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Veterans' Perceptions of Military Stigma and the Shame Associated with Combat-Related Posttraumatic Stress

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MS, Capella University, 2012

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Military stigma is a heavy burden of social stigma internalized by veterans who are diagnosed with posttraumatic stress disorder (PTSD) during post-deployment psychological screening. PTSD is classified as a mental disorder associated with widespread reluctance to seek medical assistance. Among military veterans who suffer from combat-related posttraumatic stress (PTS), military stigma is considered a widespread problem. The purpose of this phenomenological study was to explore veterans' perceptions of various aspects of military stigma, including post-deployment psychological screening, the diagnosis of PTSD, and factors associated with reluctance to seek medical assistance for PTS. In-depth interviews were conducted with a convenience sample of 10 veterans of 2 recent operations in Iraq and Afghanistan. A modified form of labeling theory was applied to address the role of cultural stereotypes in stigma (societal and self-internalized), and the discriminatory factors associated with them. Multiple themes emerged, including a commonly held view that post-deployment health screenings are superficial, inconsistent, and ineffective procedures in which veterans feel the need to lie about their experience for fear of being stigmatized with a mental disorder. The findings confirm that the stigma associated with a diagnosis of PTSD perpetuates veterans' reluctance to seek help for PTS, which results in multiple personal and professional problems. Remedies recommended by these veterans included improved post-deployment medical screening procedures, reclassification of PTSD as a war injury instead of a mental disorder, and PTS-related stigma awareness training.

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Dedication

Thank you to my parents Alex and Raquel Buelna for their unrelenting support and their encouragement throughout this process. I would like to dedicate this academic pursuit and accomplishment to my family Morgan Buelna and Sandy Whitt (U.S. Army Veteran), for believing in my abilities to achieve my personal and professional goals. It is through their lives and shared experiences that I draw my strength and vision to achieve more than I am. To lead, one must be willing to serve.

Acknowledgments

As with most of the successes I have had the opportunity to participate in throughout my life, this academic journey could not have been accomplished without the assistance, support, and guidance of some very special people. First, and foremost I would like to thank Dr. Schwab, for his patience and unwavering support in providing this old soldier with some new perspectives in life. I would also like to thank my committee members Dr. Dixon-Lawson and Dr. Cain, because without their support and subject matter expertise, I would not have accomplished this lifetime achievement of obtaining a PhD in Public Health specializing in Community Education.

I would also like to recognize my fellow veteran's for participating in this research as their contributions and sacrifice can only assist in helping others who are challenged or stigmatized from combat-related post traumatic stress. It is because of these silent heroes that we must endure in developing new and effective strategies to mitigate the ill-effects of war imposed on their lives and families.

Table of Contents

Tables

Chapter 1: Introduction to the Study

Introduction

Many wounded combat veterans are diagnosed with Posttraumatic Stress Disorder (PTSD), which is classified as a mental disorder (Sayer et al., 2009). The diagnosis can have devastating effects. The veteran tends to feel shame, disgrace, anger, and depression, which are characterized as self-stigma and which are associated with suicide (Bryan, Jennings, Jobes, & Bradley, 2012; Pietrzak, et al., 2010; National Center for PTSD, 2014). In addition, veterans (vets) given this diagnosis are often stigmatized by others, so that, for example, work becomes difficult for them to find, in the military or outside, which in turn tends to make vets reluctant to seek counseling or some other form of treatment (Mittal et al., 2013). This is based on false assumptions made by the general public exacerbated by misinformation associated with the trauma of war. This response to a PTSD diagnosis is known as military stigma (Mittal et al., 2013). According to Goffman (as cited in Gould, Greenberg & Hetherton, 2007, p. 506), the earliest version of stigma (1963) was defined as "an attribute that is deeply discrediting," but has since evolved (with respect to military stigma). It is now explained as a heavy burden of social stigma internalized by veterans diagnosed with PTSD that is attributed to military operations (Nash, Silva, & Litz, 2009). Directly and indirectly, this stigma is associated with veterans' low use of the resources designed to address PTSD issues (Ben-Zeev, Corrigan, Britt, & Langford, 2012; Gould et al., 2007; Koren, Norman, Cohen, Berman, & Klein, 2005; Nash, Silva & Litz, 2009). The gap in the literature on this topic is the lack of research on military stigma (associated with PTS/PTSD) from a soldier's

perspective, especially regarding any association between military stigma and suicidal ideation (Bryan et al., 2012; Pietrzak et al., 2010).

In this study, it is important to delineate the difference between posttraumatic stress (PTS) and PTSD, which are synonymous to a certain extent, but are differentiated by symptom intensity, duration, and treatment. In this dissertation approach, PTS has significant meaning as it applies to a vet's interpretation or perception of PTS, instead of the diagnosis and label of a mental disorder as traditionally identified by the term PTSD. This consideration is important for two reasons. For one, it focuses on the veteran population that has not been formerly diagnosed with PTSD, but acknowledges issues associated with symptomatic characteristics of PTSD. For another, it is based on the need to better understand stigma from a vet's perspective and how they will avoid getting help with symptoms associated with PTS in order to avoid the stigma associated with the label of PTSD.

Background

Contemporary research on military stigma presents a complex subject, which includes multiple issues, such as the validity of current procedures for the identification and categorization of combat-related posttraumatic stress (PTS), perceived public and self-stigma, and the relative effectiveness of therapeutic programs (Mittal et al., 2013). As there are no clear and concise solutions to these issues, the task becomes one of developing a sound approach to understanding the issue of stigma from a soldiers' perspective, while focusing on specific elements of this stigma, which reveal limited information to date (Xenakis, 2014). This study is needed to address the lack of

understanding of the stigma from a soldier's perspective and its application associated with the reluctance to seek medical or other forms of counseling or therapies.

Problem Statement

PTSD is a serious psychological injury affecting veterans and military personnel, specifically veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). According to Tanielian and Jaycox (2008), OEF/OIF military actions involved the deployment of 1.64 million U.S. military personnel, with an estimated 300,000 (18.3%) being diagnosed with PTSD or major depression after deployment. Though military stigma has been described as the fear, disgrace, and shame experienced by combat veterans who report symptoms associated with PTSD or seek psychological treatment for them, this represents a misunderstanding of various elements of stigma (Mittal et al., 2013). In general terms, military stigma includes two factors: internal shame (self-stigma) and external discrimination (public stigma; Link & Phelan, 2014).

Self-Stigma (Internal) and Public Stigma

Self-stigmatization is one of the central issues among combat veterans diagnosed with PTSD, especially in relation to suicidal ideation and suicide. It is the internalization of everyday, common issues compounded by the vet's lived experiences that creates the environment for potential negative beliefs and experiences or harm (Dickstein, Vogt, Handa, & Litz, 2010). This begets the need to consider remedies or actions that include combat-related PTSD programs in conjunction with social reeducation. In contrast, public stigma refers to how the public perceives (or stereotypes) specific groups (Corrigan & Watson, 2002).

In order to understand military stigma, it is necessary to understand the foundational elements of stigma, i.e., its characteristics and perceived consequences, its environment, and the manner in which it is typically addressed (Gibbs, Rae Olmsted, Brown, & Clinton-Sherrod, 2011). Alternative approaches to addressing military stigma are discussed in this context.

Research conducted by Sayer et al. (2009) revealed that military personnel seeking medical treatment for mental distress were apprehensive and fearful of how other people, current military employers, prospective civilian employers, or anyone else within their demographic would respond to them if they were diagnosed with a mental illness. This was especially prevalent among combat veterans who had returned from military operations in Iraq and Afghanistan (Lee, 2012; Tanielian & Jaycox, 2008; Wisco, Marx, & Keane, 2012).

A significant component of this issue is its association with the exponential rise in the suicidal ideation and suicide of veterans arising from combat operations associated with OEF/OIF (Bryan et al., 2012; Holloway, n.d.; Lee, 2012; Vasterling et al., 2006). This association suggests a need to change or modify several elements of military operations (both pre- and post-deployment) as they pertain to how stigma is addressed. Although, important research is now taking place regarding military stigma, there is a vital need to understand soldiers' perspectives on any relationships between post-deployment psychological screening , diagnosis of a mental disorder, stigma, and suicidal ideation or suicide completion is required (Holloway, n.d.; Vasterling et al., 2006).

This qualitative study explored these issues in order to reveal new or alternative approaches to psychological screening and treatment of PTS. The focus being on the participant's actual experiences and how to enhance their personal and professional lives rather than on a stigma-inducing mental disorder diagnosis. These approaches may include some form of military indoctrination (initial and continued professional development education), identification and understanding of a soldier's perspective—themes developed as a result of lived experiences—in developing treatment programs, knowledge and information regarding the reluctance of vets to seek assistance, and developing a public reeducation campaign to address misconceptions of stigma associated with combat-related PTS (Gould et al., 2010; Link & Phelan, 2014; Mittal et al., 2013). I used an approach that focused on the veterans' lived experiences while exploring why there was a reluctance to seek assistance (Creswell, 2013; Patton, 2002).

Purpose Statement

The purpose of this qualitative study was to better understand the stigma associated with receiving a diagnosis of mental disorder, especially as it applies to pre- and post-deployment psychological screening. A phenomenological approach was used to develop a clear picture of the participant's experiences regarding PTS (Van Manen, as cited in Creswell, 2013). Through this research, a new or alternative approach to screening and to addressing issues identified with PTS was sought. This was based on developing an understanding of the participant's experiences to enhance their individual personal and professional lives rather than leaving soldiers to deal (without support or information) with the stigma of a mental disorder diagnosis. This is an issue which

potentially impacts all stakeholders (military leadership, communities, families, and the combat veterans respectively), it would be logical and beneficial to consider alternative diagnostic categories to PTSD. The intended goal is the implementation of interventions and programs which may prove more suitable and effective to addressing issues arising from the stigma associated with a diagnosis of mental disorder.

Research Questions

This study was based on data gleaned from in-depth interviews. Combat veterans were asked about their perceptions of many aspects of PTSD and stigma.

- RQ1: What are combat veterans' perceptions of the military stigma associated with a diagnosis of PTSD?
- RQ2: What are combat veterans' perceptions of the post-deployment health assessment?
- RQ3: What are combat veterans' perceptions of the personal and professional impact of military stigma?
- RQ4: What are combat veterans' opinions of the available treatments and therapies for PTS?
- RQ5: What are combat veterans' ideas about how military stigma might be reduced or prevented?

Significance of Study

This research sought to better understand—from a soldier's perspective—the stigma associated with the diagnosis of a mental disorder and to recommend new ways in which combat-related PTS is assessed and treated in order to reduce stigma while

considering the elements of self-stigma (internalization) and public stigma associated with a diagnosis of a mental disorder (Corrigan & Watson, 2002; Corrigan & Penn, 1999; Watson, Corrigan, Larson, & Sells, 2007). It is important to use the respective soldier's perspective (lived experience) while determining a more effective course of action in analyzing and understanding stigma. The stigma focus is based on veterans fear of reporting symptoms associated with a mental disorder, symptoms that could impact their professional and personal lives (Mittal et al., 2013; Corrigan & Watson, 2002; Corrigan & Penn, 1999; Watson et al., 2007). This is an issue which impacts all stakeholders previously identified, especially combat veterans (current and post-military service), it would be logical and beneficial to consider alternative methods that could provide a more suitable solution to addressing issues such as diagnoses of mental disorder within this realm.

The positive social change implications of this study could be realized through a new or alternative approach to addressing issues regarding stigma associated with PTS. Thus, having the potential for immediate and long-term implications which could impact various facets of society as combat veterans reintegrate into communities throughout the nation.

Conceptual Framework

The theoretical basis for this research is a modified form of labeling theory (Link & Phelan, 2014), which proposes the existence of cultural stereotypes which are preconceived and discriminatory based on society's lack or desire for understanding stigmatized groups regardless of actual first-hand knowledge, or the lack thereof (Link &

Phelan, 2014; Scheff, 1966). The rationale for this theory is based on veterans and military personnel's understanding and interpretation of stereotypes (public and self) and the potentially threatening implications of being evaluated and/or diagnosed with a mental disorder (Link & Phelan, 2014). According to Link and Phelan (2014), this presents an important element of the social structure which lends power and credence to stigma, thus, creating a reciprocal social structure that reinforces the discrimination and stereotyping of specific groups. This is supported by the contemporary concept of societal and self-internalized stigma as presented by Corrigan and Watson (2002). In this case, as it applies to soldiers identified or labeled with PTSD through pre- or post-deployment screening. In addition, this theory is applicable to military stigma based on the reluctance in which military personnel avoid seeking psychological treatment for symptoms associated with PTSD.

Nature of the Study

A foundational understanding of this complex phenomenon can be established using labeling theory (Link & Phelan, 2014), which addresses the role of cultural stereotypes in stigma and the discriminatory factors associated with them. Additionally, the concept of stigma has been conceptualized by Corrigan and Watson (2002) as it pertains to societal and self-internalized stigma. This combined approach to understanding combat-related stigma could provide new perspective to understanding the reluctance of veterans to seek assistance through counseling or some other form of treatment.

My approach to understanding the stigma associated with a mental disorder diagnosis was to interview combat veterans while identifying and incorporating veteran's perspectives and impressions about the effectiveness of the current programs and about the benefit for veterans to report their individual PTS symptoms. These general steps could help researchers develop a new perspective and develop a new research approach to address the gap on the stigma associated with PTS/PTSD.

Definitions

Stigma. In a military context, stigma may include public stigma (stereotyped shaming) and self-stigma (internalization of the stereotype). The term is also used to refer to the avoidance of assistance for symptoms of PTS (Ben-Zeev et al., 2012).

PTS. PTS is considered a universal response to a traumatic event which is associated with nightmares, pain, trouble sleeping, anger, and interpersonal difficulties (National Center for PTSD, 2014). PTS and PTSD are synonymous, although PTS lacks the diagnosis of a mental disorder.

PTSD. PTSD is an anxiety disorder that manifests as a result of exposure to one or more traumatic event which can include: combat, sexual or physical abuse, terrorist attack, assault, serious accidents, or disasters (National Center for PTSD, 2011).

Scope and Delimitations

The scope of this research was limited to the information derived from the military participants' individual experiences (lived) as interpreted, regarding the stigma associated with combat-related post traumatic stress. This included perspectives regarding post-deployment psychological screening processes, the reluctance to seek

assistance (psychological or otherwise), and its implications and impact to their respective professional and personal lives. Limits pertaining to this study include the assessment tool being the utilization of a self-reporting questionnaire which relies solely on the participant's recollection of combat-related experiences. This application could prove bias based on memory recall and the ability of the participant's to relay their experiences.

Limitations and Assumptions

Participants

Because this was a small, exploratory study, the results were not generalizable. However, the research did identify factors that appeared to contribute to military stigma and how these factors might be reduced or prevented. Participant bias was minimized using validation and triangulation processes (Patton, 2002). The traumatic events or other associated issues could have contributed to the stigma may have affected each participant differently and recall (temporal sampling) or interpretation of the facts might have been distorted (Patton, 2002). This could also be compounded by participants' individual combat experiences and their respective military occupational specialty (MOS), which may or may not have prepared the participants adequately for combat (Patton, 2002).

Researcher bias. The qualitative approach use for this study presented potential researcher bias based on several factors but predominantly because I completed 27 years of combined active and reserve military service as a special agent/investigator within the military (as a U.S. Army Warrant Officer Four), thoroughly versed in various aspects of

subgroups, categories, and levels of management (company, battalion, and regiment) in the military. This is in addition to being an experienced combat veteran (now disabled).

Summary

Stigma associated with combat-related traumatic events creates an environment of misinformation, confusion, and a reluctance among both military personnel and the civilian community to properly acknowledge and address the problem of stigma and the shame associated with combat-related PTS. This inability to fully understand stigma, further supports the need for vets to seek out medical or psychological assistance. This is compounded by a remarkable correlation between stigma and the exponential rise in veterans' suicidal ideation and suicide arising from combat operations associated with OEF/OIF. This research presented an approach that considered the lived experiences of military personnel as an essential element in developing interventions and programs that best support the mitigation or elimination of stigma.

The literature review will present and explain the existence of stigma and its prevalence in the military community. The review will provide evidence of common themes to better explain the correlations between stigma and combat veterans, public perception, and self-stigma. The literature review will also identify the need for further research to understand stigma from the perspective of service members.

As a result of this study, a new or alternative approach to screening and addressing PTS issues could be developed; as it would focus on the participant's experiences in order to enhance their personal and professional lives.

Chapter 2: Literature Review

Introduction

Though military stigma, as previously identified, is clearly acknowledged as a fear and disgrace experienced by combat veterans who report or seek psychological treatment for symptoms associated with PTSD, there is a continued misunderstanding of various elements of stigma (Mittal et al., 2013). For military stigma comprises both an external event (discrimination) and internal experience (shame), as described by Link and Phelan (2014). As previously identified, the purpose of this qualitative study is to better understand the military stigma associated with receiving a diagnosis of mental disorder, especially as it applies to post-deployment psychological screening.

Through the realization of this research, a new or alternative approach to screening and addressing issues identified with PTS could be realized. This is based on focusing specifically on the participants' experiences, (using a phenomenological approach) with a view to enhancing their respective personal and professional lives, versus leaving soldiers to deal (without support or information) with the negative connotations associated with the stigma of a mental disorder diagnosis. This is an issue which potentially impacts all stakeholders (military leadership, communities, families, and the combat veterans respectively), it would be logical and beneficial to consider alternatives to a diagnosis of PTSD. The intended goal being the implementation of interventions and programs which may prove more suitable and effective to addressing issues arising from the stigma associated with a diagnosis of mental disorder.

PTS and PTSD

The issues associated with stigma due to combat-related PTS and the diagnosis of PTSD are extensive (Mittal et al., 2013). PTS and PTSD, are synonymous, to a certain extent. Within the context of this dissertation approach, PTS differs from the actual diagnosis of PTSD based on symptomatic intensity, duration, and treatment approach. This is an important element and a significant perspective from which to understand or interpret the lived experiences of veterans who are stigmatized by the negative connotations of a mental disorder (PTSD), who are reluctant to seek medical care (Dickstein et al., 2010; Gibbs et al., 2011). This approach focuses on veterans who have not been formally diagnosed with PTSD, but who acknowledge symptoms associated with PTS. As with much of the literature reviewed on this topic, it is important to delineate between the established research to date, incorporating various methodologies using PTSD as a factor supported by the respective literature—and PTS—as a means to explain specific symptoms. In order to understand the issues associated with combat-related PTS and the military stigma associated with a diagnosis of a mental disorder, requires the need to first explain combat-related PTSD.

PTSD is an anxiety disorder that manifests as a result of exposure to a traumatic event which can include: combat, sexual or physical abuse, terrorist attack, assault, serious accidents, or disasters (National Center for PTSD, 2011). PTSD is a serious psychological injury affecting a large majority of veterans and military personnel, specifically, veterans of OEF/OIF. Although, support has been directed toward the scholarly and clinical research of combat-related PTSD (National Center for PTSD,

2015), the issues surrounding the stigma associated with a diagnosis of mental disorder have received very little attention. There is a particular need for more research and the development of programs to address the military stigma and its underlying causes.

Military Stigma

Stigma associated with combat-related posttraumatic stress means a prejudiced or preconceived imposition of shame on a combat veteran. Although, the meaning of stigma and its application varies, it could be explained as an unjustified result of disgrace that creates a sense of fear associated with the mental disorder diagnosis of PTSD. According to Mittal et al. (2013), PTS is explained as the disgrace experienced by combat veterans who report or seek psychological treatment for symptoms associated with PTSD. The gap in this research is the lack of information about stigma from a service member's perspective and stigma's association with reluctance to seek medical or other therapies.

The major areas within this chapter, regarding the contemporary literature, pertain to various areas of military culture (variables and characteristics) as applied to the military stigma, itself. These areas include an understanding of stigma associated with PTSD; the issue of relationships which exist between combat experiences, suicide, and PTSD; gaps in contemporary research; commonality within combat operations; military operations contributing to mental disorders; the need for alternative methods of pre and post psychological screening applications, and the need to develop effective prevention programs and diagnostic capacity.

In addition to the areas and categories previously identified is the need to acknowledge the National Center for PTSD, recognized as the foremost authority within

the realm of PTSD, by the U.S. Government. The National Center for PTSD maintains the latest in approved (evidence-based) treatments and therapy programs used by government, private, and public medical practitioners. Developing a fundamental understanding of military stigma, established interventions, and perceived impact to the military personnel affected is the crucial to changing current policy, procedures, programs, as well as research methodology in the furtherance of mitigating stigma associated with combat-related PTSD.

Literature Search Strategy

Various databases, subject matter experts, and search terms were used to investigate PTSD iteratively. Once the methodology and theory were established, it became an issue of applying a search strategy to screen the available data for review. Although there was abundant information about combat-related PTSD, there was little or no data on the stigma associated with combat-related posttraumatic stress from a service member's perspective. This lack of information from a service members' perspective was compounded by the limited information on veterans' reluctance to seek medical or psychological assistance.

Investigating military stigma required a strategy which identified weaknesses, effectively culling through a multitude of information in order to identify the gaps related to the limited information which currently exists. This required an investigative plan to review and assess trends in research methodology as it applies to interventions, programs, and treatments addressing the issues associated with combat-related PTSD. The research began with databases such as MEDLINE, CINAHL, ProQuest (including the Dissertation

& Theses database), Health & Medical Complete, PubMed, ScienceDirect, and PsycINFO. The National Center for PTSD, a division of the U.S. Department of Veteran Affairs, was also instrumental. Considered the foremost authority on the latest research and education on trauma and PTSD, the center afforded access to The PILOTS Database Instruments Authority List.

The following keywords and combinations of keywords were used: *combat-related PTSD; stigma* and *veterans; OEF/OIF* and *PTSD; PTSD* and *veteran suicide; suicidal ideation; DSM* and *PTSD; PTSD* and *interventions; stigma* and *mental illness; combat* and *mental health; qualitative studies* and *combat-related PTSD; understanding military stigma; veteran reluctance* and *stigma; self-stigma; public stigma; PTSD medications; PTSD screening; PTSD diagnosis;* and *war* and *PTSD*.

There was limited research and information available regarding the specific perceptions and interpretations of combat-related stigma through actual lived experiences of soldiers, it became necessary to adjust the literature research to incorporate contemporary dissertations regarding other PTSD topics such as military sexual trauma (MST), military suicide, and military drug and alcohol addiction. This strategy was concurrent with continued research specifically keying in on specific words such as stigma and reluctance throughout other peer reviewed articles and similar research.

Theoretical Foundation

The literature makes it clear that military stigma is complex (Dickstein et al., 2010; Gibbs et al., 2011). The complexities being variables associated with individual responses to traumatic events, perceived public and self-stigma, effective and ineffective

interventions/programs, and adequate identification and categorization of PTS. Given the complexity, and our incomplete understanding of it, it is comprehensible that there are no simple solutions to the problem of military stigma. There is no clear and concise solution to issues associated with military stigma as it pertains to PTSD, the issue becomes one of developing a sound approach to an understanding of the issue, its various components, and focusing on specific elements of stigma, which reveal limited information to date. This is based on the need for the military and associated entities to acknowledge a relative association exists regarding military stigma, its elements, and applying effective strategies to positively impact these elements and their respective characteristics. This ecology of military stigma can be supported using a modified form of labeling theory (Link & Phelan, 2014), which proposes the existence of cultural stereotypes as fundamental to stigma and the discriminatory factors associated with it. This labeling theory, in itself, is derived and associated with other stereotypical concepts as part the larger theory of stigma as initially established by Scheff (1966) regarding discrimination as an element to stigmatizing individuals who are simply reacting to societal stereotypes (Bourdieu, 1987; Link et al., 1989). These additional theories include: stigma consciousness; rejection sensitivity; and concealment (Pinel, 1999; Downey et al., 2004; Pachankis & Hatzenbuehler, 2013), which all contribute to the interpretation of stereotypes and the potential harm realized. The original identification and introduction of stigma having been presented by Erving Goffman in 1963, considered one of America's most influential sociologists (Link & Phelan, 2014). Additionally, this contemporary concept of stigma can be supported through an understanding of stigma as

conceptualized by Corrigan and Watson (2002) specifically pertaining to societal and self-internalized stigma.

Very little research has been done on the reluctance of military personnel to report or seek assistance for the symptoms associated with combat-related PTSD, or potential changes to the current remedies in place within the Veteran's Administration (VA) to address this reluctance. Research conducted by Sayer et al., (2009) revealed that military personnel seeking medical treatment for mental distress are apprehensive and fearful of how other people – including current military employers, prospective civilian employers, or anyone else within their respective social demographic – would respond to them if they were diagnosed with a mental illness. This apprehension is especially prevalent among combat veterans who have returned from military operations in Iraq and Afghanistan (Lee, 2012; Tanielian & Jaycox, 2008; Wisco, Marx & Keane, 2012).

Literature Review

Stigma and PTSD

Stigma is not exclusive to the military, nor is it a new concept. One of the most contemporary perspectives on stigma is by Corrigan and Watson (2002), who established the two basic forms of stigma as being public and self. Public stigma, which refers in general terms to how the public negatively perceives or stereotypes specific groups; and self-stigma, which refers to the internalization of that negative public perception (Corrigan & Watson, 2002). In order to understand military stigma, it is necessary to review or become familiar with both these foundational elements of stigma, including their characteristics and perceived consequences, the environment in which they arise,

and the manner in which they are typically addressed (Gibbs et al., 2011). Within this context, alternative approaches to addressing military stigma are discussed. Established research regarding stigma associated with chemical or alcohol dependence is also presented to assist in determining remedies, since there are commonalities between alcohol dependence treatment (addiction) and or mental health treatment among military (Gibbs et al., 2011). This comparison allows for additional perspective and consideration in addressing active and successful interventions and programs.

Self-stigmatization is one of the central issues among combat veterans diagnosed with PTSD, especially in relation to suicide and suicidal ideation. It is the self-internalization by combat veterans which creates an environment for potential harm or negative beliefs and expectations (Dickstein et al., 2010). The premise regarding stigma (within the context of this dissertation) is identified as two-fold (public and self), there is the need to consider remedies or actions which include societal reeducation in conjunction with respective combat-related PTSD programs.

Multiple studies reveal that there is an association between stigma and its connection to military personnel and veterans who present symptoms of PTS, have been diagnosed with PTSD, or seek treatment or assistance for any other mental illness (Mittal et al., 2013; Tanielian & Jaycox, 2008; Lee, 2012; Wisco, Marx & Keane, 2012; Sayer et al., 2009; Ben-Zeev et al., 2012; Dickstein et al., 2010; Greene-Shortridge et al., 2007; Gibbs et al., 2011). Most, if not all combat veterans are required to process through post deployment psychological screening prior to being released or allowed to return to their respective families or communities, but most soldiers will not provide information

through post psychological screening questionnaires (an element related to the stigma) since their primary goal at this stage is normally to return home (Mittal et al., 2013). This avoidance and practice regarding stigma is substantiated by the lack of veteran utilization of available resources (therapies and treatments) designed to address issues pertaining to PTSD (Ben-Zeev et al., 2012; Koren et al., 2005). This stigma is compounded by additional post deployment variables that may be directly or indirectly associated with PTSD, such as combat experiences, personal and professional relationships, and military operations (Sayer et al., 2009).

Combat, PTSD, and Suicide

Considered a subculture of its own, combat veterans share similar traumatic experiences which suggest that there are common characteristics of military trauma. Although not all inclusive, these characteristics include feelings of isolation, depression, hypervigilance and anxiety, which are considered factors associated with stigma and are representative of PTS. Recent studies of military personnel and veterans post 9/11 indicate a relationship exists' between specific combat experiences, PTSD, and suicide (Brenner et al., 2008; Bryan et al., 2010; Black, Gallaway, Bell, & Ritchie, 2011; Strom et al., 2012; Lee, 2012). These studies used a variety of research designs and strategies, including retrospective cohort, case study, pilot study, longitudinal research, and quasi-experimental research in determining these respective results and conclusions.

One of the finding of these studies (Mittal et al., 2013) is that combat veterans understand that identifying their own PTS symptoms during post-deployment psychological screening delays their redeployment and release home. This dynamic is

compounded by various issues associated with combat exposure, such as types of combat, other traumatic issues confronted, and the number of past deployments. Other factors include the soldier's possible predisposition to psychological disorders and any previous medical treatments, including pharmacologic medications such as selective serotonin reuptake inhibitors (SSRIs), which, paradoxically, can contribute to suicidal ideation or suicide completion (Tull, 2010).

A common issue revealed throughout the studies identified a lack of focus to identify or investigate issues of reluctance among combat veterans to seek assistance, which may be a catalyst regarding redeployment activities and a veteran's ability to reacclimatize into society. This also constitutes the need to further investigate stigma as it is applied to combat veterans in a redeployment capacity. Despite the variation in methodologies pertaining to studies linking combat experiences, PTSD and suicide, there is an underlying consensus of variables (traumatic events) that contribute to the studies identified throughout this paper which all coincide with combat experiences and exposures (Bryan, et al., 2010; Black et al., 2011; Strom, et al., 2012; Lee, 2012). These variables and characteristics also include issues associated with gender, race, military experiences, individual mental health disposition, and types of stress which may have contributed to elevated risk of suicide (Black et al., 2011; Brenner et al., 2008; Pietrzak, et al., 2010).

Gaps in Contemporary Research

To date, there is still an insufficient amount of information surrounding the stigma associated with a mental disorder diagnosis among combat veterans. What is clear is that

attempting to collect such information would require a complex design (methodology), research assets, and the cooperation and trust of veterans to participate in a study which could be considered too overwhelming or burdensome. The research variables (previously identified) alone, contribute to the gaps of knowledge regarding stigma based on a lack of research capacity and capabilities to anticipate individual human responses which are ever changing. Within the studies identifying specific characteristics associated to combat trauma or atrocity may not support the specific development of PTSD, since not all returning combat veterans develop PTSD. Individuals react differently to stressful experiences and subsequent neuropsychological outcomes (Holloway, n.d.; Vasterling et al., 2006; Pietrzak, et al., 2010). Although this aspect or interpretation of evidence within specific studies is limited, it is clear not all military personnel who experience combat or combat exposure develop PTSD. Despite the shared commonalities, how an individual (veteran) will react is questionable as there is a lack of post-combat mental health assessment practices and applications (Bliese et al., 2007). This fact does not include the multitude of veterans or military personnel that avoid any mental health screening or diagnosis that could impede their careers, personal esteem, and relations.

There is also a remarkable lack of research regarding the specific elements of military stigma associated with a soldier's suicidal ideation, and a lack of sound theory regarding the high prevalence of suicide among military members (Bryan et al., 2012; Pietrzak, et al., 2010). For example, a soldier's reluctance to seek assistance or other remedy (as previously identified) is a contributing factor to stigma and suicide. This reluctance to seek assistance may be grounded in the stereotypical labeling by which

society tends to interpret mental disorder as some type of deviance (Mittal et al., 2013; Link & Phelan, 2014). There is a need to better understand the actual prevalence of mental health disorders in the military services and reluctance for military personnel to seek treatment or assistance (Gould et al., 2010). In order to seek assistance, military personnel need to understand the concept of stigma.

The common and recurring themes identified throughout the previous studies identified in this dissertation reveal the need to pursue information from the veterans perceived or lived experiences associated with combat trauma (Cresswell, 2013). This approach could provide new information regarding the dynamics of perceived stigma, as it exists, from a veteran's perspective. A factor commonly identified throughout the research studies is a lack of deductive variables or information provided by the clinicians of each study. What is clear regarding the subject matter for the dissertation topic and the articles previously identified is the larger subject matter regarding PTSD, the potential complexities regarding the exponential increases in veteran suicide, and the multitude of variables presenting potentially existing relationships among combat-related characteristics.

Commonality, Combat Operations, and Prevalence of Mental Health Disorders

When discussing issues associated with the military and its respective sub-culture, there is a need to acknowledge the environment of the military as its own fully functional community which is reactive, mobile, and changeable. Within the military environment, combat operations are uniquely dependent on common doctrine, training, and shared cultural experiences depending on the environment in which military personnel are

deployed (considered forward operating areas or bases). This is supported by various studies which indicate a commonality exists in various aspects of combat operations specific to the type of military unit (reserve/active duty/guard), combat operations, experience, location (Iraq or Afghanistan), as well as age, gender, and predisposition to mental disorders, provided confounding variables to their respective research while establishing a relationship between PTSD and suicide (Holloway, n.d.; Shen, Arkes & Pilgrim, 2009; Vasterling et al., 2006).

This is compounded by the reality that existing treatment programs are inadequate for combat-related PTSD attributed to OEF/OIF, as more traditional methodologies (pre 9/11) had been relied upon to establish current programs (Erbes et al., 2009). OEF/OIF veterans share common issues associated with mental health distress as it pertains to reestablishing personal and professional connections upon redeployment (Erbes et al., 2009; Lane, 2012). Various measures were used regarding the previously identified conclusions which included the PTSD Checklist, Trauma Symptom Inventory, and the World Health Organization Quality of Life Scale-Brief (Erbes et al., 2009).

Alternative Methods and Training

The perception of stigma, as it applies to the military is compounded by the subculture of military personnel and the military way of life. Because training and tradition are steadfast variables which permeate military life, what should be considered here are the fundamental methods used in the application of psychological training and indoctrination during basic and advanced training, as well as a requirement for all returning veterans during post-deployment training. The issue here being, could

indoctrinating soldiers to the potential of stigma better prepare personnel to recognize characteristics associated behaviors associated as a result of stigma? Understanding stigma becomes an issue of perception and acceptance, for which the military could apply new training elements specific to stigma, its understanding, and mitigation to various elements associated with stigma. The immediate problem pertains to two aspects of military stigma, i.e. the public stigma associated with a negative public perception of mental disorders, and the self-stigma in which these beliefs are internalized by soldiers (Greene-Shortridge et al., 2007). This supports the need for both public and military personal to change, through informational, policy/regulatory systems, and through reeducation/intervention of both society and the respective military community, as presented by Corrigan and Penn (1999).

This change can begin with what Kelly et al. (2014) refer to as "perceived organizational support" (POS), and its impact regarding perceived stigma of active duty soldiers post-deployment. POS can be aligned and applied at various levels of military processing (pre- and post-deployment) to include entry-level assessments and post deployment examinations (Kelly et al., 2014). While contemporary research in the area of military stigma continues to identify a multitude of intervention programs (National Center for PTSD, 2011), what is not readily apparent is a set of decisive actions or remedies to address the issue of stigma and the associated problems, which are detrimental to soldiers, their families, the military as a whole, and the community at large. Although, there are Internet web applications, such as VetChange developed to support the need to reach a larger or more broad demographic of veterans (who do not

have accessibility to a therapist or chose to avoid same based on self-stigma), these programs fall short of the intended goals (Brief et al., 2013). The problematic issue associated with such programs is not that the programs don't work, but rather the reluctance of veterans to use them. What is required is a combination of elements from the most successful programs to date, so that veterans feel empowered to properly report their PTS symptoms without fear of retribution. The most successful of these programs focusing on cognitive behavioral therapy (CBT), which is the utilization of one-on-one sessions with a therapist (National Center for PTSD, 2015).

The National Center for PTSD

The National Center for PTSD is considered the foremost Government authority regarding the latest research and education regarding trauma and PTSD. It is important to clarify National Center for PTSD does not provide clinical care, rather, it maintains a database on evidence regarding treatment modalities' (evidence-based) being administered or available to veterans (National Center for PTSD, 2015). To date, there is a multitude of available treatments, programs, and theories (globally) which incorporate the issues linked with PTSD and how best to address the symptomatic issues associated with combat-related PTSD. The National Center for PTSD (2015) clearly acknowledges these and other types of treatments but does not promote them without sufficient evidence to support same. Within the context of this research, contemporary treatment identification and consideration will be presented in terms that are similar to the categorization of PTSD used by the National Center for PTSD (2015). What the National Center for PTSD does not address is the issue regarding the reluctance of veterans to seek

assistance through the various treatments identified and supported by the VA, as there is limited information regarding this issue. The following treatment categories (in general terms) will include cognitive processing (cognitive, exposure, group therapies, and eye movement desensitization and reprocessing), pharmacological (medication), and alternative treatments (Prolonged Exposure and Virtual Reality Exposure Therapy).

Cognitive therapy. Cognitive therapy is considered one of the most successful types of therapy pertaining to PTSD. The dynamic usually involves the interaction between patient and therapist, wherein, the therapist assists the patient to discuss and understand the lived (traumatic) experiences of the individual (in this case the veteran) (National Center for PTSD, 2015; Najavits, 2015). The goal of this therapy to have the patient openly identify and change how he/she thinks about the traumatic event after the fact.

Exposure therapy. Exposure therapy is similar in nature to cognitive therapy with the difference being a central focus on understanding the fear of the memories as it pertains to the traumatic event(s) (National Center for PTSD, 2015). The premise being the act of discussing the traumatic event repeatedly as a means to control the fears associated with the event(s), thus, changing how the patient reacts to stressful memories (National Center for PTSD, 2015).

Group therapy. Group therapy provides a venue for individuals with similar backgrounds and experiences to discuss their traumatic experiences which may present a more amiable environment for those involved (National Center for PTSD, 2015). The key

factors in this venue, having the ability to share internalized feelings of inadequacy such as shame, guilt, and fear (National Center for PTSD, 2015).

Eye movement desensitization and reprocessing. EMDR is a therapeutic approach which focuses on eye, hand, and sound stimuli in conjunction with memory recall as an adjunct to counseling with a therapist (National Center for PTSD, 2015; Najavits, 2015). Although recognized by the National Center for PTSD, its treatment has been questioned regarding the correlation between eye movement and memory recall (National Center for PTSD, 2015).

Medication. As briefly identified, the medication of choice and consistency, as prescribed by medical facilities and other medical entities such as the VA, are SSRIs), which are considered an antidepressant. SSRI's such as citalopram, fluoxetine, paroxetine, and sertraline are prescribed and administered to veterans in an effort to impact the patient in terms of reducing or mitigating sadness and worry (National Center for PTSD, 2015; Tull, 2010).

Alternative treatments. Although there is a continued need for alternative methods to address mental health disorder among combat veterans, this dissertation does not dismiss the need for both traditional pharmacological intervention, rather, it emphasizes the need for veterans to seek support through individual or group therapy activities in lieu of a pharmacological approach. A recent study presents evidence which supports a veteran preference for prolonged exposure (PE) and virtual reality exposure therapy over the pharmacological alternative of sertraline (Gilliam et al., 2013; Najavits, 2015). This type of an approach excludes the need for pharmacological support. An

additional consideration and recurring theme for intended success in addressing the negative connotations associated with stigma reveal those soldiers exposed to high levels of combat receiving redeployment Battlemind debriefing (early psychological intervention methods and training) reported fewer post traumatic stress symptoms (Adler et al., 2011). This is considered a positive and viable form of individual and/or focus group activity versus the pharmacological alternative.

Prevention, Screening, and Diagnosis

Primary prevention. The reduction or elimination of combat deployments could be considered the logical means of eliminating issues of stigma associated with military (combat) operations. Unfortunately, military engagement is still universally regarded as the appropriate means of establishing regional and global security, as defined in established treaties between nations. This is based on established treaties and agreements between the U.S. and the allies.

Secondary prevention (screening). The manner in which our military are psychologically screened during post-deployment health assessments could be modified to consider an alternative diagnostic category regarding the *DSM-5* which may provide contemporary solutions to addressing issues arising from the stigma associated with the diagnosis of mental disorder. In essence, identifying or categorizing symptoms attributed to PTS as a battle injury. In addition, this approach or perspective could impact the public health community as a whole (administrators, policy makers, pharmaceutical industry, medical community), since all could be affected by any modification of procedures for addressing the stigma of a mental disorder diagnosis, and related issues (Solomon &

Davidson 1997, as cited in Sayer et al., 2009). There is a military initiative identified by the President George W. Bush Institute which proposes the development of a more effective classification system pertaining to PTS as an injury versus a mental disorder diagnosis, which could prove more beneficial to veterans in whole (Williams, 2014). The consideration for alternative diagnostic categories could provide the outlet needed for veterans to seek assistance and provide the information necessary to provide adequate and effective assistance (Williams, 2014).

Tertiary prevention (treatment). In terms of addressing the problem of stigma (associated with PTSD), in a preventative care approach, could be as basic as including stigma indoctrination (awareness) into military training in the same way as leadership and survival training are included and sustained (Gould et al., 2010; Link & Phelan, 2014; Mittal et al., 2013). The military subculture is grounded in training and preparation for the inevitable as well as the unforeseen consequences of military action, which, if not adequately prepared, could have detrimental effects to operational tempo and readiness. The premise for soldier awareness pertaining to stigma could potentially impact the manner in which stigma is perceived and interpreted throughout the military.

Military Culture and Perspective

The professional military life can be viewed from two general perspectives, from within, as a service member, or from outside, as someone who has not experienced military life first hand. This is important to consider when attempting to understand the problems and challenges experienced by military personnel. This is also important to clinical or other scholarly reviewed research which directly or indirectly relates to the

military. In essence, the military population is a subculture with its own identity, traits, and norms. This presents the need to gather and understand information as viewed by members of that culture, as recommended by Cresswell (2013). This begets the need to conduct research which reconstructs the lived experiences and subsequent outcomes as recalled by combat veterans. For, as Litz (2014) points out, the life and culture of combat veterans can be identified as stoic and tough, their ability to seek medical or psychological assistance may be hindered by issues associated with killing, death, and other atrocities of combat, and these can only be understood from their own self-described experience (Litz, 2014).

In essence, research regarding military stigma requires an understanding of the specific structures and dynamic relationships which exist in the combat soldier's world, and the underlying meanings to others that operate within this sub culture. Any such understanding is further complicated by the implications of a diagnosis of mental disorder in this population. Nor can military personnel without combat experience provide the required data for, as in the military, there exists a simple dichotomy between soldiers with combat experience (all of whom have been exposed to traumatic events) and soldiers with no such combat experience (Patton, 2002). Military personnel with combat experience represent a subculture of their own, which is why they alone are the focus of this research.

Summary

This literature review presented the various elements of military stigma and identified weaknesses associated with research on this topic, including a significant gap

in the literature pertaining to military stigma, and a reluctance to seek medical or other relief for PTS from a soldier's perspective. The contemporary and peer reviewed literature solidifies the reality that military personnel seeking medical treatment for mental distress were apprehensive and fearful of how other people – including current military employers, prospective civilian employers and others would respond to them if they were diagnosed with a mental illness (Sayer et al., 2009; Lee, 2012; Tanielian & Jaycox, 2008; Wisco, Marx & Keane, 2012). The literature also reveals this stigma is ingrained throughout society's discrimination against and stereotyping of people diagnosed with a mental disorder (Link & Phelan, 2014).

While assessing various aspects of stigma and PTSD linked to the specific themes and major areas designed for this research, what is clear was the common themes surrounding the need for further research regarding stigma. This is based on the redundancy of reviewed literature revealing limitations to the majority of studies presented. These limitations clearly identified problematic issues associated with the inability to collect information from a soldier's perspective (actual lived experiences). A secondary issue was the lack of information pertaining to the reluctance of veterans seek assistance and or participate in programs designed to address symptoms associated with PTSD. In addition, there is a gap in the research pertaining to the military indoctrination regarding specific training regarding stigma and its potential identifiers.

The intention of this dissertation is to use an approach which focuses on the veterans lived experiences while attempting to understand why there is a reluctance to seek such assistance. While this approach could question the role and potential bias of the

researcher, what is important to this research is understanding the soldier's perspective and how or why the veteran makes potentially harmful decisions which impact their personal and professional lives. Based on the literature recommendations and intent of this study to explore the lived experiences of vets, a qualitative phenomenological research approach will be used.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to explore veterans' perceptions of various aspects of military stigma, including post-deployment psychological screening, the diagnosis of PTSD, and factors associated with reluctance to seek medical assistance for PTS. The literature review revealed, there is a lack of research on (a) the experiences of soldiers given this diagnosis and (b) their reluctance to seek assistance (Gould et al., 2010). I used a qualitative phenomenological approach to collect data that described the lived experience of veterans (Creswell, 2013). The intent was to develop a clear picture of the problem using participants' experiences to understand the nature of the phenomenon (Van Manen, as cited in Creswell, 2013). The success of this approach was defined by collecting information which may reveal new or unique aspects to the phenomenon of military stigma while focusing on the participants' derived perspectives (Creswell, 2013).

The phenomenological approach provided an opportunity to identify and analyze the lived experiences of service members that best represent and support the participant's actual perceptions (Creswell, 2013). The vet's lived experiences are based on various characteristics that are specific to understanding the dynamics of service members, military stigma, and a diagnosis of mental disorder. This approach provided an opportunity to study all participants in the target demographic about what they did or did not have in common as they recalled their respective experiences (Creswell, 2013). Common characteristics which emerge from the research could provide information in

direct or indirect support to mitigating or eliminating the identified phenomenon (stigma and reluctance to seek assistance) which could support changes or modifications to psychological screening upon return from military combat duty. This research approach was logical and necessary to understand the real-life experiences of combat veterans and to establish a common bond between participant and researcher in order to elicit the information required to complete a valid and reliable study.

This chapter covered the following topics: research design; role of the researcher; methodology; instrumentation; recruitment, participation, and data collection; data analysis; internal and external validity; and ethical procedures.

Research Design and Rationale

Research Questions (RQ)

- RQ1: What are combat veterans' perceptions of the military stigma associated with a diagnosis of PTSD?
- RQ2: What are combat veterans' perceptions of the post-deployment health assessment?
- RQ3: What are combat veterans' perceptions of the personal and professional impact of military stigma?
- RQ4: What are combat veterans' opinions of the available treatments and therapies for PTS?
- RQ5: What are combat veterans' ideas about how military stigma might be reduced or prevented?

The focus of this research pertains to the lived experiences of the military population as they interpret the psychological screening process and its implications for their professional and personal lives. A central issue to understanding why military stigma is prevalent is determining what the central causes are regarding the reluctance of veterans to seek medical assistance in one form or another. Determining the shared combat-related characteristics which directly or indirectly contribute to the stigma experienced by the veteran population should help us understand the problem. This approach allowed us to better identify, understand, and possibly resolve problematic issues associated with current psychological screening methods and subsequent treatment programs established regarding stigma. This could increase the overall purpose and effectiveness of pre- and post-psychological screening, and greater use of programs for the treatment of PTS.

Role of the Researcher

The role of this researcher was to investigate military stigma from a soldier's (service members) perspective, and its relationship with the reluctance of many soldiers to seek treatment for posttraumatic stress (Mittal et al., 2013). As a former U.S. Army Warrant Officer Four (CW4), with over 27 years of active and reserve component service within the military (now retired), I have had extensive experience with the military Criminal Investigation Division (CID) as a Special Agent/Investigator. I am trained and experienced in complex military investigations, including interview protocols and techniques. In addition, I am also identified by the VA as disabled through service-connected actions during deployment in support of OEF/OIF. The service connected

disabilities include a diagnosis of PTSD in conjunction with sustained physical injuries. This provides additional perspective regarding post-psychological screening practices (as provided by the military and VA) and the bureaucracy (programs, interventions, and barriers) associated with post deployment activities.

The potential for researcher bias exists based on the respective challenges and barriers experienced first-hand by the researcher regarding the stigma associated with a mental disorder diagnosis. An important aspect of this researchers' experience is the fact that the stigma was overcome through the development and understanding of the processes, initiatives, and programs which currently exist to assist veterans. This is complemented by applying my own experiences and perspectives to the issue of stigma and overcoming obstacles (personal and professional) through my own positive affirmation and actions. The issue of bias will be minimized through the utilization of bracketing as it applies to phenomenological research. This consists of the design methodology and development of this study using semi-structured open ended research questions, literature research, and validity process applied through a phenomenological research approach and strategy (Chan, Fung & Chien, 2013). This approach will assist in minimizing the researchers' own first-hand knowledge and experiences regarding the military culture while validating the data collection and analysis process.

The foundation for this researchers' role is to simply identify the issues of stigma from a veterans perspective (through their lived experiences), as recounted and analyzed by a researcher who is also an OEF/OIF combat veteran diagnosed with PTSD. In addition, it presents an opportunity for research that applies the experiences and

perspectives of disabled veteran (as the researcher) who could bridge the information gap (between stigma and veteran reluctance to seek assistance) regarding potential emergent information collected from the study participants. Researcher bias will be controlled through various checks and balances which include input and coordination with this researchers' Committee Chair and Committee Member, triangulation pertaining to the research model in comparison to other contemporary studies, and the inclusion of participant input regarding potential remedies to the emergent issues identified.

Methodology

The sampling strategy for this study is a homogeneous sampling (Creswell, 2013; Patton, 2002). Using homogeneous sampling provided a method to identify combat veterans within the military complex as there are differences between military personnel having been exposed to traumatic combat events and in this case soldiers within particular military units with minimal or no combat exposure (Patton, 2002). This is in keeping with a central focus of the research to identify define specific characteristics associated with the negative (personal implications) and/or detrimental (impacting professional military status) connotations associated with a mental disorder diagnosis. This is based on various characteristics which are specific to understanding the dynamics associated with the subject population (military subculture) and the military stigma associated with a diagnosis of mental disorder. The unit of analysis in this case being combat and non-combat support veterans is based on the need to study this group in order to effect/recommend observations for change (Patton, 2002). As it pertains to this research, combat veterans are considered a programmatic group within a larger

demographic which defines military personnel based on a simple dichotomy of personnel with combat experience (exposed to traumatic events) and military personnel with no such combat experience such as combat support personnel (Patton, 2002). This dichotomy between the groups is distinctive and considered a defining subculture in itself, by the military hierarchy as well as respective combat veterans. The primary focus pertaining in this case to combat veterans.

Participants

Participants (veterans of OEF/OIF) were recruited by means of flyers (Appendix A), emails, and site visits (snowball sampling) through regional veteran support organizations (Austin, Texas based affiliates) such as the Heroes Night Out, Disabled American Veterans (DAV), Veterans of Foreign Wars (VFW), and Texas Veterans Commission (TVC). Site visits and coordination with the entities previously identified assisted in the adequate presentation of flyers (which invite volunteers to contact this researcher) as well as ensuring the email versions are disseminated throughout the veteran populations which frequent these locations. Recruitment also took place in non-traditional locations (using word-of-mouth, snowball sampling) such as fitness centers (MetroFlex Gym and Gold's Gym) and other locations which veterans use.

Sample

Consideration for the enormity of the U.S. Army creates a conundrum regarding the proper sampling size identification and selection. The purpose of this research was to explore this phenomenon in-depth in a small number of vets. The sample goal was to identify 10 participants, composed of veterans who meet the criteria for this research.

Inclusion criteria (Appendix A) for the study are: be a military veteran of Operation Enduring Freedom or Operation Iraqi Freedom or served in the military post 9/11 (male or female); have observed or experienced stigma associated with combat-related post traumatic stress; have served at least one year of honorable service in the U.S. Military (Army, Air Force, Marines, Navy, or Coast Guard); provide consent to participate in a 60-90 minutes interview regarding the stigma associated with combat-related post traumatic stress and asking any questions you believe are important to this. These 10 veterans were screened using a prescreening questionnaire (Appendix B) in order to meet research eligibility. This included a request for information regarding: OEF/OIF veteran status; have observed or experienced stigma associated with combat-related post traumatic stress; have served at least one year of honorable service in the U.S. Military (Army, Air Force, Marines, Navy or Coast Guard); honorable discharge from the military; and how much time served in the military.

Participants were not excluded based on gender, age, race, religion, education, number of deployments, or military status/affiliation. The number of participants and extent of data collected for this research may be modified or adjusted based on potential participant dropout, the depth of the data collected, the development of emergent information, and the realization of redundant information (Creswell, 2013; Patton, 2002).

The results were not generalizable, but they did yield major themes that could later be studied quantitatively in a larger sample. The justification for the sampling size was based on Lincoln and Guba (as cited in Patton, 2002), which proposes and recommends that a specific sample should not exceed or extend beyond a point of

redundancy. While 10 participants is often a sufficient sample size in studies of this kind, data collection will continue until no new data are being generated. This was based on the unique experiences shared among the military subculture (which tend to be similar in nature) regarding commonalities in traumatic events (combat), their lived experiences, and other similar variables or characteristics. This study was completed with ten participants only.

Instrumentation

The questionnaire designed for this research was developed to elicit answers to the research questions. Two specific questionnaires will be used: a screening questionnaire, to substantiate inclusion in the research (Appendix B), which is described above, and the interview questionnaire (Appendix C), which contains a set of semi-structured questions regarding various elements of the stigma associated with combat-related post traumatic stress. These interview questions will also attempt to elicit information regarding the different facets pertaining of veterans' reluctance to seek out or participate in PTS treatment initiatives or programs. The intention of this interview strategy was to elicit information which may bridge the gap between various characteristics and variables associated with stigma and the reluctance of veterans to seek assistance or complete programs/interventions initiated.

The interviews were transcribed using technology applications through a personal computer/tablet. In addition, specific protocols were used regarding the interviews as needed. The interviews were scheduled as face-to-face (local) and through electronic communication (Skype), depending on the participant's relative location. Potential

opportunities for utilization of observational techniques were used during the course of the interviews (any behavioral dynamics which may or may not assist in the interpretation of information collected).

As a seasoned combat veteran and trained investigator, I am experienced in conducting interviews of fellow veterans (regarding a myriad of subjects), and familiar with how to maintain an objective position while conducting interviews.

Data Collection Procedures

The sufficiency of data collection was based on the qualitative design study itself. Prior to conducting face-to-face in-depth interviews, this researcher developed a thorough understanding of the typology of research pertaining to contemporary characteristics and variables associated with PTSD and stigma (Creswell, 2013; Patton, 2002).

The interview questions were semi-structured allowing for the potential development of emergent themes (Creswell, 2013). Should the data reveal emerging information, consideration will be given to additional, follow-up interviews. This is based on the participants (veterans) experience and consideration as subject matter experts in operational deployments and as former of current professional soldiers. It is important and logical to consider the participants input as an element of the debriefing process. At this time, there will be no additional program staff included in this research (Patton, 2002). All materials related to this research were maintained, copied, and secured by this researcher, using various forms of technology, media storage, as well as securing hard copy transcripts while protecting the identities of the participants and any information related to this research (Patton, 2002).

Data Analysis Plan

NVivo, a computer-assisted qualitative data analysis (CAQDA) program was used to manage the majority of aspects associated with storage and management of data and comparative analysis (NVivo, 2014; Patton, 2002). Initial parameters and classifications (nodes, sources, relationships, and matrices) were established to better organize the data collected (NVivo, 2014). The premise being to establish a viable, manageable, and replicable classification system for analyzing (Patton, 2002). This application allowed for a multitude of variations attributed to emerging and developed information as a result of the semi-structured line of questioning.

Initially, general parameters and categories were established regarding this study using the NVivo program. These parameters included the categories of specific military characteristics as they apply to military occupational specialty, traumatic experiences, and other potential areas of categorization. Nodes and classifications were applied to the initial as well as emergent categories identified based on information collected and analyzed post interview. The utilization of NVivo allowed for the integration of external and internal documents, and node analysis (NVivo, 2014). NVivo presented an application that provided reports supported by analysis (charts, graphs, and tree maps) which were applied to the overall study identifying specific categories, explained in nodes, and providing opportunities for emergent data classifications in support of providing information of substantive significance (Patton, 2002).

Trustworthiness

Evidentiary validation and quality regarding the qualitative research plan, the available validation strategies, and perspectives regarding the stigma associated with combat-related post traumatic stress are considered multi-tiered and present various options to support the research approach. The intended foundation was to establish quality, trustworthiness, and credibility through the pre-screening of potential participants as subject matter experts regarding their respective military experiences (Howe & Eisenhardt, as cited in Creswell, 2013). This included the utilization of a triangulation approach revealing a spectrum of investigative or analytical actions focusing various aspects of participant/researcher inquiry (personal and professional; Creswell, 2013; Patton, 2002).

Once, a consensus (through emergent information) was developed regarding the reluctance of veterans to seek assistance, based on stigma, appropriate themes and categories were established and an analysis was completed regarding the developed themes and categories. This information was triangulated through a constant comparative analysis of content in respect to the participant's information, the researchers' capacity and capabilities, and available external subject matter experts (both scholarly and military peer review). Content validity was established using specific models and establishing parameters within a specific research typology (specific to military subculture and combat events) which assisted in establishing a more significant research product. This was supported by identifying the units of analysis (military personnel from a specific

military specialties and military units), and in this case the programmatic groups identified as combat and non-combat veterans (Patton, 2002).

Additionally, the interpretation and understanding of the experiences presented by the sampling group allowed this researcher to focus on critical incidents (people focused) compounded by crisis/traumatic events as a result of combat activity (structure focused) which may present additional information for consideration (Patton, 2002). The premise was to develop a research model which can be replicable by either one researcher (as in this dissertation), or by multiple researchers applying a respective inter-coder process (as needed) to evaluate the derived information.

Once the interviews were completed, they were analyzed in an effort to identify or develop information which supports new ideas or themes as previously revealed. As an element of the triangulation process, subsequent coordination (post interview) with participants (willing to assist) were used as a method to further develop and/or analyze derived themes, potential remedies, mitigation of stigma, and the reluctance of veterans to seek assistance. These participants became a part of the analysis process known as member checking.

Ethical Procedures

Prior to the commencement of the study, coordination was sought through the Walden University Office of Research Ethics and Compliance in order to apply for and attain approval from the Walden University Institutional Review Board (IRB). The Walden University IRB Approval number was 12-23-15-0357536 and it expires on December 22, 2016. The application and proposal are a formal request for approval to

conduct research under ethical guidelines which are approved, monitored, and regulated by Walden University (Creswell, 2013). In addition, during the planning stages of the research, this learner collaborated with available peers and interested stakeholders (military and/or combat veterans) to consider roundtable style discussions (be it through Skype or other means) regarding the opportunity to discuss ethical dilemmas and other issues which may create obstacles to accomplishing this study (Janesick, 2011). Prior to participation, all participants signed a consent form).

Issues for discussion which could impact ethical considerations included operational methodology, available assets and time constraints, and potential researcher bias (Janesick, 2011). This is based on background of the researcher (retired military) which may question objectivity and the agenda of this research. In regards to participant confidentiality, and the applications (instruments) used, the questionnaires are strictly confidential in keeping with the American Psychological Associations (APA) Ethical Standards, specifically those for research with Human Participants. The confidential information is maintained and secured within the NVivo program application accessible only to the researcher of this dissertation. Participants of this study will be afforded the opportunity to obtain the results of the research (if requested), as well as participate in the triangulation process as desired, and previously identified. Participants were provided the dissertation researchers contact information, and the contact information for the dissertation committee chair should additional inquiry or assistance regarding this process is required. No incentives were provided to the participants, other than an opportunity to

assist and contribute to potential remedies or mitigation of stigma affecting fellow veterans.

One ethical dilemma for this learner is my role as the research originator and primary investigator, with its potential for researcher bias, as noted in "Role as Researcher" above, since this is a prime example of a researcher studying his/her own group (Janesick, 2011).

Summary

The purpose of this research was to identify, ascertain, analyze, and understand the stigma associated with receiving a diagnosis of mental disorder as it applies to post deployment psychological screening. A qualitative phenomenological approach best served this purpose. The subject population was considered a subculture of its own, there was a need to understand particular military characteristics. Specifically, what motivates a soldier to act or react within specific parameters (as trained and during redeployment) after experiencing combat traumatic events. This was in keeping with a central focus of the study to identify define specific characteristics associated with the negative (personal implications) and/or detrimental (impacting professional military status) connotations associated with a mental disorder diagnosis.

This methodology was in keeping with focusing on the gap of information pertaining to the stigma associated with combat-related posttraumatic stress while developing an understanding of the veteran's reluctance to seek assistance. The goals and objectives of this dissertation were developed in keeping with bridging this gap of information from the soldier's perspective while potentially providing results which may

solve or mitigate this reluctance. Hence, providing a methodology which can be applied (replicable) to better understand what does, or does not motivate a veteran to seek assistance and alleviate the stigma associated with PTS.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to explore veterans' perceptions of various aspects of military stigma, including post-deployment psychological screening, the diagnosis of PTSD, and factors associated with reluctance to seek medical assistance for PTS. The literature review revealed, there is a lack of research on (a) the experiences of soldiers given this diagnosis and (b) their reluctance to seek assistance (Gould et al., 2010). Military stigma comprises both an external event (discrimination) and internal experience (shame), as described by Link and Phelan (2014). The focus of this qualitative research was to understand what factors were directly or indirectly associated with this stigma, which tended to make veterans reluctant to seek assistance for medical issues associated with PTS. Understanding the various elements of this stigma could reveal a new or a modified approach to the developmental indoctrination (awareness training) specific to mitigating or reducing stigma associated with PTS. The primary objective was to answer the following research questions:

- RQ1: What are combat veterans' perceptions of the military stigma associated with a diagnosis of PTSD?
- RQ2: What are combat veterans' perceptions of the post-deployment health assessment?
- RQ3: What are combat veterans' perceptions of the personal and professional impact of military stigma?

- RQ4: What are combat veterans' opinions of the available treatments and therapies for PTS?
- RQ5: What are combat veterans' ideas about how military stigma might be reduced or prevented?

Although not a primary focus of this study, the dynamic environment of their military deployment was also taken into consideration when evaluating the responses of participants to the interview questions. This dynamic environment includes operational assets in the form of manpower and logistical strengths and weaknesses, which potentially impacted (directly or indirectly) the circumstances that existed during OEF/OIF. The reality of post-9/11 war, as it pertained to most military personnel, is that, there were no clear differences between MOS's when it came to engaging an unknown enemy combatant or experiencing other trauma under austere and unpredictable conditions. It is important to be aware of these considerations when analyzing the responses of each participant. Though each respondent's lived experiences are unique, they can be categorized within similar themes and merged into domains based on shared operational scenarios.

This chapter is comprised of various sections on the results of the interview data obtained from the 10 participants. The derived data was transcribed during the interviews and subsequently examined. These areas included participant demographics, settings, data collection and analysis, developed themes, and evidence of trustworthiness. During the course of this analysis, themes were derived from the interviews based on repeated words, similar words and phrases, and content relevant to the research question. Each of

the five research questions will be addressed within each of the specific themes identified.

Setting

The strategy for identifying suitable locations for the interview process included public and private locations which provided a modicum of privacy to conduct interviews without distraction. These interview locations also provided environments which could be identified as easily accessible without restrictions. These locations also provided ample opportunity to develop an informal rapport in order to maximize the interview experience between participants and myself. The majority of participants were recruited through snowball sampling as well as through the utilization of the research Flyers (Appendix A, Recruitment Poster), as identified in the previous chapter regarding methodology.

The interviews were transcribed using technology (software applications) available through a personal computer/tablet at the time of the interviews. The interviews were scheduled as face-to-face (local) and through electronic communication (Skype or telephonic), depending on the participant's relative location. If a telephonic interview was used, the participant was provided all relevant documentation in advance of the interview (i.e. Appendix A, Recruitment Flyer; Appendix B, Screening Questionnaire; and Appendix D, Consent Form). Potential opportunities for observational techniques were used (where and when available) during the course of the interviews (any behavioral dynamics which may or may not assist in the interpretation of information collected) when presented, resulting in negative observations made. During the course of all

interviews it was evident the participants wanted to assist this researcher in providing or identifying information in addressing the issues identified in the interview questions (Appendix C, Interview Questionnaire) pertaining to the subject of stigma. This observation is based on the rapport established during the interview process and exchange of information (eagerness of the participants) regarding former military backgrounds and mutually shared characteristics (military experiences).

Demographics

Ten veterans (currently reserve, retired, and/or separated honorably from military service) provided consent to participate in this research. Of the ten participants one was female, and nine were male. Two of the ten participants had served in multiple branches of the military service over the course of their military careers. The ages represented ranged from 26 to 48 years of age. All of the participants were veterans of OEF/OIF and considered experienced having completed multiple deployments in various mid-level management positions (Officer and/or Enlisted) associated within their respective MOS's while deployed. The demographic data regarding participants MOS's, military branch, and rank are identified below (see Table 1). The need to identify the actual MOS's of the respective participants assists in explaining the specific military specialty and occupation in which the veterans served in deployment of OEF/OIF.

Table 1

Participant Demographic Data

Participant	MOS	Military branch	Rank
1	68W/68G Combat Medic	US Army	Sergeant (E-5)
2	MA3 Master-at-Arms	US Navy/US Army	Petty Officer Third

	and 311A CID Agent		Class (E-4) and Warrant Officer 1 (W-1)
3	11B Infantry	US Army	Sergeant (E-5)
4	31B Military Police	US Army	Master Sergeant (E-8)
5	0311 Rifleman	US Marine Corp	Major (0-4)
6	311A CID Agent	US Army	Chief Warrant Officer 3 (W-3)
7	0311 Rifleman	US Marine Corp	Sergeant (E-5)
8	68W Combat Medic	US Army	Sergeant (E-5)
9	31D CID Agent	US Army	Staff Sergeant (E-6)
10	0311 Rifleman and 11B Infantry	US Marine Corp and US Army	Staff Sergeant (E-6

The unit of analysis regarding the identification of six combat arms MOS and four non-combat MOS (previously identified in Chapter 3) has been met as it pertains to the participants experiences (combat exposure) during OEF/OIF for this study pertaining to. The importance regarding the unit of analysis is based on the diverse nature which exists within the military culture. Combat veterans are considered a programmatic group within a larger demographic which defines military personnel based on a simple dichotomy of personnel with combat experience (exposed to traumatic events) and military personnel with no such combat experience such as combat support personnel (Patton, 2002). This dichotomy between the groups is distinctive and considered a defining subculture in itself, by the military hierarchy as well as respective combat veterans.

All participants had direct or indirect knowledge of stigma regarding their respective levels of military operations, combat exposure, or knowledge of combat-related post traumatic stress. The areas (cities and regions) of deployment (experience) pertaining to the research participants of OEF/OIF included Mosul, Talil, Kabul, Baghdad, Sadr City, Abu Ghraib, Diwaniya, Fallujah, Umm Qasr, Nasiriyah, Baqubah,

and the Syrian Border in Iraq, and Afghanistan. This included operational movement between cities identified and throughout multiple regions not identified. Individual participant deployments were as few as one to as many as four deployments each, since 2003.

Data Collection

Data was collected from the ten participants as previously identified. These participants will be referred to throughout the remainder of this study as Participants (P) 1 through 10, specifically. The data collected from all ten participants was in keeping with the data collection procedures identified in the previous chapter. The instrument used to collect the information involved questionnaires designed for this research (semi-structured and open-ended) and developed to elicit answers to the research questions. Two specific questionnaires were used: a screening questionnaire (Appendix B), to substantiate inclusion in the study, and the interview questionnaire (Appendix C), which contains a set of semi-structured questions regarding various elements of the stigma associated with combat-related post traumatic stress. This interview protocol provides an opportunity for the participants to respond based on their respective experiences, perspectives, and interpretive thoughts.

All interviews were conducted using the interview questionnaire (Appendix C) and transcribed (verbatim) onto a computer notebook at the time of the respective interviews and later transferred into the QSR NVivo11 software application (for coding and theme development purposes), as previously identified in Chapter 3. The only variation to data collection involved the audio recordings of the interviews, which were

not possible (as initially identified in Chapter 3) due to technical difficulties with the software recording application. This variation did not impact or hinder the interview process as the interviews and transcription were simultaneous and subsequently returned to the respective participants for member checking. I was careful to employ probative questions identified on the interview questionnaire (Appendix C) in order to avoid leading the participant in question responses, but to elicit explanations as needed. The duration of each of the interviews was no less than 45 minutes and no more than 90 minutes allowing for future follow-on opportunities (as needed) and to provide member checking which supports internal validity.

A unique aspect of this dynamic involved an almost instant familiarization between the participants and myself predominantly based on having identified shared characteristics and military experiences in the same regional locations, under similar operational events. This is due in part, to the rapport and trust developed during the actual interviews. Establishing this trust and rapport allowed this researcher to better understand the lived experiences of the participants without hesitation on the part of the participants.

Data Analysis

Information derived from the interviews revealed characteristics and variables which were identified, developed, and coded as nodes and categorized using the QSRNVivo11 software. These characteristics and variables were then reviewed from a perspective identifying redundant content and broad categories. These categories were further analyzed and blended into themes based on their content, specific meaning, and representation. These themes were subsequently developed to better explain or represent

associations (interpreted) which could define the problems regarding the stigma associated with combat-related post traumatic stress. Although, each of the themes could be viewed as independent, they are also overlapping as expressed in their respective merging.

Participants were enlisted to review and conduct member checking regarding their respective interview transcripts for accuracy regarding their lived experiences using email for additional comment or correction, as needed. These transcripts were provided to the participants after they were uploaded to the QSR NVivo software application. This approach also supports internal validity of the research. This process assisted in furthering trust while developing stakeholder camaraderie (rapport). The codes were derived from the interviews specifically identifying repetitive or similar words, text, phrases, and content relevant to the research questions previously identified, which pertain to the stigma associated with combat-related post traumatic stress.

The participants' responses were developed into twelve themes representing the various aspects of stigma within the context of this research. The twelve themes included: there is a great deal of misinformation throughout the military about PTS and military stigma; military stigma is seen as a form of stereotypical labeling that produces discriminant behavior in both military and civilian sectors; the military and media perpetuate misinformation about PTS, and the assumption that every combat veteran suffers from PTSD; veterans experience stigma as intimately connected with their experience of remorse at not having done well enough to support their brethren; post-deployment health screenings are superficial, inconsistent, and ineffective; during post-

deployment medical screening, vet's feel the need to lie about their deployment experience for fear of being stigmatized; post-deployment screening practices create an environment of stress associated with stigma that perpetuates vets' reluctance to seek help for PTS; veterans report that military stigma negatively effects their personal relationships; veterans report military stigma affects their potential employment opportunities; veterans have limited knowledge about PTS treatments or therapies offered by the VA and military; education of soldiers is needed to correct the misinformation which continues to exist regarding stigma and PTS; and stigma awareness training could change the reluctance of veterans to seek assistance.

Results

What are combat veterans' perceptions of the military stigma associated with a diagnosis of PTSD? (RQ1)

The following themes (throughout this chapter) are supported by various words, phrases, and text identified within their respective categories representing content which is considered similar in nature or overlapping. Although, similar in nature, each of the themes is singularly unique and important according to the respective responses from the participant's. A total of 73 comments and references were made by the participant's regarding Themes 1, 2, 3 and 4.

Theme 1: There is a great deal of misinformation throughout the military about PTS and military stigma. The veterans who participated in this study reported that there is a great deal of misinformation about PTS and military. The veterans believed this problem is compounded by systemic issues associated with the enormity of the

problems associated with stigma and how these issues are being addressed. The veterans also revealed this issue is exacerbated by inadequate support provided by the military chain-of-command (at various levels) as identified and used by all participants in this study. The veteran responses clearly reveal a lack of trust or confidence in the chain-of-command regarding their inaction (directly or indirectly) to support programs which provide assistance for PTS, and personnel diagnosed with PTSD.

The questions which elicited the majority of responses associated with the misinformation about PTS and military stigma, focused on what the veterans thought should be done to reduce or prevent stigma. Most responses on this topic focused on how the military could change their respective approaches to mitigating or reducing the misinformation and misunderstanding of the stigma associated with mental distress or stigma. Participant's responses were as follows:

> I think the system [government] shouldn't be so quick to label PTS as the catch all end all issue associated with the military as a general categorization or label… it should be an illness or injury that should be explained in terms that anyone can be subjected to… (P3).
>
> Rename the damn thing [referring to PTSD]… as there is definitely power in a name… I also believe PTS is an opportunity for growth which makes me stronger… (P5).

All responses from the participants reflected the need to seek alternative methods, remedies, actions, or diagnostic classifications to addressing the issues associated with the label of a mental disorder. Numerous responses from the vets also emphasized the

need for changing or categorizing symptoms attributed to PTS as a battle injury, to better mitigate or reduce the misinformation which currently exists regarding PTS. According to these vets, factors which impact the larger problem of stigma associated with combat-related PTS revolve around the official categorization of a PTS as a mental disorder, as defined by the DSM-5. The following response reveals the complexities regarding both the individual (self-internalized), as well as the issues regarding command and control of a viable PTS program:

> I think there are two sides to it [stigma], first, PTS being seen as a weakness, and the other side being veterans taking advantage (manipulating the system)… There needs to be somebody completely outside of the chain of command that can actually manage a stand-alone program [regarding PTS], which actually assists military personnel… Direct authority regarding a soldier's actions in seeking assistance must be removed from the soldier's direct chain of command, because this could negatively affect your career… The army needs to take care of its personnel first…it is about taking care of your troops…as PTS is not a priority regarding mission deployment. (P10)

Theme 2: Military stigma is seen as a form of stereotypical labeling that produces discriminant behavior in both military and civilian sectors. The data revealed a collective opinion that military stigma is perpetuated through stereotypical labeling, which produces discriminant behavior from both the military and civilian sectors. As stigma is so closely associated or defined by stereotype and/or discrimination, it was important to this study to discover which characteristics or variables manifested

from the veteran's experiences. Questions which focused on stereotype included an understanding that stigma is largely explained as veterans being stereotyped, as a result of their experiences pertaining to direct or indirect support of OEF/OIF military operations. The veteran's responses clearly reveal the existence of this stereotype as a possible result of misinformation or misinterpretations by the public regarding military service and operations, in large, pertaining to the experiences of combat veterans. As the majority of veterans interviewed explained the unique characteristics and variables which explained various aspects of military culture (and the camaraderie which exists), what was expressed involved various characteristics associated with self-stigmatization. Although, the responses may vary, they have been identified as similar in content as they pertain to stereotype, discrimination, and feelings of remorse, anger, and stress.

The following responses from participants focused on their perceptions of stigma as it either impacted them personally, or as they experienced it within their military units of assignment while supporting OEF/OIF. In an effort to more effectively represent theme 2 from the participant's perspective, the selected veteran responses have been separated into sub-categories of self-stigma and public stigma to better represent an axial coding procedure which best explains characteristics which are abstract in nature. Participant responses regarding self-stigma are as follows:

> I feel military people are groomed not to show weakness… I know of a friend who totally withdrew from his family which almost cost him his marriage… He subsequently found counseling on his own… (P2).

> Most veterans want to hide it and not claim any illness or injury related to PTS… (P3).
>
> I think it is viewed that you are mentally weak and more of a liability to the military… I think it would be a liability to my career. It would be difficult to excel in the military or private sector with the label of PTSD… It also extends to pre-deployment screening… This affects units getting ready to mobilize if any of their personnel have been diagnosed with any form of mental illness, let alone taking medications…between Physical Health Assessments (PHA) and VA disability ratings can significantly impact a unit's mobilization roster… I do have PTS and never admitted it to anyone besides my family as I know it will impact my long term career. Especially as a female… (P4).
>
> I think when we started off in our first deployments, I spoke with psychiatrists or other medical personnel to set an example that it is OK to discuss any symptomatic issues with medical personnel… I realized there was definitely a stigma pertaining to PTS based on military personnel being apprehensive to report issues associated with PTS directly affecting their performance issues pertaining to their work… I think very strongly that stigma was common among guys as there was always an issue of personnel and assets to support the war on terror, and stigma (self-stigmatization) is a result of peer pressure to support your troops and mission… (P5).

Public stigma is also complicated by how the public perceives or stereotypes specific groups and self-stigma includes the internalization of an individual's perceptions

of this negative connotation (Corrigan & Watson, 2002). This reality, as expressed by the veterans interviewed, also reveals the perpetuation of discrimination as a direct result of stereotype. Participant's responses regarding public-stigma are as follows:

> Although we all do not have the same experiences () many of us have experienced death….People here (S.) do not understand what our experiences actually were…and categorize us all the same. People lack an understanding of what we actually went through. (P1)
>
> Because society thinks people can't grow or progress from their possible combat experiences and they (soldiers) should be categorized or labeled (because of fear of the unknown)… The issue becomes 'why are only veterans being discriminated against as it is related to PTS' (P3).
>
> I think it is an issue of ignorance on the part of the public as they don't really understand the stressors military go through… Some of us (veterans) screw up and the repercussions are severe…this is what adds or complicates the stigma of PTS (P7).
>
> The public does not understand the experiences which military personnel have been through and we are automatically stereotyped…Veterans feel they are stereotyped based on misconceptions of the public (P9).

Theme 3: The military and media perpetuate misinformation about PTS, and the assumption that every combat veteran suffers from PTSD. The veterans who participated in this study identified the importance in which the media and military plays as an important element in perpetuating the problem of military stigma. The veterans also

believed the role which media and military play in perpetuating military stigma, could be identified as catalyst in promoting or perpetuating misinformation regarding stigma within the context of this research. The majority of veterans interviewed collectively revealed their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. The veterans revealed this problem is clearly linked to stigma as it is compounded by the automatic association and assumption that every combat veteran is categorized with PTSD. The professional and personal ramifications associated with a diagnosis of PTSD (or similar associations), as previously identified, are characterized (within the content of this study) through the participants' experiences, which were subsequently affected.

The questions which elicited the majority of responses were open-ended questions which focused on the experiences and knowledge of each of the participants and how the stigma associated with PTS or being labeled with PTSD may or may not have affected their personal or professional lives. These questions also elicited responses regarding how the role of the media and military play in perpetuating stigma, focused on how the military could actually mitigate or reduce the reluctance of veterans to report issues associated with stigma (within this context), as previously identified. This included their respective positions regarding how military personnel are labeled should they receive a diagnosis or classification regarding a mental disorder.

According to the veteran's this was compounded by the lack of support necessary to address this problem, specifically, being categorized based on the label of PTSD. The

majority of the responses focused on education and training regarding issues of stigma throughout the military and our society in whole. Participant's responses were as follows:

> No, as we transitioned from one chain of command [in country deployed], to a new one during the redeployment phase [military transition units for medical screening], there was a lack of familiarity, and they [medical screening personnel] were not in tune with us... The former chain of command provided the support required at the time… When I transitioned into the Warrior Transition Battalion there was a lack of interest… (P1).

These responses confirm issues of concern (as previously identified) associated with the enormity of the military, in whole, in attempting to develop solutions to address stigma.

> Yes, I do (believe there is a lack of leadership), because soldiers are reluctant based on stigma regarding illness or labeling… they should feel free from discrimination to seek the assistance needed… The chain of command is not monitored for this type of support at this time… No, I do not believe the military chain of command has sufficiently supported the military personnel they are responsible for… This is mostly due to the VA process convoluted by the other military services… Yes, I believe this because the military is a big network and issues associated with PTS or being labeled as such could hinder any professional advancements or other professional development… (P2).
>
> Definitely, how couldn't it (automatic assumption that every combat veteran is categorized with PTSD)… it affects their personal lives, i.e. weight gain, drug

> usage, hormonal issues associated with stress… I think the chain-of-command considers PTS a liability that could impact the readiness of a deployable force and impact the military in general. I think the chain of command is scared of it… Chain-of-command support is what is needed and the military should remove the D from PTSD to assist in helping vets who are reluctant because of this factor… The only thing that can really be done is education, empathy and overall awareness… (P4).

The collective opinion from the veteran's perspective is that indoctrinating soldiers to the potential issues associated with PTS could better prepare military personnel to recognize characteristics and associated behaviors arising from stigma.

> I would like to think they do, but I believe the chain-of-command (Marine Corps) is more focused on the mission first and people second… not a priority… I believe it [stigma] does impact both personal and professional lives based on how people deal with you… I felt there was a stigma associated with being an OEF/OIF veteran based on the misinformation of war and being diagnosed with PTSD. For example, in the state of Texas, I cannot obtain a Concealed Handgun License (CHL) based on having a diagnosis of PTSD… (P7).
>
> Definitely not, especially post deployment activities, as the chain-of-command does not consider this a priority and veterans themselves were not willing to be forthcoming with their information… I would say it (stigma associated with PTS) does (impact personal and professional lives), based on the misunderstandings which currently exist… I believe treatment is critical. (P8)

> There is this automatic stigma associated with military service, combat, and PTS…this is also sensationalized by media who are quick to ask questions regarding any mental issues… I believe popular pop culture promotes this stigma in the form of movies or other media which depicts all military personnel as having been through traumatic issues in some unrealistic form… The military chain-of-command are big promotors of getting help for PTS but in reality are hypocritical to actually helping… I believe Big Army as a whole, has made positive leaps and bounds regarding PTS treatments… but, as it pertains to local commands (specifically, lower echelons of command), not so much… (P9).

> Yes, first off, when interviewing for a potential job, an interviewer can make assumptions about PTSD based on your resume (military deployments) and the fact that you have all of your limbs during the interview… There is an automatic assumption veterans have some form of PTS… (P10).

Although, two respondents felt that military command support was adequate, the large majority felt that this was not the case. The following responses provided by two participants believed the military command support was adequate (as it pertained to active duty personnel only), but, were also critical of the same chain-of-command (to include the VA), regarding manpower issues, as follows:

> Support yes, adequate no… this is based on not having enough personnel to support the mission… We are in such a place with our man power, we are all deployed out and there isn't enough time to properly treat people with PTS… (P5).

> From what I can see, the Army is providing adequate support for the soldiers on active duty. However, the veterans that are getting treatment from the VA are caught up in backlogs waiting to be seen and evaluated. (P6)

Theme 4: Veterans experience stigma as intimately connected with their experience of remorse at not having done well enough to support their brethren. The majority of responses from the veterans appear to identify various aspects of self-stigmatization in the form of self-identified pressures and/or remorse presenting various elements of guilt. This remorse (within the context of this study) includes: the need to comply with the greater needs of the mission versus their own disposition (wellbeing) and need for assistance; the need to redeploy back to the combat zone; the issue of self-worth to their brethren; and how the veterans believed they are viewed by others in a negative manner.

In this case, one of the issues which was identified was the remorse developed as a direct result of post-deployment activities which perpetuates stigma directly and indirectly. The veterans expressed their belief that forms of remorse (guilt) were post-deployment feelings of not having done enough in the war on terror. This disposition appears to create an environment which encourage stereotyping and discrimination with regard to stigma.

The questions which elicited the majority of responses associated with stigma focused on understanding that stigma can be explained as veterans being stereotyped, or having feelings of shame and disgrace. The data specifically identified feelings such as remorse, anger and stress. For example:

> I do not feel shame or disgrace, but remorse that I could not do more… I feel more anger than shame… (P1).
>
> I think we ask ourselves the question: Who are we now? The first time we shoot someone - not an insignificant act, right? So we ask ourselves, Is this a Disorder? Or do we say, Yeah that was some bad hat, but look at how I've gotten stronger. (P5)
>
> Commonly, soldiers in the Army were ridiculed for showing or being diagnosed with symptoms associated with PTS… A lot of veterans who have PTS are categorized or stereotyped for having some sort of mental illness... (P8).
>
> I don't really care what people think or say, but I was ridiculed (stereotyped) by students while at the University of Texas (UT), while walking through campus (because I was in uniform) after class… (P10).

In summary, four strong themes emerged in response to Research Question 1, and "what are combat veterans' perceptions of the military stigma associated with a diagnosis of PTSD," the first was that, veterans reported there is a great deal of misinformation throughout the military about PTS and military stigma. The second, was that veterans reported military stigma is seen as a form of stereotypical labeling that produces discriminant behavior in both military and civilian sectors. The third, was that veterans believed the military and media perpetuates the misinformation of PTS, which is compounded by the automatic association and assumption that every combat veteran is categorized with PTSD. The fourth was that veterans' reported their experience of stigma is intimately connected with their experience of remorse at not having done well enough

to support their brethren. There does not appear to be any one factor which contributes to this reality, but a combination of elements largely associated with a lack of understanding (as previously expressed by the participants of this research). The over-arching issues identified being the veteran's belief that various forms of remorse and guilt are directly and indirectly associated with stereotyping and discrimination. This position, appears to be contrary to current understandings of military stigma which is compounded by an inefficient system designed to assist veterans with PTS.

What are combat veterans' perceptions of the post-deployment health assessment? (RQ2)

A total of 50 comments and references were made by the participant's regarding Themes 5, 6 and 7.

Theme 5: Post-deployment health screenings are superficial, inconsistent, and ineffective. The majority of veterans who participated in this study reported their post-deployment health screening experiences were ineffective and inconsistent (superficial) based on how they were treated throughout the medical screening. The veteran's responses also presented a collective pattern regarding a lack of trust and skepticism pertaining to the medical screening process based on what they (veterans) describe as a lack of compassion and empathy provided by the medical screeners. This lack of trust or rapport could also be interpreted as a catalyst pertaining to stigma (self-internalized stressors).

The questions which elicited the majority of responses associated with this theme were open-ended questions regarding what their (participants) experiences were

regarding post-deployment examinations. According to the veteran's response, the medical screening experiences could be described as having been completed by personnel who presented a lack of empathy or even complacent in their (medical screeners) respective duties. Participant's responses were as follows:

> …vague, not enough scrutiny during post deployment exams and screening process. I believe it is because the screening exam personnel don't really know us during this phase of the redeployment…. (P2).
>
> …pretty horrible… The redeployment examiners (medical staff) were only looking for, Red Flags, which stand out… Felt like a process or assembly manufacturing line… I remember doing a mental evaluation with colors… Depending on the colors selected would determine if you were held over for further examination… (P3).
>
> The examinations (redeployment) were in 2 or 3 phases. They (the examiners) had questions about how I was feeling, if I had seen any deaths, and exposed to any burning, or was involved in any experiences with Improvised Explosive Device (IED). (P6)

These responses clearly reveal a post-deployment health screening environment which is not conducive to the individual needs of the redeployed veterans.

> I do not recall any post deployment examinations other than filling-out some forms regarding my experiences regarding exposure to dead bodies or other traumatic experiences… (P7).

> I received one initial screening when we got back, but because I am a medic we were not screened as should be based on assumptions regarding our training in the medical field… (P8).
>
> …we have the typical questionnaire they give us… specific questions regarding hopelessness, and are you going to hurt someone are provided… Your responses are numerically scored and that's how the screening personnel decide how to address you… I did request assistance at one time or another (regarding issues with PTS), but I feel that was a mistake…The VA did not provide the help I needed… Most soldiers just want to talk with another veteran regarding their issues… (P9).
>
> The exams were more like a Checking the box mentality and the screening personnel were not really interested in delving into my experiences… The 4th time I redeployed I actually sought help… with negative results… (P10).

One respondent was especially clear that psychological evaluations, specific to his military unit, were above reproach, but inferred this only applied to his particular unit:

> Marine psych evaluations were conducted by Navy doctors attached to Marine Forces Special Operations Command (MARSOC) units. Though MARSOC personnel had access to top-notch and DOD award-winning doctors (even the University of Southern California sent folks down to study our Combat Resiliency program), I don't believe the same can be said for our straight-leg (other military branches and military units) line units. (P5)

Theme 6: During post-deployment medical screening, vet's feel the need to lie about their deployment experience for fear of being stigmatized. The participant responses revealed that veteran's feel the need to lie about their deployment experiences for fear of being stigmatized through the post-deployment medical screening process. Most, if not all veterans are required to process through post deployment psychological screening prior to being released or allowed to return to their respective families or communities, but most soldiers will not provide information through post psychological screening questionnaires (an element related to the stigma) since their primary goal at this stage is normally to return home (Mittal et al., 2013). As the veteran's revealed in overlapping themes (previously identified), they (veterans) were just going through numbers or checking the box's as they respectively identified the need to return home without diminishing their reputations by being diagnosed with a mental disorder or equivalent.

The questions which elicited the majority of responses associated with this theme were open-ended questions regarding what their (participants) experiences were pertaining to post-deployment examinations. The majority of veterans interviewed reemphasized a need to return home as soon as possible (once they began the medical screening) and considered the post-deployment screening a formality, which for the most part, could be interpreted as an inconvenience. Participant's responses were as follows:

> …just going through the numbers and just telling the hierarchy (redeployment medical screening personnel) what they wanted to hear to get through it (exam) and get home… During this screening I started revealing an aggressive side of my

> personality, especially since I was trying to redeploy back to Iraq… I actually had a situation where I snapped at the doctor. The doc asked me what my experiences actually were… and why do you want to go back? Because I was needed in Iraq… (P1).
>
> I would say on a whole, yes (as it pertains to seeking assistance)… as it applies to male veterans is an issue of male bravado in the form of I can take it or, I was raised to believe if I asked for help I was a failure…. This can be emphasized by the chain of command in the form of persecution… (P9).

Theme 7: Post-deployment screening practices create an environment of stress associated with stigma that perpetuates vets' reluctance to seek help for PTS. The veterans who participated in this study believed their experiences pertaining to post-deployment health screening practices created an environment of stress associated with stigma, perpetuating veteran's reluctance to seek help for PTS. Their (veterans) reactions revealed a lack of confidence with individual medical assessments while identifying questionable (redeployment) medical screening practices as explained by all participants in this study.

Questions regarding post-deployment health screening focused on the experiences each of the participants had regarding redeployment examinations, medical screening thoroughness, and capacity to provide a level of comfort (trust) necessary to elicit accurate and truthful responses from the redeploying military personnel. Multiple participant responses identified what could be described as internal stressors associated with an assembly line medical screening process, with no specific interest (exhibited by

the examiners) in the individuals' medical disposition. Although, some of the responses were vague in description, the responses were similar in nature and content.

The questions which elicited the majority of responses associated with this theme were open-ended questions regarding what their (participants) experiences were regarding post-deployment examinations. Most respondents reported that vets are met with post-deployment health assessment procedures that lacked any serious inquiry into the actual experience or state of mind or welfare of the soldiers, but rather seemed designed to move them through a set of cursory multiple choice interview questions as quickly as possible. This position appears to be reinforced through a need to seek comfort established through the veterans shared experiences regarding OEF/OIF. Participant's responses were as follows:

> No, as the last program I went through was made up of Vietnam and Desert Storm vets, and I was the only OEF/OIF vet… I was looking for just OEF/OIF vets who could better understand my situation… …most veterans feel as if they are by themselves… alone among a group of people (peers) who may or may not actually care for you… Vets do not want to be categorized or identified with some diagnosis which no one really understands. As the people who you speak with do not have the same experiences… coordination and care should be effected by people of similar backgrounds when and where possible… (P1).

Multiple responses by participants throughout this chapter, have revealed the preference (need) to work with health professionals or equivalent, who have similar military experiences.

> I find it very sad that I have been in the Army for 20 years, did a very intense tour of duty in Iraq, was mortared over 292 times and wasn't screened for mild Traumatic Brain Injury (mTBI) or Traumatic Brain Injury (TBI) until a redeployment was scheduled in 2015. The screening in 2015 consisted of a computer based memory program. They would show things, sequence of items, things of that sort and see if your short term memory has a certain level of capability. I had to take the test twice… I failed the first time. It was annoying and frustrating. It seems like someone at some point should have screened all of us that were deployed early on and made sure we were screened sooner than a decade after. (P4).
>
> The last real experience was in 2011/2012 where there wasn't much in mental health professional support through the MARSOC… (P5).

This reluctance to seek assistance may be grounded in the stereotypical labeling by which society tends to interpret mental disorder as some type of deviance (Mittal et al., 2013; Link & Phelan, 2014). The information shared presents various causative factors associated with veteran's reluctance to seek help for PTS. Participant's responses were as follows:

> Yes, I think for vets it is easier to decide what is best for them, but tend to hold out (as it pertains to seeking help for any post deployment issues)… it becomes an inner turmoil issue/thing… Reluctant based on how the soldiers are viewed… especially how they are medically screened… (P4).

> I was reluctant myself…after suffering personal loss, I was affected and I experienced symptoms of PTS that I had been suppressing after 7 years in Iraq and for the first time I was able to start talking about my experiences… I found myself in the same circumstance as many of my brethren… struggling with the VA for assistance… The issue being no one was interested in helping me… it took the VA over 6 months to even see me… (P7).
>
> I definitely think veterans are reluctant to seek out help because of how they would be looked upon…more so, by their peers… (P8).
>
> Yes, I think they (veterans) are reluctant, which is based on the stigma associated with being seen as weak… I have actually put off treatment because of this… (P10).

In summary, three strong themes emerged in response to Research Question 2, and "what are combat veterans' perceptions of the post-deployment health assessment," the first, was veterans reported that post-deployment health screenings are superficial, inconsistent, and ineffective. The second, was that during post-deployment medical screening, vet's feel the need to lie about their deployment experience for fear of being stigmatized. The third, was veteran's reported that screening practices create an environment of stress associated with stigma that perpetuates vet's reluctance to seek help for PTS. Veterans revealed that participating in post-deployment health screening practices created an environment of stress associated with stigma. Their (veterans) reactions revealed a lack of confidence with individual medical assessments while identifying questionable (redeployment) medical screening practices as explained by all

participants in this study. The veteran's responses presented a collective pattern regarding a lack of trust and skepticism pertaining to the medical screening process. This lack of trust or rapport could be considered a catalyst as it pertains to self-internalized stressors. The veteran's medical screening experiences could be described as completed by personnel who presented a lack of empathy or even complacent in their (medical screeners) respective duties.

These experiences presented an environment of self-internalized stressors which appear to be associated with a preconceived notion that the participant's post-deployment screening could be viewed as superficial. The participants also shared their concern for what they identified as assembly line medical screening.

What are combat veterans' perceptions of the personal and professional impact of military stigma? (RQ3)

A total of 11 comments and references were made by the participant's regarding Themes 8 and 9.

Theme 8: Veterans report that military stigma negatively effects their personal relationships. The majority of veterans interviewed collectively revealed their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. The veterans collective responses revealed that they (veterans) personally experienced or knew of other veterans who experienced difficulties associated with their personal relationships with others (both personal and professional) based on issues of trust or preconceived ideas (stereotype) that every combat veteran suffers from one form or another of PTS (stigmatized).

The questions which elicited the majority of responses were open-ended questions which focused on the experiences and knowledge of each of the participants and how the stigma associated with PTS or being labeled with PTSD may or may not have affected their personal or professional lives. This included their respective positions regarding how military personnel are labeled should they receive a diagnosis or classification regarding a mental disorder. Participant's responses were as follows:

> The stigma does affect the veterans' professional lives for sure. When a co-worker or peer finds out a veteran has PTSD, he/she are looked at differently. They may be wondering if the veteran would one day, go postal, in the work place. (P6)
>
> Although, my co-workers would say they support me, I really don't trust them based on previous reactions from them… I think it becomes an issue of trust within any relationship which dictates how people react… (P9).

Theme 9: Veterans report military stigma affects their potential employment opportunities. The veteran's responses revealed that their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. The veteran's collective responses revealed they personally experienced or knew of other veterans who experienced difficulties associated with employment opportunities based on the preconceived ideas (stereotype) and misconception that every combat veteran is suffers from PTS or is diagnosed with PTSD.

The questions which elicited the majority of responses were open-ended questions which focused on the experiences and knowledge of each of the participants and how the

stigma associated with PTS or being labeled with PTSD may or may not have affected their personal or professional lives. This included their respective positions regarding how military personnel are labeled should they receive a diagnosis or classification regarding a mental disorder. Participant's responses were as follows:

> They (veterans) would say, no way, as most people would bottle it (symptoms of PTS) up and no one would ever see it coming, meaning the outbreak and symptoms [as it pertains to negatively impacting ones' personal or professional life]… on one occasion, I was let go from a job because of my actions to subdue an individual, scared my coworkers… They were worried my skills as a former combat soldier were unstable regardless of the positive outcome of the situation… (P3).

> Yeah, as an individual who applies for employment, I am asked questions about my deployments… I even received one question that asked me if I had killed anyone… There is this automatic stigma associated with military service, combat, and PTS… (P9).

In summary, two themes emerged in response to Research Question 3, and "what are combat veterans' perceptions of the personal and professional impact of military stigma," first, veterans reported that military stigma negatively effects their personal relationships. Second, was that veterans reported military stigma affects their potential employment opportunities. The majority of veterans interviewed collectively revealed their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. The result of this misinformation impacting

both the personal and professional lives of veterans. OEF/OIF veterans share common issues associated with mental health distress as it pertains to reestablishing personal and professional connections upon redeployment (Erbes et al., 2009; Lane, 2012). In addition, participant responses regarding the reluctance of veterans to seek help for PTS could be attributed to the stigma automatically associated with military service (as previously identified).

What are combat veterans' opinions of the available treatments and therapies for PTS? (RQ4)

A total of 13 comments and references were made by the participant's regarding Theme 10.

Theme 10: Veterans have limited knowledge about PTS treatments or therapies offered by the VA and military. The veterans who participated in this study reported that their knowledge about treatments and therapies for PTS provided by the VA and military was limited, inconsistent, and vague. The veteran's responses revealed a myriad of personal experiences with actual treatments and therapies known to the veterans regarding available resources provided by the military and VA. The veteran's responses also present information which either directly or indirectly perpetuates the ongoing issues associated with a veteran's reluctance (as previously identified) to seek or enter into a program designed to assist veterans in need of help regarding PTS.

Questions which elicited the majority of responses regarding the effective treatments and therapies for PTS provided by the VA and military focused on the veteran's familiarity with current or former PTS programs, ability to access them, and

their effectiveness through actual use. Multiple participant responses identified what could be described as sporadic experiences regarding various programs without fully understanding the availability of treatments and therapies which currently exist. This coincides with a lack of information or understanding regarding what programs are available or how programs could be accessed. Although, some of the responses were vague in description, they tended to be similar in nature and content, for example:

> I do not know much about the PTS programs. (P6)

The following P7 provided multiple comments regarding his/her experiences with treatments and therapies, for which, there was an emphasis on a preference to working with therapists or programs which employed personnel having previous military experiences.

> I actually did seek help and volunteered to go into a month long treatment center regarding bio feedback treatment…my family thought I was joking about it when I was serious about seeking help… I am currently enrolled in the veteran's clinic (vet center) for monthly counseling sessions and other services such as group activity, job or training related…service dogs… I like this group because the employees are former military veterans…easy to relate and talk with them… (P7).
>
> I haven't participated in any programs myself, but I know there are programs out there… (P8).
>
> I have been diagnosed with moderate to severe PTSD after seeking assistance… Again, I consistently received screening questions regarding hopelessness and harming others… I feel as if my symptoms associated with PTS were getting

> worse over time…it became an issue of seeking help on my own based on my deteriorating behavior… (P9).

Multiple participants reported finding their own way to therapeutic help, after receiving no helpful guidance from the VA. In contrast, there was one instance where P9 identified a general comment regarding a positive aspect about the VA and its medication protocol:

> I am discovering more as I am now going through art therapy, which is a visualization therapy where you are asked to think about a past traumatic event and try to picture that image with a calming or soothing image… I have not heard anything positive regarding the VA, but I have about the medication… (P9).
>
> Yes, I know of Eye movement desensitization and reprocessing (EMDR), Prolonged Exposure (PE), and Cognitive Behavioral Therapy (CBT)… I have done both CBT and Prolonged Exposure… (P10).

In summary, the central theme which emerged in response to Research Question 4 regarding "combat veterans' opinions of the available treatments and therapies for PTS," was the universal lack of knowledge or experience of effective treatments or indeed *any* therapies for PTS provided by the VA and military. This coincides with other participants' responses identifying a reluctance to self-identify symptoms associated with PTS, and their failure to use available resources designed to address issues pertaining to PTSD (Ben-Zeev et al., 2012; Koren et al., 2005). This can also be (is likely?) associated with the stigmatization resulting from a lack of efficient and effective awareness training

(addressed later in the chapter) and the lack of military counseling regarding the positive aspects of the treatments and therapies for PTS.

What are combat veterans' ideas about how military stigma might be reduced or prevented? (RQ5)

A total of 47 comments and references stand in support of Themes 11 and 12.

Theme 11: Education of soldiers is needed to correct the misinformation which continues to exist regarding stigma and PTS. The collective opinion from the veteran's perspective is that education is the key element to preparing soldiers to the potential issues associated with PTS. The majority of veterans also revealed the need to understanding stigma from the veteran's perspective requires an approach which fortifies or changes the current training systems and programs in place, to better address issues associated with PTS through sustained training. The veterans believed this change begins with transforming the military culture which currently exists.

The questions which elicited the majority of responses pertaining to the need for education as a means to correct the misinformation which continues to exist regarding stigma, focused on whether or not the military should include training on military stigma (combat-related or associated with PTS)? Participant's responses were as follows:

> Some of the training has been established to address this issue, but, they (the military) could make it more available or push it down to the company/ detachment levels. I guess the public sees so much news and movies about how veterans are dealing with PTSD and thinks that all veterans are going through the

> same thing [regarding PTS] or have PTSD. Better information should be provided (to the public) by means of the news and social media. (P6).
>
> There is a need for transitional programs… changing the military culture, which is going to be tough based on the military culture of being Alpha types… There is always pressure to not complain or report any weakness… (P7).
>
> I would say better education… improving the methods in which soldiers are trained… to a point of developing a comfort level where all soldiers can openly discuss issues like PTS… I think it would be great if there was training or other indoctrination prior to deployment as well as post-deployment reviews… I would say establishing different training programs based on the veterans military status (active, reserve, or National Guard)… (P8).
>
> It's already being brought up with suicidal awareness training… the hard thing is the death by power point or online training videos which are redundant and boring… At least once a month, I receive videos in this manner… (P9).
>
> Death by power point is not the answer… the issue should be annual training of some sort, in small groups… (P10).

Theme 12: Stigma awareness training could change the reluctance of veterans to seek assistance. All participants of this study provided information pertaining to how military stigma might be improved, reduced, or prevented. The majority of the responses focused on indoctrination (stigma awareness training) regarding issues of stigma throughout the military and our society in whole. The issue of post-deployment screening was identified, but did not reveal alternative suggestions outside of

preventative training, as identified throughout this study. The collective opinion from the veteran's perspective is that indoctrinating soldiers to the potential issues associated with PTS could better prepare military personnel to recognize characteristics and associated behaviors arising from stigma. The majority of veterans also revealed understanding stigma from the veteran's perspective is an issue of perception and acceptance, for which the military could apply new training elements specific to stigma, its understanding, and mitigation regarding various elements associated with stigma.

Most responses on this topic focused on how the military could reduce the reluctance of veterans to report issues associated with mental distress or stigma. Participant's responses were as follows:

> Reluctant based on how the soldiers are viewed…especially how they are medically screened… (P4).
>
> The chain of command can do a better job of instructing soldiers about programs and alternative methods to assist you or other soldiers to seek assistance…it becomes a question of indoctrination into a military way of life… …the military has to embrace it… It becomes a question of saying it's OK and it won't hurt your career… (P2). …new training for soldiers… but this is controversial and could prove difficult to employ… It becomes an issue of providing information pertaining to real world scenarios which proves that reporting issues associated with PTS are not career enders… Find people that have sought or gone through treatment, that have made the transition into society successfully… disproving issues of violence or instability… (P9).

The veterans were clear, in that, there is a gap in the information pertaining to the military indoctrination and training regarding stigma awareness and its potential identifiers. Participant's responses were as follows:

> Yes, it should be implemented through Military Occupational Specialty (MOS) training from beginning to end… basically, after initial basic training and then through military leadership training… at the basic levels and in intervals throughout your career… this way it stays fresh in your head… (P1).

One respondent was especially clear that both pre-and post-deployment training is required:

> I think the training should be implemented by subject matter experts or others that are prepared to support other soldiers in the field that have or present symptoms of PTSD… This should be incorporated into training and pre and post deployment examinations and screenings… Basically education/reeducation and not being afraid to talk about it…action form the military leadership down… same as the issues related to sexual harassment… No one wants to take ownership of the problem… (P2).

> Start them (military personnel) in a program before they are released form duty (active or other)… also they should be referred to some sort of a program within 90 days prior to military separation… (P3).

Another respondent provided a clear example regarding the issue of perception and acceptance (by veterans), for which the military could apply new training elements specific to stigma:

> The reeducation of the troops and the chain of command… Following the example provided by the General Mattis, (James N. Mattis, retired Marine Corps general and Commander of the U.S. Central Command, 2010 to 2013) wherein, vets should treat or consider PTS, as self-empowering rather than self-deprivation… (P5).

The following responses by the participant's reveal various strategies to support the introduction and sustainment of training regarding stigma. These strategies included the need for using mental health professionals as advisors to the respective chain-of-command at various levels. The responses clearly identify the specific audience, where training should be introduced, and how it should be sustained as a form of continuing professional education (CPE). These responses clearly present the need for stakeholders to take ownership of the problem. Participant's responses were as follows:

> Yes, I think it (stigma awareness) should be implemented in the Primary Military Education (PME), Basic Leadership Course (BLC), and Advanced Leadership Course (ALC) as it applies to Non-commissioned Officers… This includes senior leadership officer courses… I think it is the commanders that are not getting the training needed to fully understand the issues at hand regarding PTS… They, the commanders, also need a mental health advisor…similar to the military mental health criminal courts… (P4).

> When we talk about training, I believe we really need to start studying how Southern Command (SOCOM) conducts their combat resiliency program. It truly is topnotch. That said, there are of course budgetary constraints that we have

> which make implementation across the entire armed services impractical. We could definitely take some elements, though, such as the Human Factors Council - and apply it. It's a leadership function that we've formalized. DEFINITELY NOT Death by PowerPoint!! Also, I think we can study what Nick Saban does at the University of Alabama. Really great work re: mental resiliency. (P5)

Nick Saban is the current Head Football Coach for the University of Alabama, described as an exceptional leader who has successfully coached two different collegiate football teams to multiple National Football Championships, which includes back-to-back BCS Championships (ROLLTIDE.com, 2016). Additionally, Death by PowerPoint, is a common term which identifies a major problem (negatively) in military training, which is overused (according to most veterans) and an ineffective method for training. This term is used in multiple participant responses throughout this chapter.

> I definitely think there is a need… how it should be implemented is from the beginning (initial military training)…from the lower enlisted ranks through the upper echelons… Exposing the military personnel through awareness to potential traumatic scenarios so they could learn how to cope with the potential negative issues associated with PTS and stigma… (P7).

In summary, two strong themes emerged about how military stigma might be reduced or prevented: first, that education is needed to correct the misinformation which continues to exist regarding stigma and PTS; and second that stigma awareness training could change the reluctance of veterans to seek assistance. The collective opinion from these veterans' perspective was that indoctrinating soldiers (including medical personnel)

to the potential issues associated with PTS could better prepare military personnel to recognize characteristics and associated behaviors arising from stigma. The majority of veterans also revealed that understanding stigma from the veteran's perspective is an issue of perception and acceptance, for which the military could apply new training elements specific to understanding and mitigating stigma. The responses identified the need to inform or educate the public and media regarding the reality of military experiences and how stigma could be detrimental to veteran's lives. The majority of the responses focused on indoctrination (education and training) regarding issues of stigma throughout the military and our society in whole.

These veterans' responses clearly reveal a lack of trust or confidence in the chain-of-command regarding the military's capacity to effectively sustain viable PTS programs or provide adequate support for personnel diagnosed with PTSD. The participants' responses clearly revealed a need for change to military culture in this respect, though no additional details were available from these data.

Discrepant Data

As it applies to this research study and any discrepant data pertaining to the subject matter of stigma associated with combat-related PTS, no information was identified. Additionally, (as previously identified) there is a lack of information as it pertains to an understanding of the stigma from a soldier's (service members) perspective and its application associated with the reluctance to seek medical or other treatments or therapies. Two participants did reveal, in general statements, that the military command support was adequate (to include the VA), but were also critical of other command

actions. This gap in the literature is substantiated by Bryan et al., (2012) and Pietrzak et al., (2010), as it pertains to military stigma (associated with PTS/PTSD) from a soldier's (service member's) perspective, especially regarding any association of military stigma with suicidal ideation.

Evidence of Trustworthiness

The role of this researcher has been to investigate military stigma from a soldier's (service members) perspective, and to develop an understanding of its (stigma) relationship with the reluctance of many soldiers to seek treatment for posttraumatic stress (Mittal et al., 2013). This task has proven challenging to validate based on the fact that traumatic events or other associated issues—which may or may not have contributed to the stigma associated with PTS—may have affected each participant differently and the recall (temporal sampling) or interpretation of the facts may have been distorted (Patton, 2002). This could also be compounded by individual combat experiences and their respective specialties which may or may not have prepared the participants adequately for combat (Patton, 2002).

Credibility was established in two parts: first through the utilization of the screening questionnaire (Appendix B); and second through the utilization of the interview questionnaire (Appendix C). This was complemented by the rapport and trust established at the onset of each of the interviews. Within the military culture this (rapport and trust) can be established with a minimal exchange of information such as identifying ones' MOS, rank, and shared deployment experiences (as developed through the interview questionnaire). It is through the exchange of lived military experiences among veterans

that actual information can be developed to an extent of validation and credibility. This exchange of information is common within the military culture, as most military personnel do not consider themselves strangers among their own (veterans). This approach was in keeping with the original strategy to establish quality, trustworthiness, and credibility through the pre-screening of potential participants as subject matter experts regarding their respective military experiences (Howe & Eisenhardt, as cited in Creswell, 2013).

The triangulation approach used to confirm or verify participant's data is based on derived information revealing similar, if not the same information from each respective participants (in consideration with each of their military backgrounds), as well as comparing this research model to other contemporary studies. Participants were enlisted to review and conduct member checking (internal validity) regarding their respective interview transcripts for accuracy pertaining to their lived experiences using email for additional comment or correction, as needed. Member checking was completed and effective in substantiating accuracy in the transcription of the interview data. This was also complemented with the development of additional (emergent) data based on the participant's recall, after the fact, as it pertains to providing a more in depth responses to the interview questions. Although, temporal sampling could be considered subjective and challenging to triangulate, various aspects (specific characteristics and variables) of this data were compared to other reports and or information provided through the National Center for PTSD website (external validation) for aspects of redundancy and possible saturation of information.

This was important based on the fact each participant is considered a subject matter expert (through their respective training and military experience) in their respective military occupation (past or present), which lends additional external validity to this study. This information could be identified as unique to each individual, but collectively the same in context to veterans of military operations in direct or indirect support of OEF/OIF.

The transferability or replication of this research was established in keeping with a viable, manageable, and replicable system of data collection and analysis. The premise being to develop a research model which can be replicable by either one researcher (as in this dissertation), or by multiple researchers applying a respective inter-coder process (as needed) to evaluate the derived information. This application allows for a multitude of variations attributed to emerging and developed information as a result of the semi-structured line of questioning.

This study also provided a strategy of dependability incorporating its own identified limitations regarding various aspects of participant and researcher bias pertaining to stigma. This was supported through the design methodology and development of this research using semi structured open ended research questions, literature research, and validity process applied through a phenomenological research approach and strategy (Chan, Fung & Chien, 2013). The dependability of this methodology provided a venue to elicit information which may bridge the gap between various characteristics and variables associated with stigma and the reluctance of veterans to seek assistance or complete programs/interventions initiated.

The strategies initially identified in Chapter 3 for this study regarding the data collection process were in keeping with a homogeneous sampling (Creswell, 2013; Patton, 2002). Using homogeneous sampling provided a method to identify combat veterans within the military complex as there are differences between military personnel having been exposed to traumatic combat events and in this case soldiers within particular military units with minimal or no combat exposure (Patton, 2002). This provided consistency throughout all participant interviews regardless of military branch affiliation. Also, the central focus of the research to identify and define specific characteristics associated with the negative (personal implications) and/or detrimental (impacting professional military status) connotations associated with a mental disorder diagnosis was maintained.

A unique aspect of the emergent information revealed no real differences regarding the unit of analysis (combat versus noncombat MOS) previously identified in Chapter 3 as it pertains to the participants lived experiences pertaining to stigma and the reluctance to seek assistance.

Summary

In summary, the developed themes associated with each of the research questions provided important insight (from a lived experience) into the unanswered questions and gaps of information regarding the stigma associated with combat-related PTS. As it applies to Research Question 1, and ‘the military stigma associated with a diagnosis of PTS’, the participant’s responses revealed a collective position which supports the existence and prevalence of stigma which incorporates stereotypical labeling and

produces discriminant behavior from both the military and public sectors. Regarding Research Question 2, and "their post-deployment health assessment" the participant's responses revealed a shared belief of no confidence or consistency pertaining to their individual medical assessments as well as identifying questionable (redeployment) medical screening practices. Regarding Research Question 3, and 'the personal and professional impact of military stigma' the participant's responses revealed a collective position regarding the inconsistent action, reaction, and military support (chain-of-command) to ones' personal and/or professional life. As it applies to Research Question 4, and 'the available treatments and therapies for PTS, the participant's responses revealed a collective opinion which identified a reluctance for veterans to self-identify symptoms regarding issues associated with PTS. Regarding Research Question 5, and 'how military stigma might be reduced or prevented' the participant's responses reveal a majority opinion which supports a need for change in military indoctrination (new and sustained training). The responses also identified the need to inform or educate the public and media regarding the reality of military experiences and how stigma could be detrimental to veteran's lives. This includes the opinion for the need to develop effective prevention programs and diagnostic capacity throughout the military and VA. The participant's responses also revealed a need for change pertaining to military culture, wherein, the care for military personnel should come before the operational mission.

Chapter 5 will include a discussion of, and present the significance of, the findings and their interpretation as a means to identify and consider new and improved

methods, indoctrination, and programs to address the ongoing issues associated with the stigma associated with combat-related PTS.

Chapter 5: Discussion and Conclusion

Introduction

The purpose of this phenomenological study was to explore veterans' perceptions of various aspects of military stigma, including post-deployment psychological screening, the diagnosis of PTSD, and factors associated with reluctance to seek medical assistance for PTS. The literature review revealed, there is a lack of research on (a) the experiences of soldiers given this diagnosis and (b) their reluctance to seek assistance (Gould et al., 2010). Military stigma comprises both an external event (discrimination) and internal experience (shame), as described by Link and Phelan (2014). The focus of this qualitative study was to understand what factors were directly or indirectly associated with this stigma, which tended to make veterans reluctant to seek assistance for medical issues associated with PTS. Understanding the various elements of this stigma could reveal a new or a modified approach to the developmental indoctrination (awareness training) specific to mitigating or reducing stigma associated with PTS. Military stigma results in soldiers not seeking help for combat-related trauma. This study was designed to shed light on this phenomenon and investigate how it could be changed. As identified in Chapter 1, military stigma comprises both an external event (discrimination) and internal experience (shame), as described by Link and Phelan (2014).

The key themes derived from the interview transcripts, revealed a consensus regarding the prevalence of stigma which incorporates stereotypical labeling and produces discrimination from both the military and public sectors. This conclusion was based on the development of themes using an axial coding procedure, which best explains

characteristics that are abstract in nature. The themes associated with each of the research questions provided significant insight into the gaps of knowledge regarding the stigma associated with combat-related PTS. As each of the themes are considered similar or overlapping in nature, the content within them is unique, which supports the abstract complexity of stigma and its implications for various facets of this research.

Information derived from the interviews revealed characteristics and variables unique to combat or military experiences which were further analyzed and coded as nodes, and then categorized. These characteristics and variables were then reviewed to avoid identifying redundant content. These categories were further analyzed and blended into themes based on their content and exact meaning. These themes were subsequently developed to better explain associations that could define the problems of stigma associated with combat-related, posttraumatic stress. Although each of the themes could be viewed as independent, they are also overlapping and share various military characteristics. The following themes (see Table 2) were developed in association with the research questions.

Interpretation of the Findings

The findings of this study used a modified form of labeling theory (Link & Phelan, 2014) as part of a conceptual framework to develop a clear understanding of the problem identified. As a result of this research, significant associations were identified between the characteristics identified by the participants pertaining directly or indirectly to stigma and the foundation of labeling theory used. As identified in Chapter 2, the modified form of labeling theory (Link & Phelan, 2014) supports the existence of cultural

stereotypes, which are preconceived and discriminatory, based on society's lack of, or desire for, understanding stigmatized groups, regardless of first-hand knowledge or the lack thereof (Link & Phelan, 2014; Scheff, 1966).

Table 2
Research Questions and Themes

Research Questions	Themes
RQ1: What are combat veterans' perceptions of the military stigma associated with a diagnosis of PTSD?	1. There is a great deal of misinformation throughout the military about PTS and military stigma. 2. Military stigma is seen as a form of stereotypical labeling that produces discriminant behavior in both military and civilian sectors. 3. The military and media perpetuate misinformation about PTS, and the assumption that every combat veteran suffers from PTSD. 4. Veterans experience stigma as intimately connected with their experience of remorse at not having done well enough to support their brethren.
RQ2: What are combat veterans' perceptions of the post-deployment health assessment?	5. Post-deployment health screenings are superficial, inconsistent, and ineffective. 6. During post-deployment medical screening, vet's feel the need to lie about their deployment experience for fear of being stigmatized. 7. Post-deployment screening practices create an environment of stress associated with stigma that perpetuates vets' reluctance to seek help for PTS.
RQ3: What are combat veterans' perceptions of the personal and professional impact of military stigma?	8. Veterans report that military stigma negatively effects their personal relationships. 9. Veterans report military stigma affects their potential employment opportunities.
RQ4: What are combat veterans' opinions of the available treatments and therapies for PTS?	10. Veterans have limited knowledge about PTS treatments or therapies offered by the VA and military. 11. Education of soldiers is needed to correct the misinformation which continues to exist regarding stigma and PTS.
RQ5: What are combat	12. Stigma awareness training could change the reluctance of

veterans' ideas about how military stigma might be reduced or prevented?	veterans to seek assistance.

As identified in chapter 2, the rationale for applying this theory was based on veterans and military personnel's understanding and interpretation of stereotypes (public and self) and the potentially threatening implications of being evaluated and/or diagnosed with a mental disorder (Link & Phelan, 2014). The realization of this research has identified and provided insight (participant's perspective and interpretation) as it pertains to developing a better understanding of various characteristics and variables which impact the lived experiences of the veterans regarding stigma associated with PTS.

The interpreted findings are provided in the following section pertaining to the developed themes derived in this study. The developed results from Chapter 4 provides the information which supports the interpretative findings, which, also coincides and supports the existing literature regarding the stigma associated with combat-related PTS.

There is a great deal of misinformation throughout the military about PTS and military stigma.

The veterans who participated in this study reported there is a great deal of misinformation about PTS throughout the military. An important and redundant issue revealed throughout this study reemphasized the issue or gap within contemporary research regarding a lack of information as it pertains to an understanding of the stigma from a soldier's (service members) perspective and its application associated with the reluctance to seek medical or other treatments or therapies. This misunderstanding or

misinformation is clearly linked to theme 2 regarding how “military stigma is seen as a form of stereotypical labeling that produces discriminant behaviors in both military and civilian sectors” and corroborates the complexity of this ongoing problem. The modified form of labeling theory (Link & Phelan, 2014), supports this premise based on the lack of actual knowledge regarding the mentally ill and associated diagnoses/ailments which can be described as a catalyst for stereotypical behavior.

As identified in Chapter 2, the veteran’s interviewed confirm that military stigma (within the context of this research) is best associated with a mental disorder diagnosis, which is a belief associated with the fear and disgrace experienced by combat veterans who report or seek psychological treatment for symptoms associated with PTSD (Mittal et al., 2013). The findings also revealed that the problem regarding misinformation regarding PTS is compounded by systemic issues associated with stigma, such as inadequate support provided by the military chain-of-command at various levels, and how these issues are being addressed. The veterans in this study clearly expressed a lack of trust or confidence in the chain-of-command regarding their capacity (directly or indirectly) to support programs which provide assistance for PTS, and personnel diagnosed with PTSD.

The findings also revealed a collective position from the vets revealing the need for changing or categorizing symptoms attributed to PTS as a battle injury, to better mitigate or reduce the misinformation which currently exists regarding PTS. This coincides and supports information identified in Chapter 2, as this approach or perspective could impact the public health community, as a whole (administrators, policy

makers, pharmaceutical industry, medical community), since all could be affected by any modification of procedures for addressing the stigma of a mental disorder diagnosis, and related issues (Solomon & Davidson 1997, as cited in Sayer et al., 2009). As military stigma is an issue which impacts a wide variety of stakeholders (including military leadership, communities, families, and the combat veterans themselves), there is a need to consider alternative considerations to the categorization and/or terminology defined by the DSM-5 specific to the mental diagnosis and label of PTSD. This approach may provide contemporary solutions to addressing issues arising from the stigma associated with the diagnosis of a mental disorder. This perspective (provided by the vets) coincides with literature in Chapter 2, which identifies a military initiative presented by the President George W. Bush Institute proposing the development of a more effective classification system pertaining to PTS as an injury versus a mental disorder diagnosis, which could prove more beneficial to veterans in whole (Williams, 2014).

According to the vets, this consideration for alternative diagnostic categories could also provide the outlet needed for veterans to seek assistance and provide the information necessary to provide adequate and effective assistance (Williams, 2014). As there are gaps in the literature and research regarding the potential or justification to seek changes regarding PTSD within *DSM-5*, as it applies to combat veterans, perhaps further research is warranted regarding the implications of such a change or reclassification of PTSD. It is either unclear or unsubstantiated whether such an approach in changing the *DSM-5* could actually impact our understanding of specific characteristics and variables experienced by veterans which directly or indirectly begets the issue of stigma.

Although, there was an abundance of information available pertaining to combat-related PTSD, what was realized concerns a lack of, or limited research, and data available regarding the stigma associated with combat-related post traumatic stress from a soldier's perspective. As there is no clear and concise solution to issues associated with military stigma as it pertains to PTSD, the issue becomes one of developing a sound approach to an understanding of the issue, its various components, and focusing on specific elements of stigma, which reveal limited information to date (Xenakis, 2014).

Military stigma is seen as a form of stereotypical labeling that produces discriminant behavior in both military and civilian sectors.

The findings from the participant's (veterans) interview responses revealed a collective position confirming the existence and prevalence of stigma which incorporates stereotypical labeling and produces discriminant behavior from both the military and public sectors. As stigma is so closely associated or defined by stereotype and/or discrimination, it was important to this study to discover the area of common focus (over-arching theme) as revealed by the participants. Also, that this ecology of military stigma (identified in Chapter 2) can be supported and justified using a modified form of Labeling Theory (Link & Phelan, 2014), which proposes the existence of cultural stereotypes as fundamental to stigma and the discriminatory factors associated with it.

As the majority of veterans interviewed revealed the unique characteristics and variables which explained various aspects of military culture (and the camaraderie which exists), what was expressed, in terms of their lived experiences, reaffirms various characteristics (previously identified through the participant interviews) associated with

self-stigmatization. This determination was based on the veteran's ability to clearly explain their respective experiences (inductively) regarding pre- and post-deployment activities as they worked through their deployments into and out of Iraq and Afghanistan. They (veterans) effectively identified their particular struggles associated with specific and general factors associated with military operations which supported the issue of stigma within the context of this study (professionally and personally). The veterans also confirmed that this problematic issue (stigma) was compounded by what was described as an inefficient and ineffective system designed to assist veterans with PTS in the initial stages of post deployment psychological screening. This can be linked to the veteran's lack of confidence in their respective chain-of-command, as identified in the previous theme.

The veteran's perspectives (and actual experiences) extend the knowledge base regarding self-stigmatization by supporting that stigma (within the context of this study) permeates throughout various facets (echelons of military) of what can be best described as an inefficient and ineffective paradigm to mitigating, reducing, or eliminating the stigma associated with combat-related PTS. This could be interpreted as a perpetuating factor directly or indirectly associated with stereotyping and discrimination (stigma). An important consideration in attempting to understand the participant's experiences was, that, all ten participants represented both individual and mid-management (military position/assignment) perspectives based on their respective positions and responsibilities during their deployments in direct support of OEF/OIF.

The modified labeling theory specifically identifies and elaborates on various elements of discrimination based on false assumptions and misconceptions derived from society (Link et al., 1989 and Link et al., 2008, as cited in Link & Phelan, 2014; Dickstein et al., 2010). The basis for these false assumptions and misconceptions is clearly a lack of actual knowledge regarding the mentally ill and associated diagnoses/ailments which can be described as a catalyst for stereotypical behavior. This theory can also be applied (within the context of this research) to issues of stigma associated with the participant's experiences pre- and post-deployment in support of OEF/OIF. Although, stereotypical behavior can be identified as a learned behavior, it is strengthened and emboldened by a society which promotes this type of behavior by simply ignoring the issues and problems (casualties of war as it applies to my dissertation) pertaining to the mentally ill and their respective disposition. The majority of responses from the veterans appear to identify various aspects of stigma, (both public and self).

In comparison to the contemporary literature identified in Chapter 2, the issue or gap within this research confirms the lack of information, as it pertains to an understanding of the stigma from a soldier's (service members) perspective and its application associated with the reluctance to seek medical or other treatments or therapies. Also, this gap in the literature is substantiated by Bryan et al., (2012) and Pietrzak et al., (2010), as it pertains to military stigma (associated with PTS/PTSD) from a soldier's (service member's) perspective, especially regarding any association of military stigma with suicidal ideation.

As identified in Chapter 2, public stigma is also complicated by how the public perceives or stereotypes specific groups and self-stigma refers to the internalization of an individual's perceptions of this negative connotation (Corrigan & Watson, 2002). The term (stigma) is also used to refer to the avoidance of assistance for symptoms of PTS (Ben-Zeev et al., 2012). The vets collective position coincides with this avoidance to seek assistance regarding symptoms associated with PTS based on their negative experiences associated with the discriminant behaviors specific to pre- and post-deployment activities. This is representative in terms of being stereotyped based on identified misconceptions, misunderstanding, or misinformation about military operations, their culture, and the actual experiences which have changed the lives of military personnel. The literature (Chapter 2) also revealed this stigma is ingrained throughout society's discrimination against and stereotyping of people diagnosed with a mental disorder (Link & Phelan, 2014). This reality supports the need for further research regarding potential changes to the categorization of symptoms attributed to PTS as a battle injury, to better mitigate or reduce the misinformation which currently exists regarding PTS, as associated with the previous theme.

The military and media perpetuate misinformation about PTS, and the assumption that every combat veteran suffers from PTSD.

The findings revealed that veterans believed the media and military plays as a significant role in perpetuating the problem of military stigma and in the widespread assumption that every combat veteran has PTSD. According to Link and Phelan (2014), this presents an element of the social structure which lends power and credence to stigma,

thus, creating a reciprocal social structure which reinforces the discrimination and stereotyping of specific groups, as identified in Chapter 2. The vets believe this position is substantiated by the manner and methods in which the military promote and advertise military recruitment and sensationalize the overall military mission. The vets also confirm this collective position is based on the media's representation of military operations in a popular "pop" culture environment. A subsequent result of media promotion (movies or other forms of media, entertainment) being the depiction of all military personnel as having been through traumatic issues in some unrealistic form. Vets believe this misinformation about PTS is self-serving and is used to promote or sensationalize the issue based on a respective agenda of the military and media. As there is limited information regarding the assumption that every combat veteran suffers from PTSD, further research is required.

The veterans revealed this problem (based on their respective military experiences) is clearly linked to stigma as it is compounded by the automatic (general) association and assumption that every combat veteran is categorized with PTSD. These veterans also believed the role which media and military play in perpetuating military stigma, could be identified as an important catalyst in promoting or perpetuating misinformation regarding stigma within the context of this study. This perspective is justified and supported through research conducted by Corrigan and Penn (1999), and Wahl (1995), wherein, the media is scrutinized regarding behaviors associated with prejudice and discrimination as they pertain to disrespecting people with mental illness.

This is supported by additional information previously identified in the findings of Theme 1, specific to misinformation regarding PTS.

The majority of veterans interviewed collectively revealed their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. This included their respective positions confirming how military personnel are labeled should they receive a diagnosis or classification regarding a mental disorder. This is exacerbated by the inadequate support provided by the military chain-of-command as identified and used by all participants in this study. The veteran's identified a need for indoctrinating soldiers to the potential issues associated with PTS, which could better prepare military personnel to recognize characteristics and associated behaviors arising from stigma? Although, significant support has been directed toward the scholarly and clinical research of combat-related PTSD (National Center for PTSD, 2015), the issues surrounding the stigma associated with a diagnosis of mental disorder have received very little attention. According to these veterans this was compounded by the lack of support necessary to address this problem, specifically, being categorized based on the label of PTSD.

The issues associated with stigma, regarding combat-related PTS and PTSD, are significant and extensive, as identified previously (Mittal et al., 2013). As it pertains to PTS and PTSD, they are synonymous, to a certain extent. For the purposes of this study and within the context of this dissertation approach, PTS has significant meaning for veterans regarding the interpretation or the perception of PTS, less the diagnosis of a mental disorder as traditionally identified using the term PTSD. This is an important

element and perspective to understanding or interpreting the lived experiences of veterans who are stigmatized based on the negative connotations associated with a mental disorder diagnosis of PTSD, or are reluctant to seek medical care (Dickstein et al., 2010; Gibbs et al., 2011). This significance regarding PTS versus the mental diagnosis of PTSD is justified based on the following research by Corrigan & Matthews (as cited in Ben-Zeev et al., 2012, p. 267), as it pertains to being labeled with a mental disorder:

> Given the perceived harm that can occur as a result of seeking treatment, many soldiers may decide they do not want to be identified as a "mental patient" or suffer the prejudice and discrimination that the label might entail. This form of label avoidance is perhaps the most insidious way in which stigma may impede care-seeking in the military, as soldiers with psychological concerns will remain "closeted," much like people with other concealable labels often decide to do .

The majority of the participants (veterans) interviewed revealed a collective position which identified a lack of communication between the respective vets, and their ability to seek or obtain appropriate post-combat mental health treatment. The vets view this inability to secure treatment as a systemic problem and considered a failure on the part of the military chain-of-command to support ones' professional and/or personal life directly associated with stigma. As identified in Chapter 2, according to Bliese et al., (2007), despite the shared commonalities, how an individual (veteran) will react is questionable as there is a lack of post-combat mental health assessment practices and applications available. This fact does not include the multitude of veterans or military personnel that avoid any mental health screening or diagnosis that could impede their

careers, personal esteem, and relations. This could be explained as a form of Mental Health stigma explained "as a dynamic process by which a service member perceives or internalizes this brand or marked identity about himself or herself or people with mental health disorders (PWMHDs)" (Acosta et al., 2014, p. xiv). Again, this collective position was revealed by the veterans as a direct and indirect result of pre- and post-deployment military operations (OEF/OIF). Just as previously identified, the majority of participants reemphasized a lack of command support as it pertains to the individual needs of the veterans.

These findings support the need for both public and military personal to change, through informational, policy/regulatory systems, and through reeducation/intervention of both society and the respective military community, as presented by Corrigan and Watson (2002). This proposal was subsequently developed as an Anti-stigma approach which incorporates a model for changing stigma (developed by Corrigan & Watson, 2002), which is presented in three strategies: Protest, Education, and Contact, which incorporates a myriad of approaches to deal with stigma. Although, support has been directed toward the scholarly and clinical study of combat-related PTSD (National Center for PTSD, 2015), the issues surrounding the stigma associated with a diagnosis of mental disorder have received very little attention. There is a particular need for more research and the development of programs to address the military stigma and its underlying causes.

Veterans experience stigma as intimately connected with their experience of remorse at not having done well enough to support their brethren.

The findings revealed a shared belief among the veterans that stigma contributes to self-internalized stressors (self-stigma). The majority of responses from the veterans appear to identify various aspects of self-stigmatization in the form of self-identified pressures and/or remorse presenting various elements of guilt. This remorse (guilt) includes a felt need to (a) comply with the greater needs of the mission versus their own wellbeing and need for assistance; (b) redeploy back to the combat zone; and (c) demonstrate their own self-worth to their brethren. It seems to be based on a deep concern not to be viewed by other soldiers in a negative manner. This identification of remorse (guilt) and how a soldier is viewed is best represented by Acosta et al., (2014, Table B.1):

> In modern times, stigma is understood as an invisible mark that signifies social disapproval and rejection. . . . Stigma is deeply discrediting and isolating, and it causes feelings of guilt, shame, inferiority and a wish for concealment.

Military culture, in itself, is an important factor which contributes to mental health stigma, which is understood by military personnel as being tough, or having mission focus in order to address any problem (to include injury) (Dickstein et al., 2010). This sense of duty and feeling of remorse (guilt) could be explained as a result of the military culturalization which takes place through military training and indoctrination as presented by Hipes (2011, p. 2):

> Military bases represent total institutions in that they are confined social spheres in which individuals are re-socialized into new identities and taught to abide by new norms (Goffman 1961; Zurcher 1967). Examples of these norms in the

> military include group cohesion and individual strength in coping with trauma (McFarling et al., 2011; Kirke 2010).

Although, the literature regarding the element regarding remorse or concern for their own wellbeing is limited, it presents a need to conduct further inquiry. This could be supported by Mechanic et al., (as cited in Greene-Shortridge et al., 2007, p.158) who have hypothesized the following:

> That an individual with a mental illness may incorporate stigma into one's sense of self, and, consequently, lower one's self-esteem. This inhibited sense of self-esteem could lower one's motivation to seek psychological treatment.

As revealed in Chapter 4, one of the variables identified was the issue of remorse developed as a direct result of post-deployment activities which perpetuates (according to the participants) stigma directly and indirectly. The veterans expressed their belief that forms of remorse (guilt) were reactions (post-deployment) which were explained as not having done enough pertaining to the war on terror. This veteran's perspective extends the knowledge base by further revealing the need to understand the extent of remorse or anger (self-internalized). This disposition appears to create an environment which emboldens stereotyping as a result of preconceived notions (self-internalized) by the veterans which were developed and realized through discriminative behaviors as it applies to this stigma. This too, is also supported by the contemporary concept of societal and self-internalized stigma as presented by Corrigan and Watson (2002, p.17), which reveals:

> People with psychiatric disability, living in a society that widely endorses stigmatizing ideas, will internalize these ideas and believe that they are less valued because of their psychiatric disorder.

Within the context of this study, the effect of remorse and anger were apparent within the participant's responses. These experiences presented an environment of self-internalized stressors which appear to be associated with a preconceived notion that the participant's post-deployment screening could be viewed as antagonistic. This perspective is directly aligned with research identified in Chapter 2, which, reveals individuals react differently to stressful experiences and subsequent neuropsychological outcomes (Holloway, n.d.; Vasterling et al., 2006; Pietrzak, et al., 2010).

Post-deployment health screenings are superficial, inconsistent, and ineffective.

The findings from the majority of veterans who participated in this study believed their post-deployment health screening experiences were ineffective and inconsistent (superficial) based on how they were treated throughout the medical screening. It is important to remember this sampling of participants is relatively small in composition, but that the participant's responses revealed a broad spectrum of post-deployment screening experiences. The veteran's responses also presented a collective pattern regarding a lack of trust and skepticism pertaining to the medical screening process based on what they (veterans) describe as a lack of compassion and empathy provided by the medical screeners.

This respective position of the veterans coincides with research conducted by Greene-Shortridge et al., (2007), which identifies that military personnel are less likely to

follow through with psychological referrals versus a medical referral. This is of significant concern based on a lack of trust or rapport which could also be interpreted as a catalyst pertaining to stigma (internalized stressors) which complicates and inhibits current programs established to help redeploying vets. This is further compounded by the minimal amount of military personnel who actually receive a mental diagnosis or who actually seek assistance. According to Hoge et al. (2006), this could be attributed to problematic issues with the design of the psychological screening questionnaire known as the Post-deployment Health Assessment (PDHA) revealing the following conclusion (sec. Comment):

> This suggests that the screening instrument applied immediately on return from deployment has low specificity and positive predictive value. Positive predictive value is highly dependent on the prevalence of the disorders, and the predictive value would be expected to be lower for screening tests applied on return from deployment compared with 3 to 4 months later.

The vet's perspective (derived information) extends the knowledge base by identifying and supporting what can be best described as inconsistent (flawed) post deployment screening practices from an individual's perspective. As identified in Chapter 2, and in support of previous themes, despite the shared commonalities, how an individual (veteran) will react is questionable as there is a lack of post-combat mental health assessment practices and applications (Bliese et al., 2007). This is supported by the problematic issues previously identified and associated with psychological screening instruments such as the PDHA. The veteran's responses also identify a strong possibility

that stigmatization actually exists prior to any post deployment psychological screening.

Although, research is now taking place regarding military stigma (identified in Chapter 1), a significant need to understand soldiers' perspectives on any relationships between post-deployment psychological screening, diagnosis of a mental disorder, stigma, and suicidal ideation or suicide completion is required (Holloway, n.d.; Vasterling et al., 2006). Current models being applied to understanding and addressing issues of military (mental health) stigma is the introduction of an evidence-based intervention strategy known as the Protest, Education, and Contact (also identified in support of Theme 3) presented and described by Corrigan and Watson (2002), which has been established in the civilian sector and considered applicable to the military and VA (Dickstein et al., 2010).

During post-deployment medical screening, vet's feel the need to lie about their deployment experience for fear of being stigmatized.

The findings revealed that veteran's feel the need to lie about their deployment experiences for fear of being stigmatized through the post-deployment medical screening process. These veterans' responses collectively confirm their lack of confidence in the medical screening process based on their respective experiences. They shared a concern about what they identified as assembly line medical screening, conducted on the basis of general medical screening questionnaires. The inadequacy of this process for soldiers returning from war is combined with a longing among most personnel to be united with their family and not delayed with tests and treatment. As reported by Mittal et al. (2013), most, if not all veterans processing through post-deployment psychological screening,

will not provide information on trauma or posttraumatic experiences since their primary goal at this stage is normally to return home to their families or communities. As the veterans in my sample revealed in overlapping themes, they would just be going through the general medical screening questionnaire, entering numbers or checking the boxes as they respectively identified the need to return home.

This avoidance to seek out assistance is corroborated by the research of Mittal et al. (2013) and Ben-Zeev et al. (2012), which identifies the veteran's reluctance to seek help is based largely on the stereotype associated with a stigmatized group. The participant's also revealed there was a lack of adequate personnel to provide thorough examinations which impacted the quality and effectiveness of post deployment examinations. Further, that this process for mass screening does not cater to the individual soldier or military member which is supported in the previous theme regarding viable psychological screening instruments (Hoge et al., 2006). This can be attributed to the sheer numbers of military personnel (and their unique experiences), participating in redeployment (mandatory) examinations and the lack of support personnel to deal with this reality.

As revealed in Chapter 2, multiple studies reveal that there is an association between stigma and its connection to military personnel and veterans who present symptoms of PTS, have been diagnosed with PTSD, or seek treatment or assistance for any other mental illness (Mittal et al., 2013; Tanielian & Jaycox, 2008; Lee, 2012; Wisco, Marx & Keane, 2012; Sayer et al., 2009; Ben-Zeev et al., 2012; Dickstein et al., 2010; Greene-Shortridge et al., 2007; Gibbs et al., 2011). The importance of this theme being

the central focus regarding a veteran's capacity to make an informed decision to seek help for PTS, which is complicated by the associated mental health stigma (Mittal et al., 2013). This also coincides with participant responses regarding the reluctance of veterans to seek help for PTS, could be attributed to the stigma automatically associated with military service as identified in support of Theme 3.

Post-deployment screening practices create an environment of stress associated with stigma that perpetuates vets' reluctance to seek help for PTS.

The findings revealed that veterans believed their experiences pertaining to post-deployment health screening practices created an environment of stress associated with stigma, perpetuating veteran's reluctance to seek help for PTS. Their (veterans) reactions revealed a lack of confidence with individual medical assessments while identifying questionable (redeployment) medical screening practices as explained by all participants in this study, as supported in the previous themes. This environment of stress coincides with research conducted by Link and Phelan (2014), wherein, the researchers identify the existence of various discrimination mechanisms to include structural discrimination which best supports the vet's perspective regarding stress associated with stigma that perpetuates vets' reluctance to seek help for PTS. According to Link and Phelan (2014), structural discrimination impacts stigmatized groups cumulatively, thus permeating social policies, laws, and institutional practices, among other structural level factors. This aspect of discrimination is a significant factor in creating the stressful environment.

A significant element identified throughout this study revealed that inconsistent and ineffective health screening perpetuates the reluctance of veterans to seek help for

PTS. This can be attributed to the actual experiences of vet's who prefer to be interviewed/screened by individuals who have similar or shared experiences in combat. In essence, it is natural to expect that a vet is less likely to confide or seek help from someone they do not know or respect. This preference identified by the vet's is a significant factor for modifying or developing new forms of mental health screening practices.

A common issue discovered throughout the studies identified in Chapter 2, revealed a lack of concentration or focus to identify or investigate issues of reluctance among combat veterans to seek assistance, which may be a significant catalyst regarding redeployment activities and a veteran's ability to reacclimatize into society. As identified in Chapter 2, this reluctance to seek assistance may be grounded in the stereotypical labeling by which society tends to interpret mental disorder as some type of deviance (Mittal et al., 2013; Link & Phelan, 2014). This begets the need for military personnel to understand the concept of stigma in order make informed decisions regarding their personal wellbeing.

Multiple participant responses identified what could be described as internal stressors associated with an assembly line medical screening process, with no specific interest (exhibited by the examiners) in the individuals' medical disposition. This is another redundant and significant issue which supports previous themes identified throughout this study. Most respondents confirmed that vets are met with post-deployment health assessment procedures that lacked any serious inquiry into the actual experience or state of mind or welfare of the soldiers, but rather seemed designed to

move them through a set of cursory multiple choice interview questions as quickly as possible. This position and interpretation by the participants presents a negative view of said screening practices, thus exacerbating what can be interpreted as a potentially stressful environment. As previously identified, self-stigma refers to the internalization of an individual's perceptions of this negative connotation (Corrigan & Watson, 2002).

This is also supported by the contemporary concept of societal and self-internalized stigma as presented by Corrigan and Watson (2002). In this case, as it pertains to soldiers identified or labeled with PTSD, post deployment. In addition, this theory is applicable to military stigma based on the reluctance in which military personnel avoid seeking psychological treatment for symptoms associated with PTSD. As identified in Chapter 2, the reluctance to seek assistance may be grounded in the stereotypical labeling by which society tends to interpret mental disorder as some type of deviance (Mittal et al., 2013; Link & Phelan, 2014). The information shared by the vet's also identifies weakness as a common characteristic associated with veteran's reluctance to seek help for PTS.

This element of environmental stress associated with stigma, as it perpetuates a veteran's reluctance to seek help for PTS, extends the knowledge base by identifying, focusing, and providing additional research to this area of concern. This is necessary based on the apparent need to develop an understanding of environmental stressors which impact the capacity for veterans to successfully overcome the problems directly related to said reluctance in seeking help for PTS. As the literature had revealed in Chapter 2, there is a lack of research regarding the lived experiences of soldiers diagnosed with a mental

disorder, and on their reluctance to seek assistance (Gould et al., 2010). This approach to understanding combat-related stigma from a soldier's (service members) perspective provides valuable insight and forethought to mitigating the problems associated with this problem. This represents an element of self-stigma which over laps various themes within this study.

Veterans report that military stigma negatively effects their personal relationships.

The majority of veterans collectively believed their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. The veterans confirmed that they (veterans) personally experienced or knew of other veterans who experienced difficulties associated with their personal relationships with others (both personal and professional) based on issues of trust or preconceived ideas (stereotype) that every combat veteran suffers from one form or another of PTS (stigmatized). This perspective coincides with the definition and explanation of PTS, which is considered a universal response to a traumatic event associated with nightmares, pain, trouble sleeping, anger, and interpersonal difficulties (National Center for PTSD, 2014).

This stigma is compounded by additional post-deployment variables that may be directly or indirectly associated with PTSD, such as combat experiences, personal and professional relationships, and military operations (Sayer et al., 2009). The personal and professional ramifications associated with a diagnosis of PTSD (or similar associations), as previously identified, are characterized (within the content of this research) through the participants' experiences, as these experiences have impacted their respective lives.

As identified in Chapter 2, the stigma focus is the fear of military/veterans to actually report symptoms associated with a mental disorder which could impact their professional and personal lives (Mittal et al., 2013; Corrigan & Watson, 2002; Corrigan & Penn, 1999; Watson et al., 2007). This fear or angst to report symptoms associated directly or indirectly with PTS has been identified as a major concern by the majority of vets throughout this study. This perspective further underscores the need to better understand the actual lived experiences of veterans regarding this aspect of stigma as it applies to their personal lives. As identified in Chapter 1, the vets perspectives are also supported by a modified form of Labeling Theory (Link & Phelan, 2014), which proposes the existence of cultural stereotypes which are preconceived and discriminatory based on society's lack or desire for understanding stigmatized groups regardless of actual first-hand knowledge, or the lack thereof (Link & Phelan, 2014, Scheff, 1966).

This also supports the need for both public and military personal to change, through informational, policy/regulatory systems, and through reeducation/intervention of both society and the respective military community, as presented by Corrigan and Penn (1999). The importance for understanding the depth and impact of stigma upon a vet's personal life has far reaching implications as this element of the research impacts a wide variety of stakeholders.

Veterans report military stigma affects their potential employment opportunities.

The majority of veterans in this study believed that their personal or professional lives had been directly or indirectly impacted by the terms, symptomatic issues, or diagnoses of PTSD. The veteran's collective responses confirmed they personally

experienced or knew of other veterans who experienced difficulties associated with employment opportunities based on the preconceived ideas (stereotype) and misconception that every combat veteran is suffers from PTS or is diagnosed with PTSD. According to Mittel et al., (2013), vets given this diagnosis are often stigmatized by others, so that, for example, work becomes difficult for them to find, in the military or outside, which in turn tends to make the vets reluctant to seek counseling or some other form of helpful treatment. This collective position and concern by the participants is also supported and substantiated in the previous theme, as the reviewed literature from Chapter 2 extends its explanations regarding the impact of stigma, which incorporates both personal and professional relationships, as it applies to the ramifications associated with a diagnosis of PTSD.

As identified in Chapter 2, OEF/OIF veterans share common issues associated with mental health distress as it pertains to reestablishing personal and professional connections upon redeployment (Erbes et al., 2009; Lane, 2012). This position is clearly linked to being labeled with symptomatic issues associated with PTS or being diagnosed with PTSD. As identified in Chapter 2, although this aspect or interpretation of evidence within specific studies is limited, it is clear not all military personnel who experience combat or combat exposure develop PTSD. This perspective further underscores the need to better understand the actual lived experiences of veterans regarding this aspect of stigma as it applies to their professional lives. This also supports the need for both public and military personal to change, through informational, policy/regulatory systems, and through reeducation/intervention of both society and the respective military community,

as presented by Corrigan and Penn (1999). The importance for understanding the depth and impact of stigma upon a vet's professional life has far reaching implications as this element of the study also impacts a wide variety of stakeholders.

Veterans have limited knowledge about PTS treatments or therapies offered by the VA and military.

The veterans who participated in this study reported that their knowledge about treatments and therapies for PTS provided by the VA and military was limited, inconsistent, and vague. The veteran's responses also revealed a myriad of personal experiences with actual treatments and therapies which presents an environment of inconsistency and a lack of information known, or dissemination thereof, to the veterans regarding available resources provided by the VA and the military. This is consistent with the information identified in Chapter 1, wherein, vets diagnosed with a mental disorder are often stigmatized by others, so that, for example, work becomes difficult for them to find, in the military or outside, which in turn tends to make the vets reluctant to seek counseling or some other form of helpful treatment (Mittal et al., 2013). As identified previously, this response to a PTSD diagnosis is known as military stigma (Mittal et al., 2013). A contributing factor, previously identified, reveals stigma (directly and indirectly) is associated with a low veteran utilization of available resources designed to address issues pertaining to PTSD (Ben-Zeev et al., 2012; Koren et al., 2005).

The findings also presented information which either directly or indirectly perpetuates the ongoing issues associated with a veteran's reluctance (previously identified) to seek or enter into a program designed to assist veterans in need of help

regarding PTS. As presented in Chapter 2, this is exacerbated by the reality that existing treatment programs are inadequate for combat-related PTSD attributed to OEF/OIF, as more traditional methodologies (pre 9/11) had been relied upon to establish current programs (Erbes et al., 2009). The vets multiple responses also confirm what could be described as the participants having sporadic experiences regarding various programs without fully understanding the availability of treatments and therapies which currently exist. This begets the need to develop an information delivery system or equivalent which provides every opportunity for veterans, the military, and the VA to effectively communicate with one another.

An important factor to reiterate, as identified in Chapter 2 is, what the National Center for PTSD does not address is the issue regarding the reluctance of veterans to seek assistance through the various treatments identified and supported by the VA, as there is limited information regarding this issue. This coincides with a lack of information or understanding regarding what programs are available or how programs could be accessed. This veteran reaction and reality can also be associated with the stigmatization resulting from a lack of efficient and effective awareness training and military counseling regarding the positive aspects of treatments and therapies for PTS, as previously identified.

Education of soldiers is needed to correct the misinformation which continues to exist regarding stigma and PTS.

The findings revealed a collective opinion from the veteran's that education is the key element to preparing soldiers to the potential issues associated with PTS. The

majority of veterans also emphasized the importance to understanding stigma from the veteran's perspective requires an approach which changes and fortifies the current training systems and programs in place, to better address issues associated with PTS through sustained training. The veterans believe this change begins with transforming the military culture which currently exists.

As presented in Chapter 2, the perception of stigma, as it applies to the military is compounded by the subculture of military personnel and the military way of life. The findings reveal a collective position from the vets which clearly identify training and tradition as steadfast variables which can be restructured to incorporate psychological training and indoctrination throughout the ones' military career. As identified in Chapter 2, one such method which could be introduced into the mainstream training curriculum of military personnel is redeployment Battlemind debriefing which is considered a relatively early version of psychological intervention methods and training (Adler et. al., 2011). Battlemind debriefing emphasizes and reiterates the need for understanding stigma from a vet's perspective while providing a viable information delivery system specific to stigma, its understanding, and mitigation (intervention) as it applies to various elements associated with stigma.

As identified in previous themes, and in keeping with the theoretical framework of this study, the utilization of an Anti-stigma approach, incorporates a model for changing stigma (developed by Corrigan & Watson, 2002), which is identified as three strategies: Protest, Education, and Contact. The importance of this approach presents one particular strategy identified as education, which emphasizes a position which supports

education about mental illness and its understanding to better mitigate stigma and discrimination (Corrigan & Watson, 2002). This approach also supports the immediate problem (identified in Chapter 2) which pertains to two aspects of military stigma, i.e. the public stigma associated with a negative public perception of mental disorders, and the self-stigma in which these beliefs are internalized by soldiers (Greene-Shortridge et al., 2007).

Developing methods to indoctrinate the latest in subject matter relevant to the needs of a progressive military is nothing new to the modern army in terms of military preparedness. Training and tradition are steadfast variables which permeate military life. This perspective extends the knowledge base by identifying and substantiating the need to focus on the development of new and improved training, which includes a veterans perspectives (input), for all returning veterans regarding pre- and post-deployment assimilation. The over-arching issue here, could be indoctrinating soldiers to the potential of stigma, which may better prepare personnel to recognize characteristics and associated behaviors as a result of stigma? Understanding stigma becomes an issue of perception and acceptance, for which the military could apply new training elements specific to stigma, its understanding, and mitigation pertaining to various elements associated with stigma.

Another example to consider for change (as presented in Chapter 2), can begin with what Kelly et al., (2014) refer to as 'perceived organizational support' (POS), and its impact regarding perceived stigma of active duty soldiers post-deployment. POS can be aligned and applied at various levels of military processing (pre- and post-deployment) to

include entry-level assessments and post deployment examinations (Kelly et al., 2014). As it applies to the example provided, it is not so much the program that is of importance, as much as it is the methodology in which program can be implemented and more importantly emulated to a point of efficacy. While contemporary research in the area of military stigma continues to identify a multitude of intervention programs (National Center for PTSD, 2011), what is not readily apparent is a set of decisive actions or remedies to address the issue of stigma and the associated problems, which are detrimental to soldiers, their families, the military as a whole, and the community at large.

Stigma awareness training could change the reluctance of veterans to seek assistance.

The findings revealed that the majority of veterans interviewed believe that indoctrinating (stigma awareness training) soldiers to the potential issues associated with PTS could better prepare military personnel to recognize characteristics and associated behaviors arising from stigma. The majority of veterans also revealed that understanding stigma from the veteran's perspective is an issue of perception and acceptance (as identified in the previous themes), for which, the military could apply new training criteria specific to stigma, its understanding, and mitigation regarding various elements associated with stigma. The majority of the responses focused on awareness training regarding issues of stigma throughout the military and our society in whole. This confirms the need to develop effective prevention programs and diagnostic capacity throughout the military and VA.

These findings also reiterate and emphasize the reluctance of veterans to seek assistance as it is compounded by a lack of information or misinformation regarding specific therapies and treatments which currently exist. This veteran reaction and reality can be associated with a lack of stigma awareness and military counseling regarding treatments and therapies for PTS, previously identified in this chapter. As identified in Chapter 2, the introduction of a preventative care approach, could be as basic as including stigma awareness training as a part of military indoctrination in the same way as leadership and survival training are included and sustained (Gould et al., 2010; Link & Phelan, 2014; Mittal et al., 2013). The findings also reemphasized the added value and benefit of incorporating the vets input (as subject matter experts) in the development and delivery of stigma awareness training. During the course of the interviews, the vet's responses revealed various strategies to support the introduction and sustainment of training regarding stigma. The responses clearly identify the specific audience, where training should be introduced, and how it should be sustained as a form of continuing professional education (CPE).

As previously identified and subsequently confirmed by the participants of this study, there is a need to seek new or alternative approaches to screening and treatment for PTS that focus on the participants' actual experiences, and how to enhance their personal and professional lives, rather than on a stigma-inducing mental disorder diagnosis. This position is supported by the information identified by Gould et al. (2010), Link and Phelan (2014), and Mittal et al. (2013), in Chapter 2, wherein, these approaches should include military indoctrination (initial and continued professional development

education), identification and understanding of a soldier's perspective (themes developed as a result of lived experiences) in developing treatment programs, knowledge and information regarding the reluctance of vets to seek assistance, and developing a public reeducation campaign addressing misconceptions of combat-related stigma.

An important and contributing factor also identified in Chapter 2, regarding the lack of research regarding the specific elements of military stigma, is the harsh reality of stigma as it is associated with a soldier's suicidal ideation, and a lack of sound theory regarding the high prevalence of suicide among military members (Bryan et al., 2012; Pietrzak, et al., 2010). For example, a soldier's reluctance to seek assistance or other remedy (as previously identified) is a contributing factor to stigma and suicide. This reluctance to seek assistance may be grounded in the stereotypical labeling by which society tends to interpret mental disorder as some type of deviance (Mittal et al., 2013; Link & Phelan, 2014). This reality begets the need for change while maintaining a central focus on various aspects of a vet's reluctance to seek help.

Limitations of Study

Participants

This was a preliminary, exploratory study with a small homogeneous sampling of ten veterans with post 9/11 experiences. This approach provided a method to identify combat veterans within the military complex as there are differences between military personnel having been exposed to traumatic combat events and in this case soldiers within particular military units with minimal or no combat exposure (Patton, 2002). This created a potential for bias based on the experiences of each veteran which could be

considered unique to themselves, respectively. Ten participants were identified as a sufficient sample size for this study, which may be considered small, but common among studies of this kind. I attempted to control participant bias through the employment of semi-structured interview questions as a means to better evaluate and compare emergent information (characteristics and variables) revealed through interviews completed.

Through the utilization of this interview technique (semi-structured) allowed me to validate and establish a means to triangulate the respective military experiences, MOS's, deployments, and other operational activities to specific areas of operation supporting OEF/OIF. The traumatic events or other associated issues which may or may not have contributed to the stigma associated with PTS may have affected or impacted each respective participant differently and the recall (temporal sampling) or interpretation of the facts may have been distorted (Patton, 2002). This could also be compounded by individual combat experiences and their respective specialties which may or may not have prepared the participants adequately for combat (Patton, 2002).

Researcher Bias

The qualitative approach to this study presented potential researcher bias based on several factors which predominantly include this researchers' professional background as a recently retired U.S. Army Warrant Officer Four (CW4). The potential bias is based on characteristics associated with completing 27 years of combined active and reserve military service as a detachment commander, special agent, and investigator within the military thoroughly versed in various aspects of subgroups, categories, and levels of management within the military demographic. This is in addition to being an experienced

combat and disabled veteran. The issue of bias was minimized through the utilization of bracketing as it pertains to phenomenological research. This consisted of the design methodology and development for this research which used semi-structured open ended research questions, literature research, and a validity process applied through a phenomenological research approach and strategy development (Chan, Fung & Chien, 2013). This approach contributed to minimizing the researchers' own first-hand knowledge and experiences regarding the military culture while validating the data collection and analysis process.

Additional bias could be identified based on this researcher who is also identified by the VA as disabled through service-connected actions during deployment in support of OEF/OIF. The service connected disabilities included a diagnosis of PTSD in conjunction with sustained physical injuries. In retrospect, this provided additional perspective regarding post-psychological screening practices (as provided by the military and VA) and the bureaucracy (programs, interventions, and barriers) associated with post deployment activities. An important aspect of this researchers' experience is the fact that the stigma was overcome through the development and understanding of the processes, initiatives, and programs which currently exist to assist veterans. This is complemented by applying my own experiences and perspectives to the issue of stigma and overcoming obstacles (personal and professional) through my own positive affirmation and actions.

Generalizability

Based on the fact this is a small exploratory study, the results of this research were not generalizable, but did yield major themes that could later be studied

quantitatively in a larger sample. The fact that the veterans who volunteered to participate in this study creates a form of self-bias providing information which may differ greatly from the larger military (veteran community) which did not choose to participate of have knowledge of this research. This was supported by the participants who revealed unique experiences which can be categorized as similar in nature and shared among the military subculture regarding commonalities in traumatic events (combat), their lived experiences, and other similar variables or characteristics.

Recommendations for Further Research

The findings of this study, based as they are on the lived experiences of veterans, provide a unique view of the problem of stigma associated with combat-related PTS. The initial objectives and intended goals of this research identified the need to develop a better understanding of stigma associated with receiving a diagnosis of PTSD during post-deployment psychological screening, and the results confirm the existence and prevalence of stigma which is comprised of stereotypical labeling and produces discriminant behavior based on the classification of PTSD as a 'mental disorder'. The detailed themes arising from the data have been described above, and a number of them require further research in order to clarify their existence within a larger population of combat vets, and to investigate the three principal remedies presented: improved post-deployment medical screening procedures; reclassification of PTSD as a war injury instead of a mental disorder; and PTS-related stigma awareness training.

Improved post-deployment medical screening procedures for PTS. The utilization of qualitative and/or quantitative research could prove useful in

determining the actual effectiveness of post-deployment processing which may reveal a better understanding to the various issues pertaining to PTS or similar elements which directly support post-deployment examinations and programs. Developing an interview protocol (through a qualitative approach) designed to elicit specific information regarding various aspects of the post-deployment processing (examinations from its onset through fruition) while focusing on immediate, mid, and long term post-deployment care could provide insight to what is actually effective and what is not. The focus being on how this information is currently applied, provided, and delivered for veterans as they use it to make informed decisions regarding their own benefit or referral. A review of the established goals pertaining to sanctioned treatments, therapies, and programs provided by the VA and military could provide a comparative baseline necessary for review. This could include a secondary objective (using a quantitative approach) of determining which of the preferred treatments and therapies have the best outcomes (immediate and long-term) and why. The intent being the development of a more effective and efficient medical screening process which is exponential in growth.

Reclassification of PTSD as a war injury instead of a mental disorder. The utilization of qualitative and/or quantitative research could prove useful in determining the advantages and disadvantages to reclassifying PTSD as a war injury as it pertains to existing problems of stigma associated with a mental disorder diagnosis. To fully understand the stigma associated with PTSD, presents

a need to evaluate the impact of discrimination (as a central focus) at various echelons of the military through the existence of cultural stereotypes as being fundamental to the stigma of PTSD and the discriminatory factors associated with it. Therefore, the need to conduct a qualitative (ethnographic, grounded theory, or phenomenological) and/or quantitative research of veteran's experiences focusing on discrimination within the realm of the military and the private/public sectors could prove beneficial to all stakeholders. The intended goal being to identify positive implications of changing the current classification of PTSD from a mental illness to a war injury, and how this action could mitigate, or eliminate discriminatory behavior associated with stereotype and PTSD. Developing an understanding of this problem could benefit all stakeholders involved in the long-term welfare of military personnel and the over-all military mission. This recommended study should include research regarding the automatic association (stereotype) perceived that every combat veteran is categorized with PTSD. By developing an understanding pertaining to the reality of misinformation and how veterans are perceived in the public and private sectors is significant to addressing ongoing problems associated with PTS.

PTS-related stigma awareness training. Further research should be developed regarding stigma awareness training as a means to reduce or mitigate the reluctance of veterans to seek help regarding issues associated with stigma. Developing an understanding specific to the ramifications of military operations during a time of war could create a better awareness for the individual soldier,

while reducing negative connotations associated with PTS. Regardless of the research approach (qualitative and/or quantitative), what could prove significant is determining the actual long-term implications of stigma awareness training (using a grounded theory or longitudinal approach) to address both the individual and group challenges which impact the changed lives of veterans. The potential for understanding this reluctance of vets' to seek help could benefit all stakeholders involved in the over-all military mission. What could also prove significant is an approach focusing on the introduction of military awareness training (pre-deployment indoctrination) regarding issues of stigma and how to best indoctrinate the military for potential problems associated with post-deployment activities and life changing variables. The intent and goal being to identify viable training alternatives to correcting misinformation and promoting sustained training throughout the military services.

Implications

This qualitative study contributes to positive social change through a better understanding of the stigma associated with receiving a diagnosis of 'mental disorder' during post-deployment psychological screening. The social change implications regarding this research were developed by providing a voice to the real life experiences of veterans who either have direct or indirect knowledge regarding the issues associated with the stigma associated with combat-related post traumatic stress. This approach to understanding combat-related stigma associated with PTS has clearly demonstrated the importance of actual veteran input, as it pertains to providing a new perspective to

understanding the reluctance of veterans to seek assistance through counseling or some other form of helpful treatment. The reality and results regarding the information developed are not necessarily new, but the methodology used provided significant insight through the lived experiences of the veterans, their post-deployment processing, and the aftermath of their own challenges and the barriers associated with stigma. This research has also identified the enormity of the problems pertaining with stigma associated with the mental diagnosis of combat-related PTS, which is clearly evident through the development of thirteen unique but collective themes. There is no doubt the issues regarding stigma can be described as a complex phenomenon which permeates throughout various facets of military life and culture.

A phenomenological research approach was used in an effort to develop a clear picture of the participants' lived experiences. This was accomplished using a modified form of Labeling Theory was used as the theoretical foundation to address the role of cultural stereotypes in stigma (societal and self-internalized), and the discriminatory factors associated with them. This theoretical model established a means for understanding and comparing previous research (theory) as it was applied to the typology of contemporary military operations post 9/11. This approach to understanding combat-related stigma provided new perspective to understanding the reluctance of veterans to seek assistance through counseling or some other form of helpful treatment. Through the realization of this study, new or alternative approaches to addressing issues regarding stigma associated with PTS could be realized.

This research has the potential for impacting a numerous stakeholders directly or indirectly affected by the stigma associated with a mental disorder diagnosis. The intent being to recommend new ways in which we assess, diagnose, and treat combat-related PTS in order to reduce military stigma while considering the elements of public and self-stigma (internalization) associated with a diagnosis of a mental disorder (Corrigan & Watson, 2002; Corrigan & Penn, 1999; Watson et al., 2007). While the significance of this research was to better understand the stigma associated with a mental disorder diagnosis from a soldier's perspective, it was only through the collective and emergent data developed, that positive social change implications of this study could be realized using this new information to addressing issues regarding stigma associated with PTS. An important factor which emerged as a direct result of the applied research methodology was to employ the respective soldier's perspective (lived experience) while considering and determining a more effective course of action in analyzing and understanding stigma. The immediate and long-term implications could impact various facets of military and society as combat veterans continue to reintegrate into communities throughout the nation.

Conclusion

The stigma associated with combat-related post traumatic stress (PTS) and the mental disorder diagnosis of PTSD is a serious issue affecting veterans who have deployed in direct or indirect support of OEF/OIF. One of the most important effects of a PTSD diagnosis, as confirmed in this study, is the reluctance of veterans to seek help through established veterans' assistance initiatives and programs that provide counseling

or other forms of helpful treatment. In the past, our understanding of this issue has been compounded by a lack of research or information derived from veterans' actual experiences. The question as to why the military, the VA, and society in general have hitherto failed to seek out and consider veterans' experiences in this domain remains to be explored.

This research is the first to provide data on military stigma from a veteran's perspective. Though the sample is small, the results provide a consistent set of observations and recommendations for stigma prevention and advancement of appropriate mental health support for battle-scarred veterans. These include improved post-deployment screening procedures, reclassification of PTS as a battle wound rather than as a 'mental disorder,' stigma awareness training and improved education and referral on PTS-related therapeutic services. This approach would replace the current dysfunctional process of denial with a preventative system based on a real understanding of combat-related stigma and its effect on the reluctance of veterans to seek assistance through counseling or other forms of helpful treatment.

The military chain-of-command is responsible for the over-all welfare of the soldier, not only during military service, but after service is completed. Though the findings of this study should be confirmed with a larger population of veterans, they suggest that this responsibility is not always being adequately met, especially in relation to post-deployment mental health screening and services. The results of this research provide a better understanding of factors that contribute to the stigma associated with combat-related PTS, and potential stigma-prevention measures, including policy change,

public education, and improved access to therapeutic programs. The impact of such changes could benefit generations of veterans to come.

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Appendix A: RECRUITMENT POSTER

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VOLUNTEERS NEEDED FOR A RESEARCH STUDY

Have you experienced stigma associated with combat-related post traumatic stress?

Participants Must:

- Be a military veteran of Operation Enduring Freedom or Operation Iraqi Freedom or served in the military post 9/11 (male or female)
- Have observed or experienced stigma associated with combat-related post traumatic stress
- Have served at least one year of honorable service in the U.S. Military (Army, Air Force, Marines, Navy or Coast Guard)
- Provide consent to participate in a 60-90 minutes interview regarding the stigma associated with combat-related post traumatic stress and asking any questions you believe are important to this subject

This research study is confidential and only the researcher and his dissertation advisor will have access to the information. Information regarding the results of this study will be provided to the participants directly through a summary of the results with a link to the completed dissertation. Additionally, you may contact the researcher at alexander.buelna@waldenu.edu for the results of the study.

Your participation could assist in achieving a better understanding of stigma associated with combat-related post traumatic stress, and developing new research approaches to this stigma based on the perceptions of actual veterans

To schedule an interview please contact Alexander J. Buelna, M.S. at alexander.buelna@waldenu.edu.

Appendix B: SCREENING QUESTIONNAIRE

Dear Research Participant,

My name is Alexander Buelna and I am a 27 year military veteran and a doctoral student at Walden University.

I am doing research on the stigma associated with combat-related post traumatic stress.

As a veteran, you may be aware of the problems some vets experience around getting a diagnosis of PTSD.

As a potential participant I hope you will take a few moments to review the following screening questionnaire.

If you qualify as a participant in this study, I will be asking you a few questions. The interview should last approximately 60-90 minutes.

If, as a result of participating in this research study, you experience subjective distress you may contact the Veterans Crisis Line: 1-800-273-8255, press 1 (text 838255) or Confidential Veterans Chat with a counselor; or call the 24/7 Veteran Combat Call Center 1-877-WAR-VETS (1-877-927-8387) to talk to another combat Veteran.

Participation in this research will help me develop an understanding of stigma associated with combat-related post traumatic stress, from a soldier's point of view. This may also explain the reluctance of veterans to seek psychological help when they need it.

The interviews will be audiotaped but everything you say will be kept in confidence. The information will only be used to develop themes specific to the study, its results, and conclusions. The audiotapes and their information will be secured and only utilized for this study. The audiotapes will be destroyed once I have defended my dissertation before the Dissertation Committee.

If you are willing to consent to participate with this study, you can continue in the screening process at this time, as it should only take about 15 minutes?

1. Are you a veteran of OEF or OIF?
2. Have you observed or experienced stigma associated with combat-related post traumatic stress?
3. Have you served at least one year of honorable service in the U.S. Military (Army, Air Force, Marines, Navy or Coast Guard)?
4. Were you honorably discharged from the military?
5. How much time did you complete in the military?

Thank you for your participation in the screening process.

If you are eligible participate you will be provided additional instructions for the subsequent interview. If not, the reasons for ineligibility will be explained and you will be thanked for your time and effort. Should you have any other questions, this learner will answer them to the best of my ability.

The participant (you) will then be asked again if you would like to participate in the study. If not, you will be thanked for your assistance. If so, an interview will be scheduled at a location which is mutually appropriate and convenient to you and this researcher. This interview may also be completed using a computer online application such as Skype depending on the location of the respective participant (you) and this researcher.

If you have any questions at this time or before our interview, please contact me at alexander.buelna@waldenu.edu or my dissertation advisor Dr. Schwab at Michael.schwab@waldenu.edu or 1(800) 925-3368.

Appendix C: INTERVIEW QUESTIONS

1. When and where did you deploy to in support of Operation Iraqi Freedom or Operation Enduring Freedom? How long?

2. What are your experiences with post-deployment examinations?

3. Understanding that stigma can be explained as veterans being stereotyped, or having feelings of shame and disgrace, what experiences have you had with it, either yourself or someone else?

4. As stigma is considered common among veterans regarding PTS, why do you think this is?

5. How would people you know react if you told them you are seeking help for PTS or other injury which could impact their personal or professional lives?

6. Do you believe the military chain-of-command provides adequate support for veterans regarding PTS? Please explain?

7. Do you believe veterans (in general) are reluctant to seek out help pertaining to PTS? If so, can you explain this reluctance?

8. Are you personally or professionally familiar with current PTS programs, ability to access them, and their effectiveness? If so, can you explain to what extent?

9. How could the military reduce vet's reluctance to seek psychological help?

10. Do you believe the military should include training on military stigma (combat-related or associated with PTS)? If so, how do you think this training should be implemented?

11. Do you believe the military stigma associated with PTS affects the personal and professional lives of veterans? If so, please explain?

12. What do you think should be done to reduce military stigma?

13. How old are you?

14. What was your military branch of service?

15. What was your military occupational specialty (MOS) and rank?