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AWARD NUMBER: W81XWH-11-2-0010

TITLE: Facilitating Soldier Receipt of Needed Mental Health Treatment

PRINCIPAL INVESTIGATOR: Thomas W. Britt

Contracting Organization: Clemson University, Clemson, SC 29634,

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Fort Detrick, Maryland 21702-5012

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W81XWH-11-2-0010

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6. AUTHOR(S)
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5d. PROJECT NUMBER

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Clemson University
Clemson, SC 29634

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13. SUPPLEMENTARY NOTES

14. ABSTRACT
The present report provides a summary of third year activities for the three-year project. Key accomplishments include Institutional Review Board (and MRMC Oversight approval) amendments for the second phase of the longitudinal survey study, completion of the Time 2 assessment and summary of the overall longitudinal study, and the development of the initial version of the \\Facilitating Mental Health Treatment (FMHT)" intervention. A report of the results of the longitudinal study was given to key leaders in the 3rd Infantry Division and to mental health providers at Fort Stewart. Two empirical articles based on the research supported by the grant were in press in academic journals in Year 3 of the grant, and a symposium and two presentations were delivered at two national conferences highlighting research supported by the grant. A 12-month extension was approved for the grant1 and key activities for the next quarter are completing our revision of the FMHT training and coordinating the intervention study with 3rd Infantry Division leadership.

15. SUBJECT TERMS
Mental Health Treatment, Military, Stigma, Barriers, Negative Attitudes

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			USAMRMC
U	U	U	UU	61	19b. TELEPHONE NUMBER *(include area code)*

TABLE OF CONTENTS

1. **INTRODUCTION:** Narrative that briefly (one paragraph) describes the subject, purpose and scope of the research.

The studies being supported under the grant titled "Facilitating Soldier Receipt of Mental Health Treatment" are all designed to provide a better understanding of those factors that facilitate and hinder Soldiers from getting treatment for mental health problems caused by exposure to traumatic events during combat. In the first year of the grant two qualitative studies were conducted, one with focus groups of Soldiers of different rank regarding their perceptions of the determinants of treatment seeking, and the second involving interviews with Soldiers who sought treatment while on active duty. In the second year of the grant a longitudinal study was conducted to examine the predictors of treatment seeking among military personnel. The third year of the grant involved developing unit training to improve the climate associated with Soldiers getting mental health treatment. This report identifies the SOW and accomplishments for the third year of the grant.

2. **KEYWORDS:** Provide a brief list of keywords (limit to 20 words).

Barriers, Facilitators, Military Personnel, Treatment Seeking, Unit Climate, Stigma, Attitudes Toward Mental Health Treatment

3. **ACCOMPLISHMENTS:** The PI is reminded that the recipient organization is required to obtain prior written approval from the awarding agency Grants Officer whenever there are significant changes in the project or its direction.

What were the major goals of the project?
List the major goals of the project as stated in the approved SOW. If the application listed milestones/target dates for important activities or phases of the project, identify these dates and show actual completion dates or the percentage of completion.

Statement of Work Objectives for Year 3

I. Based on the studies conducted, develop a facilitating mental health treatment (FMHT) intervention to reduce barriers to treatment seeking and to increase catalysts to care.
2. Make changes to the intervention based upon feedback from unit leaders, mental health professionals, and our consultants from the WRAIR.
3. Identify a control intervention focusing on standard stress management training of comparable length as the FMHT intervention.
4. Submit an expedited research protocol to the Institutional Review Board at Clemson University. Upon approval submit to the Office of Research Protection at Ft. Detrick, MD.
5. Work with military leaders to identify two battalions whose platoons will receive either the FMHT intervention or the standard stress management intervention.
6. Conduct the pilot test of the FMHT with the participating units, including pre- and post-intervention surveys.
7. Deliver briefings based on the pilot test of the FMHT intervention to unit leaders.

What was accomplished under these goals?

For this reporting period describe: I) major activities; 2) specific objectives; 3) significant results or key outcomes, including major findings, developments, or conclusions (both positive and negative); and/or 4) other achievements. Include a discussion of stated goals not met. Description shall include pertinent data and graphs in sufficient detail to explain any significant results achieved. A succinct description of the methodology used shall be provided. As the project progresses to completion, the emphasis in reporting in this section should shift from reporting activities to reporting accomplishments.

Objective 1: The first draft of this intervention was presented to Walter Reed Army Institute of Research (WRAIR) consultants on 12 Oct 13. We are currently revising the intervention based upon the feedback from that meeting and expect to have a revised intervention completed in the coming months.

Objective 2: As indicated above, we are in the process of making changes to the first draft of the FMHT intervention. Once we have a revised intervention that is acceptable to the WRAIR consultants, we are going to get feedback regarding the intervention from student veterans attending Clemson University.

Objective 3: This task has been completed. After consultation with our WRAIR consultant, we decided to include a survey-only control group to examine the effectiveness of the FMHT intervention.

Objective 4: This task will be completed as soon as we have a finalized FMHT intervention

Objective 5: We have begun this task by coordinating with the mental health providers at Fort Stewart, GA. IdentifYing the battalions for inclusion in the intervention study will be a priority in the first months of the 12 month extension.

Objective 6: Our goal is to conduct this intervention in the spring or early summer of2014.

Objective 7: Briefings will be given to unit leaders as soon as possible following the completion of the intervention study.

Key Accomplishments:

- Assessed 1,911 Soldiers at Time 1 regarding their perceptions of behavioral health utilization and receipt of care, and followed up with the assessment of 1,652 Soldiers at Time 2. The Time 2 data collection occurred as a function of our research team setting up a station at the Pre-Deployment Processing site for the 4^{1}h Brigade. We collected data from Soldiers for a period of three weeks at this location. Based upon the entire longitudinal effort, we obtained a matched sample of 635 Soldiers with which to conduct longitudinal analyses.

- Based on the Time 1 data collection, we factor analyzed the 62 items assessing determinants of treatment seeking among military personnel. The results revealed 10 factors underlying the items, which we labeled: Perceived stigma, positive beliefs about treatment, operational impediments, public stigma, negative beliefs about treatment, negative beliefs about medication, treatment facilitators, self-reliance, lack of information, and therapy alternatives. A measurement instrument based on these 10-factors has been given to fellow researchers in the field. The items comprising this measure are included in the first 10 pages of the Appendix.

Key Accomplishments (continued):

- In the third year of the grant, we had two manuscripts accepted for publication, and these articles will be published in the next few months. The Appendix contains the page proofs for both articles. One of the articles (to be published in the *Journal of Positive Psychology)* uses the results from the Year 1 study conducting interviews with Soldiers who sought treatment while on active duty to highlight how seeking treatment combines elements of psychological (facing inner distress) and moral (confronting potential negative reactions from others) courage. The second article (to be published in *Military Psychology)* provides a smnmary of the barriers, facilitators, and perceptions of mental health treatment based upon the Year 1 focus group and interview studies. This article highlights how new information obtained through the use of qualitative methods indicates the importance of novel interventions to increase the likelihood that Soldiers will get mental health treatment. In addition to the two articles that are in press, a symposium and two presentations were also delivered to the armual meetings of the International Society for the Study of Traumatic Stress and the American Psychological Association.

- The first draft of the FMHT was completed and given to WRAIR consultants for feedback. This intervention was based on the results of the studies conducted in the first two years of the grant, as well as existing interventions that have been conducted by other researchers on the stigma of treatment seeking in the military. The WRAIR consultants provided detailed feedback on how they wanted the intervention to be modified so that it was based more on the findings from our studies and so it was more engaging for the participants. The revised training will not "sugarcoat" the potential negative effects of seeking treatment for mental health problems, but will help Soldiers place these possible negative effects within the context of what could happen if symptoms go untreated and produce more severe effects.

What opportunities for training and professional development has the project provided?
If the project was not intended to provide training and professional development opportunities or there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe opportunities for training and professional development provided to anyone who worked on the project or anyone who was involved in the activities supported by the project. "Training" activities are those in which individuals with advanced professional skills and experience assist others in attaining greater proficiency. Training activities may include, for example, courses or one-on-one work with a mentor. "Professional development" activities result in increased knowledge or skill in one's area of expertise and may include workshops, coriferences, seminars, study groups, and individual study. Include participation in conferences, workshops, and seminars not listed under major activities.

Two graduate students have been funded during Year 3 of the grant. This funding has resulting in professional development for the students in terms of data management and analysis, writing presentations and manuscripts for publication, and designing effective unit training.

How were the results disseminated to communities of interest?
If there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe how the results were disseminated to communities of interest. Include any outreach activities that were undertaken to reach members of communities who are not usually aware of these project activities, for the purpose of enhancing public understanding and increasing interest in learning and careers in science, technology, and the humanities.

The items we developed assessing the determinants of treatment seeking among military personnel were provided to interested parties, including a psychologist working for the VA.

What do you plan to do during the next reporting period to accomplish the goals?
If this is the final report, state "Nothing to Report."
Describe briefly what you plan to do during the next reporting period to accomplish the goals and objectives.

As detailed in our quarterly reports, we have encountered delays in getting access to the Soldiers in order to complete key objectives. Most recently, the brigade of the 3'd Infantry Division we were working with deployed to Afghanistan. However, this Brigade is scheduled to return by the end of this year. In the next three months, we will reach out to leadership of the Brigade in order to obtain approval for the final intervention study proposed in the grant. In addition, we will complete the revision of the FMHT intervention for re-examination by our WRAIR consultants. Finally, we have already begun writing manuscripts based upon the longitudinal study conducted in Year 2, and hope to have them under review in the next four months.

4. IMPACT: Describe distinctive contributions, major accomplishments, innovations, successes, or any change in practice or behavior that has come about as a result of the project relative to:

What was the impact on the development of the principal discipline(s) of the project?
If there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe how findings, results, techniques that were developed or extended, or other products from the project made an impact or are likely to make an impact on the base of knowledge, theory, and research in the principal disciplinary field(s) of the project. Summarize using language that an intelligent lay audience can understand (Scientific American style).

In addition to the publications and presentations developed based on the research, the activities conducted under the third year of the grant have the potential to change the way in which the determinants of treatment seeking are perceived by the military and scientific communities. Our assessment of these determinants represents both facilitators and impediments to treatment seeking. In addition, the unit training we are developing has the potential to change the climate associated with treatment seeking so that Soldiers are encouraged to get treatment when needed and return to accomplish the unit's operational mission.

What was the impact on other disciplines?
If there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe how the findings, results, or techniques that were developed or improved, or other products from the project made an impact or are likely to make an impact on other disciplines.

Nothing to Report.

What was the impact on technology transfer?
If there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe ways in which the project made an impact, or is likely to make an impact, on commercial technology or public use, including:

- *transfer of results to entities in government or industry;*
- *instances where the research has led to the initiation of a start-up company; or*
- *adoption of new practices.*

Nothing to Report.

What was the impact on society beyond science and technology?
If there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe how results from the project made an impact, or are likely to make an impact, beyond the bounds of science, engineering, and the academic world on areas such as:

- *improving public knowledge, attitudes, skills, and abilities;*
- *changing behavior, practices, decision making, policies (including regulatory policies), or social actions; or*
- *improving social, economic, civic, or environmental conditions.*

The activities performed under the third year of the grant have the potential to be applied to seeking treatment for mental health problems beyond the military, including personnel in other high stress occupations and even the general public.

S. CHANGES/PROBLEMS: The Project Director/Principal Investigator (PD/PI) is reminded that the recipient organization is required to obtain prior written approval from the awarding agency Grants Officer whenever there are significant changes in the project or its direction. If not previously reported in writing, provide the following additional information or state, "Nothing to Report," if applicable:

Changes in approach and reasons for change
Describe any changes in approach during the reporting period and reasons for these changes. Remember that significant changes in objectives and scope require prior approval of the agency.

All changes are reported above.

Actual or anticipated problems or delays and actions or plans to resolve them
Describe problems or delays encountered during the reporting period and actions or plans to resolve them.

Problems with delays in access to military personnel for the FMHT treatment, and strategies for addressing these delays, have been provided above.

Changes that had a significant impact on expenditures
Describe changes during the reporting period that may have had a significant impact on expenditures, for example, delays in hiring staff or favorable developments that enable meeting objectives at less cost than anticipated

Nothing to Report.

Significant changes in use or care of human subjects, vertebrate animals, biohazards, and/or select agents
Describe significant deviations, unexpected outcomes, or changes in approved protocols for the use or care of human subjects, vertebrate animals, biohazards, and/or select agents during the reporting period If required, were these changes approved by the applicable institution committee (or equivalent) and reported to the agency? Also specifY the applicable Institutional Review Board/Institutional Animal Care and Use Committee approval dates.

Significant changes in use or care of human subjects

Nothing to Report.

Significant changes in use or care of vertebrate animals.

Not Applicable

Significant changes in use of biohazards and/or select agents

Not Applicable

6. PRODUCTS: List any products resulting from the project during the reporting period. If there is nothing to report under a particular item, state "Nothing to Report."

- **Publications, conference papers, and presentations**
  Report only the major publication(s) resulting from the work under this award.

  Journal publications. *List peer-reviewed articles or papers appearing in scientific, technical, or professional journals. IdentifY for each publication: Author(s); title; journal; volume: year; page numbers; status of publication (published; accepted, awaiting publication; submitted, under review; other); acknowledgement of federal support (yes/no).*

Pury, C.L.S., Britt, T.W., Zinzow, H. Raymond, M.A. (in press). Blended courage: Moral and psychological courage elements in mental health treatment seeking by active duty military personnel. *Journal of Positive Psychology.*

Zinzow, H., Britt, T., Pury, C., Raymond, M.A., McFadden, A., & Burnette, C. (in press). Barriers and facilitators of mental health treatment-seeking among active duty Army personnel. *Military Psychology.*

Statements of acknowledgment for the support of the grant were included in both documents. Although these papers were "in press" at the time of the writing of the initial report, they have recently been published. The published versions are included in the Appendix.

Books or other non-periodical, one-time publications. *Report any book, monograph, dissertation, abstract, or the like published as or in a separate publication, rather than a periodical or series. Include any significant publication in the proceedings of a one-time conference or in the report of a one-time study, commission, or the like. Identify for each one-time publication: Author(s); title; editor; title of collection, if applicable; bibliographic information; year; type of publication (e.g., book, thesis or dissertation); status of publication (published; accepted, awaiting publication; submitted, under review; other); acknowledgement of federal support (yes/no).*

None to Report.

Other publications, conference papers, and presentations. *Identify any other publications, conference papers and/or presentations not reported above. Specify the status of the publication as noted above. List presentations made during the last year (international, national, local societies, military meetings, etc). Use an asterisk (*) if presentation produced a manuscript.*

Britt, T.W. (2012, November). Chair of symposium titled *Barriers and facilitators of behavioral health care utilization in a military context: Implications for intervention.* Symposium presented at the Annual Conference ofthe International Society for the Study of Traumatic Stress, Los Angeles, CA.

Zinzow, H., Britt, T.W., Pury, C.L.S., & Raymond, M. (2012, November). Connecting military personnel to mental health treatment: Barriers, facilitators, and intervention recommendations. In T.W. Britt (Chair) *Barriers and facilitators of behavioral health care utilization in a military context: Implications for intervention.* Symposium presented at the Annual Conference of the International Society for the Study of Traumatic Stress, Los Angeles, CA.

Pury, C. L. S., Britt, T. W., Zinzow, H. M., Raymond, M.A., McFadden, A. C. (2013, August). *Low Levels of Savoring Predict Treatment Seeking in an Active-Duty Military Sample.* Paper presented at the American Psychological Association 2013 Annual Convention, Honolulu, HI.

Statements of acknowledgment for the support of the grant were included in both documents.

- **Website(s) or other Internet site(s)**

List the URL for any Internet site(s) that disseminates the results of the research activities. A short description of each site should be provided. It is not necessary to include the publications already specified above in this section.

Nothing to Report.

- **Technologies or techniques**

IdentifY technologies or techniques that resulted from the research activities. In addition to a description of the technologies or techniques, describe how they will be shared.

Nothing to Report.

o **Inventions, patent applications, and/or licenses**

IdentifY inventions, patent applications with date, and/or licenses that have resulted from the research. State whether an application is provisional or non-provisional and indicate the application number. Submission of this information as part of an interim research performance progress report is not a substitute for any other invention reporting required under the terms and conditions of an award.

Nothing to Report.

o **Other Products**

IdentifY any other reportable outcomes that were developed under this project. Reportable outcomes are defined as a research result that is or relates to a product, scientific advance, or research tool that makes a meaningful contribution toward the understanding, prevention, diagnosis, prognosis, treatment, and/or rehabilitation of a disease, injury or condition, or to improve the quality of life. Examples include:

- *data or databases;*

- *biospecimen collections;*
- *audio or video products;*
- *software;*
- *models;*
- *educational aids or curricula;*
- *instruments or equipment;*
- *research material (e.g., Germplasm; cell lines, DNA probes, animal models);*
- *clinical interventions;*
- *new business creation; and*
- *other.*

A comprehensive measurement scale assessing the determinants of mental health treatment seeking is provided in the first 10 pages of the Appendix.

7. PARTICIPANTS & OTHER COLLABORATING ORGANIZATIONS

What individuals have worked on the project?

Provide the following information for: (1) PDs/Pis; and (2) each person who has worked at least one person month per year on the project during the reporting period, regardless of the source of compensation (a person month equals approximately 160 hours of effort). If information is unchanged from a previous submission, provide the name only and indicate "no change."

Example:

Name:	*Mary Smith*
Project Role:	*Graduate Student*
Researcher Identifier (e.g. ORCIDID):	*1234567*
Nearest person month worked:	*5*
Contribution to Project:	*Ms. Smith has performed work in the area of combined error-control and constrained coding.*
Funding Support:	*The Ford Foundation (Complete only if the funding support is provided from other than this award).*

Name:	Thomas W. Britt, Ph.D.
Project Role:	Principal Investigator
Researcher Identifier (e.g. ORCID ID):	016034
Nearest person month worked:	6
Contribution to Project:	Managed the overall project. Contributed to manuscripts and presentations

Name:	CynthiaL.S. Pmy, Ph.D.
Project Role:	Co-Investigator
Researcher Identifier (e.g. ORCID ID):	007609
Nearest person month worked:	4
Contribution to Project:	Contributed to design of studies and unit training. Contributed to manuscripts and presentations.

Name:	Heidi M. Zinzow, Ph.D.
Project Role:	Co-Investigator
Researcher Identifier (e.g. ORCID !D):	041732
Nearest person month worked:	4
Contribution to Project:	Contributed to design of studies and unit training. Contributed to manuscripts and presentations.

Name:	Mary A. Raymond, Ph.D.
Project Role:	Co-Investigator
Researcher Identifier (e.g. ORCID ID):	012451
Nearest person month worked:	3
Contribution to Project:	Contributed to design of studies and unit training. Contributed to manuscripts and presentations.

Name:	Kristen S. Jennings, M.S.
Project Role:	Graduate Student
Researcher Identifier (e.g. ORCID ID):	054194
Nearest person month worked:	6
Contribution to Project:	Conducted data management and analysis; contributed to development of unit and leader training.

Name:	Hiu Ngae (Janelle) Cheung, B.S.
Project Role:	Graduate Student
Researcher Identifier (e.g. ORCID !D):	049084
Nearest person month worked:	6
Contribution to Project:	Conducted data management and analysis; contributed to development of unit and leader training.

Name:	Anna C. McFadden, M.S.
Project Role:	Graduate Student
Researcher Identifier (e.g. ORCID ID):	047533
Nearest person month worked:	2
Contribution to Project:	Conducted data management and analysis; contributed to development of unit and leader training.

8. Has there been a change in the active other support of the PD/PI(s) or senior/key personnel since the last reporting period?

If there is nothing significant to report during this reporting period, state "Nothing to Report." If the active support has changedfor the PDIPI(s) or senior/key personnel, then describe what the change has been. Changes may occur, for example, if a previously active grant has closed and/or if a previously pending grant is now active. Annotate this information so it is clear what has changed from the previous submission. Submission of other support information is not necessary for pending changes or for changes in the level of effort for active support reported previously. The awarding agency may require prior written approval if a change in active other support significantly impacts the effort on the project that is the subject of the project report.

Nothing to Report.

What other organizations were involved as partners?

If there is nothing significant to report during this reporting period, state "Nothing to Report."

Describe partner organizations- academic institutions, other nonprofits, industrial or commercial firms, state or local governments, schools or school systems, or other organizations (foreign or domestic)- that were involved with the project. Partner organizations may have provided financial or in-kind support, supplied facilities or equipment, collaborated in the research, exchanged personnel, or otherwise contributed.

Provide the following iY?formation for each partnership:

Organization Name:

Location of Organization: (i[foreign location list countrv)

Partner's contribution to the project (identify one or more)

- *Financial support;*
- *In-kind support (e.g., partner makes software, computers, equipment, etc., available to project staff);*
- *Facilities (e.g., project staff use the partner's facilities for project activities);*
- *Collaboration (e.g., partner's staffworkwith project staff on the project);*
- *Personnel exchanges (e.g., project staff and/or partner's staff use each other's facilities, work at each other's site); and*
- *Other.*

We met with personnel from the Department of Military Psychiatry at the Walter Reed Army Institute of Research in Forest Glenn, Maryland to deliver the initial version of om FMHT Intervention. The session lasted approximately 4 homs and the WRAIR researchers provided detailed feedback that was used in the creation of the second version of the training.

8. SPECIAL REPORTING REQUIREMENTS

COLLABORATIVE AWARDS: For collaborative awards, independent reports are required from BOTH the Initiating PI and the Collaborating/Partuering PI. A duplicative report is acceptable; however, tasks shall be clearly marked with the responsible PI and research site. A report shall be submitted to https://ers.amedd.arrnv.mil for each unique award.

QUAD CHARTS: If applicable, the Quad Chart (available on https://www.usamraa.army.mil) should be updated and submitted with attachments.

9. APPENDICES: Attach all appendices that contain information that supplements, clarifies or supports the text. Examples include original copies of journal articles, reprints of manuscripts and abstracts, a cmriculurn vitae, patent applications, study questionnaires, and surveys, etc.

Back-up

Factor 1: Perceived Stigma

1. Getting mental health treatment would hurt my chances of getting promoted. (.767)
2. Getting mental health treatment would lead to me getting discharged. (.662)
3. Getting mental health treatment would hurt my security clearance. (.740)
4. Members of my unit might have less confidence in me if I received mental health treatment. (.849)
5. My unit leadership might treat me differently if I received mental health treatment. (.792)
6. Fellow unit members would treat me differently if I received mental health treatment. (.821)
7. I would be seen as weak if I received mental health treatment. (.756)
8. My fellow unit members would think I was just trying to get out of work if I received mental health treatment. (.522)
9. My visit would not remain confidential within my unit if I were to receive mental health treatment. (.518)

Back-up

Factor 2: Positive Beliefs About Treatment

1. I don't trust mental health professionals. (-.522)
2. Mental health professionals are generally competent to treat psychological problems. (.519)
3. If I were experiencing a mental health problem at this point in my life, I could find relief in talking with a mental health professional. (.522)
4. Mental health treatments work. (.606)
5. I would get mental health treatment if I were worried or upset for a long period oftime. (.412)
6. If someone has a mental health problem, seeking treatment is a sign of strength. (.602)
7. If someone has a mental health problem, treatment can improve their relationships. (.939)
8. If someone has a mental health problem, treatment can improve their work performance. (.903)
9. It's OK to get mental health treatment if you need it. (.679)

Back-up

Factor 3: Operational Impediments

1. It would be easier to get mental health treatment if I could skip my chain of command. (.565)
2. I would have to wait too long to get an initial appointment with a mental health provider. (.608)
3. It would be difficult to get time off from work for mental health treatment. (.693)
4. My workload does not allow time for mental health treatment. (.669)
5. Leaders do not adequately communicate how to go about getting treatment. (.710)
6. Leaders are too busy with high OPTEMPO to recognize mental health problems among Soldiers. (.721)

Back-up

Factor4:PublicStigma

1. I would have less confidence in a unit member who had received mental health treatment. (.628)
2. I would not trust a soldier to have my back ifl knew he/she were receiving mental health treatment. (.811)
3. I would be concerned about the operational readiness of a unit member who was getting treatment for a mental health problem. (.843)
4. Soldiers who seek mental health treatment are trying to get out of work. (.701)
5. Soldiers get mental health treatment because they cannot handle military life. (.731)
6. Soldiers who get mental health treatment had problems before they joined the Army. (.665)

Back-up

Factor 5: Negative Beliefs About Treatment

1. I would feel too guilty about burdening my unit members with my responsibilities to seek treatment. (.629)
2. The idea of talking about my problems during therapy makes me uncomfortable. (.833)
3. If I received mental health treatment, I'd have to think about a lot of issues I'd rather just ignore. (.877)
4. Mental health professionals are just going to tell me things I already know about myself. (.542)

Factor 6: Negative Beliefs About Medications

1. The medications prescribed by mental health providers are usually addictive. (.705)
2. If I were to receive mental health treatment, I might be prescribed medicine that would interfere with my ability to do my job. (.712)
3. I would not want to take medication for mental health problems because I don't know how it would affect me. (.740)
4. Mental health providers are more likely to prescribe medication than to provide counseling. (.626)
5. Medications are not a good way to treat a mental health problem. (.652)

Factor 7: Treatment Facilitators

1. Friends and family would encourage me to go get mental health treatment if I needed it. (.696)
2. My leaders would encourage me to go get treatment ifi needed it. (.721)
3. My fellow unit members would encourage me to go get treatment ifi needed it. (.746)
4. I would seek treatment as a way to take care ofmyselfifi needed to. (.484)

Back-up

Factor 8: Self-Reliance

1. I prefer to handle problems myself as opposed to seek mental health treatment. (.641)
2. I deal with problems by talking with friends and family as opposed to seeking mental health treatment. (.730)
3. Strong people can get over psychological problems by themselves. (.650)
4. Psychological problems tend to work themselves out without help. (.533)

Factor 9: Lack of Information

1. I do not know where to go to get mental health treatment. (.621)
2. I am familiar with the mental health professionals who could provide treatment if I needed it. (-.740)
3. I do not know what happens during mental health treatment. (.672)

Factor 10: Therapy Alternatives

1. I would rather see a chaplain than a mental health professional for a stress or emotional problem. (.675)
2. I would prefer to deal with mental health problems by making an appointment with my primary care doctor, as opposed to seeking mental health treatment. (.696)
3. I would be more likely to seek mental health treatment if it were offered in a medical care facility, as opposed to a behavioral health clinic. (.472)

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Blended courage: Moral and psychological courage elements in mental health treatment seeking by active duty military personnel

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We propose that seeking mental health care in an environment with heightened stigma may combine elements of both psychological and moral courage. Interviews of 32 active duty US Army personnel about their process of seeking current mental health care were analyzed for themes of voluntary action, personal risk, and noble or worthwhile goals (benefits). Risks and benefits were divided into internal risks and benefits, characteristic of psychological courage; and external risks and benefits, characteristic of moral courage. Concerns about external risks were themes in all narratives, while concerns about internal risks were themes in only about half of narratives. Both internal and external benefits of treat ment were themes in approximately three quarters of the narratives, whereas doubts about internal (but not external) benefits were also expressed at a similar rate. Thus, participants described an act of blended courage, with social risks of moral courage taken for wellness goals of psychological courage.

Keywords: blended courage; treatment seeking; military, moral courage; psychological courage; stigma

Specific subtypes of courage have been proposed from the earliest days of scholarly interest in the topic by both philosophers (e.g. Plato, 1961) and psychologists (e.g. Lord, 1918). Distinctions between physical courage, shown in physically dangerous situations, and moral courage, shown when standing up to others for what is right, have a lengthy history. More recently, scholars have proposed a third type of courageous action centered on efforts to overcome physical, mental, or emotional limitations, labeled alternatively *psychological courage* (Putman, 1997, 2004) or *vital courage* (Lopez, O'Byrne, & Petersen, 2003). Although these types of courage have been proposed as fuzzy sets allowing for blended types (e.g. Lester & Pmy, 2011), only limited empirical work has been done to examine actions with features of more than one type of courage. In this paper, we examine a particular voluntary action-seeking needed psychological treatment while serving as an active duty member of the armed forces -as a potential example of a blended courage type.

The three components of courage

According to Rate (Rate, 2010; Rate, Clarke, Lindsay, & Sternberg, 2007), the three components of aU types of courage consist of: (a) volition (making a voluntary choice), (b) risks, and (c) a noble or worthwhile goal, or pursuing a benefit. Throughout this paper, we wi11 be concerned with *process courage;* that is, the way in which an individual goes about actually choosing and executing a risky action for a valued goal, rather than *accolade courage,* or the extent to which observers attribute courage to a particular action (Pury & Starkey, 2010). Whereas an action high in process courage might entail a risk for anyone taking that action, it might just as well be risky for only that particular individual at that particular time. The noble value of the goal might be immediately apparent to anyone, or its value, again, might be unique to the particular actor at that particular time (see Pury, Kowalski, & Spearman, 2007). Hence, process courage might or might not describe actions that meet the high bar required for public praise and awards.[1] Rather, process courage involves an individual deciding to voluntarily take a personally risky action to pursue a goal he or she sees as valuable.

Types of courage

Rate's (Rate, 2010; Rate et al., 2007) conception of courage, which involves both personal risks and noble goals, provides a framework for understanding different types of courage in terms of risk – goal pairs. In this approach, we argue that the universe of risk – goal pairs is lumpy and that working towards particular types of goals makes encountering specific types of risks more likely. In other words, courageous acts that involve a particular type of goal may be more likely to involve one type of risk than another. The prototypic physical courage situation involves saving someone else from a clear and present physical danger by voluntarily entering that physically

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dangerous situation, pairing rescue from physical danger with facing that same physical danger. Prototypic moral courage involves standing up to powerful others for what you believe in, with the risk that the others will treat you poorly. Prototypic psychological courage involves facing unpleasant truths or unpleasant treatment experiences in order to attain wellness.

Differences in risks based on type of courage have been supported in the literature. Asking participants to report a time in their lives when they acted with courage, Pury et aL (2007) found three factors of risks and difficulties encountered. These factors differed according to the type of courageous action described, with physical courage actions high in physical risks/difficu1ties, moral courage high in emotional/social difficulty, and risk to the image of the actor, and psychological courage high only in emotional/social difficulty.

Differentiating psychological and moral courage

In this present study, we examine treatment-seeking for psychological problems. Although psychological courage can describe actions as diverse as leaving home for educational goals to dealing with a family health c1isis (Pury et al., 2007), the concept was initially developed to describe the fortitude needed by psychotherapy patients to seek and complete treatment (Putman, 2004), particularly when that treatment involves experiencing the unsettling thoughts, memories, and emotions the patient has been avoiding. Rachrnan (1990), a pioneer in behavior therapy as well as behavioral conceptions of courage, describes the courage required for exposure therapy – the client is required to face exactly those situations that provoke extreme fear. Moreover, they are required to stay in the situation until their fear declines. Risks in psychological courage are primarily internal – facing the loss of psychological stability for personal growth. Psychological courage, then, involves both risks and goals that are internal to the individual.

Moral courage, on the other hand, involves risks of social rejection that are primarily external to the person. This social rejection can be from those immediately around the actor (in the case of a high school student standing up to friends teasing a peer) to facing societal disapproval (in the case of a public figure taking an unpopular stand). When social rejection comes on the job, the individual may face damage to his or her career and loss of current employment (e.g. Rothschild & Miethe, 1999). The goal of moral courage, standing up for what is morally right, is based on the individual's sense of how the external world should be and how she or he ought to function in it. Thus, in contrast to the internal risks and goals of psychological courage, the risks and goals of moral courage are external.

Blended courage

In real life, the risks and goals occurring with any potentially courageous action may not represent a "pure" type. As part of a large multi-method study of types of courage, Lopez and colleagues (Lopez et al., 201 0, Study 4) found evidence for a blend of psychological and moral courage. Although theories suggest that psychological courage is required to overcome the internal risks associated with mental health treatment-seeking, Putman (2004) makes a philosophical case for the societal stigma of admitting a psychological disorder being similar to the societal risks faced in moral courage. Indeed, a large amount of research has documented the stigma associated with possessing a mental illness (Corrigan, 2004; Corrigan & Watson, 2002; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) as well as the stigma associated with seeking treatment for mental hea1th problems (Vogel, Wade, & Haake, 2006; Vogel & Wester, 2003).

Although there is a stigma associated with seeking mental health treatment in society at large, that stigma is magnified in the military, where an emphasis on resilience and toughness makes seeking treatment even more difficult (Britt & McFadden, 2012). In addition to concerns about being embarrassed or viewed different by their peers and leaders as a result of seeking treatment, military personnel may also be concerned with the implications of seeking treatment for obtaining promotion and even for remaining in the military (Britt, 2000; Hoge et al., 2004).

In the present study, we examined blended courage within the context of US Soldiers who sought mental health treatment while on active duty. We interviewed active duty Soldiers who were currently in mental health treatment about the process by which they decided to seek and obtain treatment and about their perceptions regarding barriers and faci1itators to obtaining treatment (Zinzow, Britt, Pury, & Raymond, 2012). We used a semi-structured interview format to maximize the chances that we would not miss a key barrier or facilitator merely because it was not included in a population of quantitative questions. We coded barriers and facilitators based on Rate's three necessary components of courage – volition or a voluntary choice to seek (or to accept) treatment, risks of getting treatment, and goals of getting treatment. Because getting treatment occurred in the past and the larger focus of the study was on barriers and facilitators, we asked participants about the desired end state of goals – benefits, which can be present or absent – rather than about goals, which can be present when they are both likely and unlikely to be met. Risks and benefits were further divided into internal risks and benefits, characteristics of psychological courage; and external risks and benefits, characteristics of moral courage. We hypothesized that treatment seeking in an

environment particularly high in stigma and low in privacy should require elements of both psychological and moral courage.

Methods

Participants

Participants were 32 active duty US Army soldiers (29 male, 3 female) who were currently receiving mental health treatment at a clinic on a large Army post. Most (n "" 25) described their racial or ethnic background as white, with the remaining being Black *(n* = 2), Hispanic *(n* 2), and Other *(n* 3). The mean age was 29.0 (SD 6.5), and there were 17 junior enlisted (El-E4), 14 senior enlisted (E5-E9), and 1 officer. Mean years of service was 8.0 (SD 5.9), and the majority of participants *(n* 29) had deployed on at least one combat operation to Iraq or Afghanistan. At the time of the interview, 18 participants screened positive for PTSD, and 3 screened positive for an alcohol problem (Zinzow et al., 2012). Recruitment ended after data saturation was achieved (in tenns of participants not indicating new infmmation in their responses; see Onwuegbuzie & Leech, 2007).

Procedure

Mental health staff at the clinic informed the soldiers they were treating about the study and interested soldiers provided their contact information to study personnel to arrange a one-on-one interview. Soldiers signed an informed consent document in the presence of an ombudsman. Interviews were conducted by the four PhD-level authors (all civilians) in a private office on the rni1itary base. Interviews lasted approximately 45-90 min.

A semi-structured format was used for the interviews, with questions focused on the experience of seeking and obtaining the current mental health treatment. The interview was introduced to Soldiers as follows:

> The purpose of the present interview is to better understand the key factors in determining whether soldiers get needed mental health treatment, to better understand what occurs during treatment, and the risks and benefits associated with receiving mental health treatment. We also are interested in your thoughts regarding what can be done to better encourage soldiers to get needed help. We are going to use the information we get from these interviews to better identity barriers and facilitators of treatment seeking so as to better design interventions to facilitate the receipt of needed treatment

Interviewer guide questions included the following: *Please describe how you came to be in mental health treatment. What benefits did you see to getting treatment? Did you experience any doubts of your own about seeking treatment?* The complete interviewer guide is presented in Appendix 1. Because it was a semi-structured interview, these questions were guides to the topics to be covered.

Digital audio recordings were made of the interviews and professionally transc1ibed. The researchers reviewed the transcripts to develop coding categories based on identified themes. Themes related to facilitators of and barriers to treatment were reviewed, and separate codes were developed for individual Volition (High, Low, or Shared), Risk (Internal vs. External), and Benefit (Internal vs. External). Participants discussed risks and benefits as either something that was present or desired (e.g. a risk that fellow soldiers would view someone in treatment as a slacker for getting treatment, a benefit that treatment is expected to reduce symptoms) or something that was absent or minimal (e.g. a lower risk of social rejection by having a loved one say that it is OK for them to get treatment, an absent benefit seen when a buddy gets treatment and does not get symptom relief). Thus, risks and benefit categories were further described as High (present or desired) or Low (absent or reduced). Each interview was coded by two trained coders, who were psychology graduate students or advanced psychology undergraduates. Percent agreement between coders for each specific type of volition, risk, or benefit ranged from 0.97 to 0.56, with a mean of 0.75 (SD 0.12). Disagreements were resolved by a PhD third coder. Specific barriers and facilitators are discussed elsewhere (Zinzow et al., 2012), including additional barriers and facilitators not relevant for courage, such as logistical barriers.

Results

Volition

Table 1 presents Volition themes. Consistent with treatment seeking as a courageous response, the majority of participants indicated some degree of personal volition in seeking treatment. Themes indicating the participant made a voluntary choice to seek or continue treatment (High Volition) were present in 69% *(n* 22) of the interviews. These themes included making an initial appointment on his or her own, describing treatment as a personal responsibility, and putting self-care before military concerns. Themes indicating that the participant had, at least at one point, been made to attend treatment by command or lied to avoid treatment (Low Volition) were present in 41% (n = 13) of interviews. Of those with a Low Volition theme present, 54% *(n* 7) also had a High Volition theme present. This finding reflects the fact that participants may have made the decision to seek or not seek treatment at multiple points during their Army careers, as well as the fact that even mandated treatment works via activities and exercises that require cooperation and engagement by the patient. Referrals from within the Army (Shared Volition) were described

Table 1. Coded volition themes in interviews of active duty US soldiers currently in mental health treatment (N = 32).

General theme	Theme	Sample quote	Interviews containing theme	
			n	%
High volition			22	69
	Self-referral; sought appointment on own	I went there voluntarily.	11	34
	It's a personal responsibility	It's still up to individuals themselves to recognize it within themselves, to go, "I think I might have an issue."	7	22
	Need to put self-care before military	One thing I told myself was that I deserved the help and I do. That's my biggest thing, is I deserved the help, I earned it.	5	16
	It's a priority/Important	I don't believe in divorce, I won't get a divorce. This is my only marriage.	2	6
	Decided to be honest on mental health screening	They just knew that I wanted the help and they knew … with the questionnaires and everything that … that I'd answered so that they wouldn't let me leave until I had something done.	2	6
Low volition			13	41
	Ordered to attend treatment by commander or leader	While I was in [country] I experienced a lot of traumatic things that a normal human being shouldn't have to deal with. And when I got back from [country] I was kind of ordered to go seek behavioral health	9	28
	Chose to lie on mental health screenings to avoid treatment	Yeah I lie about that and I should not. So I mean to this day I mark stuff about certain stuff, I'm not going to say, but certain stuff I don't put "yes" to, I always put "no", which it should be "yes".	5	16
Shared volition			15	47
	Referred by medical provider	He started talking to me about Army One Source and that is how I actually went through to get into treatment.	8	25
	Referred by commander or leader	I felt suicidal at that time and then I went back to mental health well actually I went to my commander and told him ... And they referred me to mental health.	5	16
	Leadership identified problems	Well, my chain of command recommended me because I was going through a difficult time	5	16
	Referred by chaplain	I went to see the chaplain and the chaplain referred me to here.	2	6

by 47% (n 15) of participants. While falling short of the Low Volition of a direct command, a referral none-the-less indicates a very strong suggestion by an extema1 agent that a specific action – seeking treatment from a specified clinic – should occur.

Risks

Coded Risks are presented in Table 2.

Internal risks

High Internal Risks, consistent with psychological courage, were mentioned by a bare majority (53%, n = 17) of participants. These risks included concerns about medication side effects, the self-stigma of being "crazy" if one needs treatment, and embarrassment that treatment is needed. Low Internal Risks, indicating that either a particular type of intemal risk was unlikely or that an internal safety factor was present, were mentioned by only 6% (n = 2) of participants. Overall, risks were somewhat consistent with the risk of psychological or emotional distress expected in psychological courage.

External risks

High Extemal Risks, consistent with moral courage, were mentioned by 100% (n 32) of participants. These

Table 2. Coded risk themes in interviews of active duty US soldiers currently in mental health treatment (*N* = 32).

General theme	Theme	Sample quote	Interviews Containing Theme	
			n	%
High internal risks			17	53
	Medications will have negative side effects	Some of them get treatment and they go to the medical side and get all these pills. There are some guys I see, they just don't even function at work.	5	16
	Mental illness means you are "crazy"	I'm the crazy guy.	5	16
	Embarrassment	Rumors float around about seeing mental health.	4	13
	Don't want to depend on others	I don't want to inconvenience anybody else.	3	9
	Will get prescribed meds but don't want them	I don't want prescriptions.	2	6
	Explaining story to a new provider is emotionally taxing	And they switch them so often. I talked to four different providers now for three visits … Like you have to start all over …	2	6
	Mental illness means you are "weak" or "a slacker"	I think it is kind of a copout. I think that I want to go to behavioral health because I don't want to deal with the real Anny.	2	6
	Treatment will make symptoms worse	Mental health pill making you worse than what you started off with …		3
	Showing emotions is difficult or hannful	I didn't know if it was going to make me worse or not.		3
	The nature of treatment is unknown	I did not know I could call at any point and time and at least talk to someone on the phone.		3
	Seeking treatment for something everyone goes through means you are "weak"	He is just weak. Weak, crazy, can't handle it. That is what I would say sometimes.		3
	It is weak to show emotions	I was raised, the man provides for the woman; the man doesn't cry, the man doesn't shed a tear, you know. Men are strong and that's the image I try to put out there.		3
Low internal risks			2	6
	Treating a mental illness is like treating a physical illness	It's kind of like I know I'm not like sick but I know something is 'Wrong with me and I need help to fix it. And I see them as someone who fixes things, like a doctor.	1	3
	Treatment by a caring mental health professional	I will be honest with you, it was (provider) because he talked to me as a, as a person, not a subject or as a patient.		3
High external risks			32	100
	Stigma from military culture	They think if they go to behavior health they will get automatically looked do'WU upon for going there.	19	59
	Lack of career advancement	Like just, you know you got a lot of condition … a lot of serious issues, like, now you cannot go be a drill sergeant because you got too many issues.	13	41
	Stigma from other soldiers	Other soldiers will think that they are weak or will hold that against them.	11	34
	Leadership not supportive	My platoon sergeant would not let us schedule an appointment unless it was within 48 h from the date and that combined with the fact that the treatment that I was receiving was often mocked.	10	31
	Leaders believe soldiers in mental health treatment are malingering	My command sergeant major starting cracking down on everybody that was going to	8	25

(Continued)

Table 2. *(Continued).*

General theme	Theme	Sample quote	Interviews Containing Theme *n*	%
		appointments because he thought we were trying to get out of (work). When we came back they told us we had so much time but we already had orders to deploy again so he thought we were trying to get out of having to deploy again.		
	Differential treatment on the job (e.g. different duties, not trusted)	They started blocking you from favorable action.	7	22
	Stigma from leadership	Being pulled into your battalion command sergeant majors office and being told you did not go through anything worth needing treatment so the fact that you are going to treatment is a waste of tax payer dollars.	6	19
	Treatment itself would interfere with job duties	There's a saying in the military that you can't be a leader if you have PTSD or combat stress.	5	16
	Lack of trust in leadership	I was like "Don't none of these NCOs care, so why bother talking to them?" I don't talk to none of these NCOs (in) my company 'cause they don't care.	5	16
	Lack of confidentiality within chain of command	A lot of units have that gossip from the top to the bottom.	4	13
	Needs of unit/mission must come before O\VII needs	I would sometimes put my personal problems aside just to help out the team, neglecting… helping myself.	4	13
	Stigma from family and friends	The only thing was my parents, with like the meds and stuff. Just that whole stigma.	4	13
	Discharge from Army	'Cause I did not want them to try to kick me out of the military	3	9
	Peers would know	And there is the possibility of them talking, you know ... Not purposely but somehow letting something out of people's sessions and it did happen.	3	9
	Leadership unclear about duty assignment for soldiers in treatment	They supported me pretty much, but they really needed me to deploy again. And the first thing they Mote when they referred me to mental health was "Can he deploy?"	3	9
	Sees treatment as shirking duties, burdening others by taking time off	Because they need personnel and you kind of feel like you are letting the team down.	3	9
	Would be seen by others as malingering	I think my company is..."He's only going to behavior health", or "He's only going to the doctor so he can get out of work."	3	9
	Stigma from society	Somebody is going to be like "Oh you're crazy, you're going to behavior health."	3	9
	Commander would know	If they knew the chain of command would find out, they wouldn't go.	2	6
	Others would know	I am very superstitious of Chaplains. Due to the confidentiality of it.	2	6
	Other career problems	'Cause everybody thinks you're going to lose your security clearance and you might have to change to change your MOS.		3
Low external risks (all)			31	97
Low external risks (social support)			30	94
	Support or encouragement from family or significant other	And my wife was like, "You know you are having problems with this, you are having problems with that. Go get help."	25	78
	Support or encouragement from peer or battle buddy	I have a very supportive team on my hands	13	41

(Continued)

Table 2. *(Continued).*

General theme	Theme	Sample quote	InteiViews Containing Theme	
			n	%
	Support or encouragement from leader	(Leadership) said, you know, we support you, get the help you need.	9	28
	Support or encouragement from other friend	We're good friends we're close and we talked each other about everything, if we have issues. We try to help each other out and he's another one that was like "Hey, you should go seek help."	8	25
Low external risk':/ {other)			6	13
	Role model who shared experience of treatment without negative effects to career	My first sergeant, when I had that sit down with him and I was getting my treatment and everything was going south ... sitting dovm in the office with him, he told me he had gotten help a few times before. That just kind of encouraged me just to keep doing what ▮ was doing, you know what ▮ mean.	4	13
	Leadership approval of mental health	My sergeants were very, very easy to say "Hey, if you need to seek counseling or if you need to talk to somebody, ▮ am here" or "Let me know if you need to go seek counseling; **I'll** let you get off work."	3	9
	Knowing or exposure to someone who went through treatment without negative effects	By no means coming here will hold you (back).		3

risks included stigma for seeking treatment from the military culture, lack of career advancement, and stigma from other soldiers. A variety of other External Risks were also mentioned. Low External Risks, indicating that a particular external risk was absent or not likely, or that an external safety factor was present, were present in 97% (*n* = 31) of the interviews. These were predominantly safety factors of social support or encouragement from family or others; Social Supports were mentioned by 94% (n 30) of total participants. Aside from Social Supports, Low External Risks included role models who sought treatment without negative career effects (an indication that external risk was not present) and leadership approval of mental health issues (which might indicate lack of external risk, safety factor of social support, or both); mentioned by 13% (n 6) of participants. Overall, results were strongly consistent with concerns about the external social risks expected in moral courage, but also revealed that the Soldiers we interviewed had support systems that may have mitigated the effects of these risks.

Benefits

Table 3 presents coded Benefits.

Internal benefits

Themes of High Internal Benefits for therapy, or goals consistent with psychological courage, were present in 75% (n 24) of the interviews. These included the reduction of symptoms causing personal distress, not wanting symptoms to get worse, and recognizing the importance of mental wellness. Concerns about Low Internal Benefits of treatment – that treatment would not reduce symptoms or would fail to yield mental wellness – were present in 84% (*n* = 27) of the interviews. These include a belief that the participant can deal with problems on his or her own, substance use to deal with the problem, and denial of problems, among others. Thus, participants expressed both goals typical of psychological courage and reasons why those goals might not be obtained or were not valuable to begin with.

External benefits

High External Benefits, or goals more consistent with moral courage, were present in 72% (*n* = 23) of interviews. While still involving the individual (instead of third parties only), these benefits touched on ways that

Table 3. Coded benefit themes in interviews of active duty US Soldiers currently in mental health treatment (N = 32).

General theme	Theme	Sample quote	Interviews containing theme	
			n	%
High internal benefit			24	75
	Symptoms causing personal distress	And at that time, I just wanted to talk to somebody. Get some things off of my chest.	14	44
	Don't want symptoms to get worse	Pretty much to prevent myself from going down the -wrong road.	11	34
	Recognize importance of mental wellness	I was tired of being miserable.	9	28
	Treatment will help	Just figure if I can get help, maybe the nightmares -..vill start to diminish.	6	19
	Knowing or exposure to someone who went through treatment and symptoms improved	I've seen a few people go and do whatever they do to get their assistance and I do notice drastic improvements.	5	16
	Had successful treatment in the past	(Treatment) helped me out a while ago, maybe this will help me out.	3	9
	Role model who shared experience of treatment that improved symptoms	Our last Sgt. Major who just left, he was in treatment and he would tell the whole battalion, "I'm in treatment. If you got a problem, go."	2	6
	Exposure to someone who did not get treatment and had a poor outcome (e.g. suicide)	I've seen (untreated mental illness) affect them; where they are late to work with the sleeping. They were just not the same person,		3
Low internal benefit			27	84
	I can deal -with problems on my own/ I'm too strong to need treatment	It was me being strong and trying to say, "Hey, I am going to deal with this on my own."	13	41
	Used substances to deal with problem	I did the drinking and partying and all that other stuff.	11	34
	Denial of problems	I don't view myself as being crazy, I think that, I think that the rest of the world has a problem, not me.	10	31
	Don't trust or connect with providers, so treatment won't work	I just didn't know if they would ever understand what I had been through.	7	22
	Providers don't really care	It's just them checking the block and saying 'Well, I did my part" or "I am getting my paycheck",	4	13
	Mental toughness or being hardened to stressors will get participant through symptoms	You don't need to go to mental health. You can do this yourself.	4	13
	Confusing diagnostic system	You're confused, because you have PTSD, (then) you don't have PTSD but you have this. So you are hearing two different things from mental health personnel.	2	6
	Don't think treatment will work	Not knowing if it is really going to work out this time.	2	6
	Provider will be changed frequently, requiring treatment to start over and reducing efficacy	Starting (again) from scratch … starting from scratch isn't easy.	2	6
	Symptoms won't improve	I was going to stop because I mean I don't feel I'm getting any better.	2	6
	Providers are burned out and won't help	She was just tired of listening to people.		3
	Previous treatment didn't help	Did an initial interview and then my provider gave me Prozac and it didn't really work so I stopped taking that. I didn't see the effect.		3

(Continued)

Table 3. *(Continued).*

General theme	Theme	Sample quote	Interviews containing theme	
			n	%
	Have been through worse in the past	I just thought, "Hey, this is stress, anger, whatever, I'm going to deal with it. You know it's not that bad.		3
	This is a normal reaction and treatment won't help	It was nothing ... I am used *to* everything being hard and messed up.		3
High external benefit			23	72
	Want to be a better person for family	I need to know that I'm trying to do something, not just for me but for my son. I want to be here for him.	11	34
	Symptoms causing impairment in relationships or isolation from others	I know I am physically and mentally not there with my wife. It's like I used to be a lot more loving, more emotional with her.	8	25
	Symptoms creating a risk for self or others	I was going in because, okay, I really want to choke all these people. They know I really want to choke all these people. I should probably go talk to somebody so I don't choke all these people, for their sake and for mine.	7	22
	Treating symptoms will help career	When they started talking about me losing rank I decided I had to do something about it.	3	9
	Symptoms causing impairment at work	When you don't sleep your entire work just goes downhill rapidly.	2	6
Low external benefit			0	0
	Treatment will not improve functioning	*n.a.*	0	0

symptoms affect the individual's behavior with others, and include wanting to be a better person for one's family, symptoms causing impairment in relationships or isolation from others, and symptoms creating a risk for self or others. No interviews had themes of Low External Benefit, although theoretically a concern that treatment would not improve relationships or reduce job impairments, for example, would be possible.

Discussion

Mental health treatment seeking while on Active Duty is characterized by the defining elements of courage. In this study, Rate's (Rate, 2010; Rate et al., 2007) three defining features of courage – volition, personal risk, and worthwhile goal – were prominent themes. While previous research has described the courage needed to seek treatment (e.g. Gans, 2005; Putman, 2004), to our lmowledge this is one of the first empirical demonstrations that individuals in treatment describe their experience in terms of volition, risks, and goals (here described as their desired end state – benefits).

These risks and goals Cio not fall neatly into a psychological or moral courage category. Career and other social risks of moral courage were universally expressed by our sample. Expressed stigma, particularly from military peers and leadership, as well as harm to one's military career, were common concerns. Ironically, one form of this stigma, a belief that seeking treatment indicates psychological weakness, indicates that others see seeking treatment as cowardly (very low accolade courage) while simultaneously increasing the process courage required to successfully enter treatment.

Instances in which social support, rather than stigma, was stated by important others were described by all but *tvvo* of the participants. Thus, both social stigma and social safety signals appear to play an important role in getting into treatment for our sample. This overarching theme of social consequences of an action is most similar to moral courage (Greitemeyer, Fischer, Kastenmiiller, & Frey, 2006).

Internal risks, on the other hand, were expressed by barely half of participants. These risks involved concerns that treatment would involve unpleasant emotions, the need to accept something negative about themselves, or venturing outside one's emotional comfort zone (e.g. Pury et al., 2007). Few participants described safety signals for these concerns. Thus, while concerns about the risks of psychological courage were not uncommon, they were not as lll1iversal nor as frequently combatted as the external risks of moral courage.

Goals were more equally divided among external and internal benefits. The external benefits described all involved improvements in the participants' interaction with the external world – family and significant others, not banning others, and work. While all of these benefits were somewhat more concrete than the more abstract moral concerns of moral courage, such as fixing a wrong, they all represent a way in which the individual is striving to be a better person. Moreover, while these goals were present for the majority of participants, not a single participant explicitly described a concern that therapy might not let them achieve them.

Instead, both the internal goals of psychological courage – predominantly better emotional health (High Internal Benefits) – and concerns that treatment might be either unnecessary or ineffective in symptom alleviation (Low Internal Benefits), were common. They centered on the individual's internal experience of treatment and seem most related to psychological courage (see Putman, 2004). Notably, Shelp (1984) defined courage in medical settings as including the possibility that the desired goal might not be met. In this case, mention of concern that benefits might not occur may also add the risk of futility to stated risks. Taken together, both the high endorsement of internal benefits and the high level of concern they might not be reached is consistent with psychological, rather than moral, courage.

Thus, seeking treatment in a heightened atmosphere of stigma might best be thought of as an act of blended courage, with the social risks of moral courage being taken for the wellness goals of psychological courage. We think this has several important implications.

For courage theory, our data provides a concrete, more empirically-derived example of blended process courage. The necessary features of courage described by Rate are voluntary action, personal risk, and noble goal (Rate, 2010; Rate et al., 2007). While individual volition seems likely to be unchanging from type to type, risks and goals seem to come in natural pairs in the environment, but not always. If I want to save someone from physical danger, I might need to face that same physical danger myself, thus exhibiting classic physical courage. Except when I need to face a different risk: to keep my friend :from risking both his and other lives by driving drunk, I might need to face the social risk of taking away his keys. If I want to stand up to protect the rights of others, I might need to face the social risk of people hating me, thus showing moral courage, except when that hate turns into the genuine physical risk of being injured or killed for my (social) actions. Thus, we suggest, traditional types of courage might be best thought of as loosely-coupled types of goals and risks.

As courage research transitions into interventions to foster process courage, it may be useful to characterize the goals and risks of the courageous action being fostered separately rather than lumping them together as in physical, moral, or psychological courage. Boosting psychological courage may seem a desirable method of increasing needed mental health treatment-seeking, but this may only work insofar as the intervention helps someone see the importance of the goal of mental wellness. Stressing techniques to overcome the risks of psychological courage – baring one's soul to a stranger, for example, or enduring psychological distress during treatment – would address concerns expressed by only about half of our sample. On the other hand, techniques that might help to reduce or overcome the risks present in moral courage – losing face, losing social standing, facing career stagnation – could potentially address concems expressed by all of our participants.

Of course, this study relies on content analysis of interview data. Only the presence or absence of specific themes was analyzed, and future research should incorporate quantitative measures of risks and goals. Moreover, our design was retrospective. Prospective, or even concurrent, data collected before or during treatment-seeking would be needed to determine the extent to which our data represents the live thoughts and experiences of treatment seekers compared to their memory of that action. Our sample was also homogenous: all individuals interviewed were active duty US Army soldiers stationed at a particular post during the same limited time period. The perceived risks and benefits of seeking treatment may be different in different circumstances. Finally, because participants in our sample were all currently in treatment, it may be that they have already overcome many potential risks of treatment and experienced its benefits. They also might not represent all potential treatment seekers.

Overall, the results of this study suggest that blended courage exists and that we might most usefully think of courage in terms of types of risks and types of goals, rather than overall types of courage. Doing so will enable us to pinpoint areas to advance both courage theory and courage interventions.

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Note

1. Note that similar concerns about assessing the extent of psychological wounds (as well as enemy intent) surround the issue of issuing the Purple Heart for PTSD and other psychological injuries of war (Alvarez & Eckholm, 2009).

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Appendix 1. Interviewer guide

(1) Please describe how you carne to be in mental health treatment. (follow-up questions, if unclear: What led to your decision to seek treatment? How did you come to believe that you should get treatment?)

(2) What type of mental health treatment did you receive? (e.g. psychotherapy, pharmacotherapy, chaplain, peer support groups, treatment by doctor/psychiatrist!psychologist, etc.) (follow-up questions: how long were you in treatment? How many sessions did you attend? Do you know what your diagnosis was?)

(3) Before this, had you ever been in treatment before for any other problem? (follow-up with how many times, how long ago, how long in treatment, was it successful?)

(4) How long was it between when you first thought you might need to get treatment and when you actually got treatment? What happened in the meantime?

(5) How long were you experiencing problems or symptoms before you decided to get treatment?

(6) Why did you decide to get treatment?

(7) What benefits did you see to getting treatment? (8) Did you have support from others in seeking treatment? (if yes, What was your relationship to them? How did they offer support?)

(9) What did you think treatment would be like? How has it been / was it different?

(10) Did you put a name or diaguosis with the problems you were having before you went in for treatment, or did you just know something was not right? (if yes, Was your diagnosis the same one that the treatment provider thought you have/had?)

(11) Did you encounter any problems from the A1my when trying to get treatment? (if yes, Please describe them. How did you overcome problems?)

(12) Did you encounter any problems with family members or fiiends when trying to get treatment (if yes, Please describe them. How did you overcome those problems?)

(13) Did you encounter any problems or concerns with the healthcare system when seeking treatment? (e.g. difficulty making appointments, difficulty :finding needed services, perceived lack of eligibility, and expense)

(14) Did you have any other difficulties accessing the treatment you needed? (e.g. scheduling conflicts, time constraints, and transportation)

(15) Did you experience any doubts of your own about seeking treatment? (if yes, Please describe them. How did you overcome those doubts? (Follow-up: What about any beliefs that prevented you from seeking treatment sooner or might have initially hindered seeking treatment? (e.g. pride in self-re1iance, focus on job and family functioning, providers will not understand/believe, treatment not helpful, treatment is for the weak/crazy, and treatment is only for extreme problems))

(16) Did you encounter any other obstacles in seeking treatment? (if yes, Please describe them. How did you overcome those obstacles?)

(17) Before you decided to get treatment, did you know anyone else who had similar problems? (if yes, were they in the Army/military? What was your relationship to him/her/them? How did their symptoms affect them? How did you see your symptoms compared to theirs- better, worse, or the same? Did they get treatment? How did you see treatment affecting him/her/them?)

(18) Before you decided to get treatment, did you lmow anyone (else) in the Army who sought treatment? (if yes, What was your relationship to him/her/them? How did you see treatment affecting them, either on or off duty?)

(19) Before you decided to get treatment, did you lmow anyone outside of the Army who sought treatment? (if yes, What was your relationship to him/her/them? How did you see treatment affecting them? Were they in the military at the time?)

(20) Is there anything in particular that you told yourself or that led you to get treatment?

(21) Is there anything in particular that others did that led you to get treatment?

(22) Is there anything in particular that the Army did that led you to get treatment?

(23) What do you think was the single most helpful thing in getting you in to treatment?

(24) What do you think was the biggest barrier you faced in getting into treatment?

(25) If there was one thing that you could tell someone who needs treatment but is not getting it, what would it be?

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Barriers and Facilitators of Mental Health Treatment Seeking Among Active-Duty Army Personnel

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The purpose of the current two-phase study was to comprehensively identify the barriers and facilitators of mental health treatment seeking among active-duty service members. For Sample 1, focus groups were conducted with a general sample (n = 78) of United States soldiers. For Sample 2, interviews were conducted with soldiers who had sought mental health treatment (n = 32). Transcripts were coded using Atlas.ti software (Berlin, Germany), and descriptive analyses identified key themes. Factors identified by this study that have been underinvestigated in previous research included medication concerns, discomfort with discussing mental health problems, beliefs promoted by military culture, positive leader behaviors, and witnessing treatment seekers' experiences. Common barriers included career concerns, stigma, treatment concerns, leadership problems, and practical barriers. Common facilitators included social support, leadership support, and perceived symptom severity. Findings suggest that treatment-facilitating interventions should reframe treatment-inhibiting perceptions, change leader behaviors, and employ testimonials.

Keywords: service use, help seeking, barriers, facilitators, military

As a result of recent military operations in Iraq and Afghanistan, current military personnel are likely to have deployed multiple times and to have experienced high-intensity combat exposure during the course of these deployments (United States Department of Army Medicine, 2011). Repeated exposure to potentially traumatic events places service members at high risk for developing mental health disorders, including posttraumatic stress disorder (PTSD), depression, and substance-use disorders. Studies of service members returning from Iraq and Afghanistan have indicated that approximately 20-44% meet criteria for a mental health diagnosis (Kim. Thomas. Wilk. Castro, & Hoge, 2010; Seal el aL, 2009). Despite the significant mental health needs of recently deployed service members, only a fraction of those with psychiatric problems (13-50%) use mental health services (Hoge. Auchterlonie. & Milliken. 2006; Kehle et aL. 2010; Tanielian et aL. 2008). To address the mental health needs of this population, it is important to understand barriers and facilitators of mental health treatment seeking.

Although a number of studies have investigated specific factors associated with military personnel seeking needed mental health treatment, this area has been hampered by the lack of qualitative research examining the determinants of treatment seeking from service members' perspectives. In the present study we conduct qualitative research with active-duty soldiers to thoroughly assess their perceptions of the barriers and facilitators of treatment seeking among

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military personnel using two different samples, The first is a general sample of soldiers in an infantry division, and the second is a sample of soldiers who made the decision to seek mental health treatment while they were on active duty, We expect to find support for barriers and facilitators that have been identified in previous research, but also to identify additional factors that have not been investigated.

Factors affecting treatment seeking can be understood within the behavioral model of service use, which posits the existence of predisposing, enabling, and need factors (Andersen & Newman, 1973). Predisposing factors are preexisting factors that contribute to an individual's likelihood of seeking services, such as demographics and health beliefs. Enabling factors either impede or enhance treatment seeking, and include factors such as income, insurance, family support, and community resources. Need factors include both perceived and actual need for services, such as perceived symptom severity and mental health diagnoses,

The low rates of mental health treatment seeking in military populations suggest that barriers to care likely inhibit service use. Stigma has been found to be the most prevalent known barrier to mental health service use in military samples (Britt, 2000; Hoge et aL, 2004; Kim et aL, 20 I0), and may be a predisposing detmminant of service use. Two types of mental health stigma have been identified: public stigma, which involves negative reactions from other people toward mental illness; and self-stigma, which is the internalization of public portrayals of mental illness, and the belief in those portrayals (Corrigan & Watson, 2002). In studies of active-duty soldier and Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veteran populations, more than half of soldiers endorsed concerns about being seen as weak, being treated differently by leadership, losing the confidence of fellow soldiers, and harming their careers (Britt, 2000; Hoge et aL, 2004; Kim et a!., 2010). Existing studies have relied on only four to six items to assess stigma, such as "It would be too embarrassing" and "I would be seen as weak." It is unclear whether other stigmatizing attitudes toward mental illness exist among service members, such as concerns that one will be labeled as "crazy," or a burden to others. In addition, little research has assessed self-stigma in military personnel (Skopp et al., 2012). Previous studies have also included fears of losing security clearance or general "harm to career" as stigma-related barriers to care. However, career concerns may not all be related to perceived stigma and it is possible that career concerns represent a more complex set of baniers. Furthermore, measures of stigma employed in studies of military personnel have not analyzed the extent to which service members actually hold stigmatizing beliefs about those who seek mental health treatment. For example, do service members view others who seek treatment as detracting from the operational mission of the unit? These types of questions have not been assessed with existing measures.

Practical barriers also hinder treatment seeking, and can be framed as the negative side of the behavioral model of service use's enabling factors. Common practical barriers endorsed among military personnel include trouble getting time off work for an appointment, difficulty scheduling an appointment, and financial concerns (Hoge et aL, 2004; Kim, Britt, Kiocko, Riviere, & Adler, 2011). Again, these studies relied on structured rating scales with a limited number of items. It is possible that other practical barriers exist, such as frequent moves requiring shifts in providers, or difficulty attending multiple appointments when prolonged treatment is required. For example, McLay and colleagues (2011) conducted a treatment-outcome study for PTSD among active-duty personnel, and suggested that fluctuating assigmnents and frequently changing duty stations contributed to high treatment-dropout rates. In addition, leader behaviors, such as not allowing time off for treatment or lack of knowledge about mental health resomces, may contribute to these barriers. Because both stigma and practical barriers have been significantly associated with treatment seeking among U.S. Army soldiers, it is important to develop thorough assessments of these constructs (Britt, Greene, Castro, & Hoge, 2006).

Beliefs about mental illness and treatment comprise a third set of barriers to care. Studies have suggested a few treatment-inhibiting beliefs among active-duty soldiers, such as believing one can handle the problems alone and believing the problem is not severe enough to warrant treatment (Britt et al., 2011; Kim et al., 2011; Visco, 2009). Such beliefs may be en-

couraged by military culture, where soldiers are expected to "tough out" difficult emotions (Vogt, 20 I1), but the role of military culture has not been assessed by existing scales.

Negative perceptions of mental health treatment may also inhibit treatment seeking among soldiers, including beliefs that mental health professionals are untrustworthy, treatment does not work, treatment should be a last resort, or that medications will have negative side effects (Hoge et aL, 2004; Kim et aL, 2011; Sayer et aL, 2009), The literature on mental health treatment seeking in civilian populations suggests that individuals also avoid treatment due to treatment fears, such as the fear of how a mental health professional might treat him or her, as well as the fear of discussing painful emotions (Vogel, Wester, & Larson, 2007), Confidentiality concerns may also arise due to policies that allow commanders to be informed of a soldier's mental fitness for duty (Milliken, Auchterlonie, & Hoge, 2007). It is possible that lack of knowledge about treatment can contribute to these fears and concerns. However, these factors have not been previously identified or assessed in studies of military personnel. Although most of these factors represent predisposing factors for service use, perceptions of illness severity and recognition of symptoms relate to perceived need for treatment.

Although less commonly studied, several factors may increase the likelihood of soldiers using mental health services. One set of treatment facilitators relates to enabling factors in the environment. For example, one study found that active-duty soldiers who reported unit cohesion and skilled leaders were less likely to report practical barriers and stigma toward treatment seeking (Wright er aL, 2009), A second study indicated that reductions in negative leader behaviors reduced perceived stigma, whereas positive leader behaviors were associated with fewer practical barriers (Britt, Wright, & Moore, 2012). Another set offacilitators relates to perceived mental health needs, including trauma exposure, symptoms that interfere with functioning, and recognition and acceptance of a disorder (Fikretoglu, Brunet, Schmitz, Guay, & Pedlar, 2006; Sayer et aL, 2009), A third set of facilitators relates to beliefs about mental illness and treatment. These were described in a small qualitative study of Vietnam and OEF/OIF veterans with PTSD, which identified beliefs that treatment is socially acceptable, helpful, and provided by a trustworthy system (Sayer et aL, 2009), Another set of facilitators described in the civilian literature relates to the presence of a social network that is accepting and encouraging of treatment seeking (Vogel et aL, 2007), Individuals who know someone who sought help or had a support person that recommended treatment have been found to be more likely to seek treatment (e,g,, Dew, Bromet, Schul berg, Parkinson, & Curtis, 1991; Tijhuis, Peters, & Poets, 1990), Finally, the anticipated utility of seeking help has been found to significantly predict attitudes about seeking mental health treatment (Vogel, Wester, Wei, & Boysen, 2005), These factors have yet to be identified in military populations,

In sum, little research has been conducted on the facilitators of mental health treatment seeking among active-duty soldiers, and most researchers of barriers to treatment have employed predetermined rating scales and have included a limited number of items. Thus, it is likely that there are additional barriers and facilitators to be discovered. Finally, most studies did not simultaneously examine predisposing, enabling, and need factors. Researchers studying culture particularly favor naturalistic open-ended questions and recommend them when (a) there may be additional unknown factors associated with a problem (e.g., Bernard, 2006; LeCompte & Schensul, 2010), (b) when not all settings and combinations of those factors are known (e,g,, LeCompte & Schensul, 20 I0), and (c) when one is interested in the processes by which a decision is made (e.g,, Bernard, 2006), We believe that all of these conditions are met by the current state of research into barriers and facilitators of treatment seeking in active-duty military culture, Thus, we employed open-ended questions to elicit soldiers' unconstrained nominations of predisposing, enabling, and need factors. We believed that this methodology would yield a more holistic and expanded picture of the barriers and facilitators of treatment seeking in the military and might be used to create more comprehensive scales. We used focus-group and interview methodologies with two groups of active-duty soldiers: (a) a general sample and (b) a sample of current treatment seekers.

We aimed to answer the following research question: What are the perceived barriers and

facilitators of mental health treatment seeking among active-duty soldiers seeking treatment and not seeking treatment? We hypothesized that we would identify many of the barriers and facilitators found in previous research with military personnel, including public stigma, practical barriers, beliefs about treatment, self-reliance, and perceived mental health needs. Based on civilian literature and related research with ntilitary personnel, we also hypothesized that our findings would reveal the following factors: self-stigma, discomfort with treatment, specific career concerns, confidentiality concerns, military cultural factors, leadership behaviors, anticipated utility of treatment, and social network support. Finally, our methodology may reveal additional barriers and facilitators beyond those measured in previous research. Identification of these factors is important, not only to develop more comprehensive assessment instruments, but also to determine targets for intervention that could improve the likelihood that military personnel will get mental health treatment when needed.

Method

Sample 1: General Sample

We recruited a general saruple of 78 active-duty Atmy personnel through chain of command at a large U.S. Army post in the Southeast. The infantry division issued an operations order, and unit leaders recruited participants from different rank categories. We requested that groups include both soldiers from combat-arms units and combat-support units. Three focus groups were conducted with each of four rank categories, resulting in a total of 12 focus groups. Each focus group consisted of 3-8 soldiers. The rank categories included junior enlisted (E1-E4, $n = 19$), noncommissioned officers (E5-E7, $n = 19$), company-grade officers (O1-O3, $n = 21$), and field-grade officers (O4-05, $n = 19$). The majority of participants were White (64%), followed by Black (13%). The majority of participants were male (80%), the mean age was 31.1 (SD = 6.9), mean years of service was 9.3 ($SD = 6.3$), mean number of combat deployments was 1.8 ($SD = 1.2$), and 91% had been on a combat operation in the last 10 years.

The focus groups were conducted by the four study investigators during September, 2011. Participants signed an informed consent form in the presence of U.S. Army ombudsman. Focus groups followed a semistructured interview guide that assessed barriers and facilitators of mental health treatment seeking. To maximize the chances that themes were not lintited by item content, questions were all open-ended. Sample items included, "What factors do you feel may influence a soldier to seek treatment?" HWhat makes it easier for soldiers to seek treatment when they need it?" and "Many soldiers who experience psychological problems do not seek treatment for their difficulties. Why do you think this is the case?" Other questions assessed the roles of stigma and organizational support in treatment seeking, beliefs about mental health treatment, and perceptions of mental health professionals. Potential open-ended follow-up probes were included to be used as needed (e.g., "How much do attitudes of friends and family members serve as barriers to treatment seeking? What are the beliefs about how it will affect job performance?") Sessions lasted approximately 60-90 min.

Audio recordings were made of focus-group sessions, which were later transcribed. The four study investigators reviewed each of the transcripts and independently identified common themes in the data. The investigators started with a coding scheme based upon the themes that have been addressed previously in the research literature, and then added novel themes that came up in the focus groups. The themes were pooled and codified, and the coding scheme underwent several revisions based on feedback from each investigator and repeated reviews of the transcripts. Definitions for each code are presented in Table 1a and Table 1b. Four graduate student research assistants were trained on the coding scheme and performed content analysis on the transcripts. Two research assistants coded every transcript for half of the codes, and two research assistants coded every transcript for the other half of the codes. Codes were assigned using Atlas.ti (Berlin, Germany) software. It was possible for quotations to be coded in more than one category. Mean percent agreement between coders for the codes included in this study was 74%. Disagreements were resolved by the study investigators. Demographic information and codes for each focus

Table 1a
Barriers of Mental Health Treatment Seeking Identified During Focus Groups With Soldiers

Themes	Enlisted (n6)	Officers (n = 6)	Codebook definition	Sample quotations
Career concerns	6	6	Concerns about harm to career • Lack of advancement • Discharge • Differential treatment (e.g., different duties, held on location longer/shmter, not trusted by other unit members) • Interference with job duties	▮ know people who have been going to mental and then they have issues in their professional area because that comes back and some of them lose their career . . . and got moved to other areas.
Stigma	6	6		
Self-stigma	4	4	Soldier's personal beliefs that mental health problems/treatment seeking reflects negatively on oneself, such as beliefs that he/she is •Crazy • Weak • A slacker • Faking	Some people, ▮ believe, will never go unless they are referred to go by their command. They've either been in the Anny too long, or they themselves see it as a weak gesture to go. They personally will never go get mental health, regardless of what's happened in their life or on deployment, they will not go get help.
Public stigma	6	4	Leadership, other soldiers, or other people perceive mental health problems/treatment seeking to mean something negative about the soldier, such as perceptions that the soldier is • Crazy • Weak • A slacker • Faking	Most people hear it from family, friends, or other soldiers that they work with that it could be weakness. Mental health makes people think "He's crazy. I can't trust him.."
Treatment concerns	6	5	• Don't want to talk to others about problems • Dissatisfied with past treatment • Don't think treatment will work • Know there will be a big delay in getting treatment • Medication side effects • Get prescribed medications when don't want them • Don't trust/connect with providers • Not knowing how long treatment will take • Providers are burned out • I won't be treated for primary presenting problem • Providers outrank patient	After a while soldiers just get frustrated and they're like 'Well obviously they can't fix it, they're just going to continuously medicate me on whatever it is, I continuously have . . . side effects. So I'm just going to deal with it [on my own]"

Table 1a *(continued)*

Themes	Enlisted (n6)	Officers (n 6)	Codebook definition	Sample quotations
Leadership problems	6	5	• Lack of confidentiality within chain of command • Lack of trust in leadership (i.e., don't go to leaders for help) • Perceptions from leadership that soldiers are trying to "get out of work," "whine," "malinger" • Leadership too busy with high optempo to recognize problems/provide support • Leadership unclear about ramifications of treatment (e.g., how much time will this soldier need off? What duties can ▮ assign him/her?)	[Leaders] don't actually care about the soldier anymore, they don't communicate. They just watch them self-destruct and don't do anything for that soldier any more. And ▮see that a lot v.rith leadership now. So, it starts even as low as us being unifonned, that we don't get the help from the people we're supposed to look up to.
Practical barriers	5	5	• Schedule availability (for soldier) • Limited availability of providers • Fast job tempo--too pressed for time to complete mental health screens, make appointments, etc. • Concerns about shirking duties, burdening others by taking time off • Financial concerns	It takes a long time for rehabilitation and the treatment process is not in and out It's a matter of the time it takes and the time that takes you away from work.
Confidentiality concerns	6	3	Concerns that peers, leaders, or others will find out about treatment seeking or mental health problems	HI was the soldier, to me, the privacy would be a big issue ... I'd want to go knowing that I could just keep it between me and the person and not have to get my whole chain of command involved. So I think [confidentiality is] probably a big one for a lot of people.
Lack of honesty on mental health assessments	4	5	Not answering honestly on mental health assessments, so problems aren't identified	you. I could tell you all this stuff that's \VTong with [Reintegration] is really the worst time to ask me [assessment questions]. They're not going to tell me, or I could go unwind for 30 days. I think I'll just unwind for 30 days, and then if I still feel anything, I might tell you. Because you're just sitting there like 'no, no, no' [to all the questions]. Nothing's wrong with me.
Military beliefs	3	5	• Mental toughness, hat·dened to stressors/emotions • Everyone else has been through something as hard or worse; don't acknowledge the problem because it's seen as normal	Everywhere you look, they put the image of ...soldiers ... just being strong, heroes, waniors, protectors of America ... They put you in such a positive light so if they need to seek help, they just feel weak and not living up to that image of a sttong soldier.

(table continues)

Table la *(continueci)*

Themes	Enlisted (*n* 6)	Officers (*n* 6)	Codebook definition	Sample quotations
Substance use	4	3	Soldiers using substances to deal with the problem in a way that inhibits treatment seeking	Drugs were kind of a problem and that was more of an outlet for a soldier I was dealing with. There were mental problems related to a previous deploymenL He . . . wasn't able to cope, but his outlet was the use of marijuana, primarily. It was one of those things that he just refused to try to get the help he needed.
Lack of peer support	2	5	• Lack of social support for the soldier (that inhibits treatment seeking) • Peers' perceptions of soldier malingering when getting treatment	Young males, 18- or 19-year-old males; it's like a bullpen. They beat each other up, and don't give each other any slack. If you say, "I'm having a rough time; I think I need to go talk to the chaplain," by-and-large, you have to catch flack . . . you're still going to get busted on, especially by your peers.
Perceptions of mental health symptoms/treatment	2	3	• Can deal with it on your own • I'm too strong to need it. • Other perceptions that inhibit treatment seeking	[Soldiers think that] they don't need treatment, that they can handle it on their own . . . not realizing they are having an issue and coping with it in a different way.
Lack of information	2	2	• When to get treatment (e.g., waiting until problems are severe) • Nature of treatment • Who to call if need treatment • Where to go	A lot of soldiers don't have the information. They're scared to even get information because if I get the information, then [everyone is] going to be like, "something's wrong with me."
Self isolation	2	2	Soldiers isolate themselves from others, inhibiting treatment seeking	They'll start segregating themselves to a degree. And then, you know, just more problems end up building.
Other	2	3		I think you almost have an even bigger problem, among [soldiers who want to get out after 4 years] because they say "I'm gonna be out soon" you know what I mean, so "I'll be away from all this and I won't need it."

Table 1b

Facilitators of Mental Health Treatment Seeking Identified During Focus Groups With Soldiers

Themes	Enlisted (n 6)	Officers (n6)	Codebook definition	Sample quotations
Leadership support	5	6	• Allow soldiers time off to seek treatment • Schedule flexibility • General support of treatment seeking • Provide information on where/when to seek treatment • Role model who has had treatment • Leaders identify problems/refer soldiers to treatment	I think one of the things that really helps is when a senior leader, who has been through it and got help, is willing to give a testimony to the larger group . . . somebody . . . who is successful . . . saying, "Look, I had a moment there when I wasn't doing well, I reached out and got help and it helped me."
Social support	5	5	• Family/spouse encouragement • Peer/battle buddy encouragement • Having a trusted person to talk with	If your wife wants you to go get treatment because of the issues that you're having at home, it will help. It will help influence [your decision to seek treatment]. Usually, it will push beyond even [if] you're worried about what your chain of command might think
Logistics		3	• Knowing where to get treatment • Schedule availability	If people don't think there is help available then they're not paying attention because the Army has put a lot of time and a lot of effort and a lot of pressure on leaders to ensure that soldiers know that all of that is available and to allow soldiers to go to it . . . When I was a company commander and in my time here, I have not seen an issue where someone was not allowed to go to an appointment because there was something else going on.
Symptoms inte1iering with life	2	2	The problem is severe enough to significantly interfere with the soldier's life	I found it usually takes some kind of, an incident . . . that impacts their life that they end up having to go get help. You know getting a DUI, getting into trouble somewhere
Treatment beliefs		2	Seeking treatment • Is a way to take care of yourself • Won't harm your career • Is like treating a physical health problem • Will work	I think it's a valuable resource actually, especially in a combat environment there's enough stress out there as it is that if people need a way to let that out, I think it's a valuable resource.

(table continues)

Table **lb** *(continued)*

Themes	Enlisted (*n* 6)	Officers (*n* 6)	Codebook definition	Sample quotations
Knowing who providers are			Knowing who the treatment providers are	Having a behavioral health rep down at the brigade helps [facilitate access to care], and then having that person always out, always circulating with the units. That way you may not want to be like, ··I have to go schedule something with that person at that person's office where someone may, you know, see me," as some may be worried. **But,** that [rep] is always out and you can just [have] a short discussion with that person [who is] just moving through a unit area.
Other	4	4		I think [that treatment is] a last measure. Meaning, something might happen and that soldier might have received some type of corrective counseling and been directed to go seek counseling He was told to [by his command].

group were entered as variables in an SPSS database. Descriptive statistics were employed to aggregate the data,

Sample 2: Treatment Seekers

We recruited a sample of 32 soldiers who were currently seeking mental health treatment from fhe behavioral health clinic on post, Potential participants were informed of the study by mental health professionals at the clinic and interested participants were contacted by a member of the research team to be scheduled for an interview at a private location on base. Participants included 17 junior enlisted, 14 senior enlisted, and one officer. The participants in the majority were White (78%) and male (91%), The mean age was 29,0 (SD = 6,5), mean years of service was 8,0 (SD = 5,9), mean number of combat deployments was I,7 (SD = 0,9), and 91% had deployed on a combat operation in Iraq or Afghanistan,

Interviews were conducted by the four study investigators between August, 20II and February, 2012, Participants signed an informed consent form in the presence of a U.S. Army ombudsman. A semistmctured interview guide assessed barriers and facilitators of mental health treatment seeking. Questions were primarily open-ended; when close-ended, they were followed by open-ended probes. Sample items included "What led to your decision to seek treatment?" and "What do you think was the biggest barrier you faced in getting into treatmentT Close-ended questions asked participants whether they had experienced any problems from the Army, friends, family, the health-care system, doubts of their own, practical barriers, or other obstacles when they sought treatment, Follow-up questions asked participants to describe the problems and how they overcame these barriers. Items also assessed whether other people or the Army facilitated participants' treatment seeking, Sessions lasted approximately 60-90 min, Soldiers completed a questionnaire including the PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993) and the Two-Item Conjoint Screen (TICS) for alcohol-use problems (Brown, Leonard, Saunders, & Papasouliotis, 2001), Screening criteria forPTSD were met by 56%, and 9% screened positive for alcohol-use problems,

Audio recordings of the interviews were transcribed, As with the previous sample, the four study investigators independently reviewed each of the transcripts to identify common themes, and a coding scheme was developed based on key themes in the data. The investigators began with a coding scheme based upon previously identified barriers and facilitators of treatment seeking, and then modified that scheme as additional factors were identified in the interviews. The coding scheme underwent several revisions based on feedback from each investigator and repeated reviews of the transcripts. Definitions for each code are presented in Table 2a and Table 2b. Two research assistants were trained on the coding scheme and performed content analysis on the transcripts. Each research assistant coded all codes for each transcript. Codes were assigned using Atlas.ti software. It was possible for quotations to be coded in more than one category. Mean agreement between the coders included in this study equaled 75%, Disagreements were resolved by the study investigators. Demographic information and codes for each interview were entered as variables in an SPSS database, Descriptive statistics were employed to aggregate the data.

Resnlts

Sample 1: General Sample

Barriers, Table !a provides the most frequently identified barriers to treatment seeking among the focus groups, as well as sample quotations from participants in the group that reflected the banier. Frequencies were reported separately for focus groups with enlisted members and focus groups with officers. The most frequently endorsed barriers were career concerns, public stigma, treatment concerns, and leadership problems.

Key career concerns included worries that treatment seeking would hinder advancement or lead to discharge from the military. Other concerns included different treatment from unit members or leaders (such as being assigned less-desirable duties), time needed for treatment interfedng with job duties, and unduly burdening other unit members who completed work assignments missed for appointments.

Both self-stigma and public stigma were also described. Self-stigma included internalized be-

Table 2a

Barriers of Mental Health Treatment Seeking Identified in Interviews With Treatment-Seeking Soldiers

Themes	Junior enlisted (n = 17)	Senior enlisted/officer (*n* 15)	Codebook definition	Sample quotations
Practical barriers	16	14	• Lack of schedule availability for soldier • Limited availability of providers • Long wait times to schedule an appointment • Long wait time in between appointments • Wait time in the waiting room • Fast job tempo--too pressed for time • Concerns about shirking duties, burdening others by taking time off • Financial concerns • Lack of continuity--soldier moved around • Lack of continuity--providers frequently changed • Concerns about changing providers	They have so many cases and so few [providers} that it's kind of hard to see everybody, so you don't feel like you are getting too much resolved.
Treatment concerns	13	12	• Don't want to talk to others about problems • Dissatisfaction with past treatment • Don't think treatment will work • Know there will be a delay in getting treatment • Worried about medication side effects • Concerns about being prescribed medication even if they don't want it • Don't trust the provider-- treatment won't work • Don't trust the provider-- treatment will cause harm • Providers don't care • Providers are burned out • Don't know how long treatment will take • Concerns about not being treated for presenting problem • Concerns symptoms will be worse after treatment • Won't get symptom relief • Providers out-rank the patient • Showing emotions in treatment will make things worse • Only able to access military providers • Problems with civilian providers • Taking time out of the day other than work time • Confusing diagnostic system	I just didn't know if they would ever understand what I had been through . . . If they haven't been there or experienced it then how do they know the reasons why I have the problems that I have?

Table 2a *(continued)*

Themes	Junior enlisted (*n* = 17)	Senior enlisted/officer (n 15)	Codebook definition	Sample quotations
Public stigma	11	13	Leadership, other soldiers, family/friends, other people, or society perceive mental health problems/treatment seeking to mean something negative about the soldier, such as perceptions that the soldier is • Crazy • Weak • A slacker • Faking	I could hear Ithe Sergeant] talking about how much of a burden ▮ was . . . . That ▮ am a profiler. That now ▮ am going to mental health and all this stuff.
Leadership problems	11	10	• Lack of confidentiality within chain of command • Lack of trust in leadership (i.e., don't go to leaders for help) • Perceptions from leadership that soldiers are trying to "get out of work," "whine," "malinger" • Leadership too busy with high optempo to recognize problems/provide support • Leadership unclear about ramifications of treatment (e.g., how much time will this soldier need off? What duties can I a<;sign him/her?) • Unsupportive leadership	Command is [saying] 'You need to be here training, you don't need to be sitting in the behavioral health clinic' . . . And they think they're just shamming you know trying to get out of work.
Career concerns	▮▮	9	Concerns about harm to career • Lack of advancement • Discharge • Differential treatment (e.g., different duties, held on location longer/shorter, not trusted by other unit members) • Interference with job duties	I did not want them to *try* to kick me out of the military, if I was found to be too crazy or something. It was scaring me. So l just didn't do anything about [my symptoms].
Mental health beliefs	6	▮▮	• Can deal with it on my own • Don't want to depend on others • I've been through worse • Nothing is wrong with me • My peers aren't getting help	The biggest barrier was myself. Just the fact that I kept telling myself I could push through it by myself. I didn't need it. I didn't need anybody else. I had ftiends. I could deal with it alone.

(table continues)

Table 2a *(continued)*

Themes	Junior enlisted (11 = 17)	Senior enlisted/officer (n 15)	Codebook definition	Sample quotations
Lack of peer support	8	6	• Lack of social support for the soldier (that inhibits treatment seeking) • Peers' perceptions of soldier malingering when getting treatment	It's kind of like peer pressure, because they're sitting there telling you, 'you don't need to go [get help] or you are just making it up' . . . These are the [same buddies] that if you rolled outside the wire that you are supposed to trust your life with. These are the same people that, at least in this case, are turning right back around and saying you don't need help.
Symptom interference	6	6	• Symptoms interfere with compliance • Substance use to deal with the problem (that inhibits treatment seeking) • Symptoms interfere with getting treatment in the first place (e.g., isolation, mistrust)	I went down a destructive path first [before I sought help]. ▮ did the drinking and partying and all that other stuff and . . . it didn't help.
Self stigma	5	7	Soldier's personal beliefs that mental health problems/treatment seeking reflects negatively on oneself, such as beliefs that he/she is • Crazy • Weak • A slacker • Faking	▮ just thought I'd be less of a man [if ▮ sought help].
Military beliefs	4	7	• Mental toughness/Hardened to stressors/emotions will get soldier through this • Mental toughness/Hardened to stressors/emotions -- treatment would harm this toughness • Everyone else has been through something as hard or worse; Don't acknowledge the problem because it's seen as normal • Need to subvert personal needs for the need of the unit or the mission	I'm in combat arms so I am not supposed to ıseek helpJ. There is no reason I should go see them, you know. It's my job, brush it off.
Confidentiality concerns	2	8	Concerns that peers, leaders, or others will find out about treatment seeking or mental health problems	At first, I was very reluctant to actually get help just because I knew that if I told somebody that everybody would know . This is my personal life. I don't think everybody that I work with and everybody that I work around should know my business.

(table continues)

liefs that being diagnosed with a mental illness **is embarrassing and means that one is crazy or** weak. Public stigma included concerns that **leaders, unit members, friends, and family** members would perceive or treat a soldier differently if they knew he or she sought mental health treatment. Public stigma was mentioned **in the larger portion of focus groups with enlisted** members, compared with focus groups with officers.

The most frequently noted treatment concerns were about medication, including side effects and how these side effects might interfere with job duties. In addition, soldiers described **concerns that medications or other treatments would not work, and that medications are overused** or used inappropriately. Others described **their concerns about treatment providers, including discomfort with providers and perceptions that providers were "burned out.n**

Regarding leadership problems, both leaders **and junior-enlisted personnel noted that leaders** often perceive soldiers who seek mental health **treatment as "slackers" or malingerers. Soldiers** also reported problems with trusting their leaders **enough to discuss mental health problems with them, including concerns that information** would not be kept confidential. Furthermore, **participants noted that leaders were sometimes** unclear about what treatment entailed (e.g., how much time off would be required) or were busy with the high work demands and therefore unable to be supportive.

Other frequently reported barriers included **practical constraints, confidentiality concerns,** lack of peer support for treatment seeking, and **lack of honesty on mental health assessments (e.g., underreporting symptoms to avoid visits** with mental health professionals or speed processing **after deployments). Practical constraints** included limited availability of providers, inability to get timely appointments, and limited availability in soldiers' schedules. Confidentiality **concerns were reported in a larger portion of focus groups with enlisted members, as compared** with focus groups with officers.

Participants also described treatment-inhibiting beliefs that were promoted by military culture, **such as the importance of retaining mental toughness and prioritizing the unit mission above one's own needs. Another aspect of mil**itary culture described by participants is that **fellow soldiers are often perceived as having**

Table 2b
Facilitators of Mental Health Treatment Seeking Identified in Interviews With Treatment-Seeking Soldiers

Themes	Junior enlisted (n17)	Senior enlisted/officer (n15)	Codebook definition	Sample quotations
Encouraged by support person	16	13	• Family/spouse encouragement • Peer/battle buddy encouragement • Other friend encouragement • Wanting to be a better person for your family	[M"y wife] pointed out [that I was always angry] and just said, "You know, maybe you should go see somebody." ▮ didn't want it to affect my maniage, so before that happened, I'd rather go see somebody.
Symptoms interfering with life	16	13	• Problem became severe (e.g., suicidal ideation/attempts, DUis) • Symptoms caused personal distress • Symptoms caused relationship impairment/ isolation from others • Symptoms caused impairment at work • Symptoms creating risk for self or others • Don't want symptoms to get worse	[I started coming to treatment because] there was stuff I'd seen on *[my* first] deployment and when ▮ got back, my wife said ▮ had changed, which ▮ see it as well. ▮ don't go to sleep until 2:00 or 3:00 in the morning and just lay in bed for 2 or 3 hours before I even get to sleep ... [Also] ▮ was just really angry, outbursts and breaking stuff and ▮ know ▮ am physically and mentally not there with my wife.
Witnessed other treatment seekers' experiences	13	8	• Knowing someone else who had treatment and symptoms improved • Knowing someone else who had treatment and it had no negative effects • Generally knowing someone who had treatment • Knowing someone with a similar problem • Observed the negative effects of others not getting treatment	▮ learned that people were doing counseling or had done counseling in the past as well as meds. That at least adds a little bit of reinforcement on what ▮was doing. That, "Hey okay, maybe it was the right thing to do."
Supportive leadership	10	9	• Approval of treatment seeking • Scheduling flexibility or time off • Trustworthy leadership • Provided information on where/when to get treatment • Leader was a role model • Leaders identified problems • Leaders treated people the same after they got treatment	[During the deployment], my team leaders and squad leader were very supportive of going to get help. The platoon sergeant, as long as he knew where I was he didn't really have an issue with it. He didn't try and stop me from going. It's the same issue [in garrison]. You plan accordingly; they [also plan] accordingly and somehow make it fair and make it work.

Table 2b *(continued)*

Themes	Junior enlisted (*n* 17)	Senior enlisted/officer (*n* 15)	Codebook definition	Sample quotations
Referred by someone	10	8	• Decided to be honest on screenings/referred through a screening • Primary care doctor or other provider referred • Referred by chaplain • Ordered by a superior or otherwise compelled • Refened by commander/leader	My chain of command forced me to go to mental health. After seeing a therapist, [they said I] wasn't suicidal, wasn't homicidal, but [they] told me I needed to take stress management, anger management . . . and one on one therapy.
Treatment beliefs	9	10	• A way to take care of yourself • Won't harm your career • Will help your career • Like treating a physical health problem • Treatment will work • Need to put yourself before the military • It's a personal responsibility • It's a priority	I had to say, you know, "Hey, I'm going to this appointment, I understand the consequences if there *is* a mission and I don't make it. Yeah, Article 15, reduction in rank, I understand that. But that [doesn't] outweigh what I could do to myself that would not . . . hurt me but my family, you know, because my family is more important than my job." And then over the years, putting everybody first. I kind of was like. "You know what? It's about time I put myself first"
Life history	4	11	Experienced a lot of losses or other traumatic/ stressful events	Last year I was shot by a sniper in [country] and blown up about 3 or 4 times. So, that is why I am seeking treatment.
Past treatment experience	4	3	• Experience with prior successful treatment • Experience with prior treatment where side effects were not bad • Caring mental health professional	When I was [a teenager], I was given a choice to either stay at the house or go to this [juvenile delinquency] group home . . . Our therapist was good at what she did. That was very helpful.
Information about treatment	3	3	• Knowing about the existence of behavioral health options • Gained knowledge about different treatments (e.g., through the Internebooks) • Knowing who the providers are	I called Army OneSource because one of my NCOs was like, "Oh you can call them, they set you up with a counselor off post." I called them up, and they're like, "Ok, we can get you therapy on post." And I had an appointment that day.

been through similar or worse life stressors, and therefore the soldier's own problems are perceived as insignificant, abnormal, or not deserving of mental health treatment. These beliefs were described in a larger portion of the officers' focus groups than in the enlisted focus groups. Another frequently reported treatment-inhibiting belief was the perception that a person should handle his or her problems alone. Participants also discussed how certain mental health symptoms could interfere with treatment seeking, such as isolating oneself from others or excessive substance use, which can lead to avoiding a problem or "self-medicating." Finally, participants noted lack of information on the nature of treatment, where to get it, who the providers were, or how long it would take.

Facilitators. As seen in Table lb, the majority of focus groups identified leadership suppmt and social support as facilitators of treatment seeking. Supportive leader behaviors included allowing time off and flexibility in assignments so that soldiers could attend appointments. Supportive leaders were also described as trustworthy and encouraging of seeking tteatment. Soldiers noted that it was especially powerful when leaders sought treatment themselves, openly described these experiences to unit members, and continued to perform their jobs successfully. In terms of social support, participants described support from family, friends, and fellow unit members as critical facilitators to seeking treatment.

A prominent portion of focus-group members discussed practical facilitators and recognition/perceived severity of symptoms as facilitators to seeking treatment. Practical facilitators were described in a larger portion of the officers' focus groups, and included schedule availability and knowing where to get treatment. Regarding symptom severity, many soldiers described severe incidents that can prompt recognition of the need for treatment, including Dills, physical assaults, and suicide attempts. Others identified general distress, not wanting symptoms to get worse, problems in relationships, and impairment in occupational functioning as potential triggers to seek treatment. In a few of the focus groups, participants described positive perceptions of mental health treatment seeking (e.g., perceiving it as helpful or efficacious) and familiarity with mental health providers as facilitators of treatment seeking.

Sample 2: Treatment Seekers

Barriers. Table 2a provides the most frequently identified barriers among the treatment seekers, as well as sample quotations relevant to these barriers. The most prevalent impediments were practical barriers, treatment concerns, public stigma, leadership problems, and career concerns. Discussions of practical barriers, leadership problems, and career concerns largely mirrored the themes from the focus groups. Discussions of treatment concerns differed somewhat from focus-group themes. The most frequently raised treatment concerns involved not feeling understood or cared for by providers. Some participants also discussed concerns that treatment would not work, discomfmi with talking to someone about their problems, previously negative experiences with treatment, perceptions that they were only able to access military providers, and concerns that they would need to start again with a new provider if they or their providers were geographically reassigned. Identification of stigma also differed from focus-group discussions in that self-stigma concerns were raised less frequently among treatment seekers. In addition to the leadership concerns identified in the focus groups, many interview participants reported feeling generally unsupported by leadership in their treatment-seeking efforts. Similar to focus groups, other baniers identified by interview participants included negative mental health beliefs, lack of peer support for seeking treatment, symptom interference, military-related beliefs, confidentiality concerns, and lack of information. In relation to junior-enlisted members, a larger portion of senior-enlisted interviewees described the following barriers: self- and public stigma, mental health beliefs, military beliefs, and confidentiality concerns.

Facilitators. Table 2b provides the most frequently identified facilitators among treatment seekers, including encouragement by a support person, symptom severity/interference, refenal by medical or military personnel, witnessing other treatment-seekers' experiences, supportive leadership, and positive perceptions of treatment seeking.

Interview participants most frequently identified encouragement from family members, particularly spouses, as representing a primary reason for seeking treatment. Many discussed

wanting to be a "better person" for their families. Several participants also described observing other successful treatment seekers' experiences as a factor that helped reduce stigma and served as an impetus for them to seek treatment themselves. Discussions of leadership support, as well as symptom severity, were similar to the themes that arose during focus groups. Many noted that it was not until symptoms reached a high level of severity that they recognized the need for treatment.

The most frequently reported positive perceptions of mental health treatment seeking were beliefs that addressing one's own mental health needs is a priority and a personal responsibility. Several participants stated that they overcame barriers to care by deciding to place their own needs before the needs of the military, or by deciding that the positive consequences of addressing their mental health needs outweighed the negative consequences of contending with public stigma. Other positive perceptions included beliefs that treatment would work and that treatment could actually help rather than harm one's career. Finally, additional facilitators included having information about treatment, past positive treatment experiences, and a history of life stressors that soldiers were unable to manage on their own. Compared with junior-enlisted participants, a larger portion of senior-enlisted participants described treatment beliefs and life history as treatment facilitators.

Discussion

Stigma was one of the most frequently identified barriers to care in both samples, consistent with earlier studies. Public stigma was mentioned most frequently; however it is important to note that self-stigma was also commonly reported, particularly among the general sample. Self-stigma has not been consistently measured in earlier studies of military samples, and these findings suggest that it should be included as a construct on future rating scales (Skopp et a!., 2012) and considered as a possible target for intervention. The fact that self-stigma was mentioned less frequently among treatment seekers suggests that overcoming self-stigma may be an important part of the decision to seek treatment, although longitudinal studies are needed to establish this relationship.

As in previous research, career concerns, practical barriers, and treatment-inhibiting beliefs about mental illness and treatment all emerged as additional barriers to care. Regarding career concerns, our findings add to existing literature by identifying specific concerns about advancement, discharge, and burdening other unit members. These findings suggest that career concerns warrant measurement as a more complex and separate construct in future quantitative assessments of barriers to care. Similar to earlier studies, practical barriers were largely centered on scheduling problems. Financial conce1ns were not frequently discussed, perhaps due to the fact that we interviewed participants on post who likely had access to affordable care through the military.

Little is known about specific treatment concerns among active-duty soldiers, including concerns about medication side effects and lack of knowledge about treatment. These concerns were particularly prevalent among the general sample, which suggests that nonseekers of treatment lack accurate information about treatment. Other treatment concerns that were novel to this study included concerns that providers are "burned out," soldiers/officers do not feel understood by providers, they sense a lack of familiarity with providers, and are uncomfortable with discussing problems with providers. This discomfort is intensified when the Soldier or therapist is moved to a different location and the soldier needs to tell his or her story again to a different provider. Finally, we identified beliefs specific to the ntilitary climate that inhibit treatment seeking, such as the need to prioritize the mission over personal problems. Treatment-inhibiting beliefs that were consistent with previous findings included the beliefs that a soldier/officer must handle a problem on his or her own, that there was a lack of recognition of his or her problems, that treatment will not work, and that providers generally lacked trustwmthiness.

This study identified several additional barriers to care that have not been previously described and may be unique to ntilitary culture. These included perceptions among leaders that soldiers with mental illness are malingering; leaders also have confidentiality concerns, and lack knowledge about mental health problems. Other novel baniers included symptom interference with treatment seeking, unsupportive

peers, general confidentiality concerns, and lack of honesty on mental health assessments.

Regarding treatment facilitators, positive leadership behavior, perceived symptom severity, and social network encouragement were common facilitators in both samples. Positive leadership behaviors have not been elaborated in the literature, and our findings suggest that these consist of allowing scheduling flexibility, engendering trust, and serving as role models for successful treatment seeking. Given the strong leadership structure of the military, leadership support may be particularly important in an active-duty setting (Britt et al., 2012). Findings related to perceived symptom severity were of concern, in that many soldiers did not acknowledge the need for treatment before a severe or life-threatening incident occurred. This suggests that more efforts need to be directed toward early recognition of symptoms as problematic and deserving of treatment. Encouragement by peers and family members was one of the most important facilitators identified by soldiers seeking treatment. Of particular interest was the importance of knowing other people who sought treatment and had to overcome barriers to mental health care. This is consistent with literature on stigma-reduction interventions, which suggests that contact with people who have mental illness is one of the most effective ways of reducing stigma (Corrigan & Penn, 1999). Consistent with the civilian literature (Vogel et al., 2005), perceived utility of treatment was also identified as a facilitator. This was mostly the case among treatment seekers, indicating that increasing anticipated utility of treatment among nonseekers of treatment could help alter behavior.

The factors that we identified in this study can be understood within the framework of the behavioral model of service use. Specifically, important predisposing factors included perceptions of mental health treatment, stigma, and social modeling from successful treatment seekers. Enabling factors included access to care, scheduling flexibility, leadership support, and social support from peers and family members. Need factors included perception of illness severity, life stressors, and symptoms that interfered with social and occupational functioning.

Given the qualitative nature of our data, it is difficult to draw conclusions about differences in barriers and facilitators across rank categories. However, stigma and confidentiality concerns appeared to be more prevalent among enlisted members; within the interviews, this was particularly the case for senior-enlisted personnel. Senior enlisted and officers also appeared more likely to describe barriers within the military culture. These findings may reflect the fact that senior enlisted and officers were older and had often served more years in the military. Senior enlisted and officers also more frequently described facilitators such as schedule availability, knowing where to get treatment, positive perceptions of treatment, and life experiences that led to treatment. It is possible that senior enlisted and officers are more aware of services and why they are needed. Future research is needed to establish the stability and origins of these differences between service members of different ranks.

Although this study possessed several strengths, such as recruitment of an active-duty sample that included both treatment seekers and nonseekers of treatment from different ranks, certain limitations should be noted. First, the methodology employed with the general sample (i.e., focus groups) differed from the methodology employed with the treatment seekers (i.e., interviews). In addition, it is possible that the general sample included some participants who had previously sought or were currently seeking treatment. Therefore, our ability to draw comparisons between the two groups is limited. Fmihermore, focus-group data might not accurately reflect the number of individual participants who would nominate a particular theme if interviewed individually. In addition, the interview participants were not representative of all rank stmctures and all participants were recruited from a single installation. Therefore, findings may not be reflective of the broader population of active-duty soldiers. To address these limitations, future studies should consider conducting interviews with both treatment seekers and treatment nonseekers from different installations. Finally, our use of qualitative methods limits our ability to quantify findings or to determine significant associations between barriers/facilitators and treatment-seeking behavior. Therefore, quantitative studies are needed to better establish these relationships.

Conclusion

Our findings have several implications for research and practice. Regarding research, our results suggest that several constructs should be added to existing quantitative assessments of barriers and facilitators of mental health treatment seeking. Barriers that could be added to existing measures include self-stigma, confidentiality concerns, specific treatment concerns, perceptions of malingering, military-related beliefs, leader and peer behaviors, and dishonesty on mental health assessments. Very little research has examined facilitators, and the current study provides guidance for developing a quantitative measure of treatment facilitators. In addition to previously identified facilitators such as symptom interference, measures could assess social network encouragement, positive perceptions of mental health treatment, and positive leader behaviors. Further study is also needed to determine the extent to which these barriers and facilitators generalize to other branches of the military, and how these factors differ by rank.

Regarding practice, our research identified several modifiable barriers to care, highlighting the potential utility of interventions that facilitate treatment seeking among active-duty soldiers. By connecting soldiers to needed mental health treatment, these interventions could increase early intervention, and thus reduce the negative consequences associated with untreated mental illness. Among service members, these negative consequences include disability, occupational impairment, suicide, health-risk behaviors, and disrupted family relationships (Tanielian & Jaycox, 2008). Our results suggest that such interventions could focus on providing accurate information on mental illness and treatment, challenging treatment-interfering beliefs, improving leader behaviors, and reducing practical barriers to care. For example, to challenge some of the treatment-interfering beliefs identified in this study, treatment seeking could be reframed as a form of courage that ultimately improves a soldier's performance in his or her unit. Accurate information could be provided on medication side effects, mental health symptoms that merit intervention, the nature of treatment, confidentiality policies, and any potential career consequences. It is possible that altering treatment-inhibiting perceptions would not only facilitate treatment-seeking behavior, but would also improve early identification of symptoms and increase honesty on widely employed mental health screening instruments.

Our findings indicate that employing testimonials from successful treatment seekers would help to reduce stigma and address treatment concerns. Contact with clinicians prior to seeking treatment could, in addition, improve familiarity with providers, allow for the provision of pertinent information, and reduce stigma. The fact that friends and family play an important role in facilitating treatment also highlights the need to involve these individuals and provide them with information on mental illness and treatment. Furthermore, separate interventions may need to be developed for leaders that focus on recognizing symptoms, improving unit culture toward treatment seeking, and allowing flexibility for attending treatment sessions. Finally, several treatment adaptations have been developed that may help reduce practical barriers, such as brief treatments, treatments that are integrated into primary care settings, and telehealth interventions (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012).

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