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An Exploration of Attitudes Among Veterans and Military Personnel Regarding Care and Reintegration

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This is to certify that the doctoral dissertation by

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Abstract

An Exploration of Attitudes Among Veterans and Military Personnel Regarding Care Seeking and Reintegration

by

Mavis Jean Christopher

MSW, Florida State University, 1994

BA, University of North Florida, 1990

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Reintegration is a complicated process and becomes more difficult due to stigma toward care seeking. Stigma can act as an influence to avoid treatment or terminate treatment early. The problem is that the attitudes of veterans and military personnel toward care seeking prior to discharge are unknown, particularly with respect to the lack of anonymity or privacy. Also unknown is what these populations desire to be included in reintegration treatment/training. The purpose of this study was to discover and interpret the attitudes of this population toward care seeking. The conceptual framework included military culture, masculine ideology, and stigma. The research questions addressed the attitudes held by veterans and military personnel regarding care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy, in addition to the elements that veterans and military personnel think should be included in reintegration treatment/training. Using a qualitative case study design, findings corroborated previous findings in the literature regarding negative attitudes toward care seeking. Other findings revealed a desire on the part of the participants for comprehensive training for resource acquisition at discharge. There is evidence of an undeveloped theory of career-protecting behavior. Avoiding care seeking to protect career, rank, job, or assignment is more than avoidance in order to not appear weak or to sidestep stigma toward weakness. A suggestion would be to explore care seeking by gender and rank. Positive social change may include a better understanding of the attitudes toward care seeking in the military and what elements are desired in a reintegration treatment/training program, informing practice and individual client care.

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Dedication

This proposal dissertation is dedicated to my committee, and my U.R.R. mentor, Dr. Medha Talpade for their expertise, help, encouragement, and unfailing kindness. Thanks to program directors Dr. Anthony Perry and Dr. Amy Sickle for their leadership and encouragement. Finally, important is my gratitude to my Creator, from whom I get encouragement and love unbounded.

Acknowledgments

A professor I had in my first course at Walden University had a great deal of influence on me. Due to this professor's dedication to APA standards in writing and her call for excellence in all writing by Walden University students, I began my academic career at Walden, not only on the right track, but with a healthy respect and concern for the rules and principles of scholarly writing. This professor, while ardently prodding students toward excellence, never reduced, for any reason, her own standards or those of Walden University. I will forever be grateful, for the in-depth expertise, enduring willingness to help, and unfailing encouragement toward scholarly writing in students. Dr. Lerman, you are the best.

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Chapter 1: Introduction to the Study

In this study, I addressed veteran and military personnel attitudes toward care seeking for medical problems (mental health and physical injury) with respect to the lack of anonymity or privacy, and their desires for elements to be included in reintegration training. Reintegration is a complicated process and produces varied attitudes among veterans and military personnel toward reintegration and the military reintegration programs (Ben-Zeev, Corrigan, Britt, & Langford, 2012). Reintegration problems that veterans and military personnel face are threefold: (a) the need for help with medical problems and social skill building for reintegration (Danish & Antonides, 2013; Koenig, Monroy, Mayott, & Seal, 2014; Marek & D'Aniello, 2014), (b) the enduring effects of stigma (Acosta et al., 2014; Ben-Zeev et al., 2012) and the accompanying masculine ideology (Braswell & Kushner, 2012) in the military culture, and (c) the lack of any means for veterans and military personnel to receive prior to discharge that offers the opportunity for anonymity or privacy (Dickstein, Vogt, Handa, & Litz, 2010).

Not discussed in this study report, and yet important for successful reintegration into civilian life, is *not* the standard (approximately 1-2 week) reintegration training offered in all branches of the military just prior to discharge, nor the short term treatment programs, such as Military One Source (www.militaryonesource.mil), but a reintegration treatment/training program for diagnosed medical and social problems such as social adjustment problems or spousal communication problems, prior to discharge.

Reintegrating military personnel may have major physical or mental health problems due to combat trauma. These problems are generally referred for treatment

during the standard reintegration treatment/training offered by the military just prior to discharge. These reintegration problems, and treatment/training to alleviate these problems, are beyond the scope of the standard short-term treatment/training programs currently offered by the various branches of the military prior to discharge (Meredith et al., 2011), or the short-term programs such as Military One Source (www.militaryonesource.mil) that reintegrating personnel can be referred to immediately after discharge. For help with serious problems the military usually refers the individuals to outside care, and during this study, individuals who asked for help with any of these problems were furnished with information to seek care, via services offered by the Veterans Administration and other out-reach services. Re-entry and reintegration are complicated processes.

For the purposes of this study, re-entry was considered the simple act of leaving the military and returning to civilian life (Doyle & Peterson, 2005), whereas reintegration was considered a more involved process of leaving the military (Doyle & Peterson, 2005), returning to civilian life, and becoming a productive part of society, engaged in family and social activities and institutions (Doyle & Peterson, 2005), and leaving behind the military culture and its extensive and substantial influence. All aspects of military culture have considerable influence on the individual and therefore are not easy to extract one's self from.

For this study, *military culture* was defined as a written or unspoken set of beliefs, values, language, manners, customs, traditions, and expected behaviors that are evidenced in rank, creeds, regulations, social groups, lifestyles, and behaviors (Gibbons,

Migliore, Convoy, Greiner, & DeLeon, 2014). Concerns about reintegration include attention to mental health problems, marital problems, general civilian functioning (Sayer, Carlson, & Frazier, 2014), and the effects of stigma associated with seeking care in the military culture which can negatively affect reintegration (Herrera-Yee, 2015; Schreiber & McEnany, 2015; Smith & True, 2014). Reintegration programs for medical (physical or mental health) problems are discussed further in the background section of this chapter and in the literature review in Chapter 2. Reintegration, a complicated process, is made more complicated by the effects of another element of the military culture, stigma.

For this study, *stigma* in general was defined as the process of labeling, stereotyping, or being made to feel set apart (Link & Phalen, 2001). Stigma in the military culture includes the general definition of stigma, plus the military context of negative stereotyping of any sign of weakness. In the military, superiors and other military personnel have access to the individual's medical records along with any diagnosis and treatment plan (Acosta et al., 2014). Unlike stigma in civilian society, military culture stigma affects all aspects of the individual's life including promotions, pay, work assignments, and more (Ben-Zeev et al., 2012). In the end, stigma in the military culture can have a debilitating effect on reintegration success (Ben-Zeev et al., 2012; Hipes, Lucas, & Kleykamp, 2015; Gould et al., 2010; Hoge et al., 2004; Pietrazak, Johnson, Goldstein, Malley, & Southwick, 2009). In some cases, veterans and military personnel avoid seeking treatment or terminate treatment too early, due to military culture stigma (Sirey et al., 2001). All of this can negatively affect the reintegration

process (Schreiber & McEnany, 2015). Although the Army has made efforts to reduce stigma in the military culture (Dingfelder, 2009; Herrera-Yee, 2015; Nash, Silva, & Litz, 2009), stigma, and the accompanying masculine ideology (Braswell & Kushner, 2012) are persistent problematic issues for veterans and military personnel (Marek & D'Aniello, 2014; Sayer et al., 2014). The concept of masculine ideology, a multifaceted phenomenon, to begin with, refers to strong emotional control by individuals (Hockey, 2003). Stigma and the masculine ideology in the military culture are discussed further in the background section of this chapter and in the literature review of Chapter 2.

From here forward the term *medical problems* is used to represent mental health problems and major physical injury, and therefore to refer to a wide range of problems experienced by personnel when returning to civilian life. I found no reintegration treatment/training for medical problems (prior to discharge) that offers the opportunity to remain anonymous during treatment (Meredith et al., 2011; Weinik et al., 2011), which might offer individuals the opportunity to avoid the negative effects of stigma (Weinik et al., 2011). All programs for medical problems prior to discharge require individual identification, which in turn, may make participants susceptible to the effects of stigma based on the perception of weakness (Benn-Zeev et al., 2012; Herrera-Yee, 2015) because they do not have anonymity or privacy. Because there has been no opportunity in the military for anonymity during treatment/training and no study has addressed the attitudes of veterans and military personnel toward care seeking, with respect to lack of anonymity or privacy, information about their attitudes was sought along with what elements they desire to be included in reintegration treatment/training.

This study provided evidence that shows what elements these populations desire to be included in reintegration treatment/training. This study could lead to a new approach to reintegration readiness. Surprising evidence shows veteran and personnel career-protecting behaviors, a step beyond avoiding treatment to avoid the stigma of weakness. The information that this study revealed is important, and it is also important to consider the limitations, the scope and delimitations, the main assumptions, the nature of this study, the theories behind this study, the research questions for this study, the purpose and problem statement, programs to reduce stigma in the military culture, and programs to improve reintegration success; all these issues are considered in the literature review section of Chapter 2 as well as the following background section.

Background

Reintegration programs are aimed primarily at increasing the chances of successful reintegration into civilian life (Denning, Meisnere, & Warner, 2014). Affecting the success of these pre-discharge programs is stigma in the military culture toward care seeking (Acosta et al., 2014). Discussed in the following paragraphs are the efforts to reduce stigma in the military culture and research efforts toward developing reintegration treatment/training programs.

Research Literature: Reintegration Programs

As far as this study is concerned, the terms *reintegration programs* or *treatment programs* referred not to the standard reintegration training offered by the military just prior to discharge or the short-term programs such as Military One Source, but to reintegration treatment/training for medical problems (physical damage and mental health

problems) that require referral and long term help. Most current reintegration help is aimed at specific problems or issues, such as family dysfunction (Marek & D'Aniello, 2014; Sayers, 2011; Sayers, Farrow, Ross, & Oslin, 2009) and interpersonal conflict (Gibbs, Clinton-Sherrod, & Johnson 2012; Knobloch, Ebata, McGlaughlin, & Ogolsky, 2013; Marek & D'Aniello, 2014; Sayers et al., 2009; Theiss & Knobloch, 2013) and often are accompanied by at least one mental health problem such as PTSD (Hipes, Lucas, & Kleykamp, 2015) or depression (Greden, et al., 2010). A few programs are aimed at associated but different issues and are offered on the Internet.

A few of the reintegration programs offered via Internet-based programs, such as for rural veterans (Allen et al., 2013), include training for, or help with, information dissemination (Borzekowski et al., 2009). Internet-based programs have been used successfully for nonmilitary populations (Bowman, Chingos, Lack, & Nygren, 2014; Carlbring et al., 2006; Einhorn et al., 2008; Schifferdecker, Berman, Fall, & Fischer, 2012), as well. Reintegration programs for treatment of medical problems are discussed further in Chapter 2. Although some training for reintegration success is offered via Internet-based programs, no treatment for medical problems, via the Internet or otherwise, has offered the opportunity for personnel to remain anonymous, a solution that may mitigate the effects of stigma on treatment seeking or reintegration training in the military culture (Dickstein et al., 2010). Therefore, the focus of this study was to discover the attitudes of veterans and military personnel toward acre seeking prior to discharge with respect to the lack of anonymity and what elements they desired in reintegration treatment.

Research Literature: Stigma in the Military Culture

Stigma was defined as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001), as an attribute that is deeply discrediting (Goffman, 1963), and as a mark given by society to define a person as flawed (Jones et al., 1984). The military culture model of stigma (Acosta et al., 2014; Ben-Zeev et al., 2012) includes the concept of stigma as a dynamic process by which the individual internalizes a marked identity and includes the context which the person lives in, the military culture (Acosta et al., 2014). Although discussed further in the theoretical framework section of this chapter and in Chapter 2, the main point to press here is that stigma in the military culture influences people to view care seeking or reintegration treatment for medical problems as a sign of weakness (Harris et al., 2015; Herrera-Yee, 2015; Srinivasan, 2012). Those in need of help may delay getting help for reintegration issues (Ben-Zeev et al., 2012; Rodrigues et al., 2014). Delaying care may worsen the problems (Rodrigues et al., 2014). Professionals (Dingfelder, 2009; Herrera-Yee, 2015) have been determined to find an avenue to help veteran and military personnel, in a way that avoids the negative effects of stigma.

In a published article (Dingfelder, 2009) about stigma in the military culture, it was reported that the American Psychological Association (APA) advised the military to fight stigma by providing more confidentiality for veterans and military personnel seeking help. Since there has not been a reintegration program that offers the opportunity of anonymity during treatment prior to discharge and no one has measured what is thought about such treatment or what elements veterans and military personnel desire in

reintegration programs, a gap in the knowledge exists regarding these attitudes and desires. No study has addressed the attitudes of veterans and military personnel regarding treatment/training for reintegration with respect to the lack of anonymity or privacy, or what elements they desire to be included in reintegration treatment/training. This gap in the knowledge was addressed in this study

Gaps in the Knowledge this Study Will Address

It is unknown what the attitudes might be of veterans and military personnel toward treatment/training prior to discharge for medical problems with respect to the lack of anonymity or privacy. It is also unclear what elements these populations might desire to be part of such treatment/training for reintegration readiness. In this study, I focused on developing an understanding of what the attitudes of military personnel and veterans might be toward treatment/training for medical problems prior to discharge with respect to the lack of anonymity or privacy. The goal was to shed light on what these populations think reintegration treatment/training programs prior to discharge should included.

Why This Study is Needed

This study was needed to address these questions: would veterans and military personnel express an attitude about reintegration treatment/training that signifies a distaste for programs that do not allow anonymity or privacy. Do they have an opinion? This study was also needed to survey what individuals think should be included in reintegration treatment/training prior to discharge. These issues inspired the development of the problem statement.

Problem Statement

Veterans and military personnel often need help to successfully reintegrate into civilian life (Bowling & Sherman, 2008; Danish & Antonides, 2013; Gibbs et al., 2012). The enduring problem of stigma in the military culture may pose a barrier to care (Hoge et al., 2004; Iverson et al., 2011; Pietrzak et al., 2009), further impeding reintegration. The problem is that no study has sought to discover what the attitudes are among veterans and military personnel are toward care seeking, with respect to the lack of anonymity or privacy, or what elements they desire in reintegration treatment/training programs. Since there is no reintegration treatment/training program or published studies addressed these attitudes, this was the phenomenon of interest for this study.

Currency of Problem and Significance to Psychology

Currently there are multiple programs (Meredith et al., 2011; Weinik et al., 2011) aimed at all aspects of reintegration. Some programs (Dingfelder, 2009; Herrera-Yee, 2015; Iverson et al., 2011; Rodrigues et al., 2014; Schreiber & McEnany, 2015; Vogt et al., 2014) are aimed at reducing the effects of stigma toward seeking help in the military culture, albeit with little success (Acosta et al., 2016). It has been shown (Marek & D'Aniello, 2014) that reintegrating personnel need help with specific reintegration problems to successfully return to civilian life, and personnel may have combat-related damage they have learned to live with rather than have superiors and others know they need help (Ben-Zeev, et al., 2012). It has also been shown (Ben-Zeev et al., 2012; Harris et al., 2015) that these populations may avoid seeking help due to stigma in the military culture.

Finally, in two small studies (Klee et.al, 2016; McGlinchey et al., 2014) it has been shown that military personnel and veterans asked for (Dingfelder, 2009) more private and accessible treatment/training reintegration programs, and that there has been a call (Schreiber & McEnany, 2015) for the combination of technology and improved confidentiality as a method to improve reintegration programs for veterans and military personnel. Yet, it is unknown what the attitudes are of these populations regarding reintegration programs with respect to anonymity or privacy, or what elements they would they desire to see as part of such training.

Purpose of the Study

The purpose of this qualitative case study was to identify and describe the attitudes of veterans and military personnel toward reintegration treatment/training prior to discharge for medical problems with respect to anonymity or privacy, and their desire for elements they wish to be included in reintegration programs. The phenomenon of interest was the attitudes regarding these two aspects of reintegration programs (with respect to no anonymity and elements they desire in programs). This phenomenon of interest drove the development of the research questions.

Research Questions

1. What are the attitudes held by veterans and military personnel regarding care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy?
2. What elements do veterans and military personnel think should be included in reintegration treatment/training?

Theoretical Framework

The theoretical framework for this study included the theory of stigma, the theory of military culture, including the theory of masculine ideology, and the combination theory of stigma in the military culture. A theory of stigma was developed in the 1960s, whereas the concept of stigma in the military culture has been investigated in recent years due in large part to the suicide rates among personnel and the concept of treatment avoidance associated with stigma toward weakness (Acosta et al., 2014). The qualitative research paradigm was chosen as an avenue to survey attitudes to describe participants' thoughts and feelings regarding seeking care and the fear of exposure accompanied with care seeking in the military culture (Acosta et al., 2014). The phenomenon of interest, then, was what the participants (veterans and military personnel) think about care-seeking prior to discharge with respect to the lack of anonymity or privacy in care seeking. These theories of stigma, stigma in the military culture and the masculine ideology fixed the focus of the study.

Theoretical Foundation

As mentioned, the theories that influenced this study were the theory of stigma (Goffman, 1963), and the theory of stigma in the military culture (Acosta et al., 2014), partnered with the concept of masculine ideology (Gilmore, 1990; Hockey, 2003) in the military culture. Described in the following paragraphs and in depth in Chapter 2, these theories supported the focus that was chosen for this study.

Theory of Stigma

A theory of stigma, which originated as early as 1963 (Goffman, 1963), states that stigma identifies an individual as "marked" or "not normal" (Goffman, 1963; Jones et al., 1984) (such as military personnel showing sign of need for care seeking). This concept of being outside of what is acceptable tends to be internalized by veterans and personnel (Drapaliski et al., 2009), and in order to avoid other military personnel discovering this *defective* state, the individual may avoid seeking care (Rodrigues et al., 2014), for reintegration treatment/training for medical problems (physical and mental health) such as depression or PTSD, or may terminate treatment too early (Sirey et al., 2001). Although a concept and understanding of stigma in society has been accepted for some time, there are elements of military culture stigma and the masculine ideology that pertain only to the veteran and military personnel populations. It requires a complicated effort to understand the effects of stigma in the military culture. A large part of what makes stigma in the military so damaging stems from the masculine ideology.

Theory of Stigma in the Military Culture and Masculine Ideology

Care seeking, or treatment seeking, are seen as signs of weakness at a level stronger than in civilian cultures (Harris et al., 2015; Herrera-Yee, 2015; Srinivasan, 2012), due in part to the effects of the masculine ideology in the military culture (Braswell & Kushner, 2012). Masculine ideology includes an attitude of complete control and suppression of emotion or any measure of pain, emotional or physical. The major point that is significant to the military-culture model of stigma is the integral part of the model design that is based on the military institutions and policies that affect every aspect

of life for the individual, which is also be discussed further in Chapter 2. This significance is based on the unique lifestyle of the military person, whose home lives and work lives are not separate, but uniquely combined (Acosta et al., 2014).

The definition of military culture stigma used for this study included the experiences of service members in response to military institutional factors that lead to discrimination, and includes the attitudes, beliefs, and behaviors of other personnel toward service members with medical (mental health or physical injury) problems or toward those who seek reintegration help (Acosta et al., 2014, p. 12). The assumptions of the theory of military culture stigma begin with the military context, or the military culture and norms, which affect the institutional context of military policies and programs, and treatment systems, which in turn, affects the social context of family, friends, and military unit, all together affecting the individual context, the service member, and his perceptions of stigma (Acosta et al., 2014). The effects of this public, institutional, and social contextual design is twofold: *Proximal impacts*, interpersonal outcomes, coping, and attitudes associated with treatment, and *distal impacts*: well-being, readiness, quality of life, treatment seeking, and treatment success (Acosta et al., 2014). In the military culture these contexts are all interconnected (Acosta et al., 2014), and is discussed further in chapter two. This significance is based on the unique lifestyle of military personnel whose home lives and work lives are not separate, but uniquely combined (Acosta et al., 2014).

A civilian individual, while also affected by stigma, can more successfully maintain his or her anonymity when seeking help or care (Goffman, 1963), whereas

veteran or military personnel records are available to all superiors and may affect promotion, pay, standing, deployment, special assignments, and even unwanted discharge (Acosta et al., 2014). Based on this, one would think stigma and its influence to avoid treatment would cease as soon as the individual leaves the military. That is not the case. Veterans seem to carry a fear of disclosure into civilian life (Acosta et al., 2014). The effects of the military context of stigma is that treatment success is reduced (Acosta et al., 2014). Discussed further in Chapter 2, and important to understand here, is the idea that regardless of the multiple programs to reduce or eliminate stigma in the military culture (Herrera-Yee, 2015; Schreiber & McEnany, 2015), no study has addressed what the attitudes of veterans and military personnel might be toward the prospect of anonymity when seeking reintegration treatment/training for medical (physical or mental health) problems prior to discharge or what they desire as part of reintegration treatment/training programs. Therefore, the relevance of the concept of stigma to this study seemed strong.

Relevance to the Study

Relevant to this study, was the concept that military culture stigma has *not* been reduced despite the programs with that aim (Herrera-Yee, 2015). The need for treatment continues for various reintegration issues (Marek & D'Aniello, 2014). The suggestion has been made to cultivate more confidentiality (Schreiber & McEnany, 2009) and increase the use of technology (Dingfelder, 2009) to improve treatment and reintegration success. Anonymity during treatment programs for medical (physical and mental health) problems may be a solution for reintegration success. It was relevant to know what the veterans' and military personnel's attitudes are regarding care seeking prior to discharge, and what

elements they desire to be included in reintegration treatment/training. The reader is encouraged to view the Flowchart of Military Life and Unknown Attitudes Toward Care Seeking (Appendix A). These were the phenomena of interest chosen for this study within a conceptual framework in a military lifestyle context.

Conceptual Framework

The conceptual framework is described in the following paragraphs, and in depth in Chapter 2. To begin with the phenomenon of interest, the attitudes of veterans and military personnel was surveyed and interpreted. These attitudes of participants were analyzed in the context of the setting, military life, and the prevailing military culture stigma against any sign of weakness, triggered by care seeking, and effects of experience in combat. The conceptual framework therefore involved several issues: the contextual lens including day-to-day life in the military culture, possible physical and mental damage, the residual effects of stigma, and the phenomenon of interest.

Phenomena Description

The phenomena of interest were the attitudes or perceptions of veterans and military personnel toward care seeking for medical problems prior to discharge, with respect to lack of anonymity or privacy, and what elements they think should be included in a reintegration treatment/training program. These phenomena exist in the context of the military lifestyle that is evidenced in a contextual lens with multiple facets.

Contextual Lens

The contextual lens was complicated and consisted of three integrated and mutually dependent elements: (a) the day-to-day military life and shock of returning to

civilian life, the need for help with reintegration treatment for medical (physical or mental health) for successful reintegration into civilian life (Danish & Antonides, 2013; Koenig et al., 2004; Marek & D'Aniello, 2014), (b) the problems dealing with the effects of military-culture stigma (Acosta et al., 2014; Ben-Zeev et al., 2012), and (c) the residual effects of experiences in a combat zone complicated by the shock of returning to civilian life (Adler et al., 2011; Knobloch et al., 2013). The need for mental health care after returning from a combat zone should not be over-looked, but should be understood as an integral part of the reintegration process (Blevins, Rocca, & Spencer, 2011; Gibbs et al., 2012; Knobloch et al., 2013), and part of the contextual lens of this study. When military personnel are discharged, they have a variety of physical, and psychological problems (Danish & Antonides, 2010), which in combination with the shock of returning to civilian life can, in many cases, develop into a need for help adjusting (Marek & D'Aniello, 2014), for the individual and for family members (Gibbs et al., 2012; Knobloch et al., 2013). Sometimes there is physical damage to contend with.

Physical damage from combat may require adjustments for the entire family (Gibbs et al., 2012; Knobloch et al., 2013), including medical treatment (Sayer et al., 2014), reduced or limited income (Sayer, Noorbaloochi, Frazier, Carlson, & Gravely, 2010), or logistics coordination (Sayers, 2011). Psychological damage can require hospital or doctor visits (Sayers et al., 2009). There may be anger management problems (Theiss & Knobloch, 2013), along with loss of stability (Theiss & Knobloch, 2013), and possible jeopardized intimacy (Theiss & Knobloch, 2013). These issues can contribute to an individual's reintegration problems. The individual can experience social and cultural

shock when returning to civilian life (Adler et al., 2011; Knobloch et al., 2013), due to loss of military aspects of life such as regimentation, chain of command, comradery with fellow personnel, and financial security (Hinojosa & Hinojosa, 2011). These problems, situations, or conditions affect and are affected by individual perceptions of day-to-day life as they knew it to be in the military, such as resilience.

A major feature of the day-to-day military life is the military training for resilience, and the attitude that is inherently part of the life style in the military culture: *No matter what comes up, my training has prepared me to successfully handle it* (Bowles & Bates, 2010). This attitude permeates the whole of military life (Bowles & Bates, 2010), due in part to the masculine ideology in the military culture (Braswell & Kushner, 2012), which among other things, influences the individual to suppress the need for help to adjust to civilian life (Danish & Antonides, 2013). Beyond this, the individual must relearn the common, but forgotten aspects of civilian life.

Upon discharge, the individual is faced with the shock of nearly forgotten civilian goals and skills to succeed as a spouse, a parent, a friend (to nonmilitary people), and a co-worker, often with people who do not know what he has experienced in the military, nor the problems and frustrations he might be experiencing, as he tries to return to civilian life. While in the military, he/she saw himself/herself as part of a highly trained and respected war machine, and after discharge, he/she sees himself/herself as a less than successful individual trying to fit into civilian life (Danish & Antonides, 2013). This frustration and disappointment affect and are affected by military culture stigma.

As described previously, military culture stigma and the accompanying masculine ideology (Braswell & Kushner, 2012) can influence individuals to postpone or terminate treatment/training early for reintegration problems (Pietrzak et al., 2009; Sirey et al., 2001). The veteran may not get the help he/she needs to reintegrate successfully because he/she does not feel safe talking about his/her problems and may be worried that fellow military personnel may discover his/her need for help (Ben-Zeev et al., 2012). Marital problems or other reintegration problems can increase. Searching for employment can be frustrating and demoralizing, and the feeling that no one understands can be pervasive (Russell, Butkus, & Figley, 2016), which is only a small part of the over-all reintegration dynamic.

The contextual lens, and these elements that make up the lens, are discussed further in Chapter 2. Stigma, the shock of returning to civilian life, physical and mental health problems, and the need for reintegration treatment/training are all intertwined and may affect reintegration success. All of these examples of reintegration issues comprise the contextual lens, through which this study sought to understand what the attitudes of veterans and military personnel might be toward care seeking prior to discharge with respect to lack of anonymity or privacy and the elements they desire to be included in reintegration treatment/training. It became clear that a specific research design and plan would best partner with the contextual lens, and best suit a desire for a deep understanding of veteran and military attitudes regarding the phenomenon of interest: a qualitative case study design. The nature of the study was designed with this plan to

procure an in-depth understanding of attitudes toward care seeking prior to discharge with respect to lack of anonymity or privacy.

Nature of This Study

As mentioned, the qualitative design for this study was aimed at describing and interpreting the phenomena of veteran and military personnel attitudes toward care seeking prior to discharge with respect to lack of anonymity or privacy and what elements veterans and military personnel desire to be included in reintegration treatment/training programs. I chose a research design with these phenomena in mind.

Rationale for Design

A qualitative case study questionnaire with open-ended questions, and follow-up interviews, also with open-ended questions were chosen for this study. This design was appropriate because it allowed for a deep understanding of the attitudes of veterans and military personnel toward care seeking prior to discharge, with respect to lack of anonymity or privacy and what elements they desired in reintegration treatment/training. This case study design, along with a qualitative thematic analysis, was appropriate because the desire was to gain an in-depth understanding of the attitudes toward seeking help, while watching for reference to lack of anonymity or privacy. A thematic analysis allowed for identifying patterns and themes without beginning the analysis with preconceived categories or concepts (Patton, 2015, p. 551).

Key Phenomenon

The main phenomenon of interest was the attitudes of participants regarding care seeking prior to discharge, looking for references to the lack of anonymity or privacy. A phenomenon that was also measured was the stated desires of elements to be included in any reintegration treatment/training program for reintegration success. Although participants were asked in the follow-up interview (of open-ended questions) about anonymity or privacy, the survey questions, while open ended and subject to many different answer avenues, did not specifically address lack of anonymity or privacy, in order to see if participants mentioned these concepts survey answers. A summary of the methodology follows but is explained in depth in Chapter 3.

Description of Methodology

Veterans and military personnel were recruited to participate via an ad on Facebook, along with possible veteran or active duty personnel from Walden University participant pool. Participants were asked to answer a short survey questionnaire, with open-ended questions and take part in a short follow-up interview, either via email on the phone. The answers were evaluated for themes and an analysis was developed that described the attitudes (related to their lived experiences) of participants (Astalin, 2013, p. 122). The reader is again encouraged to view the Flow Chart of Military Life and Unknown Attitudes Toward Care Seeking (Appendix A). Beyond the conceptual context, there were several definitions that I needed to clarify, and these definitions were developed based on the connection with military personnel and the military culture-way of life.

Definitions

Definitions include those for reintegration, reintegration treatment, military culture, stigma, military culture stigma, masculine ideology, and the concept of anonymity during treatment/training. The following definitions are presented in the military context and concepts that relate to life outside the military culture are not explained.

Reintegration: Reintegration is the process of leaving the military, returning to civilian life, and becoming a productive part of society, engaged in family and social activities and institutions (Ben-Zeev et al., 2012). Reintegration programs mentioned in this proposal refer to training for specific problems encountered during reintegration attempts, such as intimate relationships, communication problems, job seeking difficulties, or education prospects.

Reintegration treatment/training (Bowling & Sherman, 2008; Danish & Antonides, 2013): This refers to treatment/training for specific medical problems (not to be confused with the standard reintegration civilian orientation offered in all branches of the military prior to discharge). This treatment/training would be for specific medical problems such as PTSD or depression, or for physical injury.

Military culture: This is a set of beliefs, values, customs, traditions, and expected behaviors, reflected in rank, regulations, lifestyles, and behaviors (Gibbons et al., 2014) and includes expected obedience, service, never failing, or quitting (p. 368). Military culture is pervasive and extends to all parts of the military person's life.

Stigma: This is the social processes of labeling, stereotyping, cognitive separation, and emotional reactions, and is evident in the outcome of being made to feel set apart (Link & Phelan 2001). Stigma is pervasive in the military culture.

Military culture stigma: This is a dynamic process by which the military person internalizes a marked identity in the context which the person resides in, the military culture (Acosta et al., 2014, p. 8), which is partnered with the masculine ideology (Braswell & Kushner, 2012). Since it is common knowledge that medical records are open to superiors, it is not likely that military personnel can escape being affected by military culture stigma. This model includes a conceptualization of stigma as a staged process: stage 1: stigmatization (symptoms, emotional distress, or receiving a diagnosis), stage 2: these cues elicit negative beliefs and stereotyping, and stage 3: people indorse the stereotypes and stimulate a negative emotion, which leads to discrimination (Ben-Zeev et al., 2012). The outcome of military culture stigma is that inherent in seeking care is the knowledge that the individual will be viewed as weak and 'marked' as not normal (Acosta et al., 2014, p. 12), and may expect to lose standing and respect from peers.

Masculine ideology: With regards to masculine ideology in the military, which is characterized as excessive social integration into every aspect of the military person's life (Braswell & Kushner, 2012), and based on the concept of complete emotional control by the individual (Hockey, 2003), masculine ideology in the military culture has been called the *cementing principle* (Harrison, 2003, p. 75). And, paramount to the understanding of masculine ideology in the military culture is the concept that is drilled into every

individual: A soldier is expendable (Gilmore, 1990, p. 12), which can produce an overriding influence to deny symptoms (p. 12).

The concept of anonymity during treatment: This refers to a hypothetical opportunity for anonymity during treatment for medical problems for veterans and military personnel, which may avoid the effects of stigma attached to seeking care.

Assumptions

Certain assumptions about the effects of stigma and the masculine ideology were critical to this study. A simple assumption that should be mentioned is that anyone who does not have experience in the military would not understand the concepts and would not seek to take part in this study. It was important to clarify the assumptions about military culture stigma.

Assumptions Critical to the Meaningfulness of the Study

Stigma (Ben-Zeev et al., 2012) and accompanying masculine ideology (Braswell & Kushner, 2012) in the military culture influences the individual to avoid treatment or care seeking for reintegration success (Ben-Zeev et al., 2012; Hoge et al., 2004; Pietrzak et al., 2009; Rodrigues et al., 2014), or to terminate treatment early (Sirey et al., 2001). Keeping this in mind served to view questions about care seeking prior to discharge with trepidation due to the fear of being stigmatized and the prospect of loss of anonymity. For this reason, participant bias may reflect less an answer based on objectivity and more a desire for a new opportunity to access care.

Stigma in the military culture persists, in spite the of military efforts to reduce it (Dingfelder, 2009; Herrera-Yee, 2015; Schreiber & McEnany, 2015). Multiple efforts

have not succeeded in reducing stigma, which may produce a negative attitude toward another new program that may be viewed as *not likely to offer relief from stigma*. This may be due, in part, to the masculine ideology (Braswell & Kushner, 2012), which along with military culture stigma (Schreiber & McEnany, 2015), was discussed further in chapter two, under conceptual framework. A very complete explanation regarding the reason for this study included a desire to discover participant attitudes toward the prospect of care seeking prior to discharge for medical problems (mental health and physical damage) while paying attention to attitudes reflected in answers that suggested a desire for anonymity and their desires for elements to be included in reintegration treatment/training programs for reintegration success.

Stigma in the military culture is stronger and more influential than stigma in civilian life (Link & Phelan, 2001; Srinivasan, 2012). Although obvious to any military person, what is not obvious to non-military individuals, is the extent to which the military-culture-influence extends to every aspect of the individual's life (Theiss & Knobloch, 2013). This was kept in mind when wording the research questions, and the questions were stated in several worded forms to ensure sensitivity to the military mind-frame, and perspective. These assumptions were important to keep in mind because the nature of the military culture, which extends to every aspect of the individual's life, required that this population be viewed as a unique subculture with specific customs, beliefs, values, and sense of community, which actively maintains these parameters that serve to distinguish it from the larger culture in which the individual lives.

This is evident in one last assumption: It was assumed that any individual willing to participate in this study would have past or current military service, or there would be no interest in participating. Hence no proof of military service was required to participate. The military culture is so different from civilian life that the concept of objectivity in responses to the survey questionnaire and the follow-up interview may not be possible, and where that was revealed to be the case, these issues were discussed as a limitation or a delimitation, and considered when defining and reporting the scope of the study.

Scope and Delimitations

The phenomena addressed in this study were the attitudes of veterans and military personnel toward care seeking prior to discharge, for medical (mental health and physical injury) problems with respect to the lack of anonymity or privacy, and the elements they desired to be included in reintegration treatment/training. The following paragraphs explain the aspects of the research problem studied, the boundaries of the study, and potential transferability.

Aspects of the Research Problem Addressed in the Study

This focus was chosen for several reasons. Because it has been suggested that technology and privacy (Dingfelder, 2009) may be the best route to reducing the effects of stigma attached to treatment/training seeking, it became of interest what personnel (current or past) thought about stigma and treatment seeking. It was also important what personnel hoped for in any reintegration treatment/training, thinking that might shed light on problems they anticipated. In summary, it was determined advantageous to understand what the attitudes toward care seeking prior to discharge with respect to the lack of

anonymity or privacy might be, and what elements they desire to be in reintegration treatment/training.

Boundaries

Participants (both male and female) were recruited via an ad on Facebook, and from the Walden University Participant Pool. Past or current military service and the age of at least 18 years old were the only criteria for participation. Veterans and military personnel who do not use Facebook or would not be able to go into the participant pool, were not represented in this study.

Although most studies concerning veterans and military personnel revolve around or include suicidal behaviors and suicide prevention (Meredith et al., 2011; Weinik et al., 2011), that subject was not addressed in this study, unless it became a theme by inclusion in answers to the open-ended questions. Veterans and military personnel who do not use the website Facebook or are not a student or faculty at Walden University were not be included in this study. This study may have produced increased frustration regarding stigma in the military culture toward care seeking, which may have presented a limitation. Participants were furnished with resources to deal with frustration and other problems. This is discussed further in chapter five.

In summary, past or current military personnel (males and females), who were at least 18 years old, who answered the ad on Facebook for participants or went to Walden University participant pool, were accepted as participants in this study. Therefore, the boundaries of this study included: any and all veterans and military personnel who responded to an ad on Facebook or volunteered to participate via the participant pool, and

who had been in the military were included in the study. Those who have been in the military, but do not respond to the Facebook ad or the participant pool, for various reasons such as they do not have a computer, will not be participating. Veterans and military personnel who do not use Facebook (and cannot see the ad) or are not students or faculty at Walden University, will not be included in this study. Participants had to be at least 18 years old, but beyond that, age was not a boundary nor was gender. There were conceptual frameworks that were not directly addressed, such as suicide; this study addressed only the theories behind stigma, stigma in the military culture, the effects of stigma on care seeking prior to discharge, and what elements they desire to be included in reintegration treatment/training.

Potential Transferability

Potential transferability included the transfer of new levels of confidence gained through taking part in a study looking at their attitudes toward care seeking, or a study inquiring what elements they think should be part of reintegration treatment/training. It was possible that with the knowledge of the prospect of such training, veterans and military personnel might gain confidence and positive attitudes toward seeking care or mental health treatment. There was a possibility of bias, in as much as it was expected that there would be positive attitudes toward a study seeking expression of their attitudes in their own words. This bias may have also posed a limitation.

Limitations

It is difficult to remove all biases toward the military culture tradition and structure that resists change and effects on individuals who need care, and aids in the

persistence of military culture stigma. Discussed herein are design limitations and biases, along with the efforts to reduce them.

Limitations Related to Design

Recruiting participants via social media excluded those who may not use social media, such as rural veterans, and older veterans and indirectly excluded those who do not use Facebook and are not participants in the Walden University Participant Pool. Therefore, data collected may not have reflected attitudes of all groups of veterans and military personnel.

Another issue that may have posed a limitation (or delimitation) is veteran and military personnel suicide. While a major part of current military research efforts, it was not be directly addressed. These considerations will be discussed further in chapter three, while the significance of this study may include positive social change, and a revelation that veterans and military personnel have positive attitudes about treatment/training for medical problems that allows anonymity.

Methodological Weakness

A qualitative design is the best choice of design for evaluating attitudes, yet it allows for misinterpretation of themes, and poor coding. Using peer-researchers to evaluate coding and themes will help reduce weaknesses. Although research (Weinik et al., 2011) does not show any gender differences regarding military or veteran attitudes toward care seeking, not including gender differences may have been a weakness. Also, although research (Hoge et al., 2004; McGlinchey et al., 2014) does not show attitudes toward care seeking to be measurably different across age (and subsequent military

arena), this may have posed a weakness. These differences may have also posed a specific limitation to transferability.

Limitations of Transferability

Since participants from the Vietnam era (for instance) expressed attitudes less negative (regarding care seeking) than those who served in Desert Storm, it might have been due to a prevailing philosophy among these early veterans that was indicative of the sixties: personnel do not criticize the government. Whereas personnel of today, may have less hesitance to express discord with the government and the VA. In other words, these differences could be due more to the socio-cultural times than levels of dissatisfaction. This also reflects on the limitations of dependability

Limitations of Dependability

The same aspect of open-ended questions that allowed a wide variety of interpretation to answers also allowed for a wide interpretation of question meaning. This was addressed by simplifying the wording of questions, and by wording questions in more than one way. The follow-up interview also reduced the possibility of participants misunderstanding the focus of a question, by again asking the same questions in different forms. The meaning of a participant's responses may have changed with further explanation during the follow-up interview. Still, biases could have crept into the survey protocol via misunderstanding.

Limitations of Biases

Personal bias may have crept into analysis and measures were taken to reduce biases, such as outside monitoring and research center evaluations. More important to the

development of accurate themes were the efforts to understand the meaning and use of specific words contained in answers. Not having a military background, it is possible that I may have missed the true meaning of a response simply because a term was unfamiliar. A colleague (who does have military experience) was recruited to review answers randomly to evaluate understanding of terminology. These efforts aimed at reducing bias, and other weaknesses also served to reveal significance.

Significance

There are potential contributions of this study to the discipline of psychology. And there are potential contributions that may advance practice, and there are implications for positive social change. The contribution of this study is important, as it addresses the lack of anonymity or privacy while care seeking prior to discharge, and the attitudes personnel and veterans might have about that, given the established (see Acosta et al., 2014; Ben-Zeev et al., 2012; Gibbons et al., 2014; Green-Shortridge et al., 2007) theory that care seeking avoidance is due in a large part to the lack of anonymity or privacy in the military culture. Participants in multiple studies (Blevins et al., 2011; Dickstein et al., 2010; Gibbs et al., 2012) have reported a desire for anonymity. Potential contributions are addressed in the following paragraphs.

Potential Contributions That Advance the Discipline

There are multiple avenues by which this study may advance the field of psychology. The problem of unknown attitudes of veterans and military personnel regarding care seeking prior to discharge, with respect to lack of anonymity or privacy is the focus of this study, but there were` other contributions revealed. For instance, this

study revealed what the participants felt about concepts such as shame felt when seeking care or dissatisfaction with the VA in general. This study also revealed what the participants felt should be included in reintegration treatment/training programs.

Potential Contributions for Positive Social Change

The findings from this study may be the catalyst for the military to implement reintegration treatment/training that is more sensitive to the shame felt when care seeking. Programs that offer treatment via the Internet, may see the evidence of positive attitudes as inspiration to make Internet-based treatment anonymous.

Practice may be advanced if care professionals offer treatment/training in a forum that allows the individual to remain anonymous, and more individuals may seek care if they can avoid the stigma attached to care seeking. Positive social change might include a new approach to treatment/training that allows individuals to remain anonymous and avoid the effects of stigma during medical treatment/training for reintegration. Positive social change may include new insights into what elements these populations desire in reintegration treatment.

Summary

Stigma (Ben-Zeev et al., 2012) and accompanying masculine ideology (Braswell & Kushner, 2012) in the military culture toward care seeking or reintegration treatment/training is debilitating (Ben-Zeev et al., 2012; Hipes et al., 2015). In the military culture care seeking is viewed as a sign of weakness (Harris et al., 2015), and stigma persists (Marek & D'Aniello, 2014; Sayer et al., 2014) regardless of military efforts to reduce it (Dingfelder, 2009; Herrera-Yee, 2015).

Reintegration treatment/training for specific problems with some anonymity, has been offered (Denning et al., 2014) via the Internet (Allen et al., 2013; Klee et al., 2016), yet no military program has offered the opportunity of anonymity during treatment/training for medical problems prior to discharge, to avoid the effects of stigma (Dickstein et al., 2010). Stigma in the military culture has been shown to be more pervasive and debilitating than stigma in civilian life (Harris et al., 2015; Herrera-Yee, 2015). In the military culture, stigma has been resistant to efforts to reduce it (Rodrigues et al., 2014). Treatment or training programs offered via the Internet have successfully helped non-military individuals (Bowman et al., 2014; Carlbring et al., 2006; Einhorn et al., 2008; Schifferdecker et al., 2012). There has been a call for increased efforts to offer treatment via the Internet for veterans and military personnel (Dingfelder, 2009). Yet, it is unknown what veterans and military personnel think about care seeking prior to discharge with regards to lack of anonymity or privacy, or what elements personnel desire in treatment/training programs

I addressed the phenomenon of unknown attitudes toward care seeking prior to discharge with respect to lack of anonymity or privacy, and what elements are desired in a reintegration treatment/training program. This study will add to the knowledge base by providing an understanding of the attitudes of veterans and military personnel toward care seeking and toward what they desire to be included in reintegration preparedness, and possibly point to a new avenue for service delivery. Prior to implementing this study, it was necessary to understand what efforts had already been made toward understanding attitudes regarding care seeking for medical problems and what elements might be

desired in reintegration programs, therefore, a literature review was the prerequisite next step.

Chapter 2: Literature Review

Introduction

Veterans and military personnel often need help to successfully reintegrate into civilian life (Denning et al., 2004). The enduring problem of stigma in the military culture may pose a barrier to care seeking prior to discharge (Ben-Zeev et al., 2012) and because no reintegration treatment/training prior to discharge offers anonymity or privacy (Weinick et al., 2011), and because no study (Meredith et al., 2011; Weinick et al., 2011) has addressed the attitudes of veterans and military personnel regarding the elements they desire to be included in reintegration treatment/training, there were the phenomena of interest for this study. Multiple programs (Meredith et al., 2011; Weinik et al., 2011) are aimed at all aspects of reintegration, and multiple programs (Dingfelder, 2009; Herrera-Yee, 2015; Iverson et al., 2011; Rodrigues et al., 2014; Schreiber & McEnany, 2015; Vogt et al., 2014) are aimed at reducing the effects of stigma toward care seeking prior to discharge in the military culture (Acosta et al., 2014). Veterans and military personnel about to discharge may avoid seeking help with reintegration problems due to the stigma in the military culture attached to care seeking (Ben-Zeev et al., 2012; Harris et al., 2015).

It is unknown what the attitudes of these populations might be regarding treatment/training for medical (physical and mental health) problems, prior to discharge and what elements they desire to be included in reintegration programs. These unknown attitudes were the phenomena of interest and the purpose of this study.

The purpose of this case study was to identify and interpret the attitudes of veterans and military personnel toward care seeking prior to discharge and to discover what elements they desire to be included in reintegration programs. The intent was to describe the attitudes toward care seeking and to describe a consensus of the desires of these populations to regarding elements they think should be included in reintegration training. The literature revealed some insights regarding attitudes of military personnel toward care seeking prior to discharge in the military culture and the effects on reintegration success.

Literature Synopsis and Preview of Chapter 2

The literature shows that military life is unique (Hall, 2011) and reintegration is a complicated process (Knobloch et al., 2013). Military personnel often need help with reintegration medical problems (Danish & Antonides, 2013; Marek & D'Aniello, 2014; Sayer et al., 2014; Sayers, 2011), especially if they have physical wounds (Gerber, 1994) or mental health problems that were initiated by combat or are related to combat (Rodrigues et al., 2014). Again, the reader is encouraged to view the Flowchart of Military Life and Unknown Attitudes Toward Care Seeking (Appendix A) to understand the complicated relationship between all the parameters involved in this study. I felt it was important to understand that in the military culture, military regulations, beliefs, attitudes and social structure, accompanied by the masculine ideology (Braswell & Kushner, 2012), permeates all aspects of life (Hall, 2011), which often influences military personnel and veterans to delay care seeking due to stigma in the military culture attached to seeking care, or asking for help (Gibbons et al., 2014). Some reintegrating individuals

may have a combination of problems (Sayer et al., 2010), such as PTSD (Hipes et al., 2015) or depression (Rodrigues et al., 2014) in combination with social problems such as marital discord (Gibbs et al., 2012). Addressing these problems is hampered by stigma in the military culture. Asking for help or care seeking is viewed as a sign of weakness which is an ongoing and persistent problem (Schreiber & McEnany, 2015), regardless of the multiple programs in the military aimed at reducing stigma (Herrera-Yee, 2015). A reintegration treatment/training program that offers individuals anonymity or privacy to avoid the effects of stigma may be a way to get help for problems during reintegration while avoiding stigma attached to care seeking (Schreiber & McEnany, 2015). Discussed in depth in this chapter are studies regarding these issues, followed by the theoretical foundation, the conceptual framework, the literature review for qualitative studies of measuring attitudes, stigma in the military culture and reintegration programs, all of which began with an intensive literature search.

Literature Search Strategy

I searched multiple databases in preparation for this proposal dissertation. Discussed in the following paragraphs are the databases, the key words and combination of words, and the iterative process.

Databases

I viewed a database search via a university library system as going in the front door of a warehouse and looking for something that might be a solution to a problem. One must take several paths to find all of what might be available. Using the Walden University Library, I searched the following databases: PsyINFO, PsyARTICLES,

SocINDEX, Sage Premier, Medline, and PRO Quest Central. When searching a topic or key term, I established a protocol for each database and search term combination and kept a ledger of these methods. For instance, for a variable such as "theory of stigma," I searched PsycINFO with the terms *stigma, theory of stigma, stigma in the military, stigma in the military culture,* and *theory of stigma in military life*. Each search revealed slightly different results. I then proceeded to do the same with other databases until there were basically only duplicated results forthcoming. I then turned to another approach.

I viewed using Google Scholar like using a backdoor (of the warehouse) for researching articles: Looking for articles this way can give a narrower set of results, or a fantastically broad set of results, depending on the search terms used. Although it is possible to specify a year, results one gets are often representative of a wide expanse of years. To supplement with articles for stigma, I used Google Scholar and the key terms: stigma, stigma 2014, stigma 2015, theory of stigma 2014, theory of stigma 2015, theory of stigma 2016, and others. I continued in this manner until I felt I had all or most of the articles on the subject available and moved on to the search for articles regarding my proposal methodology. When searching for articles regarding a qualitative study, measuring attitudes, I used basically the same procedure as mentioned above, plus I also used Sage Research Methods Online. For these searches, it was necessary to use multiple combinations of terms, and key search terms.

Key Search Terms and Iterative Process

For the topic of military life, key terms included *military life, military culture, military life and programs, military culture and programs, military life and Internet-*

based programs, military culture and Internet-based programs, military life and reintegration, and *military culture and reintegration*. For the topic of reintegration, key terms included *reintegration, reintegration programs, reintegration and family, reintegration tools or measurement, reintegration and mental health,* and *reintegration and mental illness*. For the topic of stigma, key terms included *stigma, theory of stigma, stigma in the military, stigma in the military life, stigma in the military culture, stigma and treatment, stigma and treatment termination, reduction of stigma, stigma and treatment avoidance,* and *reduction of stigma in the military*.

I searched through all the databases listed previously in the same manner as stated above using Google Scholar. Using Google Scholar, I combined sets of terms for a more specific topic search, such as: suggestions for future research in the military, suggestions for future treatments in the military, suggestions for future research in the military culture, suggestions for future stigma reduction in the military, future research regarding military stigma, future research regarding reintegration, and future research regarding stigma and treatment. I also used: what the American Psychological Association suggests regarding stigma, what the American Psychological Association suggests regarding reintegration, and what the American Psychological Association suggests regarding reducing stigma.

I continued in this manner until I began to receive duplications. The literature searches have garnered me nearly 200 articles. I continued to do an updated search every three months, usually in the first week of a new semester, searching only in the current

year. Chief among the acquired resources, were several articles that examined established theories and some that suggested new, or lesser established, theories.

Theoretical Foundation

This study involved the application of several theories: the theory of military culture, the theory of stigma and the theory of stigma in the military culture. The theoretical foundation was, therefore, complicated and it was necessary to understand and keep in mind that the nature of military life, military culture, stigma, and stigma in the military culture include a unique set of assumptions and propositions (see Appendix A). These tenets drove the theoretical foundation for this study and had to be examined and understood at the onset, particularly the concept of the military culture.

Theory of Military Culture

Military culture is first, a system of beliefs, some written and some simply understood, and includes values, language, customs, traditions, and notably, expected behaviors (Hall, 2011). Expected behaviors are evidenced in rank, structure, regulations, social groups, and lifestyles (Gibbons et al., 2014). Identity is shaped by indoctrination, creeds, and culture, which promote core values of integrity, service before self, and excellence in every task (Rondeau, 2011). Military identity is closely tied to the military spirit of never failing or quitting, mission first, never leaving another member behind, and professional pride (Gibbons et al., 2014). Another aspect that is important to keep in mind is the masculine ideology in the military culture, which is driven by excessive integration into every aspect of the military person's life (Braswell & Kushner, 2012), and based on the concept of complete emotional control (Hockey, 2003). The concept

and theory of military culture is discussed further in the literature review of this chapter. Bearing in mind the basic assumptions of military culture, allowed a more realistic view of stigma in the military culture and the power of stigma to impede care seeking and reintegration success and acquisition of quality of life, it became obvious to me I needed to research next, the theory of stigma.

Theory of Stigma

The concept of stigma includes the negative social attitude or connotation attached to a characteristic of an individual that is regarded in general as having a (mental, physical, or social) deficiency (Goffman, 1963). For the individual it is the understanding of being set apart or seen as not up to standard, that impairs the individual's successful inclusion in the social structure, all based more or less on a person's feelings about himself and his relationship with people accepted as normal (Goffman, 1963). Discussed further in the literature review of this chapter, stigma is described as the co-occurrence of its components: labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001).

However, it is the essence of being a discounted person (Goffman, 1963, p. 3) that marks the person and leads to devaluing, making any escape from stereotyping due to sociocultural environments, nearly impossible (Yang et al., 2007). Stigma is self-perpetuating, debilitating, and destructive to the individual's psyche (Corrigan, 2004; Drapalski et al., 2013; Link & Phelan, 2001; Yang et al., 2007). In the military culture context, stigma can negatively affect the individual's ability to seek care and to

reintegrate successfully into civilian society (Ben-Zeev et al., 2012), based primarily on elements unique to military culture and stigma.

Theory of Stigma in the Military Culture

The theory of stigma in the military culture and the theory of stigma in civilian society are similar, yet different. Mental health stigma is a particularly powerful deterrent to care seeking (Dickstein et al., 2010; Slone, Friedman, Southwick, Stecker, & Washam, 2008; Zinzow et al., 2013). There are pervasive concerns regarding social consequences of using V. A. services for mental health problems and even for physical disabilities (Vogt et al., 2014).

At the base of it all is the idea that all of military training is aimed at crushing any sign of weakness (Srinivasan, 2012), a concept that is part of the masculine ideology in the military culture (Braswell & Kushner, 2012), any service use for mental health problems is seen as evidence of weakness (Dickstein et al., 2010; Harris et al., 2015; Nash et al., 2009), causing many to live with treatable psychopathology (Vogt, 2014). It has been shown that delay of treatment can increase the impact of depression (Rodrigues et al., 2014) and PTSD (Hipes et al., 2015). Since the military culture extends to every aspect of life for the individual, stigma is part of the service person's military education and orientation (Gibbons et al., 2014), and ultimately the problem is deepened due to tensions between the need for individual privacy and the need for commanders to assess unit and individual fitness, by having access to all personnel medical records (Acosta et al., 2014). Discussed further in the literature review of this chapter, military culture stigma and the accompanying masculine ideology (Braswell & Kushner, 2012) in the

military culture is pervasive, influencing personal identity, psychological health, and community and organizational functioning (Gibbons et al., 2014). Military culture stigma is strong, pervasive, and drives the conceptual framework.

Conceptual Framework

The phenomenon of interest for this study was the unknown attitudes of veterans and military personnel toward care seeking prior to discharge, for medical problems, and what elements they mentioned were their desires to be included in reintegration training. As mentioned in chapter one, the contextual lens was complicated and consists of three integrated and mutually dependent elements: the day-to-day military life and culture, military culture stigma, and the residual effects of experiences in a combat zone, and, for those reintegrating, a whole new set of civilian-life stressors.

Key Concept: Shock of Returning to Civilian Life

Mentioned previously, returning personnel and new veterans have experienced a culture shock trying to reintegrate into civilian life (Marek & D'Aniello, 2014). Reintegrating personnel are disoriented; there may be a conflicting tension between the still active military identity and the impending civilian identity (Koenig et al., 2014). The returning individual has what she/he sees as a *new assignment* (reintegrating into civilian life) which he/she might be inclined to attack with the same fervor as previous military assignments. This while family members, who have learned to function without the military person who was on assignment, have difficulty adjusting to the person's reintegration (Gibbs et al., 2012). Bowling and Sherman (2008) reported that there are four main tasks facing returning personnel: 1. redefining roles and expectations and

deciding division of labor in the family, 2. managing strong emotions, 3. creating intimacy in relationships, and 4. creating shared meanings with family members and friends (p. 451). Some returning personnel see the partner's more laid-back approach as interfering with the process (Knobloch et al., 2013; Theiss & Knobloch, 2013). Relearning to communicate with family may be the most important first step (Doyle & Peterson, 2005), before tackling the unique set of stressors that affect all aspects of the experiences of returning to civilian life.

Key Concept: Military Life

Just as the military life extends to every aspect of the individual's life, so too does the re-adjustment to civilian life (Doyle & Peterson, 2005). The disorienting aspects of returning to family can be debilitating (Marek & D'Aniello, 2014). Besides that, returning to the status quo may *not* be possible (Marek & D'Aniello, 2014) because too much has changed in the family compared to before deployment. Due, in part to, long separations (Marek & D'Aniello, 2014), a returning individual finds he/she does not have a clear idea of his/her place in the family or the community (Bowling & Sherman, 2008). There are the losses: loss of structure and regimentation (Gibbons et al, 2014), loss of clear-cut system of beliefs, values, and customs (Gibbons et al., 2014), loss of income stability (Greden et al., 2010), loss of immediate and available medical help (Koenig et al., 2014) and loss of comradery and support (Marek & D'Aniello, 2014). There is often psychological and physical damage incurred from serving in a combat zone (Sayer et al., 2014). The individual may find himself/herself in physical pain, experiencing unwanted thoughts and dreams, trying to fit into a family that has learned to function without

him/her, possibly in need of medical and psychological care, having reduced income, and feeling that no one in his/her current (civilian) environment understands what he/she is going through, while all he/she really wants is for someone to tell him/her what to do, or what his/her role is (Marek & D'Aniello, 2014). It is in this environment of confusion the individual also faces relentless stigma attached to asking for help (Marek & D'Aniello, 2014).

Key Concept: Stigma in the Military Culture

Stigma, in the military culture, toward care seeking begins with the *take charge* approach and *show no fear* attitude that is an integral part of military readiness training and the combat perspective (Sayer et al., 2014) and stems in part from the masculine ideology that calls for total emotional control (Hockey, 2003). Masculine ideology is a concept that has been called the "cementing principle" in the military culture (Harrison, 2003, p. 75). As mentioned, it includes the concept of emotional control (Hockey, 2003), the concept of a soldier's expendability (Gilmore, 1990, p. 121), and an over-riding influence to deny symptoms of PTSD or other mental health or physical problems (Whitworth, 2008, p. 109). The masculine ideology cannot be ignored when considering stigma in the military culture. There are other contexts to consider when trying to understand stigma in the military culture.

Acosta et al., (2014) reported that stigma in the military culture is a dynamic process by which the person perceives and internalizes a marked identity about himself/herself. It is an interaction between the service member and the key contexts the service member resides in, whether serving on a Naval carrier, flying a jet, or training

local military in a foreign country. These key contexts can be considered in general as the public context (how he/she perceives he/she is viewed as a member (or former member) of the most elite fighting force on Earth), the individual context (with his/her set of symptoms and individual idiosyncrasies), and the social context which is how he/she is viewed by cohorts and family that he/she interacts with daily (Acosta et al., 2014). In this respect, stigma influences personal identity, psychological health, and community/organizational fit (Gibbons et al., 2014). Because stigma is so pervasive in the military culture, it can contribute to cultural shock when reintegration begins (Adler et al., 2011), which in turn negatively affects other life processes, and may influence the individual to postpone or terminate treatment early (Pietrzak et al., 2009). The individual is left with an over-riding feeling that no one understands what he/she is going through (Russell et al., 2016). It is this environment of confusion about reintegration, lingering stigma beliefs and effects, training governed by the masculine ideology, and cultural shock that I sought to study veteran and military personnel attitudes toward care seeking prior to discharge for medical problems with respect to lack of anonymity or privacy, and to discover what they desire to be included in reintegration treatment/training programs. Military culture stigma and reintegration training will be discussed further in the literature review of this chapter, along with reintegration problems.

Reintegration problems have a combined root-cause, including military training and military culture, reintegration shock, and military culture stigma. Reintegration difficulty is not the product of a linear set of events, but a complicated process with influential elements ranging from military structure and military culture tenets, to military

training, combat, age and era of combat, physical and psychological trauma, family structure and, perhaps more than anything, reintegration shock. The reader is again encouraged to couple reading this chapter with viewing the Flowchart of Military Life and Unknown Attitudes Toward Care Seeking (Appendix A). In order to gain an in-depth understanding of the veteran reintegration burden and the effects of stigma, it was first necessary to explore in depth these elements in the literature

Literature Review

The following paragraphs discuss the many research studies relevant to this qualitative case study: Reintegration, stigma, stigma in the military culture. There are many such studies in these categories; mentioned here are the major or definitive studies.

Military Culture

As mentioned previously, military culture is a system of beliefs that includes values, language, customs, traditions, and notably, expected behaviors (Hall, 2011). Expected behaviors are evidenced in rank structure, regulations, social groups, and lifestyles (Gibbons et al., 2014). Identity is shaped by indoctrination during training and day-to-day life in the military. This includes written or unspoken creeds, and cultural expectations, which promote core values of integrity, service before self, and excellence in every task (Rondeau, 2011). The military identity is closely tied to the military spirit of never failing or quitting, mission first, never leaving another member behind, and professional pride (Gibbons et al., 2014). This is accompanied and influenced by the masculine ideology (Braswell & Kushner, 2012), which promotes emotional control (Hockey, 2003). In a review of the literature, Hall (2011) concluded that “it is important

for professionals to understand the unique culture of the military" (p. 5) and the stresses on the family in the military that include, long separations, and frequent moves (p. 5), along with the idea that some personnel may feel trapped (p. 5). These concepts begin with why individuals join the military.

Wertsch (1991) identified four main reasons people join the military: family tradition, benefits, identification with the warrior mentality, and as escape. Writing from her own experiences as a "military brat", Wertsch (1991) interviewed 80 American military personnel and is considered an expert on this branch of American culture. Family tradition is not simply following in the footsteps of those who came before the individual, but also about choosing a lifestyle the individual knows and understands (Hall, 2011, p. 6). If the individual grew up in a military family, the individual may realize they know truly little about life as a civilian (Hall, 2011, p. 6). Connected to joining the military due to family tradition is the incentive of the benefits package. Steady income, signing incentives, and other financial incentives encourage individuals to join the military, especially if they are from areas with few economic opportunities, or have no clear idea what they want to do with their lives and see the military as a transition (Hall, 2011, p. 6). The concept, of the *warrior identity* also plays a part in the decision to enlist.

The need to merge one's identity with that of the warrior (Wertsch, 1991, p. 17) includes the desire for the structure, rules, and expectations of the military and the reassuring security and sense of purpose (Hall, 2011, p. 7). Hall (2011), in a review of the literature, wrote that in many cultures, going to war is thee test of manhood, or combat is seen as a test of manhood and an effort to surpass the father's or brother's bravery by

going to war (Hall, 2011, p. 7). The identity of the *warrior* is reassuring to those who grew up in military families. Wertsch (1991) also stated that the military satisfies a need for some to escape from painful life situations, and into a more predictable life they did not have as a child (p. 17). The military becomes the surrogate family for the individual who did not experience security and predictability in their youth (Hall, 2011, p. 7), one of the misunderstood characteristics of the military culture.

Wertsch (1991) defined the military society as a "Fortress" (p. 15) and points out the paradox that "military members are the guardians of American democratic values, yet do not live in a democracy themselves" (p.15). Wertsch (1991) goes on to describe the characteristics of "living-the-fortress" concept she discovered during interviews with adults who had grown up in military families. These characteristics include: (a) authoritarian family structure, (b) isolation and alienation from friends and extended family, (c) class system with a gulf between enlisted personnel and officers, (d) parent absence, or fear of parent absence, (e) importance of mission above all needs of the family, and (f) preparation for eminent disaster. The authoritarian structure of the military culture extends into the structure of the family and home life (Wertsch, 1991, p. 25). She pointed out that, reflecting the military structure, the family structure can include: clear rules, with narrow boundaries for behavior and speech, little tolerance for questioning authority, frequent violations of privacy, while children are discouraged from activities that reflect individualism (Wertsch, 1991, p. 25). Children sometimes end up blaming the military for all their problems because they often do not have the 'freedom' they see other youth enjoying (Hall, 2008, p. 47). This can lead to multiple problems for youth

growing up in military families, and problems the family unit contends with, since 60% of military personnel have families (Drummet et al., 2003). Long deployments are problematic for the entire family.

Depending on whether one's country is in a war, deployments can mean long separations, but excluding war, deployments can mean the family might relocate with the service person (Marek & D'Aniello, 2014). This cycle of pre-deployment, deployment, post-deployment and reintegration, can cause difficulties for the whole family regarding emotional health, mental health, coping, adaptation, family bonds, and connectedness (Saltzman et al., 2011). Looking at data from a National Military Data collection, researchers (Marek & D'Aniello, 2014) also found strong relationships between PTSD and relationship problems, and when asked, service members ranked their partner's mental health as poor (p. 447), and this was important in the light of another, unusual element.

A surprising factor regarding family life in the military is evidence (Lundquist & Xu, 2014) that the military promotes marriage. Using in-depth interviews for life histories, to generate an understanding of life events and experiences, Lundquist and Xu (2014) found what they called the 'homesteading policies' of the military. Although this phenomenon may also stem from the advantageous compensation package and better housing benefits for married couples (Lundquist & Xu, 2014), Lundquist and Xu (2014) concluded that, the military is intrinsically structured to encourage early marriage among its recruits, because marriage helps the military to function more efficiently (p. 1076). This is reflected in a picture of marriage numbers more reminiscent of 1950's civilian life

(Lundquist & Xu, 2014, p. 1063). Therefore, early marriage coupled with immersion in a relocation cycle, along with common characteristics of the military culture "fortress" way of life, from authoritarian family structure to mission over family needs (Wertsch, 1991, p. 250) which contributes to an unstable and stressful family life.

As alluded to previously, family life stress, outside of combat, revolves around three main stressful experiences: relocation, separation, and reunion (Drummet et al., 2003). In a literature review to generate interest in evaluation of family life education programs, Drummet et al. (2003) found that families were not satisfied with relocation assistance (p. 280), and the children and youth in these families had a high level of psychopathology (p. 280), with the frequency of moves proving to be the most disruptive element (p. 280). Regarding separation, Drummet et al. (2003) reported that separations were the greatest source of dissatisfaction with military life (p. 281), and can be evidenced in 4 main problems: issues related to child care, relationship maintenance, boundary negotiations, and media coverage of military events (p. 281). Although one might think reunion is the solution to these problems, these authors (Drummet et al., 2014) also reported that reunion can be as challenging as the separation (p. 282). The problematic reunion factors include: Roles and boundaries, household management, honeymoon effects, little social support, parental rejection and accompanying anxiety, and the service member's physical and mental condition (p. 282). The military person, who may have gotten married too early, while trying, along with family members, to adapt to one of the relocation-reunion factors, also must consider a growing concern regarding the welfare of the children and youth in the family.

Two studies (Morris & Age, 2009; Palmer, 2008), highlight the growing problem of violence among military children. Morris and Age (2009) reported that violent military youth also had problems with PTSD and major depression (p. 695). Morris and Age (2009) also reported problems could include: anxiety, substance abuse, and conduct disorders (p. 695). In the second study, Palmer (2008) reported psychological and academic problems in military youth based on what they term as "the military family", which consists of an authoritarian father, a depressed mother, and out-of-control children (p. 205). Although aimed at a review of resilience programs, Palmer (2008) also reported risk factors for families to include: relocation (p. 206), PTSD (p. 207), deployment (p. 209), and reunion (p. 210). Therefore, military members, who may have gotten married too early, trying to adapt to some stage of relocation or reunion, with children who may have become out-of-control, face what Hall (2011) called a misconception in the worldview of their lives. All of these problems faced by families during relocation or reunion, along with complications of the masculine ideology in the military culture, served to influence my choice for research methods, especially since very few studies used interviews or questionnaires to directly assess the attitudes of service personnel or veterans toward care seeking prior to discharge with respect to the lack of anonymity or privacy.

Military Culture and Research Methods: Relevance to This Qualitative Case Study

Most studies were either literature reviews (Campbell et al., 2011; Drummet et al., 2003; Gibbons et al., 2014; Hall, 2011; Lundguist & Xu, 2014; MacLean & Edler, 2007; Morris & Age, 2009; Palmer, 2008), or records and data set searches (Lucier-

Greer, et al., 2014; Marek & D'Aniello, 2014; Saltzman et al., 2011), though a very few studies (Elder, 1968; MacLean & Elder, 2007) were surveys or questionnaires, and two older studies were based on interviews (Rondeau, 2011; Wertsch, 1991) or interviews in combination with data searches (Saltzman et al., 2011). I had difficulty finding studies have focused on gathering information or perceptions directly from the military personnel and veterans regarding the subject of military life and culture. Considering that the major portion of research among military personnel was done by the military, one is struck by the very little research that has been done that sought to understand feelings and attitudes of personnel toward the lack of anonymity or privacy. Obvious though it may be, I am compelled to point out that the military structure by its very design, has little incentive to measure personnel attitudes. This is relevant to my study because I seek to gain an in-depth understanding regarding the attitudes of veterans and military personnel toward the prospect of an anonymous Internet-based reintegration treatment program. That was the reason I chose to use a questionnaire with open-ended questions, in combination with follow-up interviews via phone or email.

Reintegration

As mentioned in Chapter 1, reintegration is the process of leaving the military, returning to civilian life, and becoming a productive part of society, while engaged in family dynamics and social activities and institutions (Doyle & Peterson, 2005). In a combined literature review and case study, Doyle and Peterson (2005) reported that in order to accomplish successful reintegration, the person should take advantage of programs to improve communication (p. 361). Programs are available to improve

communication, moderate distress, and relieve other problems during reintegration (Doyle & Peterson, 2005, p. 361). Reintegration training begins with the family before the military person returns home via information sharing from the military, informing family members regarding what they might expect (Doyle & Peterson, 2005, p. 366). The military person receives reintegration training while he/she is still at the deployment location, which is a reorientation to civilian life. It appears this program does not address any specific problems because (in most cases) specific reintegration problems have not yet been revealed (Doyle & Peterson, 2005, p. 366).

Even with the pre-return training, the military person is disoriented (Koenig et al., 2014, p. 418), and may come to realize they need help for reintegration. Based on data from semi-structured interviews, Koenig et al. (2014) reported that veterans experienced a tension between their military identity and the emerging civilian identity (p. 418), making the individual feel like a *misfit* (Gerber, 1994). Koenig et al (2014) also reported efforts to manage stress across three categories of interactions: *inter*personal, professional/educational, and *intra*personal (p. 417). Besides the conflicts between identities and managing stress, a data base search revealed more regarding conflicts.

Following a database search, Gibbs et al. (2012) reported reintegrating personnel can experience interpersonal conflict (p. 1180). While junior enlisted personnel were the most likely to report interpersonal conflicts (p. 1180). Gibbs et al. (2012) also reported that health and behavioral problems were significantly associated with interpersonal conflict (p. 1180). These conflicts might be expected, due to combat experiences, but one problem experienced by veterans during reintegration, was surprising.

An unexpected aspect of reintegration stress that has been reported (Knobloch et al., 2013; Theiss & Knobloch, 2013) in some recent studies, is the perceived interference from partners. Two studies (Knobloch et al., 2013; Theiss & Knobloch, 2013), which were surveys, delivered via the Internet, reported partner interference when the relationship between the veteran and the spouse was in turbulence (Knobloch et al, 2013). Surveying 118 recently reunited couples, Knobloch et al. (2013) reported partner interference when relationships were influx (p. 761), which may be due to mental health problems, on the part of either the military person or the spouse (Knobloch et al., 2013; Marek & D'Aniello, 2014). Theiss and Knobloch (2013), also reported partner interference during reintegration (p. 1112). Both studies reported reintegration problems to be part of the reintegration process and not due to combat experiences or mental health problems, while offering no evidence to that effect. A clearer explanation for reintegration stress was reported by a research team via a review of the literature (Bowling & Sherman, 2008).

Bowling and Sherman (2008), in their literature review, reported that there are four major tasks facing the reintegrating veterans: 1) redefining roles and division of household responsibilities, 2) controlling and governing intense emotions, 3) cultivating new intimacy in spousal relationships, and 4) and creating a sense of meaning between the veteran and those in close relationships (p. 452). For gay, lesbian, and transgender personnel, reintegration can present special challenges; issues include fear, secrecy, and reprisal (Bowling & Sherman, 2008, p. 456). These special circumstances extend to

women and racial minorities (p. 456). There are other complicating elements that may exacerbate difficulties with reintegration.

Reintegration is made more difficult if the veteran has pain or other physical problems (Morin, 2011), whether due to service-related injury or not (Sayer et al., 2014), or has mental health problems (Sayer et al., 2014), whether due to combat or not. With results from a survey, Morin (2011) reported that 66% of those who reported reintegration problems also reported symptoms of PTSD and flashbacks. Also, with results from literature review studies (Sayer et al., 2014; Sayers, 2011), surveys (Sayers, 2011; Sayers et al., 2009), and a Veterans Administration records search (Sayer et al., 2010), several studies suggest that PTSD and depression are strongly associated with reintegration difficulties. Due to stigma in the military culture toward seeking care, many who need help do not seek it (Greden et al., 2010) which constitutes what Danish and Antonides (2010) called the untreated casualties of war (p. 556). The military branches have made efforts to improve reintegration success (Bowles & Bates, 2010; Danish & Antonides, 2013; Saltzman et al., 2014), by training for specific reintegration problems. Some programs included military friends to help encourage the reintegrating veteran (Greden et al., 2010; Hinojosa & Hinojosa, 2011), and showed promising prospects. There are multiple studies regarding reintegration difficulties, using many different research designs, with varying results.

Reintegration Research Methods: Relevance to This Qualitative Case Study

The research methods in these studies are varied, including literature reviews, database searches, surveys, interviews, and combinations. A portion of studies regarding

reintegration problems and treatment programs used surveys. A few studies used interviews and a few used surveys. I find it encouraging that researchers are seeking information directly from the veterans and military personnel. Although surveys can gather information directly from participants, surveys are pre-written questions and seldom allow for open-ended answers. I chose a case study survey questionnaire with open-ended questions, followed up by interviews by either phone or email, to gain an in-depth understanding of the attitudes of veterans and military personnel toward care seeking prior to discharge with respect toward the lack of anonymity or privacy.

Stigma

The concept of stigma begins with the negative social attitude attached to a characteristic of an individual that is regarded as having a (mental, physical, or social) deficiency (Goffman, 1963). It is the understanding of being set apart or not up-to-standard, that impairs the individual's successful inclusion into desired civilian society. These elements are based on a person's feelings about himself and his perception of his relationship with people who are accepted as normal (Goffman, 1963). Described as the co-occurrence of its components: labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001), the essence of stigma is the internalized self-concept of being a discounted person (Goffman, 1963, p. 3) that marks the individual. This can make escape from stereotyping nearly impossible (Yang et al., 2007). Stigma is self-perpetuating, debilitating, and destructive to the individual (Corrigan, 2004; Drapalski et al., 2013; Link & Phelan, 2001; Yang et al., 2007), though stigma can impact the individual in other ways revealed in several literature reviews.

In a series of literature reviews, Corrigan (Corrigan, 2004; Corrigan, 1998; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Corrigan & Watson, 2002) developed an interpretation or theory regarding how stigma impacts individuals and families and is impacted by mental health problems. One of the first to suggest that people may avoid or postpone seeking help for family problems and reintegration problems due to stigma (Corrigan, 2004, p. 622), Corrigan (1998) also reported that stigma has a cognitive structure (p. 201) and suggests cognitive therapy may be successful in changing the individual's and society's attitudes regarding seeking help (p. 219). The impact of stigma on people reintegrating into society is two-fold (Corrigan & Watson, 2002): 1) public stigma, and 2) self-stigma (p. 16). Finally, writing about college students, Corrigan and colleagues (Corrigan et al., 2003) reported that, in keeping with the attribution theory (Kelly & Michela, 1980), causal attributions inspire an individual's beliefs about his responsibility for his condition (p. 162). So, not only does an individual (either in the military or discharged) have to contend with what he or she perceives his family and friends might think of him or her, what he or she comes to think of himself or herself, but the individual may experience a growing concern that he/she somehow caused himself/herself to be a failure (Kelly & Michela, 1980, p. 162). Taking another path, researchers (Yang et al., 2007) considered stigma as a moral issue.

Yang et. al (2007) reported stigma definitions have moved from an individualistic focus to a more social approach (p. 1524). Reminding the reader that stigma spans physical, emotional, social, and cultural domains (p. 1531), Yang et al., (2007) hypothesized that stigma threatens what is most important to the individual; what is at

stake, by "actually destroying the lived value" (p. 1530). Beyond threatening what matters most, Yang and colleagues (2007) proposed that stigma is socio-somatic and distinct physical experiences may occur with loss of social position (p. 1532). Stigma is intersubjective at the interpersonal level between people via words, gestures, or feelings (Yang et al., 2007, p. 1532). Measuring stigma requires multiple perspectives, including from people who may influence the conception of stigma, such as family members, friends, coworkers, or superiors (Yang et al., 2007, p. 1533). The sociocultural perspective of stigma and the sociocultural environment of the military (the lived experiences of military life and culture) must be kept in mind when evaluating stigma in the military culture, along with its very specific ramifications as reflected in the Flowchart of Military Life and Unknown Attitudes Toward Care Seeking-With Respect to the Lack of Anonymity or Privacy (Appendix A).

Stigma in the Military Culture

It is important to keep in mind the concepts attached to military culture, mentioned previously, when considering stigma in that realm: beginning with indoctrination and extending through the entire military career (Bowles & Bates, 2010). Military culture tenets include being strong, not admitting weakness, and being successful no matter what the demands are (Gibbons et al., 2014). These tenets affect the military person's reaction to stigma. As mentioned previously, stigma in the military culture exists in partnership with the masculine ideology (Braswell & Kushner, 2012). This has been called the *cementing principle* in the military culture (Harrison, 2003, p. 75). The masculine ideology includes the concept of complete emotional control

(Hockey, 2003), the concept of a soldier's expendability (Gilmore, 1990, p. 121), and an over-riding influence to deny symptoms of PTSD or other mental health problems (Whitworth, 2008, p. 109). The masculine ideology cannot be ignored when considering stigma in the military culture.

Acosta and colleagues (2014), writing a combined literature review and editorial message regarding a Rand Corporation review of programs and treatment efforts to reduce stigma in the military culture, reported that the service member, after perceiving the likelihood he may have a marked identity (as a person who is the focus of stigma) regarding his/her need for services, may internalize the marked identity. This develops into an interaction between the service member and the key contexts in which he resides (Acosta et al., 2014, no p.). These interactions between the key concepts are: 1) Public, where there are concerns about other service personnel's and superiors' opinion and reaction to his/her mental health problems, 2) Individual, where there are concerns about what the service member perceives and in turn tells himself/herself about his problems, and 3) Social, where there are concerns about the reactions of friends and family, and possible losses of relationships, associated with hi/hers problems (Acosta et al., 2014, n.p.). These interactions, in turn, effect his/her reintegration success.

With results from a laboratory experiment (mixed methods, with interviews), Rodrigues et al., (2014) reported personnel delayed getting treatment for PTSD and depression due to stigma attached to seeking care, which in turn can have a negative impact on the treatment or training outcomes (p. 141). Rodrigues et al (2014) also reported participants saw depression and other reintegration problems as weaknesses (p.

137) and avoided alerting others that they may need help by avoiding seeking care (p. 137). Another reason to avoid seeking care includes avoidance of the depression label (Rodrigues et al., 2014, p. 139). The researchers (Rodrigues et al., 2014) concluded they could not find a quantitative link between stigma and treatment utilization (p. 140). However, via a grounded thematic analysis they found that participant perceptions suggested that stigma played an important role in treatment use or avoidance (p. 140). This conclusion mirrors what has been reported often and reflects findings from another study using a survey.

Researchers (Harris et al., 2015), reported results of a survey and concluded that those in need of help (physically, psychologically, or socially) are seen as weak in the military culture, including via the perceptions of those very individuals who need or seek help (p. 180), and attention should be paid to internalized stigma in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans (p. 179). Internalizing of stigma in veterans and military personnel results in self-stigma, which leads to reduced self-esteem and reduced motivation to seek help (Green-Shortridge, 2007, no p.). Harris et al. (2015) reported that those who need help are not only seen as weak in the military culture (p. 180), but those with a diagnosed disability and disability benefits have an even harder time developing stigma-resistant protection (p. 182), and have more difficulty resolving stigma-related alienation than other veterans (p. 183). Stigma affects other aspects of life such as employment and status.

In another laboratory experiment with military personnel, researchers (Hipes et al., 2015) found that stigma influenced lower status, which in turn negatively affected

employment gain, emotions and outcomes in social interactions and cooperation from others (p. 490). The point to focus on here is that stigma is pervasive (Gibbons et al., 2014), extends to every aspect of military life and military culture (Srinivasan, 2012), and negatively effects mental, physical and social problems (Hipes et al., 2015; Rodrigues et al., 2014). Stigma effectively acts as a barrier to seeking care, pursuing needed training, or using services (Dickstein et al., 2010; Harris et al., 2004; Hoge et al., 2004; Pietrzak et al., 2009; Slone et al., 2008; Zinzow et al., 2013) in the military culture, while possibly impairing reintegration success (Hipes et al., 2015). Via results from their lab experiment, Hipes et al (2015) concluded that (holding performance constant) participants of their study did not see recent veterans (from Iraq and Afghanistan) as competent compared to their perceptions of those who did not go to Iraq or Afghanistan. This means stigma was in place regarding these arenas and anyone who went there was seen as weak merely for going there, affecting the process of reintegration (Hipes et al., 2015, p. 491).

Writing in a review of the literature, Ben-Zeev et al., (2012) concluded that many veterans experienced adjustment problems during reintegration (p. 265). Ben-Zeev et al. (2012) also reported that some programs aimed at reduction of stigma in the military culture include education and contact with respected peers and may prove to be helpful at reducing the negative effects of stigma during reintegration (p. 270). Writing an editorial, Bowles & Bates (2010) suggested a more positive approach (p. 382): For military branches, it might be more advantageous to focus on resilience training, in order to develop and maintain the individual's, families', organization's and community's ability

to adapt to adverse stress in order to produce effective performance and reintegration success (p. 362).

Though, on the surface, these approaches to the problem of stigma sounds positive, Dickstein and colleagues (2010), in a review of the literature, suggested a different point of view: The consequences of military culture stigma is that personnel and veterans are living with treatable forms of psychopathology (p. 227), rather than seek care. Summarizing future possible approaches to reintegration and stigma reduction efforts, Dickstein and colleagues (2010) reported that among the proposed models of stigma reducing and reintegration enhancing programs (video-based, one-on-one, online, and group-based mediums), Internet-based strategies may be the most promising (p. 230) due to its possibility of anonymity and empowerment (Vilaitis, 2005). This viewpoint coincides with the objectives of this study

and also speaks to the ideology of the strategy choice for this study.

Stigma in the Military Culture Research Methods: Relevance to This Qualitative Case Study

It seems commendable that two of the studies mentioned above were laboratory experiments (Hipes et al., 2015; Rodrigues et al., 2014). The literature reviews (Acosta et al., 2014; Ben-Zeev et al., 2012; Dickstein et al., 2010) certainly covered many aspects of stigma in the military culture. But, I believe it is the strategies that sought information directly from the participants (Harris et al., 2015; Mishuris et al., 2014; Rodrigues et al., 2014), one (Harris et al., 2015) via a survey, and one (Rodrigues et al., 2014) via interviews, that produced the deeper understanding. This confirms what I have been

thinking regarding the need for more qualitative inquiry in research strategies with these populations, and further confirms my choice to conduct a case study using a short questionnaire with open-ended questions followed-up by interviews.

Summary and Research Method Choice for This Study

Of the studies mentioned in this review of the literature, eleven were literature reviews: four (Hall, 2011; Drummet et al., 2003, Morris & Age, 2009; Palmer, 2008) were about military life or culture, four (Bowling & Sherman, 2008; Sayer et al., 2014; Sayers, 2011; Sayers et al., 2009) were regarding reintegration, and three (Acosta et al., 2014; Ben-Zeev et al., 2012; Dickstein et al., 2010) focused on stigma in the military culture. These literature reviews have clarified subjects ranging from the need to understand why people join the military (Hall et al., 2011), to the fact that frequency of moves is the most difficult experience for military families (Drummett et al., 2003). There is a growing problem of violence among the youth in military families (Morris & Age, 2009; Palmer, 2009). The literature reviews also reported four major tasks involved with reintegration: 1. redefining roles, 2. intense emotions, 3. intimacy, and 4. maintaining a sense of meaning (Bowling & Sherman, 2008), along with the importance of dealing with medical (psychological or physical) problems during reintegration (Sayer et al., 2014; Sayers, 2011; Sayers et al., 2009).

Regarding stigma in the military culture, the literature reviews explained concepts of public, individual, and social stigma (Acosta et al., 2014), and suggested using military peers to help veterans cope with stigma (Ben-Zeev et al., 2012). They also reported that military personnel and veterans are living with treatable psychopathology rather than risk

the effects of stigma when getting treatment (Dickstein et al., 2010), and proposed the suggestion that Internet-based treatment may be the most promising way to deliver treatment because of the anonymity possibilities (Dickstein et al., 2010).

Two laboratory experiments (Hipes et al., 2015; Rodrigues et al., 2014), showed results that reflect participant's own stereotypical thinking (Rodrigues et al., 2014). In these studies, stigma extends to anyone who was returning from Iraq and Afghanistan, whether they had mental health problems or not (Hipes et al., 2015). Other studies in this review of the literature include nine studies using either surveys or interviews. Using interviews, Lundquist & Xu (2014) reported about the *homestead* policies of the military, and Koenig et al. (2014) reported about conflicts between the military identity and the impending civilian identity. Again, using interviews, Rodrigues et al. (2014) reported that military personnel and veteran perceptions about stigma influence treatment avoidance. Using surveys, researchers (Knobloch et al., 2013; Theiss & Knobloch, 2013) reported veterans, during the process of reintegration, perceived interference from their partners. And, in surveys, researchers (Morin, 2011; Sayer et al., 2011; Sayers et al., 2009) pointed to the importance of evaluating reintegrating veterans for PTSD or other mental health problems. In the face of all the programs that I have read about, I noticed one glaring omission.

There is no program that offers military personnel and veterans the opportunity to remain anonymous during care seeking prior to discharge, and no study has asked personnel what they think about that. The question then is, what would military personnel and veterans think of care seeking prior to discharge with respect to lack of anonymity or

privacy? To gain an understanding regarding what these populations might think about care seeking and any ideas they may express about anonymity or privacy, I decided to use a short questionnaire with simple open-ended questions, worded in several forms, followed by a short interview via phone or email, and hope for a deep understanding of what the attitudes of military personnel and veterans might be regarding care seeking, and anonymity or privacy.

Chapter 3: Research Method

Introduction

The purpose of this qualitative case study was to identify and interpret the attitudes of veterans and military personnel toward care seeking prior to discharge with respect to the lack of anonymity or privacy, and to discover what elements these populations desire to be included in reintegration treatment/training. The phenomenon of interest being the attitudes toward these issues. This phenomenon of interest, unknown attitudes, determined the research questions, and other aspects of the research design. The research design is explained in the following paragraphs, along with the role of the researcher, the methodology, the main study (recruitment, participation and data collection), the data analysis plan, issues of trustworthiness, and ethical concerns, beginning with the research design and rationale.

Research Design and Rationale

The research design was a qualitative case study and consisted of a short questionnaire with two open-ended questions, worded in two different ways, to reduce question bias and ensure question rigor (Patton, 2015, p. 448), and a follow-up interview via a phone call or email. The phenomenon of interest, the attitudes of military personnel and veterans toward care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy, and what elements veterans and military personnel desire to be included in reintegration treatment/training was straight forward. In keeping with the qualitative tradition of research, participants were encouraged to provide in-depth explanations. At the end of the short survey, participants were invited to participate

in a short 10-to-20-minute interview via phone or email, as they prefer, all aimed at answering the two research questions. The phenomenon of interest designed and drove the research questions**.**

Research Questions

1. What are the attitudes held by military personnel and veterans toward care seeking for medical (physical and mental health) problems prior to discharge with respect to the lack of anonymity or privacy?
2. What elements do veterans and military personnel think should be included in reintegration treatment/training?

Research Tradition and Rationale

The research tradition chosen was qualitative case study, because what was sought via this study was to evaluate the overall essence of the experience (Creswell, 2013, p. 260) of the participants, regarding their attitudes toward care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy, and elements they desire to be included in such treatment/training. Because the context was complicated: military culture and accompanying masculine ideology, stigma in the military culture, military life and perspective, and the lack of anonymity in any care program for medical problems which acerbates the effects of stigma. The phenomenon of interest is more complicated than simply attitudes about care seeking. Stigma, and the participants' attitudes about it, can take many forms and cannot simply be ascertained by asking participants "what are your attitudes about …." Therefore, follow-up interviews were used to get an in-depth understanding of the phenomena.

Creswell (2013) stated that a case study may be used to understand a specific issue, or concern, by selecting multiple cases to illustrate the issue, referred to as a collective case, (p. 99). The researcher begins by deciding that a case study is appropriate for the study plan for studying the phenomenon. Creswell (2013) goes on to say that a case study is a good choice when the researcher has clearly definable cases (veterans and military personnel who have attitudes regarding seeking care prior to discharge) with boundaries (this study only included participants with current or past military experience) (p. 100). The study was an illustration of a single event (Astalin, 2013, p. 122): what participants think of care seeking prior to discharge, coupled with what their desires are for elements to be included in reintegration treatment/training. Beyond choosing the type of study, the role of the researcher is extensive.

Role of the Researcher

The role of the researcher for this qualitative case study was observer and interpreter. This included developing the research questions, recruiting participants, implementing the study (sending the participants the questions), conducting short interviews, receiving and collecting the data, coding the data and ascertaining themes, analyzing the data and themes, and reporting the findings. Although researcher bias was not expected (there were no power relationships), there was a possibility that the wording of the research questions could have posed some bias, by wording questions in such a way that gave a participant the impression a particular answer was expected. During the interviews, questions again were worded in the least bias form, and open-ended. Personal biases could have been simply be that certain responses to the questions on the

questionnaire and in the interview were expected. Questions were worded with care and two veterans reviewed the questionnaire and the interview protocol to determine if respondents were influenced to answer in a specific manner. All these efforts become part of the methodology plan.

Methodology

The planned steps of this phase of this case study were arranged as per Soy's (2015) suggestion: (1) "Determine and define the research questions, (2) select the cases and determine data gathering and analysis techniques, (3) prepare to collect the date, (4) collect data in the field, (5) evaluate and analyze the data, and (6) prepare the report" (p. 1/9). Following these steps focused attention on every step and to avoid weakening the study by short-changing any one step. The reader is encouraged to view the List of Procedural Steps for Collecting Data (Appendix B). The methodology for this qualitative case study consisted of a short survey questionnaire and a follow-up interview delivered by phone or email. The survey questionnaire (see Appendix F) consisted of two open ended questions about care seeking prior to discharge with regards to the lack of anonymity or privacy and two open ended questions about what elements participants desired to be included in reintegration programs, followed by a question offering the participant the opportunity to add anything else he/she thought was important. This made a total of five questions on the survey questionnaire. This was delivered via the Internet, on the Facebook social media website, and to potential participants from Walden University Participant Pool.

At the end of the survey questionnaire, participants were invited to participate in a 11-question follow-up interview, either by phone or email. They were asked to provide either their phone number or their email address. Their information was used to contact them and set an interview time and date. All of those who wished to participate in the follow-up interview chose to do so via email. The follow-up interview was emailed to them and after completing it they emailed it back to me.

Population

Research (Weinik et al., 2011) has shown little or no relationship between gender and military culture, therefore this study will not make note of gender, but will consider any evidence of a relationship between age and attitudes as important enough to report. The population for this study included and was limited to veterans and active duty personnel in any of the military branches: The United States Army, the United States Marine Corps, the United States Navy, the United States Air Force, and the United States Coast Guard, as well as veterans who served in these military branches. No proof of service was required of participants, since it was assumed anyone who did not serve in any military branch, would not know about or be concerned with military culture stigma attached to care seeking, or reintegration training, and therefore were not likely to fraudulently try to participate in this study. Sampling strategy, sample size, and saturation were based on suggestions from Crabtree and Miller (1999).

Sampling

The sampling process did not go as planned and was extended, as an effort to ultimately acquire 10 or 12 participants. After one year attempting to get 10 to 12

participants, it was decided to analyze data from six participants that were acquired. Discussed in the following paragraphs are the sampling strategy, the sample size, and the population criteria.

Sampling Strategy Sample Size

The sampling strategy for this case study was a purposeful sampling procedure (Creswell, 1998, p. 118). Crabtree and Miller (1999) reported that, since the goal is to achieve an understanding and formulate a description of phenomena, sampling should be purposeful (p. 258). Case studies favor criterion sampling (Crabtree & Miller, 1999, p. 43), and that is what was chosen for this study. Participants who met the criterion of current or past military service were sampled.

Recruits who were at least 18 years old and volunteered to participate and who reported current or past service in any branch of the U. S. Military, were selected for participation. Saturation, or data adequacy (Creswell, 2013), will be a point at which it was felt nothing new is likely to be learned by further inclusion of new participants. The goal of sample size was a small number so it was hoped saturation will be met quickly. It was not.

As mentioned earlier, this study was posted on Walden University's Participant Pool and Facebook social media site. The study was first posted in the Participant Pool at Walden University but after a year, with only one willing subject via this avenue, whose participation I could not accept because he/she did not sign the consent, it was then posted the social media site, Facebook. Then, after a year, when only a few people volunteered to participate, reach was expanded by joining 12 military and veteran support

groups on Facebook, such as Veteran Coffee Group, Veterans Priority Group, Veterans Helping Veterans, Women Veterans, and Texas Veterans. However, this did not garner immediate results. Military personnel in uniform and veterans (recognizable by articles of clothing that read “Army”, etc.) in public places were queried as to why they thought response was so slow. Generally, they thought it might be because personnel and veterans might think a researcher would not understand their perspective, or know what they experienced, and therefore might not be enthusiastic to participate. Joining the various support groups that were connected to Facebook, such as those mentioned above, eventually did garner some willingness to participate. After a year and six months of recruiting, a total of six participants had volunteered for the study. This number was determined by my committee to be sufficient for this study because it is a hard-to-recruit population and extending the recruitment efforts may not have yielded additional participation. For the purposes of this qualitative approach valuable data would be gleaned from the six participants.

Participation Criteria

All respondents to the ad on Facebook who disclosed they were veterans or current military personnel, were admitted to the study. Criteria did not include age or gender. In summary, participants were chosen based on their response to a request for participants via an ad on Facebook (Pedersen et al., 2015) and who reported some past or current military experience. The short survey questionnaire and the follow-up interview were the only instruments used for the data collection.

Data Collection Instrument and Source

As mentioned, data was generated by responses to the short survey questionnaire (total of 5 questions), and a short follow-up interview with 11 questions. These instruments were designed by myself and approved by my committee (see Appendix F and I).

As mentioned, at the end of the short survey questionnaire, participants were invited to participate in a short follow-up interview. They had their choice to participate in the follow-up interview by phone or via email. All chose to be interviewed via email and were asked to provide their email, and I emailed them the interview protocol. At the end of the short questionnaire, the introduction to the follow-up interview (see Appendix D).

The follow-up interview questions (see Appendix J) were similar to the those in the survey questionnaire and were meant to elicit further information regarding the attitudes of participants, regarding care seeking prior to discharge-with respect to the lack of anonymity or privacy. After they completed the interview, they saw a page thanking them for their participation, their service, and offering resources.

The development of the survey questionnaire and the follow-up interview protocol, were based on the observation (Mareck & D'Aniello, 2014; Pickett et al., 2015; Rodrigues et al., 2014) that active duty personnel and veterans have negative attitudes regarding care seeking prior to discharge-with respect to the lack of anonymity or privacy, and on the failure of programs to reduce stigma in the military culture attached to seeking care (Rodrigues et al., 2014; Schreiber & McEnany, 2015) or reintegration

help. It seemed, therefore important to discover what these populations might think about care seeking and privacy or anonymity, since it was the hope that eventually the military may consider trying a treatment/training program that offers the option of anonymity, which would possibly relieve the perceived effects of stigma in the military culture. The questions designed were formulated to elicit the most information regarding participants' attitudes toward care seeking prior to discharge, and to ensure content validity.

Content Validity

The questionnaire questions and the follow-up interview questions were tested with colleagues at Walden University, to evaluate if the questions were clear and made sense. Two veterans were asked to review the questions to see if they were easy to understand.

Haynes, Richard, and Kubany (1995) reported that content validity is defined as the "degree to which elements of an instrument are relevant and representative of the targeted construct" (p. 238). This includes the directions, questions, and response sections, etc. (Haynes et al., 1995, p. 238). The construct in this case study would be the attitudes of the participants. This means, does the short survey and follow-up interview protocol measure what they are intended and reported to measure: The attitudes of veterans and military personnel toward care seeking prior to discharge with respect to the lack of anonymity or privacy, and the elements they desire to be included in reintegration training. Based only on the individual responses to the survey and the follow-up interview, it was obvious that the questions measured the attitudes of the participants

regarding care seeking prior to discharge, and what elements they desire in reintegration treatment/training programs. This was verified by peer review and by committee review.

Study Recruitment, Participation, and Data Collection

Beginning with the Facebook add (see Appendix C), an introduction to the study and an invitation to participate in the short survey questionnaire (see Appendix D), the consent to participate in the survey questionnaire (see Appendix E), then the short survey questionnaire (see Appendix F), the length of time was estimated to take to complete the survey questionnaire was about 10 minutes. Following the survey, participants were thanked for their participation and offered resources for services (see end of Appendix H). At this point, participants were invited to take part in a short follow-up interview either by phone or email (see Appendix F). This was followed by a commitment page (see Appendix G), which asked for their contact information, so I could contact them and set a time and date for the interview. If participants opted to not participate in the follow-up interview, they were thanked for their participation and given resources (see Appendix I) and were exited from the website. If they chose to participate in the short follow-up interview, by offering their contact information on the Commitment Page, I contacted them and set a time and date for the follow-up interview or sent them the follow-up interview (see Appendix J).

The introduction to the survey questionnaire were worded thus: “I am interested in studying what military personnel and veterans think about care seeking prior to discharge with respect to the lack of anonymity or privacy. Since no treatment/training, care, or help offers military personnel anonymity when seeking help for medical

problems, and since all efforts toward reducing stigma in the military culture associated with seeking help or treatment/training, have failed to reduce perceived stigma, I would like to know what you think of the idea of seeking help for common reintegration problems in an anonymous way, which makes it impossible for anyone else in the military or VA to know what problems you are dealing with. The following are questions seeking information that will help me understand how you feel about these subjects. There is also an opportunity to add anything you might think is important to know, to understand care seeking prior to discharge, or getting treatment/training, and what is thought of those who need help. Please feel free to answer in any way you want to and you may take as much space as you like."

Pedersen et al. (2015), used the social media website, Facebook, to recruit veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) for their online alcohol intervention study. I placed an ad on Facebook (see Appendix C) to recruit participants. The ad described the study and what the phenomena of interest was and allowed the individual to click through to the survey website. An explanation included that this study was a PhD student's dissertation study followed and gave directions for answering the questionnaire. After clicking onto the study site, the participants were presented with an explanation of the study the consent and then the survey questionnaire.

Beside the 4 questions on the survey questionnaire, there was a space for them to offer any other information they might wish to share (such as war experience, rank at discharge, injury, etc.). It was planned the recruitment period would last for as many days

as was necessary to garner at least 10-120 participants. However, after one year of recruiting, after consulting with my committee, I decided to evaluate the data for the 7 participants I did have.

At the end of the survey, participants were thanked for their participation and presented with contact resources for services (see Appendix F). They then saw a page that invited them to participate in a short follow-up interview so I might gain further understanding of their attitudes toward the prospect of anonymity during reintegration treatment/training (see Appendix G). Following the invitation to participate in the follow-up interview participants saw another consent they had to sign for the follow-up interview (see Appendix I). Participants then moved to the next page. The Commitment Page (see Appendix H) and they were asked if they prefer to participate in the follow-up interview via phone or email. They were then asked to provide their contact information. I contacted participants and conducted the follow-up interview (see Appendix J). Only four individuals participated in the follow-up interview, all via email. The last question of the follow-up interview offered participants the opportunity to add anything they deemed important (see Appendix J). At the end of the follow-up interview, participants saw a page thanking them for their participation and their military service and offering contact resources for services (see Appendix K).

The recruitment period was set to last 20 days but lasted one year. It proved impossible to reach saturation (12) via Facebook, and I sought additional participants from Walden University participant pool, ending with a total of seven participants.

Study Data

As mentioned, the study data came from a short survey questionnaire with open-ended questions, followed by the short follow-up interview of 11 questions. The data collected were the replies to questionnaire survey and the follow-up interview protocol. Participants could participate in the interview either by phone or by email. It was expected that the answers to the survey and the short follow-up interview would reflect the attitudes of the individuals toward care seeking prior to discharge with respect to the lack of anonymity or privacy, and what elements they desired to be included in reintegration treatment/training programs. This proved to be the case. It was hoped that the answers would reveal themes about the lived experience regarding stigma and care seeking of the participants and all the ramifications connected to care seeking prior to discharge and what elements they desired to be included in reintegration preparation. Data collection was a simple process of retrieving the survey and follow-up interview answers, transcribing the responses, looking for themes and analyzing the data-themes.

Data Collection

The short survey questionnaire (see Appendix F) took the participants from 5 to 10 minutes, and the data from the survey was collected once every day. The follow-up interview protocol (see Appendix J) had 11 questions and took between 10 and 20 minutes. For the follow-up interviews, it was planned to transcribed data using the Atlas.ti software package (https://atlasti.com/qualitative-research-software/) for qualitative research data. However, this application proved to be overly complicated and since data from only 6 participants was collected, it was decided to transcribe the data by

hand. Data from the survey and the follow-up interview, were kept in a special folder in my computer, with password protection.

Whether participants decided to take part in the follow-up interviews or not, at the end of the survey questionnaire, they saw a page offering contact resources for services offered by the Veterans Administration (VA), the VA hotline, and veteran volunteer services that offer outreach contacts and opportunities for the participants to get help or to help other veterans. Participants were also thanked for taking part in the study, and for their military service (see Appendix F). They then exited the survey website. If they decided to participate in the follow-up interview, they provided their contact information, I contacted them and sent them the follow-up interview.

At the end of the follow-up interview, participants again saw a page offering contact resources on mental health services offered by the Veterans Administration (VA), the VA hotline, and veteran volunteer services that offer outreach contacts and opportunities for the participants to get help or to help other veterans (see Appendix K). Participants were also thanked for taking part in the survey, and for their military service. There are no follow-up procedures planned. It was made clear that this study was only to gain an understanding regarding what military personnel and veteran attitudes might be toward care seeking prior to discharge with respect to the lack of anonymity or privacy, and what elements they might desire to be part of reintegration treatment/training. No promise or hint was presented regarding any future study. Data collection was a simple process and the data analysis plan was a thematic data analysis, which will be an evaluation of possible themes that provide an understanding of the participants possible

attitudes toward care seeking prior to discharge and what elements they desire in treatment/training.

Data Analysis Plan

It was planned that the data would be evaluated and interpreted via Atlas.ti, the data analysis software (www.atlasti.com). This analysis program was excessively complicated and in the end the data that was generated was so simple that it was analyzed by hand. It was examined for underlying ideas, and ideologies, that may have shaped the semantic content (Braun & Clarke, 2006, p. 34). For this thematic analysis, then, the analysis was not only descriptive, but also theorized. The coding scheme used a comprehensive inductive and deductive approach to identify experience and meanings (Patton 2015), as preparation for a thematic analysis.

A thematic analysis is an accessible and flexible method of data analysis (Braun & Clarke, 2006, p. 77), while not partnered to any pre-existing theoretical framework (p. 81), and it reveals experiences, meanings, and the reality of participants lived lives (p. 81). Braun and Clarke (2006) reported there are 6 phases to thematic analysis, which this qualitative study followed: Phase 1. The researcher familiarizes himself/herself with the data (p. 87), Phase 2. The researcher produces initial ideas about what is interesting in the data (p. 88), Phase 3. After the data is coded and collected, the researcher sorts the different codes into themes (p. 89), Phase 4. With a set of possible themes, the researcher considers reorganizing themes, and in some cases disposing of some listed themes, ultimately to refine the themes and compare them to the entire data set by producing a thematic map (Braun & Clarke, 2006, p. 91), Phase 5. With a workable thematic map

(Braun & Clarke, 2006), the researcher makes final refinements, to identify the essence of each theme. That is, what portion of the research questions each theme captures (p. 92), Phase 6. With a full set of themes (refined and defined), the researcher conducts the final analysis and reports the findings (p. 93). This this framework was essentially the guide to the process for this study. The process hinges on adequate and proper coding of themes.

Coding and Discrepant Cases

The survey questionnaire and the follow-up interview were coded for themes. The coding system consisted of the code name, code definition, text examples, and coding rules (Buria et al., 2006). The coding scheme used the data-driven-inductive plan (Boyatzis, 1998). The coding scheme was then refined where needed (Fereday & Muir-Cochrane, 2006). Stages of coding included: Stage 1. Developing the code manual, Stage 2. Testing the reliability of codes, Stage 3. Summarizing data and identifying initial themes, Stage 4. Applying template of codes and additional coding, Stage 5. Connecting the codes and identifying themes, and Stage 6. Corroborating and legitimating code themes (Fereday & Muir-Cochrane, 2006).

Stage 1: Developing the code manual. It is understood that a code manual would act as a data management tool, to organize and to assist in interpretation (Crabtree & Miller, 1999). It was hoped this would provide a clear train of evidence to reflect the credibility of the study (Fereday & Muir-Cochrane, 2006). This template was developed based on Schutz's (1931/1967) phenomenology and four categories are planned to be devised: motives, relationships and stigma, mental stress and stigma, and anonymity and stigma. Codes were written (inductive) as Boyatzis (1998) suggested, the encoding

process: 1. The code name, 2. The definition of the theme, 3. And, A description will be devised of how to know when the theme occurs (p. 31).

Stage 2: Testing the reliability of the code. Boyatzis (1998) reported developing a good framework for analysis determines the correctness of the codes regarding the raw information. A peer researcher was asked to code a sample question, for comparison. The code template would have been modified if needed.

Stage 3: Summarizing data and identifying initial themes. Boyatzis (1998) reported that this summarizing step is a sort of "conscious processing" (Boyatzis, 1998, p. 45). It was important to keep in mind that a single comment is as important as the interpreted meaning of a whole paragraph or answer (Boyatzis, 1998, p. 45). A summary of each participant's response to a question may be a single summary or could be several summaries. The summaries for the questions reflected the initial processing of the information and provided an early opportunity to sense potential themes.

Stage 4: Applying template of codes and additional coding. The codes from the codebook were applied to the text (responses) with the intent to identify meaningful elements. The codes from the code manual were entered, then clustered (in themes), using a process of data retrieval (Hwang, 2008). As Boyatzis (1998) suggested, during the coding of answers, inductive codes would be assigned data that described a theme observed in the answer. Depending on how many different paths (themes) the answers take, themes were coded until all themes were categorized.

Stage 5: Connecting the codes and identifying themes. When a theme or pattern in the data was discovered, it was placed under a specific heading (category name). There

emerged a consensus emerging in response to a question. Recent veterans served multiple tours and endured long and multiple separations from loved ones, while Vietnam veterans served usually only two years in theater (combat-zone), so some differences emerged due to era of service.

Stage 6: Corroborating and legitimating coded themes. Themes were further clustered at this stage and findings confirmed. Special care was taken not to fabricate evidence, a process that can happen even when not intended (Crabtree & Miller, 1999, p. 170). Themes then were assigned short phrases to describe the meaning of the theme, and a sum-total of large core themes that represent the phenomenon were counted and recognized.

If a question did not have a response it would have been considered discrepant and removed. Beyond this, there were no other discrepant cases. Doing this ensured credibility and other desired elements, such as trustworthiness.

Trustworthiness

Creswell (2007 summarized the concept of trustworthiness as validation to assess the accuracy of findings (p. 249) and suggested using the term *validation* in place of trustworthiness because it is "more demonstrative of the meaning of a process aimed at documenting the accuracy of studies (p. 250)." He (Creswell, 2007) went on to suggest other possible processes such as prolonged engagement, triangulation, peer review, negative case analysis, clarifying researcher bias, member checking, rich description, and external audits (p. 250). He suggested qualitative researchers use at least two of them. Peer review and clarifying were both used to look for researcher bias. Further attempts at

evaluation included examinations of credibility, transferability, dependability, and confirmability.

In her review of the literature, regarding concepts of qualitative approaches, Marrow (2005) suggested that credibility in qualitative research corresponds to internal validity in quantitative research (p. 251). Transferability in qualitative research corresponds to external validity (or generalizability) in quantitative research (Marrow, 2005, p. 252). Dependability in qualitative research corresponds to reliability in quantitative research (Marrow, 2005, p. 252). And confirmability in qualitative research corresponds to objectivity in quantitative research (Marrow, 2005, p. 252). Although these qualitative concepts do not accomplish the same goals as their corresponding standards in quantitative research, and qualitative research leads to different kinds of information, it is still possible to think of these corresponding concepts, in order to organize one's thinking regarding qualitative versus quantitative rigor. These four concepts beginning with credibility are discussed in the following paragraphs.

Credibility

The concept of credibility refers to internal consistency (Marrow, 2005, p. 252), and constitutes an effort to demonstrate that a true picture of the phenomenon of the study is being presented (Shenton, 2004, p. 63). It also includes how rigor is ensured (Shenton, 2004, p. 64). Peer researchers examined procedures, analysis, and researcher reflexivity (self-questioning and self-understanding) (Patton, 2015, pp.). Credibility was enhanced by detailed explanations of the participants lived experiences regarding the

phenomena, along with the contexts in which the phenomena are lived (Marrow, 2005, p. 252), revealing the possibility of transferability.

Transferability

Marrow (2005) suggested transferability refers to the extent to which the reader can generalize the findings of a study to his/her own context. This addresses the core issue of how this study could make claims regarding the application of the findings and the general population of military personnel and veterans. Qualitative data cannot be generalized in the same manner as the data from a quantitative study; no claims of generalization to the whole population of military personnel and veterans was made of the findings. However, it is suggested that findings might reflect the attitudes of some military personnel and veterans since all military personnel and veterans know and experience stigma (Harris et al., 2015), a phenomenon of long standing in the military culture (Ben-Zeev et al., 2012), reflecting also an aim toward dependability.

Dependability

Marrow (2005) suggested dependability refers to the way a study is conducted across time, participants, and locations. The procedure, in which the theme-findings and the careful tracking of the research design are derived, are explicitly explained. A chronology of data collection activities and analysis are recorded and reported. Influences on data collection, and emerging themes, categories, and definitions are recorded. The audit trail was examined by peer reviewers, and my dissertation committee, improving the likelihood this study has confirmability and to the extent possible, objectivity.

Confirmability

Marrow (2005) suggested the concept of confirmability should be based on the idea that research is never totally objective (p. 252). That is, this study and the findings should represent, to the extent it is possible, the situation being researched. It represented the attitudes of these participants toward the prospect of avoiding stigma (in treatment/training) based on their perceptions of stigma, and not on my beliefs about stigma in the military culture. Basically, the procedures used to ensure dependability also was applicable for a related concept, confirmability, particularly the audit trail (Marrow, 2005, p. 252). These concerns about measuring the participants' attitudes, rather than representing my attitudes, led me to think about other ethical issues, along with efforts and approaches that help to insure ethical procedures.

Ethical Procedures

The student researcher should begin the ethical research-evaluation by understanding the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). The code in its entirety should be understood by any PhD student, but specifically the following sections for student researchers: The Preamble: beneficence and maleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity, especially Sections 8.01 institutional approval, and 8.02 informed consent. Beyond these general code of conduct rules, this study abided by the ethical standards of the Association of Internet Researchers (Ess & AoIR: Association of Internet Researchers, 2002) and every effort was made to avoid breach of

confidentiality (Zimmer, 2010) of participants who participated in the survey questionnaire and the follow-up interview.

Dedication to the rights of participants began with the trust placed in the Walden University Institutional Review Board (IRB), approval code:10-16-17-0112694. The application itself asked for the plans for this study, who were the stakeholders, what were the risks and benefits, what was the data retrieval procedure, what was the data storage plan, what were the data integrity safeguards, what was the developed data collection tool, where there any confidentiality issues, and where there any potential conflicts of interest. Simply by knowing what the IRB expected informed what things should be concerned about. In summary, concerns I for this research study included: confidentiality, anonymity, treatment of data, data collection, recruitment processes, institutional review board permissions, treatment of participants, beginning with access to participants.

Access to Participants

Based on Patton's (2015) ethics checklist, ethical concerns were approached thus: The purpose of inquiry was explained to participants in such a way that was clear, made sense, incorporated critical details, and included the expected value to them and to the military in general. It was explained why the participant should take part in the study, which was to help discover and understand what participants think about the prospect of anonymity during treatment/training. Participants were thanked for taking the survey and for their military service. There were no risks to participants; their information remained confidential, and the questions were constructed to be as innocuous as possible. The IRB

guidelines and rules for informed consent were adhered to. This researcher was the only person who had access to data, and it was password protected.

Also, what was sought was only the attitudes regarding care seeking prior to discharge with respect to the lack of anonymity or privacy. Any ethical challenges faced during the main study were reported to the committee: Asking for the email to send participants the follow-up interview protocol made it possible in 2 cases to learn the participants possible names, since many people use their names when inventing an email address. Patton (2015) also posted a list of ethical issues to consider in qualitative research on the Internet, which includes knowing when it is ethical to do research studies on the Internet and knowing this helped protect the confidentiality of participants (p. 343). It was originally planned to recruit participants from Walden University's Participant Pool. When no viable participants from the participant pool were recruited the study was placed on the social media site, Facebook, as Pederson et al. (2015), inviting people (with current or past military service) to participate in a short survey questionnaire. Those willing to participate used a direct link to the survey questionnaire, provided by the study data manager, Survey Monkey (https://www.surveymonkey.com). Before the actual questions began, a clear explanation (see Appendix D) of the study was offered, directions, and a consent form (Appendix E) was given which the individuals had to sign before they could move to the study questions. Consent was only the first of concerns regarding the treatment of participants.

Treatment of Human Participants and The Institutional Review Board (IRB)

Participants were asked for their age and military service on the consent form (see Appendix L). All personal information including answers to the four open-ended questions and fifth *blank* question remained confidential, stored in this researcher's computer, and secured by a password. All institutional permissions and research procedures were adhered to, and IRB approval was obtained to conduct this study, along with safeguards connected to the recruitment processes.

After completing the survey, participants were thanked and then invited (See Appendix G) to take part in the short follow-up interview. They were asked to complete the Commitment Page (see Appendix H), which asked for their contact information. After completing the follow-up interview, participants were thanked and offered resources for services. No participants were interviewed via a phone call. Those who participated in the follow-up interview by email were thanked and a written thank you with resources appeared on the last page of the study. The participants were offered no compensation. No promise of further research or studies was made. There were other ethical concerns, some that relate to recruitment.

Ethical Concerns of Recruitment

Because there is such a high level of PTSD (Bryan, Graham, & Roberge, 2015; Blevins, Roca, & Spencer, 2011) and depression (Sayer et al., 2010) among returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) personnel, it was expected that some would be interested in getting help for these issues. Information was made available regarding mental health treatment, the VA hotline, and the VA outreach

programs. The consent form (see Appendix E, I) stated that participants could stop participation in the study at any point, and their information would be deleted. Beyond these concerns, there were ethical concerns regarding the collecting of data.

Ethical Concerns of Data Collection

For the survey questionnaire (see Appendix F), data collection was via two open-ended questions asked in two forms, plus an open-ended question where they could add anything they wanted to, a total of five questions. The follow-up interview protocol had eleven questions (see Appendix H). These questions were an extension of the survey questionnaire and were aimed at gaining further in-depth understanding of the attitudes of participants toward care seeking prior to discharge with respect to the lack of anonymity or privacy, and what elements they desired to be included in reintegration treatment/training. Because military personnel and veterans have been dealing with the effects of stigma in the military culture for some time (Ben-Zeev et al., 2012) it was possible that this study could have posed a risk of sadness. It was made clear that this was a dissertation study to discover prevailing attitudes toward care seeking. No promise was made regarding forthcoming studies. It was hoped this would reduce any possible stress this study could have incited.

Treatment of Data

Data was and is stored in this researcher's computer, kept confidential, and is password protected. It will be used only for this study. Jones (1994) reported there is a tension between the old rules and new technology (no p.). However, a properly working research ethics committee could provide valuable support and guidance (Fulford &

Howse, 2016, p. 90). Zimmer (2010) reported researchers should recognize their own gaps in understanding the changing nature of confidentiality and strive to put together a committee that covers these gaps. Beyond this, knowing one's own reflexivity, strengths, and weakness and idiosyncrasies, is important to produce successful and ethical research (Zimmer, 2015, p. 514). Data will be kept for 5 years, password protected, then deleted from the computer file it is stored in.

Summary

This chapter has covered all aspects of methodology, from design to data collection and analysis, to credibility, transferability, and confirmability, and ethical procedures. Participants were recruited based on formalized criterion, data collected, and confidentiality maintained. Established ethical procedures and university guidelines were followed. Data was stored and password protected for 5 years, then deleted. Participants were thanked for their participation and for their service. Information was made available to participants regrading V. A. Programs, the V. A. Hotline, and out-reach programs participants could use or volunteer to be part of. In summary, ethical issues and procedures were devised to address all ethical concerns. Plans were in place for presentation of results.

Chapter 4: Results

Introduction

Considering the multitude of research projects and studies conducted by the Veterans Administration (see Weinik et al., 2011), and a large number of other research projects with promising results on subjects from resilience building (Bowles & Bates, 2010; Meredith et al., 2011; Saltzman et al., 2011) to self-stigma (Harris et al., 2015), study results have yet to show much *evidence* of what are the attitudes of military subjects about care seeking with respect to the lack of anonymity or privacy. What is included in the attitudes, perhaps even cause the attitudes about seeking care is stigma, toward weakness. It appears stigma is not reducing in the military and may be more intrenched than thought possible.

The purpose of this study was to identify and describe the attitudes of participants toward reintegration treatment/training prior to discharge for medical problems with respect to anonymity or privacy, and to report their desires for elements they wish to be included in reintegration treatment/training. It was expected that there would be an influence from stigma against care seeking (Acosta et al., 2014; Ben-Zeev et al., 2012; Dickstein et al., 2010; Iverson et al., 2011; Rodrigues et al., 2014). So, considering how stigma operates in military life and the effects of stigma that have catastrophic outcomes, such as suicide, violence, or mental illness, this study sought to form a clearer view of attitudes personnel and veterans have toward care seeking and what would facilitate their over-coming stigma and risk exposure by seeking care. This study asked two research questions.

1. What are the attitudes held by veterans and military personnel regarding care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy?
2. What elements do veterans and military personnel think should be included in reintegration treatment/training?

In this chapter, I present the settings and demographics, data collection and analysis, trustworthiness, and study results. The setting was expected to be the participant's home.

Setting

It was expected that the setting for each participant would be similar, their home. The setting was also wherever else the participant accessed the Internet (home, work, school, etc.). Since the Internet can be accessed via smart phones, it is possible participants might have taken the survey anywhere (the hairdresser, the beach, the DMV etc.). The important thing to focus on regarding the setting for this study, is that the participants had the freedom to participate or not to participate and to do it at any time of their choosing, and at nearly any location. Therefore, freedom is the common element of each participant's setting, whether home, workplace, doctor's office, etc. Length of study may have contributed to the participants' freedom.

The plan was for this study to be conducted for 20 days, or until 12 participants were recruited. This study was originally posted in the Participant Pool at Walden University, but the posting in the Participant Pool garnered no viable participants. It was then posted in Facebook for over one year, therefore, it was possible that a large

percentage of Internet-active personnel and veterans saw the study posted on Facebook for many months. This may have caused a feeling of familiarity due to the length of time the study was available and advertised. It is unknown if the length of tie the study was available was ana advantage or disadvantage. Reactions from veterans on Facebook were positive and helpful. Examples were “thank you for caring” and “I hope this study goes well.” Recruitment for the study was very slow. Friends, some veterans, were asked why this might be. It was suggested that those considering participation, via the Facebook posting, may have concluded that this study was being conducted by someone who was not a veteran and could not possibly understand what they might be feeling. Though not part of the study data, a record of comments by visitors posted on Facebook to an ad for the study were recorded, such as: “Thank you for caring,” and “Good luck.” On Veterans Day, or Memorial Day, of 2019, I spoke to veterans collecting donations for Special Olympics. Comments reflected the idea that participating I this study was not important because it was not conducted by the military or the VA.

There did not seem to be any global, national, weather, or social events during the year the study was available that might have affected willingness to participate. The opinion of potential participants toward myself or the study always appeared to be friendly. Still one is forced to consider the length of time the study was before the eyes of potential participants as part of the setting. Simply put, one’s attitude toward something could be considerably different whether one just saw an ad recruiting participants, compared to what it might be if one had first seen the ad for the past eight, ten or twelve months and saw it every day or so. Even with no purposeful influence, potential

participants' attitudes toward participating could have changed. In any case, many things contribute to what is referred to as the *setting* of a study, and I believe that in this case, length of time the study was constantly available perhaps should be considered part of the setting. I do not think there was any other issues that played into the *setting* of the study. In summary, the setting conceivably included the locations that the participants accessed the Internet, the availability of the study for a year on Facebook, my frustration and urgency toward recruiting participants, and constant attention in the media toward suicide. Closely connected to these parameters of setting, is the individual demographics.

Demographics

Participants ranged from age 36 to 73 years old, with experience in the military (past or present). Five participants had experience in the Army, with one of these also serving in the USAF, and one participant served in the Navy. The literature (Weinik, et al., 2011) shows there is no significant difference among genders regarding stigma or suicide in the military life, so gender of participants was not recorded. Though gender was not recorded, participants in this study appeared to choose male-sounding pseudonyms. The majority (60%) of participants appeared to have made the military their career. In summary, participants were from 36 to 73 years, with generally, more than minimum enlistment in the military. In other words, no young (20-somethings), new military personnel individual participated in this study. In the end, only 6 individuals qualified for and participated in the study, all via Facebook. There was one person who volunteered via the Walden University Participant Pool, but that person did not sign the consent, so his/her responses were not included. Of the six participants who were

included, three also participated in the follow-up interview, all by email. Data collection was relatively easy.

Table 1

Demographics

Pseudonym	Age	Years of Service	Branch
Warhorse	44	26	Army
Wes Michaels	73	20	Navy
Brock	36	4	Army
Soldier	48	28	Army
John Doe	46	4	Army
Thurlow	71	17 and 5	USAF Army

Data Collection

Data was collected from a total of six participants, via the Internet from Facebook social media site in the form of dialog answers to open-ended questions on a short survey questionnaire and a follow-up interview delivered via email. Responses represented the opinions (revealing attitudes) of participants toward care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy, and what elements they desire to be included in reintegration treatment/training. Data was recorded on a five open-ended question survey questionnaire, advertised on, and posted on Facebook and an 11 open-ended question follow-up survey delivered via email. Data was collected daily, retrieved and managed by Survey Monkey (surveymonkey.com). The survey questionnaire consisted of open-ended questions asked in 2 forms each, and a blank where participants could add anything they desired, to encourage in-depth answers. Participants were encouraged to take as much space and time as they desired. The short

survey questionnaire was followed by an invitation to participate in an optional follow-up interview via either phone call or email (all opted for email). The open-ended forum and amount of space available for responses were meant to encourage participants to take as much time and space to complete answers as they wanted to. The follow-up interview responses were completed on a form I emailed to participants and they answered and emailed back to me. There were no variations from the plan of data collection, other than it took far more time than expected.

There were no unusual circumstances or events that caused any alteration in the data collection plan. The intent was to collect data and conduct a thematic analysis, an evaluation of the themes that presented themselves, in order to discover their attitudes toward care seeking prior to discharge with regards to the lack of anonymity or privacy and to uncover what elements they desired to be included in reintegration treatment/training. Themes appeared saturated as I was recruiting key informants, and a total of 6 participants was adequate. I proceeded to organize my data for analysis.

Data Analysis

As mentioned in chapter three, the coding of the survey and interview protocol themes was completed by this researcher. The coding system consisted of the code name, code definition, text examples, and coding rules or definitions (Buria et al., 2006). The code book included the category or theme name, definition, and a description of, and procedure used to recognize the theme (Boyatzis,1998). The coding scheme used the data-driven-inductive plan (Boyatzis, 1998) and an a-priori template of codes-deductive approach (Crabtree & Miller, 1999). Organizing data for analysis began with

development of a code book. The code book helped to provide a clear train of evidence that reflected the credibility of the study (Fereday & Muir-Cochrane, 2006). Also, it helped to establish preliminary categories for phenomenology (Schultz 1967). Originally, the main categories were designed to be motives, relationships, mental stress, anonymity and stigma. During this process the code categories or themes changed and evolved. During the development of the code book the reliability of each code was tested. During this process, summarizing data and evaluating themes or considerations to alter them improved reliability. There was some difficulty developing clear categories of responses because across the board, responses were succinct, consisting of one or two sentences generally. This might have been expected from military participants, from the many veterans spoken to in public places. Great care was taken not to over-interpret the meaning of such short responses. For instance, when asked about concerns regarding seeking care, Warhorse answered: "Any leader who seeks care before retirement will soon be viewed as mentally weak and removed from leadership." The shortness of this answer made it difficult to decide whether it belonged in the privacy category or the concerns about career category.

There were, at one point 12 categories, but no dynamic implications from the responses as to how they should be categorized. In the end the number of categories was reduced to four, mainly by concentrating on the main purpose of the study: what personnel and veterans think about seeking care, regarding privacy and anonymity. An advantage of surveying or interviewing military personnel or veterans is that they seemed to have little trouble *knowing* what they think about the issues in question. This attribute

may be due to military training, but it had the effect of possible over-interpretation and a temptation to second-guess categorization choices.

Responses and Code Assignment

Though it was hard to settle on a final number of coded themes and corresponding definitions, three coded themes were chosen with regards to attitudes about care seeking: 1. Privacy, effects of stigma and shame, 2. Jeopardizing career, job and/or leadership role, 3. What would help veterans or personnel to seek care? A fourth category was: What elements they desired to be included in reintegration treatment/training. There did not appear to be any discrepant cases or need therefore for any special categorization. Code assignments are explained further in the following paragraphs, under the Results section. The appropriateness of final code assignment was clarified by evaluation of trustworthiness.

Trustworthiness

As mentioned in Chapter Three, Creswell (2007) suggests several methods to assess the accuracy of findings, and says researchers should focus on credibility, transferability, dependability, and confirmability (p. 249). In the following paragraphs it is explained how I focused on each, beginning with credibility.

Credibility

Marrow (2005) says credibility refers to internal consistency (p. 252) of a study and is the sum efforts of research procedures aimed at demonstrating a true picture of the phenomena being studied (Shenton, 2004, p. 63). Credibility was enhanced in my study by pursuing detailed explanations of the participants lived experiences, using peer

evaluations (two recruited peers from my PhD program dissertation class, one qualitative researcher and one quantitative researcher) and researcher reflexivity (self-questioning/understanding) This plan was relatively easy to follow since the only criteria for participation, other than signing the consent, was to have military experience (and be at least 18 years old). Either a potential participant had or did not have military experience. This also helped to reveal dependability.

Dependability

Marrow (2005) says dependability refers to how a study is (consistently) conducted over time and across different sets of potential participants, with clear explanations and detailed records kept of data collection (p. 252). Careful records were kept of data collection, and all other procedures. Although it was extremely difficult to recruit participants for this study, taking over one year to recruit seven participants (six viable, one removed) no deviation happened from the procedure through the recruitment period. Data collection for this study was conducted in the most simplified and organized way: Advertise the study, recruit participants from participant Pool and Facebook, deliver the survey questionnaire, recruit each to take part in the follow-up interview, deliver the interview via Survey Monkey, and retrieve the data. All straightforward efforts also helped to make it possible to ensure transferability of the findings from this study.

Transferability

Transferability refers to the likelihood that findings could be generalized to the general population (Marrow, 2005). A multitude of studies (Weinik et al., 2012) with military personnel or veterans, have, over the years, revealed that these populations are

very similar (whether, active duty personnel or veteran, career personnel or minimum term of service personnel, from the Viet Nam era or the Afghanistan theater), have all reported a measurable stigma against care seeking, little difference in attitudes between genders, and common dissatisfaction with the Veterans Administration. Since qualitative data cannot be generalized in the same manner as the data from a quantitative study, It cannot be said that the findings from this study can reflect the attitudes of the general population of military personnel and veterans, but it is possible to suggest that the findings represent the attitude of these populations in general about stigma at least. In addition, the small number of participants limits transferability. All military personnel and veterans experience stigma (Harris et al., 2015), which is a phenomenon of long standing in the military culture (Ben-Zeev, et al., 2012), and this is reflected in the confirmability of this study.

Confirmability

As stated in chapter three, Marrow (2005) suggests the concept of confirmability is based on the idea that research is never completely objective (p. 252). In this study, the findings were based on the participants' attitudes toward care seeking and desires regarding elements in a reintegration treatment/training. The focus of data collection was on exploring participants' attitudes (in their own words), rather than writing about attitudes from literature, and this helped to ensure rigor and to have confidence in the results, and that the results reflect what they were meant to reflect, the attitudes of participants toward care seeking and their desires for elements to be included in reintegration treatment/training.

Results

The results revealed great concern regarding seeking care and the consequences of doing it. The results also show personnel and veterans have opinions regarding what should be offered in reintegration treatment/training. Explained herein, the results are organized by research question.

Research Question 1

What are the attitudes held by veterans and military personnel regarding care seeking for medical problems prior to discharge with respect to the lack of anonymity or privacy?

Literature shows that the military culture and masculine ideology pose roadblocks to care seeking. So, it was not surprising the responses to the first research question fell into several categories. Categories were grouped and, in the end, three category themes covered all responses. Within each category (A, B, and C) several subthemes were included. Therefore question 1. Category A included the themes of concerns about privacy, effects of stigma, and shame. These themes are summarized and reflected in participant quotations.

Research Question 1. Category A: Concerns about privacy, effects of stigma and shame. Category A included concerns about privacy, effects of stigma and shame. Responses seemed somewhat contradictory. One respondent reported (referring to care seeking) “service members have a negative stigma to address” but says “there is nothing wrong with asking for help.” In all, there was a consensus that one should ask for help if one needed it.

Warhorse, 44 years old, with 26 years in the Army, said "Nothing wrong with asking for help. The issue is more when treatment effects performance. The treatment will involve medications or therapies that decrease clear thought and ability to perform Soldier duties (deploy into combat zones). Service members have a negative stigma to address Mental Health issues. (Regarding the military's efforts to reduce stigma) It's all for show."

Thurlow, 71 years old, with 17 years in USAF and five years in the Army, said (regarding asking for help) "I have no problem with it."

John Doe, 46 years old, with four years in the Army, said "If you need help, ask. There should be no shame in knowing you need assistance."

Soldier, 48 years old, with 28 years in the Army, said (regarding asking for help) "It's not as easy as one might think. I struggle with it. (regarding what he might be concerned with) Time away from work."

Wes Michaels, 73 years old, with four years in the Navy, said "If having problems, I would ask for help. (regarding concern with getting help) The VA has been a disappointment. I tried to get a cardiology consult and it took 6 months."

Question 1. Category B included the themes of concerns about jeopardizing careers, job, and/or leadership roles. These themes are summarized and reflected in participant responses.

Research Questions 1. Category B: Jeopardizing career, job, and/or leadership role. Category B included concerns that care seeking could jeopardize one's career or job, and negatively affect getting or keeping a leadership role. Some

respondents declared they would like more privacy or confidentiality and would seek care as long as it doesn't "negatively affect my career." In all, the consensus was that if there was a likelihood one's job or career could be affected, one might not seek care.

Warhorse, 44 years old, with 26 years in the Army, said "Any leader who seeks care before retirement will soon be viewed as mentally weak and removed from leadership roles. Leaders deny the need for assistance. In the "always ready" and "Soldier Lethality" environment anything that degrades the environment is viewed as weakness and avoided by most Soldiers, especially leaders. (Regarding need for care) May decrease my likelihood or motivation to accept greater responsibility."

Brock, 36 years old, with 14 years in the Army, said (regarding asking for help) "I don't mind asking and receiving help as long as it doesn't negatively affect my career. (regarding concerns) Career impacts."

Thurlow, 71 years old, with 17 years in USAF and 5 years in the Army, said (I am concerned with the) "Wrong people getting into the mix."

Question 1. Category C included the themes of concerns about what the military or the VA could do immediately to make it easier to seek care. This was not a planned category, nor was this asked directly. However, every participant voiced some concern or idea as to how things could be made easier with little bureaucracy or fanfare. These themes are summarized and reflected in the participants responses.

Research Question 1. Category C: What could the military or the VA do immediately to make it easier to seek care? Category C included suggestions made by

respondents. Suggestions ranged from having the ability to seek care on the weekends when personnel would not be around, to seeking care in civilian clothes.

Warhorse, 44 years old with 26 years in the Army, said "Would like to be offered to seek assistance when subordinate Soldiers are 'not around' and it would be normal to be in civilian clothes. (Regarding remaining anonymous when seeking care) Briefs well. The higher up in the rank and leadership the easier for subordinates to learn about it and discuss it at length."

John Doe, 46 years old with four years in the Army, said (referring to what would help make getting care easier) "Close medical and psychological input."

In summary of responses to research question one, the themes that emerged from research question one (asking about the participants attitudes toward care seeking) varied somewhat but generally follow themes that included: 'There is stigma to worry about when I seek care,' 'If I seek care I could jeopardize my job, my career, or my leadership position' and "There should be some way to seek care that is private or confidential.' Responses for the last category of themes were tied to the 2nd research question. Response were of basically two different concerns: The military can't just train a person to be a soldier, then return him/her to civilian life with out retraining, and the military should train better for resource acquisition upon discharge. This point leads to the second research question.

Research Question 2

What elements do veterans and military personnel think should be included in reintegration treatment/training?

As mentioned, participants voiced concerns about the need for mental health or psychological help with returning from battle, trying to fit back into the family structure, and navigating the maze of benefits and resources. Some participants alluded to these issues in previous responses, (to research question 1.) but when asked directly what they think should be part of reintegration treatment/training, participant responses were in depth and appeared tinted by emotion.

Warhorse, 44 years old with 26 years in the Army for 26 years, said (regarding what should be added to reintegration treatment/training) "A complete list of all available resources and contact information for specific geographic region reintegrating to. Current things are appropriate. There is a re-evaluation after 90 days post-deployment. I feel that is not sufficient. Do a 180 and a 365 (day) re-evaluation of integration. (also) Leader's training on questions to watch for."

John Doe, 46 years old with four years in the Army, said (regarding what the military should add to reintegration treatment/training) "Knowledge of services available. Some supervised workout and guided mental health discussions."

Wes Michaels, 73 years old with fours in the Navy said, "The military used to have a "Civilian Readjustment Program". Some combat vets are still in need of a great deal of help. Expend that program with qualified mental health specialists. Initial mental health evaluation should be mandatory prior to release from service and periodic re-evaluations should be available. This country cannot take its youth, train them to kill, and then release them back in the community without retraining. Period."

Thurlow, 71 years old with 17years in USAF and five of experience in the Army, said (regarding what the military should add to reintegration treatment/training) “Close medical and psychological input. Reengaging with intimacy and relating to children. Stress management!”

It was not too surprising that those with long military careers were concerned about effects on career advancement. Participants often said if a person needed ‘help’ they should ask for it, and yet seemed to insist on career protection over care-seeking. Warhorse wrote “There is nothing wrong with asking for help” but later said “Service members have a negative stigma toward mental health issues” and “any leader who seeks care…will be soon viewed as weak.”

The following table, Major Concerns, shows the percentage of participants who revealed concerns about three of the issues focused on in this study. 1. Concerns about loss of privacy, effects of stigma, and feelings of shame associated with care seeking, is designated category as “Shame.” 2. Concerns about jeopardizing career, job, and leadership role, is designated category as “Jeopardy.” 3. Concerns about what the military and the VA could do now to make it easier for personnel and veterans to seek care, is designated category as “Care Seeking.”

Table 2

Major Concerns

Participants	Shame	Jeopardy	Care Seeking
Warhorse	X	X	X
John Doe	X		X
Thurlow	X	X	X
Solder	X	X	X
Wes Michaels	X	X	X
Brock	X	X	X

The second themes table (Table 3), Reintegration Preferences, shows desired elements to be included in reintegration treatment/training programs. 1. Desire1: A complete list of resources and benefits and correlating training, is designated as "Benefits/Resources." 2. Desire 2: Ongoing psychological and medical evaluation, is designated "Mental Health Help."

Table 3

Reintegration Preferences

Participants	Benefits and Resources	Mental Health Help
Warhorse	X	
John Doe	X	
Thurlow		X
Solder	X	
Wes Michaels		X
Brock		X

Summary

In summary, the data analysis was clearly complicated, the hardest part being settling on category themes and interpreting (not over-interpreting) short succinct

answers. Category themes were expected to be straight forward and not to change or need re-organizing so much. The four categories settled on appear to be the best choices in order to address the research questions. Thinking of the categories this way allowed for ease of result evaluation and ultimately the decision about how the results confirmed or disconfirmed expectations and the evaluation of any new attitudes regarding stigma, career protecting, or reintegration programs. In the following chapter, findings are interpreted, recommendations made, and implications are suggested.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to directly ask veterans and military personnel what their attitudes were toward care seeking for medical problems (physical or mental health) prior to discharge with respect to the lack of anonymity or privacy and what they think should be included in reintegration treatment/training programs. Research (Weinik et al., 2011) has, to a large degree, avoided asking this population directly for their opinions regarding care seeking. Discussed in the following paragraphs are the attitudes veterans and military personnel have toward care seeking with regards to the lack of anonymity or privacy and what are the elements they desire to be included in reintegration treatment/training. Included are the interpretation of findings, the limitations of the study, recommendations and implications, beginning with a reminder of the purpose and nature of this study.

Purpose and Nature of the Study

As stated in Chapter 1, the purpose of this study was to identify and interpret the attitudes of veterans and military personnel toward care seeking, for medical problems (physical and mental health) prior to discharge with respect to the lack of anonymity or privacy, and what elements they desire to be included in reintegration treatment/training, In light of the fact that much effort (Dingfelder, 2009; Herrera-Yee, 2015; Russell et al., 2016; Sayer et al., 2010; Zinzow et al., 2013) has been made to stop or reduce stigma in the military in order to improve care seeking, it seemed useful to discover (directly from personnel and veterans) what they think about seeking care. It has been reported

(Schreiber & McEnany, 2015) that efforts toward reducing stigma and improving care seeking have been largely unsuccessful. Personnel and veterans experienced this failure and continue to avoid treatment (Ben-Zeev et al., 2012: Gibbons et al., 2014; Herrera-Yee, 2015). No study (Denning et al., 2004; Gibbons et al., 2014) has asked personnel or veterans directly, with open ended questions, about their attitudes, in order to gain an understanding of their attitudes toward care seeking. The nature of this study was qualitative case study design, with open-ended questions in a short survey questionnaire and a short follow-up interview. This study used a survey questionnaire and follow-up interview to directly ask military personnel and veterans what they think about care seeking, and what they think should be included in reintegration treatment/training. The findings revealed negative attitudes toward care seeking in general, an attitude reflecting acceptability or necessity of career protecting behaviors over care seeking, and a strong desire for better resource information and help with resource acquisition.

Interpretation of Findings

When planning this study, there were a few topics in the literature that seemed to be connected to the focus of this study. Chief among these topics were stigma and what the military or VA could do immediately to improve care seeking. These topics showed up in the findings. Interpretation of findings in this report is organized by these four topics: Stigma, career protecting behaviors, what the military and the VA can do immediately to make it easier to seek care, and what elements participants desired to be in reintegration programs. Findings are explained/organized as the general topic, findings affected by the conceptual and contextual frameworks involved, findings this study

confirmed, findings this study did not confirm, and findings that revealed how this study extended the knowledge. Therefore, the topic of stigma the subtopics are: “Findings concerning stigma,” “Findings affected by conceptual and contextual frameworks and stigma,” Findings that this study confirmed regarding stigma,” “Findings that this study did not confirm regarding stigma,” and “Findings that revealed how this study extended knowledge.” For the other three main topics (career protecting behaviors, what the military and the VA can do immediately to make it easier to seek care, and what elements they desire to be included in reintegration programs) organization followed the same route. Therefore, the four topics each are explained in five ways (general, frameworks, confirmed findings, non-confirmed findings, and extending knowledge. Findings concerning stigma in general is necessary to show/understand why the question of attitudes about care seeking is connected to stigma.

Stigma

The literature shows stigma in the military culture persists (Yang et al., 2007) and threatens what matters most (p. 1,533), family, coworkers, and superiors. Existing in partnership with masculine ideology (Braswell & Kushner, 2012), stigma in the military culture effectively acts as a barrier to seeking care (see Zinzow al., 2013), and consistently has played an important role in treatment avoidance (Rodrigues et al., 2014, p. 140). The findings revealed a negative attitude toward care seeking with regards to stigma. One participant stated, “Service members have a negative (attitude) toward stigma.” Another stated (referring to asking for help) “It’s not as easy as (one) might think.” And another (referring to the military’s efforts to reduce stigma) “It’s all for

show." The findings of this study showed a negative attitude about stigma associated with care seeking which appeared as part of the conceptual and contextual frameworks.

Conceptual and contextual frameworks and stigma. The very situations that stigma is revealed to exist in, are often the strongest contributing factors to its perpetuity (Corrigan, 2004; Gibbons et al., 2014; Dickstein et al., 2014). These factors include the structured military culture with the contributing factor of masculine ideology (Gibbons et al., 2014). The concept of stigma in the military culture is debilitating and tyrannical (Gibbons et al., 2014; Green-Shortridge et al., 2007). Stigma was certainly part of the contextual and conceptual frameworks in which this study was conducted.

The contextual framework of this study consists of three elements: 1. The day-to-day military life and the shock of (or anxiety about) returning to civilian life and need for help reintegrating, 2. The effects of stigma in the military culture on one's career, job, or advancements, and 3. The common and normal residual effects of experiences in a combat zone. The conceptual recipe of masculine ideology and the military culture cements the regime of stigma against any sign of weakness in this environment. Efforts to reduce stigma in the military culture seem, not only futile, but counterintuitive, since just talking about stigma may serve to entrench stigma further (Vogt et al., 2014). This study sought to discover attitudes toward care seeking, which, though not asked about directly, revealed findings that included attitudes regarding stigma during care seeking. What was sought though the study was an understanding of the attitudes of personnel and veterans, attitudes that possibly originate in the conceptual and contextual frameworks in the military life. Participants were asked: "What could the military and VA do immediately

that would make it easier to get help" and Warhorse suggested "The ability to seek help on the weekends or during off times from work.….to seek assistance when subordinate soldiers are not around and it would be normal to be in civilian clothes." This is a suggestion clearly aimed at skirting discovery and at avoiding stigma, rather than trying to reduce or eliminate stigma in the military. However, efforts aimed at reducing the debilitating effects of stigma certainly have merit. This study confirmed findings from other studies about stigma in the literature.

Stigma findings. Participants in this study reported problems with stigma. John Doe stated, "If you need help, ask. There should be no shame in knowing you need assistance." Regarding asking for help, Soldier stated "It's not as easy as one might think. I struggle with it." Across the board, participants in this study acknowledged the existence of stigma, and reported they grapple with the fear of or effects of stigma when considering care seeking. One wonders, if stigma did not affect care seeking, wouldn't John Doe have stated "There <u>is</u> no shame in knowing you need assistance" instead of "There <u>should</u> be no shame in knowing you need assistance?" Advancement in reducing effects of stigma has been pursued, but findings from this study do not show much change in the attitudes toward stigma in the military culture, as some report (Dingfelder, 2009; Gibbons et al., 2014; Herrera-Yee, 2015). This study did not confirm any outlook for stigma reduction.

This study reflects little advancement in the war on stigma in the military culture (Dingfelder, 2009; Gibbons et al., 2014). In some reports the military revealed an invigorated push toward resilience in military families (Saltzman et al., 2011) and

appears to be making some headway (Schreiber & McEnnay, 2015) on behalf of active duty personnel and veteran populations living with stigma (Rodrigues et al., 2014). However, when asked what they thought of the military's efforts to reduce stigma, Warhorse stated "It's all for show." This study reflects that some, though very little, success has been achieved in reducing stigma.

Stigma findings: extend knowledge. In recent years, studies (Drapalski et al., 2013; Gibbons et al., 2014; Harris et al., 2015; Hipes et al., 2015; Rodrigues et al., 2014; Schreiber & McEnany, 2015) focused on reducing stigma, including self-stigma, in the military culture. Participants in this study did not mention or refer to self-stigma explicitly, but Warhorse stated "Service members have a negative stigma to addressing mental health issues", and (regarding his possible need for care and how it might affect self-view) "…may decrease my likelihood or motivation to accept greater responsibility." This response appears to reflect some level of self-stigma (Dickstein et al., 2010). Considering the responses in this study, it was clear a careful interpretation of the findings and a determined guarding against over-interpretation of responses from participants were called for. Another major finding from this study was the emergence of the concept of career-protecting behaviors, among personnel and veterans who were career personnel and even minimum enlistment personnel. These signs of self-stigma are an extension to the knowledge.

Career Protecting Behaviors

Oddly enough, it seemed that all participants of this study (active long and short term, and veteran long and short term) showed concern with anything that could affect an

extended military career. This included participants who were career military, retired or active, and minimum enlisted, whether retired or active. All participants revealed concern about how stigma might affect one's career. Clearly, concerns regarding military careers, are important across the whole of military culture (active or inactive).

The literature is sparse on issues about career protecting. Precisely because the literature is sparse, it was exciting to get clearly demonstrative responses that pointed to career-protection when the aim of inquiry was specifically not career-protection. Participants showed an attitude toward career protecting. Warhorse stated, "Any leader who seeks care will soon be viewed as mentally weak and removed from leadership roles." This study confirmed findings from other studies (Gibbons et al., 2014; Green-Shortridge et al., 2007; Herrera-Yee, 2015; Schreiber & McEnany, 2015) that hint at (though not specifically named) career protecting behaviors. Findings concerning career protecting behaviors were evaluated regarding conceptual and contextual frameworks, findings that are confirmed, findings that are not confirmed, and findings that extend knowledge.

Conceptual and contextual frameworks of career protecting behavior. As mentioned above, the conceptual framework of this study consists of three elements: 1. The day-to-day military life and the shock of (or anxiety about) returning to civilian life and need for help reintegrating, 2. The effects of stigma in the military culture on one's career, job, or advancements, and 3. The common and normal residual effects of experiences in a combat zone. The conceptual recipe of masculine ideology and the military culture cements any career protecting behaviors. The contextual framework, as

mentioned above, includes the tyrannical hold stigma has on personnel and veterans regarding the battle between the need to get help and the fear that others who find out they need help could damage their career, job or advancement. The contextual framework extends across the span of military life, including family, cohorts, prospects for advancement, special assignments, along with pressure to perform at the highest levels, the pressures to conform to the masculine ideology, and the 'show-no-weakness' attitude of today's military. The combined contextual and conceptual frameworks work to inspire the individual to conduct career protecting behaviors, chief of which are, avoiding care seeking (Ben-Zeev et al., 2012; Gibbons, et al., 2014). Brock stated, "I don't mind asking and receiving help as long as it doesn't negatively affect my career." Warhorse stated "(referring to stigma) In the 'always ready' and soldier lethality' environment anything that degrades the environment is viewed as weakness and avoided by most soldiers, especially leaders." Although the literature is sparse regarding career protecting behaviors among military personnel and veterans with respect to effects of stigma, this study confirms that career protecting behaviors are real.

Career protecting findings. While analyzing data, I realized that this study indicated there might be evidence that career personnel would admit to choosing career-protection over mental or even physical health. A literature search showed there had not been much interest (Vogt, 2011; Zinzow et al., 2013) in this facet of stigma, that is, the effects of stigma that inspired career protecting behaviors. It can be argued that this side of the question exists in all research about stigma and care seeking avoidance. My point is that few studies have directly evaluated care avoidance to protect careers, no one has

asked personnel or veterans why they avoid care seeking or treatment because of stigma. Though there have been studies (Weinik et al., 2011; Zinzow et al., 2013) aimed at understanding the level to which career personnel would deny the need for, or avoid care seeking when there was a conceivable threat to career, yet there was no link presented between the avoiding behavior and the threat to career. The reader may be tempted to think it obvious that if a person chose the military as a career, that the person would take extreme measures to protect that career. However, astonishingly, these same career personnel seemed to be the most vocal about negative effects of stigma on care-seeking and the need to seek care if one needed it. They say things that seem to show they think people in need of help should go get it. In this study, John Doe stated "There should be no shame in knowing you need assistance." And Brock wrote "I don't mind asking and receiving help as long as it doesn't negatively affect my career." Finally, Soldier stated (regarding asking for help and suggesting effects on career) "It's not as easy as one might think. I struggle with it. (and worry about the) time away from work." Findings from this study confirm an attitude of concern and behaviors aimed at career protection.

This study did not confirm any earlier findings reflecting career protecting behaviors, it only noticed responses that appeared to reflect an attitude of protection toward careers. All comments or references to career in participants answers revealed the same on-going somewhat conflicting attitudes that have prevailed in the military culture since concerted efforts (Corrigan, 2004; Corrigan et al., 2003; Corrigan 1998) began looking at stigma and its effects. Personnel, and veterans say they know stigma exists, and individuals should get help for problems, but would avoid care rather than jeopardize

their careers. Every participant, referring to effects of stigma, especially the careers-committed personnel (current or veteran), across the board, make statements that reflect concern for those who need help, the damage stigma can do in lives of those who need help, and a die-hard willingness to avoid care seeking if their own career is in danger. This said there was a somewhat exiting revelation in my study.

Career protecting findings: extend knowledge. As mentioned above, this study revealed a military and veteran concern regarding the effects of stigma on the careers of long-term commitment personnel. It was expected that there might be a level of concern about stigma among career personnel, but it was a surprise to see concern for the effects of stigma on careers from short-term enlisted personnel (current or veteran). There was no real explanation as to why short-term personnel would care about the careers of those career commitment personnel. Interestingly this level of concern extends into the veteran area enough to make any military personnel concerned with its effect whether they are affected or not. It was fortunate, considering this revelation, that participants of this study were directly asked their attitudes toward anything the military or the VA could do immediately to make care seeking easier.

What the Military or VA Can Do to Make Care Seeking Easier

Change takes effort and time, and it is likely that change in an environment as structured as the military might also take time. As mentioned, there have been many studies (Ben-Zeev et al., 2012; Denning et al., 2004; Dingfelder, 2009) regarding reduction of stigma in the military culture. The military and the VA (Denning et al., 2004; Dingfelder, 2009), as well as civilian researchers (Gibbons et al., 2014; Harris et

al., 2015), have endeavored to stop or reduce the effects of stigma on care seeking, by aiming attention toward the act of showing or reacting to stigma regarding signs of weakness (Herrera-Yee, 2015; Iverson et al., 2011), and by increased attempts to promote resilience in personnel and veterans (Meredith et al., 2011). In summary, the VA and military are trying to reduce stigma or make people stronger so they can put up with it. When asked what they think of efforts to reduce stigma, as mentioned, Warhorse responding to the question summed it up with "It's all for show." These attempts, by military, veteran, and civilian efforts, to reduce or stop stigma, must be considered in conjunction with the conceptual and contextual frameworks attached to programs, those aimed at reducing stigma, and making care seeking easier.

Conceptual and contextual frameworks and making care seeking easier.

Conceptual frameworks of stigma, stigma effects, treatment avoidance, and the masculine ideology that consists of promoting visions of strength and denying the possibility of any weakness, all have and will continue to affect any effort on the part of the VA or military to make it easier for personnel or veterans to seek care. Contextual frameworks that include family structure, military life permeate all aspects on an individual's life, and entrenched military structures all have and will affect the success of anything the VA or military might try to do to make care seeking easier for veterans or military personnel. Any attempt to directly train personnel, educate veterans, or provide programs aimed improving care seeking by reducing stigma would be affected by the conceptual and contextual frameworks that function to cement stigma in the military and veteran life.

And multiple efforts (Weinik et al., 2011) have demonstrated this to be so, as confirmed by the findings of this study.

Making care seeking easier findings. There seemed to be no study that offers an approach such as skirting around stigma in a fashion where others cannot discover one needs help**.** Findings from this study confirm the interest in offering an individual the opportunity to get treatment in a way that others would not notice. The attitudes of participants revealed what the military could do. Warhorse stated, "I would like to be offered to seek assistance when subordinates… are not around." Findings from this study confirm that military personnel and veterans continue to fear effects of stigma on their military careers and have attitudes about what the military and VA could do immediately to make care seeking easier.

However, there is sparse research regarding anything that the military and the VA could straight-away do to make care seeking easier, with regards to stigma against care seeking. This study disconfirms other study findings regarding anything that the military or VA could do, to make care seeking easier: a focus on reducing stigma. This refers to any new treatment or method to reduce stigma and its effects on care seeking.

Making care seeking easier findings: extended knowledge. This study extended the knowledge about care seeking and stigma blocking care seeking behaviors, by adding the information that personnel and veterans want the opportunity to seek care on days when there would be less attention on care seeking, and possibly have the opportunity to wear civilian clothes, further hiding the care seeking behavior. Participant Warhorse suggested a unique insight with "The higher up in rank and leadership the

easier for subordinates to learn about it (care seeking behavior) and discuss it at lengths." It might seem that a higher rank would provide more anonymity, contrary to what Warhorse states. But it seems the VA and the military could implement immediately, with little or no preparation, weekend scheduling for care. It seems attitudes of personnel and veterans reveal a new idea (that high rank is not protective anonymity) that something could be changed with little effort. Personnel and veterans would accept this opportunity, evidenced by their comments. This finding was a bit of a surprise.

Desired Elements in Reintegration Programs

The second research question, What elements do personnel and veterans desire in reintegration programs? is the final portion of findings. Though the military has several programs for reintegration success, participants displayed two distinct desires.

Conceptual and contextual frameworks and desired reintegration elements. In an conceptual environment that perpetually enforces a negative view of any sign of weakness or need for care seeking, and a contextual environment that maintains a masculine ideology and military culture structure, I did not expect personnel to have clearly negative attitudes toward military reintegration programs. Participants responded with emotion regarding what they saw as inadequate reintegration training. The main compliant focused on a perceived need for better, more complete, training in the resources available and how to access them. Also, in this environment it was somewhat surprising to see a participant call for more in depth and extended mental health care after discharge.

Desired reintegration elements findings. Of the multiple efforts to improve reintegration programs, especially resource acquisition, the military reports greater numbers are taking advantage of resources available. This is an increase in umbers, though not any indication that access is easier or more streamlined. This study does did not confirm appropriateness or adequacy of the current mental health follow-up system.

This study did not confirm the adequacy of the mental health follow-up program. Also, the VA has reported improvements in mental health programs availability, which this study cannot confirm. This study showed emotional demands for better reintegration training regarding recourses and how to access them.

There have been multiple reintegration initiatives focused on improving accessibility of resources after discharge and asserts access is better. This is more a VA problem than a military shortcoming, however, reintegration processes start before discharge, so it appears that the military and the VA are not yet providing adequate training regarding resources and how to access them, and this study cannot confirm that assertion.

Desired reintegration findings: extend knowledge. This study did not reveal any significant extension of knowledge regarding what elements personnel and veterans desire in reintegration programs. The only finding worth noting is the emotion that was attached to participants' responses about resource acquisition.

Unexpected Findings Summary

At times, the literature may present something new. In the case of this study, something unexpected appeared regarding care seeking and attitudes: There might not be

a difference in attitudes between regular enlisted personnel and career enlisted personnel (retired or active), with regards to attitudes toward treatment/training with regards to lack of anonymity or privacy. This study also showed no major difference in attitudes regarding career protecting behaviors between career-enlisted personnel or veterans and minimum enlisted personnel and veterans. Another small misconception from reading the literature in general was that the higher the rank of a person the more power or ability that person might have to hide his or her care seeking needs, which participants Warhorse discounts. There seemed to be no literature revealing any study particularly considering this element of care seeking.

A loosely connected aspect to the oppressiveness of stigma, is what the literature shows might be the situation with career-military veterans. About 50% of the participants in this study appeared to be career personnel. The literature suggests that, even as veterans, career personnel are less likely than minimum-service personnel to seek care (Harris et al., 2015), and this attitude showed up in participant's responses. Thurlow, a veteran male with 20 years in the Army stated: (regarding asking for help) "It's not as easy as one might think. I struggle with it" and (regarding what he might be concerned about) Time away from work." If this is so, it leads one to consider just how powerful stigma might be, if its power extends to care seeking into the veteran years.

Limitations of the Study

As mentioned in chapter one and chapter three, trustworthiness refers to validity of the findings and includes concepts of credibility, transferability, dependability, confirmability. Credibility (internal consistency) and transferability (generalizability)

may be of limited trustworthiness in this study. Demographics were minimally noted in this study; there was no concern paid as to the gender of participants. Although minimum commitment versus career commitment personnel were surmised to be close to 50 to 50 in this study, attitudes regarding stigma and career protection, were uniform across groups. Although this study had only six participants and did not request sex of participants, it is not clear if there are any differences between the sexes. Recommendations could include studies regarding attitudes about care seeking and gender, high rank versus low rank, and other issues.

Recommendations

Based on the strengths (dependability and confirmability) and the limitations (credibility and transferability), it seems logical to suggest a future study with these populations including measuring differences between gender, rank, and length of enlistment. The literature is sparse regarding differences in attitudes toward stigma between minimum enlisted and career committed personnel. It is hard to make recommendations based on the small number of recruits in this study, but it may be important to point out that as far as this study goes, short-term enlisted personnel are as concerned as career personnel about stigma and its effects on military job, advancement, or career. It appears that it does not matter whether a person intends to serve just a few years or make a career of service in the military, or if a person is retired from the military or still on active duty, they care about avoiding stigma and stigma's effect. This implies that the career protecting attitudes and behaviors might be similar for all. This might affect any career that deals with positive social change. Several authors have suggested

stigma (against any perceived weakness) may be built into the military life, and no amount of effort will stop stigma in the military culture. However, concerned practitioners and military leaders should consider ignoring stigma in the military if it is not likely to change, and look for ways personnel and veterans can avoid the effects of stigma, rather than trying to reduce stigma or eliminate it. Based on responses from participants in this study, though not specifically stated, one gets the impression that veterans and personnel know stigma exists and see it as a natural element in a military culture that focuses on strengths and eschews any sign of weakness. A recommendation is to develop a program that makes it easier for personnel (and veterans) to access care in a anonymous way, as Warhorse stated "I would like to be offered to seek assistance when subordinates are not around and it would be normal to be in civilian clothes."

Implications

The implications for positive social change may not be as obvious as one might think. Walden University defines positive social change as many things, among which is a concerted effort to improve conditions of lives of humans. Reflected in Walden 2020: A vision for Social Change (Walden University, 2019) positive social change includes efforts to raise social change consciousness. As mentioned, multiple programs and projects have sought to reduce the effects of stigma on care seeking in the military culture, while others sought to reduce or curtail stigma in general. There appears to be a possibility for positive social change if personnel (and veterans) were given the opportunity to seek care while remaining anonymous. Positive change could improve life at the individual and family level, but potentially could impact life at an organizational or

societal level if individuals were no longer forced to choose between career (and career protecting behaviors) or getting care, to such a degree that suicide seems an option compared to being disclosed as weak. Recommendations for practice are to find a way to allow personnel and veterans to seek care anonymously. The new and growing discipline of treatment online may be an option. A suggestion is to help personnel to get care on weekend days and in ways (in civilian clothes) that do not alert others as to their care seeking. This idea seems obvious given the level of influence stigma exerts in the military culture and suggests some conclusions.

Conclusions

Stigma is strong and entrenched. Career protecting behavior is common in the military and veteran communities, and currently consists of avoiding care seeking. A possible solution may be treatment online. A solution that could circumvent stigma and could help personnel and veterans to seek care without disclosing their identity may be to produce an opportunity for individuals to seek care on the weekends and in civilian clothes in order to offer more anonymity. Among the suggestions offered from participants, was this very suggestion.

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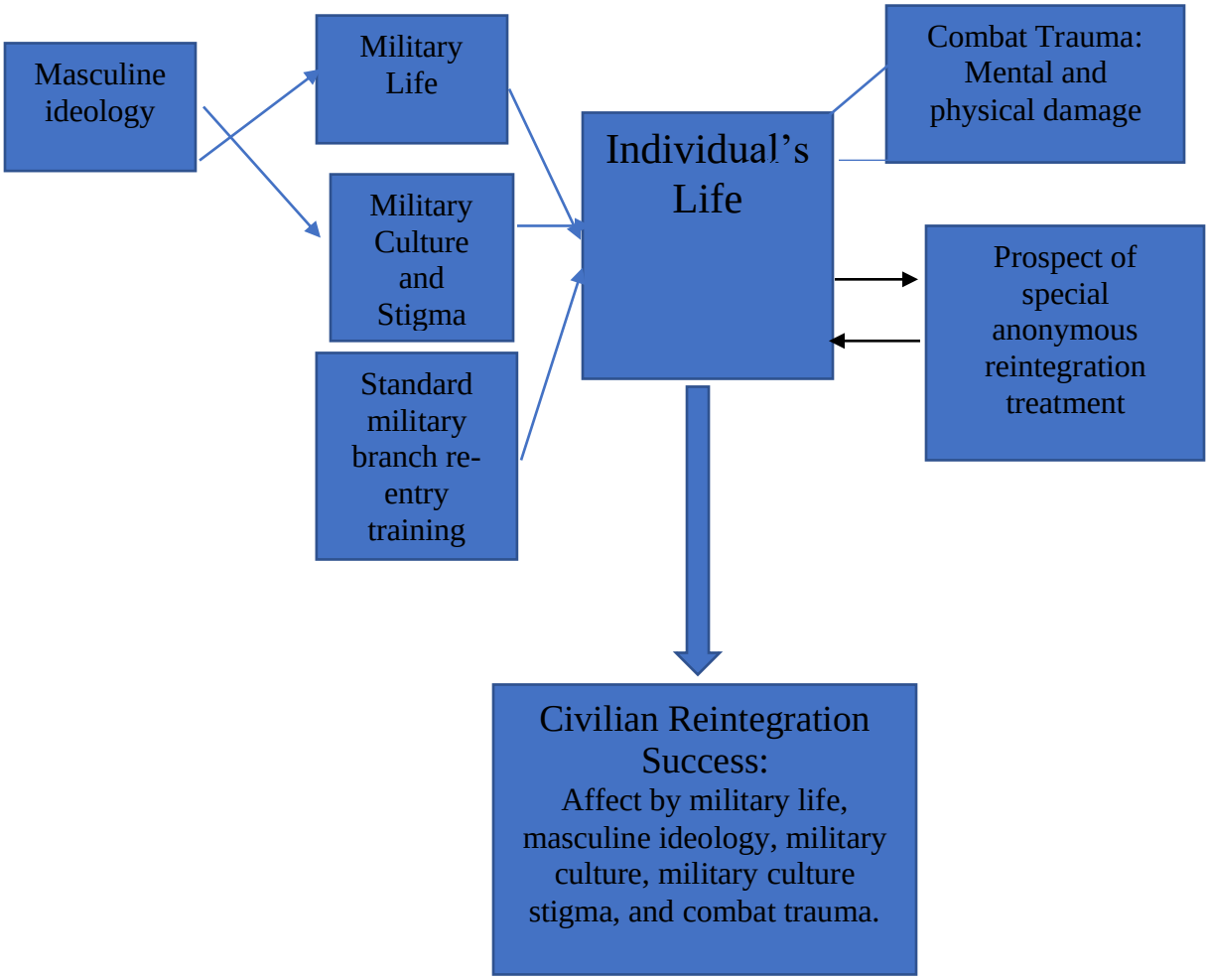
Appendix A: Flowchart of Military Life and Unknown Attitudes Toward Care Seeking-

With Respect to the Lack of Anonymity or Privacy



Appendix B: List of Procedural Steps for Collecting Data

1. Place add for the study on Facebook.
2. Page describing the study.
3. Consent I: for the questionnaire.
4. Questionnaire.
5. Transition page: Thank you for participating, Invitation to Interview.
6. Commitment page: Explain the interview, choice to participate
7. Choice not to participate: thank you for participating, and resources page.
8. Choice to participate in interview:
9. Consent II: for the interview
10. Contact information page: pseudonym, email or phone number, choice to interview via email or phone
11. Contact the participants, set time for interview.
12. Interview protocol
13. Exit: thank you, resources.

Appendix C: Facebook Ad

All that you do is appreciated!

"I am interested in studying what military personnel and veterans think about care seeking prior to discharge with respect to the lack of anonymity or privacy. The following are questions seeking information that will help me understand how you feel about these topics. Please feel free to add anything you think is important."

Appendix D: Introduction to the Study, Invitation, and Demographics

You are invited to participate is a short questionnaire survey of just 5 questions. I am interested in learning what veterans and military personnel think about the prospect of anonymity when taking part in reintegration treatment/training. How do you think you might feel if you had the chance to get training or help for problems that come up when returning to civilian life, while your information and answers to questions remained private? Your efforts may help others in the long run by informing those of us who try to help veterans and military personnel. If you decide to participate in this short study, you will be asked to sign a consent form, which follows, and then you will be directed to the questionnaire survey. Thank you for considering participation.

If you are willing to participate in this short study, please complete the consent form on the following page.

Appendix E: A Short Study of Attitudes Among Veterans and Military Personnel Regarding Care Seeking and the Lack of Anonymity or Privacy

CONSENT FOR SURVEY QUESTIONNAIRE

You are invited to take part in a research study about attitudes of military personnel and veterans toward seeking care prior to discharge and the lack of anonymity or privacy, and what you think should be part of reintegration treatment/training. Only those who have current or past military experience can participate. To participate you must:

1. Be at least 18 years old
2. Give consent
3. Have military experience

Background:

This study is being conducted by myself, Mavis Christopher, a doctoral student at Walden University. The purpose of the study is to understand what veterans' and military personnel's attitudes might be toward the prospect of anonymity or privacy when getting help, counseling, training, or treatment for reintegration.

Procedures:

If you agree to be in this study, you will be asked to:

1. Answer a short 5-10 minutes questionnaire.
2. Participate in a short follow-up interview about the same topic, in order to see if you have other ideas or concerns about anonymous treatment for medical problems.

Voluntary Nature of the Study

Participation in this study is voluntary. You are free to accept or turn down this invitation. No one connected with the military will know if you participate or not, and no one will treat you differently. If you decide to be in the study now, you can still change your mind later.

Risks and Benefits of Being in the Study:

Being in this type of study involves some minor discomfort that can be encountered in daily life, such as fatigue, stress associated with memories of military experience, or becoming upset. Being in this study does not pose risk to your safety or wellbeing and you may stop at any point. There are no direct benefits to you, beyond knowing that you helped to inform the research community about attitudes of military personnel and getting help or care. You may ask any questions that you have now, or if you have questions later, you may contact the researcher via email at: mavis.christopher@waldenu.edu. If you wish to talk privately about your rights as a participant, you can also call the Research Participant Advocate at Walden University: 612-312-1210. Walden University's approval number for this study is 10-16-17-0112694 and it expires on October 15, 2019. Please print or save this consent form for your records.

If you feel you understand this study well enough to make a decision about participating in the questionnaire and follow-up interview, please indicate your consent by completing the items below.

Obtaining Your Consent:

Please provide a first name (it may be your real name or a made-up name) _____

Your age (you must be at least 18 years or older) _____
Today's date: _____

Proceed to the questionnaire and follow-up interview by clicking on the link below.

\

Appendix F: Veterans and Military Personnel Attitudes Survey Questionnaire

1. What do you think about asking for help with problems you are dealing with?

2. What are your concerns with getting help?

3. What things should be part of reintegration treatment?

4. What kind of training would you like to take for reintegration?

5. Please add anything else you think is important. You may share information about your experiences, about asking for help, about what others might think if they knew you needed help or anything else.

Thank you for participating in this short survey questionnaire and thank you for your service. I am grateful for your dedication. During the time you took to complete this interview, you may have realized you might want to get help with certain problems. The Veterans Administration (VA) has many programs available to you. If you think you might want to consider getting help for an issue, I suggest you start with the VA website
Veterans Administration (VA) website: va.gov
VA Crisis Line: 1-800-273-8255 (Press 1)
Veterans Administration (VA): Customer Service 1-800-827-1000
Veterans Administration (VA) Emergency: 1-877-927-8387
Again, thank you very much for your service.

Appendix G: Invitation to Participate in a Short Follow-up Interview

I am interested in further understanding your feelings about remaining anonymous during treatment. You are invited to participate in a short follow-up interview by email or by phone. If you do not wish to participate beyond the questionnaire that is fine. However, if you wish to continue participating either by phone or email please indicate so by providing your contact information on the following page. I will call you or email you and set a time that fits your schedule to interview you. The Interview will take about ten to twenty minutes, depending how much you wish to share. During the interview you may stop at any time if you wish. If you wish to participate in the interview, please continue to the next page.

Appendix H: Personal Contact Information for Follow-up Interview

Thank you for deciding to participate in the short interview. It should take approximately ten to twenty minutes, and you can stop at any time. In order to interview you I will need your contact information. If you wish for me to interview you via the phone, please provide your phone number and a preferred time to call you. If you prefer that I interview you via email, please provide your email address and I will email.

Today's date _____

I wish to be interviewed by phone, here is my phone number: _____

A good time to call me is _____

I prefer to be interviewed via email, here is my email address _____

_____

Appendix I: A Short Study of Attitudes Among Veterans and Military Personnel Regarding Care Seeking and the Lack of Anonymity or Privacy

CONSENT FOR FOLLOW-UP QUESTIONNAIRE

You are invited to take part in a research study about attitudes of military personnel and veterans toward seeking care prior to discharge and the lack of anonymity or privacy, and what you think should be part of reintegration treatment/training. Only those who have current or past military experience can participate. To participate you must:

1. Be at least 18 years old
2. Give consent
3. Have military experience

Background:

This study is being conducted by myself, Mavis Christopher, a doctoral student at Walden University. The purpose of the study is to understand what veterans' and military personnel's attitudes might be toward the prospect of anonymity or privacy when getting help, counseling, training, or treatment for reintegration.

Procedures:

If you agree to be in this study, you will be asked to:

3. Answer a short 5-10 minutes questionnaire.
4. Participate in a short follow-up interview about the same topic, in order to see if you have other ideas or concerns about anonymous treatment for medical problems.

Voluntary Nature of the Study

Participation in this study is voluntary. You are free to accept or turn down this invitation. No one connected with the military will know if you participate or not, and no one will treat you differently. If you decide to be in the study now, you can still change your mind later.

Risks and Benefits of Being in the Study:

Being in this type of study involves some minor discomfort that can be encountered in daily life, such as fatigue, stress associated with memories of military experience, or becoming upset. Being in this study does not pose risk to your safety or wellbeing and you may stop at any point. There are no direct benefits to you, beyond knowing that you helped to inform the research community about attitudes of military personnel and getting help or care. You may ask any questions that you have now, or if you have questions later, you may contact the researcher via email at: mavis.christopher@waldenu.edu. If you wish to talk privately about your rights as a participant, you can also call the Research Participant Advocate at Walden University: 612-312-1210. Walden University's approval number for this study is 10-16-17-0112694 and it expires on October 15, 2019. Please print or save this consent form for your records.

If you feel you understand this study well enough to make a decision about participating in the questionnaire and follow-up interview, please indicate your consent by completing the items below.

Obtaining Your Consent:

Please provide a first name (it may be your real name or a made-up name)
_____

Your age (you must be at least 18 years or older) _____
Today's date: _____ _____

Proceed to the questionnaire and follow-up interview by clicking on the link below.

Appendix J: Follow-up Interview Protocol

1. What do you know about stigma in the military culture? _____

   _____

2. If this has affected you, could you please explain? _____

   _____

3. What do you think about the military's efforts to reduce stigma? _____

   _____

4. What reasons would stop you from seeking help or getting care? _____

5. What would make it easier for you to seek help or get care? _____

6. Could you explain further? _____

7. Do you know of others who avoid seeking care or getting help? Could you explain further? _____

8. What do you think about the idea of remaining anonymous? _____

9. Could you explain how this might affect you? _____

10. Is there anything else you would like to add about these subjects? _____

11. Is there anything else you would like to add to help us understand your thought and feelings about the prospect of anonymous reintegration training? _____

Appendix K: Thank You for Participating and Resources

To be emailed to those who participated in the interview via email, or postal mailed. And to be emailed, or sent by postal mail, to those who participated in the interview by phone.

THANK YOU

Thank you for taking the time to participate in the short follow-up interview. I realize your time is valuable and appreciate the time you have given me. Thank you also for your service in the military. I am grateful for your dedication. During the time you took to complete this interview, you may have realized you might want to get help with certain problems. The Veterans Administration (VA) has many programs available to you. If you think you might want to consider getting help for an issue we suggest you start with the VA website

Veterans Administration (VA) website: va.gov

VA Crisis Line: 1-800-273-8255 (Press 1)

Veterans Administration (VA): Customer Service 1-800-827-1000

Veterans Administration (VA) Emergency: 1-877-927-8387

Again, thank you very much for your service.