ABSTRACT

During recent conflicts in which the United States military is engaged, research exposed the high number of conflict veterans suffering from behavioral health problems. Existing research primarily focuses on the individual psychological processes of those suffering from mental disorders and the perceived barriers to care, the most salient of which is fear of stigmatization (Hoge et al. 2004, Ouimette et al. 2011). In order to explore mental illness stigma from the unique perspective of U.S. military service members, data were collected during semi-structured interviews with ten active duty U.S. Army officers and nine East Carolina University Reserve Officers' Training Corps (ROTC) cadets. Personal semantic analysis and narrative analysis revealed that army officers demonstrate strong cognitive links between physical fitness and behavioral health. They also experience an acute awareness of top-down pressure regarding job performance leading to fear of mental illness affecting accomplishment of duties and tasks. It is contradictory that the unwillingness to seek professional treatment coincides with the expressed need to support and encourage others to do so.

EXPLORING CULTURAL INFLUENCES AND MORAL EXPERIENCES BEHIND MENTAL ILLNESS STIGMA IN THE U.S. ARMY

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CHAPTER 1: INTRODUCTION

Military service members in the United States have been engaged in combat operations for over a decade, and many return from deployments suffering from behavioral health disorders. Affected individuals often do not seek treatment due to fear of the pervasive mental illness stigma within the military. I witnessed the negative effects of this stigma in the military culture during my experiences as an active duty U.S. Army officer. However, finding a practical solution to reduce its negative effects requires comprehending the ways in which this stigma operates . We can achieve that by developing a critical framework and methodology of understanding the triggers (background?) behind specific attitudes. The goal of this research was to explore mental illness stigma within the U.S. Army in order to understand its formation, perpetuation, and exacerbation.

I developed four specific objectives to investigate mental illness stigma in the local social world of the U.S. Army. With moral experiences representing what is most at stake, these objectives intend to reveal the underlying values and practical engagements threatened by mental illness stigma. The first objective of this research was to explore service members' current beliefs regarding illness and affliction affecting themselves and fellow service members in order to understand stigma perpetuation. I hypothesized that cadets and officers would assign legitimacy and illegitimacy to illness, affliction, and emotional distress based on idiosyncratic evaluation rather than the parameters of medical or psychiatric professionals. I expected that most cadets would consider mental illness a detriment to order, discipline, and accomplishment of duties, and believe that mental illness may lead to loss of life while in a deployed environment. In addition, I assumed that most officers would express frustration with physical

and mental illness in others, viewing it as a hindrance to accomplish their everyday tasks and operations for which they face immense pressure from superior officers.

Because stigma is learned during enculturation, understanding its formation relies on elucidating early influences. Therefore, the second objective addressed service members' childhood experiences with illness and affliction in order to understand early influences on mental illness stigma. I hypothesized that most cadets and active duty officers experienced "tough love" in childhood illness and witnessed parents "pushing through" emotional distress, prioritizing obligations and responsibilities. I also expected that informants would believe it is a childlike burden to receive comfort or care in times of emotional distress that removes the element of power from their lives.

In comprehending the moral experience of a particular local social world, it is necessary to delineate norms and values within that world, in this case the U.S. Army. The third study objective examined U.S. Army service members' reasons for pursuing military service in order to understand major moral experiences threatened by mental illness stigma. I hypothesized that cadets' motives for joining military service largely center on belief in the military's existential mission to protect the people and ideals of the United States. I expected most officers would share a belief in the existential mission but would also report other factors involved in their decision, including financial motives and career enhancement.

Many service members that meet the screening criteria for mental disorders after deployment see stigma as a salient barrier to care. The fourth objective aimed to investigate attitudes toward professional treatment to see if other factors involved from earlier experiences influenced the lack of willingness to seek care. I hypothesized that most cadets and officers would claim they would encourage others to seek treatment, but maintain the personal preference

to internalize emotional distress and avoid professional treatment. I expected that most service members would fear stigma, but also doubt the ability of professionals to properly treat the individual according to his or her specific needs and place high priority on speed of recovery. I also expected that most officers also perceive professional treatment as a potentially interfering with their ability to accomplish tasks set forth by their superior officers.

This study is significant because it contributes to the larger theoretical body of knowledge concerning stigma and the key processes involved in assigning and enabling stigma. Identifying these processes may assist in developing educational programs, treatment strategies, and evaluation tools for existing programs and methods. These developments may improve support mechanisms for the stigmatized individuals and facilitate enhanced understanding of the stigmatizers.

In the midst of U.S. military engagement in ongoing conflicts in which many veterans return with mental health problems, this study is especially relevant. Mental illness results in far-reaching consequences that affect the lives of the afflicted and often those around them. Because stigma is a salient barrier to care, understanding mental illness stigma as it relates specifically to the U.S. Army community is essential to advance education and treatment programs. In the next chapter, I will review literature on the military culture, approaches to preventing and treating mental illness in the military. That chapter is followed by a description of the conceptual and theoretical approach to studying stigma and moral experiences employed in this research. The last two chapters of this thesis will present the findings of this study, followed by a discussion and an outlook for future studies.

CHAPTER 2: LITERATURE REVIEW

2.1: Military Anthropology and the Warrior Culture

Anthropology's relationship with the military varies in times of war. The work of Margaret Mead and other social scientists' role in direct support of the allied war effort during World War II remains a contentious application of the discipline (Mabee 1987). Project Camelot was a Vietnam-era U.S. program aimed at recruiting civilian social scientists to predict civil breakdown. It was cancelled the year after its inception following a congressional hearing (Gusterson 2003). Criticism of anthropology's role in support of military efforts reemerged during the recent Global War on Terror (GWOT) and major conflicts in the Middle East and Southwest Asia. In 2007, the U.S. Army launched a program called the Human Terrain System (HTS) in which social scientists deploy with military units to provide operational commanders with an enhanced understanding of the cultural environment. A flurry of articles appeared in response to HTS warning of mercenary anthropology and questioning the ethical implications of collecting and using anthropological data in U.S. military operations (e.g. Calhoun 2010, Gonzalez 2007, Sluka 2010).

Aside from the debate among anthropologists to either lend their expertise to the military or refuse even non-operational support, military service members continue to occupy unique positions in American culture. Brown and Lutz (2007) explain that the unfiltered words of soldiers constitute "Warrior Knowledge." Although often crass and without critical framing, these words nevertheless represent the voices of millions of Americans with firsthand accounts of enemy engagement. The authors note the myriad literature on personal, unadulterated accounts of war fighting that demonstrate the depth of understanding gained from soldiers directly involved in conflict.

Along with Warrior Knowledge comes a distinct Warrior Culture encompassing attitudes, values, customs, practices, and traditions based in a mission-first, selfless service oriented foundation (Siegl 2008). Brown (2008) explores military service members' acquisition and application of cultural knowledge, illustrating disagreement in mainstream cultural models between conventional U.S. Army forces and both Special Operations Forces and the Marine Corps. He describes the importance of highlighting "inherent contradictions involved when an institution that was built on industrial lines to efficiently deliver lethal violence . . . is tasked with peacekeeping and nation building" (Brown 2008:450).

Exploring the use of cultural knowledge, Silliman (2008) investigates the use of "Wild West" metaphors in everyday operational discourse among deployed troops. This analysis demonstrates a particular instance of overarching cultural knowledge influencing service members' orientation to their operational environment (Silliman 2008). In a role-reversing view of cultural influences in a military context, Lutz (2002) offers a civilian perspective of the intersection of values in the militarization of the United States following the events of September 11, 2001. The author claims that fervent patriotism, fear of future terrorist attacks, and ardent support for the U.S. military and its ideals resulted in a climate of legitimization of violence and military dominance (Lutz 2002).

These insights provide an important foundation to approaching research within the military. Understanding mental illness stigma through the lens of Warrior Knowledge will impart the intuitive views of those with direct experience in the Warrior Culture. This insider perspective will inform methods and models intending to combat stigma.

2.2: An Historic Overview of Responses to Mental Illness in the U.S. Military

The effects of conflict on the societies involved and accounts of deployed life are abundant, but anthropological literature lacks explorations of the cultural influences framing the unique challenges faced by the returning soldiers, and their perceptions of one another rather than the enemy abroad. Given the mental health problems suffered by many veterans of combat deployments, soldiers' views on mental illness are of particular importance. Combat and interpersonal aggression are especially troubling events that increase severity and duration of trauma given the inherent human aversion to violence (Grossman and Christensen 2004). As Barrett (2011) stated: "we expect that soldiers trained in the art and science of combat are somehow also prepared—by happenstance—for the mental punishment and trauma of sustained military action" (97).

Psychological disorders in military service members returning from combat deployments do not represent a new phenomenon. Previously labeled "shell shock" or "battle fatigue, post-traumatic stress disorder (PTSD) was not a recognized clinical condition until 1980. The National Vietnam Veterans' Readjustment Study conducted in the 1980s found that 35.8% of men and 17.5% of women returning from combat zones during the Vietnam War met the screening criteria for PTSD. Other common disorders included depression, generalized anxiety disorder, antisocial personality disorder, and alcohol abuse or dependence (Kulka et al. 1990). Among veterans of the Persian Gulf War, 3% of men and 8% of women met the screening criteria for PTSD (Wolfe et al. 1999).

A 2004 survey of U.S. military personnel revealed 15.6-17.1% returning from Iraq and 11.2% returning from Afghanistan met the screening criteria for depression, anxiety, or PTSD (Hoge et al. 2004). In 2012, deaths from suicide among service members exceeded those

suffered from combat losses (Chappell 2013). The U.S. Army recognized these statistics and, in an attempt to address the contributing factors, began focusing on the concept of building resilience in soldiers.

Tugade and Frederickson (2004) define resilience as having the resources to endure, recover, and grow stronger through the ability to adapt when faced with stress and dynamic environments. The processes through which resilience is built and maintained include strategies and qualities on the individual and group levels. Adaptive coping refers to adjusting as necessary to changing environments and possessing or developing the ability to thrive under stress by confronting difficult situations rather than avoiding them (Pietrzak et al. 2009). Hoge et al. (2007) find that adaptive coping in service members serves to decrease symptoms of PTSD and helps to prepare them in advance for stressful situations potentially faced during deployments. The authors also discuss personal control, in which individuals assert a view of control over their lives and the situations that affect them, finding that this strategy helps people adapt and overcome. Numerous studies indicate that service members asserting ideas of personal control prior to deployment contributed to their ability to deal with stressors during deployment, compared to those who did not express a sense of personal control (Maguen et al. 2008; Poulsny et al. 2009; Simmons and Yoder 2013).

Researchers have also explored the concept of hardiness and its influence on the physical and behavioral health of service members. Hardiness encompasses ideas about the attributes that facilitate an individual's ability to survive and undergo personal growth when faced with challenges, and is thought to develop through childhood experiences (Funk 1992). Each of these strategies and characteristics is strengthened by social support. Service members facing the stressors of daily life in the military and the dynamic nature of deployment and post-deployment

transitions have indicated a reliance on family and close relations to cope (Brenner et al. 2009).

Army leaders have attempted to promote resilience and simultaneously decrease stigma by implementing various programs developed in concert with behavioral health professionals. The Comprehensive Soldier Fitness (CSF) program initiated in 2008 intends to equip soldiers with necessary skills prior to deployment to help them endure and cope with the physical and emotional effects of stress (Cornum et al. 2011). The program's framework encompasses physical, emotional, familial, and spiritual domains, providing assessment and training to identify soldiers in need of resources and support (Casey 2011; Pargament and Sweeney 2011). Randomized, controlled measures are currently in process to quantitatively evaluate the program (Lester et al. 2011).

However, Simmons and Yoder (2013) address attributes and strategies promoted by CSF to conceptualize resilience in service members and to determine the need to examine resilience in active duty service members. Additionally, Eidelson et al. (2011) criticize CSF for the potential ethical ramifications of involving soldiers in essentially a research project for which they do not provide informed consent. The authors also question the moral issues associated with the program's aim to better prepare soldiers for combat and thus potentially make them more willing to engage in dangerous, traumatic situations (Eideson et al. 2011). They conclude that perhaps "soldiers might be helped more by finding nonmilitary ways to resolve the conflicts and concerns for which they carry such heavy burdens" (Eidelson et al. 2011:644).

My research explored values internalized by service members across these dimensions and outside the boundaries of specific programming. Understanding these processes is crucial in evaluating and continually developing and modifying programs to meet the needs of soldiers. As Cornum et al. (2011) state regarding the importance of such research, "Psychology and related

disciplines will prove instrumental to success in 21st-century warfare and 21st-century peacekeeping" (8).

Despite the efforts to address mental illness in the military, of the many affected service members, only 23-40% sought mental health care (Hoge et al. 2004). The leading reported barrier to care was the fear of mental illness stigma under which service members anticipate possible embarrassment, career detriment, differential treatment, and the perception of weakness (Ouimette et al. 2011). Foregoing treatment results in a cycle of worry and self-punishment, perpetuating and increasing the severity of disorders prevalent in the military community (Pietrak et al. 2011). To address these issues, it is necessary to focus on understanding the stigma.

2.3: Stigma Theory and Moral Experiences

Stigma is a shared cross-cultural experience with exclusive influences behind formation and consequences depending on the individual culture. Formation of a stigma involves a culture's designation of an attribute as a deviant condition, leading to devalued social identity. The processes of cognitive categorization link undesirable characteristics to individuals with labeled differences, providing a rationale for delegitimizing the "other." (Yang et al. 2006). The result for the stigmatized is self-prejudice and self-discrimination due to negative cultural images, and for the stigmatizers, the stigma embodies a defense against threats to fundamental values (Link and Phelan 2001).

Mental illness stereotypes are learned during enculturation, informed by perceived threats to existential, moral, and physical realms, and reinforced by continued discrimination and status loss of the afflicted (Yang et al. 2006). With enculturation central to the formation process, stigma must be understood in relation to particular cultural influences. The literature on stigma

introduced above has reported on public perceptions of those with mental illness, outlining three themes: authoritarianism, fear and exclusion, and benevolence. The authoritarianism theme refers to a belief that individuals with mental illnesses are unable to function by themselves. Fear and exclusion expects that those affected should be isolated from the rest of society, and benevolence is a trend of viewing those with mental illness as childlike and innocent (Greene-Shortridge et al. 2007).

Research shows that individuals often seek care and support from those outside the medical profession, such as family, clergy, or others (Cooper et al. 2003). Addressing stigmatizing attitudes is directly linked to an individual with mental illness seeking and adhering to treatment. Link et al. (1999) report in a study of public conceptions of mental illness that nearly half of respondents indicated they would be very or somewhat likely to distance themselves in social situations from individuals with severe mental illness.

Attribution theory seeks to comprehend how mental illness etiology is understood, and have found that those with a mental illness were seen as more responsible for their illness over physical injuries. This attribution leads to less sympathy toward those with problems, and the idea that the individual can control their mental illness (Weiner 1995). In general, U.S. culture tends to place responsibility on the individual for behavioral disorders much more than for physical injuries a person has encountered. As a result, a person with a behavioral disorder is more likely to receive more blame, and exclusion from society. Military service members experiencing psychological problems recognize the social stigma at large and therefore understand the disapproval they might face by fellow service members and the overarching U.S. culture if they choose to admit their problems and seek care (Greene-Shortridge et al. 2007).

This disapproval represents a threat to service members' moral experiences in the Warrior Culture.

The individual and collective idioms of mental health and categories of trauma behind a diagnosis of mental illness may vary. Afana et al. (2010) found Palestinians experiencing conflict in the Gaza strip categorize traumatic experiences and mental illness based on gravity of the trauma and persistence of consequences (76-77). The degrees of legitimacy assigned to traumatic experiences and resulting mental health problems suggest the possibility of variation in assignment of illness authenticity in certain local worlds. Brown's (2008) description of the distinct difference in the use of cultural knowledge among the various branches of military service suggests the importance of focusing on a particular branch to understand the exclusive mechanisms of stigma.

According to Yang et al. (2006), moral experiences represent "what is most at stake for actors in a local social world" (1525). Stigma threatens individual experience and potentially spoils one's identity by jeopardizing the symbolic and metaphoric ideas of purity and conformity to cultural norms (Goffman 1963). The cognitive constructs assembled as a result of such threats are characterized by negative cultural images and manifest at both the individual and systemic levels. Both the stigmatized and stigmatizers feel the weight of the threats to their idiosyncratic values and their position in the social structure (Yang et al. 2006:1531). In the United States, a study of stigmatized schizophrenics revealed a view of mental illness as a threat to individualism and societal inclusion (Jenkins and Carpenter-Song 2008). These values are central to the experiences of individuals and groups and demonstrate the interpersonal and pragmatic dangers perceived with assignment of stigma. The military environment fosters the identity of a tough service member unaffected by physical or mental ailments and U.S. Army leaders acknowledge

that this contributes to stigma (Casey 2011). Often this leads to crisis when soldiers face stressors (Finley 2011). Collura and Lende (2012) state that the "issue of identity formation requires a closer look into the cultural constructs that are responsible for what stress and trauma mean to each individual soldier (138)."

The methodology for this research was developed for the particular local social world of the U.S. Army. Inquiries focused on delineating early influences, moral experiences, idioms of distress, and responses to stigma by service members. The intent was to provide the in-depth look, framed by the theories and conceptualizations outlined above, at the cultural constructs guiding stigma in the Warrior Culture.

CHAPTER 3: RESEARCH METHODOLOGY

3.1: Site Selection and Sampling Strategy

I wanted to understand attitudes about mental illness stigma and perceptions of mental illness in the U.S. Army; therefore I needed a non-probability sample. I originally intended to compare two groups and their attitudes, namely officers and enlisted service members. However, I experienced difficulty enrolling enlisted service members after disclosing that I am a former U.S. Army officer. A separation exists between officers and enlisted service members to maintain an ordered and disciplined environment. Enlisted personnel indicated that their place in the rank structure is to follow orders without complaint. The noncommissioned officers I attempted to enroll lacked enthusiasm and displayed a reluctance to discuss mental illness stigma. I deduced from their responses to me that speaking about these issues with an officer would potentially bias their answers.

I decided to enroll East Carolina University Reserve Officers' Training Corps (ROTC) cadets to compare the views of incoming officers to the established views of officers serving on active duty for several years. I used a purposive sampling strategy to enroll informants (Bernard 2006). ROTC participants were selected from a list of volunteers provided by a cadet in a student leadership position. Active duty participants were selected via respondent-driven sampling, utilizing pre-existing contacts from my prior military service to recruit participants near Fort Benning, GA and Fort Bragg, NC. Many soldiers stationed on these installations attend professional military education courses for combat arms branches. The courses consist of service members from various backgrounds with diverse military experiences. To protect informant confidentiality and avoid institutionalization of this study, I did not enter the military installation

in order to recruit informants, rather I remained separate from the installation to assure informants' comfort, privacy, and voluntary informed consent.

Given time constraints and project feasibility, only men were included to remove gender as a component of comparison. I enrolled nine ROTC cadets and ten active duty officers to compare data between persons preparing to enter military service and those with several years of active service (see Table 2.1). Criteria for ethnicity and relationship status were recorded but not considered for enrollment given the correlation to active duty military units, in which diversity of these variables typically fluctuates. Cadets' ages ranged between 18 and 21 years, one was married, five single, and three were in a serious relationship. Seven cadets were white, one white and Hispanic, and one white and African American. Active duty officers ranged in age between 26 and 37 years; eight were married and two single. Nine officers were white and one Hispanic.

Table 3.1: Informant Demographics

ROTC Cadets			
Class Standing	**No Prior Military Experience**	**2 Years Army National Guard**	**Sum**
Freshman	1	0	1
Sophomore	1	2	3
Junior	0	1	1
Senior	2	2	4
Total	4	5	9
Active Duty Army Officers			
Rank/Years Active Service	**1 Deployment**	**2 or More Deployments**	**Sum**
CPT/4-5 years	6	2	8
CPT/6+ years	0	2	2
Total	6	4	10

3.2: Data Collection Methods

I interviewed informants using semi-structured instrument with different approaches to data collection. The instrument included open-ended questions regarding physical ailments and

emotional distress in childhood, at present, and during experiences in military service (see Appendix B). Some questions focused on general physical and mental illness while others specifically related to views on PTSD. Certain questions elicited data regarding military values to explore the moral experiences at stake for U.S. Army service members. The questions were developed to address the four research objectives and modified during a pilot study with ROTC cadets.

After the semi-structured questions, I asked questions about personal relationships, social support, and trust in others when interviewing cadets. The social network analysis paradigm serves as a measure of the ways in which individuals frame their social structures (Molina et al. n.d.; Wasserman and Faust 1994; Wellman et al. 1988). These networks provide individuals with sources of information, social support, influences, and pressures. The egocentric approach is particularly applicable to explore the stigma phenomenon in an individual organization—the U.S. Army. This methodology was selected to understand the composition and structure of ego networks and potentially reveal relations of interest that pertain to social support and influence regarding mental illness stigma. Informants chose the person or persons in their network that best fit the question and provided the person's relationship to them, age, ethnicity, and any additional clarifying comments. Some questions asked about the people informants depend on for assistance in tasks such as changing a tire, for social activities like seeing a movie, and for advice on issues ranging from class selection to major life decisions. Other questions asked about people with specific positions in informants' networks, such as mental health professionals or members of religious groups. Two questions explicitly asked about military and ROTC related issues (see Appendix C).

I interviewed six of the nine ROTC cadets before interviewing officers. During these first six interviews, I determined that the personal network questionnaire did not sufficiently address my four research objectives. I continued to use it in the remaining cadet interviews for consistency. However, I developed a different data collection instrument that I used to collect statements from officers.

Following semi-structured questions in interviews with officers, I screened three video clips as props: a PTSD awareness campaign commercial, a mental illness stigma reduction public service announcement, and a U.S. Army recruitment video. Videos, photos, and other forms of visual media can act as cues to examine accuracy in recollection about past events and to elicit impressions and data about cultural acceptance in reaction to the material (Bernard 2006; Hockings 2003). The video props were used to capture initial utterances on mental illness in the military and the overarching U.S. culture, and military values expressed to appeal to potential service members. They were also meant to gather data on the effectiveness of conveying information in the particular format and script of the individual videos.

Additionally, I developed three vignettes conveying specific hypothetical scenarios with multiple variables that I presented to officers after screening the video clips. This methodology is used to uncover judgments and opinions about the situation, and the ways in which informants would respond if faced with that scenario (Bernard 2006). Researchers use vignettes for many types of surveys and studies to understand the emic perspective on a particular topic. For example, Link et al. (1999) used vignettes that portray individuals with mental illnesses to study public recognition of mental illness and beliefs about underlying causes, Golge et al. (2003) developed scenarios to study attitudes toward rape in Turkey, and Young and Garro (1986) included vignettes in a study of how a particular group of people in Mexico made decisions on

how to treat illnesses. The vignettes presented to officers covered physical and mental ailments suffered by military service members and traumatic family events in order to gauge initial responses to and judgments of circumstances they might encounter (see Appendix D). For each vignette, I read the general scenario to the officers and provided two different lines of follow up information. Officers were asked to give their impressions of each scenario and discuss how they would respond if they encountered the situation.

3.3: Data Analysis Methods

Interviews were transcribed and the text coded and analyzed for themes using ATLAS.ti software (ATLAS.ti 2013). I intended to find links between sources of influence and support that may explain the perceptions and attitudes toward mental illness that lead to perpetuation of stigma. I conducted both qualitative and quantitative methods of data analysis. I accounted for similar phrases in particular questions, occurrences of words or phrases used in tandem, and variations and patterns in description of experiences and beliefs, and quantified occurrences and co-occurrences of themes (Bernard and Ryan 2010). ATLAS.ti is one of many software packages used for data analysis. I chose ATLAS.ti for its range of tools for coding, queries, and outputs. The program has been utilized and evaluated for its effectiveness as a combined tool for qualitative and quantitative analysis (Lewis 2004; Annechino et al. 2010).

After transcribing interviews, I uploaded the individual documents into ATLAS.ti and coded each document with a list I created and maintained within the program. Coding in ATLAS.ti is based in grounded theory and density: the number of data segments associated with codes and the number of associations between codes (Strauss and Corbin 1997). I used the ATLAS.ti code analyzer to eliminate redundancy and the Coding Analysis Toolkit (CAT) to calculate reliability. Then I ran the tools the program offers to sort and analyze similar codes into

code families and determine common themes, and generated frequency and co-occurrence reports.

I conducted Personal Semantic Analysis to understand the meaning behind expressions of language used by service members (Goddard 2011). Personal Semantic Analysis is an established analysis method that has been used by anthropologists to understand particular terminology and how it is used in the context of specific social worlds (e.g. Burling 1964; Gelaye 1998; Kelly and Baserman 2003). To conduct this type of analysis, I identified key words, phrases, and expressions that were used repeatedly within and between informants, and took note of strong or weak emotional intonations in answers to particular questions. I looked for words, phrases, or expressions that informants associated with powerful memories, ideas, ambitions, or self-image. This approach added to understanding the centrality or peripheral nature of themes, delineating shared cultural associations, and recognizing how these themes and associations are related to behaviors and ideas regarding mental illness among service members (Strauss and Corbin 1990). I also related network data back to informants' answers to semi-structured interview questions to compare narratives of early childhood influences to composition and structure of current personal networks.

I conducted narrative analysis based on the assumption that informants' ideas come from shared discourse.. I looked for both inconsistencies and similarities within and between narratives conveyed by informants. These narratives reveal both references for the physical world and indicators of why stories are told in particular ways (Dauite and Lightfoot 2004; Riessman 1993). Conflicting beliefs manifested as one of three cognitive patterns: compartmentalization in which the informant is unaware of two conflicting ideas, ambivalence in informants' awareness of inconsistent ideas, or integration of multiple ideas merged into a

viewpoint informants consider rational despite remaining outside the boundaries of general cultural discourse. This analysis allowed for understanding how ideas are internalized in informants, as these ideas influence actions. It also exposed meaning behind particular ideas regarding mental illness (Quinn 2005).

I looked for indicators of informants' awareness, or lack of awareness, of how their ideas conformed or competed with general opinion. In the warrior culture where shared ideas and conformity to set standards is valued, this analysis was important in understanding what ideas service members find common, debatable, controversial, or taken for granted. It also provided an understanding of the motivation and reasoning behind decisions service members make (Mathews 1998). Ideas either adhering to or differing from what they deem popular opinion signified the controversial viewpoints were noted to address their role in stigma perpetuation. This method of analysis has been used by numerous researchers in understanding individual and shared cultural models of physical and mental illness (e.g. Carless and Douglas 2008; Jones et al. 2007; Lysaker et al. 2002; Mathews et al. 1994; Stern et al. 1999). Throughout chapter 4, I will illustrate the findings with quotations, labeled with gender, age, and ethnicity, that represent the majority of informants' perspectives.

CHAPTER 4: WHAT SERVICE MEMBERS REALLY THINK

The narratives of cadets and officers provide rich sources of information to understand the influences behind formation, perpetuation, and exacerbation of mental illness stigma in the U.S. Army. The language they used to describe their perspectives and experiences in the army community stems directly from warrior knowledge, colloquialisms, slang, and terminology unique to their service. Many terms are descriptive of military ranks, positions, unit designations, or army-related activities. They used many abbreviations and acronyms in reference to army policies, activities, and programs. Some terms were also used in both the general sense and with specific connotations attached. For example, being "on quarters" refers to specific instructions given by a medical professional for a service member to remain at home due to illness, injury, or a convalescent period. A profile, or "being on profile," is a document issued by a medical professional restricting physical activity due to an injury or illness for a given amount of time. A service member may receive either quarters, a profile, and in some cases both.

Table 4.1 summarizes and juxtaposes viewpoints of cadets and officers regarding several themes that emerged in this research. The following sections will further describe these themes and others that emerged during this research. They will also show how the use of particular terminology unique to military service guides and frames service members' articulation of their perceptions regarding mental illness in the Warrior Culture (Siegl 2008).

Table 4.1: Juxtaposition of Viewpoints between Officers and Cadets

Topic	Cadets	Officers
Motivation to enter military service	Higher purpose, 9/11, patriotism	Higher purpose, 9/11, patriotism, atypical career
Perceptions of Army Values	LDRSHIP (DoA 2005)	Ability to complete routine tasks, response to pressure from superiors
Reported Childhood Experiences with Illness and Distress	Firm parental expectations, example set to transcend illness or distress	Emotional support, example set to transcend illness or distress
Ideas on Root Causes of Mental Illness	Traumatic events, death of close relations	Traumatic events, stress caused by change in normal patterns
Judgments of Legitimacy/Illegitimacy of Illness or Injury	Patterns of illness/injury	Patterns of illness/injury, personal knowledge about individual
Perception of Professional Treatment	Regimented, unsuited to individual needs	Regimented, unsuited to individual needs, too much time away from work

4.1: "Suck it Up and Drive On": What Service Members Associate with Mental Illness

The most frequently used phrase, verbatim or in a similar variation, that cadets and officers used in reference to attitudes toward and expectations from those suffering from a mental illness was "suck it up and drive on." The phrase was used in two meaningful ways. Most cadets used it as a proclamation of the presumption that one suffering from a mental illness should conquer their problems quickly and continue serving without any change to routine or loss of productivity. Officers tended to use the phrase with sarcastic intonation to describe the mentality of those around them, and to describe how they believe they must behave when affected by either a physical ailment or emotional distress. Table 4.2 illustrates the frequency of the six most often used phrases service members used in association with mental illness.

Table 4.2: What Service Members Associate with Mental Illness

Word/Phrase	Frequency
Suck it up and drive on	37
Legitimacy	33
Combat Stress	27
Malingering	22
Family Support	19
Isolation	14

The close link between values of physical and mental resilience is evident in the prevailing assignment of these criteria to descriptions of a soldier fit for military duty. Cadets and officers admitted everyone becomes ill at some point, and assigned legitimacy and illegitimacy regarding both physical and mental illness. They generally assess illness as legitimate based on seriousness, contagiousness, and doctor approval, remarking that simply "a cough or a headache" should not prevent a soldier from participating in physical training or daily duties. Another stratum of illegitimacy forms through the perception of a pattern of excuses or identification of an individual as lagging behind in physical fitness. One officer explained his perspective by separating being hurt from being injured:

> *If you're hurt, suck it up and keep going, because we all get hurt. If you're injured, that's a different situation because…injury implies to me that there is something wrong that will not get better without taking some measures, be it rest, whatever. Hurt stuff, you know, guys always have sore shoulders, sore knees, sore arms, stressed out about life. That always happens, you just kinda gotta roll with it, that's life. So it's the difference between being hurt and injured. Injured guys I don't mind when they're on profile. Hurt guys, like I said, maybe once I'll cut you a break because you need to recoup but if it's a habitual thing, that becomes an issue. [Male (M), 26 years old, Ethnicity: White (W)]*

A cadet linked personal values to perceived patterns of excuses, discussing a female classmate:

> *She's a great friend, but she's got some integrity violations. She always tries to—pardon my language—half-ass things a lot. . . . It's almost like common*

> *knowledge that, you know, this person is sometimes shaky on their values. [M, 20, W]*

Future illness or injury in those identified as following such a pattern is seen as an excuse to "get out of doing something" and prompts challenges to individual values. When asked what others may think when they personally become ill or injured, cadets often responded with "they all know me, I'm not like that," meaning not like "them", the people with corrupt values and a pattern of obtaining physical profiles or expressing emotional distress. Officers expressed this sentiment, linking job performance, capabilities, and personal worth to physical fitness. Officers also stated their reactions to a soldier's injury or illness resulted from overall evaluations of the soldier, based on past job performance and medical history. One officer discussed such evaluations and judgments as a common practice:

> *They know what they think about you before that happens. So, if they think "this guy's a shitbag", then it doesn't matter if I do suck it up and go on the run, I'm still gonna be a shitbag to them. Or vice versa…if they think I'm good at my job and I do my job well, I don't think they'd going to begrudge me for, you know, taking a day off because I needed a day off or vice versa. Just like I'm watching them and I've made up my decision, I kinda have an opinion of who they are before they come to me with "hey I can't do the PT test because I hurt my knee," or whatever [M, 28, W]*

Another officer spoke of mental illness in terms of the army and the country in general, speculating that those incapable of handling responsibilities succumb to "normal" levels of stress:

> *I would say…a portion of those are really living the stress of life. Some of them are probably outright faking it to get the benefits, some of them have some very serious legitimate issues, they need help. . . . I think there's a portion in the middle that have just, uh, people have kinda gotten soft overall in the world and the stresses of life which used to just be the stress of life has now become an illness. [M, 36, W]*

Informants frequently alluded to the paradigm of adult responsibilities preventing expression of or seeking treatment for mental distress. As with physical ailments, cadets often

described communicating emotional hardships to others as unacceptable because they don't wish to "be babied" or they must react as one cadet described: "I'm supposed to go solve it and be an adult, I'm supposed to be strong, I didn't want to bring anybody else down." With officers, communicating emotional hardships was also unacceptable based on potentially diminishing their expected image. However, they also identified a need to preserve the trust and confidence their superiors place in them to accomplish routine duties, long-term tasks, and overall mission accomplishment. One officer declared: "I'm not sure if mental illness stigma is 100% a bad thing, because soldiers need resilience."

4.2: "Indecisiveness is a Killer": Qualities Soldiers Associate with a Good Soldier

When asked what qualities make a U.S. Army service member a good soldier, cadets most often suggested physical fitness and mental resilience, and reiterated this suggestion when describing a soldier fit for duty. Qualities such as discipline, trustworthiness, reliability, and accomplishment of duties were mentioned only after probing. Officers generally described a good soldier as more well-rounded, giving equal importance to problem-solving, intelligence, dedication, and physical and mental resilience:.

> *Probably the most important thing is just common sense. Being grounded in what's going on. Had a lot of good soldiers who weren't necessarily the smartest guy, the strongest guy, those are obviously features you look for, you look for somebody who's bright, somebody who can handle the physical demands of the job [M, 27, W,].*

However, officers also suggested a soldier fit for duty requires physical and mental fitness and often linked it to the responsibilities of an officer:

> *Well obviously there's the physical fitness piece, which means you need to be able to do your job and meet the standards at a minimum. I think most people would agree the standards are actually pretty low. At least for physical fitness you should probably be exceeding them but you need to be able to do your job and then, do it under stress. . . .anybody can do it when it's easy, anybody can do it in*

> *a classroom, anybody can do it when you have four hours to sit around and make the perfect decision. The leaders, they pay you the big bucks to make a decision when you don't know what's going to happen. And you're expected to have the training to make an imperfect decision at an imperfect time . . . . indecisiveness is definitely a killer. [M, 28, W]*

One officer gave an example of one of his peers, who struggled in physical activities and was given a series of profiles for multiple injuries. His expression was bemused as he described these details and claimed the officer's personality indicated an emotional unwillingness or mental inability to succeed in the military. The informant said if it were him, he would "be at PT every day…and at least try, and then my soldiers would see I was trying to push through it even though I had a profile."

Angry, sulky, depressed, mood swings, and detachment are ways in which cadets and officers described symptoms of mental illness, specifically PTSD. Cadets and officers view these potential symptoms as detrimental to order and discipline if they surface during the course of performing duties. The source of understanding what is right and wrong in the eyes of service members regarding the behavior, stature, and persona a soldier must assume has roots in the environment created by initial entry training. Informants reported that during basic training there was no room for complaints and individual failure reflected upon the group, leading to mass punishment in the form of additional duties or difficult physical activity. Individual and group success was dependent on trainees' ability to suppress emotional reactions, hide discomfort, and project strength and stoicism. This behavior gained them respect from their peers and approval of instructors. Table 4.2 illustrates the frequency of the six qualities of a good soldier most often mentioned by service members.

Table 4.3: What Service Members Perceive as the Qualities of a "Good" Soldier

Word/Phrase	Frequency
Physical Fitness	46
Mental Toughness	42
Duty	29
Discipline	23
Honor	16
Intelligence	13

Cadets more often reflected on physical and mental resilience in an emblematic sense. They recalled the good soldiers among their peers as those who, during basic training and ROTC training, exceeded the standards and didn't complain. Farther along in military service, officers generally described good soldiers as those who get their jobs done and effectively avoid admonishment from superiors similar to the intense rebuke instructors often hand down during basic training. After several years of active service, the pragmatic notion of accomplishing a myriad of routine tasks and training requirements leads officers to place less emphasis on image and more on performance.

4.3: "You gotta get that mission done": Moral Experiences at Stake for Service Members

Informants stated that, in the military, lives are at stake and the soldier's role of the protector is too great a responsibility to suffer distress and burden others. Cadets view those that suffer physical or mental ailments as unfit for duty and in many cases unfit for military service. Service members believing so firmly in their hero status perceive such judgments as a great threat to their own moral experience. The military values of physical and mental toughness exacerbate mental illness stigma through fears that a sufferer will cause harm to the mission and place the lives of others in jeopardy. Officers took more of a pragmatic perspective, claiming that while patterns of illness or injury may indicate an unfit soldier, one might still be able to perform

their duties, but at a subpar level. The concern was less about a threat to the general military image and more a threat to the personal image of the affected soldiers' superiors in the event they did not perform their duties to standard.

When asked what comes to their minds when someone mentions mental illness, cadets often immediately replied with a specific illness or condition, e.g. dementia, mental retardation, autism, paranoid schizophrenia, Attention Deficit Hyperactivity Disorder (ADHD), in addition to PTSD. They frequently described those with mental illness as abnormal, different, "not all there," having "something missing," or alluding to physical manifestations or acute behavioral differences. When asked to recount reactions toward mental illness he's witnessed, one cadet recounted:

> *I remember we had one kid in my graduating class . . . he had like a form of autism maybe? I want to say that's what it was. He was just like, he always was talking. He'd consistently talk and, you know, if you didn't understand that there's something wrong with him you'd just be like, shut up, this is one of those people that's always talking. [M, 20, W]*

And again from his time in Initial Entry Training:

> *You could, you know, say his name ten times and he wouldn't respond to it. I remember once . . . it was like the first exercise we did, it was an obstacle course. I remember someone came up to him and hit him in the back and was like, "Good job, man," and he freaked out, he was like, "don't touch me." Just like, freakin' out. And that's just kinda how he was all the time. [M, 20, W]*

Such narratives suggest the forces that maintain the mental illness stigma in the military are not limited to personal consequences regarding the ways in which others will perceive them. Cadets also possess an acute awareness of potential consequences to order, discipline, and mission accomplishment. A common speculation regarding the outcome of a soldier suffering from a mental illness in a deployed environment is that the soldier may cause harm to others. In the civilian world, those with mental illness are burdensome. In the military, those with mental

illness are not simply a burden, but also potentially dangerous. One cadet elaborated with a scenario he personally fears:

> *If things get rough, I don't want you to be crying and stuff like that. You can do that when we're off mission or not doing something . . . just buckle down and get through it. You're going to let a lot of people down. I always imagine, you have your best friend next to you, they go down, we're supposed to return fire, and if you don't return fire some other person's gonna go down. So you gotta get that mission done. [M, 20, W]*

Officers also suggested that lives might be at stake, but expounded with the idea that the decisions of leaders were important factors involved. Several officers recounted experiences in which lives were lost in the course of carrying out a mission, and the lingering effects paralyzed leadership from making quick, sound decisions.

The cadets all revealed a distinct admiration of heroism inherent to military service. They believe firmly in the existential mission to serve a greater purpose—to protect the people of the United States and engage in humanitarian efforts across the globe. Cadets frequently reported the events of September 11, 2001 and notions of nationalism and patriotism influenced their decision to enter military service. One cadet related the moment he decided to join:

> *September 11th. Saw the twin towers fall and all that stuff. . . . Right after, the next day I was watching TV and I saw a Marines commercial come on and I was like, oh I want to do that, like, serve my country and get back at the guys who did this. [M, 21, W]*

And yet another expanded on his moral justification:

> *All the areas we go into, it's not like we're going and invading England, who has a stable government and a great society and stuff like that. We're going to places where there's some extremists that want to hurt people, not just us. If they weren't hurting us, they'd be hurting someone else. They just don't do it to us, they do it to people in their own country, so I believe, you know, it's a good mission they've been going on for years. I want to be a part of that. [M, 20, W]*

Officers reported some similar reasons for joining the military, indicating that they wanted "to be a part of something greater than myself," the events of 9/11, and service to the

U.S. heavily influenced their decision to join. Along with patriotism, a sense of duty, need for a higher purpose, and wanting to be part of a military family, they also mentioned desiring an atypical career, the chance to travel, and financial benefits. After years of service and often several deployments, the greater existential mission can become altered. Three officers stated they questioned the worth of some of their combat missions, seeing small benefits but unclear on any greater impact. When they lose a fellow soldier in the process, they may begin to feel that the mission was not worth the lost life. However, they claim that it cannot stop them from accomplishing their duties. Therefore, the existential mission is still at play for officers, but their moral experiences at stake shift to also encompass personal successes and failures as a leader of soldiers.

Service members describe the army values in terms of the 7 Army Values set forth officially in the acronym LDRSHIP: loyalty, duty, respect, selfless service, honor, integrity, and personal courage (Department of the Army 2005). The LDRSHIP values were often mentioned in passing, as though a mandatory reference or central, accessible entity. Informants reported their introduction to this concept came in either basic training or the advent of their participation in the ROTC program, in which instructors used these values as a tool to indoctrinate trainees into the Warrior Culture.

Cadets placed more importance on adherence to this specific military mentality than officers. Their responses were framed by values rather than descriptions of specific responsibilities and tasks, and speculated about deployed environments in a vague sense of what actually may take place. Officers placed more emphasis on the top-down, institutional pressure from superiors to accomplish routine daily tasks. They discussed values in relation to responsibilities, but most often referred to their own experiences in the army as changing their

perspective. Rather than judge fellow service members solely in the context of their adherence to prescribed army values, officers gauged fellow service members' abilities to complete tasks under the pressure of condensed timeframes and higher-echelon requests.

The perception of such a profound obligation to protect others heightens sensitivity to the concept of fitness. Childhood experiences of witnessing parents placing the welfare of the family as a top priority transform into a prioritization of the welfare of family, friends, the nation, and the world. Associating the inability to carry out this scared duty exacerbates mental illness stigma by threatening the core ideals of military service. Cadets and officers have obvious common viewpoints regarding these ideals, but differ in their experiences with service.

4.4: "Rub Some Dirt on it and Keep Going": Childhood Experiences with Illness and Injury

Most informants admitted receiving "tough love" in childhood regarding physical injury or illness. Parents urged children to go to school and engage in activities despite illness or injury. This notion is carried over to military service. The ROTC cadets prefer to "push through" illness and injury in order to participate in ROTC events and attend classes. One cadet, stated that as a child:

> *I could be sick for one day, and after that one day it was pretty much like, you should be better. And I'd be going to school. And if it was my dad, I'd be going to school if I was sick or half dead—I'd be getting out the door. [M, 20, W]*

One officer claimed his parents represented a middle ground of "not over-coddling me but not like rub some dirt on it and keep going." He prefaced this notion with the prideful justification that:

> *I didn't have too many experiences where I got hurt or sick but it was pretty, uh, I was certainly not over-medicated, you know. . . .I can count on one hand the number of times I took Tylenol with fingers leftover. But once I got to high school*

> *and started playing sports I took, like, Aspirin and Motrin but other than that, you know, some Sprite, some chicken noodle soup, sleep it off. [M, 28, W]*

The concept of transcending illness confirms the rationale for devaluing others to ensure mission completion above all else—including personal health and safety. Informants were often taught as children to discuss emotional problems and received comfort from parents in order to teach them how to properly deal with emotions in the context of cultural norms, such as learning appropriate responses to anger in avoiding heated confrontations or physical altercations. Despite the emphasis on comfort and discussion of sorrow and grief with others, the example set by parents was that with adult obligations comes a responsibility to compartmentalize and internalize emotional distress rather than reliance on the childlike burden of comfort. The power of parents and other authority figures must not be threatened by the revelation of mental illness, which might interfere with their jobs and ability to provide for their families.

Cadets reported tough love in childhood, as did officers to a certain extent, however the latter were more inclined to discuss the emotional support they received. For both groups, the example set by parents was one of transcending illness, injury, or emotional distress in order to ensure maintenance of adult responsibilities. This indicates overarching cultural agreement that physical or mental distress may prevent one from achieving the accepted standard of the provider and caretaker. They could not miss work without facing reprimand or placing their employment in jeopardy, and they had to compartmentalize in order to place the needs of their family before their own. This is exemplified in soldiers who feel attending to their emotional or physical distress may cause them trouble with their superiors. They also report that they expect to lose trust among their peers, and disappoint their army family within their unit if they were to give in to their emotional distress.

4.5: "Pushing through" on their own: The Social World of Service Members

Both officers and cadets tend to place their trust mainly in parents and significant others. This was indicated in responses regarding both childhood and military experiences. Often the cadet or officer claimed he would first go to a family member if they believed they had symptoms of a mental illness.

For cadets only I used a personal network instrument. In this series of questions, four cadets who named friends as trusted confidants also listed parents or significant others under the same heading. Only one cadet named a friend as a person he trusted to have his best interests in mind, and just two cadets listed friends as people they trusted to seek advice on emotional problems. Friends were listed commonly when it came to social activities and seeking help for schoolwork. However, when it came to seeking advice for major life decisions, five cadets listed a combination of family and significant others, and two cadets claimed no one in their network fit that role, preferring to make decisions on their own.

Participants reported heavy parental influence during childhood, and parental examples shaping the formation of mental illness stigma. The analysis of relationships to personal network members indicates a continuation of this influence along with a profound trust in parents to help guide their decisions. This is possibly a result of the age and circumstance of the informants. The nine ROTC informants are unmarried college students, perhaps with reliance on parents a lingering notion from childhood as they begin independent adult lives.

Cadets revealed a preference to first confide in and rely on close family before seeking mental health counseling if faced with symptoms of Post Traumatic Stress Disorder or other mental illnesses. The trust relationships revealed in personal network analysis indicate seeking familial relations for guidance and comfort in distress rather than friends, peers, or fellow cadets.

The two cadets who claimed no one has his best interests at heart also demonstrates the pervasive idea that service members can "push through" or "tough out" emotional problems on their own.

The size of cadets' networks also varied, ranging from one to seven people per question. Two informants mentioned only one or two relations, three informants selected between two and five for each, and one selected between three and seven. These numbers suggest variation in network structure, and appear to have little impact on the beliefs and experiences related during semi-structured interviews. Cadets designate family as primary relations with whom they share trust over fellow ROTC cadets, despite many statements in which they claimed the military is akin to family. Cadets often pointed to the immeasurable trust and bonds with fellow service members they felt necessary to accomplish their duties and existential mission. However, they identified non-ROTC friends as those with whom they attend social events, seek advice to resolve conflicts with other friends, and place some measure of trust. Five cadets identified fellow cadets in their networks, and only when needing class notes or advice, making a decision related to ROTC duties, and identifying with whom they discussed a news story related to the U.S. Army.

These network structures may result from the cadets' circumstances and environment in relation to one another. The ROTC environment differs from an active duty army unit, in which over a number of years service members work, train, and deploy together. Cadets conduct physical training, participate in field exercises, and attend some classes with one another, however they may not have the time invested or experiences encountered to form closer bonds.

There were several sources of variation regarding persons in cadets' networks that might fill specific social support roles. Three cadets indicated knowing church members socially, in each case a mixture of family and friends. Two of these three stated that they depend partly on

prayer to help them navigate mental distress, which illustrates a unique form of social support compared to other informants. Two cadets listed several friends in their networks who are members of sororities or fraternities. Only one of the two mentioned the fraternity friend as one he would trust with emotional problems. One informant listed a therapist he saw as a child, but no longer sees. This cadet claimed in his answers to semi-structured interview questions that his experiences with this therapist as a child had no bearing on his current opinion of professional mental health treatment. These variations negate the predictive aspect of network composition on influences behind mental illness stigma.

In each of the seven cases at least two friends were selected for multiple questions regarding social activities, advice on resolving trouble with friends, and in three cases as people they trusted with emotional problems. These variances in the composition of cadets' networks seem to have little effect on the themes found during semi-structured interviews. Many of the themes found through personal network analysis indeed provided a look at influences behind mental illness stigma stemming from the social structure of ROTC cadets. This suggests personal network analysis may be a useful tool in studying stigma within local social worlds. In future studies, I will use this method the further elucidate informants' personal networks.

4.6: "Boredom broken up by moments of sheer terror": Sources of Stress in the Military Environment

Cadets and officers cited fear of stigma as a prominent barrier to care and the greatest threat as the potential loss of confidence in their leadership abilities by superiors and subordinates. Informants recognize the stigma exists, and they perpetuate it through this fear of being stigmatized and often thinking and behaving in ways that discourage the option of disclosing emotional distress. Officers and cadets report they would encourage others to seek

help while holding a personal preference to internalize problems. They also emphasize the importance of personal choice in the decision to seek treatment. The justification is often a fear of forcing someone into an unwanted situation, or an extension of the personal conviction that individuals know best if they need professional help or if they "feel like they'll get over it on their own."

Informants suppose mental illness can happen to anyone for a number of reasons and affect people differently through various experiences. Cadets were more likely to mention a tragic loss of a family member, friend, or fellow soldier, or going through a traumatic combat experience as root causes of mental illness. Officers approached it from a different perspective, including those traumatic events, but also discussing other types of combat stress. They view deployment as often fast-paced, sometimes dangerous, and many times filled with tedium. One officer described it as "probably the most honest description…it could be mostly boredom, broken up by moments of sheer terror." They see sources of stress stemming from changes in normal patterns and the worry and fear associated with austere, dynamic environments—going from quiet to loud, relaxed to on alert, irregular communication with friends and family at home, sleep deprivation, and boredom punctuated by high-stress situations, either combat or demands from superiors to produce results.

As with physical ailments, both cadets and officers assigned legitimacy and illegitimacy based on their individual perceptions. One cadet provided an example:

> *We have a guy in my unit who claimed he had a mental breakdown because his girlfriend broke up with him so he could get out of deployment . . . I think he told me he was only with her for, like, six months and, I mean, it's not enough where you need to have a full mental breakdown. [M, 21, W/H]*

Officers agree that, based on their own observations, a soldier might claim to suffer emotional distress in order to avoid responsibilities. They are significantly less likely to judge

legitimacy or illegitimacy on surface value. While going over vignettes during interviews with officers, a hypothetical scenario was given, broadly outlining a brief history of a soldier and a physical problem that soldier faced. All officers said they would need to know more about the soldier, his or her history, past performance, and a discussion with the health care provider regarding the specific problem. Officers tend to view mental illness as too broadly defined and that the portion of soldiers who might fake symptoms cause those with legitimate distress to fall through the cracks. They frequently recounted experiences with soldiers suffering from a diagnosed mental illness, and responses varied from those affected being engaged and performing well to others being "lazy dirtbags." One officer claimed that he could tell which of his soldiers would have issues before, during, and after deployment, identifying them as younger and more immature. He stated that for these cases, deployment is not the cause but rather the catalyst to developing mental illness.

4.7: "Between a really big rock and a really hard place": Service Members' Attitudes Toward Seeking Professional Treatment

Ouimette et al. (2011) showed that institutional barriers such as access to or sensitivity of caregivers were minimal compared to fear of stigma. However informants frequently showed skeptical or untrusting attitudes toward counselors' ability to treat mental illness effectively. Most prefer a close friend, family member, unit Chaplain. Two cadets reported childhood experiences with psychologists or psychiatrists, and both stated it had no bearing on their current opinion of professional care. Both cadets indicated their personal uneasiness with psychiatric treatment resulted from interpreting the need for care in general as a suggestion that they were in some way broken and in need of fixing. Other cadets and officers without personal experiences with therapy echoed this sentiment in speculating that people experience mental illness

differently and professional treatment might focus on rapid and regimented treatment unsuited to the individual.

The majority of officers were concerned that treatment could never be completely anonymous, as accountability of their whereabouts is always necessary. They also feel many times their superiors aren't very empathetic, and while somewhat willing to allow them time to address their emotional distress, there is always a deadline. Failing to meet such a deadline could effect promotion potential or movement into positions of more responsibility needed for career enhancement. Several officers said it's inspiring to see soldiers overcoming their challenges with professional treatment, and the attitude needs to shift to providing better, more flexible resources.

Coping strategies are employed by those affected by mental illness in the overarching U.S. culture, demonstrated in a specific case by schizophrenics using strategies to protect themselves against stigma, including illness concealment and trying to "act normal" without complaints (Jenkins and Carpenter-Song 2008). Informants mirror these strategies and deal with emotional distress and physical ailments by trying to "push through it" or "suck it up". Cadets and officers related similar experiences of turning to distractions rather than confronting problems, either engaging in other activities or disengaging entirely. A cadet whose mother was diagnosed with PTSD following a tour in Iraq as a civilian military contractor said his mother doesn't discuss her mental illness, and nor would he if ever diagnosed:

> *It's something you keep to yourself, something that you almost hide it. You can't hide a cough or you can't stop sneezing or whatever, but people expect you to be able to suck it up when it's a mental illness because it's all in your head. [M, 18, W/AA]*

Cadets and officers believed they would receive significantly more empathy and understanding from those who previously suffered or continue to suffer from a mental illness. Many cadets expressed concern that the civilian community expects returning heroes with no

indication of emotional distress following a deployment. They assume civilians either "don't want to hear about it" or expect them to adhere to the image of the tough, stalwart soldier.

Officers prevailingly believe the opposite, that the civilian community recognizes combat veterans may face a difficult adjustment period. When they viewed the PTSD public service announcement during interviews, three officers brought up treatment of Vietnam veterans. They noted poor treatment received by these veterans after returning from longer duration deployments, under worse conditions, that saw higher numbers of wounded and killed in combat. The three officers believed the public concern for the emotional well-being of returning soldiers is the result of recognizing the past mistake.

Officers also made a connection between the PTSD-specific video and the general mental illness stigma awareness campaign video. They saw both as indicative of a general willingness among the public to encourage treatment, communication, and support. However, several officers made a point to say they didn't like the PTSD public service announcement (PSA), doubting statistics quoted in the video, finding it an embarrassing use of patriotism, and weary of yellow ribbons, bumper stickers, and other such military support props displayed by the public. They also believe it seemed "cheesy and fake," inadequately representing ongoing efforts to help soldiers struggling with mental disorders. They preferred the mental illness stigma video, which they believed did a better job of not singling anyone out, sending a message that through support networks and teamwork, mental illness stigma can be diminished and those affected seek treatment without fear.

However, one officer felt perhaps this wasn't such a good thing: "I sometimes wonder if it's not becoming a self-fulfilling prophecy where people expect that there's going to be problems and so there are problems." Officers also elaborated on their own post-deployment

experiences in which they spoke of the one month long block leave given to all soldiers after returning from deployment. They claimed that while given this time, the expectation from superiors was to return ready for duty, in many cases to begin preparing for the next deployment. They discussed their image among the general U.S. population as one who makes sacrifices to defend freedom, spread democracy, protect national security, and stop terrorism. But, as one officer stated, echoed in various ways by others, the Army is concerned with accomplishing the mission, and that could include writing a report or going into combat. Despite the lingering pressure of the multiple sources of tension in deployed environments, officers also stated an acute awareness of expectations by their unit leadership to return to "normal" rapidly without added time spent on transition. One officer summarized his sentiment regarding post-deployment transitions:

> *It's like the saying about being stuck between a rock and a hard place, you know. You don't go get treatment, you don't get better and maybe your work suffers or your personal life suffers. But you go get treatment, you either miss out on getting work done or people think there's something wrong with you and that you won't be able to get things done. So you're just stuck between a really big rock and a really hard place [M, 27, W].*

CHAPTER 5: DISCUSSION

5.1: How Service Members' Perceptions Inform the Warrior Culture

The patterns revealed by the analysis of interview transcripts indicate that the mental illness stigma currently prevalent in American culture is learned during childhood and early adulthood, and carries over into military service. The attitude that "death is a part of war" and other hardships are to be expected leads to justification of the demands and expectations of military service by linking adult responsibilities with the greater military mission (Collura and Lende 2012:132). Informants' early experiences set the stage for service members' reactions to stress and trauma in which the idea of "pushing through" hardship leads to perpetuation of unhealthy coping strategies. This creates a compelling dissonance in service members' minds between a sense of duty and the mental and physical effects of stressors.

The data confirm my hypothesis that informants would assign legitimacy and illegitimacy to illness and distress. Values of physical fitness linked with mental resilience and performance in combat situations are ingrained during service members' enculturation into the Warrior Culture. However, physiological responses to stress are controlled by the autonomic nervous system and remain outside of service members' control (Barrett 2011). These responses are not linked to a service members' score on a physical fitness test and need to be taught to soldiers in their introduction to combat training. It should also be taken a step further in the sense that encouraging service members to address physical ailments in the military is often stymied by the attitude that it "fosters a lax atmosphere" (Barrett 2011:99). Physical fitness is indeed important to one's ability to succeed in the expected duties of military service and to aid in maintaining a healthy lifestyle. My findings suggest instructors in basic training should make it clear that illnesses and injuries are not indicative of poor values or a lack of personal worth. This

viewpoint should also be encouraged and reinforced by army leaders throughout their service. Currently, cadets and officers alike claim they would encourage others to seek help while holding a personal preference to internalize problems, perpetuating the stigma through fear of being stigmatized and often thinking and behaving in ways that discourage the option of disclosing emotional distress.

Officers mentioned that they experience the added burden of institutional pressure to accomplish routine daily tasks. Power is essential to the cultural production of stigma (Yang et al. 2006:375). Respect, discipline, and toughness are valued characteristics in the military and closely linked to evaluations of efficiency and effectiveness in performance of duties. Those who possess physical and mental resilience receive respect and authority, and rank plays an important role. Superiors in the military wield immense power over their subordinates as an inherent aspect of the rank structure. Upon graduation and completion of the ROTC program, cadets receive commissions as second lieutenants, the lowest among officer ranks yet outranking all enlisted service members. Both roles—a leader of soldiers and a subordinate to higher-ranking officers—hang in the balance if assigned a stigma.

American cultural values of individualism, self-reliance, autonomy, and choice are threatened by perceived mental illness symptoms and their capacity to limit opportunity (Jenkins and Carpenter-Song 2008:383). Informants' responses support my initial hypothesis that ideas of adult responsibility were learned in childhood by parental example. In the military, these values are outwardly removed due to the highly regimented nature of rank structures and orders, and the emphasis on values of teamwork, camaraderie, and mission completion.

The prevailing notion of the army as a close-knit team or a family makes it difficult for military service members to admit to suffering symptoms of mental illness. The "others" within

the army family are those that don't meet the stringent ideals of physical fitness and mental agility, and stigma threatens not only the reputation of the individual but also that of the entire unit. Data from the 2009 Mental Health Advisory Team VI report assessing soldiers serving in Afghanistan show that "nearly half of those surveyed believed that they would be treated differently if they sought behavioral health care. Nearly 34% believed that doing so would harm their careers. Forty percent believed that leaders would blame them for the problem. And, over 50% believed that they would be seen as weak" (Casey 2011:2-3). Data collected during interviews suggest that these fears and attitudes still represent barriers to seeking behavioral healthcare.

Informants confirmed my hypothesis that the existential mission was an important factor, and officers expressed the desire for an atypical career. In addition, another dimension emerged regarding moral experiences at stake for service members. The military values that service members internalize during enculturation into the Warrior Culture inform their sense of identity (Siegl 2008). Fellow service members and the outside culture alike begin to view them as a soldier with only one purpose: to perform combat missions. This carefully fabricated sense of self is not necessarily the reality. Profession defines a part of the sense of self, but not exclusively. Military service members put those aspects other than profession by the wayside, suppressing the additional facets that inform their sense of self. Rather than cope with stress and trauma, soldiers focus on maintaining the image grilled into their minds since basic training that they must "suck it up and drive on" in order to complete their mission.

Despite the similarities in descriptions of a good soldier and one fit for duty applied to the group in general, cadet and officers both stated that responses to trauma and stress depend on the individual person. This suggests that there remains some semblance of an understanding, perhaps

subconsciously, that individual identity is retained, and, more importantly, it is this individual identity that is referenced in regard to professional treatment. Cadets placed greater emphasis on the group identity than officers, who draw from a wider range of experiences in the military and are several years removed from the tough indoctrination of basic training. However, officers still retain an acute awareness of such a mentality in those around them. Conforming to the group is an integral part of building the mindset of an army unit preparing to deploy and face combat scenarios. It also suppresses specific facets of individual identity. This aspect of suppression remains unacknowledged by others and by the affected individual in the face of mental illness.

Greene-Shortridge et al. (2007) discuss strategies to reduce mental illness stigma specifically within the military, the first involving protesting, in which efforts are made to suppress negative attitudes and behaviors. However, the authors find that this strategy might worsen stigma by associating more sources of disapproval toward mental illness. As much as informants of this study recognized negative attitudes toward mental illness, they did not indicate any efforts by themselves or others to openly address them. This in line with my assumption that service members would report they would avoid seeking professional treatment.

In an evaluation of a PTSD psychoeducational program, Gould et al. (2007) find that military service members feel encouraged to share their experiences with others who experienced PTSD, a sentiment echoed by the officers and cadets of this study who stated only those who themselves have experienced mental illness in the military can truly empathize. Perhaps a program in which affected service members can anonymously gather to share their experiences with others, under the direction and guidance of a behavioral health professional, would serve as an environment in which negative attitudes would be absent.

A second strategy proposed to reduce mental illness stigma seeks to educate and inform

both service members and society about mental illness, with emphasis on the value of professional treatment (Greene-Shortridge et al. 2007). The Comprehensive Soldier Fitness (CSF) program instituted by the U.S. Army serves as a prevention effort to assist soldiers in holistically preparing for the stresses of military life (Cornum et al. 2011). However, Barrett (2011) observed that "the military is not, as a rule, a particularly introspective organization, and . . . those ordering, conducting, and participating in this training do not understand or even wonder (1) what makes it work or (2) what its psychological and sociological side effect might be" (102). Informants indicated viewing differences between types of injuries and illnesses. The perception that visible injuries are legitimate and injuries or illnesses they cannot see are illegitimate suggests the need for more knowledge regarding the effects of mental illness. Breaking down this barrier may allow service members to view mental illnesses with the same lens as physical injuries.

It is noteworthy that none of the informants mentioned CSF or any other program, possibly indicating either a lack of awareness or knowledge about potential resources available, or they don't see them as effective. Service members are more aware of the associated stigma than of measures to improve resiliency, cope with stress, or address mental illness in themselves and others. Several officers referred to certain training sessions as events completed hastily and without much sincerity, simply to complete another requirement amidst many others dictated by superiors. While developing such training is an important endeavor, service members' responses to such programming are indicative of their willingness to internalize the intended message. Additionally, without better knowledge of potential responses to stress and more understanding of the causes of mental illness, service members will not comprehend measures to enhance resiliency or develop the ability to cope with stressors and trauma. The CSF program needs to

undergo empirical assessment in order to evaluate its effectiveness in conveying this knowledge and its impact on creating a more encouraging environment for soldiers to discuss stress and seek treatment for psychological disorders.

5.2: Limitations and Directions for Further Study

Further studies should include more participants from various groups within the military to allow for new insights based on comparisons. The rank structure of the military includes a regulatory and social divide between officers and enlisted personnel, therefore differences between the groups may exist. In-depth conversations about stigma triggers could also be applied to comparisons between branches of military service rather than just the army. An interviewer with no prior military experience may eliminate the potential bias in enrolling enlisted service members and influence them to speak freely.

A larger sample size would allow for further elucidation of themes and variation with regard to this topic. In my research I limited the demographic profile of my informants. Experiences may vary between women and men and across age groups, ethnicities, and socioeconomic strata (Jansen 2005). Expanding these criteria would provide a more comprehensive study of mental illness stigma across the demographic spectrum of U.S. Army service members. I would also like to add a component of focus groups to investigate the similarities or differences in discourse when interviews are conducted one-on-one and among a peer group.

Upon delineating themes regarding cultural influences on mental illness stigma, formulating questions regarding service members' personal ideas for changes that may lessen the existing stigma would provide further perspective. The vignettes and video clip props used in interviews with officers proved very useful in gaining insights into service members' ideas about

effective ways to impart knowledge and preferred responses to specific situations. Additionally, drawing from analysis already completed for this study, interviews with mental healthcare providers would provide a unique perspective on the issue of mental illness stigma and treatment options. A further project that would benefit service member needs active collaboration with mental health professionals treating active and former soldiers is essential. I did not include a comprehensive examination of the psychological processes behind mental illnesses. More time on these processes and the ideas and viewpoints of mental healthcare providers will add depth to the understanding of the ways in which stigma operates in the U.S. Army community.

Another important factor is the way in which stigma as a barrier to care for mental illness carries over to effects on the families of service members. Hence, I would like to suggest that future projects interview families of service members to investigate and learn more about the sources of influence beyond the childhood influences uncovered in this project. Informants cited family as their main source of support and the people they would turn to first if they felt they had symptoms of a mental illness. The CSF program also recently began including families of service members in training and outreach efforts (Casey 2011). This inquiry would benefit from personal network analysis, as that method informed this research on the social world of service members and their preferred sources of confidence. Incorporating the perspective of the service members' families may provide a more comprehensive look at how family might influence or fail to influence a soldier to seek professional treatment, and determine in what ways family members attempt to provide support to affected service members.

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APPENDIX A – INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL LETTER

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · **www.ecu.edu/irb**

Notification of Initial Approval: Expedited

From: Social/Behavioral IRB
To: Jessica Handloff
CC: Christine Avenarius
Date: 5/11/2012
Re: UMCIRB 12-000580 Culture and Stigma in the U.S. Army

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 5/11/2012 to 5/10/2013. The research study is eligible for review under expedited category #6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

The approval includes the following items:

Name	Description
Handloff Thesis Interview Questions.doc	Interview/Focus Group Scripts/Questions
Handloff Thesis Proposal.doc	Study Protocol or Grant Application
Informed Consent Document.doc	Consent Forms

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418 IRB00004973
East Carolina U IRB #4 (Behavioral/SS Summer) IORG0000418

APPENDIX B – SEMI-STRUCTURED INTERVIEW QUESTIONS

Age/Sex/Ethnicity
Rank
Relationship Status
Highest Level of Education
Years in the Military/Number and Location of Deployments

1. What matters most to you in life? Why? How do you want people to see you?

2. When you were growing up, what happened when you got hurt or sick? How did people react? How did they expect you to deal with it?

3. What happened when you were sad, or upset? How did people react? How did you learn to deal with it?

4. What's an example of an emotional hardship you've experienced?
   a. What did people around you expect you to do about it?
   b. How did you deal with it? Why?
   c. What have you seen along these lines with those close to you?

5. Why did you join the military?
   a. How long ago did you make this decision?
   b. What kinds of things do you associate with military service?

6. What are the main values expressed by the Army?
   a. When is the first time you remember learning about them?
   b. Are these values lived up to by you? Others?

7. What makes someone a "good" soldier?
   a. What makes someone "fit for duty"?
   b. How do you feel about someone that doesn't fit these criteria?

8. What do you think when a soldier is given quarters for an illness?

9. What do you think when a soldier receives a profile?

10. What happens when you get sick now? What do superiors, peers, subordinates say? What might they be thinking?

11. What comes to your mind when someone mentions mental illness?

12. Please describe the characteristics of people who suffer from behavioral disorders—not the symptoms, but the type of person that may be susceptible.

13. What positive reactions to mental illness have you witnessed?

a. Within the military?
b. Outside the military?

14. What negative reactions to mental illness have you witnessed?
    a. Within the military?
    b. Outside the military?

15. What are the differences between the way men and women deal with emotional distress?

16. What kinds of emotional problems can be overcome? What do people need to do to overcome them? Which can't be overcome?

17. What can make you mentally or emotionally stronger?

18. What kinds of things go on downrange?

19. What's expected of you when you return?

20. What do you consider to be an acceptable emotional scar? What is not?

21. What do you think are the symptoms of PTSD?

22. What would you do if you felt you had these symptoms?
    a. Who would you go to first?
    b. Why/why not seek counseling/therapy?

23. How do you think people would react if you told them you had these symptoms?
    a. Family/friends?
    b. Superiors?
    c. Peers?
    d. Subordinates?

24. What would you think if someone came to you with these symptoms?
    a. Family/friends?
    b. Superiors?
    c. Peers?
    d. Subordinates?

25. What are the differences between the ways in which male and female soldiers handle PTSD?

26. What would be most important to you if you were
    a. Going to seek treatment? Why?
    b. Sending someone to seek treatment? Why?

Following these questions, I proceeded to the personnel network questionnaire with cadets (see Appendix C) and the vignettes and video clips with officers (see Appendix D).

APPENDIX C – PERSONAL NETWORK QUESTIONNAIRE

Question	Relationship to Informant	Gender	Age	Ethnicity	Notes
Who would you go to if you had a flat tire?					
Who would you go to if you needed to borrow money?					
Who do you go to first to go see a movie or similar social activity?					
Who do you go to if you need to borrow class notes or class material?					
Who do you go to for advice on resolving trouble with friends?					
If you're unsure about a military (ROTC) decision you're about to make, who do you go to for advice?					
Who do you go to for advice on choosing classes to take?					
Who do you trust the most with personal and/or emotional problems?					
Who do you trust has your best interests in mind?					
Who in your life do you trust the most and also feel has your best interests in mind?					
Who have you spoken to about the recent shooting in Afghanistan committed by an Army Staff Sergeant?					
Do you know anyone socially who attends church?					
Do you know anybody socially in a fraternity/sorority?					
Do you know any therapists/psychologists/ professional mental health counselors?					

APPENDIX D – VIGNETTES AND VIDEO CLIP SOURCES

When presenting vignettes, I read the initial scenario and then read option a. Officers were asked to give their impressions and explain how they would respond. Then I read option b and asked again for their impression and an explanation of how they would respond.

1. After returning from a year-long deployment to Afghanistan, a soldier comes to you and says he's been having frequent nightmares and fighting constantly with his wife and he would like to go to mental health. The soldier comes back with a profile from mental health stating he may not participate in an upcoming FTX.
   a. This soldier received a BSM [Bronze Star Medal] for his actions downrange [deployed], rarely, if ever, complained, and was indispensible to his squad leader.
   b. This soldier rarely, if ever, left the FOB, frequently complained about working night shifts at the TOC [Tactical Operations Center], and received an Article 15 [Disciplinary action] for falling asleep while on guard duty.

2. A man's wife passes away suddenly in an accident one afternoon. He picks his two kids up from school, as usual, does not tell them about their mother's death, and takes them on a trip to an amusement park. He tells them about their mother the next day, and the week following the funeral sends his children back to school and goes back to work.

3. A 14-year-old girl has a headache and feels weak.
   a. Her parents keep her home from school but do not take her to the doctor, and both go to work that day.
   b. Her parents give her some aspirin and send her to school, reminding her she has volleyball practice after school.

4. At PT formation the day of a 6-mile ruck march, a squad leader tells you he feels sick and requests to go to the clinic in lieu of participating.
   a. In his nine months with the unit, the NCO had a 30-day profile for a sprained knee three months ago and failed the diagnostic AFPT after coming off the profile.
   b. In his nine months with the unit, the NCO has been on 24-hour quarters twice but no injuries that resulted in a profile.

30-sec PTSD Public Service Announcement
http://www.youtube.com/watch?v=KRzmAUT8KKE&feature=related

Change a Mind About Mental Illness Public Service Announcement
http://www.youtube.com/watch?v=WUaXFlANojQ

"Army Strong" Recruitment Advertisement
http://www.youtube.com/watch?v=OkdPfbOp_8g