seeking, and culture as categories. Next, selected passages and codes were inserted next to the appropriate constructs in each spreadsheet. All codes were then aggregated into one Microsoft Word (Version 15.0.4531.100) spreadsheet with a column for

all codes, separated by each construct. These corresponding constructs and codes were then created in Dedoose (Version 4.5). Finally, each code was matched with its corresponding passage in Dedoose (Version 4.5) and redundant codes were removed. After removal, the researcher identified 44 individual codes across 10 constructs.

For phase two, the primary researcher made use of the field notes and memos completed during the interviews and phase one of data analysis. The field notes consisted of an observation form which asked the process observers to detail the setting, participant related activities, and the interview as a whole. Phase two also included personal notes which consisted of “comments” made on the Microsoft Word (Version 15.0.4531.100) transcription during open coding in phase one. Both the field and personal notes were used in phase two to incorporate any observations which may have been missed during line by line coding. To achieve this, the primary researcher read each set of notes and compared the observations to the codes entered into Dedoose (Version 4.5). This resulted in changes to some code names to better describe the text segments. During phase two, Ward & Besson (2012) also used memos to identify the stages of analysis during the condensation process. The primary researcher also updated the ongoing memo to increase reflexivity and make note of the research process.

Phase three included comparative analysis until saturation was reached across the data set by exploring final thematic coding. Van Manen (1990) described themes as the underlying structures of phenomena, essentially finding the point of the experience through simplification. Themes are drawn by considering how the topics are related and going beyond the topics presented to understand the “why” of the information (Richards, 2005). Per van Manen (1990), the primary researcher looked under each construct in Dedoose (Version 4.5) and grouped like codes in an effort to simplify the information presented. Then, as suggested by Richards (2005),

the primary researcher used the codes and corresponding text segments to assess the meaning behind the codes and shared experiences.

The suggestions of the aforementioned authors resulted in thematic labels which described the underlying experience based on the grouped codes. Theme names were created using differing methods depending on code groups. For example, codes with a shared word, such as “education,” received a theme name based on the shared word. Theme names were also created based on the type of experience shared as codes such as “fear” and “apathy,” perceived as negative emotions, was grouped as “Negative Emotional Outcomes”. This process was continued as the primary researcher analyzed the codes in each construct.

During this time, the primary researcher and a dissertation committee member conferred on emerging themes until a consensus was reached regarding the data. Additionally, the primary researcher used member checking exercises to confirm the emerging themes. This was achieved by discussing each theme with a participant and discussing their views on the perceived shared experiences. Two participants also answered four follow up questions which were used to support or refute the emerging themes. This process was important as Moustakas (1994) observed that refinements to themes bring new perspectives, allowing phenomenological researchers to correct perceptions as they explore the experience. Sharing emerging codes with the committee member and participants allowed the primary researcher to refine and analyze the validity of the themes in relation to the experiences they described. After comparative analysis, 17 themes were found based on the data collected.

Phase four included synthesis of the data by integrating the observations of the participants into one narrative. For the purposes of this study, the CSM, stigma, help-seeking, and military culture we used as a priori code groups during phase one. These a priori groups

were used to organize codes which were condensed to themes. The goal of phase four was to draw together the themes found in phase three into an overall narrative which would describe the thoughts, feelings, and beliefs of the participants in regards to mental health.

To begin, the primary researcher analyzed the definitions of the seven constructs of the CSM and their relationship to research question one. The primary researcher compared the definitions provided by Diefenbach and Leventhal (1996) and Moss-Morris et al. (2002) to each construct addressed in research question one. Assessment included best placement of each CSM construct in relation to research question one which referred to the thoughts, feelings, and beliefs of the participants. For example, *illness coherence* refers to an individual's understanding of mental illness (Moss-Morris et al. 2002). Using this definition, *illness coherence* was placed into the category of "thoughts" as the primary researcher believed that the knowledge attainment based themes contained within this construct fit the CSM definition of how the participants understood mental illness. Similarly, the construct of *emotional coherence* was placed in the construct of "feelings" as both of these constructs assessed the emotional reactions of the participants in response to mental health. Finally, the construct of "beliefs" included the last five constructs of the CSM (*identity, cause, cure/controllability, timeline, consequences*) based on the definitions provided by Diefenbach and Leventhal (1996). This decision was supported by the research presented in Chapter two which emphasized that cultural beliefs influence how individuals perceive factors such as the causes of mental illness, ability to identify symptomology, and possible cures (Greenberg et al., 2009; Reavley & Jorm, 2011; Wong et al., 2010). The final constructs of stigma, help-seeking, and military culture were added to the overall narrative as they applied to the constructs of research question one. For example, portions of the construct of stigma were related to the "feelings" construct as a participant

expressed fear of serving with a service member who has been diagnosed. This same methodology was applied to help-seeking constructs as it related to research question one. Military culture was left separate from thoughts, feelings, and beliefs as these views did not contribute to the Mental Health Belief Systems of the participants, but to their beliefs about those who join military organizations.

The goal of phenomenology is to arrive at a textural description of how the phenomena are experienced by extrapolating the thoughts and underlying structures of the phenomena (Moustakas, 1994). Data analysis led to an overall narrative which presented by the participants thoughts, feelings, and beliefs regarding mental health. Starks and Trinidad (2007) stated that the reader should feel as though they have vicariously experienced the phenomena; the goal of phase four of this investigation was to present the participants' experience in a cohesive manner through narrative interpretation. This final narrative which encompassed phase four is presented in Chapter 4 of this study.

Validity and Verification Strategies

Assessing the strength of the research in qualitative studies entails using validation strategies to ensure that the research is unbiased and reflects the experiences of the research participants and not the researcher (Creswell, 2013). Similar to validity and reliability in quantitative research, terms such as trustworthiness and rigor are used in qualitative research to ensure that the data obtained is not subject to researcher bias. For the purposes of this study, the researcher used the five methods for trustworthiness as outlined by Carlson (2010). These methods include audit trails, reflexivity, thick and rich description, triangulation, and member checking.

Audit trails are described as records which document the primary researcher's reflections during the research process (Richards, 2005). Carlson (2010) suggested keeping an audit trail should an external auditor need to review the research process. The primary researcher used memos during the data collection and analysis process to record events including scheduling and changes during sampling. Carlson (2010) also noted that interview recordings can also be used as an audit trail. Per IRB policy, the primary researcher had requested to keep the recordings for a year after the research study had closed.

It is important that qualitative researchers include mechanisms for transparency in their research, detailing how the researcher is a producer and product of the research (Creswell, 2013). Reflexivity allows researchers to detail thoughts during the research process to reduce biases as, unlike quantitative researchers, qualitative researchers are directly involved in the interpretation of the data (Richards, 2005). Carlson (2010) suggested journaling which records the "thoughts, feelings, uncertainties, values, beliefs and assumptions that surface throughout the research process (p. 1104)." For the purpose of this study, the primary researcher's thoughts were also included in the recorded memos, which were used as references during the data analysis process to analyze possible themes. Additionally, in the interests of transparency, the researcher also completed a positionality statement (see Appendix K) which requires disclosure of any academic experience, experience with the population, and potential biases which may impact how the research is viewed.

Next, the primary researcher employed thick and rich description, which included contextual details that enhanced the overall narrative. Carlson (2010) detailed that the descriptions include settings, participants, and data analysis and collection procedures. The primary researcher achieved this description through descriptions of the research facility in this

Chapter and demographic descriptions of the participants in Chapter four. Finally, the memos which have been recorded also count as thick and rich descriptions as they show the primary researcher was “diligent in their attempts to conduct respectable research” (Anfara, Brown, & Mangione, 2002).

The fourth method, triangulation entails using multiple methods and sources to obtain corroborating evidence regarding the overall theme of the research (Creswell, 2013). For the purposes of this study, the researcher employed different forms of data collection to ensure triangulation. Data collection methods included the individual interview recordings and transcripts and observer forms. Regarding analysis, the primary researcher used two forms of analysis including Microsoft Word (Version 15.0.4531.100) and Dedoose (Version 4.5) to compare codes and final themes.

Carlson’s (2010) final method included member checking, which is the process of allowing participants to view the distilled themes to ensure that the analyzed data reflects the participants’ recorded experiences. Early thematic analysis can be used as information for reflection, allowing the researcher and the participants to collaborate on more focused themes (van Manen, 1990). For this study, the researcher presented themes to one participant in an interview format including four additional questions for validation. The primary researcher asked that the participant confirm or deny the themes as necessary and recorded the interaction for analysis. Finally, two other participants were emailed the member checking protocol and asked to confirm or deny the conclusions found within a week’s time frame.

As an extra validation strategy outside of those listed by Carlson (2010), the primary researcher also employed peer review during different points of the investigation. Peer review is the process of including an outside entity to assess the methodology of the research study to

ensure interrater reliability (Creswell, 2013). The investigation included a committee whose purpose is to question and improve the integrity of the study. For the purposes of this study, a dissertation committee member involved in the structuring of the methodology in order to ensure reliability. The committee member has published qualitative research and has completed a qualitative dissertation in counselor education, giving her experience with the process of completing a qualitative study. Additional efforts to include peer review included several committee members reviewing the interview questions to be used with the participants. Additionally, there were several levels of review by military personnel in order to ensure that the questions to be used will be culturally appropriate. Parties include the Department Chair of Military Studies at the research university and two active duty members of the US Army.

Summary

The purpose of this Chapter was to detail the research methodology to be employed in this study. The author began with the purpose of the research study followed by how the overarching research questions were formulated. Next the author introduced the research design, Hermeneutic Phenomenology, and the theoretical framework, the Common Sense Model for illness representation, which was used to analyze the data gathered from the interview questions and member checking. The Chapter also detailed the data collection and analysis process including interview question development, and coding methods for the final textual description of the participant's experience of the phenomena. Finally, trustworthiness strategies were discussed including audit trails, reflexivity, thick rich description, triangulation, and member checking. The next Chapter will detail the results of the study, presenting themes found after data collection.

CHAPTER IV

Introduction

The purpose of this study was to investigate the thoughts, feelings, and beliefs of US Army ROTC students in relation to mental health. The author used hermeneutic phenomenological methodology to organize the data and identify meaning. Thematic analysis of 8 interviews and two member checking exercises was performed, producing several themes which were named by the author and one committee member. The Common Sense Model for illness representation (CSM; Deifenbach & Leventhal, 1996) was also used as a guide during data analysis. The following Chapter will detail the findings of this study by presenting the sample, verification strategies, and the data analysis process. Finally, the Chapter will include detailed descriptions of the themes and conclusions reached by the researcher based on these themes.

Participants

The sample for this study consisted of 8 US Army ROTC students at a large institution in the state of Florida (Table 1). Demographic information was collected for later data analysis. The study included males ($n = 6$) and females ($n = 2$) between the ages of 19 and 22 ($m = 20.25$). All of the students were at the Military Science II level with sophomore ($n = 6$) and junior ($n = 2$) level participants. Additionally, students described their hometown as either suburban ($n = 7$) or urban ($n = 1$). Finally, regarding ethnicity, participants described themselves as White ($n = 3$), Black/African-American ($n = 2$), Hispanic ($n = 1$), and Bi-Racial ($n = 2$).

All participants completed an individual interview which consisted of 12 interview questions related to the research questions; each interview lasted an average of 30 minutes. Two participants also completed a member checking exercise where they were asked four questions

developed from the individual interviews to clarify themes and questions regarding the codes found by the primary researcher. One participant answered questions regarding the themes and codes found by the researcher in an interview format while both participants answered the four supplementary questions. The other participant only answered the four supplementary questions in an email format.

Table 1
Participant Demographics – ROTC Students

Participant	Age	Academic Level	Hometown	Ethnicity	Gender
1	22	Sophomore	Suburban	White	Male
2	19	Sophomore	Suburban	Black	Male
3	20	Sophomore	Urban	Bi-Racial	Female
4	19	Sophomore	Suburban	White	Male
5	21	Junior	Suburban	Hispanic	Male
6	20	Sophomore	Suburban	Bi-Racial	Male
7	20	Sophomore	Suburban	Black	Female
8	21	Junior	Suburban	White	Male

Verification of the Results

As discussed in Chapter 3, the researcher utilized several verification strategies throughout the study to ensure vigor and trustworthiness. These included audit trails, reflexivity, thick and rich description, triangulation, and member checking as outlined by Carlson (2010). Audit trails (documents which outline the process of research) were achieved through various efforts to document the research process including memos and recording of the interviews.

Reflexivity (tools to enhance transparency) was attained through journaling using the memos, and the positionality statement. Thick and rich description is included in the following narrative and the observation forms while triangulation included all of the various forms of data collection. Finally, member checking (a second interview to verify themes) was achieved through individual interview and email correspondence to verify codes and themes found in the data. Finally, the primary researcher employed outside auditors at various points of the study to ensure trustworthiness.

Data Analysis

Data analysis consisted of several steps to aggregate, distill, and draw meaning from the data presented. This process included using both Microsoft Word (Version 15.0.4531.100) and Dedoose (Version 4.5) to help organize the data and to search for additional themes by observing where codes and demographic data cross referenced. Dedoose (Version 4.5) is an organizational web-based tool which allows researchers to collect and display data in a visual format. The following section will describe the data analysis process including organization of the data and thematic analysis.

Organization of the Data

Each interview was transcribed using the transcription service Nonotes. Nonotes is an online transcription service where one can upload audio files to be transcribed by an outside party. After the initial upload, transcriptions are returned in an average of two to three days. During the initial coding, the primary researcher listened to each interview while reading the transcript to ensure accuracy (see Appendix H). The transcriptionist enclosed the time of the interview in brackets to note when they were not able to understand the dialogue. Additionally, the transcriptionists were possibly of European origin, as many spellings and phrases required

changes to ensure that the interview coincided with the transcription. Finally, each transcription was given line numbers to ease recall during the coding process.

The data was then organized for efficiency and clarity by using tables in Microsoft Word (Version 15.0.4531.100) (see Appendix L). Each participant was given a separate file which included tables that described the demographic information, the seven constructs of the Common Sense Model (CSM; Diefenbach & Leventhal, 1996) for illness representation. Additionally, the transcriptions and the demographic information for each participant were entered into Dedoose (Version 4.5). After analysis was completed in Word, codes and corresponding text was also entered into Dedoose (Version 4.5).

Theoretical Framework

A theoretical framework can be described as an analytic lens which is used to inform the collected data and construct thematic conclusions (Creswell, 2011). For the purposes of this dissertation, the primary researcher used the Common Sense Model (CSM) of illness representation (Diefenbach & Leventhal, 1996). The authors of the model assert that individuals create a cognitive schema of illness based on social and cultural cues. Through these cues, individuals learn how to identify and treat illness based on type and severity. Illness is assessed through five constructs including identity, cause, cure/controllability, timeline, and consequences. Two additional constructs, illness coherence and emotional representation, were included after the creation of an illness perception index (Moss-Morris et al., 2002). For the purposes of this study, these constructs were used to analyze US ROTC students' thoughts, feelings, and beliefs regarding mental illness.

The CSM was used for this study because the overarching purpose of the model is to categorize how individuals perceive illness overall (Diefenbach & Leventhal, 1996). The

primary researcher assessed participants' overall Mental Health Belief Systems (MHBS) by using the model to analyze their thoughts, feelings, and beliefs about mental health. The constructs of the CSM were divided between the three constructs of research question one which included the thoughts, feelings, and beliefs of the participants in regards to mental health. Using the definitions provided by the authors of the CSM (Diefenbach & Leventhal, 1996; Moss-Morris et al. 2002) and research presented in Chapter two, the primary researcher aligned the CSM constructs with the appropriate constructs from research question one. "Thoughts" about mental health were aligned with *illness coherence* as the definition of illness coherence entailed how individuals understand illness (Moss-Morris et al., 2002). This was similar to the themes found under thoughts about mental health as they primarily detailed knowledge attainment and how the participants gained understanding about mental health overall. "Feelings" about mental health were linked to *emotional representation* as the definition of this construct relates to how participants feel about illness. Finally, the remaining constructs of the CSM were aligned with beliefs about mental health as they related to beliefs about mental illness presented in Chapter two. Placing *identity, cause, cure/controllability, timeline, and consequences* with the "beliefs" construct was supported by the research presented in Chapter two which emphasized that cultural beliefs influence how individuals perceive factors such as the causes of mental illness, ability to identify symptomology, and possible cures (Greenberg et al., 2009; Reavley & Jorm, 2011; Wong et al., 2010).

Thematic Analysis

After organizing the data in Microsoft Word (Version 15.0.4531.100), the primary investigator used line-by-line coding to begin data analysis. Each document was coded by hand and the primary investigator highlighted text segments related to the construct being identified

(CSM, stigma, help-seeking, military culture) at the time of review. The highlighted material was then represented using one or two word codes which best assessed the main idea of the text segment. After all interviews were read and coded for each construct, the codes were collected into one spreadsheet to create the primary code book. The text segments and initial codes were transferred to Dedoose (Version 4.5) for ease in review and to assist in data analysis. Each code was then reviewed for accuracy and codes were condensed to remove redundancy. Once all codes were collected and finalized, the author began to draw primary themes from the codes by grouping like codes and assessing for the meanings in their relationship. The primary researcher also used the information provided by outside observers that noted details of each interview including surroundings and actions which may not have been observed by the primary researcher. The primary researcher's own memos, member checking exercises, and collaboration with a committee member were used to confirm codes and themes, resulting in a final set of 17 themes. Table two describes the major themes and codes used in the data analysis. The following section will present the themes found based on the research questions presented in Chapter 3.

Table 2

Major Themes and Codes

Themes	Codes
Education	Formal Education, Informal Education, Limited Information
Contact	Exposure, Adaptation, Privacy, Group Impact
Mind/Body Connection	
Negative Emotional Outcomes	Apathy, Fear, Remorse
Emotional Adjustment	Apprehension, Empathy
Illness Identification	Symptom/Disease Identification, Explanation of Behaviors
Stress Related	Psychotic Break, Trauma, Environment
Interpersonal Issues	Family/Home
Acceptance	Acknowledgement, Adjustment, Client Buy- in
Treatment Options	Efficiency, Group Approach, Self- Medication, Professional Engagement
Civilian vs. Military Expectations	
Duration	Acute, Lifelong, Situational
Interpersonal Impact	Daily Life, Familial Issues, Job Performance, Distrust
Intrapersonal Impact	Internal Conflict, Harm to Self or Others
Intrinsic Factors	Patriotism, Education, Success

Themes	Codes
Extrinsic Factors	Class, Diversity, Power
Judgment for Treatment	

Findings

The results were analyzed using the two research questions presented in Chapter Fthree. The first of these investigated the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. The second research question investigated the themes found from students MHBS and the implications for prevention efforts, treatment protocols, and the field of counseling.

The data will be discussed using a combination of both research questions with students' thoughts, feelings, and beliefs will be presented thematically in Chapter Four. Also, themes regarding military culture, stigma, and help-seeking will also be presented in Chapter Four. Chapter Five will include an illness representation of student's MHBS and discuss how the information can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members. The following sections will include the overall constructs from research question one, the theoretical framework used to analyze the construct, the themes found, and finally the codes which contributed to the theme.

Research Question One

Research question one sought to discover US Army ROTC students' thoughts, feelings, and beliefs regarding behavioral health. To analyze this question, the author used the Common Sense Model (CSM; Diefenbach & Leventhal, 1996) of illness representation to examine the

responses provided by the participants. Portions of research question two will also be used to answer research question one as research question two presents a thematic analysis of the themes found in the research. The remaining portions of research question two, which presents the implications of these themes, are found in Chapter Five. Finally, the constructs of mental health stigma and help seeking will be addressed within the constructs of thoughts, feelings, and beliefs regarding mental health. Beliefs based regarding mental health stigma and help-seeking will be denoted as sub-sections within each construct.

Thoughts about Mental Health

Research question one was used to determine respondents' thoughts in regards to mental health. Overall, 57 responses addressed how participants understand mental health through knowledge attainment. Participants Seven and Eight recorded the most responses (15 and 14 respectively). In terms of the ethnicities of the participants, African-American (25) and White participants (21) expressed the most experiences regarding thoughts about mental health. In this study, the respondents shared experiences which primarily detailed the sources of their knowledge about mental health. The researcher found three themes (Table 3) that related to participants' thoughts about mental health as a result of the participant's experiences including education, contact, and mind/body connection.

Table 3

Thoughts about Mental Health

Theme	Codes
Education	Formal Education, Informal Education, Limited Information
Contact	Exposure, Adaptation, Privacy, Group Impact
Mind/Body Connection	

Education

This theme corresponds to answers which detailed learning related to school based instruction regarding mental health. The label for this theme was chosen due to two of the three codes (formal and informal education) were related to attainment of mental health knowledge. Five participants responded that they received *formal education* about mental health both prior to and after joining the ROTC. In terms of frequency, Participants Eight and Seven referenced some form of formalized education regarding mental health. Participant Eight remarked that he learned about behavioral health in:

An AP psych class in high school so I learned about them then, I just learned more information which is always good to learn more about something to influence your opinion, but that was where I just I gained more knowledge on it.

Participant eight also attempted to recall information from his Freshman year psychology course. There was also the recognition of personal research to increase knowledge regarding mental

health issues, specifically Post-traumatic Stress Disorder (PTSD), with participant four remarking, “*So I mean that research as well as they know like there is countless studies out there that this is an actual problem that exists and it’s not just in the military.*” The participant seemed particularly proud of his outside research with the observer who noted smiling during the sharing of this accomplishment.

As a result of time spent in the Air Force Academy, Participant Seven recalled official briefings where information was shared regarding warning signs of suicide, depression, and other mental health issues. The participant also reported seeking information from psychological services to keep herself informed, remarking, “*I was like I would just go and stop by and, “hey can I get some information? Can you talk to me in just, tell me what to look for” so that is what I would do.*” Finally, two participants recalled receiving education about mental health during ROTC training, recalling videos about PTSD and lectures regarding how to address service members in distress. Participant Six, during member checking, was able to confirm these statements, mentioning classes on stress reduction primarily during the first year of ROTC. When asked how often he remembers discussions regarding stress reduction, the participant responded that it was at least one class per semester. However, Participant Six also noted that these conversations did not continue into the second year as the instructors focused more on other ROTC topics. The participant believed that these classes in the first year are sufficient as the information would not be in use until later on in the ROTC career.

Outside of classroom instruction, seven respondents also reported receiving *informal education* in the form of anecdotal evidence from friends, commanding officers and other sources of reading material. For example, Participant Eight made five references to informal education, participant seven made three references, and participant four also made three

references, providing the most matching responses. In terms of ethnicity, White participants made twice as many references (8) to informal education as African-American participants (4).

In terms of specific responses related to formal education, Participant Four shared that, *“I mean you always hear stories, you always hear stories about people like friends of friends who come back and they’re just not right.”* Participants also shared that they’ve participated in conversations outside of class where mental health issues were discussed. Participant Three recalled learning from parents and society what was normal and abnormal behavior, receiving knowledge of mental health by taking cues of what was unacceptable behavior. *Informal education* also came from commanding officers with Participant Seven recalling receiving sporadic emails a few times a month with instruction to *“look out”* for fellow service members and *“help them out, talk to them because we don’t want any of those issues.”*

Finally, five respondents remarked receiving *limited information* regarding mental health. Responses were spread equally between these participants and were the third most frequently referenced item regarding thoughts about mental illness. However, regarding ethnicity, White participants (7) provided more answers than all ethnic groups. According to excerpts, participants responded that they were given some information about what mental health is or its symptomology, but this knowledge was incomplete. Participant three remarked:

I don’t think we’ve gone into mental health really as far behavioral health. The only thing that I know that we’ve learned as far as behavior goes is oh we received like a SHARP training which is like a sexual harassment training and that’s pretty much it.

Information regarding mental health was also limited due to perceived necessity with participant four sharing, *“I’m sure that doesn’t really come up much because overall most the kids who are Military Science I and II they’re all college kids.”* Finally, participant one was not able to recall

direct sources of messages, noting that there were, “*Not many official messages, I just kind of hear things.*” Again, the students mentioned receiving information but the source was unclear.

Contact

The second theme of *contact* detailed how respondents learned more about mental health through direct contact with those who have mental health issues. Also, this construct contains experiences regarding how this knowledge of mental health impacts them and others and expected behaviors when confronted with those who have mental health issues. The theme received this label as all the corresponding codes (*exposure, adaptation, privacy, and group impact*) shared the experience of learning through contact with those who had or may have had a mental health issue. Exposure details experiences of contact with differing personalities or those with mental health issues and how this may prepare them to deal with those who have mental health issues in the future. Exposure was referred to most frequently mentioned theme regarding thoughts about mental health with six participants mentioning exposure to personalities or those with mental health issues a total of 24 times. Of these 24 references, African-American participants account for half with 12 responses.

In regards to the code *exposure*, participant two shared that:

Dealing with different people who have come from different walks life yes. Being able to actually deal with certain personalities is definitely something that you would do as ROTC student. How to handle it, get along with it and deal with it.

ROTC membership gave students the opportunity to be exposed to a larger population with differing personalities and behaviors. Participation in the ROTC also exposed students to those with more information regarding mental health. This information may have been due to personal

experiences with those who have mental health issues or through vicarious learning through shared anecdotes.

Exposure to those with experience regarding mental health has also created awareness about mental health knowledge. The participants have an understanding that new knowledge has been absorbed or more research must be completed. Three participants recalled how their knowledge of mental health had grown due to contact with family members who had mental health issues with participants two, four, and seven having family members who had been diagnosed with dissociative identity disorder, PTSD, and schizophrenia, respectively. Participant Four remarked:

It definitely made me more aware of like problems that are out there and how some people believe, a lot of like soldiers sometimes believe that PTSD is just like a sign of weakness and nobody really has these problems but actually these problems do exist I mean there are studies on it.

Outside of these participants, member checking illuminated that other ROTC members have had family that have served in the Army, giving them a “*first hand*” experience with mental illness. Participant Six went on to state that individuals from ROTC student’s personal lives would also create opportunities for exposure. However, within the ROTC community, participants remark that they are not often exposed to those with mental health issues. Participant Seven, who spent time in the Air Force Academy prior to coming to the research institution, noted that while in the Academy, she was often exposed to people committing suicide and with PTSD issues but had not encountered anyone with mental health issues while at the research institution. Participant seven shared the most responses regarding exposure to those with mental health issues with nine excerpts matching this code. Participants also understand that they may eventually be exposed to

those who have mental health issues and have made strides to understand diagnoses pertinent to the population. Participant eight noted:

I made note that in the future I will need to do more research on post-traumatic stress disorder, since I will be an officer in the future I will have to I guess aware of my fellow soldiers and as well as an ROTC my fellow cadets and I know I will need to be aware it is not a big of a thing at the moment but like a path to knowing I need to be aware.

Direct or possible contact with people who have mental health issues caused some participants to learn how they would adjust to the event, which necessitated a code for *adaptation*. Four participants shared a total of 10 experiences related to this *adaptation*. Regarding racial groups, African-American participants also shared the most responses for adaptation. Regarding individual responses, participant two, who mentioned the most instances of the code at four, stated:

You have to adapt on how to deal with it, I don't...when you are faced with somebody who has an issue behavior wise, you have to adjust the way you come and approach them, handle like conversation. You have to really understand where they are coming from and along with the mental health.

Adaptation also includes involvement based on necessity, where participants would only engage issues regarding mental health after processing the severity of the situation. Participant Eight remarked that they would first assess the situation before direct involvement. If addressing the behavior displayed by a mental health issue is not “detrimental” then there is no need to bring it to the person’s attention. Finally, *adaptation* is also a personal skill where one participant notes

how past stressors helped him add to his knowledge of how to deal with future stressors.

Participant Five believed:

You've got to keep going you can't stop so I mean I guess it helps you so like if you ever encounter like another obstacle in life it is not going to put you down because you are already mentally, you have gone through that stage where it has been more brutal.

The contact with and subsequent knowledge of how to address stressful situations contributed to future behaviors. Participants learned to change behavior to address possible future engagements. For example, during member checking, Participant Six noted that exposure to those with mental health issues helps one to understand “*the best logical way to go through things*” when encountering someone with mental health issues. In these instances, participants were required to change their thought and behavior patterns to best fit the situations, leading to the code of *adaptation*.

Although some participants may have direct contact with individuals who can increase their knowledge of mental health issues, their knowledge was limited due to the amount of information the other person is willing to share. *Privacy* was the least used code regarding thoughts about mental health with Participant Two sharing three experiences, the most for this code. Participant Two as also African-American, and accounted for the most responses in regards to ethnicity. Finally, only males shared responses for this code.

Participant Two shared that both parents and a sibling were in different branches of the military, Army and Navy respectively. However, those in his family were reticent to share experiences, remarking, “*I tried to get some things out of my dad but he doesn't talk about a lot of the stuff.*” Additionally, the participant's mother would only speak about basic training and

nothing of active duty. Due to this, the participant chose to refrain from asking questions which may have increased mental health knowledge stating *“I just see that as not my place”*.

Finally, participants shared how knowledge of mental health issues can affect other members of their unit, leading to the code *group impact*. The participants noted how widespread mental health issues can be if not addressed. Overall, six participants shared experiences which necessitated this code. Participant One stated:

Just how serious mental illness is, how much it can impact brigades, groups of...how you have to take into consideration things like when you are being an officer, you are managing those types of people. So it is definitely special consideration you learn.

This demonstrates that the ROTC students understood how mental health issues can affect all those under their command and how important their leadership skills are to managing these issues.

It is also important to note that six responses for exposure were also referenced for group impact, as those who have been exposed to individuals with mental health issues understand that mental health issues may have the capacity to affect others. For example, Participant Four remarked:

So I mean that research as well as they know like there is countless studies out there that has dictated this is an actual problem that exist and it's not just in the military. It's in like police; even in non-combat related services. It is a very real problem and I think having a personal connection to it has made it more apparent to me on that.

Additionally, some members remarked that knowing the impending mental health issues that service members face creates the need for increased group cohesion. Participant Seven stated,

“Just pay attention to those warning signs and it makes me want to definitely get closer to people and find out about them.” The participants’ knowledge of mental health needs and experiences with those who have had mental health issues shaped his need to create a facilitative environment for future service members to obtain assistance. Overall, these examples show that the participants recognize that knowledge of mental health issues can affect others within the unit and may need to be addressed.

Mind/Body Connection

Participants often noted physical fitness as a necessity for ROTC and Army membership. These physical requirements were also noted as coping mechanisms for stressors, necessitating the theme of *mind/body connection*. The theme was named as such to demonstrate how mental health and physical fitness were related to overall wellness according to the participants. Two participants, both males, added to this theme with Participants Eight, who was Caucasian, and Five, who was Hispanic, making eight references. Participant Eight had the most responses at six, one of these being:

I have done a lot of research on being athletic and how it makes you feel better overall and as I guess feel like running like having problems I can run them away so I guess I really feel like strong correlation between being athletic and not having behavioral issues or having negative effects.

In the preceding excerpt, the participant recognized how physical fitness can improve mood and possibly stem behavioral issues. Participant five also made this connection and again stated that the skills are transferable, noting that physical fitness teaches you to *“keep going”* because *“you are already mentally, you have gone through that stage where it has been more brutal.”* Member checking confirmed that these ideas are being reinforced by commanding officers, as students are

told that working out is a factor of good mental health, helping to clear the mind from stress. For this theme, students noted the importance of overall wellness, an idea which was reinforced by their instructors.

Summary

In summary, regarding the illness coherence of the students in this study, the participants' thoughts about mental health were informed through various channels of education, contact with those who may have mental health issues, and the knowledge that there is a connection between the mind and body in terms of wellness. Participants shared experiences where they were informed about mental health issues through official channels such as commanding officers and research. However, some reported limited information due to the lack of shared knowledge from instructors. Participants also learned about mental health through contact with others who may have had mental health issues or those who have known others with mental health issues. Exposure to those with mental health issues increased knowledge of how to address those who display symptomology, causing participants to learn to adapt to those who may be mentally ill. Additionally, although the participants may have been exposed to individuals who could give them more information about mental health, due to privacy concerns, participants did not feel comfortable to probe for more information. The participants also recognized how those who have mental health issues can impact those around them and that it is important to give assistance to these individuals before others are affected. Finally, the respondents noted a link between mind and body in regards to mental health, denoting knowledge that both factors must be in balance for overall wellness.

Feelings about Mental Health

Feelings about mental health is the second construct contained in research question one. Through the interview process, the researcher sought to understand how respondents felt about mental health and those who presented with mental health issues. Codes within this construct were used a total of 28 times and again, White (11) and African-American (9) participants shared the most answers for this construct. The researcher found two major themes in relation to feelings about mental health; *negative emotional outcomes* and *emotional adjustment* (Table 4).

Table 4

Feelings about Mental Health

Theme	Codes
Negative Emotional Outcomes	Apathy, Remorse, Fear
Emotional Adjustment	Apprehension, Empathy

Negative Emotional Outcomes

Upon contact with those who have mental health issues or were suspected to have mental health issues, one of the results of this contact was *negative emotional outcomes*. This theme can be defined as unwelcomed emotional reactions when encountering those with mental health issues. Codes in this theme included *apathy*, *remorse*, and *fear*. The name of this theme was derived from the negative connotations of the preceding codes. When displaying *apathy*, respondents reported trying to ignore behavior of the mentally affected individual. *Apathy* received the second most number of responses regarding feelings about mental health with six participants making references. Overall, Participant Eight made the most responses (3) and

represented three out of the four total answers for White respondents. The other responses were spread equally between the remaining participants at one per participant.

Regarding specific responses about *apathy*, participant four, when speaking of a family member who was diagnosed with PTSD, remarked, *“I tried to act as normal as I can round him.”* Similarly, participant five, when answering questions regarding how they would behave if encountering someone with mental health issues, the participant stated they would *“Just go along with it.”* Apathy also corresponds to feelings regarding the frequency of mental health issues. In reference to a friend who committed suicide, participant seven stated, *“He wasn’t the first one and he would definitely not be the last one.”*

The second code, *remorse* regarding someone with mental health issues, was only shared by one participant, an African-American female. As noted above, participant seven experienced death due to mental health issues with a friend committing suicide due to pressures during membership in the Air Force Academy. The participant expressed remorse at not being available to the friend after leaving the Academy for the research institution. Regarding the aftermath, the participant stated:

Gosh, I was sad for weeks. It personally impacted me because I felt I knew what he was going through and I kind of felt guilty because I wasn’t there to help him.

Obviously I couldn’t help him physically because I wasn’t at the academy. But I felt like I should have made my presence more known for him to be able to come to me and talk to me.

The participant concluded that she learned from the encounter, promising to be more vigilant in recognizing mental health symptomology in others. Upon member checking, participant six supported these beliefs, stating that there would be feelings of remorse if the participant knew

they were able to affect change and did nothing. While the participant did not say so directly, this is possibly due to his feelings of apprehension of serving with those who have mental health issues as the participant stated that they would feel responsible for anything that happened due to not speaking out.

When encountering someone who displayed mental health symptomology, three participants responded with *fear* to their particular encounter or possible encounters. Fear was only mentioned five times within the emotional representation construct but was one of the most impactful. White participants shared the most responses at five total, followed closely by African-American participants at three. In regards to *fear*, Participant One shared that he has plans to be a doctor and would be fearful of those with mental health issues due to lack of knowledge about the lucidity of potential patients. An encounter with a schizophrenic family member left Participant Two fearful from the experience, remarking, “*And I was scared and I just stood there and then she mumbled under her breath, she threw up her hands and then she walked away.*” Essentially, both of these participants expressed *fear* of those with mental health issues due to concerns for safety within their professional and personal lives.

Fear and Mental Health Stigma. Specific to the military environment, some participants shared feelings of *fear* serving with those who **divulged** mental health issues. This is different from stigmatic beliefs presented later in this chapter regarding mental health stigma and help-seeking. In regards to *fear* and mental health stigma, Participant Six expressed that he wouldn’t want to go into combat with someone who is mentally ill, fearing access to live ammunition:

If you are in the army and you do have to carry out your duties, I feel like you wouldn’t want to be fighting with someone who has the mental problems, especially when

people's lives are at stake... I feel like there has been a lot of stuff and they are just people, it's just a bad combination to have mentally unfit people with guns and live ammunition.

These statements were again reiterated by the same participant during member checking, stating that the combination of mentally unstable service members and live ammunition was not best for the group. These beliefs can be classified as stigmatic as the participant has the perception that they will be harmed as a result of associating with service members with mental health issues. Participant Six also shared, *"I feel like if you aren't feeling up to it then you should get out immediately almost."* While this may be perceived as necessary for the safety of others, the statements are still stigmatic and possibly damaging.

Emotional Adjustment

The second theme which emerged regarding feelings about mental health was *emotional adjustment*. This theme included adaptation techniques used when participants encounter someone with mental health issues. As opposed to the previous theme, the theme of emotional adjustment contains elements of evaluation and understanding, with primary themes of *apprehension* and *empathy* emerging from the data. The theme received its name as the grouped codes suggested a mental evaluation of the participants' feelings, sometimes followed by a change in behavior.

The code of *apprehension* was used six times across four participants. Within these responses, participants responded that they would *"conduct themselves differently, more appropriately to the situation* (Participant 1),” when encountering someone with mental health

issues, while others found that interactions would be “*awkward*” and that it would be “*a little difficult to communicate* (Participant 3).” Participant seven stated:

What happens to me, usually I tend to try to take a step back and evaluate why they are behaving the way they are behaving and I try to see in what possible way I can interact with them without harming them or without harming myself.

Participant six’s comment regarding being fearful of serving with someone who had mental health issues was cross-coded with apprehension. The primary researcher felt that this fit both codes as the participant expressed fear of soldiers with mental health being equipped with live ammunition and apprehension about serving with someone who has mental health issues, as they may not be able to fulfill their duties effectively.

Participants also expressed *empathy* as a result of encountering those with mental health issues. *Empathy* was the code used most often with ten overall mentions across five participants, with White participants sharing five responses and African-American participants sharing three. Primarily, personal connections created feelings of empathy with those who may be experiencing mental health issues, having learned how to address and adapt to those displaying symptomology. Succinctly, it has been described as “*stepping into their shoes for a bit.* (Participant 2).” Giving more detail, participant two shared:

I think dealing with my grandma because I didn’t understand how things were going until I was actually with it. You could hear about certain symptoms and all that stuff but you don’t really understand the effect it has on that person and the people around him that goes on. It’s surreal when you actually step into that but we are dealing somebody who has it is definitely an eye opener.

During member checking, participant six was better able to understand those with mental health issues after personalized experiences with a parent. Similarly, participants four and seven found that having close connections with those who have mental health issues caused them to perceive others with these issues differently. The direct experience has made the symptomology more tangible, as participant four stated:

So having a personal connection it's like made me change what I thought and see that it is an issue and people have it and they say they have it, if they are diagnosed with it by doctors, they have it.

Essentially, direct experience with those who have mental health issues creates memories which participants can use to draw from for future encounters.

Summary

To conclude, feelings about mental health were encapsulated using the two themes of *negative emotional outcomes* and *emotional adjustment*. *Negative emotional outcomes* are defined as adverse reactions after being exposed to individuals with mental health issues. Within this theme, participants either expressed *apathy, fear, or remorse*. Many participants chose to ignore those displaying mental health issues until confronted with them directly, choosing to “go along with” the behavior while evaluating the situation. Conversely, some expressed fear of those with mental health issues, citing possible harm. Regarding *remorse*, one participant felt guilt due to the fact that she was not available to a fellow service member prior to that member completing suicide. The other theme of *emotional adjustment* was marked by a cognitive shift in understanding mental health after encountering someone with mental health issues. Participants expressed apprehension, finding encounters would be awkward and difficult if faced with someone who has mental health issues. Finally, the participants also showed empathy to those

with mental health issues, using prior exposure as a reason to give more understanding to those displaying symptomology.

Beliefs about Mental Health

The final construct to be discussed in research question one is ROTC students' beliefs regarding mental health. Beliefs in this regard include the ability to progress through the course of mental illness from identification to cure. Mental health beliefs were shaped by the participant's ability to identify disease and behaviors, thoughts regarding if mental illness can be cured, how long someone may have been mentally ill or how long it takes to alleviate mental illness, and what happens as a result of having or coming into contact with someone who has mental illness (Table 5).

Table 5
Beliefs about Mental Health

Theme	Codes
Illness Identification	Symptom/Disease Identification, Explanation of Behaviors
Stress Related	Psychotic Break, Trauma, Environment
Interpersonal Issues	Family/Home
Acceptance	Acknowledgement, Adjustment, Client Buy-in
Treatment Options	Efficiency, Group Approach,

Theme	Codes
	Self-Medication, Professional
	Engagement
Civilian vs. Military	
Expectations	
Duration	Acute, Lifelong, Situational
Interpersonal Impact	Daily Life, Familial Issues, Job Performance, Distrust
Intrapersonal Impact	Internal Conflict, Harm to Self or Others

Illness Identification

The theme of *illness identification* refers to the participants' ability to identify mental illness in various ways. This was achieved through specific labeling of mental health diseases or an explanation of normal versus abnormal behaviors. The theme was named after the CSM construct of "identity" which details an individual's ability to identify illness. Codes for this theme include *symptom/disease identification* and *explanation of behaviors*. Combined, these codes received 55 references across six participants. White (25) and Bi-Racial (17) participants shared the most answers within this category in regards to race.

The code of *symptom/disease identification* was drawn from participants' ability to name specific mental health illnesses. Primarily, due to contact with others who have had the illness, the participants were able to name diseases such as PTSD, schizophrenia, Attention Deficit Hyperactivity Disorder (ADHD), depression, anxiety disorders, substance addiction, and

Dissociative Identity Disorder (DID). *Symptom/disease identification* was mentioned 26 times with participants two (8) and four (7) creating the most references. White participants (14) shared the most experiences regarding with this code with African-Americans (9) sharing the second highest number of experiences.

Regarding mental health diagnoses, some participants were often able to name specific mental health diagnoses and their corresponding symptoms. For example, Participant Two, when describing schizophrenia, knew that the symptomology included hearing voices and included, “*not being able to separate reality from what you’re imagining, that’s how I understand it.*” During an explanation of when one should go seek treatment, Participant Four was able to describe the symptoms of PTSD. The participant remarked:

“And then afterwards, if you start having mental problems or mental issues such as like having trouble sleeping, you hear loud things and you think you’ve been shoot at or something like that, then I believe you should go see a doctor more than once.”

This specification of knowledge was primarily due to the participant experiencing the disease directly as the participant’s step-brother was diagnosed with the disease after returning from Afghanistan.

In lieu of naming specific behaviors, participants were often able to give general definitions of “normal” versus “abnormal” behavior, resulting in the *code explanation of behaviors*. *Explanation of behaviors* was the most often referenced code within the theme of *illness identification* with 31 applications. Participants Seven (9) and Two (6) provided the most responses and African-Americans (15) were three times as likely to provide a response for this code as White participants (5) and almost twice as likely as Bi-Racial participants (8).

For *explanation of behaviors*, participants shared their views on positive versus negative mental health functioning. When asked their definition of behavioral health, participants responded with definitions including “*mental stability* (Participant Two),” and “*behavior accepted by society* (Participant Three).” Following this question, participants were asked to give a definition of mental health. Both the primary researcher and the observer noted that some participants were not able to define these two terms. However, upon probing, some participants gave more detailed explanations of behaviors when asked their definitions of mental health. For example, Participant Five noted that someone who has good mental health is:

“*Just someone who is not inclined into doing drugs or inclined to go on to like party a lot; just focused on what they want to do and just basically, like, if there is something that frustrates them like there is a family issue they just kind of look past it.*”

Explanation of behaviors also included some level of emotional control, a response only noted by males, which included restraining from emotional outbursts. Finally, Participant Five noted that mental health is not “*looking crazy.*” When asked what crazy looks like, the participant replied, “*Crazy looks like a lot of things [laughter] talking to yourself, not really interacting with people, doing things that aren’t considered normal like dressing funny, talking funny acting funny and things like that,*” describing a set of behaviors which would describe someone who is not of the norm and would need further analysis.

Stress Related Factors

The next theme, *stress related factors*, explores one of the explanations for the causes of mental health issues. This theme was named as such as the corresponding codes relate to negative events which contribute to emotional distress. *Stress related factors* can be defined as overwhelming environmental factors which cause one with possible mental health issues to

display behaviors. Codes for this factor include a *psychotic break, trauma, and environmental factors*. Beliefs related to causes of mental health issues were referenced 47 times across all participants and in terms of ethnicity, responses were spread fairly equally with Whites (17), African-Americans (13), and Bi-Racial (12) participants sharing the most answers.

The first code, *psychotic break*, refers to a mental breakdown as a result of stressful events. Only one participant, a Bi-Racial female, mentioned a psychotic break as a cause for mental illness, citing violence as a possible outcome. Participant Three noted that soldiers can just “*snap,*” resulting in violence. Additionally, the participant noted that if soldiers who have “*violent thoughts*” or “*noticed they’re becoming violent*” should seek treatment immediately. During member checking, Participant Six noted that that a psychotic break may occur due to a series of issues, building to an eventual release.

Six participants noted some form of *trauma* as a cause for mental health disorders with White participants sharing the most experiences with this code at five. Overall, *trauma* was mentioned a total of ten times across six participants with approximately equal distribution. Participants noted traumatic events such as rape, sexual harassment, violent attacks, and grief as triggers for mental health issues. Participant One defined trauma as “*problems dealing with stress or.... a significant event.*” Combat was also noted as a traumatic event where Participant Five remarked:

Just like I guess may be a lot of demand in the war zone. If they are surrounded by guns firing all the time or anything and then maybe if their friend got shot or best friend gets shot then it is very, they get very upset and might want to drop the army or whoever they are.

Within this statement, the participant noted consistent battle and possible grief and loss due to service member deaths as traumatic events which may contribute to mental health issues. Taken together, participants mentioned several unique stressors which can contribute to mental health issues within the service member population.

Traumatic events were understood as important stressors and participants did not express stigma for help-seeking as a result of these factors. For example, Participant Seven experienced exposure to suicide, rape, and other stressors as a result of her time in the Air Force Academy. This time and exposure to these stressors removed stigma for this participant, changing her beliefs about mental health:

Before I guess you could say my opinion before I graduated high school my opinions would be like oh they are crazy. But now definitely I see a need for it. I think that somebody who does that is brave and they definitely care about their mental state and their behavioral health and all that because it is like at least they are trying to talk to somebody. If you can't talk to me, if you can't talk to anybody else go talk to somebody.

So I definitely, I felt like there was a need for it so I think I'm completely an advocate for go ahead and do it because I wouldn't look at you mainly differently because I felt like I was on the wrong side to do it.

As a result of the exposure to viewing others experiencing traumatic events, Participant Seven's beliefs about the causes and consequences of mental health and help-seeking behaviors were altered. The participant became an advocate for help seeking to prevent mental health issues within her immediate circle.

The last code included *environmental factors* which may exacerbate stress and lead to mental health issues. *Environmental factors* were mentioned 25 times across six participants.

Under this code, three sub-codes were identified including *alcohol* (2), *school* (4), and *combat* (11). *Alcohol* was only identified by Participant Four, a White male, as a catalyst of mental health symptomology. Regarding the step-brother who was diagnosed with PTSD, alcohol was a catalyst for displays of symptomology. The participant remarked, *“I don’t know why but I guess all the stories a lot of it comes like those episodes like get heightened when they’re drunk or have been drinking or something like that.”* The participant noted that symptoms were manageable prior to becoming intoxicated and were less severe after drinking.

School pressures were also identified as a cause of mental health issues. Participant Five shared a story regarding a friend who had issues at home due to failure in school. Participant Six listed responsibilities in school as an added stressor in student’s lives which may contribute to mental health issues. When speaking of the Air Force Academy as an academic setting, Participant Seven shared the following:

Just military academics are rough. Taking like 5, 6 classes and then on top, there, you have to be physically fit, and on top of that your room has to be in inspection order then, on top of that, you have to have all these military knowledge.

The participant went on to share that the school environment, in addition to military responsibilities, were contributors to her friend completing suicide. The participant continued:

So he overdosed on pills and apparently it was because at the academy there are a lot of factors that are thrown at you now for you to get through your day. Like you have to focus on them yet you have to focus on academics, you have to focus on sports, you have to focus on being physically fit and all those things. And he had academics down pat and he had military down pat because he was part enlisted but he could not get his physical part down at all. Then I guess that is just finally got to him and he snapped.

The participant concluded the experience, noting the marked difference between the Air Force Academy and the research institution's ROTC program. Specifically the military expectations of the ROTC were not as strenuous those of the Academy, remarking lowered stress as a result of the different standards. However, academics were still listed as a contributor to the overall stressors.

Stigma and Causes of Mental Illness. The last sub-code included *combat* as an *environmental* stressor. Within this code, participants noted that combat and exposure to battle were major contributors to mental illness. Four participants mentioned *combat* as a cause of mental health issues. It should be noted that some participants displayed stigmatic thinking regarding those who admit to mental health issues, believing that those who enlisted should be acutely aware of the possible damages of war and to avoid the military if they are not able to mentally handle the stressor. Primarily, Participant Five noted:

It was their choice to go to the military and they should have known that that was, it is going to be what they had to go through and why they had to do so... .. In a way like if they go a specialist for that, for their mental issue then it is their fault they got into that so now they have get themselves out. Like became mentally stable again like themselves so and with help it is fine I'm not saying they shouldn't.

With this statement, the participant believed that it was understood that combat can create mental health issues, and that service members should get treatment, however, the service member should have entered the military with the knowledge that trauma due to combat was a possibility. While the participant makes non-judgmental statements regarding treatment seeking in later passages, the presented statements are judgmental towards service members who actually admit to mental health issues.

However, other participants recognize that not every service member who experiences combat is destined to experience mental health issues, stating, “*I believe that like in the same way if you have a mental health not everybody gets PTSD there is people who go to combat see combat and don’t get PTSD.*” These two responses to the sub-code of *combat* represent a dichotomy within the beliefs regarding the causes of mental health issues, as each perspective recognizes combat as a possible mental health stressor but while some believed that *combat* is a preventable stressor.

Interpersonal Issues

The second theme associated with causes for mental health issues are *interpersonal issues*, primarily those which involve familial issues or loss of contact with home life due to deployment. This theme received this name as its sole code, *family/home*, refers to causes of mental health which are related to intimate relationships. *Family/home*, which was referenced 13 times in total, was only referenced by males as a possible cause for mental health issues.

Individually, participants noted “*family problems (Participant Two),*” or “*troubles with your marriage (Participant Four)*” as *interpersonal issues* related to causes of mental health issues. Two participants experienced this directly, participating in various forms of therapy after their parents divorced. In reference to military specific issues, several participants believed that deployment and inability to be directly involved in family life can be a cause of mental health issues. Participant Eight shared the following experience:

I can think of once, I don’t remember if this was in class or I just watched it on YouTube, there was an Army video called “Shoulder to Shoulder,” and it was about, I remember, there was a guy in there whose his wife, he was in Iraq or Afghanistan, and his wife was saying she was going to leave him so he was all down and depressed and I

guess he tried to shoot himself but his friend one of the other soldiers noticed what just happened.

Other participants also noted separation as an issue, questioning, “*how do you like mediate with somebody who is like thousands of miles away and bring families tighter that are separated (Participant Two)?*” As this separation is inevitability due to the nature of deployment, it is important that students note this as an exacerbating issue early on for possible prevention of mental health issues.

Acceptance

The theme of *acceptance* was noted as the first theme regarding beliefs about how to cure mental health issues. This theme was named as concession was necessary prior to beginning mental health treatment. Three codes were found within this theme including *acknowledgement*, *adjustment*, and *client buy-in*. Beliefs regarding how to cure mental health issues received 73 mentions with White participants contributing the most responses at 32, representing almost half of the total responses. *Acceptance* is indicated by some form of recognition that there is a mental health issue through affirmation of abnormal behaviors. These behaviors can either be brought to the attention of the individual by an outside party or the individual may have a personal realization of the issue.

Acknowledgement can be described as accepting the possibility of having a mental health issue after recognizing abnormal behaviors in self or having others bring these behaviors to one’s attention. Overall, *acknowledgement* was applied to 32 responses across all participants. Finally, regarding race, African-American participants presented the most references at 13 responses with White participants following closely at 10.

Participants noted an internal process of an admission mental health issues prior to treatment. For example, Participant Two shared:

I would just say that they know that they are facing a situation that they themselves have been like not able to actual deal with or don't have the proper tools to deal with, so they go to somebody who actually can and can provide the help.

Similarly, when speaking of when they would personally seek treatment, Participant Seven's 10 responses alluded to self-acknowledgement of mental health issues, where acknowledgement is a "preventative measure" or "early warning system." There is also a link between self-acknowledgement and outside recognition. Participant Eight, who had the most responses at 15, stated:

Right and then I will be like oh I guess I do need to go seek help I feel like if it is just in my mind, "that's just in my mind", and I am might be thinking I have a problem but when someone tells you it is definitely not in my mind I should probably go seek help.

With this statement, the participant has begun to acknowledge his own issues and uses the views of others as confirmation of possible issues.

Conversely, individuals may not have the self-awareness to recognize their own issues and may need assistance from outside sources. Others notice mental health issues prior to those experiencing the issues due to time spent in a group setting. For example, Participant Eight stated:

Right, and it is like you have class twice a week and PT (Physical Training) three times a day so like people are going to pick up on that [abnormal behavior]. If you stop showing up they're gonna ask you about that and they check your grades. If they are falling and [sic, they'll] ask you about that and then kind of like be on top of you. I guess

like on top of your routines kind of helps with if there is a problem it might be easier to identify.

Upon member checking, Participant Six's statements lie somewhere in between the aforementioned beliefs. The Participant believed that even after acknowledgement of mental health issues from the outside parties, he would need further convincing before acknowledging the issue himself. The participant continued that even if the directive for help-seeking came from a superior officer, the participant would be reluctant to go. However, this is the same participant who noted being reluctant to serve with someone who has mental health issues, creating a set of conflicting beliefs. The aforementioned statements demonstrate that students believe that some form of acknowledgement is necessary for treatment to begin and can originate from self-recognition, recognition of issues from others, or a combination of the two.

Four participants made mention of some type of *adjustment* period or thought process during contemplation for treatment. For example, when speaking on overcoming issues, Participant Five stated he realized he could get past his issues and they weren't permanent. The Participant learned to adjust to the presenting stressor prior to seeking treatment, negating the necessity for other forms of intervention. *Adjustment* may also relate to, prior to suggesting help-seeking, adapting to the abnormal behaviors of others in relation to their symptomology. Participant Seven shared a story where she felt it necessary to report a roommate's erratic behavior:

So I was in the air force so them being my wingman I had to sit there and work with them and try to figure out why it was they were acting this way and I went to my superiors and we got to sat down and try to figure this out and everything.

The participant experienced a process of observation of mental health issues and an *adjustment* of personal behavior prior to seeking solutions for the issue.

Outside of *acknowledgement*, participants mentioned personal investment into treatment for treatment to be effective, coded as *client buy-in*. This code was applied eleven times across five participants with White participants receiving the most code applications at nine. For example, Participant One attended both individual and family after his parents divorced. However, the Participant did not feel that the treatment was worthwhile, remarking, “*it just didn’t seem to work for my family or me*” and “*it didn’t really help me in my family situation. So I don’t find comfort, I don’t find [therapy] a valid way of dealing with it.*” Conversely, some participants praised those who engaged in treatment seeking calling them “*strong* (Participant Two)” and “*brave* (Participant Seven)” for personally investing in treatment seeking. These participants believed that to buy into counseling was a sign of taking control of one’s mental health and necessary for treatment to be effective.

Treatment Options

Along with *acceptance*, participants also noted *treatment options* available to those who have mental health issues. This theme was defined as different methods for seeking care and stakeholders who should be involved in the treatment of mental health. Common ideas regarding methods for care were used to create the name for this theme. Codes for this theme include *efficiency*, *group approach*, *self-medication*, and *professional engagement*.

The first code of *efficiency*, with seven references, outlined the need for quickly addressing mental health issues once they become known. Respondents were all males and expressed urgency for mental health treatment, partially attributed to service members’ access to weapons, creating a necessity for quick and effective treatment responses. Sharing a story

regarding problem solving training regarding service members who have mental health issues, Participant Two stated:

Like how to deal with certain issues where they are faced with loneliness and they are stuck with like a gun and you don't know what they are going to do. You have to learn how to solve that situation quickly and effectively.

Concurrently, as described in the *stress related factors* theme, the experience of combat can be a trigger for mental health issues. When mental health issues are identified due to combat, participants have stated that mental health treatment should be sought as soon as possible.

Participant Six described a scenario where immediate treatment may be necessary:

I just feel like it you might feel like trapped there almost because you don't really have options once you become deployed, [sic] I almost feel like if you get claustrophobic and you are supposed to be sucking that air in and you can't do anything about it and if you don't deal with it well you should get help immediately.

Between training in ROTC and expectations of the difficulties of combat, participants feel that mental health treatment should be sought as quickly as possible to stem further issues in theater.

Group approaches to treatment were observed in participant experiences with responses listing interpersonal supports as treatment options. For this code, participants sought ways to approach treatment by involving other service members or commanding officers to cure mental health issues. Seventeen responses fit the criteria for group approaches, with six participants providing experiences. For example, during the individual interviews and member checking, participants felt that commanding officers can be detrimental to pointing individuals to resources for mental health issues:

The [cadre] will talk to you or direct you to the right resources on campus or where ever is needed and we all have their [number]. We normally have like our cadre like in class and if they are a professor, we will have like their personal phone numbers. I have sergeant [redacted] number and they like made it known that if you have any problems then we can point you in the right direction (Participant Eight).

During member checking, participant six added that cadre members often give their personal numbers to students and know ROTC members by name, acting as a resource for those who may need assistance.

Participants also remarked that unit members are expected to monitor each other's behavior and to use each other for mental health resources. For example, Participant Seven mentioned, *"taking care of your wingman and then in the army looking out for your battle buddy, making sure that you pay attention and you communicate with your peers,"* as tactics for ensuring the mental health of those around them, noting a *group approaches* for treatment engagement. Participant Six supported these beliefs during member checking, endorsing working out with students as a way to relieve stress during exams. The Participant stated, *"I think actually it's just team work and bonding and stuff like that that can help a lot in the army."* Reinforcing *group approaches* to treatment, participant two saw the military as a "family," stating:

"...in the service you are stressed to have that team aspect, almost like, it's a family. You go and you help your family member out."

Finally, interpersonal resources outside of one's cadre and unit were also seen as a possible effective method of treatment, with Participants Five and Six citing friends as resources to help alleviate mental health issues. Member checking with Participant Six and Eight also confirmed this belief. However, when asked they believed they were a resource for mental health

treatment, both participants were skeptical of their own abilities to assist others but noted that they would at least attempt to point someone to resources. Participant Eight noted that a positive attitude was helpful while Participant Six noted that using Google would be the best start for finding resources, followed by working one's way up the command chain. The aforementioned experiences outlined participants' beliefs that reliance on other unit members or commanding officers is an effective method of help-seeking.

Prior to officially seeking treatment from a professional, many participants advocated for methods which allowed the individual to attempt to self-heal prior to therapy. The code of *self-medication* includes various methods, both negative and positive, which one may elect to use to alleviate mental health symptomology without professional engagement. Sixteen excerpts for this code were found across six participants, all males. White participants provided more than twice as many answers as participants of other races at eight out of the 16 responses.

Participants noted a spectrum of methods regarding *self-medication* which were both socially unacceptable and acceptable methods were presented. In reference to unacceptable methods, Participant One suggested, "*Illicit drug activity is [appropriate]. If that's what they need, I'm okay with that. I personally don't find offence to that even though I don't partake.*" As discussed above, participant four's step-brother would often self-medicate with alcohol to alleviate symptoms of PTSD. These examples demonstrate that participants were aware of, and sometimes endorsed, *self-medication* methods which involve illicit drug or alcohol use to alleviate symptomology.

The last code drawn from the theme of *treatment options* is that of *professional engagement*, the second most often used code in relation to beliefs regarding cures for mental illness. This code was applied 27 times across seven participants. Again, White participants

shared double the responses of other races at 14 and accounted for half the code applications.

Professional engagement included statements where participants include seeking treatment from a mental health professional as an option for treatment. Only participant three did not mention engaging a mental health professional in alleviating mental health issues. Professional engagement was seen as an option when service members are overwhelmed by their issues and need outside help after exhausting other options.

Participants noted instances when it would be appropriate to seek mental health treatment. For example, Participant Five stated:

I mean it's like, if you have a mental issue [and] if you don't really know how to deal with it and you need to go to a professional person to help you with that, you do that I mean it is not a big deal. I mean it is what it is. I honestly like never had something that put me down as much to, like, go to a professional for help but yeah, I don't think much of it, it is what it is, some people need it.

The participant continued, stating that seeking a professional would be seen as a last resort, using group approaches such as friends as a primary resource prior to engaging a professional.

Participant Six, who had the second highest number of responses at five, likened seeking mental health treatment to going to a medical doctor:

Just, like, before I would say you have to have something wrong with you to go. My whole family has gone so I guess there is something wrong with all of us. If you need help, you should go. It's like you being sick you shouldn't just feel like, "I don't go to the doctor people will think I'm sick," but that is fine. It's the only way to get better is to actually go, it's the best because you need something like that.

Concluding, the participant noted, “*to get over mental stuff, you actually have to talk to someone, you can’t just be on your own or just by yourself the whole time.*” Noting the function of a mental health professional, Participant Four stated:

I mean if they [one with mental illness] need the help they deserve to have that and that’s why people go to college to get psychological degrees to help people with mental health problems. I believe that if you are suffering from a mental health disorder like PTSD, bipolar [disorder], [or] schizophrenia, I believe you should go get help and get the prescriptions or the medication or counseling or whatever you need to make yourself feel better to have and help with your disorder.

Finally, Participant Seven had one of the lowest response rates for *professional engagement* at three mentions, but strongly advocated for the act, stating:

“I think that somebody who does that is brave and they definitely care about their mental state and their behavioral health and all that because it is like at least they are trying to talk to somebody. If you can’t talk to me, if you can’t talk to anybody else go talk to somebody.”

These excerpts demonstrate that seeking professional help is a viable resource for ROTC students to alleviate mental health issues.

Stigma and Professional Engagement. Generally seen as a last resort, students understand that professional engagement is an option for treatment. However, the participants generally did not express anticipated stigma as a result of **seeking** a mental health professional. This is different from earlier presentations of stigma where students were fearful of those who **divulged** mental health issues. Overall, most participants were mostly non-judgmental of professional mental health treatment with most participants maintaining help-seeking may be

necessary as a result of combat scenarios. Participants were comfortable seeking treatment for themselves without thoughts of reprisal. For example, Participant Five stated:

I know I will not be in the war scenario probably but if I'm and something was to happen to me like mentally, psychologically then that is probably what I will do I will do to a specialist like I won't be ashamed of it.

Additionally, previous contact with mental health professionals helped to change perceptions of treatment, reducing stigma:

Just like before I would say you have to have something wrong with you to go. My whole family has gone so I guess there is something wrong with all of us. If you need help it is like you should go it is like you being sick you shouldn't just feel like I don't go to the doctor people will think I'm sick but that is fine it's the only way to get better is to actually go, it's the best because you need something like that (Participant Six).

The participant noted a level of anticipated stigma, however, felt that mental health was more important than the possible consequences. These examples highlight the belief that *professional engagement* is a viable source of help-seeking and, generally, mental health stigma does not affect the participant's desires to seek treatment.

Civilian vs. Military Expectations

The theme of *civilian versus military expectations* was the final theme noted beliefs about mental health regarding cure for mental illness. The name for this theme was chosen as the primary researcher observed a dichotomy regarding treatment engagements for different populations. The primary researcher noticed a difference between necessity for treatment when differentiating between when civilians and service members should seek treatment for mental health issues. Due to access to weaponry and the dangers of combat, participants felt that service

members should receive treatment immediately upon recognition or diagnosis. Regarding appropriateness for seeking treatment, Participant Six believed:

I'd say all the time, it has to be a lot shorter [for service members] because like I said, you have people's lives at stake, even if it is not you going insane or something. Just you not being right there in the moment where they need you to do something. So I feel like if you aren't feeling up to it then you should get out [of the military] immediately almost.

Participant Three echoed the sentiment of service members seeking treatment in a timely fashion compared to civilians, stating:

I'd definitely say about the same but I think it's a little more important that service members go see a mental health professional especially because if it's affecting their behavior and its affecting their job. That affects a lot more people than themselves especially in the Army so I'd say the same just as far as a normal civilian wants to see a mental health professional.

Participants also removed choice in help-seeking for service members, noting that mental health treatment with a professional should be mandatory for service members as a debriefing exercise:

But I believe that's something that should be done. As soon as they come back from the combat tour have them see a psychiatrist or if they're there and nothing is happening they're in like a safe area go see a psychiatrist even like combat firefighting area and then go on from there (Participant four).

During member checking, Participant Six likened mandatory services to similar professions such as a police officer, fire fighter, or anyone who “*should be on their game at all times.*”

Essentially, due to unique stressors and possible negative outcomes, participants felt that mental health treatment for service members was more imperative than treatment for civilians.

Finally, participants did not express stigmatic beliefs regarding service members who chose to engage in help-seeking behaviors, stating that they would be open to others seeking treatment if necessary. According to Participant One, “*I don’t have a skewed perception of someone who would go, I don’t think any less of them,*” when asked opinions of someone who seeks treatment. When asked specifically about service members who seek treatment, the participant continued, stating that seeking treatment is a “*good first step.*” Similarly, Participant Eight stated, “*I think they’re doing the right thing.*” From these statements, one can conclude that these participants do not have stigmatic thoughts in regards to those who engage in help-seeking.

Duration

The theme of *duration* refers to the time lapse factors regarding mental illness including how long one should wait prior to help-seeking and how long mental health issues may last.

Duration was named as a theme due to the codes referencing time lapses in regards to mental illness. There were three codes were generated after analyzing the code group: *acute*, *lifelong*, or *situational* time lapses regarding mental illness. This theme was the least referenced in regards to beliefs about mental health with only 11 responses across six participants. White and Bi-Racial participants shared the most responses at four each. It should be noted that males provided all of the answers for each code except the last, *situational*, with one response from a female.

The first code of *acute* factors acknowledged the short term nature of symptomology in addition to detailing how long one should wait before seeking treatment. Only four participants mentioned *acute* factors a total of once per participant. A month was noted as the necessary time

to wait before seeking treatment, with Participants Eight and Six stating that if they were unhappy or issues were “*affecting me to the point where I could not complete the tasks I need to do* (Participant Eight)” for this time period, they would then engage in help-seeking. *Acute* factors also described the change between symptomology in those who have mental health issues. When describing a sibling with mental health issues, Participant Two remarked “*she can really turn on you in a second*” regarding a sister’s shifting moods. Participant Four noted that a brother diagnosed with PTSD would just “*sleep it off and then he was fine in the morning,*” marking a return to normal behaviors. In conclusion, these participants noted that *acute* factors are those that should be addressed after a period of a month or how changes in symptomology can occur without warning.

Two participants made two statements which noting that mental health issues can develop over a long period, necessitating the code of *long term*. Participant One, drawing from a freshman psychology class, responded that some people have “*degenerative diseases*” which develop over time or “*congenital*” diseases which originated from birth. In terms of length of treatment participant four believed that a doctor should be seen “*more than once*” after describing symptoms related to PTSD. However, the participant did not denote exactly how long someone should seek treatment to alleviate symptoms.

Finally, the participants described *situational* exposure, with symptomology existing as long as the particular stressor is present. This code received the most applications for the theme of *duration* at six applications across four participants. After giving an example of a breakup, Participant Six noted, “*I think if you just feel bad like a whim or something you should probably wait and see if it will pass by itself.*” Similarly, when speaking of helping a friend solve a familial issue, Participant Five learned that, “*It just made me realize that like you can get past it,*

it's not like permanent.” The participants believe that activating events or environments can be contributors to mental illness; however, these events are not permanent and removal of the stressor may end the symptomology.

Interpersonal Impact

Participants shared experiences where contact with those who had mental illness had consequences for those who were close to the individual, resulting in a theme of *interpersonal impact*. Codes of *adjustment*, *daily life*, *familial issues*, *job performance*, and *distrust* were found, within the theme of *interpersonal impact*. The theme of *interpersonal impact* is related to consequences regarding mental health and received 47 applications across all participants. Regarding ethnicity, responses were spread fairly equally with African-Americans (15), Bi-Racial (15), and White (14) participants sharing the most participants.

Regarding the first of the aforementioned codes, *adjustment* entailed re-evaluating decision making as a result of being diagnosed with mental illness or being in contact with those with mental health issues. *Adjustment* received the lowest number of responses for the theme of *interpersonal impact* at three applications. *Adjustment* occurred as a protection against negative decision making due to stressors and as a litmus test for recognizing abnormal behavior. For example, Participant Six remarked:

[I] *ask myself questions before I react, I feel like if you are unstable then you won't do that. You'll just be compulsive and do what you are going to do first and then take it out of that later.*

Similarly, adjustment occurs during contact with those who have mental health issues, not just when the issues are personal. Participant Seven stated:

What happens to me, usually I tend to try to take a step back and evaluate why they are behaving the way they are behaving and I try to see in what possible way I can interact with them without harming them or without harming myself.

In both cases, there is an evaluation of behavior which causes the, affecting decision making whether this be for their own safety or others.

Participants also marked a change in *daily life* as a result of mental illness, which received nine responses across four participants. In reference to when someone should seek treatment for mental health issues, Participant Two stated, *“When you start to see that your daily life is starting to be affected by it, when things that you were in control of you are no longer in your control.”* This response denotes that the inability to continue daily functioning is a marked sign of mental illness and help-seeking should occur at this time. Similarly, Participant Eight stated, *“I guess especially once it becomes an issue with their daily lives, like their routine or something of the sort, [when] it becomes detrimental and affects them in a negative way then they should go [seek treatment].”* The idea of change in routine continued with participants noting changes in their own daily functioning as consequences of mental health issues.

Participant Seven, sharing a story of impending depression, detailed the following:

So it was right before graduation and I was like “I don’t think I’m going to get an appointment to the academy” and..... I eat my feelings. Again I was skinny, and then all of a sudden I gained all this weight. I couldn’t fit my uniform anymore, I couldn’t fit in my clothes anymore, and then I realized that I would be content to just sit in my room watching TV on the computer.

I wanted to sit in the dark, like windows closed, door closed, head phones on lying in my bed or sitting in my chair watching TV. And then my roommate she made an

observation, she was like “hey, are you okay” and I really sat there and I thought about that and I said no I’m don’t think I’m okay.

Others shared this idea, noting that when others noticed change in *daily life*, that mental health issues were present. Regarding ROTC *daily life*, Participant Eight shared:

It’s like you have class twice a week and you [have] PT three times a day so like people are going to pick up on that. If you stop showing up, they’re gonna ask you about that and they check your grades if they are falling and ask you about that and then kind of like be on top of you I guess like on top of your routines.

Finally, other participants noted other events or behaviors which may affect daily functioning as a result of mental illness. This includes DUI charges (Participant Six), lack of focus (Participant Three), and withdrawal from others in a communal setting (Participant Seven).

Mental health issues affect not only the individual, but those in the individual’s vicinity. Participants noted that the consequences of mental illness can reverberate throughout the family structure, necessitating a code of *familial issues*. It should be noted that only males made references where this code would apply. In regards to specific examples, Participant One, sharing an anecdote from a friend, recalled a story where a service member returned from theater with PTSD. The participant stated, *“he came back with that [PTSD] and she [friend] actually told me that that destroyed their marriage and they [the service member] had to move out for a little bit because he was just crazy.”* Additionally, a family may be affected by issues where the family was not the cause of the issue. Participant Four shared that the entire family was sometimes necessary to aid the participant’s step-brother during his struggle with PTSD. Both of these examples demonstrate how the mental health issues of the individual may have consequences for their family as well.

Similar to *daily life*, participants noted instances where mental health issues can affect *job performance*, marking a decrease in effectiveness. Five participants noted issues affecting *job performance* as a consequence of mental health issues, with 10 total responses. African-American participants provided more than half of the responses for *job performance* at six code applications. Primarily, participants noted the danger in decreases of job performances in theater, as others' safety is directly affected by loss of focus. Participant Two remarked, "*Your job could be so crucial to the point where, if you are not behaving a certain way, that can affect other people's lives. So it's pretty important for somebody in the service to get help.*" The participant continued:

Not getting along with certain members of your team, you are going to have to get that, you are going to have to go through that as team work is crucial.

Finally, Participant Seven felt that decline in job performance, as a consequence of mental illness, is a major motivator for treatment seeking. The participant stated, "*I feel like they [service members] care about their job first and foremost because obviously, you don't want your bread and butter, you don't want your career to be severely impacted when you start feeling a certain way*"

Stigma and Interpersonal Impact. During member checking, Participant Six noted stigmatic beliefs related to *job performance*, stating that those who shared their mental health status would lose respect, particularly commanding officers. When asked where the participant received these messages, the participant remarked that, primarily, the messages came from former active duty soldiers who have returned to college and joined the ROTC program, citing "*machoism*" and masculine belief systems. From these statements, one can see that some participants felt that issues affecting job performance are a consequence of mental illness,

sometimes promoting help-seeking behaviors. However, another consequence may be a change in how one's *job performance* is perceived due to stigmatic beliefs about those with mental illness.

Finally, at four responses, participants mentioned *distrust* as a consequence of mental illness. Each of these responses were provided by the male participants. The participants felt that trust in fellow soldiers is necessary for completion of missions and *distrust* of those with mental health issues was a factor. Participant Two remarked, “*Not being able to trust say like a colonel or anything, you need that because trust is like a key point in the military, trust within the military and trust with military and civilians.*” Participant Six reiterated this point during member checking stating that he would feel “uneasy” and, “*it would be hard to trust them because you can't trust them to think logically and to have everyone's best interest in mind or even their own best interest in mind.*” Finally, while not related to the military, Participant One admitted to developing trust issues with women as a result of parental mental health issues. These examples demonstrate that participants felt that loss of trust is a possible result of mental health issues.

Intrapersonal Impact

Participants also believed that mental health issues can also have consequences that result in internal processing or damage. These processes may cause the individual to inflict physical damage to themselves or others. The second theme regarding beliefs about consequences of mental health issues, *intrapersonal issues* are marked by internal issues as a result of mental health issues. This theme received this name due to the consequences of mental health being internal versus external, as with *interpersonal impact*. *Intrapersonal impact* received two codes: *internal conflicts* and *harm to self or others*.

The first code, *internal conflicts*, marks issues where participants noted inner turmoil as a result of mental illness. This code was referenced 12 times across six participants with Bi-Racial participants providing the most excerpts at five. Participants noted going into “*deep depressions* (Participant Three),” experiencing “*psychological scars* (Participant Four),” and being “*mad at yourself* (Participant Five)” as signs of internal conflicts.

Causing physical *harm to one’s self and possibly others* was also a code for intrapersonal impact with suicide being the primary indicator. *Harm to self and others* was applied 19 times and mentioned in some form by all participants. Participant Seven spoke at length of a friend who completed suicide as a result of his time at the Air Force Academy. The participant shared:

I guess my friend he committed suicide, would that be considered a behavioral thing? My friend committed suicide and this is after I had left Colorado I was back here in Florida. He was up there at the Air Force academy and I got a call from my friend that night saying that Jim had committed suicide.

Other participants also noted that suicidal thoughts were a possible consequence of mental illness with three participants noting that this may be a reason to seek treatment. Participant Three believed that suicidal and violent thoughts were reason to engage in help-seeking. Again, participants only mentioned suicide in regards to self-harm and no other self-harming techniques such as cutting.

Finally, for the code of *harm to self or others*, participants noted harm to others as a possible consequence to mental illness. Participant Four recalled a story of having to restrain a family member with PTSD:

And then, like, he started getting, like, violent so we like tackled him to the ground and restrain him and then my step dad came out and my other step brother and like took him inside and he was still like in a state but he was calmer after that point.

Participant Four's brother engaged in physical altercations with his family as a result of mental illness. Participants One and Three noted more violent outcomes such as shooting sprees as a possible consequence of violent thoughts. Mentioned previously in *stress related factors*, participants believed that violent thoughts necessitate help-seeking. These examples show that *harm to others* can result in smaller altercations which can be alleviated quickly or larger issues which require more intervention.

Summary

To summarize, the beliefs of ROTC students regarding mental health were analyzed using the identity, cause, and cure/controlability constructs of the CSM. The first factor, identity, encapsulated the participants' ability to recognize mental health diagnoses and the symptoms or behaviors associated with mental illness. Participants were able to name several diagnosable illnesses and the corresponding symptomology. In lieu of this, they were given definitions of normal versus abnormal behavior and relate these definitions to mental health.

Regarding the causes of mental health, one of the factors related to how mental illness begins are stress inducing events. The participants described psychotic breaks where individuals would just "snap," causing a marked change in behavior. Additionally, traumatic events such as grief, loss, or sexual assault were mentioned as stressors which could contribute to mental illness. Finally, environmental factors were seen to both cause and exacerbate mental health issues. Both school and combat were seen as causes to mental illness, as stressors in both areas could be found overwhelming to those who may suffer. Alcohol was found as a catalyst, with

one participant sharing that a family member's PTSD was made worse after drinking. Finally, interpersonal issues were found as causes, primarily issues with family members or at home. Participants noted family strife and, for service members, separation from home life as reasons for mental health issues.

The third factor, cure/controllability was defined as the ability to either be rid of or manage mental illness. To begin, a level of acceptance needed to happen prior to treatment beginning. This included acknowledgement of the issue either internally or externally where the mental health symptomology is brought to the individual's attention. Next, there is an adjustment period which includes reflection for those with the illness or those who have been exposed to the illness. Finally, there must be some level of client buy-in for treatment to be effective, as hope for success drives treatment engagement.

Participants also shared a number of treatment options available to those with mental health issues. Whatever the chosen method, participants noted that a level of efficiency was necessary due to the serious nature of combat. The participants also appreciated a group approach to treatment, noting friends or commanding officers as resources for treatment. Self-medication, both positive and negative, was mentioned as possible methods of treatment with participants mentioning overall wellness, group intervention, or substance abuse as ways to treat mental illness. Finally, participants noted professional engagement was seen as an option, but not necessarily the first choice to fix mental health issues

Although not one of the CSM constructs, another theme that was noted was the difference between civilians and service members in regards to treatment engagement. Due to access to weaponry and the necessity of vigilance in theater, participants felt that service members should seek treatment immediately upon discovery of a mental health issue. When

speaking of civilians, treatment should be sought if they feel they need it while service members were given less of a choice.

The CSM factor of timeline refers to how long an individual will suffer from a mental health illness or how long mental illness develops before symptomology is shown. Acute issues are those which can disappear overnight or develop instantly depending on the diagnosis. Also, participants believed a month was the average time to wait before seeking treatment. Lifelong issues are those which have developed either from birth and that treatment should be sought until symptomology is alleviated. Finally, issues were also found to be situational, with a particular event contributing to mental health issues, while removal of the event can be all that is necessary for a cure.

Finally, the CSM factor of consequences refers to the results of mental health issues. Within this factor, themes of interpersonal and intrapersonal impact were observed from the data. Within interpersonal impact, there is a need for adjustment either due to being diagnosed with a mental illness or due to contact with someone who has mental illness. Participants also shared that mental illness can affect one's daily functioning, home life, and ability to perform effectively at one's job. Finally, the participants shared that they may be distrustful of those with mental illnesses. In terms of intrapersonal impact, students shared that there would be internal conflicts which would outwardly affect an individuals' performance. Additionally, there may be harm to self or others, primarily in the form of suicide or, less often, violence inflicted upon others.

Military Culture

To understand the culture of the Army and ROTC, participants were asked to detail the characteristics of one who joins the Army and one who joins the ROTC. Students explained how

service members and students may behave upon membership to either of these organizations. The participants also discussed motivations for joining either the Army or ROTC. Sixty six excerpts were used to code participant experiences with participants five (13) and seven (11) contributing the most responses. Responses were spread almost equally across participants regarding ethnicities with Whites (23), African-Americans (18), Hispanic (13), and Bi-Racial (12) participants providing a similar number of answers. Themes found within this construct include intrinsic and extrinsic factors (Table 6).

Table 6
Military Culture

Theme	Code
Intrinsic Factors	Patriotism, Education, Success
Extrinsic Factors	Class, Diversity, Power

Intrinsic Factors

The first theme, *intrinsic factors*, includes codes which include motivators for joining the Army or ROTC which are internal. The theme name was derived from these internal motivating factors for joining these organizations. Participants shared motivators for membership and noted that those who join either of these branches of service do so of their own sense of duty or need for self-improvement. The codes found in this theme include *patriotism, education, and success*.

Patriotism was primarily referenced as reasons for joining the Army with 11 total responses. Of these responses, White and Bi-Racial participants shared the most responses at five and four, respectively. Several participants listed “*a strong sense of patriotism*” as a characteristic of one who would join the Army. Participant Eight believed that prior to

enlistment, one that joins the Army, “*Want[s] to be a part of something bigger than themselves, I guess it a good way to describe it. They want to better the institution and themselves at the same time.*” This sense of patriotism may also develop after enlistment, as Participant Four states, “*it may start out just as a job and then turns into something more, strong patriotism to your country.*” Member checking confirmed these beliefs, with Participant Six reiterating that those who have a strong sense of *patriotism* are “*willing to defend it [the US] and fight for it and sacrifice yourself....it’s a tough thing to do and it’s definitely not for everybody.*” Additionally, the participant noted a difference that was not mentioned during the individual interviews, stating that, as an ROTC student, he doesn’t really concern himself with the patriotism aspect of joining the military but more for the increased level of discipline needed for college life. Overall, the participants noted a high level of dedication to country in regards to this code.

There was also a child code of *high moral standards*. Participants listed high morality as reasons individuals would join the Army or the ROTC, however, some believed ROTC members had more questionable moral standards. Participant Two stated, “*there are some people who may not hold as high of more moral standard but like I said it’s just some people come in just to try things out.*” Those with lower moral standards will either raise them during their time in the ROTC or fail to meet the standards for commission.

Primarily, opportunities for higher *education* was listed as a reason students joined the ROTC. *Education* was the third highest code among students with 13 responses across six participants. African-American and White participants shared the most responses for this code at six each. Students felt that the ability to be able to have access to career options was important, with the understanding that high academic standards were required to remain viable candidates for commissioning. Participant Seven felt that the ROTC was the “*best of both worlds*”, with

membership being for, *“someone that wishes to still have their college experience but they know that they want to be committed to like the service in the government when they graduate.”* For this participant, the ROTC also served as a bridge to a stronger career track after graduation for what she considered “weaker” fields such as psychology or anthropology.

As stated above, participants acknowledged the high academic standards required for the program. Participant Four stated:

I mean ROTC they make you that you, I mean GPA is everything. So to want to do ROTC you have to understand education requirements you should have that college degree in order to get commissioned and you have to understand that you have to perform well academically to do well in your army career.

The participant states that while in the ROTC, high academic standards are always present and these standards will continue into the Army career as an officer. Member checking clarified these findings, as the participant stated that commanding officers expect at least a 3.0 depending on one’s chosen major. There is an increased expectation of academic excellence depending on the type of job one wants to attain upon commission. For example, those who would like to go into infantry or military intelligence must attain higher scores and grades to increase eligibility. Additionally, those who want to be considered for active duty instead of reserve must also achieve higher grades to ensure that they are in contention for the more desired positions. Conversely, when referring to the type of person that joins the Army versus the ROTC, Participant One stated that those who joined the Army would not have gone towards the ROTC as they are *“not really higher education oriented.”*

In addition to career options, participants use the ROTC as a scholarship opportunity, noting the financial benefits that come with membership. Participant two stated, *“For me I say*

that I want to go into the medical field and I see that army can help pay for medical school, so otherwise if they could provide scholarship money and help financially.” Others may turn to the ROTC after other opportunities fall through, as participant five turned to the ROTC after a volleyball scholarship did not pan out.

Participants noted a need for *success* as a reason for joining the Army or ROTC, with the word “drive” often being listed as a form of motivation. Although there were 15 responses used for this code, many of the responses were short and very similar, mentioning the Army or ROTC as a means for prosperity. Of these responses, White participants provided slightly less than half of the responses at seven. This drive is tied to a need to improve one’s current status, as Participant Eight remarked, *“there is a wide range of people who joined the army they are practically everyday people just stay got this drive to better.”* This drive also fueled career *success*, with participants noting that joining the Army or ROTC gives them access to *success* in chosen fields, similar to educational attainment. Member checking confirmed these findings, Participant Six noted joining the ROTC for increased career opportunities and discipline needed for lifelong *success*.

Extrinsic Factors

The theme of *extrinsic factors* were found as motivating forces which influenced Army or ROTC membership that were outside of the participant’s control. These factors were found to be both positive and negative and existed primarily as societal influences. The name for this theme derived from the factors for service membership which existed outside of self. Codes for this theme include *class, diversity, and power*.

The code of *class* received seven applications across four participants. Within this code, participants marked a distinct difference between those who join the Army versus the ROTC

based on access to higher education. For example, Participant One believed the Army was for “*hard-headed people,*” while Participant Four stated that, for some, “*the military is like the first place to go out of high school.*” Participant Six echoed these beliefs, believing those that join the Army are generally “*rural people usually out of high school,*” and can be described as engaging in “*redneck type stuff.*” This lack of options creates a soldier who would rather be doing something else, with Participant Seven stating:

The type of people that I have interacted with are people who have no other choice pretty much but to join the Army and actually they are usually very cynical about the Army but because that was the only way out that is what they are joined.

Participants noted a distinct line between those who enlisted and those who joined the ROTC and, essentially, those who chose to attend college. Member checking added more information to this code as Participant Six agreed that some people chose enlistment due to having a lack of options but did not view this action negatively. Instead, the participant believed that those who enlisted may have wanted to achieve higher education but did not want to incur loans so instead went to the military, stating, “*I feel like they always have at least a couple of options and they look at them and they think that army is their best options out of the options that they have.*” The participant also stated that some who join the Army may have done the JROTC in high school and choose to just continue down that career path.

Participants detailed *diversity* in the Army as a reason for membership, sharing six experiences over four participants. Participant Eight stated that there are, “*a wide range of people who joined the Army they are practically everyday people that just got this drive to do better.*” Similarly, Participant Five believed that one who joins the Army is “*looking forward to working with a group of people as a team and looking forward to a mission.*” However, this

diversity becomes negative when referring to the ROTC due to the lack of moral and emotional maturity. Participant Two believed that one has to learn to get along with different people who come from all walks of life in the ROTC. Participant three stated that, “*you probably get a lot more of like varying personalities as far as ROTC goes because a lot more people are allowed into ROTC so it’s a little more diverse I would say,*” which means that “*occasionally we do get irresponsible people.*” Within the ROTC, participants feel that they are forced into a situation where they are required to adapt to diverse personalities, which is not always preferable.

Finally, *power* was found to be a factor in service membership with both positive and negative connotations. The code for *power* was used the most of all codes in the culture group with 16 applications across all participants. Participants listed opportunities for leadership, a form of *power*, as a factor for joining the Army or ROTC. Additionally, *power* was also found to be a measure of physical prowess, with several participants noting that those in the Army or ROTC had to be in good physical shape.

In regards to individual answers Participant Seven noted physical demeanors, specifically that those who join the Army are “*tough,*” “*serious,*” and “*don’t play around.*” Participant One found that those who joined the Army were “*cocky in some ways*” and that they are more interested in rank than education. Regarding the ROTC, *power* in the form of leadership was seen as a motivator. Many participants noted that ROTC students needed good leadership skills to be an effective member as the ROTC prepares members for leadership roles. However, this desire for leadership was found to be negative or positive depending on the level of maturity held by those in power. Some found that those placed in leadership roles were not able to lead effectively:

Some can be very overwhelming and like strong and just really like, some can get really power hungry because of the fact that say, like trying to remember you gave them a responsibility; that would be it. Otherwise everybody has got the same goals but they have different way of approaching it, so you have to understand that, because they have different paths, you kind of have to ride with it, stand your ground and learn to deal with the blues (Participant Two).

These members lacked the maturity to be able to effectively lead a group due to their inability to be leaders without becoming overwhelmed with *power*. Member checking illuminated some differences between types of leaders as there are those who actively seek *power* and those who do not. Participant Six noted that some are more “up front” and would be best suited for infantry positions while others are more “helpers” and would do well in an office setting, believing that those who are more vocal have more of a “commanding presence.” The Participant felt that both of these types of personalities can wield *power* effectively, but using different tactics for control.

Summary

The purpose of this portion of analysis was to examine students’ responses regarding military culture and the characteristics of those who join the Army or ROTC. Participants shared intrinsic and extrinsic reasons for joining the military on either side, with each of these themes containing positive and negative connotations. Regarding intrinsic motivations for those who enlist in the Army, participants believed that a strong sense of patriotism and morality with opportunities for success were primary indicators. An opportunity for higher education was listed as a major factor for those who join the ROTC. Extrinsic factors for those who join the Army included a division of class systems, as those who joined the Army were seen as less likely to have the opportunity to pursue higher education and stereotyped as “rednecks” by some

participants. Students who joined the ROTC saw diversity in participants due to the lower standards for admission. Finally, students felt that people joined both the Army and ROTC to seek leadership positions or were those who were physically formidable and fit the role of a service member.

Summary

The purpose of this chapter was to explore the constructs of research question one which entailed the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. The chapter began by discussing the demographics of the participants of this study and measures used to ensure trustworthiness. Next, the data analysis process was summarized including how the data was organized, the theoretical framework used to analyze the data and the themes found using the data. Finally, the chapter explored the concepts of thoughts, feelings, and beliefs regarding mental health in a narrative format in addition to addressing the participant's beliefs regarding mental health stigma and help-seeking. The next chapter will summarize research question two which explores the implications of the aforementioned themes in relation to the presented data.

CHAPTER V

Introduction

The purpose of this dissertation was to investigate the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. This investigation provided information which was used to compile a view of the overall Mental Health Belief Systems (MHBS) of US Army ROTC students at a large institution in the south. MHBS are comprised of the views and opinions a population carries about the character and competence of those with mental health issues and people's comfort level in associating with those who have mental health issues (Vogt et al., 2013). The collected information was analyzed using the Common Sense Model for Illness Representation (CSM; Diefenbach & Leventhal, 1996) which asserts that individuals use cultural cues and social learning to make personal meaning of illness. The CSM was applied for this study to investigate ROTC student's beliefs regarding mental health and what cultural cues contribute to these beliefs. Within these beliefs, the author also analyzed for beliefs regarding mental health stigma and their relationship to help-seeking behaviors.

The following sections will present information from the second portion of research question two which includes implications for the collected data presented in Chapter Four. Prior to this, the researcher will outline the limitations of the study followed by an illness representation of the participating population. This will be followed by the implications for the research data which include how the results can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members. Finally, there will be implications for further research and a concluding statement.

Limitations

Prior to presenting the illness representation and implications of the collected data, it is necessary to discuss the limitations of the research study. To begin, there are limitations inherent to the research method that must be addressed. The first of these is the lack of generalizability inherent in qualitative research due to purposive sampling. Being a known issue, the presented data should be viewed in the context of this specific population and not necessarily applied to similar populations. Additionally, the subjectivity of qualitative research means that the collected data is more interpretative than what would be found in quantitative research. To combat this, the primary researcher included the five verification strategies outlined by Carlson (2010) including audit trails, reflexivity, thick and rich description, triangulation, and member checking. There was also the additional step of peer review suggested by Creswell (2013). Even with these measures in place, the results are still subject to the inherent limitations of the research methodology.

In addition to design limitations, there were also limitations due to errors during data collection. Primarily, there was a sampling error which created a homogenous participant group as noted in chapter three. Due to incentives offered outside of the researcher's control, all of the participants were Military Science (MS) II students. This error was controlled for by rescinding an offer presented by an outside presence and ensuring consent in light of the incentive. The second error occurred due to attrition of participants. Originally, the researcher was to conduct focus groups as a triangulation exercise, however, due to attrition, the exercise was changed to member checking. The change in methodology reduced the amount of feedback the primary researcher was able to gather regarding the themes from the collected data. Three participants agreed to take part in member checking exercises, however, only two completed some form of

interview. The first was completed as a face to face interview; the second was through email correspondence. However, there was little information gained from the email exchange as the researcher sent the participant an incorrect form, resulting in answers to four follow-up questions but nothing related to the discovered themes. This final error severely limited the amount of data that might have been gained through the member checking. As a result of the presented errors, the presented implications should be viewed in light of the events which have hindered parts of the research process.

The Common Sense Model of Illness Representation

One of the goals of this dissertation was to present an overview of the mental health beliefs of ROTC students using the Common Sense Model (CSM) of illness representation developed by Diefenbach and Leventhal (1996) and Moss-Morris et al. (2002). Illness representations are schemas regarding illness which are comprised of seven constructs: *illness coherence*, *emotional representation*, *identity*, *cause*, *cure/controllability*, *timeline*, and *consequences*. These seven constructs are informed by cultural cues and social interactions and when taken together, these constructs can be used to illustrate an overview of one's perceptions of illness. For the purposes of this dissertation, the CSM was used to understand the overall mental health belief systems (MHBS) of US Army ROTC students as suggested by Vogt (2011).

It was found that the CSM model was a good fit for the data. The construct of *illness coherence* was used to address "thoughts about mental illness" as *illness coherence* refers to an individual's understanding of mental illness (Moss-Morris et al. 2002). The researcher believed that the knowledge attainment based themes contained within "thoughts about mental illness" fit the CSM definition of how the participants understood mental illness. The construct of *emotional coherence* was placed in the construct of "feelings" as both of these constructs assessed the

emotional reactions of the participants in response to mental health. Finally, based on supported research from chapter two (Greenberg et al., 2009; Reavley & Jorm, 2011; Wong et al., 2010) in regards to MHBS, the construct of “beliefs” included the last five constructs of the CSM (*identity, cause, cure/controllability, timeline, consequences*). The constructs of stigma and help-seeking were added to the overall narrative as they applied to thoughts, feelings, or beliefs about mental health. Military culture received a standalone section as the views expressed for this construct were not related to research question one. The next section details the mental health thoughts, feelings, and beliefs of the current population which is a summary of their MHBS using the CSM.

Thoughts about Mental Health

Mental Health Knowledge Attainment

The only CSM construct used to analyze thoughts about mental health was *illness coherence* which refers to the individuals’ beliefs about their understanding of mental illness (Ward & Heidrich, 2009). For the purposes of this study, illness coherence referred to the channels through which students gained their understanding or knowledge (i.e. thoughts) about mental health which included several channels. Participants developed their thoughts about mental health through formal channels during instructor-led presentations and informal channels such as personal research and anecdotal information from others. Students reported more informal information, leading to respondents’ thoughts that information regarding mental health was limited. This was evidenced by students’ inability to define “behavioral health” or “mental illness” clearly. This observation was confirmed by outside observers during certain interviews. However, as a definition for behavioral health, some students did mention overall wellness, giving attention to the connection between the mind and body in terms of mental health.

It is prudent to note that student answers differed from enlisted members' thoughts regarding mental and physical health, particularly in regard to stigma. Britt (2000) observed that service members felt more stigma for issues related to mental health than physical health. Conversely, students in this study thought that mental and physical health were connected and did not present stigmatic thinking regarding treatment seeking. Some students did not make a distinction between mental and physical treatment, believing both were necessary for optimal performance. The sources of these ideas possibly lie in the ROTC training where students noted commanding officers emphasized the necessity of health in both areas for best performance. This difference would suggest that the knowledge ROTC students receive regarding mental health creates different thoughts than those received by enlisted members. Therefore, one can surmise that stigmatic messages connected to mental health knowledge are not firmly established at the ROTC level.

Based on the answers provided regarding "thoughts", ROTC students have some knowledge on mental health but this knowledge is incomplete. They were able to provide definitions of mental health but this was not across all those interviewed. For example, African-Americans were more likely to describe behaviors rather than name specific diagnoses and symptoms, similar to work completed by Ward and Besson (2012) where African-American males named several behaviors related to the mentally ill. Ward, Clark, and Heidrich (2009) found that African-American women viewed mental illness as a normal part of life. Taken together, one can surmise that African-Americans may not always name specific diagnoses because some signs of mental illness may be seen as everyday behavior, as cultural exposure plays a part in the ability to name symptomology (Diefenbach & Leventhal, 1996). Therefore, one may conclude that the African-Americans in the current investigation may be more behavior

oriented and may have the knowledge of how unhealthy mental health functioning looks, but are unable to label the symptomology. These findings suggest that steps should be taken to give African-Americans the tools to properly identify the abnormal behaviors they already recognize.

It was also found that students primarily gained knowledge about mental health through direct exposure to those who had mental health issues or from hearing second hand accounts from those with direct experiences. Diefenbach and Leventhal (1996) emphasized that one's thoughts about illness are informed by cultural contexts which are developed through societal exposure. Therefore, one can surmise that cultural contexts regarding illness are developed through exposure to the illness, as has been demonstrated by previous research (Penn & Watermeyer, 2014). In terms of this study, students' cultural contexts were developed by exposure to those with mental health issues, creating a useful knowledge base. These experiences suggest that students are building schemas regarding how to associate with those with mental health issues. While not guaranteed, these schemas may carry to future encounters with enlisted service members who may be in need of mental health treatment. More investigation is necessary to see if these beliefs will change over time in regards to the ROTC students' schemas regarding mental health.

Finally, ROTC students in this study understood that knowledge of mental health issues is necessary as mental health symptomology has an effect on others. The students noted that it is necessary to know how to manage those with mental illness as their symptomology may affect others in the unit. However, one student noted a level of privacy around mental health knowledge. The participant noted that older service members were reluctant to share information regarding mental health, causing the participant to refrain from inquiring about the subject. The need to keep mental health issues private may reflect the reports of service members who

thought that their mental health visits would not be kept confidential (Iversen et al., 2011). Additionally the participant who shared this experience developed cognitive schemas of masculinity based on relationships with male service members (Good & Roberson, 2010), learning from military members that divulging information about mental illness, a perceived weakness, was unacceptable. The absorption of cultural beliefs regarding mental health reflects studies which found that adolescents eventually adopt the MHBS of older adults (Olmstead & Smith, 1980), suggesting that those new to the military or who have grown up in military families learn through cultural reinforcement how to approach mental health. Taken together, the participant from the current investigation developed a culture based schema regarding mental health, suggesting that ROTC students may enter the organization with preconceived thoughts regarding divulging mental health statuses. Therefore, it may be prudent to continue to investigate thoughts about mental health to encourage ROTC students to be more open about mental health issues. This may expand their mental health knowledge so that they may stem issues before these issues impact others under their command.

Feelings about Mental Health

Emotional Reactions to Mental Health

Emotional representation entails individuals' feelings about those with mental health issues (Moss-Morris et al., 2004) and was the CSM construct used to analyze feelings about mental health. Students presented an emotional spectrum in regards to their reactions to those with mental health issues. At the negative end, students presented with apathy, attempting to ignore those with mental health issues, remorse at not being more active prior to negative consequences due to mental health issues, and fear of those with mental health issues, primarily due to physical safety. It should be noted that this fear was present regardless of sex; however,

only males in this study noted fear of serving with soldiers who had mental health issues. This observation runs counter to scholars' (Sigmon et al., 2005) observations that women display more fear regarding mental health than males. Concurrently, the level of fear wasn't measured and the fear that the males expressed was specific to serving with service members with mental health issues. Therefore, further investigation is necessary to understand how much fear is a factor in serving with those who have mental health issues and if this feeling exists outside of gender.

For this study, the fear of those with mental health issues changed depending on the stressor, as women in the study expressed fear due to personal encounters. However, the males in the study who expressed fear of those with mental health issues was attributed to feelings that those with mental health issues would not be able to properly assist service members during combat, reflective of work completed by Gibbs et al. (2011). There were also feelings that those with mental health issues should not have access to weaponry, possibly fearing violence against others as mentioned in the consequences construct in Chapter Four. These statements are indicative of mental health stigma and reflect studies which suggest that service members are distrustful of those who have mental health issues (Gould et al., 2010; Iversen et al., 2011; Kim et al., 2011). Taken together, it can be surmised that stigma in these cases may be born out of fear for one's own life and the abilities of others to protect service members in battle. Those who feared serving with individuals with mental health issues were in the minority, however, it is still imperative to monitor these individuals as their feelings may determine if enlisted members are comfortable with seeking treatment. Therefore, psychoeducation and continued monitoring of these feelings is necessary to familiarize ROTC members with symptomology to possibly minimize fear responses.

At the positive end, students experienced apprehension and empathy. Apprehension may not seem like a positive emotion, however, apprehension and empathy do imply some form of acceptance. For these participants, apprehension implies an openness to change feelings about those with mental health issues with mental health issues as opposed to the fear described in the previous paragraph. Therefore, it is possible that this openness to change in feelings can leave the door open for empathy, which allows students to change their feelings on those with mental health through cognitive and emotional understanding of those with mental health issues. Researchers (Ward & Besson, 2012; Ward, Clark, & Heidrich, 2009) found that participants who displayed empathy as an emotional response also showed compassion to those with mental health issues. This is important as students who are compassionate towards those who are mentally ill may be more inclined to assist enlisted members in help-seeking and carry less stigmatic feelings. Additionally, students who showed signs of empathy were also those who were exposed to those with mental health issues. Due to this exposure, one can conclude that their cultural context included a reduction of stigmatic feelings resulting in behavior to assist those with mental health issues. Future interventions for this population may include methods for building empathy for those with mental health issues as a way to increase the encouragement of help-seeking.

Beliefs about Mental Health

Diagnosis Identification

The CSM construct of *identity* is defined as the ability to identify mental health diagnoses and symptomology (Diefenbach & Leventhal, 1996) and is the first construct which was used to analyze the participants' beliefs about mental health. The ability to identify symptomology and specific diagnoses is important as it allows students to accurately identify those with mental

health issues, hopefully increasing knowledge of best practices for addressing specific diagnoses. Identity is also important for acknowledgement of mental health issues as those who are willing to identify their own symptomology are likely to engage in active coping strategies (Hagger & Orbell, 2003). This is necessary as both enlisted members and officers are susceptible to mental health issues due to similar stressors. Regarding specific diagnoses, many respondents in this study were able to specifically name mental health issues pertinent to service members including depression and PTSD, similar to participants in the Reavely and Jorm (2011) study. Additionally, due to contact with others who have had mental health diagnoses, some participants were able to recognize schizophrenia, dissociative identity disorder, and anxiety disorders. Parham (2002) and Sue and Sue (2003) stated that individuals learn how to identify mental health symptomology through social interactions, confirming that students' interactions with specific diagnoses informed their ability to identify diagnoses by name.

As a word of caution, it is also thorough social interactions where stigmatic beliefs can also develop (Corrigan, 2004). Within this study, exposure to those with mental health issues was often a source of participants' mental health knowledge confirming, research that asserts that contact with those who have specific illnesses can influence cultural beliefs about that illness (Penn & Watermeyer, 2014). However, students mostly left these encounters without apparently forming stigmatic beliefs, but instead, learned to adapt to and empathize with those who had mental health issues. Though some participants did exhibit fear during these encounters, these negative beliefs did not negatively contribute to how those with mental health are identified and therefore were less of a contributor to stigma. One can conclude that if ROTC students are exposed to those with mental health issues during their ROTC program, after they become officers, they may be less likely to hold stigmatic beliefs regarding service members with mental

health issues. However, more research is necessary to understand if beliefs about mental health at this early stage of cultural indoctrination are carried through to the officer stage.

In addition to specific diagnoses, some participants were also able to identify the symptoms which accompanied them, demonstrating an important ability to connect symptoms with the identifying disease. Students were also able to understand that diseases are comorbid and symptoms are linked. This is important as PTSD and depression are often diagnosed together (Bray et al. 2010) meaning that a service member's ability to note both of these illnesses important for recognizing when help-seeking is necessary. In lieu of direct identification, students gave definitions of behaviors which were deemed "crazy," suggesting that better informed vocabulary of mental health diagnoses may need to be increased. Care and Kuiper (2012) found individual's perceptions of symptoms were affected by how they conceptualized illness, suggesting that if one cannot identify an illness, they also cannot identify the accompanying symptoms. This is important to note as the ability to identify symptomology and attach them to their respective illness means that it may be possible to identify illnesses earlier, preventing further mental health issues from becoming more severe. Therefore, it is important for ROTC students to be able to identify symptomology for early interventions, while avoiding labels such as "crazy," to increase prevention efforts.

Diagnosis identification is important as it is one of the first steps in establishing beliefs about mental illness. As stated above, perceptions about mental illness are based on an individuals' conceptualization of illness (Care & Kuiper, 2012). Therefore, it is important for ROTC students to be able to identify mental illness so that their conceptualizations are based on accurate labels and symptomology. Assessing beliefs at this stage allows researchers to

understand how much work still needs to be done to properly educate future leaders regarding common mental illnesses which they may encounter in their enlisted membership.

Causes of Mental Illness

Diefenbach and Leventhal (1996) outlined the construct of *cause* as the individual's beliefs regarding the origins of an illness. This construct was used to analyze the ROTC students' beliefs regarding causes of mental illness. Stress was found to be a common cause of mental health diagnoses across illnesses (Baines & Wittkowski, 2013) and the participants of the current study provided a varied list of stressors which they believed contributed to mental health issues. A few participants believed a psychotic break, generally explained as a "snap" and often resulting in violence. More often, students believed that a traumatic event such as sexual assault or violence could serve as a possible catalyst for mental health issues. It should be noted that both women and men mentioned sexual assault, however, only one female (Participant Two) mentioned receiving sexual harassment training. The experience of only one participant mentioning sexual harassment training is alarming due to the high incidences of sexual assault in the military with 26,000 incidents reported in 2012 but only 3,374 of these being reported ("*Sexual Assault*," 2013). Therefore, it is important for ROTC instructors to emphasize sexual harassment training during mental health debriefings as sexual assault is a likely cause of mental health issues within the enlisted population.

Combat was also noted as traumatic, however, some believed this to be a function of the environment of war and therefore, service members should be cognizant of its traumatic effects. Similarly, Hoge et al. (2004) found that participants believed that commanding officers would blame them for their mental health issues, suggesting that service members should be responsible for their own adaptation to combat. A few in the current investigation echoed these statements,

believing that service members should have been mentally prepared for battle prior to joining the military, suggesting forward knowledge of the stress of battle. These beliefs are worth investigating as it denotes stigmatic thinking on behalf of the students. Those who believe that service members should be mentally prepared for war may stigmatize those who need treatment, reducing their willingness to be open to those who may approach them with mental health issues. For this reason, more investigation is necessary with these individuals to assess their views on the effects of war and mental health outcomes for those who experience trauma.

Stressors of war such as firefights and death of comrades have been found to be common experiences for service members (Hoge et al., 2004) and can also be contributors to mental health issues. Experiences such as these may contribute to PTSD as it has been found that traumatic events are contributors to this illness (Wong et al., 2010). While service members believe that mental illnesses are legitimized through combat (Gibbs et al., 2011), participants in the current investigation also believed that combat did not always cause mental health issues. These conflicting views suggest that some participants recognize that there are other causes to mental health issues, and while combat may be a factor, it may not be the only contributing event.

Other causes of mental illness included school pressures such as classes, testing, and balancing ROTC responsibilities. ROTC students are in a unique position that is not offered to enlisted members as they are both college students and (in essence) military staff simultaneously. It has been found that that high self-esteem is a buffer for stressful college events (Byrd & McKinney, 2012), suggesting that future research is needed in the area of self-perception and self-esteem as it pertains to ROTC students. This is important to note as ROTC members are still students prior to commission and protecting their mental health during this time is important to

building coping skills. Understanding their self-esteem and capacity for resilience may illuminate how students handle future stressors.

Finally beliefs about, interpersonal issues were also seen as a potential stressor, with familial issues being listed as a contributor. Unique to the military, participants believed separation due to deployment as a possible stressor. This is important to note as service members are separated from their families for extended periods of time due to deployments and researchers suggest that both the service member and the family suffer due to these deployments (Hall, 2011). As future officers, ROTC students must be aware of this as a possible stressor and to be aware of any participants who may be experiencing issues due to separation, as these may be catalysts to mental health issues.

Causes of mental health issues allow individuals to identify triggers which may contribute to symptomology. It is important to understand what ROTC students believe about the causes of mental health issues as it allows for instructors to educate future leaders on pertinent issues which may contribute to mental health issues. If future leaders are able to identify likely triggers within enlisted membership, they may be able to increase help-seeking and reduce stigma by approaching enlisted members with triggering issues prior to the presence of symptomology.

Mental Health Treatment

Regarding treatment, the researcher used the CSM construct of *cure/controllability* to analyze beliefs regarding how students addressed ways to alleviate mental health symptomology. The ROTC students in this study presented a wide range of options and beliefs regarding mental health treatment. Participants overall believed that mental health issues were manageable and that it was possible to alleviate symptoms through different treatment options. This is important

as Hagger and Orbell (2003) found, through meta-analysis of several CSM studies, that controllability was related to active coping. As it relates to this study, this finding suggests that ROTC students are more likely to engage in treatment as they believed mental health issues are manageable.

The participants outlined a continuum of help-seeking beliefs beginning with acknowledgement and ending in professional engagement. Acknowledgement of mental health issues were necessary prior to treatment and may come from self-realization or after others illuminate symptomology. In a qualitative examination, Gibbs et al. (2011) found that service members expressed increased stigmatization after acknowledgement of a mental health issue. However, very few participants in the current investigation showed signs of stigmatizing those who acknowledged mental health issues, instead, seeing acknowledgement as a necessity for treatment. The only participant that did share stigmatic beliefs regarding acknowledgement of mental health issues held the belief that service members should be prepared for the stressors of war prior to enlistment, making help-seeking unnecessary. Further investigation is necessary to investigate how widespread these stigmatic beliefs are within this population.

Additionally, the participants did not mention self-stigmatization if there was need for them to seek treatment in the future. Self-stigmatization is important to note as researchers have found that “self-positivity bias” contributes to shorter duration of symptomology, less negative consequences, and less severe personal labeling (Care & Kuiper, 2012). This suggests that those who have less self-stigma regarding their illness have an easier time during treatment, as they will be less likely to judge themselves negatively for seeking help. At this time, however, it may be too early to know if this lack of self-stigma is applicable to other ROTC students outside of the current study. Due to the qualitative methodology chosen for this investigation, it is difficult

to generalize the beliefs of self-stigma beyond the current sample. More investigation is necessary before more sweeping conclusions can be made regarding ROTC students and self-stigma.

Within the current sample, the participants believed that after symptomology had been acknowledged, there was a period of adjustment to the news. This adjustment may take place within those expressing symptomology or those who are affected by symptomology. This adjustment is primarily mental, as those with mental health issues must believe that treatment is a viable option for wellness before treatment took place. These beliefs reflect research where service members would like to believe treatment will be effective prior to engagement (Clark-Hitt, Smith, Broderick, 2012). Baines and Wittowski (2013) also found that participants who believed that treatment was a viable option for mental health illness control were more likely to adhere to treatment. This is important as it has been demonstrated that approximately 30% of service members who are diagnosed with mental health issues didn't seek treatment (Seal et al., 2010). Taken together, one can surmise from these beliefs that it is important to reach the service members who may not seek treatment and attempt to help them see professional engagement as a viable option. As future officers, ROTC students will be placed with the responsibility of recognizing those who have been diagnosed but may not be seeking treatment regularly. Therefore, prior to commissioning, ROTC students should be cognizant of ways to encourage service members adhere to treatment to alleviate mental health issues so that service members can quickly return to duty.

There were also responses related to beliefs regarding timing of treatment, specifically efficiency and speed related to help-seeking. While only males believed that efficiency was necessary in mental health treatment, none of the answers provided alluded to male gender

norms regarding help-seeking outlined by researchers (Kessler, Brown, & Broman, 1981; Tudiver & Talbot, 1999; Wills & Depaulo, 1991). From this finding, one can conclude that the males in this study did not believe that service members should seek treatment for symptom alleviation to maintain a masculine male image, removing a barrier for treatment. Primarily, the beliefs related to efficiency were combat related as participants believed that those with mental health issues should get treatment as soon as possible to ensure the safety of others. From these findings, one can conclude that ROTC students want to address mental health issues quickly and effectively, however, there needs to be work to decrease students' fears of those with mental health issues. Additionally, more research is necessary to investigate how to ensure these beliefs regarding efficiency are carried through to commissioning and beyond.

Regarding stigma and help-seeking, participants felt that both service members and civilians should seek treatment if necessary, reserving no judgment for either group. These beliefs support work completed by Stecker et al. (2007) where service members believed that they would be supported by those in the military upon seeking treatment for mental illness. However, participants also believed there should also be a sense of urgency for service members regarding treatment seeking, likening service members to police officers and fire fighters. This belief that others' safety is paramount engenders a sense of group support, where participants believe that friends and family members can serve as mental health resources. These beliefs are similar to work completed by previous research where participants believed that family members were viable resources for help with mental health issues (Greenberg et al., 2009; Iversen et al., 2010). Group support is also important to note as researchers (Britt, Wright, & Moore, 2012; Wright et al., 2009) found that higher levels of unit cohesion and leadership support resulted in lowered stigma levels. Britt, Wright, and Moore (2012) in particular, used non-commissioned

officers for their studies on stigma. As ROTC students become commissioned officers, the findings of this study are important to note as their beliefs about mental health will also affect those seeking treatment. However, it is unknown if these beliefs are maintained over time, necessitating research with commissioned officers to understand their beliefs regarding help-seeking.

One of the primary modes of treatment mentioned by participants was forms of self-medication. Participants believed negative methods such as illicit drug usage or alcohol were appropriate methods of treatment for mental health issues. While this is not a sanctioned method for alleviating symptoms as it may be damaging to one's career, service members see it as an alternative. Rae Olmstead et al. (2011) noted that service members feel less stigmatized for engaging substance abuse treatment than for mental health treatment; however, Iversen et al. (2011) reported those in treatment for alcohol abuse still experienced decreased trust from their unit. This would mean that even though service members may feel less stigmatized for seeking treatment for drug and alcohol related issues, they would still experience negative impacts as a result of their method of treatment seeking. Therefore, students should be aware of those who may be drinking to excess or using illicit drugs as they may be negatively coping with mental health issues.

Students also noted positive beliefs about methods to alleviate mental health issues, primarily focusing on overall wellness by improving physical fitness. Physical fitness was noted as a self-care method to reduce stress, which can improve overall mental health, similar to beliefs that physical fitness is an effective way to cure depression (Godoy-Izquierdo, Lopez-Chicheri, Lopez-Torrecillas, Velez, & Godoy, 2007). This is an important note as physical fitness is an expectation of service members, creating an accessible mental health cure as individuals are

more likely to engage in self-care if the actions are easy to perform (Hagger & Orbell, 2003). Although physical fitness alone will not alleviate severe mental health issues, it is important that students continue to engage in these behaviors as they are necessary for job functioning and may open the door for other forms of treatment seeking. From these beliefs, one can surmise that the ROTC students in this sample have absorbed the mental health beliefs of their instructors regarding overall wellness and have incorporated these beliefs into their daily lives.

Finally, participants believed that professional engagement was a viable option for treatment. For some, this is seen as a last resort for those overwhelmed by their issues while for others, it is seen as a first option and even a preventative measure. Angermeyer et al. (2013) and Munizza et al. (2013) noted that individuals believed that a general practitioner or a mental health specialist would be the best resources for mental health help-seeking. For this study, participants primarily noted the profession of psychology as a mental health resource. However, no one mentioned a general practitioner, which may have been due to the phrasing of the question regarding help-seeking, as general practitioner was not listed as a mental health professional. Additionally, the primary researcher did not note licensed clinical social worker as a treatment option, removing an important resource from the list of options. Future research may do well to omit options for mental health professionals and instead include “help-seeking professionals” to allow participants to add their own answers regarding the type of professional. However, it should be noted as positive that students see professional engagement as a treatment option. More education regarding the types of treatment professionals and their functions may serve to give ROTC students more options in regards to resources for themselves and enlisted officers. The current investigation demonstrated that ROTC students in this sample are at least

aware of mental health professionals as viable options for treatment, possibly reducing the amount of psychoeducation necessary to update ROTC students regarding treatment options.

Duration of Mental Illness

Duration of mental illness included how long students believed one should wait to seek mental health treatment or how long mental health treatment should last. This belief was analyzed using the CSM construct of *timeline*. Overall, students provided the least amount of answers regarding beliefs about how long those who are diagnosed with mental health issues may present with symptomology before needing treatment. Regarding a specific time limit, participants believed that a month was sufficient regarding the time one should wait prior to seeking treatment. According to Diefenbach and Leventhal (1996), this timeline would be considered acute, meaning symptoms are unexpected and present themselves within a short time period. The month long time period was believed to be sufficient as certain issues may have been due to a specific situation. Participants believed that a resolution of the situation, or a change in environment, may resolve the mental health issues before it is necessary to engage a professional. Environmental change reflects CSM research completed by Godoy-Idzquierdo, Lopez-Chicheri, Lopez-Torrecillas, Velez, and Godoy (2007) who found that participants believed a change in environment can alleviate symptoms of depression. However, it is unknown how long one may suffer from mental illness, even with a change in environment as each individual and their symptomology is unique. Therefore, the participants in this study may need more education regarding the duration of mental illnesses as their belief that a month of observation or a change in environment prior to mental health help-seeking may not be accurate for all illnesses.

Participants also believed that mental health issues may have come from birth or developed due to consistent exposure to stressors. This definition is similar to chronic illness, where symptoms are long lasting and reoccurring over time (Diefenbach & Leventhal, 1996). This is important to note as diagnoses such as Post Traumatic Stress Disorder have chronic symptoms which build over time and must be consistently managed through treatment. Researchers completing meta-analysis of CSM have found that individuals believe that mental health issues are chronic in nature (Baines & Wittowski, 2013), therefore, if students are aware of the approximate time in which mental health issues to develop, they may be able to intervene before symptoms become debilitating.

Again, beliefs regarding duration of mental illness were very limited in the current investigation. Future research is necessary to draw more information regarding beliefs about the duration of mental health issues and particularly specific illnesses. Schuz, Wurm, Warner, and Ziegelmann (2012) found that perceived control of illnesses were related to timeline, meaning that those who knew how long they may have to endure mental health issues may feel they have more time to investigate treatment options. This is important to note as it gives ROTC students another source of information for themselves an enlisted members in helping to control mental health issues. After continued research, possible interventions may include information regarding the duration of mental illnesses common to the service member population such as Post-Traumatic Stress Disorder and depression.

Consequences of Mental Health Issues

Finally, participants discussed beliefs regarding the consequences of having mental health issues or being exposed those who need mental health treatment. The CSM construct of *consequences* was used to analyze beliefs regarding the aftermath of mental health issues. Beliefs

were separated between interpersonal and intrapersonal outcomes, these consequences primarily included changes in lifestyle and adjustment to those who had mental health issues. Regarding changes to daily life, participants believed changes to routines, events which can affect daily life (i.e. DUI charges), or withdrawal from social circles were examples of consequences regarding mental health. These changes can also affect job performance, a primary concern for participants as they engage in combat scenarios and situations where trust is a factor for those fighting together. It should be noted here that researcher have found that service members who screened positive for mental health issues believed that there would be repercussions if their mental health issues were known including less trust from leadership and unit members and that their mental health issues would be career harming (Hoge et al., 2004; Iversen et al., 2011; Kim et al., 2011). Participants in this study did note that damage to career was a possibility as a result of mental health issues, suggesting stigmatic thoughts regarding service members' ability to perform their duties if mental illness is present. There were some participants who believed that they would lose trust in someone as a consequence of mental health issues while others were more concerned about a service member's loss of income.

Participants believed another consequence of mental health issues is stigma as a result of disclosure. Some students in this study stated that they would be wary of fighting with someone with known mental health issues, beliefs which verify the anticipated stigma felt by service members in disclosing their mental health status (Hoge et al., 2004). It should also be noted that the only participants to express stigmatizing beliefs were White or Bi-Racial (Black and Italian). As of 2011, 77% of Army officers were White; however, it is unknown how many of these officers were commissioned through the ROTC (2011 Demographics Report). Additionally, after analyzing National Survey on Drug Use and Health (NSDUH) data, Ojeda and Bergstresser

(2008) noted that White males were more likely to engage in stigma avoidance behavior regarding mental health treatment. The authors noted that this may be due to fear of losing privileged status in society as a result of mental health issues, a status that even race cannot protect. Taken together, one can conclude help-seeking service members are more likely to encounter a white male officer who may or may not have stigmatizing beliefs. If service members were to encounter the aforementioned ROTC students as commissioned officers, the service members may face the risk of discrimination due to their diagnoses, resulting in loss of promotions or removal from active duty. While these students were a minority in beliefs regarding those with mental illness, their views must still be taken into account as they have now been found to exist within this sample. Therefore, this study was important as it illuminated that a portion of students had stigmatizing views of service members which may carry into commissioning. More research is necessary to investigate how prevalent these views are within the ROTC population.

Additionally, participants believed that mental health issues may affect the family of the participant, resulting in changes to the family system. Researchers (Coll, Weiss, & Yarvis, 2011; Hall, 2011) have detailed how military life affects both the service member and their family. During this study, participants noted how a family member's PTSD due to combat exposure negatively impacted family life. Taken together, one can conclude that mental health issues would have an impact on family life, as the perceived consequences of mental health issues (loss of position, income, etc.) will also negatively affect the service member's home life. While none of the students in this study had families of their own, this finding is important as the students will need to take the information into consideration as help-seeking service members may have families which would be affected by the students' decisions. Future research may be necessary

how much ROTC students understand about the implications of their decisions regarding enlisted members mental health status, career, and familial support.

Lastly, participants believed the consequences of mental health issues may include internal conflicts which can result in harm to others or self. Evidence of harm to others has resulted in mass murders such as the 2009 and 2014 Fort Hood shootings. While one cannot make the connection that the perpetrators of these events were mentally ill, it is important to note that certain diagnoses may result in harm to others due to symptomology. Additionally, participants noted harm to self to primarily include suicide. As noted in earlier Chapters, suicide has risen post 9/11, creating concern for the Department of Defense (Garamone, 2014). One participant in this study had direct exposure to suicide as a result of military life, creating empathy for those who may suffer from mental health issues. Both positive and negative consequences of internal conflicts are important to note as students who become commissioned officers may have the ability to prevent these events if they encourage mental health help-seeking prior to these negative consequences. Therefore, it is prudent for ROTC students to be aware of signs of internal distress prior to negative outcomes of mental health issues. However, further research is necessary to see how widespread these beliefs are within the ROTC community and beliefs regarding negative outcomes of internal stressors.

Stigma, Help-Seeking, and Culture

In Chapter Four, beliefs regarding mental health stigma and help-seeking were included in the constructs of thoughts, feelings, and beliefs regarding mental health. However, in this chapter, it is important that beliefs regarding stigma, class, and help-seeking be given individual attention as these are important concepts are prevalent within the enlisted community. There must also be conversation regarding the connection between male cultural norms in the military

and help-seeking. Within the enlisted service Dunivin (1994) spoke of the Combat Masculine-Warrior (CMW) paradigm, which emphasizes qualities such as bravery while deemphasizing displays of emotion (Wessley, 2006). When probed about what type of individual joins the military, participants believed physical prowess and high moral caliber were necessary for joining the military. However, when probed about help-seeking, beliefs including masculine norms were in a minority of responses. These included beliefs regarding perceived masculinity in regards to help-seeking and emotional control in regards to feelings about mental health. In terms of the majority, one participant actually alluded to ignoring masculine beliefs, stating that there was no “code of the warrior” in terms of when one should seek help for mental health issues. However, Participant Six was the only participant to directly state that one may be perceived as “weak” or “unreliable” by other service members if mental health issues are present, confirming previous research presented by Iversen et al (2011). The participant remarked that these beliefs originated from service members who were previously active duty but entered the ROTC later in their military careers. As very few participants noted these masculine ideologies, the participant’s responses would suggest that stigmatic beliefs regarding mental health are reinforced sometime at basic training or at points outside of ROTC, confirming research by McFarling et al (2011). With this knowledge, future research should focus on different stages of military involvement including those who go from active duty back to the ROTC level. However, it is positive to note here that overall, male gender norms were not a hindrance to help-seeking and that students felt open to help-seeking behaviors. Hopefully, these beliefs will continue through commissioning, removing a barrier for help-seeking in enlisted service members. The current investigation has demonstrated that beliefs regarding CMW are not

present within the current sample; however, research with other ROTC programs is necessary to assess these beliefs in other students.

The Combat Masculine-Warrior paradigm (MCW; Dunivin, 1994) has elements of an emotional toughness needed for service; however, very few ROTC students shared these beliefs. It is possible that the emotional toughness required of service members described by researchers (Nash, Silva, & Litz, 2009; Sayer et al., 2009) may not have filtered to all ROTC students and therefore is not a part of their cultural beliefs regarding the military. Researchers (McFarling et al., 2011; Petrovich, 2012) have suggested that basic training reinforces the masculine ideals of those in the military; however, all ROTC members have not participated in basic training (particularly the sample used in this study), leading to an absence of masculine ideals and stigmatic beliefs regarding mental health and help-seeking. The absence of these beliefs would also suggest that there was little Male Gender Role Conflict (MGRC) present when deciding when to seek-treatment, contrary to the results observed by Fleming (2012) and Price (2011). Researchers (Hoge et al., 2004; Gould et al., 2010; Kim et al., 2011) also stated that service members with possible or diagnosed mental health issues believed that they would be seen as “weak” for disclosing mental health issues. However, very few students expressed this belief, instead, some praised service members for seeking treatment, believing them to be brave for doing so while encouraged help-seeking, sometimes as a preventative measure. Only one participant held beliefs related to masculinity in regards to disclosure of mental health issues but did not hold the same beliefs regarding help-seeking. Instead, the participant believed treatment to be a matter of necessity for the safety of themselves and others. Therefore, contrary to research (Good, Dell, & Mintz, 1989; Good et al., 2006; Hammer & Good, 2010), participants did not note a conflict of masculine ideologies prior to seeking treatment. As stated above, more

research may be necessary to include those who have participated in basic training prior to joining the ROTC and/or those who have completed Officer Candidate School, to assess their beliefs on mental health in order to look for masculine ideals. However, for this study, one can conclude that the sample of students did not experience MGRC in regards to treatment seeking, allowing for a more facilitative environment in regards to help-seeking behaviors. Further research is necessary to see if these beliefs are exclusive to this population or if they are shared among other ROTC students.

Finally, class was noted as a theme within participants' answers which may have implications for help-seeking. Some participants had a negative belief of those who enlisted, noting a difference in economic class, believing that those who enlisted had fewer options for success. Rosen and Corocoran (1978) found that commanding officers in the Air Force felt paternalistic and benevolent feelings towards service members who needed mental health treatment, however, these findings run counter to the views of some of the participants of this study. Some of the students viewed enlisted members almost disdainfully even prior to connections with mental illness, noting that those who enlist in the Army could be categorized as "rednecks." While these beliefs were not connected to help-seeking behaviors they should still be noted as views which can possibly contribute to future stigma and help-seeking. Those of lower socio-economic status have less access to mental health treatment (Ojeda & Bergstresser, 2008), meaning that they may be more susceptible to the practical barriers to treatment including affordability and transportation. It should be noted that unlike service members in other research (Hoge et al., 2004; Gould et al., 2010), none of the ROTC students regarded practical barriers as a hindrance to treatment. However, ROTC students who regard enlisted members to be of a lowered class system may believe that service members of lowered socioeconomic status may

not have knowledge of mental health resources though they are present within the military community. These views may be noticed by enlisted members, meaning that they may feel less comfortable speaking with commissioned officers about their mental health issues due to anticipated stigma. Therefore, more research must be conducted to investigate ROTC students' beliefs of enlisted members to investigate the presence of stigmatic beliefs.

Summary

The preceding section presented the mental health beliefs of a group of ROTC students at a southern institution. Using the Common Sense Model for (CSM) illness representation (Diefenbach & Leventhal, 1996), the primary researcher made meaning of the data presented in Chapter Four. The purpose of this study was to investigate the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. Additionally, the researcher was interested in the possible connection to mental health stigma and help-seeking within the aforementioned constructs in an early stage of one's military career. It was found that the CSM model was a good fit for the data as each of the seven constructs fit within the constructs of thoughts, feelings, and beliefs about mental health.

“Thoughts” about mental health were encapsulated using the CSM construct *illness coherence* where participants shared the sources of their knowledge regarding mental health, primarily classroom instruction and anecdotal storytelling. “Feelings” about mental health were addressed using the CSM construct of *emotional representation*. For this construct, participants shared how they felt when encountering someone with mental health issues, presenting a spectrum ranging from fear on the negative end, to empathy on the positive end. Finally, “beliefs” were analyzed using the remaining CSM constructs of *identity, cause, cure/controllability, timeline, and consequences*. Participants in this sample were able to identify

several mental illnesses and corresponding symptomology including Post-Traumatic Stress Disorder (PTSD), schizophrenia, and depression. Regarding the causes of mental health, participants believed that psychotic breaks, trauma, and environmental stressors were all contributors to mental illness. Regarding cures for mental illness, participants believed that self-medication, group interventions, and professional interventions were acceptable methods of treatment. Participants believed that approximately a month was necessary to assess symptomology of mental illness and purported a change of venue to change this time period. Finally, participants believed that one may harm themselves or others and that there would be changes to daily functioning as a result of mental illness.

In regards to mental health stigma and help-seeking, the participants in this study were mostly open to help-seeking in the various forms listed. However, some participants shared stigmatic beliefs regarding those who divulged mental illness due to beliefs that the possibility of mental illness should have been known and fear for personal safety during combat. The aforementioned beliefs, however, were not the majority, leading to the supposition that upon commissioning, ROTC students may be open to enlisted members seeking treatment. Finally, masculine cultural norms were found to have a minimal influence on beliefs regarding stigma and help-seeking, with most participants failing to mention male cultural norms in their beliefs regarding mental health and help seeking.

The completed research is important as assessing beliefs regarding illness allows care providers to create more focused interventions (O'Mahen, Flynn, Chermack, & Marcus, 2009). Therefore, this study was important as it gives researchers an initial view of these ROTC students' mental health beliefs, which may be used for further treatment models. While this was a preliminary study, the findings are important as it opens avenues for further investigation. The

following sections will detail implications for these findings and possible avenues for future research.

Implications

The purpose of this dissertation was to assess the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. The data collected from the ROTC students was used to create an overview of the overall mental health belief systems of a sub-group of the military as suggested by Vogt (2011). Due to the nature of qualitative research, it is beyond the scope of this dissertation to generalize these results to all ROTC populations. However, the collected data does have implications which may be used for further research. The following sections will detail information from the second portion of research question two. These include implications for the collected data including prevention improvement, development of treatment protocols, preparation for future counselors, development for the field of counseling, community education, and implications for future research.

Prevention Improvement

While it is not possible to entirely prevent mental health issues, it may be possible to reduce mental health stigma and improve treatment seeking within the service member population. After data analysis, the primary researcher found that exposure to those with mental health issues was beneficial for the students. These benefits included increased knowledge about mental illness and emotional development. Learning, adaptation, and empathy development occurred after experiences with those who had mental health issues. Therefore, it would be beneficial to expose ROTC students to veterans or active duty service members with mental health issues to increase knowledge and teach usable skills for working with enlisted members

who have mental health issues. This may be achieved through guest speakers during class time or volunteering for organizations which work with veterans.

Another method for increasing knowledge about mental health could be to increase formal communication between ranks. Much of the communication between students regarding mental health was informal and major lessons were only partially recalled. Some students remembered specific classes but much of the information carried was from anecdotal stories and through exposure to other service members, particularly enlisted members. Students would benefit from increased communication about mental health from commanding officers regarding the mental health issues they and those in their care may face upon commissioning. Additionally, as the ROTC members are still students, techniques for balancing college and military life may also be beneficial. These formal lessons may carry through to commissioning where the students will have to adapt to balancing other aspects of life with the military.

Finally, it would be beneficial for students to be aware of official resources which exist for those who may need mental health treatment. While two students acknowledged instructors as a mental health resource, only one other student mentioned knowing appropriate services on campus. Many students use each other as a resource but use professional engagement as a last resort. This limited knowledge would suggest that students should be informed about what mental health resources are available to them on campus and in the surrounding community for the prevention of exacerbating symptomology. Additionally, students should be aware of the functions of mental health professionals to best direct themselves or others to appropriate services. This knowledge will hopefully carry to commissioning where the students will be required to inform service members of the appropriate treatment professionals.

Treatment Protocol Development

It is beyond the scope of this dissertation to recommend treatment protocols for this specific population. Developing treatment protocols based on one qualitative study is not advisable as van Manen (1990) suggested that qualitative studies aren't universally generalizable. Much more research must be completed to understand the mental health needs of ROTC students prior to development of proper mental health prevention methods. However, it may be prudent to formally introduce students to mental health issues with increased psychoeducation so that they may be aware of common illnesses within the military. Participants were able to name several illnesses, behaviors, and symptomologies but the knowledge was not common to the sample.

Based on the results of this study, one can surmise that psychoeducation would be beneficial for ROTC students as enlisted members have requested psychoeducation to better understand their mental health symptomology (Stecker et al., 2007). If psychoeducation is increased at the ROTC level, commissioned students would be better equipped to assist enlisted members with this request. Additionally, a level of mentoring occurs between students of different academic levels, necessitating knowledge of mental health issues which affect college students. Participants shared issues which may cause them to seek treatment but this list is in no way exhaustive. This data from this study can be combined with current literature on college counseling to develop culturally relevant psychoeducation materials.

Officer Preparation

As this was an inaugural study, it is difficult to make conclusions about the development of ROTC students in relation to their future engagements with enlisted members with mental health issues. However, one can begin to make conjectures about elements that should be put in

place to develop future officers who are equipped to assist enlisted service members with mental health issues. The current investigation showed that ROTC students were beginning to form supportive beliefs regarding mental health and help-seeking. In regards to thoughts, feelings, and beliefs regarding mental health, most of the students were aware of mental health diagnoses and different methods for help-seeking including seeking a mental health professional. However, these beliefs were in their infancy and would be well developed by including psychoeducation in the Military Science curriculum. The burgeoning beliefs of this sample would have been enhanced with details regarding common triggers for mental health symptomology such as Post-Traumatic Stress Disorder. Additionally, students' beliefs would be better informed with more information regarding how long those with mental health issues express symptomology and methods for assisting those experiencing mental health episodes. Finally, military science instructors can help ROTC students understand the practical consequences of mental health issues by discussing how symptomology and diagnoses systemically affect those who are experiencing mental health issues. For example, guiding lessons regarding how their decision making in relation to mental health will affect service members, their families, and their career paths are necessary. Conversations such as these may encourage ROTC students to think critically about their beliefs regarding mental health and how these beliefs will affect those in their command.

Development for the Field of Counseling

In regards to the implications for the field of counseling, the current investigation begins by increasing the cultural knowledge of ROTC students and their mental health beliefs. Currently, the field of counseling has not yet identified all of the sources of stigma within the military population. Additionally, the counseling field has not yet explored the needs and beliefs

of ROTC students in regards to mental health. Due to the current investigation, counselors now have a preliminary view of the ROTC population's help-seeking views and possible sources of mental health stigma. However, it is now imperative for the field of counseling to continue the work to explore the needs of this population. Most research within the military has been completed by psychologists and social workers, leaving counselors and counselor educators out of important work being done with this population. Therefore, it is important that the profession begin to take more of an interest in research with this population so that they are more knowledgeable of the needs of their needs and can add to the body of knowledge overall.

The investigation also has contributed to how ROTC students learn about mental health and their depth of knowledge regarding the subject. The aforementioned results showed that psychoeducation and exposure to those with mental health issues were how the participants learned about mental health issues. Counselors have the knowledge necessary to inform this population about mental health issues which may affect service members they will later encounter. Engaging this population in their Military Sciences courses may increase their mental health knowledge and possibly lower mental health stigma regarding enlisted membership with mental health issues.

Community Education

The ROTC community includes both the university and military systems, as the client must operate in both of these worlds. Again, while the knowledge acquired from this study is not indicative of the feelings of all ROTC students, it can be used as a basis for further investigation into the needs of this population. College counselors may be required to address the needs of this population in regards to mental health treatment. Therefore, it is imperative that these counselors be informed of the possible issues and mental health beliefs of this population. Cadre and

commanding officers in the military system are training these students to excel as leaders with enlisted service members. It is therefore important for these entities to understand the mental health beliefs of this population so that they may tailor their military training courses to best serve the needs of the students and the future service members who will be under the student's care.

Implications for Future Research

This study was a preliminary view into the mental health beliefs of Army ROTC students. As this study was the first of its kind, there is a need for repetition to explore further the phenomena. Qualitative investigation needs to be repeated with different ROTC students to see if the experiences of this study are homogenous and to determine where experiences converge. Samples must be spread across demographics including academic levels, age, and hometown, as these factors were not explored in this study due to the homogenous population. The homogenized sample in this study did yield much information regarding the demographic information discussed in Chapter Two (age, location/hometown, rank), necessitating further research into these areas.

There were questions which were illuminated during this study that were not able to be addressed by the current investigation. One of the goals of this study was to investigate the sources of stigma within the military population. While fear of personal safety and messages from returning soldiers were found to be sources of stigma, there is not enough information present to mark these experiences as the only sources of stigma. Additionally, links to outside research highlighted differences in race as contributors to stigma. Further investigation is necessary to understand the sources of stigma within this population so that stigma may be minimized prior to commissioning.

Unexpectedly, the primary researcher also found class related belief systems during data analysis. Participants negatively described enlisted members using stereotypical and derogatory terms which may contribute to belief systems. It is important to note these thoughts as commissioned officers are an integral part of the leadership of the military. More investigation is necessary to see how prevalent these beliefs are within the ROTC population and, possibly, how they can potentially impact future officers' thoughts, feelings, and beliefs of the mental health needs of the soldiers they lead.

Before treatment protocols can be developed for this population, more research is necessary to understand the Mental Health Belief Systems (MHBS) ROTC members. Knowledge of belief systems allows researchers to create more culturally appropriate treatment protocols (O'Mahen, Flynn, Chermack, & Marcus, 2009). The current investigation explored the thoughts, feelings, and beliefs of this ROTC sample regarding mental health and the researcher believes that the findings addressed the research questions presented. As this was the first study to attempt this, the knowledge gained from this study is important as it begins a line of research which investigates the MHBS of an influential population. However, continued research is still necessary to understand more about the MHBS of this population. For example, beliefs were sparse in regards to how long ROTC students expect to remain in mental health treatment or the duration of symptomology. Additionally, it was found that self-concept was related to help-seeking behaviors, a factor that was not considered in the design of this study. More research is necessary to determine how these factors contribute to the overall mental health belief systems of the population. Eventual development of this population's mental health beliefs using quantitative methodology would also be beneficial. The Common Sense Model for illness representation (CSM; Diefenbach & Leventhal, 1996) was an appropriate framework to use in

this investigation and has the potential to be used in further research. For example, the model also has a quantitative measure which could be used to assess a larger number of individuals for a wider picture of their mental health beliefs. This greater scope of this population's cultural beliefs would be helpful in determining treatment models and possibly influencing ROTC curriculum.

Conclusion

The purpose of this dissertation was to investigate the thoughts, feelings, and beliefs of US Army ROTC students in regards to mental health. Researchers (Seal et al., 2010) found that as much as 30% of service members who are diagnosed with a mental illness do not seek treatment. Upon further investigation, Hoge et al. (2004) found mental health stigma to be a contributor to reluctance in help-seeking. The Department of Defense, therefore, instituted resilience programs to attempt to stem these issues but mental health prevalence continued to rise. Further research illuminated connections between leadership and mental health stigma, with service members reporting less mental health stigma and increased help-seeking when officers were perceived to be more open to mental health treatment. However, literature was sparse regarding the origins of mental health stigma in military leadership.

Through qualitative investigation, specifically hermeneutic phenomenology, the researcher sought to understand the lived experiences of US Army ROTC students in relation to mental health. The purpose of using this population was to assess the mental health beliefs of military leadership at the earliest point of cultural indoctrination. Using the Common Sense Model for illness representation (Diefenbach & Leventhal, 1996; Moss-Morris et al., 2002), the primary investigator analyzed the collected data to create an illness representation of the

population's views on mental health. Finally, implications for the collected research were presented along with implications for future research.

APPENDIX A: PERMISSION LETTER

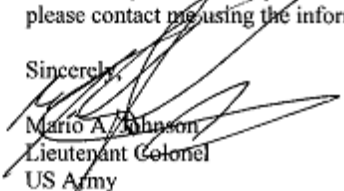
March 6, 2014

Dr. Sophia Dziegielewski
Chair
Office of Research and Commercialization
Institutional Review Board
University of Central Florida

Dr. Dziegielewski:

The purpose of this letter is to inform you that I, LTC Mario Johnson, Head of the Department of Military Science have given permission for Kristopher G. Hall, doctoral candidate in Counselor Education and Supervision, to work with the US Army ROTC program to complete his dissertation work. Kristopher will be recruiting participants during the MSI and MSII courses and upon completion of recruitment, has my permission to interview students in our Multi-Purpose Room. I understand that the data collection process will take approximately a month and will consist of no less than 7 but no more than 20 individual interviews and at least one focus group. Finally, I have approved of the interview questions he will be asking the students and believe they are culturally relevant and applicable to the population. If there are any questions, please contact me using the information below.

Sincerely,



Mario A. Johnson
Lieutenant Colonel
US Army
Professor of Military Science
"Fighting Knights"
Work – 407-823-1872
Cell – 407-883-9539
University of Central Florida
Mario.johnson@ucf.edu
Mario.johnson@us.army.mil

APPENDIX B: RECRUITMENT LETTER



Greetings,

My name is Kristopher G. Hall and I am a Counselor Education and Supervision doctoral candidate at the University of Central Florida. I am currently conducting a qualitative research study under the direction of my dissertation chair Dr. W. Bryce Hagedorn which will focus beliefs about behavioral health with US Army ROTC students. The purpose of this study is to find out what students believe about behavioral health prior to their enlistment in the US Army and when it is appropriate to seek treatment. I am looking for students who are currently enrolled at the University of Central Florida and members of the UCF Army ROTC program. Participation will consist of completing individual interviews and possibly one focus group. Both the interviews and focus groups will be untimed but will take approximately an hour and two hours, respectively. There will be compensation in the form of a \$20 gift card for completing this study and your participation will aid in understanding a previously unexplored population, as there has been very little research done with ROTC members. Participants must be 18 and older and in good standing with the university's Army ROTC program. If you are eligible and would like to participate, please use the information provided below to contact me and schedule an interview time. Anyone requesting more information about the research study can also feel free to contact me using the information provided below.

Sincerely,
Kristopher G. Hall
Doctoral Candidate
Counselor Education and Supervision
University of Central Florida
Kristopher.g.hall@knights.ucf.edu
(646) 243-5156

APPENDIX C: IRB ADDENDUM 1



University of Central Florida Institutional Review Board
 Office of Research & Commercialization
 12201 Research Parkway, Suite 501
 Orlando, Florida 32826-3246
 Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

**From: UCF Institutional Review Board #1
 FWA00000351, IRB00001138**

To: Kristopher G. Hall

Date: April 09, 2014

Dear Researcher:

On 4/9/2014, the IRB approved the following minor modification to human participant research that is exempt from regulation:

Type of Review: Exempt Determination
 Modification Type: Study participants will receive a \$25 gift card as compensation for taking part in the study. A revised consent document has been approved or use.
 Project Title: Getting To The Source: Understanding the Mental Health Messages of US Army ROTC Students
 Investigator: Kristopher G Hall
 IRB Number: SBE-14-10164
 Funding Agency:
 Grant Title:
 Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 04/09/2014 10:01:13 AM EDT

IRB Coordinator

APPENDIX D: MEMOS

Memos

Date	Observations
4/1/14	<p>Study officially starts today with the first round of recruitment. Visited MSI classroom. They seemed disinterested, I stumbled a bit as this was my first one. Took a while to get things started as I had to pull up my presentation from Dropbox. Will remember to move my presentation from Dropbox to USB for faster access. Also had to edit the powerpoint more that morning to make sure only the most pertinent information is included. Looked at the recruitment letter and forgot to remove participant numbers. Will remove for next presentation.</p>
4/3/14	<p>Did second classroom visit. Students seemed disinterested but I felt more at ease with my presentation. Tried to demonstrate that their future soldiers will fall into these categories but nobody knows what them as future leaders think about these things.</p> <p>Talked to a student in the hallway of the ROTC building. Not sure if he'll participate but I know it's important to try and build a rapport with the students as he may tell others to join. Also building a very good rapport with the secretary. This will possibly make scheduling easier however, she is leaving sometime in June. Hope to have all my interviews done by then.</p>
4/7/14	<p>Got first participant. Trying to schedule for some time this week. Student said they would be available primarily this week and possibly next week for Wednesday and Friday. Emailed research team to see their availability.</p>

	<p>Had a quick meeting with chair to discuss process. Will not be introducing the incentive program until 4/21 to make sure that every participant is informed of the study in the same way. Finished MSI classes, planning to do MSII this week. Discussed that time is running out and necessity of focus groups and how this needs to fit into the schedule.</p>
4/8/14	<p>Went to start study intro with MSII students but they were not in the room. Went to look for instructor and found out that they would not be meeting, as he was planning various events. Allowed me to come speak to the classes next week during finals. Previously thought I would not have access to them at this time but I am being allowed to go in.</p> <p>Research team not available this week to start interviews. Have to email team again to get a better handle on their schedules. Hopefully this won't be a continuing issue as I can't continue the study without an observer present.</p>
4/10/14	<p>Ran into one of the research team today. Have to think of how to introduce demographics to them during the coding process. Want to give them the opportunity to be open with their coding but due to research, I believe that the demographics chosen may yield data. Will have to introduce and explain CSM as that is the theoretical framework. Want to cut down on the apriori coding and let the data speak for itself.</p>
4/14/14	<p>Contacted interested participant to try and reschedule interview. Stated he would be available the same times/days this week as well.</p>

	<p>Emailed research team to get their times. 2/3 have responded. At this point, interviews will primarily take place on Wednesday and Friday afternoons, as this is their only availability.</p>
4/15/14	<p>Visited first MSII class to present study. Instructor forgot I was coming and made students stay a few minutes. Stated that there would be a grade incentive if students participated. Had to repeal this during my presentation as this may compromise the study and skew the participant numbers.</p> <p>Scheduled interview for Friday with Mrs. McBride. Discussed how difficult it is to schedule interviews with 4 moving parts. Emailed participant to confirm interview and to make myself available if he has any further questions.</p>
4/16/14	<p>Visited Ms. McBride to see if multipurpose room would be available for weekends. Only available after filling out a form and then there's a 14 day wait. Restriction will hamper some scheduling. May have to seek another venue for weekends but this may affect consistency of interviews.</p> <p>Final research team member has sent their schedule. Everyone's schedule looks to be tentative at this point. Will probably get a better handle on things once summer classes start. Also have to secure my own schedule as I will be switching jobs again and will be back over at the college of education.</p>
4/18/14	<p>Eventful day. Was supposed to be the first interview but it didn't happen. Was very excited and nervous to begin but it was not to be. I sent a reminder email</p>

	<p>to the participant around noon with no response. I arrived a little early to make sure the room was empty and set up the chairs to make things as comfortable as possible. Closer to the interview time of 3pm I met Jessica to show her where the room was. Due to the room's placement, it is difficult to see people coming and going which is a good and bad thing. It protects anonymity but restricts the ability for me to keep a look out on my participants as they approach. We waited for the participant for a half hour before I sent another email asking if he was going to come. He originally rescheduled due to his work schedule and I figured that he was running late due to his job. After another half hour (now 4pm) I decided to give up on the participant and leave the interview room. I thanked Jessica for her time and took her back to her car on the other side of campus.</p>
4/20/14	<p>Today I sent out some emails to make sure that I had everyone on the same page. The first was to Friday's participant thanking them for their initial interest and requesting that he reschedule if still interested. I haven't decided the frequency of contact as I don't want to annoy the participant.</p> <p>The second was to the MSI/II instructors, LTC Johnson, Mr. Morales, and Hagedorn to begin the second round of recruitment through email and to introduce the incentive program. The MSI instructor wasn't sure about if he was allowed to post the letter and had to check with LTC Johnson. I told him to let me know if there were any issues and I would speak with LTC Johnson myself.</p>

4/21/14	<p>The MSI instructor emailed me this morning to let me know he got permission and posted the letter in his class. However, LTC Johnson interjected that if the students are conscripted, they are not allowed to take any denomination over \$20. Hagedorn suggested just cutting out the middle man and lowering it to \$15 and I suggested \$20 because that seemed too low. He is also starting to stress about participants and asking for backup plans. This is the first time he has been nervous about me getting done and I was slightly annoyed. I'm much more interested in getting this done than he is, no need to worry about that.</p> <p>Also contacted the second participant to see if they were available this week. They agreed to meet Wednesday. I made sure the room was open, reserved it, and checked with my research team to see who was available. Joseph volunteered and everything is set for Wednesday.</p>
4/23/13	<p>Today is the second interview and I'm hoping my participant shows. I sent him an email this morning as a reminder and will be at the venue at the appropriate time. My grandmother died yesterday so I will not be able to do any interviews this Friday, not that anyone has bothered to contact me anyway. As much as I didn't want to do it, I may have to try snowball sampling or opening up my population outside of MSI/II students. A few weeks ago, a vet asked if he could be a part of the study and I had to decline. I'll be tracking him down soon as I can't afford to turn away participants anymore.</p> <p>The interview went well for a first one. About a half an hour and that was with</p>

follow-up questions. I tried to make sure that I didn't lead the participant. Most of my follow-up questions included asking for examples or explanations regarding what he talked about. What was interesting was that he had experience with mental health treatment but could not fully endorse it as it did not work for him. Instead, he suggested (service members) use any means necessary to make themselves well, mentioning illicit drug use as an option. He also didn't seem to know much about the common disorders affecting service members (he could not remember the acronym PTSD but did remember the symptoms). This is surprising as he is an MSII student AND he plans to become an MD, and with service members being more comfortable seeing an MD, his knowledge of this area would be important. The student asked me to let Maj Beam know that he participated so that he could get his class credit. I was wary of this as it would skew the people participating but Hagedorn's worry about participants has made me forget about that. Will just have to write it in Chapters 3 and 5.

After the interview and a short debriefing with Joseph, I went to speak with Maj Beam to let him know the participant finished. While waiting for him, I spoke with Mrs. McBride about the possible participant who was previously interested. I was given his name by Maj Beam and informed that he was an MSII even though he was in the masters program. Maj Beam also sent out another notice through Canvas letting the students know that they could get final exam credit for working with me. After that, I received 4 emails of new

	<p>participants asking when they could sit with me. There was also two students recruited right there in the lobby. This will severely affect the anonymity of the study and I'm wondering if this will affect the data. Those who emailed will only be anonymous to each other, not their CO, which was an issue in the literature. Those who were recruited in the lobby know of each other. All I can do now is assure that their answers will stay confidential as their identities have been compromised.</p> <p>Called research team to see if I could knock out some of these interviews today. Joseph and Jessica have papers to do so I know not to ask Saron. Still trying to get in touch with Melissa and see her schedule for the afternoon as the MP room is available for the rest of the day. Also emailed Mrs. McBride to ask about tomorrow.</p> <p>Mrs. McBride told me that the room would be available next week on Monday from 1-5 and all day Wednesday. A quick text to my research team told me that Melissa and Jessica were out, however, they were still available to help today. Saron hasn't responded yet and Joseph is available from 12-3. Room is available tomorrow from 1-5. Also have Jessica and Melissa on board for interviews. Time to begin the scheduling.</p>
4/25/14	<p>Yesterday, after the meeting with Maj Beam, I went to the counselor ed office to inform Hagedorn about the changes. He seemed hesitant but seemed glad</p>

that my participant count was going up. I continued to receive emails from interested participants which I then began scheduling when I got home. However, I had to stop when Hagedorn expressed concerns about how the grade incentive may have compromised the study and that there were ethics and replication issues with allowing my study to count for class credit. He then said that I needed to contact Maj. Beam and ask him to retract the grade incentive and reiterate that there would still be the \$20 incentive if students were still interested. At this point, I had a line of emails that I needed to return and I'd already begun scheduling 4 for interviews. Together, we drafted an email to send to Maj Beam and I waited all evening with no response.

When I got up today, I still hadn't heard from him. I stayed calm, went to campus, and tried to find Maj. Beam. Mrs. McBride said that he was out running errands and called him for me. I spoke with him for a few minutes and he informed me that he got my email and understood about the retraction (though he had not sent an email) and would tell the students to see him for an alternative assignment. After this meeting, I continued with my scheduling for the 4 I started and had to inform them that there would no longer be a grade incentive but the money was still available. All 4 agreed to still participate. The rest were emailed to let them know about the changes and see if they were still interested. In total, there were 6 other participants who I attempted to schedule for next week and 2 more who were put on the waiting list.

<p>P2 showed up a little late (had issues finding the MP room) and was kind of perky. The first half of his interview was kind of static but once he started talking about his grandmother, there seemed to be a lot more activity. One thing I noticed was that there weren't a lot of personal stories shared regarding military experience though both his parents, grandfather, and brother were service members. His father seemed more comfortable sharing other people's stories and he was socialized not to ask about his family's experiences.</p> <p>P3 Seemed clueless. She could not really give clear definitions for behavioral/mental health and struggled for examples. When asked about ROTC influences, she did mention a sexual harassment course which was required yearly. During the interview, I was thinking that I wasn't going to get much out of the data. However, since her narrative so strongly contrasted with P2, I think the comparison between the two will be worthwhile.</p> <p>The next appointment didn't show up and the one after was early, who became P4. Almost all of his experiences were influenced by his experience with his brother, a Marine who has PTSD. He seemed to be very open to treatment after witnessing his brother's ordeal.</p> <p>Prior to each interview, I had to make sure that they knew that there was no grade incentive attached to participation, only the \$20. I stated in each verbal informed consent that there would be no incentive based on grades and the</p>
--

	<p>participants still agreed to the study. This, combined with the emails should be enough to hopefully undo the damage done by Maj. Beam's incentive.</p> <p>During the interviews I continued to get calls and emails asking to volunteer for the study. I went upstairs to visit Maj. Beam who reiterated that he understood about the integrity of the study and wanted to help. I told him I appreciated his enthusiasm but wanted to make sure my study was done correctly with the proper integrity. I am glad to have someone like him who is enthusiastic about my research and is so willing to help, even though it doesn't always end well.</p> <p>I continued to field calls and emails for scheduling and wait listing.</p>
4/25/14	<p>Saron got back to me this morning about her schedule. She's very eager to participate but is also very busy, making her hard to schedule for interviews. We've been back and forth all morning with her letting me know that she will be able to help me on Wednesday, mid-morning. I managed to schedule 2 interviews in the time Joseph will be there and I'll try to schedule 2 more from the waiting list. That will bring me up to 8 interviews total, but I may throw out the first interview because it was the one that started the sampling error. Will have to talk to Hagedorn about whether I should keep it or not. It's still data but it may be compromised data.</p>
4/30/14	<p>Managed to get 2 more interviews today. Getting closer to my final number. Don't think I'll be able to get the full 10 Hagedorn has been asking for but I'll</p>

	<p>at least get my 7. Still difficult to schedule interviews due to other people's schedules. I have to stop putting a time limit down on things because my schedule keeps getting blown out. The way I figure it, if I do another week of interviews, that carries me into May. I then have about 6 weeks to write Chapters 4 and 5. Depending on how long it takes me to get through data analysis, that shortens the time. Given the back and forth needed during the editing process, this can be problematic. I really need to make a concerted effort to get Chapters 1-3 re-edited so that I can fully focus on the final 2.</p>
5/2/14	<p>Today is graduation and while I'm very happy for my cohort and those who are finishing, I'm disappointed in myself for not walking with them when I wanted to. I know that everything works out the way it's supposed to but I planned to be finished by now and of course, it's not happening. Playing the woulda, coulda, shoulda game will get me nowhere and I just need to move on.</p> <p>Emailed Mrs. McBride today to check on the schedule for the room, she hasn't got back to me yet.</p>
5/5/14	<p>Got in touch with Mrs. McBride through phone. Called earlier and left an email and she called back. The room is very open due to the semester being over and no one being around on campus. This is good and bad. My possible participants should be wide open as far as availability but that's IF they're still on campus.</p> <p>Since I have the room schedule, I emailed my research assistants to see when</p>

	<p>they would be open. Jessica is out due to comps this week. I emailed Saron and locked her down for Thurs and Fri since she said she was going to be available during these days last month. Melissa has agreed to do the Fri morning stint. Joseph has been my rock on Wednesdays and I really appreciate him.</p> <p>For my final push, I've gone down my waiting list and basically anyone who has contacted me and emailed 16 participants to see if they would be open. So far I've heard back from 2, kind of. One has secured an appointment for Wednesday. The other got the day wrong and thought that I meant Tuesday. I emailed them again to get the right day but haven't heard back yet.</p>
5/6/14	<p>Went to Jen's proposal defense to give her some moral support. After the defense, had a sit down with Dr. Hopp as I hadn't seen her face to face in some time. Let her know about the sampling error and the steps I took to fix it. She understood and basically said that all I could do was report it and that nothing can be done now. She also said she had some phenomenology stuff to give me which should be helpful. The BEST piece of news I got was that I didn't need the whole research team to help with the coding. This will cut down my analysis time IMMENSELY and give me more time to write 4-5. Jessica showed me a really good book with a coding flow chart that I want to use to give the study more structure. Dr. Hopp asked me to send her a preliminary code sheet with my sets of constructs and some of the codes I expect to see, did that. I also emailed the 14 participants I didn't hear back from to see if they</p>

	<p>were interested. The way I see it, I have 6 interviews now. My Chapter 3 said I'd need 7 for saturation so technically I only need one more. If I throw out the initial one due to coercion thanks to the grade thing, I'll need 2 more to make 7. Either way, I'm just barely going to make my mark and that will have to be enough. I am out of time and out of people to ask to participate.</p>
5/7/14	<p>Drawing to a close on the data collection for this phase. It looks like I'll just make my minimum with this participant. This participant was the most interesting as she has had previous military experience but it was different because she's gone from Air Force, to Air Force ROTC, to Army ROTC. I'm not sure how this will affect the data but I got a lot of rich information from her. I think most of the info I got will be attributed to the culture section I've been trying to build. I will have to be careful to distinguish her time between Air Force and Army. I did ask her the difference but many of her experiences came from Air Force and those are two distinct cultures, which she did state at one point.</p> <p>If I don't have to throw out my first interview, this will make my minimum. If I do, I'll be one short but I have another interview scheduled on Friday. I've decided to end individual interviews with this interview because it would seem no one else is interested in participating and my email requests are going unanswered. I'm also excited to begin the data analysis process. I've sent my recordings to Nonotes.com which gives me 5hrs of transcription for \$180. This will cover all of my time as the interviews are about a half hour each. I'm</p>

	<p>almost wondering if I have enough info to analyze and reach saturation but I pulled as much out of them as I possibly could. I noticed sometimes when I tried to probe a little further, they would just look at me blankly. I took that to mean they had nothing else to give or they were just going to tell me something so that I could have an answer, which isn't good.</p>
5/9/14	<p>I'm very glad to have my last individual interview done as it marks some progress. Makes me feel accomplished and like this project is moving towards completion. Last night I sent another email blast and didn't hear back from anyone so today was definitely my last one. The participant today seemed very "all American" if that's really a thing. Clean cut and boy scoutish. He was like a short captain America. I don't know why I noticed this but based on his answers, he seemed like the "New Army." Lots of the things he was saying were the things I would want soldiers I interview later to say. How he didn't stigmatize those who had mental health issues and would want anyone with them to go seek treatment. He may not be the norm but it was refreshing to see that there were people who thought this way headed towards the army.</p> <p>I also spoke with my mother today and she put into perspective exactly how much money I've spent on incentives. I was hoping to get through this dissertation paying for administrative costs (editing) but it wasn't meant to be. I've had to buy 8, \$20 gift cards with \$5 fees per card. That's \$200 in total on those cards. I know some people have spent way more on their dissertations but they're not me. I barely had the money to spend and my financial situation</p>

	<p>isn't optimal right now. It's been very annoying to hear people ask me if I had a grant like I wasn't TRYING to get one in 2012. Unfortunately, my original research idea didn't pan out so the grants I wanted to go for couldn't happen. Either way, hopefully I can get the students to come out to the focus groups without having to pay them. I only need about 5 so we'll see what happens.</p>
5/12/14	<p>Yesterday I got a few books from Jessica and I'm making my way through the Richards text. I'm glad I got it from her because I FINALLY have instructions on coding where the Creswell book was a lot more nebulous. I definitely plan to buy this book when I get to USD. Also I finished the van Mannen text and got some good stuff from it. Last night I emailed Hagedorn and asked for a defense date. I think I'll be ready either in the last week in June or first week in July. I'm going to send the committee 1-3 early and then send them 4-5 after that. Hopefully it'll cut down on their reading if they can break things down into chunks. Also, it'll give me a little more time to go back and forth with the last two Chapters before they get it all. Time to get back into the writing heavily though, that's agitating but necessary. I'm close.</p>
5/17/14	<p>Got all the transcripts back and have started coding as of a few days ago. Have to do better at memoing since I'm coding now. Probably doing it less because I am making notes in the margins on the transcripts. Doing invivo coding with the transcripts and pulling out main quotes at this point. So far, between the two, noticing that familial experience is a major theme on MHBS, which confirms culture as a factor. Most experience comes from either being directly involved in counseling or having family with mental health issues. There</p>

	<p>seems to be a disconnect between identifying symptoms and identifying others family members with mental health issues. They can tell stories about people they know but cannot tell what MH looks like.</p> <p>Also talked to Dr. Hopp today while driving back to Orlando after the dissertation retreat. Need to think about focus group questions. Have to add questions about familial messages as a source of cultural beliefs. Must also ask about if they've ever heard the term behavioral health prior to me asking the question during the individual interviews.</p>
5/23/14	<p>Just spent a week of marathon coding and I'm finding that a. I can barely think anymore; and b. things are crossing. I'm definitely able to articulate some of the major themes I'm finding (which I've noted in the margins of the text) but I'm finding similar codes across the constructs. Dr. Hopp and I will be sitting together to try and whittle this down so that things are a lot more simplified. I'd done line by line coding for a few of the transcripts last week but I had to kick it up this week. Sunday and Monday I finished line by line coding for the rest of the participants. Excruciating. Tuesday and Wednesday I gathered preliminary codes for all the participants. Today I aggregated all the codes into one document so that Dr. Hopp and I can begin looking for themes. I also need to get her password for Dedoose so that I can see what technology says about the codes before we talk about things. Also need to match up the observations to the participants so that we can look for themes there as well.</p>

	<p>Also met with Hagedorn today and we worked towards setting a date for the defense and about organizing my focus group. Since I put it in my Chapter 3 and it's a measure for rigor, I still have to do it, time be damned. I need to send an addendum informed consent to the IRB committee as agreed upon to reflect that this consent is for the focus group. I MUST have the whole process done by the time next week is out so that I can get back to writing. I plan to write as much as I can in Chapter 4 over the weekend so that I can begin getting things together for the final draft. I feel good going into this defense because I've been able to articulate preliminary findings to several people now and do it coherently.</p>
5/25/14	<p>Spent the weekend really starting to dig into the data with Dr. Hopp. I put all of the data that I coded over last week into Dedoose and didn't find it very helpful. It gave me a great visual representation of my data to see where the links are but I've realized that the entire story is in my head. I have a good conceptualization of what the data is telling me. Basically, a lot of the student's understanding of what mental health is consists of personal contact with others who have had mental health issues, primarily family members. Very few of them directly know anyone who has had mental health issues and even less have seen mental health issues as a result of military experiences. Additionally, education on mental health issues is spotty, with some students claiming that commanding officers speak to them about mental health while others say they have very little instruction on what mental health is and how to deal with those who have mental health issues. Much of the information they</p>

get is anecdotal and sprinkled through their courses with some saying “we don’t talk about that much” and others saying they got nothing more than a PowerPoint slide.

Regarding stigma and help-seeking, the stigmatic views are low at this point with most endorsing help-seeking and low judgment for those who do seek treatment. There has been a spectrum of those who endorse it with some saying that it doesn’t work for them but they’d encourage others while another participant stated that she’d stop by and seek services for ANYTHING, even just information. One of the respondents disturbed me because within his statement, he basically stated that if you go into the military, you should know that mental health issues are possible so if you get them, it’s your own fault. Another respondent stated that he wouldn’t want to fight with someone who had mental health issue (textbook stigma), and would want them basically kicked out of the services until they get help. Knowing things like this is essential because it is beliefs such as this which contribute to the anti-stigma and anti-help seeking behaviors of the enlisted.

What I have to work on now is getting these interview questions together for the focus group while I work on writing up the analysis. Dr. Hopp helped me work on how I need to relate the data back to my questions, which confused the hell out of me but as I told her, once I start writing, things will begin to come together. I have a general idea of the whole situation in my head, it’s the

	<p>details (as usual) which have not congealed yet. Once I get started, I think I'll start to understand a lot more.</p>
6/3/14	<p>Last week consisted of trying to get members for the focus group. After putting read receipts on my emails, I found that participants are not reading the emails at all. At first I sent them to the students I interviewed with and then to all the students. I have to assume that most of them are gone because of the summer semester. I did schedule one participant, which now makes my focus group, member checking. Due to this change, I put in an IRB addendum last week and managed to get the approval. A few of my participants stated that they were willing to participate by phone or email so today I put in an IRB addendum.</p> <p>Participant six showed up for the member checking exercise. We went over the codes and themes and he confirmed many of the codes and themes which I found from the data. What was interesting, he actually gave a source for where stigmatic thoughts came from. Although he was the only one to name it, it was important as it was one of the main reasons I started the study. He noted that many of the negative views students got from active duty members who returned to college and then told students stories about being in theatre. He couldn't name any other ROTC students without previous experience who gave these types of accounts. This gives me some ideas about where I might want to take the research during my next study.</p>
6/5/14	<p>The IRB was returned from the committee, meaning I'm free to send the</p>

	<p>member checking form by email. Sent it out right after the IRB came in. I asked the participants to fill in their views and return the document by the 11th. That gives me enough time to fold in their narrative and the other interview into the overall document of Chapter 4.</p>
6/11/14	<p>One participant returned the form and I was never able to reach the other participant who agreed to the email response. However, when I got back the document, I realized I sent the student the wrong one. The only thing that was on the protocol was the four questions for clarification. Now I REMEMBER typing detailed explanations of each theme and I THOUGHT I emailed them to the student. Unfortunately, I couldn't find the document I typed in any of my document storage areas, leaving me to believe either the document is lost or I can't remember exactly where I saved it. I'll have to check other places to see if I can locate it but in the meantime, I have SOME answers from the student, the other member checking exercise went well and I have due dates.</p>

APPENDIX E: ORIGINAL IRB



University of Central Florida Institutional Review Board
 Office of Research & Commercialization
 12201 Research Parkway, Suite 501
 Orlando, Florida 32826-3246
 Telephone: 407-823-2901 or 407-882-2276
 www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

**From: UCF Institutional Review Board #1
 FWA00000351, IRB00001138**
To: Kristopher G. Hall
Date: March 25, 2014

Dear Researcher:

On 3/25/2014, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination
 Project Title: Getting To The Source: Understanding the Mental Health Messages of US Army ROTC Students
 Investigator: Kristopher G Hall
 IRB Number: SBE-14-10164
 Funding Agency:
 Grant Title:
 Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 03/25/2014 04:30:57 PM EST

IRB Coordinator

APPENDIX F: INTERVIEW PROTOCOL

Interview Protocol

The purpose of the interview protocol is to introduce consistency between interviewers. Please follow the protocol as closely as possible to ensure that all participants experience the same process. As these are semi-structured interviews, please read the questions as written; however, you are allowed to ask for elaboration or clarification if necessary. An interview protocol needs to be taken into each interview or focus group. During this process, please take field notes on the back of the protocol as the students are responding. Note any observations you make including changes in body language, vocal inflections, or hesitations in speech. At the top of the interview protocol, write the letter P and which interview number you're about to complete. For example, if I was to complete my first interview, I would write "P1."

Please use Smart Voice Recorder to record the interviews. Start the recording, say "Test" three times, then stop the recording. Play back the recording to ensure that you can be heard properly. Delete the test recording and then begin another recording. After recording begins, please say the following:

Thank you for agreeing to participate in this study. The purpose of this interview is to find out your beliefs about behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews. Both myself and the observer may make notes during the interview which will be used in data analysis. Before we begin, I'd like to talk to you about consent. [Read consent form] By giving your verbal permission, you are agreeing to participate in the current study and also consent to being audio recorded. Your identity will not be shared with anyone and you are allowed to remove yourself from the study at any time. [Give student consent form]. Please read over the consent form and please say "I agree to participate in this study" to give your verbal consent.

To begin, I'm going to ask you a few questions for demographic purposes. We will not ask any identifying questions but would like to get a more complete picture of you as an ROTC member.

Could you please state your rank, age, and level in school?

Thank you, we will now begin the interview questions.

1. What kind of person joins the Army (or the ROTC)?
2. What comes to mind when you hear the term behavioral health? (or mental health?)
3. What happens to you when you encounter someone with behavioral health issues?
4. Is there someone in your life who struggles with a behavioral health issue? If so, how has that impacted you? Service members?
5. Have your opinions about behavioral health been influenced? By what?
6. Have your experiences as an ROTC student influenced your opinions about behavioral health?
7. What messages about behavioral health have you received as an ROTC student?
8. Was your idea of behavioral health different before joining the ROTC? How?
9. What are your opinions about someone who goes to see a behavioral health professional (counselor, psychologist, psychiatrist, etc)? Service members?
10. When would it be appropriate to see a behavioral health professional? When would it not be appropriate? What about for service members?
11. For what issues (current, future) would you personally go see a behavioral health professional? For service members?

Thank you for participating in the interview. You may be contacted to take part in a focus group at a later date. Again, you're allowed to withdraw your participation at any time.

[Stop the Recording]

Please ensure that the interview has recorded by pressing play on the last saved file. If successful, please email the file to Kristopher.g.hall@knights.ucf.edu. In the email, please let the primary investigator know when you are available to collect the consent from and your field notes.

APPENDIX G: OBSERVATION GUIDE

In a Classroom...

Space: physical setting (classroom) - describe the layout of the location—what is located where?

A wide open multipurpose room, many seats available. The trio is gathered around a small table.

Actor: people present (student and teachers)—how many people, what is the age/ethnicity/gender of each, describe each physically including what they are wearing. Also note how the students interact (is it egalitarian, hierarchical, casual, formal?).

Interviewee is a 22 year old Caucasian male, dressed casually, brought in a gallon of water, pierced ears without earrings. Observer is a 32 year old Caucasian male, with a laptop on his lap, dressed in a polo shirt and pants. Interviewer is dressed professionally with a manila folder and a pen for jotting notes.

Activity: related acts that people are performing (learning AP/biology)—are people working together? If so, who is working with whom and what are they doing?

The activity is a one-sided interview with an observer.

Object: things present in the physical setting (objects used for science, bulletin boards, etc.)—describe the objects within this physical setting; what appears to be each object's function?

There is a printed out informed consent for the interviewee. There is a recording device between the interviewer and interviewee. Interviewer is using a pen for notes. There is a very large white board, 3 exits, 18 lockers, 2 water fountains.

Act: single actions performed by people present learning activities)—what is each person in the workplace doing over the course of the day?

Observer stayed quiet and avoided making eye contact with the interviewer and interviewee.

Interviewee clarified and answered questions. Interviewer jotted notes and asked questions.

Event: related activities performed by people (group activities, projects, etc.)—what is the good they are, as a group, making, or, what is the service that they are, as a group, providing?

A discussion.

Time: sequence of events occurring (entering classroom, preparing for class, etc.)—keep a running log of who does what when, especially the order of events that people follow in the course of their workday.

Interviewee entered the room and was prompted by the interviewer for his name. Upon confirmation a seat was offered. The recorder was tested. Informed consent was explained, then provided for the interviewee to read, and clarifying questions were answered. A group of people interrupted the process to cut through the room. The interviewee frequently required clarification of questions. A couple of times the lights automatically cut off and the interviewer stood up and waved his arms to signal the motion detector.

Goal: what people are trying to accomplish (learning AP Biology)—what is the point of the work the workers are doing in this setting? What is their mission?

The goal is to learn about the interviewee's experiences and understandings about mental health

Feeling: emotions observed on the part of participants (frustration, laughing)—do people get along, are there conflicts? Do people seem happy, sad, excited, bored?

The interviewee comes across as considerate, often asking for questions and words to be clarified to ensure he is answering the questions appropriately. The interviewer often prompts the interviewee to delve deeper into answers.

(from: Michael Angrosino, *Doing Cultural Anthropology*, 2006).

APPENDIX H: DEMOGRAPHICS SHEET

Demographics Form

Thank you for agreeing to take part in this study. Prior to the interview, please complete this short demographics form so that we may know more about you and your experiences prior to joining the ROTC:

Age: _____

Academic Level: Freshman or Sophomore; MSI or MSII

Current Rank: _____

Hometown: Urban Suburban Rural

Ethnicity: _____

Gender: _____

APPENDIX I: IRB ADDENDUM 2 & 3



University of Central Florida Institutional Review Board
 Office of Research & Commercialization
 12201 Research Parkway, Suite 501
 Orlando, Florida 32826-3246
 Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

**From: UCF Institutional Review Board #1
 FWA00000351, IRB00001138**

To: Kristopher G. Hall

Date: June 04, 2014

Dear Researcher:

On 6/4/2014, the IRB approved the following minor modification to human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Modification Type:	In lieu of focus groups, as initially approved, the researcher will phone selected participants and review themes by phone. These phone calls will be recorded and participants will give verbal consent. A revised protocol has been uploaded in iRIS and a revised consent document has been approved for use.
Project Title:	Getting To The Source: Understanding the Mental Health Messages of US Army ROTC Students
Investigator:	Kristopher G Hall
IRB Number:	SBE-14-10164
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 06/04/2014 08:31:19 AM EDT

IRB Coordinator



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Kristopher G. Hall**

Date: **June 04, 2014**

Dear Researcher:

On 6/4/2014, the IRB approved the following minor modification to human participant research that is exempt from regulation:

Type of Review: Exempt Determination
Modification Type: Approval for the PI to collect data through e-mail with a list of questions pertaining to the themes found during data analysis. All emails will be kept behind a locked account and analyzed using discourse analysis.

Project Title: Getting To The Source: Understanding the Mental Health Messages of US Army ROTC Students

Investigator: Kristopher G Hall
IRB Number: SBE-14-10164
Funding Agency:
Grant Title:
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 06/04/2014 01:46:35 PM EDT

IRB Coordinator

APPENDIX J: MEMBER CHECKING PROTOCOL

Interview Protocol

The purpose of the interview protocol is to introduce consistency between interviewers. Please follow the protocol as closely as possible to ensure that all participants experience the same process. As these are semi-structured interviews, please read the questions as written; however, you are allowed to ask for elaboration or clarification if necessary. An interview protocol needs to be taken into each interview or focus group. During this process, please take field notes on the back of the protocol as the students are responding. Note any observations you make including changes in body language, vocal inflections, or hesitations in speech. At the top of the interview protocol, write the letter P and which interview number you're about to complete. For example, if I was to complete my first interview, I would write "P1."

Please use Smart Voice Recorder to record the interviews. Start the recording, say "Test" three times, then stop the recording. Play back the recording to ensure that you can be heard properly. Delete the test recording and then begin another recording. After recording begins, please say the following:

Thank you for agreeing to participate in this study. The purpose of this interview is to find out your beliefs about behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews. Both myself and the observer may make notes during the interview which will be used in data analysis. Before we begin, I'd like to talk to you about consent. [Read consent form] By giving your verbal permission, you are agreeing to participate in the current study and also consent to being audio recorded. Your identity will not be shared with anyone and you are allowed to remove yourself from the study at

any time. [Read consent to student]. Please say “I agree to participate in this study” to give your verbal consent.

I agree to participate in this study.

Now we will begin the interview:

Education – Participants shared that they received both formal and informal education regarding what mental health is and what mental health symptoms looked like. Formal education including classroom instruction and informal education including anecdotes in the form of stories from commanding officers or fellow service members.

Contact – Participants shared that they learned about mental health through contact with others who have had mental health issues or from stories of those who have come into contact with mental health issues.

Mind/Body Connection – Participants believe that there is a connection between the mind and body and that both are connected in terms of overall wellness.

Negative Emotional Outcomes – Participants who encounter those with mental health issues may feel emotions including fear, apathy, and remorse after interactions with those who present with illness symptomology.

Emotional Adjustment – Participants experience a process of emotional restructuring after encountering individuals with mental health issues. As a result of these encounters, participants learn strategies for best practice if they are to encounter someone with mental health in the future.

Illness Identification – Participants were able to specifically name several illnesses and symptoms related to these illnesses. Additionally, participants were able to identify “normal” versus “abnormal” behaviors in regards to mental health.

Stress Related – Participants felt that mental health issues are caused by stress related events including traumatic experiences (i.e. grief, sexual assault) and environmental factors (i.e. school, combat).

Interpersonal Issues – Participants felt that mental health issues are caused by stress from familial situations including separation due to deployment, divorce, or other home issues.

Acceptance – Participants believed that before treatment began, those with mental health issues must go through some process of acknowledgement and acceptance of mental health issues. This process can include self-realization of issues or mental health issues being brought to the individual's attention by outside parties.

Treatment Options – Participants were able to list treatment options available to those with mental health issues. These options include engaging a mental health professional, using friends as a resource, or finding other ways to self-medicate.

Civilian vs. Military Expectations – Participants felt that both civilians and those in service should have access to mental health care, however, some participants believe that those in the military should receive treatment sooner due to the nature of their job.

Duration – Participants believed that mental health issues can appear very quickly due to stressful events. Removal of these stressful events may alleviate the mental health issues. Finally, participants noted a month as duration between when someone notices they have a mental health issue and when they should seek treatment.

Intrinsic vs. Extrinsic Factors – Participants shared that individuals join the Army or ROTC join these services for reasons within their control and due to outside circumstances. Intrinsic reasons include a sense of patriotism and morality, desire for more education, and success. Extrinsic reasons include a way to escape the hometown environment and due to a lack of

Judgment – Participants felt that they would not have issues with those who needed to seek mental health treatment and that professional engagement is necessary for overall mental health. However, some participants would be apprehensive to serve with someone diagnosed with mental health issues and that they should have been mentally prepared prior to service.

Had you heard of the term “behavioral health” prior to our last interview?

Do you see yourself as a mental health resource?

Where do you think soldiers get their knowledge about mental health?

Would you serve with someone who has mental health issues?

How much do your personal connections influence your thoughts on mental health?

Thank you for participating in the interview. You may be contacted to take part in a focus group at a later date. Again, you’re allowed to withdraw your participation at any time.

[Stop the Recording]

Please ensure that the interview has recorded by pressing play on the last saved file. If successful, please email the file to Kristopher.g.hall@knights.ucf.edu. In the email, please let the primary investigator know when you are available to collect the consent from and your field notes.

APPENDIX K: POSITIONALITY STATEMENT

The purpose of this investigation was to complete my dissertation work for a terminal degree in Counselor Education. I began this investigation as a 30- year old African American male and I'm currently 31 at the conclusion of this investigation. Prior to completing this research, I had no direct experience with the military outside of my current research and two presentations. The first presentation was completed at the European Branch of the American Counseling Association's annual conference in Germany in the fall of 2012. Prior to this, I had never had an interest in with the military; however, due to the needs of the conference, I curved my research to fit the population. I presented the same presentation during the 2013 Association for Counselor Education and Supervision conference in Denver. At this point, I still had not done any actual research with this population.

During selection for my dissertation topic, my initial desire was to assess multicultural skill development in counselors in training. However, this idea was not supported by the faculty, making it necessary to choose another topic. My dissertation chair and I then brainstormed ways to include the military in my dissertation based on the two presentations I had completed. The literature review that I had completed for the prior presentations left me with questions regarding mental health stigma. I could not figure out the sources of mental health stigma based on the literature I'd read. It was decided that I would investigate this phenomena at the earliest point of cultural indoctrination. There were discussions of using newly enlisted service members but this was not done due to fear of IRB issues. The next most likely population was the ROTC. There was a brief discussion about looking at potential alcoholism within the ROTC population but that idea was not entertained for more than a week.

As stated above, prior to this dissertation I had completed no research with the military. I am not a member of the military and have had limited contact with active duty members of any

branch. However, I have several friends who belong to the US Army, US Army Reserves, and the US Navy. My grandfather was a member of the US Navy but retired before I was born. Upon his death, he received a military burial in Maryland. Due to this lack of experience, I was only versed in very stereotypical depictions of those in the military. Due to war movies, limited contact with service members, and hearsay, I had preconceived notions of service members. Specifically, I was expecting them to be very rigid and terse. In regards to the data, I was also expecting a lot of masculine ideologies and behaviors as far as beliefs regarding mental health. These expectations shaped my research to include these beliefs in Chapter Two, spending time on masculine ideologies and male gender role conflict. I was also expecting to see more stigma within this group as they were being taught by those who may have held the stigmatic beliefs I was looking for.

Instead, I found the complete opposite of what I was expecting. The students in my sample rarely mentioned masculine tropes in their responses. Most of them were very open to help-seeking and didn't see it as feminine or going against expectations. Additionally, I found very few instances of stigma within the group in regard to help seeking. The results ran very counter to my expectations and stereotypical beliefs about the service member population. As a result of this investigation, I plan to do more work with this population, as my initial question was not fully answered and there have been requests by several parties for me to continue this work. Additionally, this topic has helped me to attain a teaching position, necessitating that I continue the work I've started.

APPENDIX L: TRANSCRIPTS

Interviewer: Thank you for agreeing to participate in this study. The purpose of this interview is to find out your beliefs about behavioral health there will be another person in the room while complete the interview to ensure consistency between the interviewees. Both myself and the observer may make notes during the interview process, they are going to be used later for data analysis. Before we begin I'd like to talk to you about inform consent.

So here is the form of consent, we study many topics here and to do this we need your help and you have agreed to take part in this study. What you need to know is, I am going to explain the research study to you, the research study is something that you volunteer for, whether you do or do not take part is up to you. You can remove yourself from the study at any time.

If you change your mind later, just say I don't want to be a part of it anymore and any of the data that you have provided will be removed from this study. We won't be collecting your name so there will be no identifying information here. At the end of the study you would be compensated with a gift card of twenty five dollars. Please acknowledge that I have read this to you and you've have had a chance to read it.

Go over it, just take a look at it and afterwards giving your verbal consent just say I agree to participate in this study.

Interviewee: Quick question, Mike's mentioned about a focus group, [crosstalk].

Interviewer: Okay, so that's just halfway blew confidentiality right there.

Interviewee: Do you want to restart?

Interviewer: No not at all. This is qualitative so it all goes in. For a focus group, after we analyzed the data the first time, we may find that there is a couple of questions extra questions that we may want to ask, so we would put you and about three or four others in a room and just do another interview to clarify some things and if you are okay with that you would be one of the people that's called.

Interviewee: I agree with the study.

Interviewer: Okay, thank you very much. Now, to start we just have a short demographics form so we can get more information about you as a whole besides the questions. How old are you?

Interviewee: 22.

Interviewer: And what's your academic level, freshman, sophomore?

Interviewee: Sophomore.

Interviewer: And that would make you MS 2?

Interviewee: Yes.

Interviewer: And your current rank?

Interviewee: I don't believe I have one.

Interviewer: You don't have one, private, first class?

Interviewee: Private.

Interviewer: Okay, and would you describe your hometown as urban, suburban or rural?

Interviewee: Suburban.

Interviewer: Your ethnicity?

Interviewee: White mixed I guess...

Interviewer: What would you describe mixed as?

Interviewee: European.

Interviewer: And your gender?

Interviewee: Male.

Interviewer: I know it, I can see it, I just had to ask.

Interviewee: I understand.

Interviewer: Thank you, and we'll begin the interview questions, could you describe for me the type of person that joins the army?

Interviewee: A person who is **driven**, wants to **succeed** in life, wants to **serve** their country. Those would be the biggest things.

Interviewer: So these would be the top three for you?

Interviewee: Yes.

Interviewer: Anything else?

Interviewee: Could you re-ask that question?

Interviewer: What type of person joins the army?

Interviewee: What type of person? I guess I am relating this to why I joined the army but that's not the question.

Interviewer: That's fine.

Interviewee: So people that join the army, I would kind of, you see a lot of I guess you could say **hard headed people**. People who are kind of like **cocky** in some ways, a lot of it is not for the majority of people, they are **not really higher education oriented**. In certain ways yes, in certain ways it is not really like, it is hard to describe. It is really hard to describe, like not people who are necessarily looking for the education aspect of this as much as the **rank aspect**.

Interviewer: Okay. [Crosstalk] and I do appreciate you being here because I know your brain is kind of all over the place right now. Did you have anything to add about that?

Interviewee: No.

Interviewer: What comes to mind when you hear the term behavioral health?

Interviewee: Probably that...can you give a synonym of recently like other associated terms?

Interviewer: Mental health.

Interviewee: Like maybe people who have **problems dealing with situations**, mentally or **socially incompetent** maybe.

Interviewer: You said socially incompetent?

Interviewee: **Don't do well in social situations it could be a stem from mental issues.**

Interviewer: So those are the first concepts that come to your mind?

Interviewee: Yes.

Interviewer: Anything else?

Interviewee: With?

Interviewer: When you first think about the term mental health, what does that look like to you?

Interviewee: It really could stem in so many different ways, so you could have people with **degenerative diseases**, you can have people who came from, it's more like acquired situation where they were **born into** messed up homes and apparently had **bad situations**. Yeah I think those are the two biggest ones, **congenital ones and history related**.

Interviewer: So congenital and environmental?

Interviewee: Yeah.

Interviewer: Okay. What happens to you when you encounter someone with mental health issues?

Interviewee: I guess I would say I conduct myself differently, more appropriately to the situation.

Interviewer: What does that mean to you?

Interviewee: Trying to understand and consider the disability of that person and in certain ways trying to be more sensitive to the issue.

Interviewer: Could you give me an example?

Interviewee: Okay. So if a girl has had a rape issues I would make sure not to make any comments that could be hurtful in those ways. Obviously when we are flirting with a girl there are lines that you push but you can't push those lines with some females. Even if the situation would be to where I like the girl and I would want to hit on her. But if she had that mental illness in her past or a past event, then I would be a lot more withdrawn with that.

Interviewer: Did you have anything to add regarding that question?

Interviewee: No.

Interviewer: Is there someone in your life who struggles with mental health issues?

Interviewee: Clinically not proven but I think my mum and dad have quite a few mental health problems. My dad is...I forget what they call it, reoccurring liar; I forget the term they used in that. My mum just has a lot of hormonal problems that could probably stem to being construed as mental. But more so on my dad's side he just, he just doesn't understand that he is lying to everyone, he kind of alienated himself from everyone.

Interviewer: Would you mind providing me with an example?

Interviewee: Okay, when I was young, just to get my respect I guess, he told ne he had all sorts of money and he had a viper sitting in storage bin somewhere and he promised my mum that he'd had her like a pink Rolex that his friend was holding it for him,. Something like that.

Interviewer: So continue, pick Rolex you said, he's holding...

Interviewee: Yeah, just small stuff like that just to kind of build a false trust or confidence from people that he was going to help them and stuff but he just never came through on it.

Interviewer: How has this impacted you?

Interviewee: **Trust issues**, definitely trust issues, I don't take what anyone says, I take with a grain of salt.

Interviewer: What about regarding your mother and her issues, how has that impacted you?

Interviewee: There has been, I don't know if this stems with her but there was like a lot of trust issues there too I think that has stemmed from just how messed up she was in her. The way he made it seem that she always kind of cheated on him and did all these other stuff and so with me seeing the dynamics of that relationship, **I don't have a lot of trust with women in particular and so I didn't have any relationships. So I am very careful with who I select as a partner.**

Interviewer: Anything else to add?

Interviewee: No.

Interviewer: All right, thank you. Do you know any service members who have been impacted with mental health issues?

Interviewee: Yeah, there is actually a, I don't know him personally but one of my good friends, she is a student here with me and I just got her job in my lab. **Her dad** came back with, I forget what it is, it's one of those diseases that you guys were looking at, like he hears a sound and he gets frightened...

Interviewer: PTSD?

Interviewee: Yeah **PTSD**, and he came back with that and she actually told me that that **destroyed their marriage** and they had to move out for a little bit because **he was just crazy**. And I guess after a while they said **he'd calm down and he did receive treatment** I know that. But he was **trying to get into his daughters and he calmed down pretty much** but yeah **they are still divorced**.

Interviewer: And how did hearing something like that impact you?

Interviewee: It's **kind of frightening** because I am trying to become a doctor so I would be dealing with a lot of these people. So it's **going to be a challenge** because **how can you treat people that aren't always in the right state of mind**, on the same page with you? **If they lie to you, try to manipulate you for certain things or, how can you treat a patient taking into consideration their well-being if you are not seeing all the parts of that.**

Interviewer: So their issues make you leery regarding the type of the job that you are going to go into.

Interviewee: Yeah, like how am I going to be the best health care provider I can be if the subjects are mentally incapacitated?

Interviewer: So you want to be able to provide the optimum amount of care for them?

Interviewee: Yeah.

Interviewer: Anything to add for that?

Interviewee: No.

Interviewer: All right. Have your opinions about mental health been influenced?

Interviewee: From what?

Interviewer: Any type of outside influences or inside influences of what has gone into forming your opinions about mental health.

Interviewee: Probably about **how serious the condition is**. I mean it's not too prevalent in the civilian world but I'm starting to make the branch over into the army sector. **It's a real thing** because **people are in all these bad places, other vets are just suffering from this and it's causing their life style, their older lifestyle is degrading.**

I feel that **after you serve you should have a pretty lifestyle you shouldn't worry, have this have this health thing on your shoulder, just [Inaudible]**

Interviewer: So your time here has kind of shown you the different sides of mental health?

Interviewee: To what I know now **I am sure I am not even fully informed but using as a contrast from civilian life and then out in the ROTC you learn more about some of the challenges.**

Interviewer: Can you explore what you've learned?

Interviewee: I'm sorry.

Interviewer: Can you explore more about what you've learned?

Interviewee: How so?

Interviewer: You said you now know more about the mental health as a result of being here. What kind of things have you learned?

Interviewee: Just **how serious mental illness is, how much it can impact brigades, groups of...how you have to take into consideration things like when you are being an officer, you are managing those types of people.** So it is definitely special consideration you learn.

Interviewer: What messages about behavioral health have you received as an ROTC student?

Interviewee: Not many official messages, I just kind of hear things throughout the ...

Interviewer: Such as?

Interviewee: Nothing in specific, you just hear like people's family members who suffered from that, people whose dad or brother has that illness and just hearing people's effects.

Interviewer: Is that formally as former members of the services or is that just?

Interviewee: Former usually.

Interviewer: Okay. Was your idea of mental health different before joining the ROTC?

Interviewee: I wouldn't say different, I would just say, well I guess it would be different, it was uninformed and so I wasn't really aware. Especially here since I came to school, obviously I'm doing the medical singling more and more about illness and everything else.

Interviewer: And where specifically are you learning those things?

Interviewee: Through my physiology class and my neurobiology class that's probably a big one in mental health. But that's more along the lines of structural deficiencies and such as that, so much as like the physiological and psychological aspect of it.

Interviewer: Some more brain chemistry and less skill thing?

Interviewee: Yes, exactly.

Interviewer: Okay. What are your opinions about someone who goes to see a behavioral professional and that would be a counselor, a psychologist, a psychiatrist?

Interviewee: I don't have skewed perception on someone who would go, I don't think any less of them, personally I went when I was younger too and it didn't really help me in my family situation. So I don't find a comfort, I don't find a valid way of dealing with it.

Interviewer: Would you mind sharing more details about your experience with them?

Interviewee: Yeah, I guess, like what?

Interviewer: About why you didn't find it helpful, what kinds of things went on when you went?

Interviewee: When I went, they basically would sit everyone around and will talk about every ones actions and things you could do to better to improve that and stuff. And it just seemed like once everyone left that room the same problems would start even though people, would say, oh yeah we are going to change or we are going to try and do this. And I know that changing is a hard nut to crack sometimes but it just didn't seem to work for my family or me.

Interviewer: Okay, what are your opinions about service members who seek mental health treatment?

Interviewee: My opinion, I think it can definitely be helpful for some people, obviously I don't find it helpful for me...sorry, can you ask the question one more time?

Interviewer: What do you think about the service members who go and seek mental health treatment?

Interviewee: I think it is definitely a good step to take for them because if you are active and searching for a way to deal with this then you are going to eventually find some way. I think it's a good first step.

Interviewer: First step and what would be the subsequent steps in your view?

Interviewee: It just depends on the person, we are so different. So however you deal with your problems you should do that or could write diaries or punch pillows. I have heard a bunch of different things dealing with stress, I don't know about PTSD.

Interviewer: So any treatments that are necessary you feel it works for them it works for them.

Interviewee: Yeah, unless [crosstalk] killing people probably wouldn't be appropriate.

Interviewer: Not at all.

Interviewee: Better deal with that.

Interviewer: What would you consider illicit activity besides killing others?

Interviewee: I think that would probably be the main one. Illicit drug activity is, if that's what they need I'm, okay with that. I personally don't find offence to that even though I don't partake. I think that's it. Besides anything, besides causing anyone bodily harm I think would be, find a way to deal with whatever you need to take care of, whether it is PTSD or any other ...

Interviewer: Okay, for what issues would you, current or future would you personally go see a mental health professional?

Interviewee: I'm sorry repeat that question.

Interviewer: Are there any issues that you can see yourself seeing a mental health professional for?

Interviewee: No.

Interviewer: What about service members, what issues do you think they would probably need to see a mental health professional for?

Interviewee: I am open to the idea that whatever a soldier need to help them through, to help them do their job and to help them be mentally and physically fit to do it, I think would be a ok to see a mental health professional. So if they have problems dealing with stress or they have had a significant event occur or anything like that I think that would be an acceptable time for them to see a mental health professional.

Interviewer: Any other events or?

Interviewee: Sexual harassment, rape, stuff like that.

Interviewer: Okays, so we have stress, significant events, sexual harassment, rape, anything else can come to mind?

Interviewee: No.

Interviewer: Is there anything else that you might have wanted to add that I didn't ask?

Interviewee: No.

Interviewer: Okay, so that would conclude our interview. It is the 24th, this is participant one, it is now 1.17 pm.

(Interview completed 4/23/14)

Interviewer: All right 1.17 today is the 24th, this is participant two. The purpose of this interview protocol...wrong part...thank you for agreeing to participate in this study. The purpose of this interview is to find out your beliefs about behavioral health there will be another person in the room while complete the interview to ensure consistency between interviewees.

Both myself and the observer may make notes during the interview which will be used in the data analysis process, before we begin I'd like to talk to you about inform consent. With the inform consent what you should is that, I'm going to explain the study to you which I have already done, we are going to ask you questions about behavioral health. The research study is something that you will volunteer for.

We need to reiterate that you were not coerced that the grading portion of the participant promise has been waved and I stead you'll receive a \$20 incentive to participate. You can agree not to participate, you can also agree that you may change your mind and want your answers revoked from the study and you'll be removed, feel free to ask any questions that you want ask.

Your answers are going to be recorded and transcribed for later analysis. So everything is going to happen here in this research room and it is going to take about an hour to forty five minutes just depending on how much time you need to answer the questions. There is no risks to, I've got to change that, there is no risk to completing the study and I would you to just get that a quick once over and once you've read it and agreed to what's there please say I agree to participate in this study.

Interviewee: I agree to participate in this study.

Interviewer: All right and that is your copy to keep. And just to correct something on there that should be twenty not twenty five on your compensation.

Interviewee: Okay.

Interviewer: All right. Could you please state your age?

Interviewee: 19.

Interviewer: And you academic level, freshman, sophomore?

Interviewee: Sophomore.

Interviewer: And you are MS 1 or 2?

Interviewee: Two.

Interviewer: And your current rank?

Interviewee: I have no rank.

Interviewer: Okay, and would you describe your hometown as urban, suburban or rural?

Interviewee: Suburban.

Interviewer: Your ethnicity?

Interviewee: Black.

Interviewer: And your identified gender?

Interviewee: Male.

Interviewer: Thank you, and now we'll begin the interview questions. Could you describe for me the type of person that joins the army?

Interviewee: Somebody who is dedicated to their country takes into consideration of national pride and respects where they come from.

Interviewer: What type of person joins the ROTC?

Interviewee: Somebody who wants to excel in leadership goals and pursue a career that otherwise they probably would not have been able to pursue in the first place.

Interviewer: How so?

Interviewee: For me I say that I want to go into the medical field and I see that army can help pay for medical school, so otherwise if they could provide scholarship money and help financially.

Interviewer: Any other characteristics that you can think of?

Interviewee: That's all I could think of.

Interviewer: What comes to mind when you hear the term behavioral health?

Interviewee: Behavioral health? Mental stability, that's all I could think of.

Interviewer: Mental instability.

Interviewee: Yeah.

Interviewer: What about when you hear the term mental health?

Interviewee: The same thing.

Interviewer: Same thing, so behavioral stability that's what you said right?

Interviewee: For behavioral health is how you interact with certain things and mental health is how you perceive, comprehend that sort of thing.

Interviewer: Could you give me an example?

Interviewee: Behavioral is sort of I step into a room, just like this and I start going crazy just because it's quite I step into a room that's full of people I behave a certain way, I respect the surroundings. But mental I guess being like a schizophrenic.

Interviewer: Okay, can you describe a schizophrenic?

Interviewee: like hearing voices.

Interviewer: Okay.

Interviewee: All right, not being able to separate reality from what you are imagining, that's how I understand it.

Interviewer: Okay, so what you are seeing versus what is going on in your head. Okay, any other terms or things you can think of with mental health?

Interviewee: Personality disorders, that's about it, I don't know depression.

Interviewer: And you just mentioned personality disorders can you name any?

Interviewee: Dissociative, I don't know that's the only one I know of, I know there is, that's the only one I can think of right now.

Interviewer: Okay, so anything else that comes to mind when you hear those two terms?

Interviewee: No.

Interviewer: Okay, what happens to you when you encounter someone with behavioral health issues?

Interviewee: You have to adapt on how to deal with it, I don't...when you are faced with somebody who has an issue behavior wise, you have to adjust the way you come and approach them, handle like conversation. You have to really understand where they are coming from and along with the mental health.

Interviewer: And what does that adjustment look like?

Interviewee: Say dealing with like a grandmother who's got dementia. I'm going to have to play along with the fact instead of trying to force her to cooperate with everybody else in the

room. But I have to comply with her, her mental needs so she doesn't start getting weird and crazy.

Interviewer: So getting into their world?

Interviewee: Yeah, stepping into their shoes for a bit.

Interviewer: All right, anything to add to that?

Interviewee: No.

Interviewer: Is there someone in your life who struggles with behavioral health issues?

Interviewee: No, not that I could think of.

Interviewer: Nobody, friends, family, friends of friends?

Interviewee: I may have a couple of friends, I think so, I don't know if it is just them when we are all together in a group and that's just how we get like I'm not crazy. When you hanging out with your friends you influence each others' behaviors; I have never really hang out with a couple of them isolated where I get to see how they are.

Interviewer: Could you describe like the difference then because it seems like something is going on in a group but you haven't necessarily seen it alone yet?

Interviewee: Go to a shopping mall in a group and you guys are just really rowdy, just like really loving the fact that you guys are together and it is just, in each others presence and you just want to like enjoy what's going on right there and then. So you go into the door and you just start like get hot top or something. Like one of those goofy stories and you put on glasses and you start showing up or whatever just because you want to have fun.

But if you are one on one you might act a different way because you don't really have a lot of other people to feed off of.

Interviewer: So it sounds like more outside influences?

Interviewee: Yes.

Interviewer: And how has that behavior impacted you?

Interviewee: I see naturally I'm calm but when I am around like more I would say like fat people I get really, really nut case. I'd get really excited because of the fact that I am around so many friends.

Interviewer: So you go with the flow.

Interviewee: Yes, I am more susceptible to do or agree to things that like I normally wouldn't when I am just by myself because I don't want to.

Interviewer: Can you give me an example?

Interviewee: Say they are like, hey let's go sky diving. I would not do that by myself, I would definitely do that with a group of friends.

Interviewer: Have you?

Interviewee: That was just like...

Interviewer: That's just an example of something that could happen.

Interviewee: Yeah, definitely.

Interviewer: Okay, have you ever known any service members that have behavioral issues?

Interviewee: No, both my parents were in the army and I've yet to see anything negative, and my brother is in the navy, my aunt is in the air force I don't see any behaviors issues there or mental issues.

Interviewer: Have they told you stories of others who may have had issues?

Interviewee: No. My dad keeps quite about this stuff and my mum she only talks about what happened at basic but other than that everybody keeps mum about certain things.

Interviewer: Certain things pertaining to?

Interviewee: My brother is active; I don't ask him like a lot of things that happens on the ship. That's just, for me I just see that that is not my place, it is not my, we don't have that common ground there. We are in the military but we are not in the same branch, so I don't feel the need to have to start getting to know all that.

Interviewer: So unless he volunteers information you don't ask.

Interviewee: Yes, unless he tells me stuff I don't start digging, that's just not how I am.

Interviewer: And what about with your parents, you said they didn't really talk about it.

Interviewee: I tried to get some things out of my dad but he just doesn't talk about a lot of the stuff.

Interviewer: And your mother you said only told you about basic.

Interviewee: Yeah, she would just talk about what happened on basic, her winning awards and they just from there.

Interviewer: Okay and this is the way it has always been?

Interviewee: It has always been like that. I'll only hear about like accolades like for my, or like notable mentions for, like my grandpa when he was in the navy, he was...Japan had surrounded on his ship and that is all I heard.

Interviewer: That was it.

Interviewee: Yeah that was it, also because my grandpa, I never met my grandpa but nobody expands on all the subjects.

Interviewer: Okay, so anything else to add about you encountering people with mental health issues, whether that would be on the street or whether that would be with service members?

Interviewee: I may have met a couple with mental issues but I don't know if they are in the service or not. I have been around people like just passer bys where I have noticed that there is something going on but it is not like I know that they are private service or anything.

Interviewer: What has influenced your opinions about behavioral health?

Interviewee: I think dealing with my grandma because I didn't understand how things were going until I was actually with it. You could hear about certain symptoms and all that stuff but you don't really understand the effect it has on that person and the people around him that goes on. It's surreal when you actually step into that but we are dealing somebody who has it is definitely an eye opener.

Interviewer: Would you mind describing that experience for me?

Interviewee: She had multiple personality disorder and she had dementia. So they had diagnosed her, she probably had more than twenty personalities that would just come and go whenever they felt like. So one time we went to go visit her and at one point in life she was a dancer, like she is in the hospital bed and I am sitting there and all of a sudden she just brightens up, just gets out of her like sickly mood and she is like let's dance but she can't.

She doesn't know that she can't, but she wants to dance. So we are sitting there and I would just grab her hand and we are like, and like [0:14:17.9] just toss her head a little bit and she thinks she is in a ballroom. So that's like, I didn't understand like how deep that person could really delve into that stuff and really believe that a hospital room is a ballroom, I didn't understand that.

Interviewer: So in her mind she was somewhere else and you were there with her.

Interviewee: In her mind she could have been in Jamaica, she could be in a ballroom dancing, she could have been like overseas in china and it was real weird seeing those things. And like I

was seven or so when she first cursed at me, because she was describing a story but she just was not aware of whom she was talking to. She thought I was my dad. So yeah that's, one of her personalities kind of took over that and didn't care who was listening she just went on with her story and cursing and all, but I accepted it, that's that.

Interviewer: Okay, have there been any other influences that you can think of?

Interviewee: I think my sister, we don't share the same mother but she could be very distant sometimes. She can be very like lovey dovey and all of a sudden just switch switch, she just doesn't want to be touched with anyone and she doesn't want to talk to anybody. She left our house when she was like fifteen and I was like four and I didn't see her again until she got pregnant down the line, it is like four years ago. But she can really turn on you in a second.

Interviewer: So it seems like there are two sides of her?

Interviewee: Yeah, it's almost like my grandmother even though there is no blood relation, just like her.

Interviewer: Okay, I understand, have you ever experienced as an ROTC student influenced your ideas about behavioral health?

Interviewee: Dealing with different people who have come from different walks life yes. Being able to actually deal with certain personalities is definitely something that you would do as ROTC student. How to handle it, get along with it and deal with it.

Interviewer: What about those personalities?

Interviewee: Some can be very overwhelming and like strong and just really like, some can get really power hungry because of the fact that say, like trying to remember you gave them a responsibility; that would be it. Otherwise everybody has got the same goals but they have different way of approaching it, so you have to understand that, because they have different paths, you kind of have to ride with it, stand your ground and learn to deal with the blues.

Interviewer: So everybody is trying to get to the same place but they are getting there differently and they are going to do it differently.

Interviewee: Everybody has a different mindset, everybody wants the commission, that's the angle and everybody wants commission. But its how we get there that everybody has to learn how to mingle.

Interviewer: Okay.

Interviewee: Like say we are being lab and we are running a mission, people are going to have different ways of performing their mission and if you don't understand where they are coming from or how they are going to perform it, you can get a little turned around, we'll no it is this

way, it is that way but it's learning how to adapt to certain situations. Like confronting something that you are unknowing but still going with it.

Interviewer: So just kind of trusting the person to lead.

Interviewee: Definitely you have to learn how to trust people because even though you don't really get along with them you are going to have to put your grade sometimes in their hands.

Interviewer: All right, what messages about behavioral health have you receive as an ROTC student?

Interviewee: Say we had a couple of lectures in the beginning of the year in the first semester where you had to, where we were talking about soldiers in need, say we are commissioned, they are putting us into real life situation saying we commissioned and subordinates comes to us and says hey I am dealing with some problems, like with my wife at home, overseas and I don't know how I feel and that stuff is also affecting my work.

They start getting like real depressed like how to deal with certain issues where they are faced with loneliness and they are stuck with like a gun and you don't know what they are going to do. You have to learn how to solve that situation quickly and effectively. So we learn certain possibilities that could happen and how to confront those things.

Interviewer: Could you think of any other examples from that?

Interviewee: We've deal with depression, suicide and loneliness; those are just the main pointers because that's all you are pretty much faced with. Everything else is minor home problems, how do you like mediate with somebody who is like thousands of miles away and bring families tighter that are separated.

You just got to come from a calm even ground and you're going to learn how to deal with it. It's either to deal with the teams, if you don't know how to deal with then you get a surrogate who's been around there for years to help so that you could actually monitor how to deal with the situation.

Interviewer: Okay, so if you don't understand how to do something you definitely bring in other people.

Interviewee: Yeah, because you are fresh, we are fresh when we come in there; we have no respect when we come in there, it's like a doctor. You are going to trust the doctor who has been performing for twenty years other than a kid that just came out of med school. So you go after the person that's below you that has been around there for years and know how to deal with the soldiers in there.

So that you could see how he deals, what level to come at in the next time if something happens like that and they are also familiar with the fact that you trust who they trust and it is just like a chain reaction after that.

Interviewer: Okay, so you said you learned how to deal with issues like that in teams, did you pick up anything else from that?

Interviewee: No, not that I could think of.

Interviewer: So basically you can't help find a buddy.

Interviewee: Yeah, if you don't try to take on a situation that you are doubtful of; always go in there with a plan or with someone who has a plan.

Interviewer: Okay, was your idea of behavioral health different before joining the ROTC?

Interviewee: I would say ROTC kind if reiterated a lot of things I learned in high school dealing with family members on situations, but it just kind of reinforced, had an army aspect of it, like battle buddy assistance, that kind of stuff; like no man is alone, island.

Interviewer: So you learned more of a team approach thanks to ROTC.

Interviewee: Yeah.

Interviewer: Okay, what are your opinions about someone who goes to see a behavioral health professional, this would include a counselor or a psychologist or a psychiatrist.

Interviewee: Nothing negative, I would just say that they know that they are facing a situation that they themselves have been like not able to actual deal with or don't have the proper tools to deal with, so they go to somebody who actually can and can provide the help, but I don' see it as anybody who is like weak or, I would just say ill equipped to handle that.

Interviewer: Could you explain ill equipped?

Interviewee: They don't know how to just, like what to tap into to deal with certain situation, because some people panic, some people don't know how, like just from doing a [0:23:31.2] like missions, they are faced with like an impromptu kind of things say like your team leader is down, all of a sudden the second in command is in charge.

That second in command who hasn't been paying attention, they're gonna get nervous, they don't know what's going on they just thought they were going to slide by and like, no. So it's like learning to adapt to that, but if they don't know what they are doing, it's going to be a tough time.

Interviewer: Okay, you are going to have a bad time.

Interviewee: Yeah it's going to be a real bad time. [Laughs]

Interviewer: All right, so what about if that person is a service member?

Interviewee: I would say it's the same thing, I'd say it's the same thing, they don't trust in the fact that they themselves are going to handle it, so they know that they need the help. Then knowing that they need help, I see as being strong in the fact that you are giving up knowing that, not really giving up but you acknowledge that you are going in there without the proper tools, so you need it. It's like going into a fight without any of that.

Interviewer: Okay, so it is like going for a different kind of training.

Interviewee: Yeah, that's exactly it.

Interviewer: Okay, all right, so my next question, when would it be appropriate to see a behavioral health professional?

Interviewee: When you start to see that your daily life is starting to be affected by it, when things that you were in control of you are no longer in your control. Especially when you are unaware of it, if you are unaware of it and it's brought to your attention, I think you should go after it somehow.

Interviewer: So which one would be more important?

Interviewee: In what way?

Interviewer: As far as if you are aware and you go or if you are unaware and you go.

Interviewee: You mean unaware and go for help? I would say it would be more helpful if you are aware of it and you get some help because it had to be brought to your attention at some point. If you are unaware and you go to get some help and all of a sudden something else... I don't know how that person is going to do it, I don't if they are going to do well. I can do that, that's a lot and I think it's something that you have to see for yourself or have somebody show you and you deal with that after that.

Interviewer: It might be brought to your attention but you wouldn't necessarily accept it.

Interviewee: Yeah.

Interviewer: But if you knew about then you can go ahead...

Interviewee: It's like you would rather deal with something that was brought to your attention and is it is like you start to see it develop, other than something where you just go get some help and all of a sudden it just sprung in the last minute, you are this, you are that. Well I don't see that, I don't know where it is coming from; you would rather have the evidence of it instead of somebody just kind of jump into assumptions in your perception.

Interviewer: When would it not be appropriate to seek treatment?

Interviewee: I guess if you know how to go about things, I think if you had a problem with dealing with situations then there is no problem at all because you are just going to nip it in the bud right there and then. But if were able to handle it by yourself I don't see any reason for it.

Interviewer: And what would be an indicator of you not knowing how to handle it by yourself?

Interviewee: If you see positive progress, it's brought to your attention you would be like, okay I'll work on it, and then it is just gradually getting better. Now if that happens again and you drop off and it starts happening more, then I see that you might need some help. But if you are able to work on it slowly, I see that as progress.

Interviewer: All right, when would not be appropriate or inappropriate for a service member to seek treatment?

Interviewee: I don't see any inappropriate time because in the service you are stressed to have that team aspect, almost like, it's a family. You go and you help your family member out. Your job could be so crucial to the point where if you are not behaving a certain way that can affect other people's lives. So it's pretty important for somebody in the service to get help.

Interviewer: Okay, so if they feel that there is an issue it's all okay.

Interviewee: Yeah, even if it's minor, minor situation I see as your peers can help with that and in a way that they can. But if it's major you definitely have to do that, but either way you still, that helps still needs to come.

Interviewer: What issues current or future would you personally go see a behavior health profession?

Interviewee: First I could get in like, if I was passive aggressive with everything, I didn't know where the anger is coming from, temptation to kill yourself, I see that as getting help. Not getting along with certain members of your team squad, you are going to have to get that, you are going to have to go through that as team work is crucial.

Not being able to trust say like a colonel or anything, you need that because trust is like a key point in the military, trust within the military and trust with military and civilians.

Interviewer: Okay, and what issues do you think service members should go seek treatment, current or future?

Interviewee: Family problems, depression, that's it.

Interviewer: So did you have anything else to add that I didn't ask about mental health or your understanding of it, can you think about it?

Interviewee: No, I think it's pretty good.

Interviewer: Okay, so we'll stop here.

(Interview completed 4/24/14)

Interviewer: It is 1.58 today is April 24th this is participant number 3, hello?

Interviewee: Hi.

Interviewer: Thank you for agreeing to participate in this study the purpose of this interview is to find out you beliefs about behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews both myself and the observer may make notes during the interview which will be used in data analysis.

Before we begin I would like to talk to you about consent; what I have here is the inform consent which you will be given a copy of. Before we start this research study you need to know that someone will explain the study to you which I have just done we are doing a study just to get your ideas and thoughts about behavioral health.

The research study is something that you volunteer for so as you've read an email and I'll explain to you now this is not connected to any type of grading incentive however you will receive a 20 dollar incentive for completing the study at the end of the interview. Whether you do or don't take part is up to you, you are free to withdraw at any time you can stop the interview time or you can request that your information be withdrawn at any time.

Your identity will not be shared with anyone, this is completely confidential. You can agree to again to take part now, later and then change your mind whether you decide to take part or not it won't be held against I'll still like you as a person. Feel free to ask any questions that you may have anytime during the interview and your answers are going to be audio recorded and they're going to be transcribed for later analysis.

All right so what I would like you to do is read the inform consent and at the end if you agree to participate in the study just please state for the record I agree to participate in this study.

Interviewee: Then what do I do then?

Interviewer: If you agree to participate in the study just state I agree to participate in the study.

Interviewee: I agree to participate in the study.

Interviewer: All right thank you and you can keep the inform consent and what I have now is just a short demographics form to learn a little bit more about you to round out the question that we are going to ask.

Interviewee: Okay.

Interviewer: What's your age?

Interviewee: 20.

Interviewer: And your academic level?

Interviewee: Sophomore.

Interviewer: And you are MS1 or MS2?

Interviewee: MS2.

Interviewer: And do you have a rank?

Interviewee: No I don't.

Interviewer: Okay and would you describe your home town as urban, suburban or?

Interviewee: I'll definitely say urban.

Interviewer: Okay your ethnicity?

Interviewee: I'm half black half white.

Interviewer: And your gender?

Interviewee: Female.

Interviewer: All right and we will begin the interview portion. Please tell me about the kind of person that joins the army?

Interviewee: Definitely say let's see. It probably have to be someone with **high moral standards**, someone who is **patriotic** I'm not really sure as far as like no personality wise but and then of course he has to be **in good physical shape** those are like the main three.

Interviewer: Okay so you said physical shape, patriotic, higher moral standing any other characteristic you could think of?

Interviewee: I'll probably say they would have to have **good leadership skills**.

Interviewer: Okay and what kind of person joins the ROTC?

Interviewee: Probably about the same characteristics but with ROTC I think maybe it's a little less I wouldn't say **less dedication** but I'd say it's probably about the same.

Interviewer: Okay. Can you describe the difference between the two levels you said less dedication what would it look like one of the other?

Interviewee: I wouldn't say less dedication. **I don't think you are held to as much of standard as if you were actually going straight into the military because a lot of people come in just to try it out.**

Interviewer: And what does that look like?

Interviewee: [Laughs] well you probably get **a lot more of like varying personalities as far as ROTC goes because a lot more people are allowed into ROTC so it's a little more diverse** I would say.

Interviewer: Would you mind describing those personalities?

Interviewee: I mean occasionally **we do get some irresponsible people**, there're **some people who may not hold as high of more moral standard** but like I said it's just some people come in just to try things out.

Interviewer: Okay, so definitely a different personality dynamic between...

Interviewee: Yeah I'd definitely say is more maybe due to their maturity **different maturity level.**

Interviewer: All right so anything else to add for that one?

Interviewee: I think that's about it.

Interviewer: Okay what comes to mind when you hear the term behavioral health?

Interviewee: I guess someone who would, I'm not sure **normal behavior** is something that is accepted by, **behavior accepted by society maybe.**

Interviewer: What about the term mental health?

Interviewee: Mental health not really sure **I think that's a little more personal.**

Interviewer: Okay you mean personal for you or?

Interviewee: No, no I mean like it's not, really not sure, I guess it **wouldn't be observed by society as much. I'm not really sure how to explain it.**

Interviewer: Okay well take me through it what would society think about the term mental health?

Interviewee: Well I guess when most people maybe hear mental health **they would think I guess mental health would determine behavioral health** I'm not really sure.

Interviewer: Okay so you see the two as linked?

Interviewee: Kind of I'm not really sure.

Interviewer: Okay let's try the next one. What happens to you when you encounter someone with behavioral health issues?

Interviewee: And that's a little hard to think about because I guess I'm still kind of unsure about exactly what behavioral health is.

Interviewer: Okay, so if lets it seems like you had a little bit more handle on mental health. If you encountered someone in the streets who you felt had a mental health issue how would you react to that?

Interviewee: I'm not really sure but I notice someone like obviously had a mental health issue I wouldn't say I would treat them any different from anyone else but I mean I definitely wouldn't be able like to hold normal conversation with them or interact with them normally.

Interviewer: You said you wouldn't be able to?

Interviewee: I don't think I would be able to.

Interviewer: Okay so what would that interaction look like then?

Interviewee: Probably a little awkward [Laughter] yeah I think it would be probably be a little difficult to communicate.

Interviewer: So you would find that you wouldn't have to be able to have a normal conversation with him?

Interviewee: I don't think I would much.

Interviewer: Okay all right. Is there someone well this will be a different question again just from semantics again. Is there someone in your life who struggles with behavioral health or mental health issues?

Interviewee: As far as mental health I would say I do know a couple of family members who are schizophrenic and I think that's where we are at now other than that not really.

Interviewer: So no other friends or other acquaintances?

Interviewee: No.

Interviewer: Okay so if family members who you said you've known who are schizophrenic how has that impacted you?

Interviewee: I wouldn't say that it's had a really big effect on me, I don't think it's really affected me.

Interviewer: Okay are these close family members or they are more distant?

Interviewee: They're more distant.

Interviewer: Okay. Do you know of any services members who have had mental health or behavioral health issues?

Interviewee: No I don't, not personally.

Interviewer: Not personally what about other things you might have seen?

Interviewee: I have heard about certain things happening but I don't know like particular names I don't know them personally. I have never met these people but like you hear stories.

Interviewer: Could you describe the stories for me please?

Interviewee: Well actually my dad is military and he actually told me about someone that he knew and this particular person I guess he didn't have very good mental health and there was an incident where he actually tried to commit suicide. He pretty much just left post, didn't tell anyone where he was going, didn't say anything to anyone, he was missing for a couple days people tried to find him and then when they found him they found out that what he was actually was trying to do was trying to kill himself.

Interviewer: Okay and this is one of you said your father is military is this one of the only stories that you heard about others?

Interviewee: Other than stories in the news I mean there is some soldiers who just kind of snap and they go shooting but those just cases.

Interviewer: Okay. Have your opinions about behavioral health been influenced by anything?

Interviewee: Not anything particular I mean I guess maybe like what I was raised to think is normal behavior or I have abnormal behavior that's the only thing.

Interviewer: Could you describe for me the differences between the two?

Interviewee: Between normal and abnormal behavior okay I think like someone that would exhibit abnormal behavior from what I was raised from the society, I was raised to be like if someone was trying to have a conversation with you but they can't hold eye contact or they look away or they look down that would be abnormal from what I was taught.

And then normal would be like holding eye conversation with someone looking them directly in the eyes while you are talking to them.

Interviewer: Okay and you mentioned society and how you grew up. What do those encompass?

Interviewee: What do you mean?

Interviewer: Like you used those two as examples of where you kind of got your cues about normal and abnormal what makes those up? Like what goes into society, what goes into how you grew up or who are the people in those two categories? Who makes up society and who makes up how you grew up?

Interviewee: How you grew up is kind of mix between home life and society and then but society I think it's, that can be anything from the people you went to school with or the people that you work with, people you encounter like everyday, if you go to the store or restaurant or something like that.

Interviewer: And what about you in particular?

Interviewee: For me for society, I'll definitely say growing up in school had a lot to do with as far as society goes and then how I was raised. I would say probably my father was the main influence as far as home life goes.

Interviewer: So in between school and then your father that's where you got a lot of the cues about behavioral health?

Interviewee: Yes.

Interviewer: Okay. Have your experiences as ROTC student influenced your opinion about behavioral health?

Interviewee: Not really.

Interviewer: Okay so nothing you've learned here as a member of ROTC is changed your mind about?

Interviewee: Not that I can think of no.

Interviewer: Okay. My next question would be what messages about behavioral health and mental health have you received as an ROTC student?

Interviewee: I don't think we've gone into mental health really as far behavioral health. The only thing that I know that we've learned as far as behavior goes is oh we received like a SHARP training which is like a sexual harassment training and that's pretty much it.

Interviewer: Okay, could you describe that please?

Interviewee: The sharp training? It's like an online module you go through and they go through what's considered sexual harassment, what type of behavior is associated with that and then they go into further details about what the army consider sexual harassment and behavior. It's just like its like a few online majeure its takes a couple of hours to do.

Interviewer: Okay and I'm guessing that's about how long it took you, is just a couple of hours?

Interviewee: Just a couple of hours and we do it every year.

Interviewer: Okay is it the same one or is it different ones?
Interviewee: It's the same one.
Interviewer: Okay and that's the only thing that you can think of when it comes to mental health or behavioral health that you experiences as an ROTC member?
Interviewee: I think that's about it.
Interviewer: Okay was your idea of behavioral health different before joining the ROTC?
Interviewee: No.
Interviewer: Okay, so pretty much from those outside influences you were talking about before and now it's pretty much the same thing?
Interviewee: Same.
Interviewer: Okay what are your opinions about someone who goes to see a behavioral health professional and that will include a counselor, a psychiatrists or a psychologist?
Interviewee: I'd just say probably they're able to see that they have a problem and they just go to get help. I don't see anymore than that.
Interviewer: Okay and what are your opinions about someone who goes to see them if they're a service member?
Interviewee: They're still the same person; I'd say it's the same thing.
Interviewer: Okay, so really no differentiation between a civilian and a service member seeking?
Interviewee: As far as seeking mental health I don't think so.
Interviewer: Okay when would it be appropriate for a person to see a behavioral health professional?
Interviewee: I guess if someone has told them that someone is like noticed they behavior isn't normal and to let them know or maybe they know that they're behavioral isn't normal and they're able to see that they have a problem and say that's when they should go.
Interviewer: Okay when will it be inappropriate?
Interviewee: I'd say I'm not sure I guess it's not that big of an issue if it doesn't affect say their job or the way they just carry out everyday life then I don't think its something that needs to been seen by a mental health professional.
Interviewer: Can you give me an example of something that's not a big deal?
Interviewee: Breaking up with your boyfriend or girlfriend I don't think you really if you are upset about it I don't think you need go see a mental health professional.
Interviewer: Okay, so to you something like that will kind of?
Interviewee: I'd say inappropriate.
Interviewer: Okay when would it be appropriate for a service member to seek treatment?
Interviewee: I'd definitely say about the same but I think it's a little more important that services members go see mental health professional especially because if its affecting their behavior and its affecting their job. That affects a lot more people than themselves especially in the army so I'd say the same just as far as a normal civilian wants to see a mental health professional.
Interviewer: Okay so you believe, what I'm hearing is like for services members is going to impact more people; okay anything to do add for that?
Interviewee: I think that's the main thing.
Interviewer: Okay all right, for what issues current or future would you personally go see a behavioral health professional?

Interviewee: Me personally, I'd say maybe if I like let's say I suffered a significant loss of family member or something and then I went into like a deep depression and I wasn't able to focus on school like I was, my grades started dropping, not showing up ROTC or something like that that's what I would say go see a health care professional.

Interviewer: Okay. Can you think of any other examples?

Interviewee: I don't just really know anything I would think of.

Interviewer: Nothing in the future, what about outside of the here and now?

Interviewee: I guess if I had the same issue as an officer I would go see a health care professional just the same with like I said on I had really bad depression or something like that.

Interviewer: Okay. For what issues do you think a service member should seek a behavioral health professional?

Interviewee: I think maybe if they're having like violent thoughts or they noticed they're becoming violent, they're having suicidal thoughts or something like that.

Interviewer: Okay, any other symptoms or any other problems?

Interviewee: No, those are just the only ones I could think off.

Interviewer: Okay that's fine. All right that concludes our questions, is there any other information that you would like to add maybe questions that I didn't ask about your thoughts on mental health and behavioral health?

Interviewee: No I think that's pretty much it.

Interviewer: Okay.

(Interview completed 4/24/14) Interviewer: All right thank you for agreeing to participate in this study. The purpose of this interview is to find out our beliefs about behavioral health. There will be another person in the room while we conduct our interview; she is going to ensure consistencies between the interviews. Both myself and the observer my take notes during the interview which is going to be used in data analysis process.

Before we beginning I'd like to talk to you about informed consent; this is our informed consent and I'm just going to go over some highlights with you. I just explained the study to you so basically we just want to get your ideas about behavioral health, mental health, how you feel about it. You can back out of this study at anytime, if you would like for your answers to be removed from the study just let me know and you would basically just be removed from the study just like you were never here.

There will be a 20 dollar incentive after you've complete the survey. However I must inform you that the incentive of the great is in no way shape of form connected to the study so I can't promise you that, I actually had to go through and make sure that that was a stipulation within the IRB. So if you could please read the informed consent and agree to participate in the study just say I agree to participate in the study and if you have any questions ask them at this time.

Interviewee: Okay I agree to do the study.

Interviewer: Okay thank you and now we are just going to ask a couple of demographic questions to round out some of the information that we are going to ask in our interview questions.

Interviewee: Okay.

Interviewer: What's your age?

Interviewee: 19.

Interviewer: And your academic level?

Interviewee: MS2.

Interviewer: Okay you are a freshmen or sophomore?

Interviewee: I'm sophomore.

Interviewer: Okay you have a rank?

Interviewee: No.

Interviewer: Would you describe your uptown as urban, suburban or?

Interviewee: Suburban.

Interviewer: And your ethnicity?

Interviewee: White.

Interviewer: And your gender?

Interviewee: Male.

Interviewer: All right thank you. So our first question could you tell me what kind of person joins the army?

Interviewee: I would have to say person who they're two different types of people there is people who have a genuine like want to serve their country and a genuine like loyalty to their country and there is other people who do it for as job. And those people maybe they have a hard time finding a job, maybe they just they think this is the military is like the first place to go out of high school so that's just what I think.

Interviewer: And what do those two different things look like for you?

Interviewee: What do you mean?

Interviewer: You said one of them is strong patriotism and loyalty to the country and the other one is just a job; how do the two of those put themselves?

Interviewee: Well I mean I think the latter that just it may start out just as job and then turns into something more strong patriotism to your country and that's all good I have a lot of friends who joined the military at high school. So there is that and then as far as the first one very strong patriotism I believe that those are people that end up making a career out of the military and instead of whatever contract states when you enlist going to the army.

Interviewer: What kind of person joins the ROTC?

Interviewee: That person usually falls under the first category, for ROTC to me is like it's a way for you to better yourself and have a career. You are making yourself an officer in the military, you are holding yourself to a higher standard and that is a lot of your peers and you are a leader. You are going to be out there leading people and you have to have strong moral conviction as leader as prime individual and those are the things that I believe a type of person joins the ROTC for.

Interviewer: Okay, so I heard moral conviction, I heard leadership anything else you want to add?

Interviewee: High intelligence.

Interviewer: Okay.

Interviewee: I mean ROTC they make you that you, I mean GPA is everything. So to want to do ROTC you have to understand education requirements you should have that college degree in order to get commissioned and you have to understand that you have to perform well academically to do well in your army career.

Interviewer: Okay, what comes to mind when hear the term behavioral health?

Interviewee: Behavioral health as in like give me an example like behavioral health issue?

Interviewer: Behavioral health issue, all right lets switch it what about if you heard the term mental health?

Interviewee: PTSD.

Interviewer: Okay that's the first thing?

Interviewee: Yeah.

Interviewer: Anything else?

Interviewee: I guess mental health I guess I mean this is just like for the army so a lot of things like PTSD related. Personally my step brother is diagnosed with PTSD from when he was in Afghanistan. So that's just like that's the only reason why is the first thing that comes in mind but I guess other things could be like social problems, not being as social as you once were, I guess other mental health problems.

You could become an alcoholic; I think that counts as mental behavioral thing. And then other sorts of problems I guess could erupt from it, I guess some people could become schizophrenic or something like that less really all I could think of.

Interviewer: Okay what happens to you when you encounter someone with behavioral health or mental health issues?

Interviewee: I mean generally like I guess can just say of, of my personal experience like my step brother I tried to act as normal as I can around him. I mean he still acts normal just sometimes he'll like get all wound up about something. Just treat them as like a normal person and if an episode like does come up you try to calm him down the best way you can. And just make sure he understands that things are what maybe what he thinks and that he needs to come down and listen to the other people as they're with him and understand that we are here to help him and stuff like that.

Interviewer: Would you mind giving me an example of when you had to do that?

Interviewee: Yeah it was actually before I came to college actually like during my first semester I was home a lot of my step brothers PTSD issues comes when he's drinking. And so he got drunk one night and came home and he was yelling about stuff outside and like smashed like a liquor bottle out in the street and it was one of his friends and I we were out there trying to calm him down.

And then like he started getting like violent so we like tackled him to the ground and restrain him and then my step dad came out and my other step brother and like took him inside and he was still like in a state but he was calmer after that point.

Interviewer: Okay, so what took a lot of you all to kind of getting him back to not necessarily where he was before but somewhere close?

Interviewee: Somewhere close to that and then like he slept it off and then he was fine in the morning; but like a lot of his issues like stems from alcohol as far as the PTSD and stuff goes.

Interviewer: Could you explain that for me you said it stems from that?

Interviewee: Like a normal lie when he is sober he's fine he doesn't like have psychotic episodes of you hear like loud bangs, and fireworks and you think oh duck and cover stuff, stuff like that. But a lot of it is like, and at least in my eyes I think it stems from like alcohol for him. And when he has alcohol in the system and I think he starts thinking about things and then he has flash backs or like stuff like that.

Interviewer: Okay, so my next question is how his struggles with mental health impacted you?

Interviewee: It definitely made me more aware of like problems that are out there and how some people believe, a lot of like soldiers sometimes believe that PTSD is just like a sign of weakness and nobody really has these problems but actually these problems do exist I mean there are studies on it.

Actually I did a study in PTSD in my high school physiology class. So I mean that research as well as they know like there is countless studies out there that has dictated this is an actual problem that exist and it's not just in the military. It's in like police; even in none combat related services. It is a very real problem and I think having a personal connection to it has made it more apparent to me on that.

Interviewer: Okay, so it's made a lot more tangible for you?

Interviewee: Yes.

Interviewer: Have you seen any other either civilian or service member struggle with mental health issues?

Interviewee: Not personally no just besides my step brother no.

Interviewer: What about impersonally any stories you've heard?

Interviewee: I mean you always hear stories, you always hear stories about people like friends of friends who come back and they're just like not right. A lot of those actually come from drinking too, I don't why but I guess all the stories a lot of it comes like those episodes like get heighten when they're drunk or have been drinking or something like that.

Interviewer: Okay, so it's seems like anything they were doing before as soon as alcohol gets involved it goes to another level?

Interviewee: It can go to another level yeah.

Interviewer: Okay. Have your opinions about behavioral health been influenced by anything?

Interviewee: Yeah I guess. Like I said the tangible-ness of having like a personal connection to it I guess it has changed my opinions on it. Like I said it's a very real thing, I used to not think it was I used to think that like you are being show shock or having PTSD I mean how is going to happen riding you know what happened is frequently or as a common as it is known to be.

Interviewer: Could you tell more about your previous thoughts?

Interviewee: I mean like I said it's just like I used to think that it was just, like I knew it can happen I just didn't think that so many people had it or so many people said they had it but I don't know if they really had it, I guess what I'm saying. It's like a way for them just to like either out of service or trying to get some kind of benefit out of it I don't know.

Obviously like knowing it now it's just like I know that was a stupid thought. So having a personal connection it's like made me change what I thought and see that it is an issue and people have it and they say they have it, they diagnosed with it by doctors, they have it.

Interviewer: So this is like this wasn't just something that is out here anymore its like I have seen it I know it exist, I know its real, and I've studied it, this is here.

Interviewee: Yeah.

Interviewer: Okay anything besides your personal experience influenced what you know about it, mental health?

Interviewee: I mean like I said that study I did in high school about it that also helped influence what I believe about it. But I say combine that with my personal experience has really like brought forth to me the attention that it deserves.

Interviewer: What about mental health overall?

Interviewee: I mean yeah there is a lot of mental problems associated with PTSD, it's like you have schizophrenia and then you have like smaller mental health issues like bipolar and stuff like that I see sometimes so yeah.

Interviewer: Okay. Have your experiences as an ROTC student...have your experiences as an ROTC student influenced your opinion about behavioral health?

Interviewee: I mean ROTC is, okay in ROTC we refer to it and It's cadet land because...

Interviewer: You said cadet land?

Interviewee: Yeah cadet land.

Interviewer: Okay.

Interviewee: Because we are all cadets I mean there is a lot prior services people in here and but not everybody is prior services a lot of people are just like college kids and wanted to do ROTC and wanted to become an officer. Like that's me I got a scholarship at high school so that's why I'm here.

But personally I don't think being an ROTC reflects anything about mental health because it's not the same. Like in ROTC we do tactical exercises with rubber in sixteen's it's not the same as firing actually M16 rounds a person.

Interviewer: So this is just kind of practice?

Interviewee: Yeah I mean I guess in some way I can see like if you are really just like if you really thought about it you could like get some sort of mental thing from it but like when its just like it's you and your friends in ROTC who are doing tactical exercises and again it's like these people who you know is not the same as you and your comrades in a fire fight and you are shooting people to save your life.

They is no life or death scenario here not in ROTC so like the mental health issues I don't think it arises here.

Interviewer: What messages about behavioral health have you received as an ROTC student?

Interviewee: Not much really I mean we talk about it sometimes like PTSD and stuff like that not really much as like a 1 or 2. I'm sure that doesn't really come up much because overall most the kids who are MS ones and twos they're all college kids. Like there is a couple who are prior service reserves, national guard or they were active then just trying to make a career move but yeah as far as, not really much.

Interviewer: You did say you talked a little bit about PTSD...

Interviewee: I mean like in a conversation not like in class like no this is mental health disorders or stuff like that, like that can arise with combat and stuff like that.

Interviewer: So could you tell what comes up in conversations?

Interviewee: I mean it's just like, it's just like conversation of like these are stories that people have and then how to like signs of PTSD or like something like that just the general things that people already know.

Interviewer: Oh okay that makes sense was your idea of behavioral health different before joining the ROTC?

Interviewee: No, like I said it was about the same personal experiences.

Interviewer: Okay. What are your opinions about someone who goes to see a behavioral health professional and that would include a counselor, psychologist or psychiatrists?

Interviewee: I mean if they need the help they deserve to have that and that's where people go to college to get psychological degrees to help people with mental health problems. I believe that if you are suffering from like a mental health disorder like PTSD, bipolar, schizophrenia I believe you should go get help and get the prescriptions or the medication or counseling or whatever you need to make yourself feel better to have and help with your disorder.

Interviewer: What about when services members seek treatments?

Interviewee: I know it's like a belief that like people like think less of them if they go see somebody I don't believe that. I believe that like in the same way if you have a mental health not everybody gets PTSD there is people who go to combat see combat and don't get PTSD. But if

you do I mean there is nothing, there is no shame or no there is no like law, there is no unwritten rule that says you can't go get mental health treatment if you need it.

Like there is no code of a soldier, there is nothing in the warrior's creed, the soldier's creed where you can't talk to somebody about things you see.

Interviewer: So you are saying that if as a service member if you need it you should go get it?

Interviewee: Yes.

Interviewer: Okay. So that kind of bridge to my next question, when will it be appropriate for anyone to see a behavioral health professional?

Interviewee: My best answer for that is whenever they feel that they're having mental issues like for instance if you go see combat and you are on a combat tour and then you come home and you are all fine then I believe you should go see a doctor once as soon as you come home or even if you are still in the combat zone; I believe should go see a doctor ones just to make sure you are all right.

And then after words if you start having mental problems or mental issues such as like having trouble sleeping, you hear loud things and you think you've been shoot at or something like that then I believe you should go see a doctor more than once. I know of like police officers and stuff like if you are in a fire fighting situation you are probably on medication leave and you have to go see like counselor, like a psychiatrist just to talk about the incident.

And then they clear you for duty and I think I don't know I can't really be sure if that's how the army does it. I don't think they have enough time to do that for that many people. But I believe that's something that should be done. As soon as they come back from the combat tour have them see a psychiatrist or if they're there and nothing is happening they're in like a safe area go see a psychiatrist even like combat fire fighting ideal and then go on from there.

Interviewer: All right. So when is it not appropriate for someone to see a mental health professional?

Interviewee: I'm thinking it's ever not appropriate. If you as an individual feel like you are suffering from a mental disorder then you should go see a psychiatrists or someone like that. It's basically what you believe as an individual. Now if you have been diagnosed with PTSD and you failed to go see a psychiatrists you are wrong because they'll help you. But if you as an individual may be you haven't been diagnosed and you want to go talk to somebody because you feel like you are having hard time sleeping or something because of something that happened, then I feel like you should go see psychiatrists because they're to help you. They may not diagnose you with something but they're still they to help you with your train your thought and help you with whatever mental issue that you are having.

Interviewer: So you kind of answered the question of when is it appropriate not appropriate for a service member, when is it appropriate or not appropriate for a civilian too seek treatment?

Interviewee: That's around like the same way not so much the same way for when is it appropriate because if you are being diagnosed with something like you had a mental breakdown in your work place, your job then it's appropriate to go see a psychologists or if you're having troubles with your marriage or something like that then it's appropriate to go see.

If you ever feel like you are mental issue then it's appropriate. As far as being not appropriate it's whatever you feel; there is never a non appropriate time to go see a mental health physician.

Interviewer: Okay. So really if you feel that this is something that you need to do then it's always okay?

Interviewee: Yes.

Interviewer: Okay, for what issues would you personally go see a behavioral health professional current or future?

Interviewee: For what issues like mental issues? PTSD, bipolar, schizophrenia, social issues...

Interviewer: Could you describe the social issues?

Interviewee: Just like not so much introvertedness but like a lack of ability to be social with somebody like you are afraid like social contact. I don't know if that's like a thing or like not being able to be like social to people especially close people like family or something like that. That maybe something that you could go see a mental health personnel, like those are four that came the top of my head I know there is more, there is countless things.

Interviewer: But for personally if you were experiencing anything like that that's where you will go for?

Interviewee: Yeah.

Interviewer: Okay. For what issues should a service member go seek some else professional?

Interviewee: Any of the above just to me there is no real differences between like a service member and a civilian because I mean yeah as a service member you sometime do things, you see things that others that civilians normally wouldn't and a lot of things may stem, may contribute to where other mental health disorder that you would have that civilian wouldn't. But at the same time you as far as it goes like between like seeing a health professional about. There is like no, to me there is no like a certain member should go see this psychiatrists for a civilian does because different things affect people different ways. There is one person may have like their dog died and then okay so like this is an example I had a friend who was walking her dog in Gainesville and her got attacked by this pit-bull and the pit-bull attacked the dog killed the dog and like attacked her like bit her arm and stuff.

And so like that caused big traumatic like episode for her and so like now she like she'll go see counselor now because it like it left a physiological scar. And she was telling me the other day how she talks this former service member who in Iraq and he's struggling with PTSD and so they talk and they have consoling sessions. They like console each other and like keep each other up.

That's to me like the perfect example of how no matter the situation a civilian and a service member, well different circumstances led to around the same psychological disorder they both require the same treatment and therefore there is no real difference in a service member getting treatment for something and a civilian you can't treat for the same thing. There is no like underline this person should get it before this person.

Interviewer: So for you no matter what they still have the same diagnosis even if it started differently?

Interviewee: Yes.

Interviewer: Okay, are there any other things that you would add to the questions that I have asked you anything that you might want to mention about your beliefs about mental health any?

Interviewee: No, I guess I said all that I thought.

(Interview completed 4/24/14)

Interviewer: Thank you for agreeing to participate in this study the purpose of this is to find out your beliefs about behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews both myself and the observer may make notes during the interview which would be used in data analysis.

Before we begin I would like to talk to you about inform consent. Within our inform consent someone will explain this research study to you which is what I'm doing now it is we are just going to ask you several interview questions about your thoughts on behavioral health and mental health. The research study is something you are volunteering for so you are not being compelled to do so. Also I have to reiterate that participating in this interview is not contingent on getting final exam credit in Major [0:00:50.4] class.

Whether or not you take part is up to you, you can choose not to take part in the research study so if at any time you feel that you don't want your answers used in the data analysis, you can contact me and have your results pulled from the study. You can feel free to ask any questions while you are reading the inform consent and at the end of the completion of the interview process today you'll get a 20 dollar gift certificate. So here is the copy of the inform consent please go over that and if you agree to participate just simply say I agree to participate in the study.

Interviewee: Okay.

Interviewer: Thank you to begin I'm going to ask you a few questions for demographic purposes. These aren't any identifying questions but we just want to get a more complete picture of you as an ROTC student. What is your age?

Interviewee: 21.

Interviewer: And your academic level, fresh man, sophomore?

Interviewee: Junior.

Interviewer: Okay junior and you are in MS1 or MS2?

Interviewee: MS2.

Interviewer: Okay and you've got a rank?

Interviewee: No. not right now.

Interviewer: Okay and what do you describe your home town as urban, suburban or rural?

Interviewee: Suburb.

Interviewer: And your ethnicity?

Interviewee: Hispanic, I was born here so gender ooh sorry.

Interviewer: Thank you, so now we'll begin the actual questions.

Interviewee: Alright.

Interviewer: Please describe to me what kind of person joins the army.

Interviewee: Someone who is dedicated and has a goal in mind and is looking forward to working with a group of people as a team and looking forward to a mission.

Interviewer: Okay can you describe that for me please.

Interviewee: Working as a group to achieve a specific goal.

Interviewer: Okay and what will those goals look like?

Interviewee: Something that is very tedious and very important to the government of course so.

Interviewer: To go along with that could you tell me what kind of a person joins the ROTC?

Interviewee: Someone who is very motivated to do so and likes physical fitness because it is a lot of physical fitness and just someone who is dedicated in general.

Interviewer: Okay so you said dedicated in general...

Interviewee: And just physical fitness, motivated yeah.

Interviewer: Okay so it's the three that come up to your head off the top? What comes to mind when you hear the term behavioral health?

Interviewee: Behavioral health just the way someone takes care of himself, health wise, the way they, the meals they eat and yeah that physical fitness is very important for now so.

Interviewer: Okay what about when you hear the term mental health?

Interviewee: Mineral health?

Interviewer: Mental health.

Interviewee: Mental health, mental health is I would say just being stable like mentally stable, not getting frustrated, practicing that skill to not get too frustrated with something.

Interviewer: So for you mental health is about keeping an even keel and not getting stressed out?

Interviewee: Yes.

Interviewer: Okay could you go more into detail for me to describe what mental health kind of looks like mentally healthy person?

Interviewee: Just someone who is not, inclined into doing drugs or inclined to go on to like party a lot just focused on what they want to do and just basically like if there is something that frustrates them like there is a family issue they just kind of look past it.

Interviewer: What happens to you when you encounter someone with behavioral health issues?

Interviewee: Repeat the question.

Interviewer: What happens to you when you encounter someone with behavioral health issue?

Interviewee: I just kind of go along with it.

Interviewer: Okay.

Interviewee: Like if there is something that is bothering them I try to just to go with it and try to see what the problem is and may be help them out if I could.

Interviewer: Can you give me an example of sometime that may have happened?

Interviewee: I'm not really like I try to stay away from drama but I guess it is just. I guess my friend one time he was just telling me like okay there is a lot, he wasn't very good in school and like his family was just putting him down and like I was just like well listen you can't be looking at that stuff, you have to just don't worry about it. Just look at what makes you happy. I don't know if he took my advice of not but he is okay now yeah. I just gave him advice and I just told him like come on you just got up don't worry about that, small stuff like it is going to, you're probably going to get over and your family will get over it.

Interviewer: So you really just asked, you helped him kind of adjust and refocus on things that were important. Is there someone in your life who struggles with behavioral health and mental health issue?

Interviewee: No not like someone really close to me no.

Interviewer: What about the people that are not close to you?

Interviewee: Not really they don't struggle with just like my buddy that one time but it was like temporary thing.

Interviewer: And even that one friend you had that had issue how did that impact you?

Interviewee: It just kind of made me realize that if that was to happen to me it would be like I would just have like tell myself the same thing. It just made me realize that like you can get past it is not like permanent.

Interviewer: So it's something that can be dealt with?

Interviewee: Right.

Interviewer: Have you ever known any service members that struggle with the mental health or behavioral health issue?

Interviewee: No, not that I know yah my sister like she is actually going to the air force and she has introduced me to several people but I don't know them enough to...

Interviewer: And then they haven't shared anything with you?

Interviewee: No not exactly they have told me, well because actually introduced me to one of the people she had met and he was in the army back in the day like he is pretty.

He is an old guy now but he just basically was telling me that because like he had a lot of, like he was in the war zone and stuff so he was just basically like kind of telling us, yeah if you want to join the military branch go with the air force like in the army you get really frustrated like because they tell you to do something and even if you don't want to you kind of have to.

You don't really have a choice, you don't really get any vacations and so he was just like the air force treats you well. It gives you a lot of benefits, and they are just, and he was just like going down with that but he didn't tell me a lot more about his military experience.

Interviewer: So nothing specific about mental health issues just more about his stay.

Interviewee: Yeah he was just saying that it was frustrating because like I said he just didn't have a choice of anything he was just kind of and you mean that he liked it because he got a lot of benefits but at the same time I don't know like he was happy with it. You know what I'm saying but that was the main thing he said.

Interviewer: Okay have you opinions about behavioral health been influenced?

Interviewee: From what he said or just in general?

Interviewer: In general.

Interviewee: Yeah I mean like I think mental health is I mean to like not be worried about it or anything like I never thought about it but like throughout the years like mental health is very important in being able to achieve your goals and stuff like you can't get frustrated, you can't be mad at yourself, if you are mad at yourself or you re not happy with what is going on, you are not going to be able to get much further and you are going to want to quit is that so. You just

have to keep that mentality; you've got to look forward to the main goal and just get there as quick as possible.

Interviewer: Could you talk to me about how that concept developed for you because it seems you kind of have an idea about it but where did those kinds of ideas come from?

Interviewee: Yeah basically after high school, in high school I was actually trying to get a scholarship in volleyball I'm tall so the coach is like yeah come on and play try to get into a scholarship. It ended up not happening and I really didn't know how I was going to pay for college and whatnot so the military is very, they help you a lot with scholarships and stuff so I decided to join because of that reason but I honestly like after because you have to wake up really early like at 5 in the morning and like go and run for like an hour and a half.

So doing that like every week you just get to a point where it is like okay you are more mentally stable like you just you are motivated to get to that. Every week you just get more motivated because they are paying for your school and stuff and yes that is the motivation factor. So that is how I developed that idea of mental health.

Interviewer: You get through motivation.

Interviewee: Yeah through motivation.

Interviewer: Have your experiences as an ROTC student influenced behavior about, your opinions about behavioral health?

Interviewee: Yeah I mean you always here in ROTC you always have to be professional so and it helps you keep your head up it is not like and you've got to be aware of things and so that and physical training helped me see them like the health factor like the mental health factor and all that.

Interviewer: Could you go into detail about that?

Interviewee: Not exactly all I can say is just training, the training they gave us, it is not like really hard it is not hard training but it is kind of like sets your mind to say okay I'm going to be better off I'm going to achieve my goal by learning this so.

Interviewer: Because I was just a little confused you started you said that there is a link between the physical training that they have you doing and mental health benefits. Could you explain that link for me?

Interviewee: Mental health benefits, I guess it is just kind of links because physical training kind of they are always like you are like okay, you've got to keep going, you've got to keep going you can't stop so I mean I guess it helps you so like if you ever encounter like another obstacle in life it is not going to put you down because you are already mentally, you have gone through that stage where it has been more brutal.

Interviewer: Okay.

Interviewee: And then the future events that happen to you and if they are harder by any chance then you could say okay I did that then maybe I can do this and then it helps you deal with future obstacles. Physical training is hard so yeah I would say that's the link between that.

Interviewer: Okay thank you. What messages about I just asked that sorry. Was your idea of behavioral health different before joining the ROTC?

Interviewee: Yeah like I said I just kind of, I didn't have much of motivation. Mental health was like I just played volleyball it was like nothing but after doing the program and doing things I just I don't know I was just I was just more mentally, like my mental health was just more up there.

Interviewer: You became more aware of it?

Interviewee: Right yeah.

Interviewer: What messages about behavioral health have you received as an ROTC student?

Interviewee: Benefits I guess just being a cadet kind of it is not an extreme obstacle but it helps me like be mentally like in my health my mental health it helps me like be a lot quicker with thinking with things and like I don't know. Yeah I don't have much to say about that question but.

Interviewer: Okay.

Interviewee: I guess it just helps me in general like I'm always able to do things that I would not be able to do a few years back.

Interviewer: So you definitely noticed your own growth?

Interviewee: Right yeah a lot more mature, and a lot more physically fit like mentally fit. Yeah it's helped me quite a bit.

Interviewer: Can you remember any specific examples of how the ROTC has influenced that growth?

Interviewee: Yes sure like just being around cadre, it is very you can't like, you have to be very professional say good morning ma'am? Good morning sir? Always like if you have to report in to the office, there is like a certain procedure to it. You have to run like usually when you wear your uniforms they have to be perfect so it is kind of like it makes you very mature. It makes you realize okay this is what the real world is; it helps you realize a lot of things.

Interviewer: So those expectations?

Interviewee: Yeah.

Interviewer: That is what it sounds like.

Interviewee: Yeah the expectations, they expect you to be very outgoing all the time you can't do this. It is kind of like a competition in a way. You kind of have to be superior to everyone else because you are trying to get best position available. A go active duty so.

Interviewer: I'm sorry say it again.

Interviewee: If you try to go active duty, you want to impress cadre or whoever it is so you always have to be professional and that helps you like that helped me mature and become the person I am today so.

Interviewer: Okay.

Interviewee: Yeah.

Interviewer: Alright what are your opinions about someone who goes to see her behavioral health professional whether that be a counselor, physiologist or psychiatrist?

Interviewee: I mean it is what it is like if you have a mental issue then the way to go is something like if you don't really know how to deal with it and you need to go to a professional person to help you with that, you do that I mean it is not a big deal. I mean it is what it is I honestly like never had something that put me down to like as much to like go to a professional for help but yeah I mean it is not that I don't think much of it, it is what it is some people need it.

Interviewer: So what are your opinions about a service member who goes to seek that type of treatment?

Interviewee: I mean that is kind of I mean is it related to like war scenarios may be they have like a psychological problem?

Interviewer: Anything.

Interviewee: Okay, if that is the reason then it was their choice to go to the military and they should have known that that was, it is going to be what they had to go through and why they had to do so. In a way like if they go a specialist for that, for their mental issue then it is their fault they got into that so now they have get themselves out. Like became mentally stable again like themselves so and with help it is fine I'm not saying they shouldn't. So it is that what I think of it.

Interviewer: Okay so what do you mean by get themselves out of it?

Interviewee: So like I guess they keep their health by doing it but it is mentally up to them and feel like.

Interviewer: Okay.

Interviewee: Because they got themselves into it and they shouldn't blame anyone else but themselves. They can't be like okay the military did this to me. It is ultimately their, it was their decision to join so.

Interviewer: And as it's their decision to join I guess any consequences that come from that?

Interviewee: Yeah so they should expect consequences from that if they decide to join.

Interviewer: Yes.

Interviewee: The consequences obviously might be psychological or physical damage it just depends so but they should know that they should know. That is what I think of it.

Interviewer: Okay my next question for what issues can occur in future can you personally go see a behavioral professional?

Interviewee: Me personally I would go like if there was something that really put me down may be like a family issue, like I'm really close to my family so if anything wants to happen may be even when I join the military. I'm going to be doing something related with IT so I will probably not be too. I know I will not be in the war scenario probably but if I'm and something was to happen to me like mentally, psychologically then that is probably what I will do I will do to a specialist like I won't be ashamed of it.

Interviewer: Okay.

Interviewee: And or just like I said a family issue that might get my get my head straight. The primary resource for me would be like friends they are like close friends but if obviously nothing is working then I will go to a professional.

Interviewer: You said for the military side kind of if there was a war zone issue you would go for. But on the other side is a family issue. Can you give me an example of the family issue that might make you seek treatment?

Interviewee: If you know like some family member was to pass away if someone was to die it would be like devastating because it is never easy so I feel like that might be one of the reasons I would be really upset and mad at myself, maybe I could do this, I should've done that so that is a reason.

Interviewer: Okay anything else you can think of?

Interviewee: No not really two things.

Interviewer: So my next question, for what issues current or future could a service member to go and seek treatment?

Interviewee: Just like I guess may be a lot of demand in the war zone. If they are surrounded by guns firing all the time or anything and then maybe if their friend got shot or best friend gets shot then it is very, they get very upset and might want to drop the army or whoever they are. They might want to drop the program but that is probably when they would want to go to like a specialist.

Interviewer: So if they see something devastating?

Interviewee: Right.

Interviewer: Can you think of any other examples or any times when they may?

Interviewee: You mean like a war scenario?

Interviewer: Either any scenario either war scenario or outside.

Interviewee: I don't know, I mean family and like your profession is like the most important things in my opinion, now if like you are married and something happens to your loved one then it is different and you are obviously going to want to talk to someone about it or get help.

Interviewer: Okay.

Interviewee: I can't think of anything else.

Interviewer: Do you have any other things you wanted to add or any questions I did not ask about your opinions on the mental health, behavioral health?

Interviewee: No I don't know I can't think of anything.

Interviewer: Okay so at this point we are going to conclude the interview today is the 30th of April.

(Interview completed 4/30/14)

Interviewer: Thank you for agreeing to participate in this study the purpose of this is to find out your beliefs about behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews both myself and the observer may take notes during the interview which would be used in data analysis.

Before we begin I would like to talk to you about inform consent. Within this consent you are basically agreeing to take part in the study. I'm explaining the research to you; we're just going to ask you a few interview questions about your thoughts on behavioral health and mental health. You are volunteering for this study and this is what the understanding that the participation in the study is not contingent on a grade in Major [0:00:42.4] class, that it's completely your choice to be here?

Interviewee: You said there was a [Inaudible]...?

Interviewer: There will be a 20 dollar incentive upon completion of the interview. You should take part in the study only because you want to and you can choose not to take part in the study as well. So if you decided at anytime that you don't want your answers used in the data analysis process, you can contact me using the information that's on this inform consent and will have your results pulled.

Feel free to ask any question before you decide. I'm going to give you the inform consent to read over and if you agree to participate in the study just state for the record I agree to participate.

Interviewee: I agree to participate.

Interviewer: At the end of reading the inform consent.

Interviewee: Right.

Interviewer: So if you can agree please state I agree to participate in the study.

Interviewee: I agree to participate in the study.

Interviewer: Alright thank you, to begin I'm going to ask you a few questions for demographic purposes. We are not asking any identifying questions we just like to get to know more about you as a student and get a complete picture of the person we'll be interviewing. To start what is your age?

Interviewee: I'm 20.

Interviewer: And your academic level?

Interviewee: I'm finishing my sophomore year right now

Interviewer: And you are in MS1 MS2?

Interviewee: I'm in MS2.

Interviewer: Okay do you have a rank?

Interviewee: No.

Interviewer: Would you describe your home town as urban, suburban or rural?

Interviewee: Suburban.

Interviewer: Okay and your ethnicity?

Interviewee: Well my mum is black my dad is Italian.

Interviewer: Okay and your gender?

Interviewee: Male.

Interviewer: Alright thank you. First question could you describe what kind of person joins the army?

Interviewee: Is this ROTC, enlisted or either?

Interviewer: Enlisted.

Interviewee: I think usually rural people usually out of high school if it's enlisted.

Interviewer: Any other descriptive?

Interviewee: Usually kind of redneck type of stuff usually, I don't know this is my opinion.

Interviewer: Okay, to ask the flip side of that same question you asked, what kind of person joins the ROTC?

Interviewee: It is kind of the same but usually people who are trying to find opportunities like if they couldn't pay for college or just to say they think they are all fitting criminal justice, they want to end up being detectives or something later on, they think it would be good experience.

Interviewer: Okay any other characteristic you can think of in the either side?

Interviewee: Yes I guess most people think of their violence.

Interviewer: They are what?

Interviewee: Violent natured people.

Interviewer: How so?

Interviewee: Usually it's the same type of person that is willing to go over and fight or kill someone for paying their country.

Interviewer: Okay so the person that you are describing has more of a violent lean?

Interviewee: Yes.

Interviewer: Okay anything else for this question that you can think of any other descriptive or characteristics for army or ROTC.

Interviewee: No, none at all.

Interviewer: Okay what comes to mind when you hear the term behavioral health?

Interviewee: Behavioral health, you said health?

Interviewer: Yes.

Interviewee: It is just your mental mind state of being sane, being happy not being depressed something like that.

Interviewer: What about when you hear the term mental health?

Interviewee: Mental health close to the same, I guess behavior is more like how you act with others mental is just being how you view yourself; it's like being sane or something.

Interviewer: Okay could you go into more detail about that? You said how you view yourself on being insane or how does that look like?

Interviewee: I guess mental health it's be harder for other people to tell but affects you a lot on how you do everything, you carry out your life just that takes me a little while to think sometimes.

Interviewer: Just go on.

Interviewee: I guess just having like a logical thought process and being able to control your emotions.

Interviewer: Alright, I am going to ask you one question on that could describe a logical thought process.

Interviewee: Just making decisions that benefit you either in the short run or long run and just taking away bad stuff that you can possibly do just focusing on what is going to help you progress and...

Interviewer: Okay on the flip side you also mentioned emotional control. What does it look like when someone has emotional control?

Interviewee: I'd say that it'll be common not be able to stay in the emotional state longer until like going from emotion to emotion.

Interviewer: Okay.

Interviewee: And may be ask themselves why they feel this way before they act upon it.

Interviewer: So some level of introspection?

Interviewee: Yes.

Interviewer: Okay next question is there someone in your life who struggles with the behavioral health issue or mental health issue?

Interviewee: That's my sister probably because my parents divorced and she had a little bit of therapy but she didn't get it not that she needed to and she's been dealing with it hard she dropped out of high school something like that. She is two years younger than me.

Interviewer: Okay and what did the whole process look like?

Interviewee: She'd get very angry, she'd break stuff she broke her laptop once. She is just anything could just set her off and she chooses to go into a fit of raging. She won't even pay attention to what she was doing just felling stuff and attacking...

Interviewer: So one moment she is fine and the next...

Interviewee: It will just set her off like a fuse or a bomb or something.

Interviewer: Did you ever kind of eventually know what would set her off and what wouldn't?

Interviewee: Yes and no sometimes it would be hard to tell like, it'd be like I'm certain that this would set her off or not so there is a lot of that. I'd know like the general things that could annoy her.

Interviewer: Alright and how has this, how has that experience impacted you?

Interviewee: I guess something from that to take away, whenever I feel upset and I try just to think why have I'm upset and go on it from there and think like is this more me or the other person? Am I just in a bad mood or something like that?

Interviewer: Okay.

Interviewee: And just to ask myself questions before I react was just I feel like if you are unstable then you won't do that, you'll just be compulsive and do what you are going to do first and then take it out of that later.

Interviewer: So you are saying it has caused you to think a little more?

Interviewee: Yes.

Interviewer: Could you describe more of that process when you are thinking?

Interviewee: Like I said this is where I think why I feel this way and also think what would happen if I do something or the repercussions. What should I do instead maybe I just I don't like where I'm and I should just leave that place and have sometime to relax and just cool down.

Interviewer: Could you give me an example of when you wanted to kind of use this tactics?

Interviewee: One I have 3 different roommates and we are not always going to agree on everything but I'm still could be living with these people. I signed a year lease it is best not to argue with them because that is just going to make it worst in the long run and that is just that. I know as time goes I will be upset from something else and I will be stressed because I have a bunch of tests coming up and it won't actually be them that's bothering me it would be the other things but I will be upset with them just because they will set me off, so this is something that you'll probably always say but it won't bother me.

Interviewer: So really not bringing one situation into another?

Interviewee: Yes.

Interviewer: Okay have you ever known any service members that struggle with the mental health or behavior health issue?

Interviewee: I don't have any service members in my family.

Interviewer: Okay.

Interviewee: I had a grandparent but I didn't really, he died when I was young so I didn't talk to them that much. My cousin she did it, but she was a vet and she didn't bring back any of that stuff she was pretty fine and I don't think she saw anything like that. She just worked on animals.

Interviewer: So any other friends or any other people you may have had about from stories?

Interviewee: No not really.

Interviewer: Okay have your opinions about the behavioral health been influenced by anything?

Interviewee: I guess just my family and my sister and maybe with my mum too.

Interviewer: You said your family, your sister, your mum; you didn't mention your mum earlier? What messages or what did you get from your mother?

Interviewee: Just how people handle situations differently, when my parents split up she took it harder because my dad was the one that ended it.

Interviewer: Yes.

Interviewee: And she drunk a lot, she then got like a DUI and it was pretty bad and she just kind of shut down, we'll she's gotten better from that but it's just, my whole family is [0:11:29.7].

Interviewer: I'm sorry say it again.

Interviewee: My whole family is getting therapy at one point just to...

Interviewer: Your family meaning who?

Interviewee: Me, my dad a little bit, my mum and my sister.

Interviewer: So your whole immediate family is what you meant.

Interviewee: Yes.

Interviewer: Could you tell more about like what happened during that time with everybody in therapy?

Interviewee: I'm not sure, it wasn't together which might have helped a little more I feel like but...

Interviewer: Alright.

Interviewee: I don't feel like I was bothered with it as my sister and my mom and I don't think my dad put much thought into it at all, he kind of did like a thing and then left, he was done with it.

Interviewer: Okay have your experiences as an ROTC student influenced your opinions about behavioral health?

Interviewee: Can you repeat that.

Interviewer: Have your experiences as an ROTC student influenced your opinions about behavioral health?

Interviewee: Not much as I thought I would do when I started it. There are people, there is hot heads, there is everything you would expect really.

Interviewer: Okay so what else did you expect or you just said hot heads and what else?

Interviewee: I'm not sure, I guess it's a little different because what ends up happening a lot is, a lot of people that are around my age 18 19 20 and they are immediately given like a powerful position where they can tell other I other people what to do and people have to respect that. I mean a lot more are going to with them and they can actually [inaudible] because they finally have the power and now they get take advantage of it because they have been, they've been in my situation where people above have been doing the same thing and now it is their chance to be the boss for a day.

Interviewer: Okay so they are kind of get that first taste and then...

Interviewee: And people handle it differently some people they are more relaxed and fine with it, they are just like okay and other people are like this is my time to shine everyone else below me is shit bags and things like that

Interviewer: Other people will handle it well and they kind of more relaxed about it than other people are kind hold it with an iron fist?

Interviewee: Okay.

Interviewer: What messages about behavioral health have you received as an ROTC student?

Interviewee: Like from classes or?

Interviewer: Anything but since you started with classes lets go with that.

Interviewee: We had something I believe, we have all the stuff like don't commit suicide, watch our for people that are displaying signs, besides that usually there is, if they had to keep you, figure out how to deal with stress, and I know there is some class about that in the first year but that was a while. And they usually say, try to keep your stress down, eat healthy and get good sleep and you should be fine.

Interviewer: Okay and you were about to say something else, you ask about class and then you said ooh what else. What other messages have you gotten as an ROTC student outside of the class?

Interviewee: I'm not sure actually not much outside of class, not that I have dealt with at least.

Interviewer: So no I guess no anecdotes, nobody else speaking nothing from commanding officers or anything of that nature.

Interviewee: No.

Interviewer: Okay.

Interviewee: I think we've watched some videos and maybe a little bit on like PTSD and post traumatic stress. No usually we don't really learn much about that that. I guess at least because usually we just focus on the stuff for CLC or we just do our land nav and we do our running, our, what would that be called, our lanes, and that's about it.

Interviewer: Okay was your idea of behavioral health different before joining ROTC?

Interviewee: Not really.

Interviewer: So pretty much stayed the same from before now?

Interviewee: Pretty much not too many key changes.

Interviewer: Okay what are your opinions about someone who goes to see a behavioral health professional and that includes the counselors, psychologists or psychiatrist?

Interviewee: Just like before I would say you have to have something wrong with you to go. My whole family has gone so I guess there is something wrong with all of us. If you need help it is like you should go it is like you being sick you shouldn't just feel like I don't go to the doctor people will think I'm sick but that is fine it's the only way to get better is to actually go, it's the best because you need something like that.

Interviewer: So what is your sign is you know something is wrong you will take of it, okay.

Interviewee: A lot of the stuff isn't going to get better by itself.

Interviewer: And what stuff isn't going to get better?

Interviewee: I feel like people have like depression issues, anxiety loneliness because that is something, all of those things you need, to get over mental stuff you actually have to talk to someone, you can't just be on your own or just by yourself the whole time. And usually if you have problems like then you probably don't have too many people around you that you can't talk to and so I think you just keep spiraling down, you keep getting worse and worse like if you had a disease or something, especially the mental disease.

Interviewer: Mental disease?

Interviewee: Yes.

Interviewer: What will be appropriate sorry one more question what is your opinions about services member who goes to seek treatment?

Interviewee: The same thing but I feel like it will be a little bit different this round. If you are in the army and you do have to carry out your duties, I don't feel like you wouldn't want to be fighting with someone who has the mental problems, especially when people's lives are at

stake... I feel like there has been a lot of stuff they are just people, it's just a bad combination to have mentally unfit people with guns and live ammunition. And I that you should definitely get help before you, you shouldn't just let it sit because I feel like it is only going to get worse. I think you should pretty much be sent home if you have mental problems because that's just a bad combination

Interviewer: Okay when would it be appropriate to see a behavioral health professional?

Interviewee: I feel like if you feel like something is wrong and you are not happy I think that is the biggest sign if you are not happy in your everyday life and you should talk to your friends about it. If nothing is helping then I think you should if you can't get help from friends and family I think you should seek a psychologist or therapist or something.

Interviewer: So really when you have exhausted all options kind of?

Interviewee: Yes.

Interviewer: When do you think it wouldn't be appropriate?

Interviewee: I think if it has just been bothering you for... I think everyone is going to have like been sad for a little while like breakup or something that. I feel like after a month or something then if you need help then you should definitely seek it. But I think if you just feel bad like a whim or something you should probably wait and see if it will pass by itself.

Interviewer: So for you it is more of a time thing. When would it be appropriate or not appropriate for a service member to seek treatment?

Interviewee: I'd say all the time, it has to be a lot shorter because like I said, you have people's life at stake, even if it is not you going insane or something just you not being right there in the moment where they need you to do something. So I feel like if you aren't feeling up it then you should get out immediately almost.

Interviewer: Okay so basically as soon as possible.

Interviewee: Yes.

Interviewer: For what issues current or future and you've not thought about beforehand, would personally go to see a behavioral health professional?

Interviewee: As just not including before but if I was unhappy for a long time over a month and I'd have to think something is wrong.

Interviewer: What about for service members what issues should they seek mental health professionals?

Interviewee: I think if they have problems like grieving like if they lost a friend or there are just problems at home and they just feel like because I feel like you need to talk especially when

you are on deployment you've just been gone for so long and not being able to help back home or do stuff. I think you need someone to talk to.

Interviewer: Can you think of anything else?

Interviewee: I just feel like it you might feel like trapped there almost if you have because you have because you don't really have an options once you become deployed, you feel like you just have to almost and I almost feel like if you get claustrophobic and you are supposed to be sucking that air in and you can't do anything about it and if you don't deal with it well you should get help immediately.

Interviewer: Okay can you think of anything else you might want to say about mental health, behavioral health are there any questions that I didn't ask or that you would like to put some input in?

Interviewee: No not really.

Interviewer: Okay.

(Interview completed 4/30/14) Interviewer: Thank you for agreeing to participate in the study. The purpose of this interview is to find out your believes on behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews. Both myself and the observer may make notes during the interview which should be used in the later data analysis. Before we begin I want to talk to you about the form consent.

Now with this consent you will be agreeing to participate in the study and with the understanding that it has no connection to major beings class, or this great incentive. You will however get a 20 dollar incentive after completing the interview. I'm explaining the study to you so basically I'm going to ask you a few questions on what you think about behavioral health and mental health, it's the interview style it will about an hour.

You are free to disengage from the study anytime so if you decide okay I won't do this anymore or I don't want my answers used your data will be pulled from the study and you won't be involved anymore. We may be conducting focus groups later so you will be may be asked a later date to sit with about three to five other people and just go through another interview just to get some more of the ideas.

If you could please read through the recipe in form consent and at the end if you could agree to participate just state for the record I agree to participate in the study. And as I remind you before you finish your identity will not be shared with anyone so no identifying information will be shared with the ROTC. The only people who will may know your identity is the research assistants, the researchers and my dissertation committee.

Interviewee: Okay I agree to participate in the study.

Interviewer: All right thank you and you get to keep that. To begin I'm going to ask you a few questions for demographic purposes as just to get a more well rounded understanding of you as a participant. What is your age?

Interviewee: 20.

Interviewer: And your academic level freshman, sophomore?

Interviewee: Sophomore.

Interviewer: You are in MS2?

Interviewee: Yes.

Interviewer: Current rank, do you have one?

Interviewee: No.

Interviewer: Would you describe your home town as urban suburban or rural?

Interviewee: My home town suburban.

Interviewer: And your ethnicity?

Interviewee: Black girl.

Interviewer: And gender?

Interviewee: Female.

Interviewer: All right, starting can you tell me what kind of person joins the army?

Interviewee: What kind of person? The type of people that I have interacted with are people who have no other choice pretty much but to join the army and actually they are usually very cynical about the army but because that was the only way out that is what they are joined.

Interviewer: Only way out of?

Interviewee: Like coming out of high school into their chosen carrier path that is the only way to get into the career, that is the only way to get out of being stuck out.

Interviewer: Okay and when would you interact with them on a regular basis.

Interviewee: I used to attend school in Colorado at the Air Force Academy and so I interacted with a lot of people on Fort Carson, a lot of people in the army so I would interact with them really much every weekend.

Interviewer: Okay and to ask you a companion question could you tell me what kind of person joins the ROTC?

Interviewee: Some one that wishes to still have their college experience but they know that they want to be committed to like the service in the government when they graduate.

Interviewer: Okay, anything else you can think of?

Interviewee: I would also say someone who is worried that their degree that they are going for in school wouldn't be enough to carry them all in the real world so they would have like only ROTC as a back up.

Interviewer: How so?

Interviewee: Like if you are usually engineers or IT, degree seeking people like usually those are easier jobs to find work. Nursing degrees and those type of carriers in medical field those are easier jobs to find when you graduate. But people let's say like physiology, anthropology, sociology those would be harder career fields to actually get started in. So you can fall back on the army just as a sort of get you in the door.

Interviewer: Okay. Can you think of any other characteristics of anyone that joins the ROTC.

Interviewee: Any other characteristics meaning what?

Interviewer: Any other words that come to mind to describe them.

Interviewee: I would say tough like they are usually people like they don't play around kind of, they are serious, I can't think of anymore words.

Interviewer: Okay, next question thank you, what comes to mind when you here the term behavioral health?

Interviewee: Somebody's mental state, how they tend to interact and behave out in like the real world, things like that.

Interviewer: Anything else?

Interviewee: Whether the state of their health is, like their behavioral health whether it's in jeopardy or something like that. Like somebody would say they are crazy and things like that.

Interviewer: And how does that look like?

Interviewee: What does crazy look like?

Interviewer: Yes.

Interviewee: Crazy looks like a lot of things [laughter] talking to yourself, not really interacting with people, doing things that aren't considered normal like dressing funny, talking funny acting funny and things like that.

Interviewer: As a follow up question what comes to your mind when you hear the term mental health?

Interviewee: Mental health?

Interviewer: Yes.

Interviewee: Somebody's mental state like their actual mental state I would say how they think, how they perceive things, just how things come together in their mind and how they choose to like choose to see it.

Interviewer: So their own personal perception of things?

Interviewee: Yeah their perception.

Interviewer: All right; anything else when you hear those two terms behavioral health, mental health?

Interviewee: No, not really.

Interviewer: Okay. What happens to you when you encounter someone with behavioral health issues?

Interviewee: What happens to me, usually I tend to try to take a step back and evaluate why they are behaving the way they are behaving and I try to see in what possible way I can interact with them without harming them or without harming myself.

Interviewer: Okay. Could you describe a situation where that happened or you may have had to do that?

Interviewee: Yeah, when I was in Colorado I had a friend who was acting crazy and I was like, it was just random like they would walk by my room just come in just start acting crazy. And like I'm not saying like playful crazy I mean like just crazy. Like I would sit right there in my chair and I would be like what is going on with them.

So I was in the air force so them being my wingman I had to sit there and work with them and try to figure out why it was they were acting this way and I went to my superiors and we got to sit down and try to figure this out and everything.

Interviewer: Okay and what was the resolution?

Interviewee: They were evaluated mentally, I was interviewed a couple of other people who were like, asked to speak and everything and they were actually asked to leave because they concluded that they weren't mentally fit to stay in the program.

Interviewer: All right, so you went through a process of really sitting back and observing, reporting it and then a follow up was that the person was discharged. Okay is there someone in your life who struggles with the behavioral health issue?

Interviewee: Yes it is a family member and they have schizophrenia and it directly impacted me one time because we were, somebody had just passed away so we were at the family's house for the wake. I was in the kitchen and she came into the kitchen and she looked right at me. And I was scared and I just stood there and then she mumbled under her breath, she threw up her hands and then she walked away.

And then I found out later on that she had schizophrenia, she hadn't been taken on medication and everything like that. And you know her mom had just passed away so she all those factors played into how she was acting.

Interviewer: Can you talk about your mind set during that time?

Interviewee: I was scared when I was younger so I was definitely scared, my mindset was just too stand back and not really do anything just kind of sit back and observe and see what they were going to do and then that was how I was going to react.

Interviewer: Okay, once again that act of observer kind of thing; anyone else that you can think of?

Interviewee: Anyone else not really.

Interviewer: Other in-service members that you know of who have had the behavioral issues?

Interviewee: I guess my friend he committed suicide, will that be considered a behavioral thing? My friend committed suicide and this is after I had left Colorado I was back here in Florida. He was up there at the air force academy and I got a call from my friend that night saying that Jim had committed suicide and I was like Jim, who what are you talking about.

So he overdosed on pills and apparently it was because at the academy there are a lot of factors that are thrown at you now for you to get through your day. Like you have to focus on them yet you have to focus on academics, you have to focus on sports, you have to focus on being physically fit and all those things. And he had academics down path and he had military down path because he was part enlisted but he could not get his physical part down at all then I guess that is just finally got to him and he snapped.

Interviewer: Okay, so he was having problems juggling all at...

Interviewee: Even when I was at the...because I was at the preparatory schools, even when I was at preparatory school that is how I really got to know him because I had problems with my PT and he had problems with his PT as well so we would be at each PT test and all those types of things and I know he definitely struggled with that.

Interviewer: Okay so you were a support for him and vice versa?

Interviewee: Yeah.

Interviewer: And can you tell me how that personally impacted you?

Interviewee: Gosh I was sad for weeks. It personally impacted me because I felt I knew what he was going through and I kind of felt guilty because I wasn't there to help him. Obviously I couldn't help him physically because I wasn't at the academy. But I felt like I should have made my presence more known for him to be able to come to me and talk to me.

I thought that is why we were as friends but I guess we weren't. So that definitely impacted me. It kind of made me a little bit more weary definitely not a support of the air force academy anymore at all because I just feel like there were a lot of people while I was out there that committed suicide. He wasn't the first one and he would definitely not be the last one. Okay so it was just it kind of made me have a negative new concept of the service as well too.

Interviewer: Which service? [Crosstalk] in general, okay. Can you tell me more about that atmosphere day you kind of mentioned in Colorado?

Interviewee: It is rough I had a friend who was raped and I heard there were a lot of people who committed suicide. The atmosphere is real, obviously it is structured because it is a military atmosphere but I would say it goes overboard. It is definitely hard to deal with and it can definitely break some people. I started off at the preparatory school. We started off with like, it was like 300 around there and by graduation it was only like 100 of us.

So just letting...that just shows you that it is like do you want to deal with this stress or do you not want to deal with this. Just military academics are roughly taking like 5, 6 classes and then on top there you have to be physically fit and on top of that your room has to be in inspection order then on top of that you have to have all these military knowledge.

When you are walking down the hallway there is somebody of a higher rank like you are considered a freshman, it would be the equivalent of a freshman but out there it is a 4th degree. You see someone that has a degree higher than you: 1st degree, 2nd degree, 3rd degree you have to be able to know their whole name, their whole title, information it is just a whole bunch of just I would say bullshit.

I feel like the main focus you are up there is to get an education and to be in military. You shouldn't have to mentally break somebody down about to rebuild them. Not through that process. I feel like there is better way to do it.

Interviewer: And just to clarify this was your high school experience?

Interviewee: No this was, I graduated high school, the air force academy is a college but they send you to preparatory school because the air force academy is a really rigorous school to get into. So they send you to the preparatory school if you are an athlete, if you are prior enlisted or if when your test scores reflected that you probably needed help in math or something like that.

Me personally my reading, my writing that was all good but math probably needed some help. So they send you into the preparatory school for 10 month program. You go through basic training you pretty much go through the same thing that you go through if you are at the actual academy, everything is on the same base. But you are just at preparatory school before you go to the academy.

Interviewer: Okay and then could you tell me about your transition here?

Interviewee: My transition was rough. So in May 2012 I decided to come here and it was rough transitioning. Up there at the academy everything is paid for you, you get paid, here I had to figure out how to rent an apartment, what I need to rent apartment I had to actually pick classes because out there all your classes...well at the preparatory school all my classes were picked pretty much chosen for me.

Here I had to learn how to, I had already written a resume but I had to rewrite my resume. I had to figure out how I can word it in order for me to get jobs because of that again I was already given the pay cheque. I was pretty much working in, working to go to school and here it's like it was just completely different the transition. It was hard but I adapted to it kind of easily but it was definitely hard.

Interviewer: What about the transition from Air force to Army?

Interviewee: Complete 360. At the air force academy I even did an air force ROTC here I was used to referring to anybody that was of a higher rank than me as sir or ma'am. And here in the army it's like don't call me sir. I'm a sergeant I work for a living. I was like I'm sorry. I was just trying to show you that respect I didn't know it was considered disrespect to refer to you that way.

And definitely with mannerisms in uniforms between army and air force, air force they are very strict about how you conduct yourself in your uniform. Army was a lot more laid back, they were carried and I was like completely blown away in air force I got in trouble for cursing during basic and all their stuff. So it was just it was complete, it was like wow like I really had to sit back and evaluate if I really want to be in the army because I was so used to being in the air force and it is like I switched to army, oh gosh.

Interviewer: What prompted this switch for you?

Interviewee: Problems with paper work coming from the air force academy and to air force ROTC, coming from one office program to another. So I just decided to make this switch to

army ROTC because air force ROTC it would have given me a lot of headaches and other things like that.

Interviewer: Okay, all right thank you that is a lot of information. Have you opinions about behavioral health being influenced by anything?

Interviewee: Definitely my experience in the military, you go to so many briefings and everything you find out about warning signs of suicide and depression and all these things. Before I had never dealt with anybody who had been depressed, anybody who had ever committed suicide and here I'm a couple of months into the service and someone is always depressed, somebody is experiencing post traumatic stress syndrome and then somebody commits suicide.

Interviewer: You said here?

Interviewee: Here, no I'm talking about the air force academy. It has just opened my eyes and it just made me aware to pay attention more, to help people act and everything just keeps my eyes open. Just pay attentions to those warning signs and it makes me want to definitely get closer to people and find out about them. So because I don't ever want anybody to feel alone like how is my friend Jim felt.

Interviewer: So you try and create more of an open connection?

Interviewee: Yes.

Interviewer: Can you tell me more about those signs?

Interviewee: The signs, geez, like the signs meaning when they are not because I know Jim he talked so much. So definitely when they just stop communicating with you, when you stop seeing them stopping by your room, when they don't really want to get involved in anything because up there we were restricted a lot of weekends so we had make our own fun on base

Like you don't want to interact with the barbeques or anything like that, when you don't want to go to the movie theatre or the bowling alley and stuff like that, it's not okay, what is going on? And then when they you ask them about it and they tend to not really want to talk about it and then when you physically see them struggling with physical PT and then sometimes that affects school work as well because your mind is so stuck on focusing on one thing you can focus on other things. So those are signs that I have noticed.

Interviewer: Can you think of any other cues or like information taken in that would have influenced your thoughts?

Interviewee: My thoughts on like behavioral? Well the stories that I have heard from my private listed friends because they have been in the air force for like a year 2 years already so they had stories to tell me and those were stories that I heard before I even actually witnessed it myself.

So those stories were they helped more aware I guess you could say. And then when I actually see it happen that is when I really took a step back, try to evaluate what was going on and then I came to conclusion and just I think that is it.

Interviewer: So really kind of hearing things buzzing around and then once the rubber met the road you were like, oh wow! This is real, okay. Have you experiences this as an ROTC student influenced your opinions about behavioral health?

Interviewee: Not really, I feel like everyone here, their state of well-being is a little bit more happier. Like that environment up there it is like okay I can't...okay my weekends aren't my own, I have to be on base, on weekday I have to be in bed by a certain time. Here I would say that people are a lot more, happier.

I'm more, happier because by the end of the day you get to go home, you get to your own room, you get to unwind and stuff like that. And every day up there it is like I'm going to my room and I had to do ACQ, that is academic time basically and then lights out by ten and I mean lights out by ten. I feel like I hadn't really witnessed anybody with severe behavior issues or anything that impacts their mental health here.

Interviewer: All right thank you. What messages about behavioral health have you received as an ROTC student?

Interviewee: Definitely taking care of in the air force, taking care of your wing man and then in army looking out for your battle buddy, making sure that you pay attention and you communicate with your peers. Or we just get some talking information or we get an e-mail hey read this or hey look out for this or passing down the chain of command to our leadership.

Leadership telling us hey if you know somebody struggling look out for them or if you know this pull them aside, help them out talk to them because we don't want any of those issues.

Interviewer: How frequently to those communications come?

Interviewee: I would say like every once in a while like a couple of times a month because it is not really formal but it is informal. Just hey this day with national suicide things like that it is just like look out for your wing man on the weekend and stuff like that when we get our safety briefings; just like little things like that...

Interviewer: And that is under air force and...

Interviewee: Air force and army side.

Interviewer: Okay so both of them kind of have that informal networks groups, formal and informal network...

Interviewee: Of communication and looking for the signs and everything like that.

Interviewer: Okay, was your idea of behavioral health different before joining the ROTC?

Interviewee: Yeah I guess you could say that.

Interviewer: How so?

Interviewee: Like honestly it is like okay I'm dealing with people committing suicide, people doing PTSD and then I get here and everyone was so happy, I was just like wow! I'm even happier. So it is just like my idea kind of shifted a little bit and that is how I came to conclusion that that environment out there was completely unnecessary and it was really severely impacting my peers.

And then I get here and I was so happy because you are going to college and you are only dealing with military part of your day or part of your week. So it kind of shifted because I was like wow everybody is happy I'm going to be happier.

Interviewer: Sorry.

Interviewee: That's okay.

Interviewer: So you've had a different experience because instead of coming straight out of high school to ROTC and college you are going to have to stop in between and then came here?

Interviewee: Definitely, like I got to see, I definitely got to witness how the military was first hand. I would get flack about oh you were in school, no I was in the military as well because I happen to be 214, I had to go through basic training, I had uniform and then definitely even on the weekends when I was like I'm not affiliated with the air force academy at all.

I was like this is my weekend I'm going to focus in hanging out with my friends. My aunt lived in Colorado, she retired from the army, her husband retired from the army and my cousins they lived up there, they lived in Germany and stuff like that. It is just like even when I started to separate from still addressing to the army because you know I'm hanging out with a lot of people in the army all weekends. Because Colorado Springs is a big army town so it is like everywhere you go someone is in military.

Interviewer: So you were constantly just surrounded by it?

Interviewee: Yeah so it was like I come here and it is completely different so I was definitely immersed in atmosphere up there and I come here it is just completely different.

Interviewer: Okay, what are your opinions about someone who goes to see a behavioral health professional be that a counselor, physiologist or a psychiatrist?

Interviewee: Before I guess you could say my opinion before I graduated high school my opinions would be like oh they are crazy. But now definitely I see a need for it. I think that

somebody who does that is brave and they definitely care about their mental state and their behavioral health and all that because it is like at least they are trying to talk to somebody. If you can't talk to me, if you can't talk to anybody else go talk to somebody.

So I definitely, I felt like there was a need for it so I think I'm completely an advocate for go ahead and do it because I wouldn't look at you mainly differently because I felt like I was on the wrong side to do it.

Interviewer: Could you talk about that time?

Interviewee: It was, I told you it was rough up there. So it was right before graduation and I was like I don't think I'm going to get an appointment to the academy and I was me personally I eat my feelings. Again I was skinny and then all of a sudden I gained all this weight. I couldn't fit my uniform anymore, I couldn't fit in my clothes anymore and then I realized that I would just be content just sit in my room watching TV on the computer.

Like I was just want, and I'm talking about, like I wanted to sit in the dark, like windows closed, door closed, head phones on lying in my bed or seating in my chair watching TV. And then my roommate she made an observation, she was like hey, are you okay and I really sat there and I thought about that and I said no I'm don't think I'm okay.

So before I had gone talk to somebody, my friends came down I have really good friends, we all talked and they got me out. They got me happy again they got me excited so that happened.

Interviewer: Okay so they kind of walked you through the issue.

Interviewee: Yeah and then I was engaged up there so my fiancée at the time we are not together anymore. He got me through it as well because he definitely could relate because he was in the army and he had been overseas and had been deployed so he knew what to say to me out of bed, funk and everything.

Interviewer: Okay and to continue with that question what are your opinions about service members who go seek a behavioral or a professional?

Interviewee: My opinions about service members, I feel like they care about their job first and foremost because they obviously you don't want your bread and butter, you don't want your career to be severely impacted when you start feeling a certain way and two they definitely care about how they feel. So I think service, that somebody that goes and see them they are just utilizing their resources.

It is there for them, they're utilizing it, it's a precaution. I mean you try to prevent something before it actually really starts happening or you see it happening. It is definitely responsible for them to go and see a professional about it.

Interviewer: So for you it is more of a preventive measure than anything?

Interviewee: Definitely, I mean even if it is a preventive measure or it is an early warning system. Like hey I see it happening in the beginning stages of it I will definitely go talk to somebody before it gets too far.

Interviewer: All right when will it be appropriate to see a behavioral professional?

Interviewee: I think it is appropriate me I like to prevent a lot of stuff. So my thing is I'll go and talk to him before I even see anything going on. I like to establish relationships with people or just for things in general .so I was like I would just go and stop by and hey can I get some more information? Can you talk to me in just, tell me what to look for so that is what I would do.

Interviewer: When will it not be appropriate?

Interviewee: I don't think it is ever not appropriate, like I will just go and say hey its Wednesday let me just go and talk to a physiologist. Even sometimes you just want to talk to somebody, so it is not necessarily I don't think it is ever not appropriate. When you just want to go and talk to somebody go talk to him. When somebody passes away in your family you need help dealing with grieve go talk to them.

When your friend commits suicide, when there is too much going on in your life and you need a way to handle to handle it go talk to somebody. So I don't think it is never, not appropriate.

Interviewer: Okay then to go along with that when could it be appropriate or inappropriate for service members to seek treatment?

Interviewee: The same thing. Go talk I mean specially when you are about to get deployed or you are about to change jurisdictions, you are about to move up in a rank that is more responsibility I don't think it is never not appropriate for them to go talk to somebody.

Interviewer: Okay, so you are completely open to basically any live situation that you need to go with...

Interviewee: Go talk to somebody, definitely.

Interviewer: For what issues current or future would you personally go see a behavioral professional?

Interviewee: Grief, dealing with the loss of someone in your family, and also if I were to get deployed, things like that because that is the whole another environment and you have to train a lot for that. And then that is a lot of added stress because you hear about all these hazards and all those things. So just trying and find a way to navigate through I will go and talk to somebody about that.

Even when I know when I have a lot of responsibility that I need to take care of I will go talk to somebody just so that I can get it out kind of like an outside party.

Interviewer: Okay for what issues do you think a service member should go seek treatment?

Interviewee: I would say before they get deployed, pretty much the same thing if they get deployed. I think when they have to get up and move, that is a big thing as well. Some people cannot handle change well and military change is everywhere. And I would also say when the military tends to make you angry kind of, when your superiors have you do things that is not your job description, or you have to stay extra after work, you have longer day or when PT test is coming up and you know you haven't been PT'ing like you should. So just like the day to day I would say.

Interviewer: Right, anything else you would like to add overall or any questions that I didn't ask that you might want to ask some important or any other statement you might want to make about mental health, behavioral health?

Interviewee: Not really.

Interviewer: All right so we will stop here.

(Interview completed 5/7/14)

Interviewer: Thank you for participating in this study. The purpose of this interview is to find about your beliefs about behavioral health, there will be another person in the room while we complete the interview to ensure consistence between the interviews. Both myself and the observer may make notes in the interview which will be used in data analysis before we begin I like to talk to you about consent. With the form consent what I am basically doing is explaining to you the study we are just looking for your views about behavioral health and mental health and what you know about it which you should think about others with behavioral issues and that sort of thing.

You can back out of the study any time so if you decide to do that your data won't be used in the study and it will be like you were never here, this is no way connected to major [0:00:48.9] great incentive for his class I have to clarify that every time pretty much however they will be a 20 dollar incentive or your participation at the end of this, there is contact information on there about the [IRB] committee and my information and my chairs information just in case you have any questions. You may be asked to participate in a focus group later on.

Sometimes when we analyze the data we have a couple of other questions that kind of answer so you maybe called to participate in a focus which will be 3 to 5 people and just kind of talking about some extra questions. So if you could read all the informed consent and after you read it state for the record I agree to participate in the study.

Interviewee: Okay, I agree to participate in the study.

Interviewer: So hold on to that it is yours to keep and to begin I am going to ask you a few questions about a few demographic questions just to get more of a well rounded understanding of who you are as a participant and that will be used in then data analysis process as well, can you tell me your age please?

Interviewee: 21.

Interviewer: And your academic level?

Interviewee: Junior going to senior year.

Interviewer: So you are MS1 or MS2?

Interviewee: I am MS2 going to MS3.

Interviewer: But technically you are a junior right now?

Interviewee: Correct.

Interviewer: You a junior going to senior year you said?

Interviewee: Yes.

Interviewer: Do you have a rank?

Interviewee: I am not sure I am a [cadet]right really, they don't really assign those in our battalion.

Interviewer: Would you describe your home town as urban, suburban or rural?

Interviewee: Sub urban.

Interviewer: And your ethnicity?

Interviewee: Polish.

Interviewer: Alright let's get started to begin can you tell me what kind of person joins the army?

Interviewee: Someone who is motivated, I guess they feel a strong sense of patriotism/motivation but there is a wide range of people who joined the army they are practically everyday people just stay got this drive to better.

Interviewer: Okay can you tell me more about the drive?

Interviewee: They want to be a part of something bigger than themselves, I guess it a good way to describe it they want to better the institution and themselves at the same time.

Interviewer: Okay anything else you can think of?

Interviewee: They want to help others I think that is about it.

Interviewer: That is fine, could you tell me what kind of person joins the ROTC?

Interviewee: I would say a lot of them are students who would have joined enlisted I feel like it is a lot of students who would have enlisted but they sort of go to college and ROTC is a good option because you become an officer when you graduate. So I feel that is a big motivator for people to join ROTC I guess they are prior enlisted who joined also because of get an officer rank after wards and they would have been doing it any ways as enlisted and get a degree at the same time.

Interviewer: Enlist and then come back is what you are saying?

Interviewee: Right like some people had prior enlisted and then when that is over they come to UCF and join ROTC program and came to UCF and joined ROTC program sort of what they looked up to they know more about being in the army.

Interviewer: So they kind of held it as a higher regard as an EA?

Interviewee: Yes.

Interviewer: Anything else you can think of?

Interviewee: A lot of people joined online ROTC program. Yes it is just good incentive, to get money that is a good motivator I suppose but...

Interviewer: My next question is what comes to mind when you hear the term behavioral health?

Interviewee: Normally I have behavioral health if someone is mentally stable then I guess for they don't have any, I don't want to say mental problems maybe like conditions and I guess just the study of behavioral conditions.

Interviewer: Can you talk some more about those conditions?

Interviewee: I can say you have say like PTSD or ADHD is the one I am thinking of or schizophrenia I guess that would also I am trying to remember my psych class, my intro to psych class so I guess just the study of how those conditions affect people or groups of individuals yes.

Interviewer: What comes to mind when you hear mental health?

Interviewee: Something it sounds pretty close to behavioral health, I guess behavioral will be how you would it is more focusing on your actions, so the mental health is focusing in the mental processes and behavioral might be how mental process affect your behavior I guess that is why.

Interviewer: That is fine anything else with that?

Interviewee: No [I think]

Interviewer: What happens to you when you encounter someone with behavioral issues?

Interviewee: It really depends on the situation I mean I don't try to bring up where like I try make it like even if it is negatively affecting the situation I don't really try to and like the person is being detrimental to the situation and make them know that kind of thing I might ask be like why are you acting like this...

Interviewer: Can you give me an example of the other situation you said you kind of you said in one instance you kind of bring it up and talk about it the other instance not so much.

Interviewee: If I bring it up and talk about it would probably be it would not be out of the blue just be like why is that person doing that why you are acting that way and be like hey man are you okay like then they would if I did bring it up they would tell me then but if I didn't it just because I decided I guess it wasn't affecting me as much so much that I needed to ask about it.

Interviewer: If it isn't like an issue you...

Interviewee: If it's not bothering me, probably not going to ask about it.

Interviewer: Can you tell me is there someone in your life who struggles with behavioral health issues?

Interviewee: No immediate family or friends that I know of.

Interviewer: What about any service members?

Interviewee: I don't know any specifically that talked about it but I am aware that service members like get PTSD is high among service members and no one seems to talk about it too much in ROTC environment I mean both my parents were navy they were retired but they have not really talked about anything like my dad flew planes so it doesn't get brought up really too much here.

Interviewer: Here as in ROTC?

Interviewee: Yes.

Interviewer: You did say it comes up now and then can you tell me about stories that you may have heard or?

Interviewee: Well I have only been in the program for a year so I am pretty sure like it will get mentioned every once in a while it will be like so in a story say that like sergeant Reyes would be like telling a story about when he had to talk to another soldier at some point in the past and they were having mental issues or yeah a lot more like stories.

Speaker: [Inaudible]

Interviewee: Stories about a cadet I remember one having suicidal thoughts and he called the cadet late at night and like talk to him like come to the office [crosstalk] I think that is biggest story I can remember.

Interviewer: Can you remember what you were talking about at the time?

Interviewee: In the class we had the presentation last semester about being army strong or something it was a power point I remember and there was a slide on mental health in that like talked about physical health and mental health and I think we had a little triangle diagram. So really to the fresh in my mind just about how physical mental spiritual health there was another point how all that converges in being army strong I believe was the term.

Interviewer: And that is really the only time you can remember?

Interviewee: That we really touched on it, compared to just throwing it around.

Interviewer: But either way...

Interviewee: The throwing it around parts are kind of vague were not too I guess important at the time or...

Interviewer: So this is the one time that you really just kind of focused on?

Interviewee: Right.

Interviewer: Thank you, have you opinions about behavioral health been influenced by anything?

Interviewee: An AP physc class in high school so I learned about them then, I just learnt more information which is always good to learn more about something to influence your opinion, but that was where I just I gained more knowledge on it, but at the time but I mean just aside from learning about it there is really nothing that is negatively positively influenced, being athletic I have done a lot of research on being athletic and how it makes you feel better over role and as I guess feel like running like having problems I can run them away so I guess I really feel like strong correlation between being athletic and not having behavioral issues or having affects negative slightly.

Interviewer: And where did you get the idea to start looking in that direction?

Interviewee: I have always been kind of athletic and research from reading magazines or articles on websites in regards to I will pick up an article and just read it so I have gotten general knowledge over that it is first hand as well like stressed out I go run like go to the gym feel great the whole day after wards.

Interviewer: Is that research stuff you sort out or things you open runners world and there it is...

Interviewee: Mix of both because being a smarter athlete is being a better athlete so I might as well read about them if they are there so like I will seek it out but also there just read it but I seek it out.

Interviewer: Have your experiences as an ROTC student influenced your opinion about behavioral health?

Interviewee: Well I made note that in the future I will need to do more research on post-traumatic stress disorder, since I will be an officer in the future I will have to I guess aware of my fellow soldiers and as well as an ROTC my fellow cadets and I know I will need to be aware it is not a big of a thing at the moment but like a path to knowing I need to be aware.

Interviewer: Can you tell me what brought that about?

Interviewee: Just general seeing articles about soldiers with PTSD/ I guess the comradery in ROTC between people and knowing that I guess is just really got a group there is a lot of group cohesion kind of thing and we need to work as a group and some general stuff I've seen in articles I have read that kind of popped out soldiers with PTSD and we have that one power point at that one time.

Interviewer: So in between the power point a lot of things that you also get are from your reading and just kind of....

Interviewee: Taking in knowledge I would say.

Interviewer: What messages about behavioral health have you received as an ROTC student?

Interviewee: That if we have any problems like something is bugging us like say for example that anonymous cadet who had suicidal thoughts or something they are always people there who are willing to talk to you about and they are places you can go to it is not in for that but it is like made it known like after that story and that's for anything you have like a problem with so and people are here for you so.

Interviewer: Who are this people?

Interviewee: The [cadre] will talk to you or our direct you to the right resources on campus or where ever it is needed and we all have their, we normally have like our cadre like in class and if they are a professor, we will have like their personal phone numbers I have sergeant Reyes's number and they like made it known that if you have any problems then we can point you in the right direction.

Interviewer: So they have really made themselves available and kind of been able to point you when you need to be just in case that has an issue?

Interviewee: Correct.

Interviewer: Was your idea of behavioral health different before joining the ROTC?

Interviewee: It pretty much stayed the same I just became more aware of well I felt like it was easier it would be easier say I was having a problem or fellow cadet was to find a way to get a resource to help with the cadre than it would be if I were not an ROTC say I think around campus there is not really I mean one area you can see like posters about anything happen any problems you can come in to counseling center, I think I saw a poster somewhere like that but I

mean it is not really put out there over here like hey come talk to us like any kind of problems I think you feel they are more resources available even though it is the same amount of resources.

Interviewer: So if you are a civilian student things are kind of there but as ROTC member you are kind of saying that you pointing towards them?

Interviewee: Right and it is like you have class twice a week and you are there PT three times a day so like people are going to pick up on that if you stop showing up they're gonna ask you about that and they check your grades are falling and ask you about that and then kind of like be on top of you I guess like on top of your routines kind of helps with if there is a problem it might be easier to identify or easier to be able to like I think I am having a problem can you help me out with this I feel like that is definitely not available to a civilian student.

Interviewer: That you have a lot of people watching over you so to speak?

Interviewee: Yes and just around you all the time and aware of how you feel.

Interviewer: Next question, what is your opinion if someone goes to see a behavioral health professional and that includes a counselor, psychologist or psychiatrist?

Interviewee: I think they are doing the right thing it is probably better than not going to see them if it's helping they should be doing it, if it is not I guess they should go running I mean it is going to point them in the right direction it is better than just wallowing in the corner and not getting help and not talking to anyone about it if it is like seriously affecting them and if it is not they can still if it is minorly affecting them it can still they can be good to help them manage it and it is pretty much think it is a good thing.

Interviewer: So what about service members go see a professional?

Interviewee: Same thing I think it is a good thing they need to go see one because it is not just your physical health that counts it is all connected. So like I injured my knee I went and saw a physical therapist, so it is all connected so you have sort of mental problem then you should go see some one for that to because it is going to be detrimental if you don't so it is a good thing.

Interviewer: Between the body and the mind you see it as one?

Interviewee: One system that if one is not working the other one is not going to work.

Interviewer: When will it be appropriate to see a behavioral health professional?

Interviewee: I guess like sometimes if someone is having some sort of behavioral issue they might not even notice themselves so I guess, it really depends on when it is noticed and then once it is noticed by maybe themselves or say their peers notice and tell them I guess especially once it becomes an issue with their daily lives like there routine or something of the sort it becomes detrimental and affects them in a negative way then they should go.

Interviewer: And when do you think it would not be appropriate?

Interviewee: If they don't notice it, they are not detrimental someone who has training in the field to notice it would notice it I feel like say telling them they had something but they didn't notice they had might be even worse than just if it is not really affecting them they don't feel like it is not detrimental they don't know that some one who has the ability to know if they have that I feel they can get in there head and it could become more detrimental and problem already was.

Interviewer: So then it is not a thing some body kind of puts it in there?

Interviewee: Right it was not there that for disorders is that book that post they make a copy of that will solve the disorders or they redo it the DSM something but normally you can't just buy that book I am pretty sure you have to like I have heard I seem to recall from my psychology class it was like they don't really put that book out there for too many people out there in the field to read because self-diagnose themselves it could end up worse for those people I feel like that sort of a parallel

Interviewer: Can you tell when it would or would not be appropriate for a service member to get help professionally?

Interviewee: Well we are supposed to get like counseled by our superiors give us counseling reports every once in a while about if they are checking on what we are doing like routines also they are supposed to pay attention to our behavioral, mental, physical health and gives us like a counseling report on it so it will be easier in that situation for a service member to pick up on if there is a problem because there is supposed to be a record of it all the time well on at least how they are doing in their job but I feel like it would be appropriate.

When there is a change say after they say home problems say like going through a divorce or something or I'd say death in the family or maybe they were deployed and something happened and wide number of things could make it appropriate for them to go I mean they are available I feel like they will be available within an army to go see someone to council them and it makes it easier feel like it will be appropriate when there is they see a change after some sort of traumatic life event whether it be at home or with an army and then they should go seek behavioral health.

Interviewer: For what issues and this is the kind of the same question for what issues current or future would you personally go see a behavioral health professional?

Interviewee: If I found any kind of change in my routine or motivation to go and I felt it was really affecting me to the point where I could not complete the tasks I needed to do and I would probably wait a good amount of time just to be sure to see what I could do I would probably wait at least a month or more maybe longer depending on if I felt I was making any progress myself but if it wasn't myself.

If felt like it wasn't just myself who was having it and my peers told me that they noticed something I would probably shorten that amount of time they told me [crosstalk] I kind of gauge myself.

Interviewer: And couple that with somebody else tell you what is wrong?

Interviewee: Right and then I will be like oh I guess I do need to go seek help I feel like if it is just in my mind, "that's just in my mind", and I am might be thinking I have a problem but when someone tells you it is definitely not in my mind I should probably go seek help.

Interviewer: Can you tell me for what issues current or future a service member can go see a behavioral health professional?

Interviewee: I guess this is same sort of events happening for me in their personal lives or the environment of being a service member then they should definitely go and see someone it is detrimental.

Interviewer: Anything else you can think of?

Interviewee: Repeat that question.

Interviewer: For what issues current or future a service member can go see a behavioral health professional?

Interviewee: I would think of once I don't remember if this was in class or I just watched it on YouTube there was an army video called shoulder to shoulder and it was about I remember there was a guy in there whose his wife, he was in Iraq or Afghanistan and his wife was saying she was going to leave him so he was all down and depressed and I guess he tried to shoot himself but his friend one of the other soldiers noticed what just happened.

He was acting really weird so he took the firing pin from his gun so it didn't work and the guy was there in the video talking about that experienced that happened that was really important to seek help. So I guess if you are feeling suicidal thoughts so that will be something that a service member should talk to someone about.

Interviewer: Now just to wrap up is there anything else that you can think of that you wanted to say about behavioral health and mental health any questions that I didn't ask or anything you want to ask or anything you want to add?

Interviewee: Not necessarily, not at the moment.

Interviewer: So we will stop here.

(Interview completed 5/9/14)

(Member Checking Participant 6)

Interviewer: Thank you for agreeing to participate in this study, the purpose of this interview is to find out your beliefs about behavioral health and that clarify some of the questions that we have. There will be another person in the room while we complete the interview to ensure consistency. Some of the observer might make notes during the interview which will be used in that analysis. Before we begin, I would like to talk you about consent.

Within this consent you will be giving your verbal permission to now participate in the study, you are allowed to withdraw at any time and if there is any time that you feel that you don't want your answers put into the study, you can ask us to revoke your data. There will be incentive today in the form of lunch and if there is any other questions on the consent my information is on there as well as my shared information. Please take a moment to read the informed consent and when you... if you agree please say I agree to participate in this study.

Interviewee: I agree to participate in this study.

Interviewer: Thank you very much, alright now we begin the interview. Thanks again for returning, the point of this is to just kind of get some clarification on some of the questions that we had. What I did was I gathered all of the data from the various interviews and I kind of put them all together, I saw what was consistent between the interview, saw the things that were different and based on what I saw I came up with a set of what is called themes. And themes are just like main ideas that kind of run through all the interview.

So one of the first things I wanted to talk about was, we...remember I asked you a question of what kind of person joins the army or the ROTC, with that I wanted to know about the factors that go into that and what I found was that there were things that were external that were like outside motivators and there were things that were internal that people did for themselves. And

one of the things as far as internal motivator was patriotism, could you talk some more about patriotism and how that really goes into somebody choosing to be in the army or the ROTC.

Interviewee: Oh yes, it's the patriotism is the love for one's country and love something you are willing to defend it and fight for it and to sacrifice yourself for or potentially sacrifice yourself for just the best of the common man is very, trying to describe this it's a tough thing to do and it's definitely not for everybody.

Interviewer: Okay, how so?

Interviewee: It's just a different way of thinking to put other people before you and especially it doesn't really happen that often, I don't even concern myself to do it to that extent so yeah.

Interviewer: Okay, so when you said that you don't even consign yourself towards it in that extent, patriotism isn't one of the things that really drew you to the ROTC?

Interviewee: No, I would say not.

Interviewer: Okay so what did draw you then?

Interviewee: Just, I guess career opportunities, when I joined there first I was having troubles thing with college and I also thought that later in the future I am also trying to get to a med school so it's be in my best interest especially if they're going to pay for both of us to join the army.

Interviewer: Okay, that makes sense.

Interviewee: And also helped me with the discipline because I was having trouble with that.

Interviewer: Could you talk me more about that?

Interviewee: Still at high school I was pretty lazy and coming to college age I didn't really have a strong foundation to just motivate myself to just study, even just to getting up to get to class before noon and so it helped a lot because then I said I am going to wake up at five or six

am or even earlier some times to start running and it just helped a lot of students before I did outside ROTC my very first semester I had about a two five overall which is pretty bad and then now after I have been in the program for a year and half almost two years I have about three eight cumulative so it has helped me out a lot.

Interviewer: So the GPA really jumped thanks at the ROTC.

Interviewee: Yeah, ever since I have been on the dean list, they are better every time.

Interviewer: So that kind of confirms another thing that I found on that education was a really big thing in ROTC in general and it gives you the opportunity to really explore some things, could you talk about the expectations that come with ROTC as far as the academics go?

Interviewee: Like what would they expect of us? I say they don't expect too much **they just want to see like around the three** once your contract is finished, once you have passed all your classes except for, if you are an engineer usually have a tough major they will give you a little bit of slack but they just want you to maintain that threeish GPA which isn't too difficult at all.

Interviewer: So that's basically what? Like a B average? Okay. So one of the things that I did hear and just more again for clarification was when it's time for commission that's really when GPA really does kind of start to make more sense as far as wanting to get that high GPA because if you have a higher GPA, you are more likely to be commissioned is that true?

Interviewee: I guess it depends what you going for, **if you want like one of the top ones like inventory or like military intelligence**, all those guys try really hard to make their SAS they want to have the perfect PT score, they want to have really high GPAs a lot of them are criminal justice majors and stuff like that so I guess its really competitive getting to those fields if you want to go active duty in those and try your chance to make a full career out of it.

Interviewer: Okay, so it really depends on which job you want after you get out.

Interviewee: Yeah, just what you want from army, what you want to do afterwards.

Interviewer: Okay so if you just want to get commissioned and go, the GPA doesn't really matter as much but if you want a higher rank or a higher... a harder field to get into you need a higher GPA.

Interviewee: I know some people that just want to go reserve afterwards so they are not really worried about that extent.

Interviewer: So there is different to it academic, because my understanding was once you were commissioned you were at the duty so you can be at the duty or reserve and be commissioned.

Interviewee: Pretty much it seems that what happens is that happens is the top people become active DOD and sometimes you go to one or two reserve but it is don't really have a need for all those lieutenants especially which we don't have any experience whatsoever. Wherever it is like a prior service outside of [0:07:21.8]

Interviewer: So I guess that ends up being an overflow.

Interviewee: Yes, exactly.

Interviewer: Got you. So one of the other things I found was a modicum of success where everybody who joins the ROTs, or the army they have a drive to be better than what they were.

Would you find that to be true?

Interviewee: Yes, it helps a lot just for motivation and discipline just like I said earlier, just the strong push forward.

Interviewer: Okay, now switching to extrinsic factors and extrinsic factors are the things that are kind of like outside of the... outside of people's control when it comes to their decisions. One

of the things that I found was that class was one of the factors where for some people the army was their only option and they couldn't do anything else. Did you find that to be true?

Interviewee: Yes, a lot of people they don't really have the option to pay for college by themselves so it was like the only option is ROTC wise even though they do offer if you don't wanna do army there is always loans and stuff like that.

Interviewer: So what does that mean then, is it more of a, this is that what I have to do because I can't do anything else or is it more of a I see this as something different to do.

Interviewee: I feel like they always have at least a couple of options and they look at them and they think that army is their best options out of the options that they have.

Interviewer: Okay, so out of all the other things they could be doing its just like oh army okay. Not bad.

Interviewee: It's just like hey I could either do this or I could have some debt and there is so much I want to do later on. You might not be comfortable with that.

Interviewer: Okay, and this is you are talking about ROTC now or?

Interviewee: Yes, ROTC. I guess when you get enlisted I feel like a lot of people maybe are a little unsure after high school so I feel like that's where a lot of people start to enlist after high school and also during my era there was JROTC so they kind have got used to the whole lifestyle throughout high school and a lot of them didn't want to go to college or get into college so they figure "well, I've been doing this my whole life, gonna go straight to enlisted. Even if they have family, they've kind of been pushed in that direction in their lives.

Interviewer: Okay, so for some people it was still a choice, it wasn't I couldn't get into college so let me do this, it was okay this is, I have had this influences before so now I might as well go

and head in. Diversity was something else that I found as far as there being a less stringent type of person that's in the ROTC is that true?

Interviewee: Define stringent.

Interviewer: Basically you have people that are in the ROTC who are not...they felt that they weren't on the same moral caliber or had the same capacity for leadership as some of the other people in the ROTC.

Interviewee: Sounds alright.

Interviewer: Okay.

Interviewee: Anything else? [Laughter] are you trying to ask me about the...

Interviewer: I am just trying to ask you are that true, is that something that you have observed?

Interviewee: Yeah, there is people that want to just be up in front they want to lead stuff and there's more are behind the scenes guy. They learn the stuff, they can help out but they are not really, gonna be calling everyone to attention they are not going to be loud or yelling at people. They have it in their head but they are just going to help around I guess that type of thing.

Interviewer: Okay so it could sound...and this is just me summarizing that there is kind of the alphas who want to be out there like definitely in the front, definitely being seen as a leader and then there is kind of the betas who have the leadership potential but don't necessarily want to be the one doing all the leading.

Interviewee: Yeah, that sounds correct

Interviewer: So that's a summary of what you just said? Alright I want to make sure. There is a lot that you can put on when you talk about this but I want to make sure it's the same, is closer to your own words as possible.

Interviewee: And I think that also is true with where they want to go with the army if some people like wanna be infantry that is going to be leading people or some of it is going to be almost like a desk job type of thing.

Interviewer: Can you explain that?

Interviewee: There is different courses I guess and if you are just going to do something where just like not out there fighting you don't really have to be the loudest guy around, you don't have to have that commanding military presence if you are not going to be doing something lets just say that's not even deployment type of stuff.

Interviewer: Okay, so they both have the capacity for leadership but that leadership changes depending on what type of job that they have.

Interviewee: In their situation yes.

Interviewer: Okay I get it now. So there is a difference.

Interviewee: But also I feel like there is a different person for these type of things too, a different person that wants to do those things.

Interviewer: So the person, just on encapsulating it

Interviewee: The person who would want to do like infantry would probably be an alpha as you described it.

Interviewer: So they both really have the potential for leadership but that leadership would show itself in different ways depending on what job they did.

Interviewee: I'd say they all have the potential but then an alpha probably have a better control of that and be better at it.

Interviewer: Okay, I get it now.

Interviewee: One of the things that I found in the very beginning when I was looking was where you get your knowledge on what behavioral and mental health is and one of the things that I found was that there was both formal/informal education when it comes to how you get your messages, did you find that to be true? Is there a different channel from where you get your info?

Interviewee: I mean you can just talk to cadets and that's kind of like informal way but in class they will have these classes where they will go over the type of things like that.

Interviewer: And what do they go over in those classes?

Interviewee: We had a class on suicide prevention the first year and we have one on just how to like deal with stress our first year, that's what we had.

Interviewer: So that was your first year and was this more than one class or?

Interviewee: This was about two classes. And usually there is like one class a semester.

Interviewer: So there is one class every semester where are you taught about this.

Interviewee: After the first year, during the first two semesters.

Interviewer: Okay, and then what about the second year?

Interviewee: Not as much on that at all really. The most is focusing on preparing to be year three so yeah, so lots of land nav and tactics and stuff like that.

Interviewer: Okay, do you feel that is enough?

Interviewee: For the mental aspects? I guess there are mostly guys in there especially since, I guess what we are doing they don't have... they have stress because they are like class work and stuff like that but its nothing that serious but if they were deployed just like us to actual scene, that probably wouldn't be enough but for now what they need is probably just fine.

Interviewer: Okay, I also found some things about contact with people with mental health; it would seem that the more you actually have been exposed to people who have mental health issues the more you know. Would you find that to be true?

Interviewee: Yes, it something that you have to experience first hand so they get a good feel about it.

Interviewer: Okay, could you talk more about that.

Interviewee: I would say just it's kind of hard to...unless you would know someone who is just like oh I why would they act like that and this is the best logical way to go through things but with that mental health they can't see that, it just overwhelms them.

Interviewer: Okay, and I don't remember everything from your interview, did you say that you knew people who had mental health issues or not?

Interviewee: I just got my mom and sister almost observing some metal health issues.

Interviewer: Okay, I remember now. I remember you said that it did kind of change your perspective about things do you think that your perspective would have been different if you didn't have that experience?

Interviewee: Yes.

Interviewer: How so?

Interviewee: I was always used to my sister kind of acting out something like that, she is always rebellious, she has like her lips pierced, the dyed hair all that but it was different when like my mom decided to act out and I didn't understand it at first but she had like an addiction and you cant just stop and its hard even to deal with those people or even talk to those people so that was just something I couldn't understand before

Interviewer: Okay, so after going through that and experiencing that definitely more...okay I get it now. And the last thing from thoughts was that there is a connection between the mind anybody when it comes to overall wellness and mental health. Did you find that to be true?

Interviewee: Yeah, especially one of the things they told us was to keep a good mental health you should have a good physical health and just doing stuff like working out that's what at least can help you clear your mind which can be very good especially under a lot of stress.

Interviewer: Have you found that to be true?

Interviewee: Yes, usually if I'm studying I take an hour break to work out or something.

Interviewer: Okay, so you have... how far had you managed to incorporate that into your daily life?

Interviewee: Just pretty much trying to get that I work out once a day or five times a week, helps out a lot and then if I am studying for a big exam usually and I plan it right in the middle with any five, like friends I study with, we work together and stuff like that.

Interviewer: Okay so this becomes a group thing.

Interviewee: Or even plan it with cadets when I get out and say okay it's time lets hit the gym and then we will come back to continue right after.

Interviewer: And can you tell me how that impacts every body's mental health overall, working out in groups. So how has doing that work out aspect in a group improved every body's overall mental health?

Interviewee: I think actually its just team work and bonding and stuff like that that can help a lot I the army. If you have people that are really care about and want to succeed and work with. If you don't then it's a not really good environment at all.

Interviewer: Okay so they do play up a group thing aspect? So have you ever known anyone to like not fit into a group?

Interviewee: Sort of, for me my first semester is tough, I didn't really know many people but after that you really start.....because they...for them most of the teams they randomly place the other so after a couple of semesters you have met at least 100 and you get to talk, you have some common interest that kind of majors and then you can make friendship and stuff like that.

Interviewer: Could you tell me more about that difficulty your first year, kind of just being the odd man out for a little while?

Interviewee: For me especially I didn't start in the fall, I started in the spring so people that have had their first year they had already got to know the people because it had been a couple of months. That was a little tough especially since during the first year its tough, they don't tell you much at all that's all up to...get your instructions from someone who is just two years older than you and sometimes they're going to forget to text you or going to forget to text you the full thing because they have already been here for three years so some small details that they don't think is important is going to make a big difference because you are not going to know where exactly to be and they will be like oh show up at battalion and you know where battalion are, where is the battalion.

Interviewer: And could you tell me did that affect your mental health at all?

Interviewee: it was a little extra stressed but luckily they don't expect too much from the first year people at all or even second year.

Interviewer: So they kind of give you some worry but the low expectation kind of made everything okay.

Interviewee: And for the cadre that actually teach like the MS1 and MS2 here and they are really responsive and they will even give you their personal number and you can just text them and just be like hey I am lost and any advice and they will say go here, go here and they will help you out especially a first year.

Interviewer: Okay so them as a resource

Interviewee: And its actually like one of the only classes where they actually know your name, even though we wear name tags these people can actually recognize you outside of class, they will go hey, really it's just something like that.

Interviewer: So they at least know what you will look like when you aren't in uniform.

Interviewee: Yes.

Interviewer: Alright, thank you for that. Moving on, one of the other things I looked at was your emotional reactions when you encounter someone with mental health issues and one of the things that I saw was that there was a measure of fear if you are placed in a certain situations if someone has mental health issues, can you talk about that?

Interviewee: Right, if you do have mental health problems it's not a good a place to be there is live ammunitions there is guns you can cause a lot of harm with that so its really the best group overall to have that person at least sit out until they have had therapy or at least some treatment.

Interviewer: And how long would that be?

Interviewee: It depends on the person I how messed up they are, some people may never be able to show up again.

Interviewer: So how would you react if you were placed in that situation where you had to fight with somebody who had mental health issues.

Interviewee: I would be really uneasy; it would be hard to trust them because you can't trust them to think logically and to have everyone's best interest in mind or even their own best interest in mind.

Interviewer: So how would that work out if you were the one with the mental health issues?

Interviewee: Hopefully I would want to get some attention or get some sort of help but if I had mental health issues I probably wouldn't do that because I would probably do something else which would be bad.

Interviewer: What do you mean?

Interviewee: I probably, find, there is something out there I am probably going to think to be like okay I shouldn't be here. Or I would probably think I shouldn't be here probably not be here but I want to think that as an option till they get help.

Interviewer: Okay, so you would kind of just go through the emotions of the day to day?

Interviewee: Probably but I just in the back of my head and do something else.

Interviewer: So what would happen if somebody pointed it out to you?

Interviewee: I not sure.

Interviewer: Because you said you would notice if you were acting strange, like you would still just kind of go about doing your job, if somebody said hey I think you might need to see somebody how would you react to that?

Interviewee: I would probably want them to prove it somehow.

Interviewer: Okay, what would it take?

Interviewee: Something like hey, I've just been seeing you have been doing this, your kind of off sometimes I will be off with my friends and we go to the gym and they are like, hey, you're

off and they I'll have like two completely different weights I am like oh I didn't even realize since I have just haven't been paying attention.

Interviewer: So you would have to really get some kind of line of okay here is ABC and D.

Interviewee: Yes, so and they actually point out while I am doing something so yea that where are you going in there and you're not supposed to be doing that, something like that.

Interviewer: Aright so in action.

Interviewee: Yeah, or even just a recounting of it, like you were doing ABCD, these things.

Interviewer: Who would you trust to tell you that?

Interviewee: My friends probably and maybe the supervisor that's there like if I didn't direct contact them or.

Interviewer: Okay, one of the other things that I found was apathy where some people would just like, I will ignore it as long as it doesn't affect me, how do you go about that?

Interviewee: Problem is it can everyone else too so that is not one of the best opinion.

Interviewer: Could you talk more about that?

Interviewee: I can say there's people's lives at stake just being just somewhere else thinking of something else while shots are fired something like that can result in someone dying not just immediately doing something crazy just not being in the zone and not being quick enough.

Interviewer: So ignoring it can put other people's lives in danger because this is something that's okay, it's obvious we see this but since it hasn't affected me directly yet I won't say anything but it still has a potential so somebody should speak up.

Interviewee: Yes.

Interviewer: Okay, another thing that I found was that there was a...feeling of remorse if you managed to again like you said identify something but didn't say anything and something

actually happens so would you feel bad afterwards if something bad happens to somebody with mental health issues you didn't say anything?

Interviewee: Yeah, definitely, especially, depends on how much I knew that if I could have made a difference or changed it.

Interviewer: Could you talk more about that?

Interviewee: In which way?

Interviewer: Like you said especially if I knew I could have made a difference, what does that mean?

Interviewee: If I had realize and it's like oh this person is acting strange then I just keep it to myself I don't tell anyone at all then I would feel especially responsible for anything that could happen because I could have prevented it by speaking out or telling someone.

Interviewer: Okay, thank you. we also kind of looked at what you believe about mental health and where you get a lot of your cues from so at one point we talked about information that's is just like factual information but then another thing we looked at was like where in the culture you get your beliefs from and one of the things that we found was that you were able to identify mental health issues of behaviors pretty well, could you tell me where you learned to do that in your outside life, outside of the ROTC, so where do you learn where PTSD was, where did you learn what schizophrenia was and how did you learn to identify those behaviors'.

Interviewee: A lot of people that are in the ROTC or otherwise had a family that has served or what not so all of them have a firsthand experience with stuff PTSD and I feel like just from your own personal life, your family your external family, you are going to deal with at least a few mental issues.

Interviewer: So that really is a primary thing, you feel that that's a primary indicator of what mental health looks like is that familial connection, okay. As far as the causes of mental health and where it comes from, one of the things that people mentioned was a... and they didn't mention it too often was a psychotic break. Do you believe that to be true?

Interviewee: Like modern day stuff or what do you mean?

Interviewer: As a cause of mental health issues like they had a problem because something happened that is... went off, they snapped.

Interviewee: For some that sounds very right, other times it's going to be like study build up or stuff like that I can say you just had like a significant other something like that, a break up like that or one of your friends gets hurt all those things could just.

Interviewer: Alright, some of the things that we all found were those traumatic experiences were causes of mental health issues which you found out to be true. Okay. Could you go into detail about what type of traumatic experiences you think would be causes?

Interviewee: Just seeing a friend get hurt or die or just having like a loved one has problems back at home and not being able to do anything about it could be very psychologically damaging.

Interviewer: We also found interpersonal issues to be a problem, basically that means stress in between and your household or other family members...sorry not other family members other friends or other people in the military system is that true.

Interviewee: Stress is a huge factor, I am sure they have a whole day just on how to deal with stress, in other words you are just like work out, eat better that will help but at least help with some of the problems will they are not like that energy especially because that's one of the themes towards us since we are college students, its not the end of the world if we do bad on the test or what not.

Interviewer: Okay, could you tell me what else they teach you about stress?

Interviewee: Lest see, eat healthy, just stuff like that, it will help it and...we didn't go too far into detail though.

Interviewer: Really, so they really gave you more of the surface stuff but not tell you how to cognitively get rid of stress.

Interviewee: Right, and then they said that you can always talk to people and they say that gets supports based on like family and friends and even like your cadre teachers and stuff like that you can talk to them and that is going to serve like a structure behind you.

Interviewer: Okay, so basically just formal and informal support to kind of pop you up if things are going bad. When it comes to getting help for your mental health issues, there seems to be a difference between actual acknowledgment and acceptance, would you find that to be true?

Interviewee: Can you rephrase that?

Interviewer: Basically meaning that this one thing for someone to pint it out, it's quite a matter for you to believe it for yourself.

Interviewee: Yeah, especially if you are the one having the problem, because there is usually need a lot of convincing if someone is going to tell me I am crazy or not.

Interviewer: Okay and we did kind of talk about that earlier that you wouldn't necessarily believe it right off the bat.

Interviewee: Right, I have to just have the facts, and after that having planning it out doing it or just like hey you have done this, this and this.

Interviewer: So what if there was a superior officer?

Interviewee: I probably be less inclined listen if it was a friend because a friend, I feel like they would know me more and superior officers a lot of times, based on my experience sometimes they are just the loudest guy well they can just be doing just be an asshole or what not

Interviewer: Okay, so if you had a superior officer tell you, you need to go seek mental health services, how would you react to that?

Interviewee: I would do just as an order but I don't know why I am doing this. That's just what usually how it goes anyway, I don't know why I am doing this but I have been told to so.

Interviewer: So you are just following orders like normal any other time. We also found out something as far as the treatment options go and we found that there is a wide amount of different avenues that you all kind of go down in order to get treatment, could you talk more about that.

Interviewee: The avenues to get treated?

Interviewer: As far as like you said talking to friends family cadre is there anything else you can think of as far as other options that you have as a service... as a ROTC student to..

Interviewee: There is probably some numbers to call and what not for that, but I would expect that if you tell people, it get's passed down and it eventually gets passed higher up to someone who, that's their job, just to deal with stuff like that.

Interviewer: So do you feel like you have options for treatment.

Interviewee: I feel like I could look it up but I don't think anyone really just like has it like saved in their phone or anything like that or what to do.

Interviewer: Okay, so you can find it if you needed it but as far as you personally right now.

Interviewee: I don't have like a card that says call us or anything like that.

Interviewer: Okay, so what would you tell someone else who came to you and said hey I think I am having issues where do I go.

Interviewee: I would google it.

Interviewer: Okay, so what if there was another ROTC student.

Interviewee: I probably would probably google it first then if that didn't work I'd talk to the higher up just keep going up the chain and talk to like a the cadre or what not...

Interviewer: We also found that there were differences in between when civilians should go seek treatment and when service members should go seek treatment; do you find that to be true?

Interviewee: Yeah, I think the service man should right away.

Interviewer: And what does right away mean?

Interviewee: As soon as someone spots it, before it gets to the point where it's affecting what they do. That should kind of notified at least just because they have a lot at stake but I think the same thing it's almost a document or even like a policeman or fireman just where they have someone's life at stake then they should be on their game at all times.

Interviewer: Okay so this is how I am a little confused because, of course here you said if you have something and somebody points it out you should go immediately but then even by your own admission you are like well, I really wouldn't necessarily go you got to prove it to me, so how does that work.

Interviewee: I just feel like if I am on from the right mental state I am not going to listen to reason and I am going to have to be proved that something is wrong because also there is a negative look on people that do have that especially in the army, they'll think you're unfit or weak or what not.

Interviewer: Where did you hear that?

Interviewee: Just talking to people around and it just seems like how the attitude that you are not supposed to show weakness sort of stuff like that, that's a big one. I feel like it would be hard for people though, especially if you are higher up you feel like it will be hard for people to have the same amount of respect for you if you kind of freaked out over something or had issues, you know they shouldn't treat you any less.

Interviewer: When you said you talked to the people who are the people?

Interviewee: Which part when I said people?

Interviewer: You said you talked to the people and they kind of said you don't always show weakness, who is the people.

Interviewee: Like if you talk around ROTC cadets even then you are not supposed to like show weakness and what not. So something as big as having like a mental health problem and stuff like that you are supposed to kind of keep to yourself almost.

Interviewer: And where do you think they get that idea?

Interviewee: Same people there is a lot of people in ROTC that are higher service like boot camp and what or not and so they have been dealing with all the whole machoism and then all that stuff.

Interviewer: Okay, so just so I understand, the ROTC itself doesn't really get that idea but you are saying and correct me if I am wrong, it kind of comes from outside and then it makes itself back...it makes its ways back into the ROTC.

Speaker2: For ROTC yes, that comes from outside

Interviewer: Say that one more time.

Interviewee: Yeah, it comes from outside though, negative aspects of it so...

Interviewer: Okay, sorry I just had to think about that for a second. So a lot of, would you say that the messages from that again come from the people who have either you said have been in boot camp or they kind of been active for a while now they are coming back to school?

Interviewee: Yes, definitely. Since we are completely different, like how I look on life with people that is on that stuff.

Speaker1: Okay, have you heard anything specifically like, or has it been person knows a person who knows a person, have you ever talked to somebody who was active who did boot and now came back and told you okay this is what's going on?

Interviewee: They all make it seem like it was very bad, like they wouldn't do it again because they learned a lot or whatever but afterwards it's not something they enjoyed at all and they had from recommended it to everyone and even most people or even their friends and stuff.

Interviewer: Okay, and what did they tell you specifically about mental health, what did you even ask?

Interviewee: I didn't really ask them directly where it comes from... there is a lot of people who have went to boot camp or have prior service.

Interviewer: Okay.

Interviewee: And you can also see because we have had like drill sergeants that are going through that program and you can just see how they act and they are just always on guard and.

Interviewer: What do you mean?

Interviewee: A lot of times if you hear anything like loud, it's usually not going to be one of the ROTC could just like that just started in college but if you see like someone like the drill sergeant or even just a sergeant they would even do some prior service they usually... they are the ones that they are going to start yelling at people just for doing things that you'd expect like a

first or second year like oh they don't really know the ropes but they are just going to [0:36:20.5] bascule that how they have been taught at the base.

Interviewer: Okay, so they like drilled . Okay with stigma, one of the things that we were trying to look for was just basically what you believe happens to people who had mental health issues as a service member and one of the things that we found was that there is... some people don't care as far as okay you have you deal with it, going about your business and then other people are like, okay this is something you need to get on ASAP would you say that's accurate?

Interviewee: More ASAP if you have you should get treated early and tell someone that can say that okay you are mentally healthy and if not you shouldn't be able to come back.

Interviewer: Okay, now just a couple of more questions about just some overall things that we were trying to figure out, had you heard the term behavioral health before our interview?

Interviewee: In like high school psychology, but I didn't really pay much attention to that.

Interviewer: Okay, so had you heard the term mental health before that?

Interviewee: Yes, but I don't really think I had noticed, I had too much of a difference in my head beforehand.

Interviewer: Do you see yourself as a mental health resource?

Interviewee: Can you define that.

Interviewer: Again like I said before, somebody came to you and said I am having this issue can you help me do you think that you could be somebody who could help them?

Interviewee: I would try but I am probably not the best for that.

Interviewer: Okay, where do you think soldiers get their knowledge about mental health?

Interviewee; Mental is like just the overall being or the problems you get to face or.

Interviewer: Either one.

Interviewee: Well I say probably you get a bunch of that stuff from just talking with your family and external family to see that the ups and downs of...its like if you put it in a spectrum you would see people that have poor mental health and people that are doing just fine...or at least appear to be doing just fine

Interviewer: So if we were to name the top three sources or where soldiers would get their mental health information what would you say those three would be?

Interviewee: Family would be up there but I feel like it's different for me just because I haven't talked with people that are like that have done that much deployment or have like had like gun fire and all that stuff, that have just seen combat really I feel like at that point you have that experience with those people but I think our family, friends and soldiers and then I guess from there you can probably just go to just anyone that in the...that's experienced with dealing like the army or what not.

I am not that firm but for me if I see some one else's it pretty much not all my classes are going to be like one person that like an army cadet and then be like [0:39:33.4] for not using the uniform or wearing the uniform we are just going to sit and talk because we have that common connection.

Interviewer: Alright, so cool that would be it

(Interview completed 6/3/14)

Interview Protocol

The purpose of the interview protocol is to introduce consistency between interviewers. Please follow the protocol as closely as possible to ensure that all participants experience the same process. As these are semi-structured interviews, please read the questions as written; however, you are allowed to ask for elaboration or clarification if necessary. An interview protocol needs to be taken into each interview or focus group. During this process, please take field notes on the back of the protocol as the students are responding. Note any observations you make including changes in body language, vocal inflections, or hesitations in speech. At the top of the interview protocol, write the letter P and which interview number you're about to complete. For example, if I was to complete my first interview, I would write "P1."

Please use Smart Voice Recorder to record the interviews. Start the recording, say "Test" three times, then stop the recording. Play back the recording to ensure that you can be heard properly. Delete the test recording and then begin another recording. After recording begins, please say the following:

Thank you for agreeing to participate in this study. The purpose of this interview is to find out your beliefs about behavioral health. There will be another person in the room while we complete the interview to ensure consistency between interviews. Both myself and the observer may make notes during the interview which will be used in data analysis. Before we begin, I'd like to talk to you about consent. [Read consent form] By giving your verbal permission, you are agreeing to participate in the current study and also consent to being audio recorded. Your identity will not be shared with anyone and you are allowed to remove yourself from the study at

any time. [Read consent to student]. Please say “I agree to participate in this study” to give your verbal consent.

I agree to participate in this study.

Now we will begin the interview:

Had you heard of the term “behavioral health” prior to our last interview? I have yet to hear much information since the last interview. I left the country a few days after and mostly everything has been in Spanish since then.

Do you see yourself as a mental health resource? I mean, I see myself as having a positive attitude and could help someone if asked. At a minimum I could direct someone to someone who could help.

Where do you think soldiers get their knowledge about mental health? I would say most likely google or from mandatory videos that the Army has us watch, such as “shoulder to shoulder.”

Would you serve with someone who has mental health issues? Yes. Although I would hope they are being treated.

How much do your personal connections influence your thoughts on mental health? I tend to form my own opinions based on what I read, so I would say that my connections have less of an influence than anything. If someone tries to influence my opinion, I am more likely to go read about it, rather than changing my opinion right then and there.

Thank you for participating in the interview. You may be contacted to take part in a focus group at a later date. Again, you’re allowed to withdraw your participation at any time.

[Stop the Recording]

Please ensure that the interview has recorded by pressing play on the last saved file. If successful, please email the file to Kristopher.g.hall@knights.ucf.edu. In the email, please let the primary investigator know when you are available to collect the consent from and your field notes.

(Email returned 6/11/14)

APPENDIX M: CODING SHEETS

Construct	Line/Quote	Code/Summary
Stigma (need, best, fit, stable)	<p>308: I don't have a skewed perception, I don't think any less of them</p> <p>310: I don't find a valid way of dealing with it</p> <p>319: they basically would sit everyone around and will talk</p> <p>321: same problems would start even though people, would say, oh yeah we are going to change</p> <p>328: I think it can definitely be helpful for some people, I didn't find it helpful for me</p> <p>334: Definitely a good step to take</p> <p>335: I think it's a good first step</p> <p>340: It just depends on the person, we are so different</p> <p>347: Killing people probably wouldn't be appropriate</p> <p>355: Illicit drug activity is, if that's what they need I'm, okay with that</p> <p>357: anything, besides causing</p>	<p>Non-judgment, Invalid, Useless, Case-by-case basis, Self-medication</p>

	anyone bodily harm	
Help-Seeking (need, stress, overwhelmed, suicide)	<p>374: I am open to the idea that whatever a soldier need to help them through, to help them do their job and to help them be mentally and physically fit to do it, I think would be a ok to see a mental health professional</p> <p>382: Sexual Harassment, rape</p>	Job performance, gender issues, sexual assault

What are US Army ROTC students' thoughts, feelings, and beliefs about behavioral health?

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>115: Problems dealing with situations</p> <p>116: Socially incompetent</p> <p>212: PTSD</p> <p>222: If they lie to you, try to manipulate you for certain things or, how can you treat a patient taking into consideration their well-being if you are not seeing all the parts of that.</p>	<p>Symptom/Disease</p> <p>Identification, Limited Information</p>

	<p>258: out in the ROTC you learn more about some of the challenges.</p> <p>278: Not many official messages</p> <p>292: I wasn't really aware</p>	
Timeline (months, years, better, until)	<p>134: degenerative diseases (indicates being born with)</p> <p>134: acquired situation (indicates development over time)</p>	Lifelong, Situational
Cause (outside, field, stress, family)	<p>120: Don't do well in social situations it could be a stem from mental issues</p> <p>134: degenerative diseases, acquired situation</p> <p>136: congenital ones and history related</p> <p>382: Sexual harassment, rape</p>	Environmental, Congenital, Trauma
Cure/Controllability (help, see someone, treatment)	<p>214: He'd calm down and did receive treatment</p> <p>215: trying to get into his daughters and he calmed down pretty much</p> <p>310: I don't find it (mental health treatment) a valid way of dealing with it</p> <p>321: It just didn't seem to work for my</p>	Client buy-in, Self-Medication, Open Options of Treatment

	<p>family or me</p> <p>328: I think it can definitely be helpful for some people</p> <p>340: It depends on the person, we're so different</p> <p>355: Illicit drug activity is, if that's what they need I'm, okay with that</p> <p>357: anything, besides causing anyone bodily harm</p> <p>347: I am open to the idea that whatever a solidier need to help them through, to help them do their job and to help them be mentally and physically fit to do it, I think would be a ok to see a mental health professional</p>	
<p>Consequences (</p>	<p>186: Trust issues</p> <p>194: I don't have a lot of trust with women in particular and so I didn't have any relationships. So I am very careful with who I select as a partner.</p> <p>213: Destroyed their marriage</p> <p>215: They are still divorced</p> <p>250: their older lifestyle is degrading</p>	<p>Distrust, Familial</p> <p>Destruction, Harm</p> <p>(self/others)</p>

	347: Killing people probably wouldn't be appropriate	
Illness Coherence (	136: Congenital and history related 272: much it can impact brigades, groups 321: once everyone left that room the same problems would start	Teamwork, Continued Issues
Emotional Representation (family	145: I conduct myself differently, more appropriately (apprehension, analysis) 150: Understand and consider the disability (empathy) 151: sensitive to the issue (sympathy/empathy) 220: kind of frightening 221: going to be a challenge	Empathy, Apprehension, Fear

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable)

Construct	
Age	22
Hometown	Suburban
Ethnicity	White, Mixed European
Gender	Male

Construct	Line/Quote	Summary/Code
Stigma (need, best, fit, stable)	<p>391: nothing negative; that they know that they are facing a situation that they themselves have been like not able to actual deal with or don't have the proper tools to deal with, so they go to somebody who actually can and can provide the help, but I don' see it as anybody who is like weak or, I would just say ill equipped to handle that.</p> <p>414: I'd say it's the same thing, they don't trust in the fact that they themselves are going to handle it, so they know that they need the help. Them knowing that they need help, I see as being strong</p> <p>417: you acknowledge that you are going in there without the proper tools, so you need it</p>	Skill/Strength Building, Acknowledgement

<p>Help-Seeking (need, stress, overwhelmed, suicide)</p>	<p>351: if you don't know how to deal with then you get a surrogate who's been around there for years to help so that you could actually monitor how to deal with the situation.</p> <p>358: we have no respect when we come here</p> <p>360: So you go after the person that's below you that has been around there for years and know how to deal with the soldiers in there</p> <p>427: daily life is starting to be affected by it</p> <p>428: things that you were in control of you are no longer in your control. Especially when you are unaware of it, if you are unaware of it and it's brought to your attention, I think you should go after it somehow</p>	<p>Experienced Assistance, Noticeable Differences, Timeliness, Self-Medication,</p>
--	---	---

	<p>438: I would say it would be more helpful if you are aware of it and you get some help because it had to be brought to your attention at some point</p> <p>442: I think it's something that you have to see for yourself or have somebody show you and you deal with that after that</p> <p>451: It's like you would rather deal with something that was brought to your attention and is it is like you start to see it develop, other than something where you just go get some help and all of a sudden it just sprung in the last minute</p> <p>454: you would rather have the evidence of it instead of somebody just kind of jump into assumptions in your perception</p>	
--	--	--

	<p>459: I guess if you know how to go about things (referring to appropriateness of seeking treatment</p> <p>461: But if I were able to handle it by yourself I don't see any reason for it</p> <p>466: If you see positive progress (in regards to handling issues by yourself)</p> <p>474: I don't see any inappropriate time because in the service you are stressed to have that team aspect, almost like, it's a family</p> <p>475: Your job could be so crucial to the point where if you are not behaving a certain way that can affect other people's lives. So it's pretty important for somebody in the service to get help</p> <p>488: Your job could be so</p>	
--	--	--

	<p>crucial to the point where if you are not behaving a certain way that can affect other people's lives. So it's pretty important for somebody in the service to get help</p> <p>499: family problems, depression</p>	
--	--	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>82: mental stability</p> <p>94: behavioral health is how you interact with certain things; mental health is how you perceive, comprehend, that sort of thing.</p> <p>105: hearing voices</p> <p>109: not being able to separate reality from what you are imagining (describing a schizophrenic)</p> <p>115: personality disorders,</p>	<p>Symptom/Disease</p> <p>Identification, Explanation of Behaviors, Secrecy</p>

	<p>that's about it, I don't know</p> <p>depression</p> <p>119: dissociative</p> <p>136: dementia</p> <p>155: see group explanation</p> <p>208: My dad keeps quite about this stuff and my mum she only talks about what happened at basic</p> <p>209: everybody keeps mum about certain things</p> <p>240: nobody expands on all the subjects</p> <p>260: multiple personality disorder and she had dementia</p> <p>261: she probably had more than twenty personalities that would just come and go whenever they felt like</p> <p>284: She can be very like lovey dovey and all of a sudden just switch, she just doesn't want to be touched</p>	
--	--	--

	<p>with anyone and she doesn't want to talk to anybody</p> <p>345: depression, suicide and loneliness</p> <p>454: you would rather have the evidence of it instead of somebody just kind of jump into assumptions in your perception</p>	
Timeline (months, years, better, until)	287: But she can really turn on you in a second	Acute
Cause (outside, field, stress, family)	<p>335: hey I am dealing with some problems, like with my wife at home, overseas</p> <p>346: Everything else is minor home problems</p> <p>499: Family problems, depression</p>	Family/Home
Cure/Controllability (help, see someone, treatment)	<p>340: You have to learn how to solve that situation quickly and effectively</p> <p>351: if you don't know how to deal with then you get a</p>	Efficiency, Teamwork, Awareness (Self/Outside), Strength, Acknowledgement

	<p>surrogate who's been around there for years to help so that you could actually monitor how to deal with the situation.</p> <p>375: Yeah, if you don't try to take on a situation that you are doubtful of; always go in there with a plan or with someone who has a plan</p> <p>391: nothing negative; that they know that they are facing a situation that they themselves have been like not able to actual deal with or don't have the proper tools to deal with, so they go to somebody who actually can and can provide the help, but I don' see it as anybody who is like weak or, I would just say ill equipped to handle that</p> <p>414: I'd say it's the same thing, they don't trust in the</p>	
--	---	--

	<p>fact that they themselves are going to handle it, so they know that they need the help. Them knowing that they need help, I see as being strong</p> <p>417: you acknowledge that you are going in there without the proper tools, so you need it</p> <p>428: Especially when you are unaware of it, if you are unaware of it and it's brought to your attention, I think you should go after it somehow.</p> <p>438: I would say it would be more helpful if you are aware of it and you get some help because it had to be brought to your attention at some point</p> <p>459: But if were able to handle it by yourself I don't see any reason for it</p> <p>474: I don't see any inappropriate time because in</p>	
--	--	--

	<p>the service you are stressed to have that team aspect, almost like, it's a family</p>	
<p>Consequences (</p>	<p>335: I don't know how I feel and that stuff is also affecting my work.</p> <p>398: what to tap into to deal with certain situation, because some people panic, some people don't know how</p> <p>427: daily life is starting to be affected by it</p> <p>428: things that you were in control of you are no longer in your control</p> <p>475: Your job could be so crucial to the point where if you are not behaving a certain way that can affect other people's lives. So it's pretty important for somebody in the service to get help</p> <p>488: , if I was passive</p>	<p>Job Performance Decline, Affecting Daily Life, Internal Conflicts, Interpersonal Conflict</p>

	<p>aggressive with everything, I didn't know where the anger is coming from, temptation to kill yourself</p> <p>489: Not getting along with certain members of your team squad</p>	
<p>Illness Coherence (</p>	<p>129: you have to adapt on how to deal with it</p> <p>130: you have to adjust the way you come and approach them</p> <p>131: really understand where they are coming from</p> <p>137: play along</p> <p>138: I have to comply with her, her mental needs</p> <p>213: I don't ask him like a lot of things that happens on the ship</p> <p>214: I just see that as not my place</p> <p>215: We are in the military but</p>	<p>Adaptation, Empathy, Privacy, Integration of Ideas,</p>

	<p>we are not in the same branch, so I don't feel the need to have to start getting to know all that 220: unless he tells me stuff I don't start digging 224: I tried to get some things out of my dad but he just doesn't talk about a lot of stuff 268: I didn't understand like how deep that person could really delve into that stuff and really believe that a hospital room is a ballroom, I didn't understand that. 297: Dealing with different people who have come from different walks life yes. Being able to actually deal with certain personalities 332: a couple of lectures in the beginning of the year in the first semester 380: ROTC kind if reiterated a</p>	
--	--	--

	<p>lot of things I learned in high school dealing with family members on situations, but it just kind of reinforced, had an army aspect of it, like battle buddy assistance</p> <p>442: I think it's something that you have to see for yourself or have somebody show you and you deal with that after that</p> <p>451: It's like you would rather deal with something that was brought to your attention and is it is like you start to see it develop, other than something where you just go get some help and all of a sudden it just sprung in the last minute</p>	
<p>Emotional Representation (family</p>	<p>143: yeah, stepping into their shoes for a bit</p> <p>252: dealing with my grandma; I didn't understand how things were going until I</p>	<p>Empathy, Familial Connection, Live Representation of Illness</p>

Construct	Line/Quote	Codes
	<p>was actually with it. You could hear about certain symptoms and all that stuff but you don't really understand the effect it has on that person and the people around him that goes on. It's surreal when you actually step into that but we are dealing somebody who has it is definitely an eye opener.</p>	

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable)

Construct	
Age	19
Hometown	Suburban
Ethnicity	Black
Gender	Male

Stigma (need, best, fit, stable)	<p>195: I'd just say probably they're able to see that they have a problem and they just go to get help.</p> <p>199: They're still the same person; I'd say it's the same thing.</p>	Self-Awareness, Non-Judgmental
Help-Seeking (need, stress, overwhelmed, suicide)	<p>205: I guess if someone has told them that someone is like noticed they behavior isn't normal and to let them know or maybe they know that they're behavioral isn't normal and they're able to see that they have a problem and say that's when they should go.</p> <p>209: guess it's not that big of an issue if it doesn't affect say their job or the way they just carry out everyday life</p> <p>213: Breaking up with your boyfriend or girlfriend I don't</p>	Acknowledgement (self/others), Severity, Situational Factors, Service vs Civilian Importance,

	<p>think you really if you are upset about it I don't think you need go see a mental health professional</p> <p>218: I'd definitely say about the same but I think it's a little more important that services members go see mental health professional especially because if its affecting their behavior and its affecting their job. That affects a lot more people than themselves especially in the army so I'd say the same just as far as a normal civilian wants to see a mental health professional .</p> <p>228: let's say I suffered a significant loss of family member or something and then I went into like a deep depression and I wasn't able to focus on school like I was, my</p>	
--	--	--

	<p>grades started dropping, not showing up ROTC or something like that that's what I would say go see a health care professional</p> <p>235: I guess if I had the same issue as an officer I would go see a health care professional just the same with like I said on I had really bad depression or something like that</p> <p>239: I think maybe if they're having like violent thoughts or they noticed they're becoming violent, they're having suicidal thoughts or something like that</p>	
--	---	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>75: normal behavior</p> <p>76: behavior accepted by</p>	<p>Normalized Behavior,</p> <p>Disease/Symptom</p>

	<p>society</p> <p>80: wouldn't be observed by society as much</p> <p>109: a couple of family members who are schizophrenic</p> <p>172: The only thing that I know that we've learned as far as behavior goes is oh we received like a SHARP training which is like a sexual harassment training and that's pretty much it.</p> <p>236: really bad depression or something like that</p>	<p>Identification, Limited Education (ROTC)</p>
<p>Timeline (months, years, better, until)</p>	<p>130: he was missing for a couple days people tried to find him and then when they found him they found out that what he was actually was trying to do was trying to kill himself.</p>	<p>Long Term</p>
<p>Cause (outside, field, stress,</p>	<p>134: some soldiers who just</p>	<p>Psychotic Break, Grief/Loss</p>

<p>family)</p>	<p>kind of snap and they go shooting but those just cases.</p> <p>228: let's say I suffered a significant loss of family member or something</p> <p>239: I think maybe if they're having like violent thoughts or they noticed they're becoming violent, they're having suicidal thoughts or something like that</p>	
<p>Cure/Controllability (help, see someone, treatment)</p>	<p>195: I'd just say probably they're able to see that they have a problem and they just go to get help</p> <p>205: I guess if someone has told them that someone is like noticed they behavior isn't normal and to let them know or maybe they know that they're behavioral isn't normal and they're able to see that they have a problem and</p>	<p>Acknowledgement (self/others)</p>

	say that's when they should go .	
Consequences (	<p>96: I wouldn't say I would treat them any different from anyone else but I mean I definitely wouldn't be able like to hold normal conversation with them or interact with them normally</p> <p>218: I'd definitely say about the same but I think it's a little more important that services members go see mental health professional especially because if its affecting their behavior and its affecting their job. That affects a lot more people than themselves especially in the army so I'd say the same just as far as a normal civilian wants to see a mental health professional.</p> <p>229: then I went into like a</p>	Adjustment, Job Performance, Group Impact, School Performance

	<p>deep depression and I wasn't able to focus on school like I was, my grades started dropping, not showing up ROTC or something like that that's what I would say go see a health care professional</p>	
Illness Coherence (	<p>137: maybe like what I was raised to think is normal behavior or I have abnormal behavior that's the only thing</p>	<p>Definition of Normality vs Abnormality</p>
Emotional Representation (family	<p>101: Probably a little awkward [Laughter] yeah I think it would be probably be a little difficult to communicate.</p> <p>115: I wouldn't say that it's had a really big effect on me, I don't think it's really affected me.</p>	<p>Apprehension, Unaffected</p>

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable)

Construct	
-----------	--

Age	20
Hometown	Urban
Ethnicity	Black/White
Gender	Female

Construct	Line/Quote	Codes
Stigma (need, best, fit, stable)	<p>201: I mean if they need the help they deserve to have that and that's where people go to college to get psychological degrees to help people with mental health problems. I believe that if you are suffering from like a mental health disorder like PTSD, bipolar, schizophrenia I believe you should go get help and get the prescriptions or the medication or counseling or whatever you need to make yourself feel better to have and help with your disorder.</p> <p>207: I know it's like a belief that like people like think less of them if they go see somebody I don't believe that. I believe that like in the same way if you have a mental</p>	Non-Judgment, Provided Professionals

	<p>health not everybody gets</p> <p>PTSD there is people who go to combat see combat and don't get PTSD. But if you do I mean there is nothing, there is no shame or no there is no like law, there is no unwritten rule that says you can't go get mental health treatment if you need it .</p> <p>Like there is no code of a soldier, there is nothing in the warrior's creed, the soldier's creed where you can't talk to somebody about things you see</p>	
<p>Help-Seeking (need, stress, overwhelmed, suicide)</p>	<p>218: My best answer for that is whenever they feel that they're having mental issues like for instance if you go see combat and you are on a combat tour and then you come home and you are all</p>	<p>Required</p> <p>Debriefings/Treatments, Limited Resources, Client Buy-in, Helping Professional Expertise, Personal Issues, Civilian vs Soldier</p>

	<p>fine then I believe you should go see a doctor once as soon as you come home or even if you are still in the combat zone; I believe should go see a doctor ones just to make sure you are all right .</p> <p>And then after words if you start having mental problems or mental issues such as like having trouble sleeping, you hear loud things and you think you've been shoot at or something like that then I believe you should go see a doctor more than once. I know of like police officers and stuff like if you are in a fire fighting situation you are probably on medication leave and you have to go see like counselor, like a psychiatrist just to talk about the incident</p>	
--	--	--

	<p>228: don't know I can't really be sure if that's how the army does it. I don't think they have enough time to do that for that many people. But I believe that's something that should be done. As soon as they come back from the combat tour have them see a psychiatrist or if they're there and nothing is happening they're in like a safe area go see a psychiatrist even like combat fire fighting ideal and then go on from there.</p> <p>235: I'm thinking it's ever not appropriate. If you as an individual feel like you are suffering from a mental disorder then you should go see a psychiatrists or someone like that. It's basically what you believe as an individual.</p>	
--	---	--

	<p>Now if you have been diagnosed with PTSD and you failed to go see a psychiatrist you are wrong because they'll help you</p> <p>239: individual may be you haven't been diagnosed and you want to go talk to somebody because you feel like you are having hard time sleeping or something because of something that happened, then I feel like you should go see psychiatrists because they're to help you. They may not diagnose you with something but they're still they to help you with your train your thought and help you with whatever mental issue that you are having.</p> <p>247: if you are being diagnosed with something like</p>	
--	---	--

	<p>you had a mental breakdown in your work place, your job then it's appropriate to go see a psychologists or if you're having troubles with your marriage or something like that then it's appropriate to go see</p> <p>251: there is never a non appropriate time to go see a mental health physician</p> <p>260: like not so much introvertedness but like a lack of ability to be social with somebody like you are afraid like social contact</p> <p>264: I know there is more, there is countless things</p> <p>272: . But at the same time you as far as it goes like between like seeing a health professional about.</p> <p>There is like no, to me there is</p>	
--	---	--

	<p>no like a certain member should go see this psychiatrists for a civilian does because different things affect people different ways</p>	
--	--	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>73: PTSD</p> <p>79: other things could be like social problems, not being as social as you once were, I guess other mental health problems.</p> <p>You could become an alcoholic; I think that counts as mental behavioral thing</p> <p>159: I mean yeah there is a lot of mental problems associated with PTSD, it's like you have schizophrenia and then you have like smaller mental health issues like bipolar and</p>	<p>Symptom/Disease</p> <p>Identification, Co-Morbidity, Anecdotal Education</p>

	<p>stuff like that I see sometimes</p> <p>so yeah</p> <p>184: Not much really I mean</p> <p>we talk about it sometimes</p> <p>like PTSD and stuff like that</p> <p>193: I mean like in a</p> <p>conversation not like in class</p> <p>like no this is mental health</p> <p>disorders or stuff like that, like</p> <p>that can arise with combat and</p> <p>stuff like that.</p> <p>257: PTSD, bipolar,</p> <p>schizophrenia, social issues...</p> <p>260: Just like not so much</p> <p>introvertedness but like a lack</p> <p>of ability to be social with</p> <p>somebody like you are afraid</p> <p>like social contact</p> <p>264: I know there is more,</p> <p>there is countless things</p> <p>280: And she was telling me</p> <p>the other day how she talks</p> <p>this former service member</p>	
--	--	--

	<p>who in Iraq and he's struggling with PTSD and so they talk and they have consoling sessions.</p>	
<p>Timeline (months, years, better, until)</p>	<p>104: he slept it off and then he was fine in the morning; but like a lot of his issues like stems from alcohol as far as the PTSD and stuff goes</p> <p>223: And then after words if you start having mental problems or mental issues such as like having trouble sleeping, you hear loud things and you think you've been shoot at or something like that then I believe you should go see a doctor more than once</p>	<p>Acute, Development, Repeated Experiences</p>
<p>Cause (outside, field, stress, family)</p>	<p>95: a lot of my step brothers PTSD issues comes when he's drinking. And so he got drunk one night and came home and he was yelling about stuff</p>	<p>Alcohol, Combat, Trauma</p>

	<p>outside and like smashed like a liquor bottle out in the street and it was one of his friends and I we were out there trying to calm him down.</p> <p>And then like he started getting like violent so we like tackled him to the ground and restrain him and then my step dad came out and my other step brother and like took him inside and he was still like in a state but he was calmer after that point.</p> <p>130: A lot of those actually come from drinking too, I don't why but I guess all the stories a lot of it comes like those episodes like get heighten when they're drunk or have been drinking or something like that</p> <p>208: I believe that like in the</p>	
--	---	--

	<p>same way if you have a mental health not everybody gets PTSD there is people who go to combat see combat and don't get PTSD.</p> <p>225: I know of like police officers and stuff like if you are in a fire fighting situation you are probably on medication leave and you have to go see like counselor, like a psychiatrist just to talk about the incident.</p> <p>279: big traumatic episode</p> <p>281: former service member who was in iraq</p>	
<p>Cure/Controllability (help, see someone, treatment)</p>	<p>88: Just treat them as like a normal person and if an episode like does come up you try to calm him down the best way you can</p> <p>And just make sure he understands that things are</p>	<p>Adjustment, Self-Medication, Qualified Professionals, Required Treatments, Acknowledgement</p>

	<p>what maybe what he thinks</p> <p>and that he needs to come</p> <p>down and listen to the other</p> <p>people as they're with him and</p> <p>understand that we are here to</p> <p>help him and stuff like that.</p> <p>104: he slept it off and then he</p> <p>was fine in the morning; but</p> <p>like a lot of his issues like</p> <p>stems from alcohol as far as</p> <p>the PTSD and stuff goes</p> <p>207: I mean if they need the</p> <p>help they deserve to have that</p> <p>and that's where people go to</p> <p>college to get psychological</p> <p>degrees to help people with</p> <p>mental health problems. I</p> <p>believe that if you are</p> <p>suffering from like a mental</p> <p>health disorder like PTSD,</p> <p>bipolar, schizophrenia I</p> <p>believe you should go get help</p> <p>and get the prescriptions or the</p>	
--	--	--

	<p>medication or counseling or whatever you need to make yourself feel better to have and help with your disorder.</p> <p>229: But I believe that's something that should be done. As soon as they come back from the combat tour have them see a psychiatrist or if they're there and nothing is happening they're in like a safe area go see a psychiatrist even like combat fire fighting ideal and then go on from there.</p> <p>235: I'm thinking it's ever not appropriate. If you as an individual feel like you are suffering from a mental disorder then you should go see a psychiatrists or someone like that. It's basically what you believe as an individual.</p>	
--	---	--

	<p>Now if you have been diagnosed with PTSD and you failed to go see a psychiatrists you are wrong because they'll help you.</p> <p>247: if you are being diagnosed with something like you had a mental breakdown in your work place, your job then it's appropriate to go see a psychologists or if you're having troubles with your marriage or something like that then it's appropriate to go see</p> <p>251: there is never a non appropriate time to go see a mental health physician</p>	
<p>Consequences (</p>	<p>81: You could become an alcoholic; I think that counts as mental behavioral thing.</p> <p>And then other sorts of problems I guess could erupt</p>	<p>Alcoholism, Misalignment</p>

	<p>from it, I guess some people could become schizophrenic or something like that</p> <p>99: And then like he started getting like violent</p> <p>129: friends of friends who come back and they're just like not right</p> <p>210: there is no unwritten rule that says you can't go get mental health treatment if you need it.</p> <p>Like there is no code of a soldier, there is nothing in the warrior's creed, the soldier's creed where you can't talk to somebody about things you see.</p> <p>280: left a psychological scar</p>	
Illness Coherence (	<p>115: soldiers sometimes believe that PTSD is just like a sign of weakness and nobody really has these problems but</p>	<p>Education, Equality, Personal Connection</p>

	<p>actually these problems do exist I mean there are studies on it</p> <p>118: So I mean that research as well as they know like there is countless studies out there that has dictated this is an actual problem that exist and it's not just in the military. It's in like police; even in none combat related services. It is a very real problem and I think having a personal connection to it has made it more apparent to me on that.</p> <p>288: There is no like underline this person should get it (treatment) before this person .</p>	
<p>Emotional Representation (family</p>	<p>77: Personally my step brother is diagnosed with PTSD from when he was in Afghanistan. So that's just like that's the only reason why is the first</p>	<p>Familial Connection, Disbelief</p>

	<p>thing that comes in mind</p> <p>87: I tried to act as normal as I can around him. I mean he still acts normal just sometimes he'll like get all wound up about something</p> <p>137: Like I said the tangibility of having like a personal connection to it I guess it has changed my opinions on it.</p> <p>Like I said it's a very real thing, I used to not think it was I used to think that like you are being show shock or having PTSD I mean how is going to happen riding you know what happened is frequently or as a common as it is known to be.</p> <p>143: I knew it can happen I just didn't think that so many people had it or so many people said they had it but I</p>	
--	--	--

	<p>don't know if they really had it</p> <p>147: So having a personal connection it's like made me change what I thought and see that it is an issue and people have it and they say they have it, they diagnosed with it by doctors, they have it</p>	
--	---	--

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable)

Construct	
Age	19
Hometown	Suburban
Ethnicity	White
Gender	Male

Construct	Line/Quote	Codes
Stigma (need, best, fit, stable)	<p>300: I mean it is what it is like if you have a mental issue then the way to go is something like if you don't really know how to deal with it and you need to go to a professional person to help you with that, you do that I mean it is not a big deal. I mean it is what it is I honestly like never had something that put me down to like as much to like go to a professional for help but yeah I mean it is not that I don't think much of it, it is what it is some people need it.</p> <p>348: I know I will not be in the war scenario probably but if I'm and something was to happen to me like mentally, psychologically then that is</p>	Non-Judgmental, Detachment

	<p>probably what I will do I will do to a specialist like I won't be ashamed of it</p>	
<p>Help-Seeking (need, stress, overwhelmed, suicide)</p>	<p>315: if that is the reason then it was their choice to go to the military and they should have known that that was, it is going to be what they had to go through and why they had to do so. In a way like if they go a specialist for that, for their mental issue then it is their fault they got into that so now they have get themselves out. Like became mentally stable again like themselves so and with help it is fine I'm not saying they shouldn't. So it is that what I think of it.</p> <p>324: they keep their health by doing it but it is mentally</p> <p>345: I would go like if there was something that really put</p>	<p>Personal Responsibility, Family Issues, Professional Expertise, Trauma</p>

	<p>me down may be like a family issue, like I'm really close to my family so if anything wants to happen may be even when I join the military.</p> <p>354: And or just like I said a family issue that might get my get my head straight. The primary resource for me would be like friends they are like close friends but if obviously nothing is working then I will go to a professional</p> <p>347: Just like I guess may be a lot of demand in the war zone. If they are surrounded by guns firing all the time or anything and then maybe if their friend got shot or best friend gets shot then it is very, they get very upset and might want to drop the army or whoever they are. They might</p>	
--	---	--

	<p>want to drop the program but that is probably when they would want to go to like a specialist</p> <p>390: ., I mean family and like your profession is like the most important things in my opinion, now if like you are married and something happens to your loved one then it is different and you are obviously going to want to talk to someone about it or get help</p>	
--	--	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>79: the way someone takes care of himself, health wise, the way they, the meals they eat and yeah that physical fitness</p> <p>88: being stable like mentally stable, not getting frustrated, practicing that skill to not get too frustrated with something</p> <p>99: not, inclined into doing drugs or inclined to go on to like party a lot just focused on what they want to do</p> <p>100: like if there is something that frustrates them like there is a family issue they just kind of look past it</p>	Normality, Stability, Emotional Control
Timeline (months, years, better, until)	<p>136: Not really they don't struggle with just like my buddy that one time but it was</p>	Temporary

	like temporary thing	
Cause (outside, field, stress, family)	<p>120: guess my friend one time he was just telling me like okay there is a lot, he wasn't very good in school</p> <p>315: if that is the reason then it was their choice to go to the military and they should have known that that was, it is going to be what they had to go through and why they had to do so.</p> <p>329: Because they got themselves into it and they shouldn't blame anyone else but themselves. They can't be like okay the military did this to me. It is ultimately their, it was their decision to join so</p> <p>374: Just like I guess may be a lot of demand in the war zone. If they are surrounded by guns firing all the time or anything</p>	School Pressures, Combat

	<p>and then maybe if their friend got shot or best friend gets shot then it is very, they get very upset and might want to drop the army or whoever they are</p>	
<p>Cure/Controllability (help, see someone, treatment)</p>	<p>122: listen you can't be looking at that stuff, you have to just don't worry about it. Just look at what makes you happy</p> <p>125: don't worry about that, small stuff like it is going to, you're probably going to get over and your family will get over it</p> <p>142: It just made me realize that like you can get past it is not like permanent.</p> <p>184: mental health is very important in being able to achieve your goals and stuff like you can't get frustrated,</p>	<p>Proportional, Necessity, Self-Assessment</p>

	<p>you can't be mad at yourself, if you are mad at yourself or you're not happy with what is going on, you are not going to be able to get much further and you are going to want to quit is that so. You just have to keep that mentality; you've got to look forward to the main goal and just get there as quick as possible .</p> <p>300: I mean it is what it is like if you have a mental issue then the way to go is something like if you don't really know how to deal with it and you need to go to a professional person to help you with that, you do that I mean it is not a big deal. I mean it is what it is I honestly like never had something that put me down to like as much to like go to a</p>	
--	--	--

	<p>professional for help but yeah</p> <p>I mean it is not that I don't think much of it, it is what it is some people need it.</p> <p>317: In a way like if they go a specialist for that, for their mental issue then it is their fault they got into that so now they have get themselves out.</p> <p>324: So like I guess they keep their health by doing it but it is mentally up to them and feel like.</p> <p>354: The primary resource for me would be like friends they are like close friends but if obviously nothing is working then I will go to a professional</p> <p>377: They might want to drop the program but that is probably when they would want to go to like a specialist (after experiencing violence in</p>	
--	--	--

	theater)	
Consequences (	<p>185: if you are mad at yourself or you re not happy with what is going on, you are not going to be able to get much further and you are going to want to quit</p> <p>335: Yeah so they should expect consequences from that (going to war) if they decide to join</p> <p>339: The consequences obviously might be psychological or physical damage it just depends so but they should know that they should know</p>	Trauma, Job Performance
Illness Coherence (	<p>200: So doing that like every week you just get to a point where it is like okay you are more mentally stable like you just you are motivated to get to that. Every week you just</p>	Awareness, Mind/Body Connection, Resilience

	<p>get more motivated because they are paying for your school and stuff and yes that is the motivation factor. So that is how I developed that idea of mental health.</p> <p>213: and you've got to be aware of things and so that and physical training helped me see them like the health factor like the mental health factor and all that.</p> <p>227: Mental health benefits, I guess it is just kind of links because physical training kind of they are always like you are like okay, you've got to keep going, you've got to keep going you can't stop so I mean I guess it helps you so like if you ever encounter like another obstacle in life it is not going to put you down</p>	
--	--	--

	<p>because you are already mentally, you have gone through that stage where it has been more brutal.</p>	
<p>Emotional Representation (family)</p>	<p>111: I just kind of go along with it</p> <p>244: program and doing things</p> <p>I just I don't know I was just I was just more mentally, like my mental health was just more up there. (in reference to motivation)</p> <p>345: I would go like if there was something that really put me down may be like a family issue, like I'm really close to my family so if anything wants to happen may be even when I join the military</p> <p>362: If you know like some family member was to pass away if someone was to die it would be like devastating</p>	<p>Adjustment, Familial Connection, Devastated, Self-Assurance</p>

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable) *Participant was a junior

Construct	
Age	21
Hometown	Suburban
Ethnicity	Hispanic
Gender	Male

Construct	Line/Quote	Codes
Stigma (need, best, fit, stable)	<p>345: Just like before I would say you have to have something wrong with you to go. My whole family has gone so I guess there is something wrong with all of us. If you need help it is like you should go it is like you being sick you shouldn't just feel like I don't go to the doctor people will think I'm sick but that is fine it's the only way to get better is to actually go, it's the best because you need something like that</p> <p>353: A lot of the stuff isn't going to get better by itself</p> <p>357: I feel like people have like depression issues, anxiety loneliness because that is something, all of those things you need, to get over mental</p>	<p>Self-Assessment, Assistance, Professional Expertise, Danger, Worsening</p>

	<p>stuff you actually have to talk to someone, you can't just be on your own or just by yourself the whole time. And usually if you have problems like then you probably don't have too many people around you that you can't talk to and so I think you just keep spiraling down, you keep getting worse and worse like if you had a disease or something, especially the men</p> <p>371: If you are in the army and you do have to carry out your duties, I don't feel like you would want to be fighting with someone who has the mental problems, especially when people's lives are at stake... I feel like there has been a lot of stuff they are just people, it's just a bad</p>	
--	--	--

	<p>combination to have mentally unfit people with guns and live ammunition. And I think you should definitely get help before you, you shouldn't just let it sit because I feel like it is only going to get worse. I think you should pretty much be sent home if you have mental problems because that's just a bad combination</p>	
<p>Help-Seeking (need, stress, overwhelmed, suicide)</p>	<p>381: I feel like if you feel like something is wrong and you are not happy I think that is the biggest sign if you are not happy in your everyday life and you should talk to your friends about it. If nothing is helping then I think you should if you can't get help from friends and family I think you should seek a psychologist or therapist or</p>	<p>Self-Assessment, Internal Resources, Timeline, Civilian vs Soldier, Grief, Detachment,</p>

	<p>something</p> <p>392: I think everyone is going to have like been sad for a little while like breakup or something that. I feel like after a month or something then if you need help then you should definitely seek it. But I think if you just feel bad like a whim or something you should probably wait and see if it will pass by itself</p> <p>400: I'd say all the time, it has to be a lot shorter because like I said, you have people's life at stake, even if it is not you going insane or something just you not being right there in the moment where they need you to do something. So I feel like if you aren't feeling up it then you should get out immediately almost.</p>	
--	---	--

	<p>418: I think if they have problems like grieving like if they lost a friend or there are just problems at home and they just feel like because I feel like you need to talk especially when you are on deployment you've just been gone for so long and not being able to help back home or do stuff. I think you need someone to talk to</p> <p>425: I just feel like it you might feel like trapped there almost if you have because you have because you don't really have an options once you become deployed, you feel like you just have to almost and I almost feel like if you get claustrophobic and you are supposed to be sucking that air in and you</p>	
--	---	--

	<p>can't do anything about it and</p> <p>if you don't deal with it well</p> <p>you should get help</p> <p>immediately.</p>	
--	--	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>114: It is just your mental mind state of being sane, being happy not being depressed something like that</p> <p>119: Mental health close to the same, I guess behavior is more like how you act with others mental is just being how you view yourself; it's like being sane</p> <p>125: I guess mental health it's be harder for other people to tell but affects you a lot on how you do everything, you carry out your life</p> <p>131: I guess just having like a</p>	<p>Overall Status,</p> <p>Symptom/Disease</p> <p>Identification, Thoughts vs. Behaviors, Emotional Control,</p> <p>Limited Education</p>

	<p>logical thought process and being able to control your emotions.</p> <p>144: I'd say that it'll be common not be able to stay in the emotional state longer until like going from emotion to emotion.</p> <p>310: we have all the stuff like don't commit suicide, watch our for people that are displaying signs, besides that usually there is, if they had to keep you, figure out how to deal with stress, and I know there is some class about that in the first year but that was a while.</p> <p>329: I think we've watched some videos and maybe a little bit on like PTSD and post traumatic stress. No usually we don't really learn much</p>	
--	--	--

	<p>about that that. I guess at least because usually we just focus on the stuff for CLC or we just do our land nav and we do our running</p>	
<p>Timeline (months, years, better, until)</p>	<p>137: Just making decisions that benefit you either in the short run or long run and just taking away bad stuff that you can possibly do just focusing on what is going to help you progress and...</p> <p>412: I was unhappy for a long time over a month and I'd have to think something is wrong.</p> <p>392: I think everyone is going to have like been sad for a little while like breakup or something that. I feel like after a month or something then if you need help then you should definitely seek it. But I think if</p>	<p>Long Term Decision Making, Month</p>

	<p>you just feel bad like a whim or something you should probably wait and see if it will pass by itself</p>	
<p>Cause (outside, field, stress, family)</p>	<p>158: my parents divorced and she had a little bit of therapy 174: Yes and no sometimes it would be hard to tell like, it'd be like I'm certain that this would set her off or not so there is a lot of that. I'd know like the general things that could annoy her. 207: I know as time goes I will be upset from something else and I will be stressed because I have a bunch of tests coming up and it won't actually be them that's bothering me it would be the other things but I will be upset with them just because they</p>	<p>Familial Issues, Interpersonal Triggers, Combat, Eventuality, Grief/Loss</p>

	<p>will set me off, so this is something that you'll probably always say but it won't bother me.</p> <p>224: My cousin she did it, but she was a vet and she didn't bring back any of that stuff she was pretty fine and I don't think she saw anything like that. She just worked on animals</p> <p>240: Just how people handle situations differently, when my parents split up she took it harder because my dad was the one that ended it.</p> <p>392: I think everyone is going to have like been sad for a little while like breakup or something that. I feel like after a month or something then if you need help then you should definitely seek it. But I think if</p>	
--	---	--

	<p>you just feel bad like a whim or something you should probably wait and see if it will pass by itself</p> <p>418: I think if they have problems like grieving like if they lost a friend or there are just problems at home</p>	
<p>Cure/Controllability (help, see someone, treatment)</p>	<p>181: whenever I feel upset and I try just to think why have I'm upset and go on it from there and think like is this more me or the other person? Am I just in a bad mood or something like that?</p> <p>198: What should I do instead maybe I just I don't like where I'm and I should just leave that place and have sometime to relax and just cool down.</p> <p>251: My whole family is getting therapy at one point</p> <p>264: it wasn't together which</p>	<p>Attribution, Group Engagement, Self-Efficacy, Lower Stress, Professional Expertise, Resources, Time Sensitive, Civilian vs Soldier</p>

	<p>might have helped a little more I feel like but... (when speaking on therapy w/family)</p> <p>313: And they usually say, try to keep your stress down, eat healthy and get good sleep and you should be fine</p> <p>345: Just like before I would say you have to have something wrong with you to go. My whole family has gone so I guess there is something wrong with all of us. If you need help it is like you should go it is like you being sick you shouldn't just feel like I don't go to the doctor people will think I'm sick but that is fine it's the only way to get better is to actually go, it's the best because you need something like that</p> <p>353: A lot of the stuff isn't</p>	
--	---	--

	<p>going to get better by itself.</p> <p>357: I feel like people have like depression issues, anxiety loneliness because that is something, all of those things you need, to get over mental stuff you actually have to talk to someone, you can't just be on your own or just by yourself the whole time</p> <p>375: And I that you should definitely get help before you, you shouldn't just let it sit because I feel like it is only going to get worse. I think you should pretty much be sent home if you have mental problems because that's just a bad combination</p> <p>381: I feel like if you feel like something is wrong and you are not happy I think that is the biggest sign if you are not</p>	
--	--	--

	<p>happy in your everyday life</p> <p>and you should talk to your friends about it. If nothing is helping then I think you should if you can't get help from friends and family I think you should seek a psychologist or therapist or something.</p> <p>400: I'd say all the time, it has to be a lot shorter because like I said, you have people's life at stake, even if it is not you going insane or something just you not being right there in the moment where they need you to do something. So I feel like if you aren't feeling up it then you should get out immediately almost</p> <p>419: I feel like you need to talk especially when you are on deployment you've just</p>	
--	---	--

	<p>been gone for so long and not being able to help back home or do stuff. I think you need someone to talk to.</p> <p>425: I just feel like it you might feel like trapped there almost if you have because you have because you don't really have an options once you become deployed, you feel like you just have to almost and I almost feel like if you get claustrophobic and you are supposed to be sucking that air in and you can't do anything about it and if you don't deal with it well you should get help immediately</p>	
<p>Consequences (</p>	<p>159: she's been dealing with it hard she dropped out of high school</p> <p>164: She'd get very angry,</p>	<p>Property Destruction, Lack of Control, Spiraling</p>

	<p>she'd break stuff she broke her laptop once. She is just anything could just set her off and she chooses to go into a fit of raging. She won't even pay attention to what she was doing just felling stuff and attacking</p> <p>170: It will just set her off like a fuse or a bomb or something</p> <p>187: And just to ask myself questions before I react was just I feel like if you are unstable then you won't do that, you'll just be compulsive and do what you are going to do first and then take it out of that later</p> <p>197: where I think why I feel this way and also think what would happen if I do something or the repercussions</p>	
--	---	--

	<p>245: And she drunk a lot, she then got like a DUI and it was pretty bad and she just kind of shut down, we'll she's gotten better</p> <p>359: And usually if you have problems like then you probably don't have too many people around you that you can't talk to and so I think you just keep spiraling down, you keep getting worse and worse like if you had a disease or something, especially the mental disease.</p>	
Illness Coherence (	<p>281: Not much as I thought I would do when I started it.</p> <p>There are people, there is hot heads, there is everything you would expect really</p> <p>289: because they finally have the power and now they get take advantage of it because</p>	<p>Personality Adjustment, Deterioration of Job Performance, Necessity,</p>

	<p>they have been, they've been in my situation where people above have been doing the same thing and now it is their chance to be the boss for a day.</p> <p>295: And people handle it differently some people they are more relaxed and fine with it, they are just like okay and other people are like this is my time to shine everyone else below me is shit bags and things like that</p> <p>345: Just like before I would say you have to have something wrong with you to go. My whole family has gone so I guess there is something wrong with all of us. If you need help it is like you should go it is like you being sick you shouldn't just feel like I don't</p>	
--	---	--

	<p>go to the doctor people will think I'm sick but that is fine it's the only way to get better is to actually go, it's the best because you need something like that</p> <p>359: And usually if you have problems like then you probably don't have too many people around you that you can't talk to and so I think you just keep spiraling down, you keep getting worse and worse like if you had a disease or something, especially the mental disease.</p> <p>371: If you are in the army and you do have to carry out your duties, I don't feel like you wouldn't want to be fighting with someone who has the mental problems, especially when people's lives</p>	
--	--	--

	<p>are at stake... I feel like there has been a lot of stuff they are just people, it's just a bad combination to have mentally unfit people with guns and live ammunition.</p>	
<p>Emotional Representation (family)</p>	<p>158: That's my sister probably because my parents divorced and she had a little bit of therapy but she didn't get it not that she needed to and she's been dealing with it hard she dropped out of high school something like that</p> <p>240: Just how people handle situations differently, when my parents split up she took it harder because my dad was the one that ended it</p> <p>269: I don't feel like I was bothered with it as my sister and my mom and I don't think my dad put much thought into</p>	<p>Detachment, Mistrust</p>

	<p>it at all, he kind of did like a thing and then left, he was done with it.</p> <p>371: If you are in the army and you do have to carry out your duties, I don't feel like you wouldn't want to be fighting with someone who has the mental problems, especially when people's lives are at stake... I feel like there has been a lot of stuff they are just people, it's just a bad combination to have mentally unfit people with guns and live ammunition.</p>	
--	---	--

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable) *Participant was a junior

Construct	
Age	20
Hometown	Suburban
Ethnicity	Mixed Race, Black/Italian

Gender	Male
--------	------

Construct	Line/Quote	Codes
Stigma (need, best, fit, stable)	<p>437: my opinion before I graduated high school my opinions would be like oh they are crazy. But now definitely I see a need for it. I think that somebody who does that is brave and they definitely care about their mental state and their behavioral health and all that because it is like at least they are trying to talk to somebody. If you can't talk to me, if you can't talk to anybody else go talk to somebody</p> <p>443: I felt like there was a need for it so I think I'm completely an advocate for go ahead and do it because I wouldn't look at you mainly differently because I felt like I was on the wrong side to do it.</p>	<p>Changed Beliefs, Necessity, Resources, Advocate, Non-Judgmental</p>

<p>Help-Seeking (need, stress, overwhelmed, suicide)</p>	<p>456: And then my roommate she made an observation, she was like hey, are you okay and I really sat there and I thought about that and I said no I'm don't think I'm okay.</p> <p>460: So before I had gone talk to somebody, my friends came down I have really good friends, we all talked and they got me out. They got me happy again they got me excited so that happened.</p> <p>466: He got me through it as well because he definitely could relate because he was in the army and he had been overseas and had been deployed so he knew what to say to me out of bed, flunk and everything.</p> <p>473: I feel like they care about their job first and</p>	<p>Acknowledgement (self/others), Self-Assessment, Professional Expertise, Preventative Measures, Openness to Help-Seeking, Large Change, Trauma, Perspective</p>
--	--	---

	<p>foremost because they obviously you don't want your bread and butter, you don't want your career to be severely impacted when you start feeling a certain way and two they definitely care about how they feel. So I think service, that somebody that goes and see them they are just utilizing their resources.</p> <p>479: It is there for them, they're utilizing it, it's a precaution. I mean you try to prevent something before it actually really starts happening or you see it happening. It is definitely responsible for them to go and see a professional about it</p> <p>485: I mean even if it is a preventive measure or it is an early warning system. Like</p>	
--	--	--

	<p>hey I see it happening in the beginning stages of it I will definitely go talk to somebody before it gets too far</p> <p>491: I think it is appropriate me I like to prevent a lot of stuff. So my thing is I'll go and talk to him before I even see anything going on. I like to establish relationships with people or just for things in general .so I was like I would just go and stop by and hey can I get some more information? Can you talk to me in just, tell me what to look for so that is what I would do.</p> <p>499: I don't think it is ever not appropriate, like I will just go and say hey its Wednesday let me just go and talk to a physiologist. Even sometimes</p>	
--	--	--

	<p>you just want to talk to somebody, so it is not necessarily I don't think it is ever not appropriate. When you just want to go and talk to somebody go talk to him.</p> <p>When somebody passes away in your family you need help dealing with grieve go talk to them</p> <p>505: When your friend commits suicide, when there is too much going on in your life and you need a way to handle to handle it go talk to somebody. So I don't think it is never, not appropriate.</p> <p>511: The same thing. Go talk I mean specially when you are about to get deployed or you are about to change jurisdictions, you are about to move up in a rank that is more</p>	
--	---	--

	<p>responsibility I don't think it is never not appropriate for them to go talk to somebody</p> <p>523: Grief, dealing with the loss of someone in your family, and also if I were to get deployed, things like that because that is the whole another environment and you have to train a lot for that. And then that is a lot of added stress because you hear about all these hazards and all those things. So just trying and find a way to navigate through I will go and talk to somebody about that.</p> <p>529: Even when I know when I have a lot of responsibility that I need to take care of I will go talk to somebody just so that I can get it out kind of like an outside party.</p>	
--	--	--

	<p>534: if they get deployed. I think when they have to get up and move, that is a big thing as well. Some people cannot handle change well and military change is everywhere. And I would also say when the military tends to make you angry kind of, when your superiors have you do things that is not your job description, or you have to stay extra after work, you have longer day or when PT test is coming up and you know you haven't been PT'ing like you should. So just like the day to day I would say</p>	
--	--	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression,	105: Somebody's mental state,	Mental Status,

<p>suicide, specific symptoms)</p>	<p>how they tend to interact and behave out in like the real world</p> <p>110: Whether the state of their health is, like their behavioral health whether it's in jeopardy or something like that. Like somebody would say they are crazy and things like that.</p> <p>119: Crazy looks like a lot of things [laughter] talking to yourself, not really interacting with people, doing things that aren't considered normal like dressing funny, talking funny acting funny and things like that</p> <p>130: Somebody's mental state like their actual mental state I would say how they think, how they perceive things, just how things come together in their mind and how they</p>	<p>Symptom/Disease</p> <p>Identification, Perception, Evaluative, Exposure</p>
------------------------------------	--	--

	<p>choose to like choose to see it.</p> <p>136: Yeah, their perception</p> <p>146: usually I tend to try to take a step back and evaluate why they are behaving the way they are behaving and I try to see in what possible way I can interact with them without harming them or without harming myself</p> <p>153: I had a friend who was acting crazy and I was like, it was just random like they would walk by my room just come in just start acting crazy. And like I'm not saying like playful crazy I mean like just crazy. Like I would sit right there in my chair and I would be like what is going on with them</p> <p>309: Before I had never dealt with anybody who had been</p>	
--	--	--

	<p>depressed, anybody who had ever committed suicide and here I'm a couple of months into the service and someone is always depressed, somebody is experiencing post traumatic stress syndrome and then somebody commits suicide</p> <p>328: I know Jim he talked so much. So definitely when they just stop communicating with you, when you stop seeing them stopping by your room, when they don't really want to get involved in anything</p> <p>333: Like you don't want to interact with the barbeques or anything like that, when you don't want to go to the movie theatre or the bowling alley and stuff like that, it's not okay, what is going on? And</p>	
--	---	--

	<p>then when they you ask them about it and they tend to not really want to talk about it and then when you physically see them struggling with physical PT and then sometimes that affects school work as well because your mind is so stuck on focusing on one thing you can focus on other things</p> <p>392: Of communication and looking for the signs and everything like that (regarding purpose of formal and informal communication from CO)</p> <p>493: I was like I would just go and stop by and hey can I get some more information? Can you talk to me in just, tell me what to look for so that is what I would do.</p>	
<p>Timeline (months, years,</p>		

better, until)		
Cause (outside, field, stress, family)	<p>159: I had to sit there and work with them and try to figure out why it was they were acting this way and I went to my superiors and we got to sat down and try to figure this out and everything.</p> <p>179: And then I found out later on that she had schizophrenia, she hadn't been taken on medication and everything like that. And you know her mom had just passed away so she all those factors played into how she was acting.</p> <p>205: but he could not get his physical part down at all then I guess that is just finally got to him and he snapped.</p> <p>235: It is rough I had a friend who was raped and I heard</p>	<p>Examination, Familial Factors, Expectations, Pressure from CO, Environment, Overwhelmed, Deployment, Grief/Loss</p>

	<p>there were a lot of people who committed suicide</p> <p>242: . Just military academics are roughly taking like 5, 6 classes and then on top there you have to be physically fit and on top of that your room has to be in inspection order then on top of that you have to have all these military knowledge</p> <p>252: You shouldn't have to mentally break somebody down about to rebuild them. Not through that process. I feel like there is better way to do it.</p> <p>336: when you physically see them struggling with physical PT and then sometimes that affects school work as well because your mind is so stuck on focusing on one thing you</p>	
--	---	--

	<p>can focus on other things</p> <p>343: Well the stories that I have heard from my private listed friends because they have been in the air force for like a year 2 years already so they had stories to tell me and those were stories that I heard before I even actually witnessed it myself</p> <p>402: So it is just like my idea (of mental health) kind of shifted a little bit and that is how I came to conclusion that that environment out there was completely unnecessary and it was really severely impacting my peers</p> <p>450: and I was like I don't think I'm going to get an appointment to the academy and I was me personally I eat my feelings. Again I was</p>	
--	--	--

	<p>skinny and then all of a sudden i gained all this weight. I couldn't fit my uniform anymore, I couldn't fit in my clothes anymore and then I realized that I would just be content just sit in my room watching TV on the computer</p> <p>455: I wanted to sit in the dark, like windows closed, door closed, head phones on lying in my bed or seating in my chair watching TV</p> <p>502: When somebody passes away in your family you need help dealing with grieve go talk to them. When your friend commits suicide, when there is too much going on in your life and you need a way to handle to handle it go talk to somebody. So I don't think it</p>	
--	--	--

	<p>is never, not appropriate</p> <p>511: Go talk I mean specially when you are about to get deployed or you are about to change jurisdictions, you are about to move up in a rank that is more responsibility I don't think it is never not appropriate for them to go talk to somebody</p> <p>523: Grief, dealing with the loss of someone in your family, and also if I were to get deployed, things like that because that is the whole another environment and you have to train a lot for that. And then that is a lot of added stress because you hear about all these hazards and all those things. So just trying and find a way to navigate through I will go and talk to somebody</p>	
--	---	--

	<p>about that. Even when I know when I have a lot of responsibility that I need to take care of I will go talk to somebody just so that I can get it out kind of like an outside party</p> <p>534: if they get deployed. I think when they have to get up and move, that is a big thing as well. Some people cannot handle change well and military change is everywhere. And I would also say when the military tends to make you angry kind of, when your superiors have you do things that is not your job description, or you have to stay extra after work, you have longer day or when PT test is coming up and you know you haven't been PT'ing like you</p>	
--	---	--

	<p>should. So just like the day to day I would say .</p>	
<p>Cure/Controllability (help, see someone, treatment)</p>	<p>438: I think that somebody who does that is brave and they definitely care about their mental state and their behavioral health and all that because it is like at least they are trying to talk to somebody. If you can't talk to me, if you can't talk to anybody else go talk to somebody.</p> <p>443: I felt like there was a need for it so I think I'm completely an advocate for go ahead and do it because I wouldn't look at you mainly differently because I felt like I was on the wrong side to do it</p> <p>460: So before I had gone talk to somebody, my friends came down I have really good friends, we all talked and they</p>	<p>Resources, Advocacy, Precaution,</p>

	<p>got me out. They got me happy again they got me excited so that happened.</p> <p>473: I feel like they care about their job first and foremost because they obviously you don't want your bread and butter, you don't want your career to be severely impacted when you start feeling a certain way and two they definitely care about how they feel. So I think service, that somebody that goes and see them they are just utilizing their resources</p> <p>479: It is there for them, they're utilizing it, it's a precaution. I mean you try to prevent something before it actually really starts happening or you see it happening. It is definitely</p>	
--	---	--

	<p>responsible for them to go and see a professional about it</p> <p>485: , I mean even if it is a preventive measure or it is an early warning system. Like hey I see it happening in the beginning stages of it I will definitely go talk to somebody before it gets too far</p> <p>491: So my thing is I'll go and talk to him before I even see anything going on</p> <p>499: I don't think it is ever not appropriate, like I will just go and say hey its Wednesday let me just go and talk to a physiologist. Even sometimes you just want to talk to somebody, so it is not necessarily I don't think it is ever not appropriate</p>	
Consequences (	165: I was interviewed a couple of other people who	Dismissal, Suicide

	<p>were like, asked to speak and everything and they were actually asked to leave because they concluded that they weren't mentally fit to stay in the program</p> <p>196: I guess my friend he committed suicide, will that be considered a behavioral thing</p> <p>201: he overdosed on pills; it was because at the academy there are a lot of factors that are thrown at you now for you to get through your day</p> <p>491: I think it is appropriate me I like to prevent a lot of stuff</p>	
<p>Illness Coherence (</p>	<p>228: I just feel like there were a lot of people while I was out there that committed suicide. He wasn't the first one and he would definitely not be the last one.</p>	<p>Inevitability, Formal Education, Awareness, Group Mentality</p>

	<p>307: Definitely my experience in the military, you go to so many briefings and everything you find out about warning signs of suicide and depression and all these things</p> <p>316: It has just opened my eyes and it just made me aware to pay attention more, to help people act and everything just keeps my eyes open. Just pay attentions to those warning signs and it makes me want to definitely get closer to people and find out about them. So because I don't ever want anybody to feel alone like how is my friend Jim felt.</p> <p>348: So those stories were they helped more aware I guess you could say. And then when I actually see it happen</p>	
--	---	--

	<p>that is when I really took a step back, try to evaluate what was going on and then I came to conclusion and just I think that is it.</p> <p>371: in army looking out for your battle buddy, making sure that you pay attention and you communicate with your peers. Or we just get some talking information or we get an e-mail hey read this or hey look out for this or passing down the chain of command to our leadership</p> <p>375: Leadership telling us hey if you know somebody struggling look out for them or if you know this pull them aside, help them out talk to them because we don't want any of those issues.</p> <p>380: I would say like every</p>	
--	--	--

	<p>once in a while like a couple of times a month because it is not really formal but it is informal</p> <p>457: And then my roommate she made an observation, she was like hey, are you okay and I really sat there and I thought about that and I said no I'm don't think I'm okay.</p>	
<p>Emotional Representation (family</p>	<p>173: a family member and they have schizophrenia; it directly impacted me one time because we were, somebody had just passed away so we were at the family's house for the wake. I was in the kitchen and she came into the kitchen and she looked right at me.</p> <p>And I was scared and I just stood there and then she mumbled under her breath, she threw up her hands and</p>	<p>Fear, Grief, Remorse, Empathy</p>

	<p>then she walked away.</p> <p>185: I was scared when I was younger so I was definitely scared, my mindset was just too stand back and not really do anything just kind of sit back and observe and see what they were going to do and then that was how I was going to react.</p> <p>221: Gosh I was sad for weeks. It personally impacted me because I felt I knew what he was going through and I kind of felt guilty because I wasn't there to help him.</p> <p>Obviously I couldn't help him physically because I wasn't at the academy. But I felt like I should have made my presence more known for him to be able to come to me and talk to me</p>	
--	--	--

	<p>226: I thought that is why we were as friends but I guess we weren't. So that definitely impacted me.</p> <p>319: So because I don't ever want anybody to feel alone like how is my friend Jim felt.</p> <p>466: He got me through it as well because he definitely could relate because he was in the army and he had been overseas and had been deployed so he knew what to say to me out of bed, funk and everything.</p>	
--	---	--

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable)

Construct	
Age	20
Hometown	Suburban
Ethnicity	Black, African-American
Gender	Female

Construct	Line/Quote	Codes
Stigma (need, best, fit, stable)	<p>200: I think they are doing the right thing it is probably better than not going to see them; I mean it is going to point them in the right direction it is better than just wallowing in the corner and not getting help and not talking to anyone about it if it is like seriously affecting them and if it is not they can still if it is minorly affecting them it can still they can be good to help them manage it and it is pretty much think it is a good thing.</p> <p>207: Same thing I think it is a good thing they need to go see one because it is not just your physical health that counts it is all connected. So like I injured my knee I went and saw a physical therapist, so it is all</p>	Non-Judgment, Better Option, Mind/Body Connection

	<p>connected so you have sort of mental problem then you should go see some one for that to because it is going to be detrimental if you don't so it is a good thing</p>	
<p>Help-Seeking (need, stress, overwhelmed, suicide)</p>	<p>216: once it is noticed by maybe themselves or say their peers notice and tell them I guess especially once it becomes an issue with their daily lives like there routine or something of the sort it becomes detrimental and affects them in a negative way then they should go</p> <p>220: If they don't notice it, they are not detrimental someone who has training in the field to notice it would notice it I feel like say telling them they had something but they didn't notice they had</p>	<p>Awareness (self/others), Professional Expertise, Self-Medication, Mandatory Assessment, Symptom/Disease Identification,</p>

	<p>might be even worse than just if it is not really affecting them they don't feel like it is not detrimental they don't know that someone who has the ability to know if they have that I feel they can get in there head and it could become more detrimental and problem already was.</p> <p>235: Well we are supposed to get like counseled by our superiors give us counseling reports every once in a while about if they are checking on what we are doing like routines also they are supposed to pay attention to our behavioral, mental, physical health and gives us like a counseling report on it so it will be easier in that situation for a service member</p>	
--	---	--

	<p>to pick up on if there is a problem because there is supposed to be a record of it all the time well on at least how they are doing in their job but I feel like it would be appropriate.</p> <p>When there is a change say after they say home problems say like going through a divorce or something or I'd say death in the family or maybe they were deployed and something happened and wide number of things could make it appropriate for them to go I mean they are available I feel like they will be available within an army to go see someone to council them and it makes it easier feel like it will be appropriate when there is they see a change after</p>	
--	--	--

	<p>some sort of traumatic life event whether it be at home or with an army and then they should go seek behavioral health</p> <p>250: If I found any kind of change in my routine or motivation to go and I felt it was really affecting me to the point where I could not complete the tasks I needed to do and I would probably wait a good amount of time just to be sure to see what I could do I would probably wait at least a month or more maybe longer depending on if I felt I was making any progress myself but if it wasn't myself.</p> <p>If felt like it wasn't just myself who was having it and my peers told me that they noticed something I would probably</p>	
--	--	--

	<p>shorten that amount of time</p> <p>they told me [crosstalk] I kind of gauge myself.</p> <p>259: Right and then I will be like oh I guess I do need to go seek help I feel like if it is just in my mind, “that’s just in my mind”, and I am might be thinking I have a problem but when someone tells you it is definitely not in my mind I should probably go seek help.</p> <p>264: I guess this is same sort of events happening for me in their personal lives or the environment of being a service member then they should definitely go and see someone it is detrimental</p> <p>271: I feel PTSD is a big one that that they make I see in the news all the time would be one of the biggest issue</p>	
--	---	--

	<p>279: So I guess if you are feeling suicidal thoughts so that will be something that a service member should talk to someone about.</p>	
--	---	--

Conceptual Framework – Common Sense Model of Illness Representation

Construct	Line/Quote	Codes
Identity (PTSD, depression, suicide, specific symptoms)	<p>68: mentally stable</p> <p>69: they don't have any, I don't want to say mental problems maybe like conditions and I guess just the study of behavioral conditions</p> <p>72: PTSD or ADHD</p> <p>73: schizophrenia; I am trying to remember my psych class, my intro to psych class</p> <p>77: Something it sounds pretty close to behavioral health, I guess behavioral will be how you would it is more focusing on your actions, so the mental</p>	<p>Mental Stability,</p> <p>Symptom/Disease</p> <p>Identification, Research,</p> <p>Education</p>

	<p>health is focusing in the mental processes and behavioral might be how mental process affect your behavior I guess that is why.</p> <p>101: PTSD is high among service members and no one seems to talk to talk about it too much in ROTC environment</p> <p>157: I made note that in the future I will need to do more research on post-traumatic stress disorder, since I will be an officer in the future I will have to I guess aware of my fellow soldiers and as well as an ROTC my fellow cadets and I know I will need to be aware it is not a big of a thing at the moment but like a path to knowing I need to be aware</p> <p>220: If they don't notice it,</p>	
--	---	--

	<p>they are not detrimental</p> <p>someone who has training in the field to notice it would notice it I feel like say telling them they had something but they didn't notice they had might be even worse than just if it is not really affecting them they don't feel like it is not detrimental they don't know that some one who has the ability to know if they have that I feel they can get in there head and it could become more detrimental and problem already was</p> <p>227: is that book that post they make a copy of that will solve the disorders or they redo it the DSM something but normally you can't just buy that book I am pretty sure you have to like I have heard I</p>	
--	--	--

	<p>seem to recall from my psychology class it was like they don't really put that book out there for too many people out there in the field to read because self-diagnose themselves it could end up worse for those people I feel like that sort of a parallel</p>	
<p>Timeline (months, years, better, until)</p>	<p>250: If I found any kind of change in my routine or motivation to go and I felt it was really affecting me to the point where I could not complete the tasks I needed to do and I would probably wait a good amount of time just to be sure to see what I could do I would probably wait at least a month or more maybe longer depending on if I felt I was making any progress myself but if it wasn't myself</p>	<p>Acute, Month</p>

<p>Cause (outside, field, stress, family)</p>	<p>241: When there is a change say after they say home problems say like going through a divorce or something or I'd say death in the family or maybe they were deployed and something happened and wide number of things could make it appropriate for them to go</p> <p>244: I feel like they will be available within an army to go see someone to council them and it makes it easier feel like it will be appropriate when there is they see a change after some sort of traumatic life event whether it be at home or with an army and then they should go seek behavioral health.</p> <p>264: I guess this is same sort of events happening for me in</p>	<p>Familial Problems, Grief/Loss, Trauma, Civilian vs Soldier</p>
---	--	---

	<p>their personal lives or the environment of being a service member then they should definitely go and see someone it is detrimental.</p>	
<p>Cure/Controllability (help, see someone, treatment)</p>	<p>136: being athletic I have done a lot of research on being athletic and how it makes you feel better over role and as I guess feel like running like having problems I can run them away so I guess I really feel like strong correlation between being athletic and not having behavioral issues or having affects negative slightly</p> <p>141: I have always been kind of athletic and research from reading magazines or articles on websites in regards to I will pick up an article and just read it so I have gotten general</p>	<p>Mind/Body Connection, Availability of Resources,</p>

	<p>knowledge over that it is first hand as well like stressed out I go run like go to the gym feel great the whole day afterwards.</p> <p>166: That if we have any problems like something is bugging us like say for example that anonymous cadet who had suicidal thoughts or something they are always people there who are willing to talk to you about and they are places you can go to it is not in for that but it is like made it known like after that story and that's for anything you have like a problem with so and people are here for you so</p> <p>172: The [cadre] will talk to you or our direct you to the right resources on campus or</p>	
--	--	--

	<p>where ever it is needed and we all have their, we normally have like our cadre like in class and if they are a professor, we will have like their personal phone numbers I have sergeant Reyes's number and they like made it known that if you have any problems then we can point you in the right direction.</p> <p>200: I think they are doing the right thing it is probably better than not going to see them</p> <p>201: I mean it is going to point them in the right direction it is better than just wallowing in the corner and not getting help and not talking to anyone about it if it is like seriously affecting them and if it is not they can still if it is minorly affecting them it can still they</p>	
--	--	--

	<p>can be good to help them manage it and it is pretty much think it is a good thing.</p> <p>277: So I guess if you are feeling suicidal thoughts so that will be something that a service member should talk to someone about.</p>	
<p>Consequences (</p>	<p>191: like you have class twice a week and you are there PT three times a day so like people are going to pick up on that if you stop showing up they're gonna ask you about that and they check your grades are falling and ask you about that and then kind of like be on top of you I guess like on top of your routines kind of helps with if there is a problem it might be easier to identify or easier to be able to like I think I am having a</p>	<p>Loss of Focus, Daily Routine</p>

	<p>problem can you help me out with this I feel like that is definitely not available to a civilian student</p> <p>216: once it is noticed by maybe themselves or say their peers notice and tell them I guess especially once it becomes an issue with their daily lives like there routine or something of the sort it becomes detrimental and affects them in a negative way then they should go.</p> <p>259: Right and then I will be like oh I guess I do need to go seek help I feel like if it is just in my mind, “that’s just in my mind”, and I am might be thinking I have a problem but when someone tells you it is definitely not in my mind I should probably go seek help</p>	
--	---	--

<p>Illness Coherence (</p>	<p>84: It really depends on the situation I mean I don't try to bring up where like I try make it like even if it is negatively affecting the situation I don't really try to and like the person is being detrimental to the situation and make them know that kind of thing I might ask be like why are you acting like this</p> <p>90: If I bring it up and talk about it would probably be it would not be out of the blue just be like why is that person doing that why you are acting that way and be like hey man are you okay like then they would if I did bring it up they would tell me then but if I didn't it just because I decided I guess it wasn't affecting me as much so much that I needed</p>	<p>Avoidance, Adjustment, Formal Education, Past Knowledge, Mind/Body Connection</p>
----------------------------	---	--

	<p>to ask about it</p> <p>118: In the class we had the presentation last semester about being army strong or something it was a power point I remember and there was a slide on mental health in that like talked about physical health and mental health and I think we had a little triangle diagram. So really to the fresh in my mind just about how physical mental spiritual health there was another point how all that converges in being army strong I believe was the term</p> <p>132: An AP physc class in high school so I learned about them then, I just learnt more information which is always god to learn more about something to influence your</p>	
--	--	--

	<p>opinion, but that was where I just I gained more knowledge on it, but at the time but I mean just aside from learning about it there is really nothing that is negatively positively influenced,</p> <p>157: Just general seeing articles about soldiers with PTSD/ I guess the comradery in ROTC between people and knowing that I guess is just really got a group there is a lot of group cohesion kind of thing and we need to work as a group and some general stuff I've seen in articles I have read that kind of popped out soldiers with PTSD and we have that one power point at that one time</p> <p>207: thing I think it is a good thing they need to go see one</p>	
--	--	--

	<p>because it is not just your physical health that counts it is all connected</p> <p>209: it is all connected so you have sort of mental problem then you should go see some one for that to because it is going to be detrimental if you don't so it is a good thing</p>	
Emotional Representation (family	95: If it's not bothering me, probably not going to ask about it.	Avoidance

Demographics (Some demographics removed due to homogeneity [MS status] or rank, which was not applicable) *Participant was a junior transitioning to senior

Construct	
Age	21
Hometown	Suburban
Ethnicity	Polish
Gender	Female

Construct	Codes	Themes
Identity	<p>P1: Symptom/Disease Identification, Limited Information</p> <p>P2: Symptom/Disease Identification, Explanation of Behaviors, Secrecy</p> <p>P3: Normalized Behavior, Disease/Symptom Identification, Limited Education (ROTC)</p> <p>P4: Symptom/Disease Identification, Co-Morbidity, Anecdotal Education</p> <p>P5: Normality, Stability, Emotional Control</p> <p>P6: Overall Status,</p>	<p>Major Theme: Symptom/Disease Identification</p> <p>Sub-themes: Co-morbidity</p> <p>Major Theme: Information Source</p> <p>Sub-themes: ROTC Education, Limited Familial Sharing (service member), Research</p>

	<p>Symptom/Disease Identification, Thoughts vs. Behaviors, Emotional Control, Limited Education</p> <p>P7: Mental Status, Symptom/Disease Identification, Perception, Evaluative, Exposure</p> <p>P8: Mental Stability, Symptom/Disease Identification, Research, Education</p>	
<p>Timeline</p>	<p>P1: Lifelong, Situational</p> <p>P2: Acute</p> <p>P3: Long Term</p> <p>P4: Acute, Development, Repeated Experiences</p>	<p>Major Theme: Acute vs. Developmental</p>

	<p>P5: Temporary</p> <p>P6: Long Term Decision Making, Month</p> <p>P7:</p> <p>P8: Acute, Month</p>	
Cause	<p>P1: Environmental, Congenital, Trauma</p> <p>P2: Family/Home</p> <p>P3: Psychotic Break, Grief/Loss</p> <p>P4: Alcohol, Combat, Trauma</p> <p>P5: School Pressures, Combat</p> <p>P6: Familial Issues, Interpersonal Triggers, Combat, Eventuality,</p>	<p>Major Theme: Combat Related</p> <p>Sub-themes: Trauma, Grief/Loss, Deployment</p> <p>Major Theme: Distance Issues</p> <p>Sub-themes: Familial Issues</p>

	<p>Grief/Loss</p> <p>P7:Examination, Familial Factors, Expectations, Pressure from CO, Environment, Overwhelmed, Deployment, Grief/Loss</p> <p>P8: Familial Problems, Grief/Loss, Trauma, Civilian vs Soldier</p>	
<p>Cure/Controllability</p>	<p>P1: Client buy-in, Self-Medication, Open Options of Treatment</p> <p>P2: Efficiency, Teamwork, Awareness (Self/Outside), Strength, Acknowledgement</p> <p>P3: Acknowledgement (self/others)</p> <p>P4: Adjustment, Self-</p>	<p>Major Theme: Acknowledgement</p> <p>Sub-themes: Awareness (self/others)</p> <p>Major Theme: Treatment Options</p> <p>Sub-themes: Professional Expertise, Self-Medication, Resources</p> <p>Major Theme: Population</p>

	<p>Medication, Qualified Professionals, Required Treatments, Acknowledgement</p> <p>P5: Proportional, Necessity, Self-Assessment</p> <p>P6: Attribution, Group Engagement, Self-Efficacy, Lower Stress, Professional Expertise, Resources, Time Sensitive, Civilian vs Soldier</p> <p>P7: Resources, Advocacy, Precaution</p> <p>P8: Mind/Body Connection, Availability of Resources,</p>	<p>Differences</p> <p>Sub-themes: Required Treatments, Advocacy, Civilian vs. Soldier, Precaution, Time Sensitive</p>
<p>Consequences</p>	<p>P1: Distrust, Familial Destruction, Harm (self/others)</p>	<p>Major Theme: Outside Consequences</p> <p>Sub-themes: Job Performance, School</p>

	<p>P2: Job Performance Decline, Affecting Daily Life, Internal Conflicts, Interpersonal Conflict</p> <p>P3: Adjustment, Job Performance, Group Impact, School Performance</p> <p>P4: Alcoholism, Misalignment</p> <p>P5: Trauma, Job Performance</p> <p>P6: Property Destruction, Lack of Control, Spiraling</p> <p>P7: Dismissal, Suicide</p> <p>P8: Loss of Focus, Daily Routine</p>	<p>Performance, Group Impact</p> <p>Major Theme: Self-Harm</p> <p>Sub-themes: Suicide, Spiraling, Alcoholism</p>
Illness Coherence	<p>P1: Teamwork, Continued Issues</p>	<p>Major Theme:</p>

	<p>P2: Adaptation, Empathy, Privacy, Integration of Ideas,</p> <p>P3: Definition of Normality vs Abnormality</p> <p>P4: Education, Equality, Personal Connection</p> <p>P5: Awareness, Mind/Body Connection, Resilience</p> <p>P6: Personality Adjustment, Deterioration of Job Performance, Necessity</p> <p>P7: Inevitability, Formal Education, Awareness, Group Mentality</p> <p>P8: Avoidance, Adjustment, Formal Education, Past</p>	
--	--	--

	Knowledge, Mind/Body Connection	
Emotional Representation	<p>P1: Empathy, Apprehension, Fear</p> <p>P2: Empathy, Familial Connection, Live Representation of Illness</p> <p>P3: Apprehension, Unaffected</p> <p>P4: Familial Connection, Disbelief</p> <p>P5: Adjustment, Familial Connection, Devastated, Self-Assurance</p> <p>P6: Detachment, Mistrust</p> <p>P7: Fear, Grief, Remorse, Empathy</p>	<p>Major Theme: Thought Based Reactions</p> <p>Sub-themes: Apprehension, Adjustment, Avoidance, Empathy</p> <p>Major Themes: Emotional Outcomes</p> <p>Sub-themes: Fear, Mistrust, Grief</p>

	P8: Avoidance	
--	---------------	--

Stigma	P1: Non-judgment, Invalid, Useless, Case-by-case basis, Self-medication	Major Theme: Openness to Treatment Sub-theme: Treatment Choice
	P2: Skill/Strength Building, Acknowledgement	Major Theme: Self-Assessment/Awareness
	P3: Self-Awareness, Non-Judgmental	Major Theme: Inevitability
	P4: Non-Judgment, Provided Professionals	
	P5: Non-Judgmental, Detachment	
	P6: Self-Assessment, Assistance, Professional Expertise, Danger, Worsening	

	<p>P7: Changed Beliefs, Necessity, Resources, Advocate, Non-Judgmental</p> <p>P8: Non-Judgment, Better Option, Mind/Body Connection</p>	
Help-Seeking	<p>P1: Job performance, gender issues, sexual assault</p> <p>P2: Experienced Assistance, Noticeable Differences, Timeliness, Self-Medication,</p> <p>P3: Acknowledgement (self/others), Severity, Situational Factors, Service vs Civilian Importance,</p> <p>P4: Required Debriefings/Treatments, Limited Resources, Client</p>	<p>Major Theme: Acknowledgement/Awareness</p> <p>Major Theme: Treatment Options</p> <p>Major Theme: Treatment by Population</p>

	<p>Buy-in, Helping Professional Expertise, Personal Issues, Civilian vs Soldier</p> <p>P5: Personal Responsibility, Family Issues, Professional Expertise, Trauma</p> <p>P6: Self-Assessment, Internal Resources, Timeline, Civilian vs Soldier, Grief, Detachment</p> <p>P7: Acknowledgement (self/others), Self- Assessment, Professional Expertise, Preventative Measures, Openness to Help- Seeking, Large Change, Trauma, Perspective</p> <p>P8: Awareness (self/others), Professional Expertise, Self- Medication, Mandatory</p>	
--	--	--

	Assessment, Symptom/Disease Identification,	
--	---	--

REFERENCES

- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help-seeking. *American psychologist, 58*(1), 5-14.
- Adler, A. B., Bliese, P. D., McGurk, D., Hoge, C. W., & Castro, C. A. (2011). Battlemind debriefing and Battlemind training as early interventions with soldiers returning from Iraq. *Sport, Exercise, and Performance Psychology, 1*, 66-83.
- Allen, J. P., Cross, G., & Swanner, J. (2005). Suicide in the Army: a review of current information. *Military Medicine, 170*(7), 580-584.
- Anfara, V. A., Brown, K. M., & Mangione, T.L. (2002). Qualitative research on stage: Making the research process more public. *Educational Researcher, 31*(7), 28-38.
- Angermeyer, M. C., Matschinger, H., & Schomerus, G. (2013). Attitudes towards psychiatric treatment and people with mental illness: changes over two decades. *The British Journal of Psychiatry, 203*(2), 146-151.
- Angrosino, M. V. (2006). *Doing cultural anthropology: Projects for ethnographic data collection*. Long Grove, IL: Waveland Press.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179-211.
- Armed Forces Health Surveillance Center. (2011). Summary of mental disorder hospitalizations, active and reserve components, U.S. Armed Forces, 2000-2012. *MSMR, 20*(7), 4-11.
- Army Health Promotion, Risk Reduction, & Suicide Prevention Report. (2011). *Journal of Special Operations Medicine, 11*, 62.

- Baines, T., & Wittkowski, A. (2013). A systematic review of the literature exploring illness perceptions in mental health utilizing the self-regulation model. *Journal of clinical psychology in medical settings, 20*(3), 263-274.
- Baldwin, J. N. (1996). The promotion record of the United States Army: Glass ceilings in the Officer Corps. *Public Administration Review, 56*(2), 199-206.
- Barker, G. (2007). Adolescents, social support and help-seeking behavior. *Geneva, Switzerland: World Health Organization.*
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the BDI-II*. San Antonio, TX: Psychological Corporation.
- Berger, J. M., Levant, R., McMillan, K. K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward psychological help-seeking. *Psychology of Men & Masculinity, 6*(1), 73.
- Blais, R. K., & Renshaw, K. D. (2013). Stigma and demographic correlates of help-seeking intentions in returning service members. *Journal of Traumatic Stress, 26*, 77–85.
- Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD Checklist (PCL). *Behaviour research and therapy, 34*(8), 669-673.
- Bray, R. M., Pemberton, M. R., Lane, M. E., Hourani, L. L., Mattiko, M. J., & Babeu, L. A. (2010). Substance use and mental health trends among US military active duty personnel: key findings from the 2008 DoD Health Behavior Survey. *Military Medicine, 175*(6), 390-399.

- Britt, T. W. (2000). The stigma of psychological problems in a work environment: Evidence from the screening of service members' returning from Bosnia. *Journal of Applied and Social Psychology, 30*, 1599–1618.
- Britt, T. W., Greene-Shortridge, T. M., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172*(2), 157-161.
- Britt, T. W., Wright, K. M., & Moore, D. (2012). Leadership as a predictor of stigma and practical barriers toward receiving mental health treatment: A multilevel approach. *Psychological services, 9*(1), 26.
- Brown, R. L., Leonard, T., Saunders, L. A., & Papasouliotis, O. (2001). A two-item conjoint screen for alcohol and other drug problems. *The Journal of the American board of Family Practice, 14*(2), 95-106.
- Byrd, D. R., & McKinney, K. J. (2012). Individual, interpersonal, and institutional level factors associated with the mental health of college students. *Journal of American College Health, 60*(3), 185-193.
- Carlson, J. A. (2010). Avoiding traps in member checking. *The Qualitative Report, 15*(5), 1102-1113.
- Care, M. N., & Kuiper, N. A. (2012). Cognitive representation in a self-regulation model of depression: Effects of self-other distinctions, symptom severity and personal experiences with depression. *Self and Identity, 12*(2), 128-145.
- Carr, W., Bradley, D., Ogle, A. D., Eonta, S. E., Pyle, B. L., & Santiago, P. (2013). Resilience training in a population of deployed personnel. *Military Psychology, 25*(2), 148-155.

- Castro, C. A., Adler, A. B., & Bienvenu, R. V. (1998). A human dimensions assessment of the impact of OPTEMPO on the forward-deployed soldier (WRAIR Protocol #700). Washington DC: Walter Reed Army Institute of Research.
- Castro, C. A., Hoge, C. W., & Cox, A. L. (2006). *Battlemind training: Building soldier resiliency*. Walter Reed Army Institute of Research Silver Spring, MD Department of Military Psychiatry.
- Center, D. M. D. (2013). Active Duty US Army Demographics as of March, 213. *Defense Manpower Data Center, 1600*.
- Chisholm, D., Knapp, M. R., Knudsen, H. C., Amaddeo, F., Gaité, L. U. I. S., & Van Wijngaarden, B. O. B. (2000). Client socio-demographic and service receipt inventory-European version: development of an instrument for international research EPSILON study 5. *The British Journal of Psychiatry, 177*(39), 28-33.
- Clark-Hitt, R., Smith, S. W., & Broderick, J. S. (2012). Help a buddy take a knee: Creating persuasive messages for military service members to encourage others to seek mental health help. *Health communication, 27*(5), 429-438.
- Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *The Journal of Abnormal and Social Psychology, 64*(5), 349.
- Cole, E., Stevenson, M., & Rodgers, B. (2009). The influence of cultural health beliefs on self-reported mental health status and mental health service utilization in an ethnically diverse sample of older adults. *Journal of Feminist Family Therapy, 21*(1), 1-17.
- Coll, J. E., Weiss, E. L., & Yarvis, J. S. (2011). No one leaves unchanged: insights for civilian mental health care professionals into the military experience and culture. *Social work in health care, 50*(7), 487-500.

- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614.
- Corrigan, P. W., Larson, J. E., & Ruesch, N. (2009). Self-stigma and the “why try” effect: impact on life goals and evidence-based practices. *World Psychiatry*, 8(2), 75-81.
- Corrigan, P., & Matthews, A. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health*, 12(3), 235-248.
- Corrigan, P. W., Michaels, P. J., Vega, E., Gause, M., Watson, A. C., & Rüsck, N. (2012). Self-stigma of mental illness scale—short form: Reliability and validity. *Psychiatry research*, 199(1), 65-69.
- Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54(9), 765.
- Creswell, J. W. (2005). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research (2nd ed.)*. Upper Saddle River, NJ: Pearson
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches (3rd ed.)*. Thousand Oaks, CA: Sage Publications.
- Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal*, 54, 88-94.
- Deane, F. P., & Todd, D. M. (1996). Attitudes and intentions to seek professional psychological help for personal problems or suicidal thinking. *Journal of College Student Psychotherapy*, 10(4), 45-59.
- Dedoose web application for managing, analyzing, and presenting qualitative and mixed method research data (Version 4.5) [Computer software]. Los Angeles, CA: SocioCultural Research Consultants, LLC. Retrieved from: www.dedoose.com

- Department of Defense, Office of the Deputy Under Secretary of Defense (Military Community and Family Policy) (2011). *Demographics: Profile of the Military Community*. Retrieved from http://www.militaryonesource.mil/12038/MOS/Reports/2011_Demographics_Report.pdf
- Diefenbach, M. A., & Leventhal, H. (1996). The common-sense model of illness representation: Theoretical and practical considerations. *Journal of Social Distress and the Homeless*, 5, 11-38.
- Dunivin, K. O. (1994). Military culture: Change and continuity. *Armed Forces & Society*, 20(4), 531-547.
- Earnshaw, V. A., & Chaudoir, S. R. (2009). From conceptualizing to measuring HIV stigma: a review of HIV stigma mechanism measures. *AIDS and Behavior*, 13(6), 1160-1177.
- Earnshaw, V. A., & Quinn, D. M. (2012). The impact of stigma in healthcare on people living with chronic illnesses. *Journal of Health Psychology*, 17(2), 157-168.
- Edlund, M. J., Fortney, J. C., Reaves, C. M., Pyne, J. M., & Mittal, D. (2008). Beliefs about depression and depression treatment among depressed veterans. *Medical Care*, 46(6), 581-589.
- Eisler, R. M., & Blalock, J. A. (1991). Masculine gender role stress: Implications for the assessment of men. *Clinical Psychology Review*, 11(1), 45-60.
- Erbes, C., Westermeyer, J., Engdahl, B., & Johnsen, E. (2007). Post-traumatic stress disorder and service utilization in a sample of service members from Iraq and Afghanistan. *Military Medicine*, 172(4), 359-363.

- Escobar, F., Espi, F., & Canteras, M. (1995). Diagnostic tests for alcoholism in primary health care: compared efficacy of different instruments. *Drug and alcohol dependence, 40*(2), 151-158.
- Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development, 36*, 368-373.
- Fischer, A. H., & Manstead, A. S. (2000). The relation between gender and emotions in different cultures. *Gender and emotion: Social psychological perspectives, 71-94*.
- Fischer, E. H., & Turner, J. I. (1970). Orientations to seeking professional help: development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*(101), 79.
- Fleming, M. (2013). Help seeking attitudes toward mental health issues among military men who have been in combat. *Dissertation Abstracts International, 73*(9-B).
- Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of traumatic stress, 6*(4), 459-473.
- Gall, M. D., Gall, J. P., & Borg, W. R. (2007). Collecting research data with questionnaires and interviews. *Educational research: An introduction, 227-261*.
- Garamone, J. (2014). *DOD releases suicide event report, changes reporting methods*. American Forces Press Service. Retrieved from:
<http://www.defense.gov/news/newsarticle.aspx?id=122126>

- Gibbs, D. A., Rae Olmsted, K. L., Brown, J. M., & Clinton-Sherrod, A. M. (2011). Dynamics of stigma for alcohol and mental health treatment among army soldiers. *Military Psychology, 23*, 36–51.
- Glesne, C. (2011). *Becoming qualitative researchers: An introduction (4th ed)*. Boston, MA: Pearson.
- Godoy-Izquierdo, D., López-Chicheri, I., López-Torrecillas, F., Vélez, M., & Godoy, J. F. (2007). Contents of lay illness models dimensions for physical and mental diseases and implications for health professionals. *Patient Education and Counseling, 67*(1), 196-213.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Spectrum.
- Good, G. E., Dell, D. M., & Mintz, L. B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology, 36*(3), 295.
- Good, G. E., Gilbert, L. A., & Scher, M. (1990). Gender aware therapy: A synthesis of feminist therapy and knowledge about gender. *Journal of Counseling & Development, 68*(4), 376-380.
- Good, G. E., & Robertson, J. M. (2010). To accept a pilot? Addressing men's ambivalence and altering their expectancies about therapy. *Psychotherapy: Theory, Research, Practice, Training, 47*(3), 306.
- Good, G. E., Schopp, L. H., Thomson, D., Hathaway, S., Sanford-Martens, T., Mazurek, M. O., & Mintz, L. B. (2006). Masculine roles and rehabilitation outcomes among men recovering from serious injuries. *Psychology of Men & Masculinity, 7*(3), 165.
- Good, G. E., & Wood, P. K. (1995). Male gender role conflict, depression, and help seeking: Do college men face double jeopardy?. *Journal of Counseling & Development, 74*(1), 70-75.

- Goodman, L. A., Corcoran, C., Turner, K., Yuan, N., & Green, B. L. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. *Journal of traumatic stress, 11*(3), 521-542.
- Gould, M., Adler, A., Zamorski, M., Castro, C., Hanily, N., Steele, N., Kearney, S., & Greenberg, N. (2010). Do stigma and other perceived barriers to mental health care differ across Armed Forces?. *Journal of the Royal Society of Medicine, 103*(4), 148-156.
- Greenberg N., Langston V. & Gould M. (2007) Culture – what is its effect on stress in the military? *Military Medicine, 172*, 931–935.
- Greenberg, N., Gould, M., Langston, V., & Brayne, M. (2009). Journalists' and media professionals' attitudes to PTSD and help-seeking: A descriptive study. *Journal of Mental Health, 18*(6), 543-548.
- Greene-Shortridge, T. M., Britt, T. W., & Castro, C. (2007). The Stigma of Mental Health Problems in the Military. *Military Medicine, 172*(2), 157-161.
- Griffith, J. (2012). Suicide in the army national guard: an empirical inquiry. *Suicide and Life-Threatening Behavior, 42*, 104-119.
- Hagger, M. S., & Orbell, S. (2003). A meta-analytic review of the common-sense model of illness representations. *Psychology and Health, 18*(2), 141-184.
- Hall, L. K. (2011). The importance of understanding military culture. *Social work in health care, 50*(1), 4-18.
- Hammer, J. H., & Good, G. E. (2010). Positive psychology: An empirical examination of beneficial aspects of endorsement of masculine norms. *Psychology of Men & Masculinity, 11*(4), 303.

- Harms, P. D., Herian, M. N., Krasikova, D. V., Vanhove, A., & Lester, P. B. (2013). *The comprehensive soldier and family fitness program evaluation report #4: Evaluation of resilience training and mental and behavioral health outcomes*. Monterey, CA: Office of the Deputy Under Secretary of the Army.
- Hayslip Jr, B., Maiden, R. J., Thomison, N. L., & Temple, J. R. (2010). Mental health attitudes among rural and urban older adults. *Clinical Gerontologist*, 33(4), 316-331.
- Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *JAMA: the journal of the American Medical Association*, 295(9), 1023-1032.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13-22.
- Hoge, C. W., Lesikar, S. E., Guevara, R., Lange, J., Brundage, J. F., Engel, C. C., Messer, S. C., & Orman, D. T. (2002). Mental disorders among US military personnel in the 1990s: association with high levels of health care utilization and early military attrition. *American Journal of Psychiatry*, 159(9), 1576-1583.
- Hogetts, D., & Chamberlain, K. (2002). 'The Problem with Men': Working-class Men Making Sense of Men's Health on Television. *Journal of Health Psychology*, 7(3), 269-283.
- Hotopf, M., Hull, L., Fear, N. T., Browne, T., Horn, O., Iversen, A., Jones, M., Murphy, D., Bland, D., Earnshaw, M., Greenberg, N., Hughes, J. H., Tate, A. R., Dandeker, C., Rona, R., & Wessely, S. (2006). The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *The Lancet*, 367(9524), 1731-1741.

- Husaini, B. A., Moore, S. T., & Cain, V. A. (1994). Psychiatric symptoms and help-seeking behavior among the elderly: An analysis of racial and gender differences. *Journal of Gerontological Social Work, 21*(3-4), 177-196.
- Hyman, J., Ireland, R., Frost, L., Cottrell, L. (2012). Suicide incidence and risk factors in an active duty U.S. military population. *American Journal of Public Health, 102*, 138-145.
- Iversen, A. C., van Staden, L., Hughes, J. H., Greenberg, N., Hotopf, M., Rona, R. J., Thornicroft, G. Wessley, S., & Fear, N. T. (2011). The stigma of mental health problems and other barriers to care in the UK Armed Forces. *BMC Health Services Research, 11*(1), 31.
- Ireland, R. R., Kress, A. M., Frost, Z. (2012). Association between mental health conditions diagnosed during initial eligibility for military health care benefits and subsequent deployment, attrition, and death by suicide among active duty service members. *Military Medicine, 177*(10), 1149-1156.
- Jones, E. E., Farina, A., Hastorf, A. H., & French, R. D. S. (1984). *Social stigma: The psychology of marked relationships*. New York: WH Freeman.
- Kahn, J. H., & Hessling, R. M. (2001). Measuring the tendency to conceal versus disclose psychological distress. *Journal of Social and Clinical Psychology, 20*, 41-65.
- Kang, H. K., & Bullman, T. A. (2008). Risk of suicide among US veterans after returning from the Iraq or Afghanistan war zones. *JAMA: the journal of the American Medical Association, 300*(6), 652-653.
- Kehle, S. M., Polusny, M. A., Murdoch, M., Erbes, C. R., Arbisi, P. A., Thuras, P., & Meis, L. A. (2010). Early mental health treatment-seeking among US National Guard soldiers deployed to Iraq. *Journal of Traumatic Stress, 23*(1), 33-40.

- Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology, 42*(1), 40.
- Kessler, R. C., Brown, R. L., & Broman, C. L. (1981). Sex differences in psychiatric help-seeking: evidence from four large-scale surveys. *Journal of Health and Social Behavior, 49*-64.
- Killgore, W. D., Cotting, D. I., Thomas, J. L., Cox, A. L., McGurk, D., Vo, A. H., Castro, C. A., & Hoge, C. W. (2008). Post-combat invincibility: violent combat experiences are associated with increased risk-taking propensity following deployment. *Journal of Psychiatric Research, 42*(13), 1112-1121.
- Kim, P. Y., Britt, T. W., Klocko, R. P., Riviere, L. A., & Adler, A. B. (2011). Stigma, negative attitudes about treatment, and utilization of mental health care among soldiers. *Military Psychology, 23*(1), 65-81.
- Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142*(11), 1259-1264.
- King, D. W., King, L. A., & Vogt, D. S. (2003). *Manual for the deployment risk and resilience inventory (DRRI): A collection of measures for studying deployment-related experiences of military veterans*. Boston, MA: National Center for PTSD.
- Komiya, N., & Eells, G. T. (2001). Predictors of attitudes toward seeking counseling among international students. *Journal of College Counseling, 4*(2), 153-160.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The Phq-9. *Journal of general internal medicine, 16*(9), 606-613.
- Kunkel, C., & Nielsen, J. M. (1998). Gender, residual deviance, and social control. *Deviant Behavior, 19*(4), 339-360.

- Lane, J. M., & Addis, M. E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. *Psychology of Men and Masculinity*, 6(3), 155.
- Langston, V., Gould, M., & Greenberg, N. (2007). Culture: what is its effect on stress in the military. *Military Medicine*, 172(9), 931-935.
- Lebowitz, B. D., & Niederehe, G. (1992). Concepts and issues in mental health and aging. In Birren, J. E., Sloane, R., Cohen, G. D., Hooyman, N. R., Lebowitz, B. D., Wykle, M. H., & Deutchman, D. E. (Eds.), *Handbook of mental health and aging* (2nd edition.). Los Angeles: Borun Center for Gerontological Research.
- Leong, F. T., & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. *British Journal of Guidance and Counselling*, 27(1), 123-132.
- Levant, R. F., & Fischer, J. (1998). The male role norms inventory. *Sexuality-related measures: A compendium*, 2, 469-472.
- Lester, P. B., Harms, P. D., Bulling, D. J., Herian, M. N., & Spain, S. M. (2011). *Evaluation of relationships between reported resilience and soldier outcomes report #1: Negative outcomes (suicide, drug use and violent crime)*. Monterey, CA: Office of the Deputy Under Secretary of the Army.
- Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, 71(12), 2150-2161.
- Lysaker, P. H., Tsai, J., Yanos, P., & Roe, D. (2008). Associations of multiple domains of self-esteem with four dimensions of stigma in schizophrenia. *Schizophrenia Research*, 98(1), 194-200.

- Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology, 34*(11), 2410-2433.
- Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behavior, 39*, 335-347.
- Martinez, L., & Bingham, A. (2011). US veterans: By the numbers. *ABC News, 11*.
- Mayfield, D., McLeod, G., & Hall, P. (1974). The CAGE questionnaire: validation of a new alcoholism screening instrument. *American journal of psychiatry, 131*(10), 1121-1123.
- McFarling, L., D'Angelo, M., Drain, M., Gibbs, D. A., & Rae Olmsted, K. L. (2011). Stigma as a barrier to substance abuse and mental health treatment. *Military Psychology, 23*(1), 1-5.
- McKay, J. R., Rutherford, M. J., Cacciola, J. S., Kabasakalian-McKay, R., & Alterman, A. I. (1996). Gender differences in the relapse experiences of cocaine patients. *The Journal of nervous and mental disease, 184*(10), 616-622.
- Microsoft Word (Version 15.0.4531.100) (Version 15.0.4531.100) [Computer Software].
Redmond, CA: Microsoft Corporation.
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Jama, 298*(18), 2141-2148.
- Moss-Morris, R., Weinman, J., Petrie, K.J., Horne, R., Cameron, L.D., & Buick, D. (2002). The revised Illness Perception Questionnaire (IPQ-R). *Psychology & Health, 17*(1), 1-16.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

- Munizza, C., Argentero, P., Coppo, A., Tibaldi, G., Di Giannantonio, M., Picci, R. L., & Rucci, P. (2013). Public Beliefs and Attitudes towards Depression in Italy: A National Survey. *PloS one*, 8(5), 1-8.
- Nash, W. P., Krantz, L., Stein, N., Westphal, R. J., & Litz, B. (2011). Comprehensive soldier fitness, battlemind, and the stress continuum model: Military organizational approaches to prevention. In J. I. Ruzek, P. P. Schnurr, J. J. Vasterling, & M. J. Friedman (Eds.), *Caring for veterans with deployment-related stress disorders: Iraq, Afghanistan, and beyond*. Washington, DC: American Psychological Association.
- Nash, W. P., Silva, C., & Litz, B. (2009). The historic origins of military and veteran mental health stigma and the stress injury model as a means to reduce it. *Psychiatric Annals*, 39(8), 789.
- Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care?. *Health Education & Behavior*, 25(6), 759-777.
- Norheim, A. B., Grimholt, T. K., & Ekeberg, Ø. (2013). Attitudes towards suicidal behaviour in outpatient clinics among mental health professionals in Oslo. *BMC psychiatry*, 13(1), 90.
- Ojeda, V. D., & Bergstresser, S. M. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: an examination of perceptions and attitudes among adults reporting unmet need. *Journal of Health and Social Behavior*, 49(3), 317-334.
- Olmstead, D. W., & Smith, D. L. (1980). The socialization of youth into the American mental health belief system. *Journal of Health and Social Behavior*, 181-194.

- O'Mahen, H. A., Flynn, H. A., Chermack, S., & Marcus, S. (2009). Illness perceptions associated with perinatal depression treatment use. *Archives of women's mental health, 12*(6), 447-450.
- O'Neil, J. M. (1981). Patterns of gender role conflict and strain: Sexism and fear of femininity in men's lives. *The Personnel and Guidance Journal, 60*(4), 203-210.
- O'Neil, J. M., Good, G. E., & Holmes, S. (1995). *Fifteen years of theory and research on men's gender role conflict: New paradigms for empirical research*. In R. Levent & W. Pollack (Eds.), *Foundations for a new psychology of men*, (pp. 164-206) New York, NY: Basic Books.
- O'Neil, J. M., Helms, B. J., Gable, R. K., David, L., & Wrightsman, L. S. (1986). Gender-role conflict scale: College men's fear of femininity. *Sex Roles, 14*(5-6), 335-350.
- O'Reilly, M., & Parker, N. (2012). 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 13*, 190-197.
- Orsingher, J. M., Lopez, A. T., & Rinehart, M. E. (2007). Battlemind training system: "armor for your mind". *US Army Medical Department Journal, 66-71*.
- Pagura, J., Fotti, S., Katz, L., & Sareen, J. (2009). Help seeking and perceived need for mental health care among individuals in Canada with suicidal behaviors. *Psychiatric Services, 60*(7), 943-949.
- Parham, T. A. (2002). Counseling models for African-Americans: The what and how of counseling. In T.A., Parham (Ed), *Counseling persons of African descent: Raising the bar of practitioner competence*. Multicultural aspects of counseling series, Vol. 18. (pp. 100-118). Thousand Oaks, CA, US: Sage Publications, Inc.

- Penn, C., & Watermeyer, J. (2014). Exploring cultural beliefs about “That Sickness”:
grandmothers' explanations of HIV in an urban South African context. *Journal of the
Association of Nurses in AIDS Care.*
- Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link,
B. G. (2001). Stigma as a barrier to recovery: adverse effects of perceived stigma on
social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric
Services, 52*(12), 1627-1632.
- Petrovich, J. (2012). Culturally Competent Social Work Practice with Veterans: An Overview of
the US Military. *Journal of Human Behavior in the Social Environment, 22*(7), 863-874.
- Pietrzak, R., Johnson, D., Goldstein, M., Malley, J., & Southwick, S. (2009). Perceived stigma
and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric
Services, 60*(8), 1118-1122.
- Prins A., Ouimette P., Kimerling R., Cameron R., Hugelshofer D., Shaw-Hegwer J., Thrailkill
A., Gusman F. D., & Sheikh J. I. (1999). The primary care PTSD screen: Development
and operating characteristics. *International Society for Traumatic Stress Studies, 15*, 100.
- Price, T. A. (2011). Stigma threat and psychological help-seeking attitudes in military personnel.
Dissertation Abstracts International, 72, 7062
- USAREC, R. 600-25 Prohibited and Regulated Activities. *Cited in para, 7*(7).
- Rae Olmsted, K. L., Brown, J. M., Vandermass-Peeler, J. R., Tueller, S. J., Johnson, R. E., &
Gibbs, D.A. (2011). Mental health and substance abuse treatment stigma among soldiers.
Military Psychology, 23, 52–64.
- Ramchand, R., Acosta, J., Burns, R. M., Jaycox, L. H., & Permin, C. G. (2011). *The war within:
Preventing suicide in the US military.* Arlington, VA: Rand Corporation.

- Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: findings from an Australian national survey of mental health literacy and stigma. *Australian and New Zealand Journal of Psychiatry, 45*(11), 947-956.
- Richards, L. (2005). *Handling qualitative data: A practical guide*. Thousand Oaks, CA: Sage Publications.
- Richardson, L. K., Frueh, B. C., & Acierno, R. (2010). Prevalence estimates of combat-related post-traumatic stress disorder: critical review. *Australian and New Zealand Journal of Psychiatry, 44*(1), 4-19.
- Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Advances in Mental Health, 4*(3), 218-251.
- Riggs, D. S., & Sermanian, D. (2012). Prevention and care of combat-related PTSD: directions for future explorations. *Military medicine, 177*(8S), 14-20.
- Ritsher, J. B., & Phelan, J. C. (2004). Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research, 129*(3), 257-265.
- Robertson, J. M., & Fitzgerald, L. F. (1992). Overcoming the masculine mystique: Preferences for alternative forms of assistance among men who avoid counseling. *Journal of Counseling Psychology, 39*(2), 240.
- Rosen, H., & Corcoran, J. F. (1978). The attitudes of USAF officers toward mental illness: a comparison with mental health professionals. *Military medicine, 143*(8), 570.
- Rosenstock, I. M. (1990). The health belief model: Explaining health behavior through expectancies. In K. Glanz, F. Lewis, B. K. Rimer (Eds.). *Health behavior and health education: Theory, research, and practice* (pp. 39-62). San Francisco, CA, US: Jossey-Bass.

- Ruckmeyer, G. K. (2013). *Classroom II, ROTC building to be dedicated*. Retrieved from:
<http://today.ucf.edu/classroom-ii-rotc-building-to-be-dedicated/>
- Sayer, N. A., Friedemann-Sanchez, G., Spont, M., Murdoch, M., Parker, L. E., Chiros, C., & Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation in veterans. *Psychiatry: Interpersonal and Biological Processes*, 72(3), 238-255.
- Scheff, T. J. (1966). *Being mentally ill: A sociological theory*. Chicago, IL: Aldine
- Schmitz, K. J., Schmied, E. A., Webb-Murphy, J. A., Hammer, P. S., Larson, G. E., Conway, T. L., Galarneau, M. R., Boucher, W. C., Edwards, N. K., & Johnson, D. C. (2012). Psychiatric diagnoses and treatment of US military personnel while deployed to Iraq. *Military medicine*, 177(4), 380-389.
- Schüz, B., Wurm, S., Warner, L. M., & Ziegelmann, J. P. (2012). Self-efficacy and multiple illness representations in older adults: A multilevel approach. *Psychology & health*, 27(1), 13-29.
- Seal, K. H., Maguen, S., Cohen, B., Gima, K. S., Metzler, T. J., Ren, L...Marmar, C. R. (2010) Mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnosis. *Journal of Traumatic Stress*, 23, 5-16.
- Sexual assault: A stain on the U.S. Military. (2013). *Journal of International Affairs*, 67(1), 211-216.
- Shin, J. (2002). Help-seeking behaviors by Korean immigrants for depression. *Issues in Mental Health Nursing*, 23, 461-476.
- Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., Bonora, I. & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the

- development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of clinical psychiatry*, 59, 22-33.
- Sherman, N. (2005). *Stoic warriors: The ancient philosophy behind the military mind*. Oxford, UK: Oxford University Press.
- Sigmon, S. T., Pells, J. J., Boulard, N. E., Whitcomb-Smith, S., Edenfield, T. M., Hermann, B. A., LaMartina, S. M., Schartel, J. G., & Kubik, E. (2005). Gender differences in self-reports of depression: The response bias hypothesis revisited. *Sex Roles*, 53(5-6), 401-411.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, 158(3), 479-481.
- Solberg, V. S., Ritsma, S., Davis, B. J., Tata, S. P., & Jolly, A. (1994). Asian-American students' severity of problems and willingness to seek help from university counseling centers: Role of previous counseling experience, gender, and ethnicity. *Journal of Counseling Psychology*, 41(3), 275.
- Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *Jama*, 282(18), 1737-1744.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine*, 166(10), 1092-1097.
- Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative health research*, 17(10), 1372-1380.

- Stecker, T., Fortney, J., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatric Services, 58*(10), 1358-1361.
- Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (2010). *United States, Mental Health, 2010*. Retrieved from <http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf>
- Sue, D.W. & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.
- Tan, M. (2009). Army investigating 14 possible September suicides. *Washington Report on Middle East Affairs, (9)*. 11.
- Tavris, C. (1992). *The mismeasure of woman*. New York, NY: Touchstone Books
- Thomas, J. L., & Bliese, P. D. (2004). Evaluating behaviorally-based leadership training tools: The effects of sleep management and feedback on leader and unit health and performance (WRAIR Protocol #1095). Washington DC: Walter Reed Army Institute of Research.
- Thompson-Sanders, V.L., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*, 19–26.
- Tudiver, F., & Talbot, Y. (1999). Why don't men seek help? Family physicians' perspectives on help-seeking behavior in men. *The Journal of family practice, 48*, 47-52.
- US Department of Health and Human Services. (2010). Substance abuse and mental health services administration. *Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health*.
- United States Office of Public Health. Veterans Health Administration. Department of Veterans Affairs. (2012). *Analysis of VA healthcare utilization among Operation Enduring*

- Freedom (OIF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans*. Washington DC: Government Printing Office.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: SUNY Press.
- Vogt, D. (2011). Mental health-related beliefs as a barrier to service use for military personnel and veterans: A review. *Psychiatric Services, 62*(2), 135-142.
- Vogt, D., Di Leone, B. A., Wang, J. M., Sayer, N. A., Pineles, S. L., & Litz, B. T. (2013). Endorsed and anticipated stigma inventory (EASI): A tool for assessing beliefs about mental illness and mental health treatment among military personnel and veterans. *Psychological Services*. Advance online publication. doi: 10.1037/a0032780
- Walker, S. (2010). Assessing the mental health consequences of military combat in Iraq and Afghanistan: a literature review. *Journal of psychiatric and mental health nursing, 17*(9), 790-796.
- Ward, E. C., & Heidrich, S. (2009). African American women's beliefs about mental illness, stigma and preferred coping behaviors. *Research in Nursing Health, 32*, 480-492.
- Ward, E. C., Clark, L., & Heidrich, S. (2009). African American women's beliefs, coping behaviors, and barriers to seeking mental health services. *Qualitative Health Research, 19*, 1589-1601.
- Warner, C. H., Appenzeller, G. N., Mullen, K., Warner, C. M., & Grieger, T. (2008). Soldier attitudes toward mental health screening and seeking care upon return from combat. *Military Medicine, 173*(6), 563-569.

- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. *In annual meeting of the international society for traumatic stress studies, San Antonio, TX* (Vol. 141, No. 7).
- Werner, S., Corrigan, P., Ditchman, N., & Sokol, K. (2012). Stigma and intellectual disability: A review of related measures and future directions. *Research in developmental disabilities, 33*(2), 748-765.
- Wessely, S. (2006). Twentieth-century theories on combat motivation and breakdown. *Journal of Contemporary History, 41*(2), 268-286.
- Wills, T. A., & DePaulo, B. M. (1991). Interpersonal analysis of the help-seeking process. In C. R. Snyder & D. R. Forsyth (Eds.), *Handbook of social and clinical psychology* (pp. 350–375). Elmsford, NY: Pergamon.
- Wisch, A. F., Mahalik, J. R., Hayes, J. A., & Nutt, E. A. (1995). The impact of gender role conflict and counseling technique on psychological help seeking in men. *Sex Roles, 33*(1-2), 77-89.
- Wong, E. C., Kennedy, D., Marshall, G. N., & Gaillot, S. (2011). Making sense of posttraumatic stress disorder: Illness perceptions among traumatic injury survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(1), 67.
- Wright, K. M., Bliese, P. D., Thomas, J. L., Adler, A. B., Eckford, R. D., & Hoge, C. W. (2007). Contrasting approaches to psychological screening with U.S. combat soldiers. *Journal of Traumatic Stress, 20*, 965–975.
- Wright, K. M., Cabrera, O. A., Bliese, P. D., Adler, A. B., Hoge, C. W., & Castro, C. A. (2009). Stigma and barriers to care in soldiers postcombat. *Psychological Services, 6*(2), 108.
- Zinzow, H. M., Britt, T. W., McFadden, A. C., Burnette, C. M., & Gillispie, S. (2012).

Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care. *Clinical Psychology Review*, 32(8), 741-753.

Zoroya, G. (2010). Military's health care costs booming. *USA Today*, April, 22.

Zung, W. W. K. (1965). A self-rating depression scale. *Archives of General Psychiatry*, 12, 63–70.