

Service Seeking Behaviors among Service Members and Spouses of Service Members:
Facilitating and Inhibitory Factors

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Thesis submitted to the faculty of the Virginia Polytechnic Institute and State University in
partial fulfillment of the requirements for the degree of

Master of Science
In
Human Development

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March 13, 2012
Falls Church, Virginia

Keywords: Mental health counseling services, Service members, spouses of Service members

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Abstract

While previous research has explored the relationship between combat exposure and mental health disorders, the effects of mental health disorders on attrition rates of Service members, the discrepancy between mental health counseling services available and utilized by Service members, and barriers to seeking mental health counseling services, the majority of studies thus far have only been conducted with Service members and have been quantitative in nature. While researchers have begun to explore the experience of deployment on Service member spouses, little research has focused specifically on their service seeking behavior regarding accessing mental health services. This is unfortunate given that multiple studies have indicated the importance of including Service member's spouses in future research. This qualitative study included both Service members and spouses of Service member's in an attempt to capture their mental health counseling service seeking behaviors. Thematic analysis was employed to develop a model of mental health seeking behavior among Service members and their spouses. The resulting model is unique in that it attempts to account for the influence of multiple contextual and ecological factors. Limitations of the study, future research and clinical implications are also discussed.

Acknowledgements

This study would not have been possible without the guidance and support of my thesis committee members. I would especially like to thank my thesis chair, Dr. Angela Huebner for her knowledge, patience, wisdom, and direction throughout this process. Dr. Huebner provided me with the opportunity to partake in the data collection process and gain experience co-facilitating focus groups. Dr. Huebner has not only been a huge part of my thesis committee, but she has also been a mentor who has supported me throughout my graduate school career. I am extremely grateful that I was given the opportunity to work as Dr. Huebner's graduate assistant as well as be a part of conducting numerous studies involving military families. Both Dr. McCullom and Dr. Falconier's recommendations during the proposal process were invaluable to the development of my study and the analysis of the data. Through their dedication to excellence in the academic field, I was challenged and motivated to produce a high quality, comprehensive study and analysis.

This study also would not have been possible without the military Service members and spouses of Service member participants that took time out of their busy schedules to partake in the focus groups. Due to their willingness to participate in the focus groups, and their openness to answering the questions, I was able to develop a model to capture their experience with mental health counseling services.

Lastly, I am grateful to my classmates, cohort, clinical supervisors, friends, and family for their encouragement and support over the last three years. I would especially like to thank my sister, Sara Brickel, and classmate, Erica Turner, for their willingness to edit my thesis throughout this process. A special thanks to my co-workers at Potomac River Running as well for their support and laughter as I navigated my way through this process.

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CHAPTER 1: INTRODUCTION

Statement of the Problem and its Setting

The Department of Defense (DoD) provides care and support to Service members each year through funding received from the United States Federal Government. In the budget proposal for the 2010 fiscal year, one of the DoD's primary objectives was "providing the necessary resources to support the troops in the field" (U.S. Department of Defense, 2009, p. 1). The budget requested \$533.8 billion to support the military, which is a four percent increase from the 2009 fiscal report. This year the DoD has also requested \$177.5 billion to use towards support services, which is a \$13 billion increase from the 2009 fiscal report (U.S. Department of Defense, 2009). It is apparent that the DoD is willing to increase its funding for the military to provide increased care and support for Service members in order to strengthen and improve the Armed Forces. This care has been provided across a wide variety of areas, ranging from funding for college, to mental health counseling services, and most everything in between. One area of particular concern is that of mental health counseling services.

Spouses of Service Members

To date, most studies conducted with the military population have only included Service members. Minimal research has included both Service members and spouses of Service members and little research has been conducted with spouses of Service members and mental health counseling services (notable exceptions Eaton et al., 2008; Mansfield et al., 2010). It is unfortunate that studies have not examined spouses of Service members' mental health counseling service seeking behavior since studies and reports have suggested that Service members' spouses influence their partner regarding reenlistment, treatment seeking, and treatment compliance. Numerous research studies have reported that a spouse's satisfaction or

dissatisfaction with aspects of the military lifestyle (e.g., length and frequency of deployment, relocations, financial benefits, etc.) impact a Service member's likelihood to reenlist (Bell, Schumm, and Martin, 2001; Orthner and Rose, 2003; Segal, 1986; Weiss et al., 2003).

Pescosolido and Boyer (1999) suggest a relationship between support from family members and treatment seeking and treatment compliance such that individuals are more likely to seek mental health services if spouses have a positive attitude towards them accessing and utilizing them.

Research has also shown the effects deployment has on Service members' spouses and the likelihood that spouses will seek mental health counseling services. In the study conducted by Mansfield et al. (2010), findings indicated that prolonged and frequent deployments were associated with an increased risk of mental health diagnoses among wives of Army soldiers. Multiple researchers have also reported that the impact of Service members returning home from deployment has led to spouses experiencing caregiver burden or "secondary traumatization" (Ben Arzi et al., 2000; Calhoun et al., 2002; Cully, Beckham, and Bosworth, 2002). Moreover, the study conducted by Eaton et al. (2008) identified barriers to care and the affects of stigma on Army spouses, such as not knowing where to get help, scheduling issues, child care difficulties, cost, and being viewed as weak. Lastly, the Task Force (2007) reported that spouses of Service members are more likely to seek mental health counseling services compared to Service members, which is consistent with the findings reported in the Eaton et al. (2008) study conducted with Army spouses. However, due to the limited number of studies that have sought to understand spouses of Service members mental health counseling service seeking behaviors (notable exceptions Eaton et al., 2008; Mansfield et al., 2010), their experiences with these services is not fully understood. A further in-depth qualitative study is needed to address the gap in the literature in order to better understand spouses of Service members' mental health

counseling service seeking behaviors. While there is minimal research and literature that includes both Service members *and* Service members' spouses, and little research has been conducted with spouses of Service members and mental health, research has been conducted exclusively with Service members, which will be presented throughout the following sections.

Prevalence of Mental Health Disorders

Service members that have served or that are currently serving in the Global War on Terrorism have been or are presently being deployed to active combat zones. Studies suggest that Service members witnessing atrocities and exposed to combat are more likely to experience mental health problems compared to Service members that do not have such experiences (Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004; Sareen et al., 2007; Seal, Bertenthal, Miner, Sen, & Marmar, 2007). A study conducted with Service members returning from deployment to Iraq and Afghanistan indicated that 25% were given a mental health diagnosis; of those, 44% with a single mental health diagnosis, 29% with dual mental health diagnoses, and 27% with 3 or more mental health diagnoses (Seal et al., 2007). Another study conducted with the Canadian military found similar results reporting that 14.9% of the Service members returning from deployment from various locations (e.g., Iraq, Rwanda, Somalia) met the criteria for a mental health diagnosis (Sareen et al., 2007). It has also been suggested that there is a relationship between combat exposure and the prevalence of post-traumatic stress disorder (PTSD). Currently, PTSD is one of the most commonly diagnosed mental health disorders among Service members (Hoge et al., 2006; Seal et al., 2007).

Prevention and Detection

Due to the large number of Service members returning from deployment with a mental health diagnosis, researchers have stressed the importance of early prevention and detection of

mental health disorders (Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2007). Mental health screening for psychological illnesses in military personnel has become a widely used method by military leaders to manage mental health disorders. In the past, screening typically only occurred immediately after deployment, but Milliken et al. (2007) reported that the number of Service members with a mental health disorder was underestimated. Because of these findings, now, Service members are screened for mental health disorders immediately after deployment *and* three to six months after deployment. Screening tests consist of a self-report questionnaire, as well as a secondary assessment completed by trained clinicians (Milliken et al., 2007). Despite this change in screening, a commentary printed in the Journal of the American Medical Association on psychological screening for Service members suggested that the number of Service members diagnosed with a mental health disorder was *still* underestimated (Rona, Hyams, & Wessely, 2005).

With the current high operation tempo, this may mean that Service members are being redeployed without addressing their current mental health concerns. Even though screening tests are also conducted prior to redeployment, a study conducted by Hoge et al. (2005) suggested that existing disorders were not always identified on this screening test. However, the mental health disorder was usually picked up within six months of the Service member being redeployed.

Attrition

There appears to be a significant relationship between diagnosis of a mental health disorder and attrition rates in the military. For example, results from the study conducted by Hoge et al. (2006) reported that Service members that met the criteria for a mental health disorder were almost one and a half times more likely to leave the service during the year following their deployment compared to the Service members that did not meet the criteria for a

mental health disorder. Another study conducted by Hoge et al. (2005) suggested that the presence of a mental health disorder after counseling or treatment impacts a Service members functioning and involves behaviors that are considered not conducive for further service. It was indicated that 45% of the Service members that were hospitalized after returning from deployment for a primary diagnosis of a mental health disorder left the military within six months after their hospitalization, whereas only 11% of the Service members that were hospitalized for other medical issues left the military within six months after their hospitalization. Of the Service members that were hospitalized for a mental health disorder, 17% were involuntarily discharged (Hoge et al., 2005). Together, these studies suggest the negative impact mental health diagnoses and hospitalizations for mental health disorders can have on a Service member's career (Hoge et al., 2006; Hoge et al., 2005).

Utilization of Mental Health Services

The military provides Service members, spouses of Service members, and military children with numerous programs, services, resources, and opportunities to assist in their daily functioning to help improve their quality of life. Confidential counseling services are available to Services members and their families through Military OneSource and the Military and Family Life Consultant Program (MFLC). Unfortunately, there is limited information available in the public domain about the utilization of these two programs (U.S. Department of Defense, 2009); however, researchers have studied the utilization of mental health counseling services among Service members.

In the study conducted by Hoge et al. (2004), only a small percentage of the Service members that met the criteria for a mental health diagnosis received help. Of the Service members that received a positive score for a mental health diagnosis, only 23% to 40% actually

received mental health care. Similar findings were reported for another study conducted with Service members returning from Iraq. Findings suggested that Service members were almost four times more likely to accept treatment if they referred themselves to mental health care as opposed to being referred by a military mental health professional. Findings further suggested that Service members that sought and received mental health care through self-referral typically had severe or co-morbid disorders (Milliken et al., 2007). Lastly, in a study conducted with Service members returning from deployment to Iraq and Afghanistan, results indicated that more than 60% of the Service members that met the criteria for a mental health disorder did not seek treatment (Hoge et al., 2006). There appears to be barriers preventing Services members from accessing mental health counseling services, even though the military has provided ways to access them confidentially.

Barriers to Access

Studies have suggested multiple barriers that prevent Service members from accessing and utilizing mental health counseling services. For example, the American Psychological Association (APA) submitted a secondary analysis of both empirically based and non-empirically based studies to examine the psychological needs of Service members before and after deployment. From the analysis, APA reported that the behavioral health services currently being offered may not provide Service members and their families with adequate support in order to meet their needs (Johnson et al., 2007), which is consistent with findings reported in other studies (Milliken et al., 2007; Task Force, 2007). Together these studies suggest that numerous programs exist, but Service members and spouses of Service members may not be able to access them due to barriers related to availability, acceptability, and accessibility (Johnson et al., 2007, Milliken et al., 2007; Task Force, 2007). Another study conducted with the Canadian

military reported that of the Service members diagnosed with a mental health disorder, those with a self-perceived need for mental health care consistently stated that their needs were only partially met or not met at all (Sareen et al., 2007). Moreover, fear of stigmatization was disproportionately the highest reported barrier for Services members compared to other barriers reported. In fact, this finding has been replicated across several studies (Hoge et al., 2004; Milliken et al., 2007).

Lastly, alcohol related problems usually go untreated for Service members because treatment services are not confidential, leading to immediate involvement of the Service member's commander, thus jeopardizing the Service member's job if compliance with treatment does not occur. This presents an issue because alcohol misuse is often co-morbid with PTSD and relationship issues (Hoge et al., 2004; Milliken et al., 2007). Therefore, as evidenced by these studies, the problem may not be a lack of mental health counseling services, but rather barriers that inhibit the Service members from accessing services.

Significance

Previous research studies have been conducted to identify the effects of combat exposure on military Service members and the attrition rates of Service members due to mental health issues (Hoge et al., 2006; Hoge et al., 2004; Sareen et al., 2007; Seal et al., 2007). The utilization rates of mental health services by military Service members have been identified, along with possible barriers affecting Service members receiving mental health care (Hoge et al., 2006; Hoge et al., 2004; Johnson et al., 2007; Milliken et al., 2007; Sareen et al., 2007). However, researchers have rarely included spouses of Services members in the aforementioned studies and research has shown the important influence spouses of Service members can have on treatment seeking, treatment compliance, and retention in the Armed Forces; research has also noted the

effects of deployment on spouses of Service members, the likelihood that spouses will seek mental health counseling services, and perceived barriers to care (Eaton et al., 2008; Mansfield et al., 2010; Pescosolido & Boyer, 1999; Task Force, 2007). This in-depth qualitative study will allow both Service members and spouses of Service members to communicate their service seeking behaviors regarding mental health counseling services.

Rationale

Minimal research has explored *both* Service members and spouses of Service members' mental health counseling service seeking behaviors (Eaton et al., 2008; Hoge et al., 2006; Hoge et al., 2004; Mansfield et al., 2010; Milliken et al., 2007). The present study added to the current research by exploring both Service members and spouses of Service members' mental health counseling service seeking behaviors. This study included a secondary analysis of focus groups that were part of the Military Family Needs Assessment. The analysis specifically focused on the feedback provided by participants about mental health counseling services. The qualitative methodology allowed the researcher to obtain a fuller understanding of the participant's behaviors that were not captured through the quantitative methodology in previous studies.

Theoretical Framework

The present study was guided by the ecological systems theory. The ecological systems theory is based on a systemic approach to understanding human development through the reciprocal and interactional effects of an individual and his or her environment. Within this theory, many intricate models are presented to understand the breadth of information. For the purpose of the current study, the researcher will use Bronfenbrenner's Process-Person-Context Model as a framework to guide the analysis of the focus groups (Bronfenbrenner, 1986).

In the Process-Person-Context Model, human development is studied through four different factors: person, process, context, and time. Using a bidirectional lens, this model evaluates how individuals are affected by their environment and how persons evaluate direct and indirect influences. Bronfenbrenner's (1986) structure of environment is divided into four different levels, which are: (1) the microsystem, (2) the mesosystem, (3) the exosystem, and (4) the macrosystem (see Figure 1). The microsystem is the level closest to an individual and encompasses the parts of an individual's environment in which he or she directly interacts. The mesosystem is the interactions within and between the different parts of an individual's microsystem. The exosystem is comprised of the interactions between aspects of an individual's social environment that he or she does not directly interact with or have control over and how these interactions affect an individual's microsystem and mesosystem. The macrosystem refers to how an individual's system is understood in cultural context. By examining an individual's environment through this lens, researchers and clinicians may better understand all the influences that may possibly impact an individual (Bronfenbrenner, 1986).

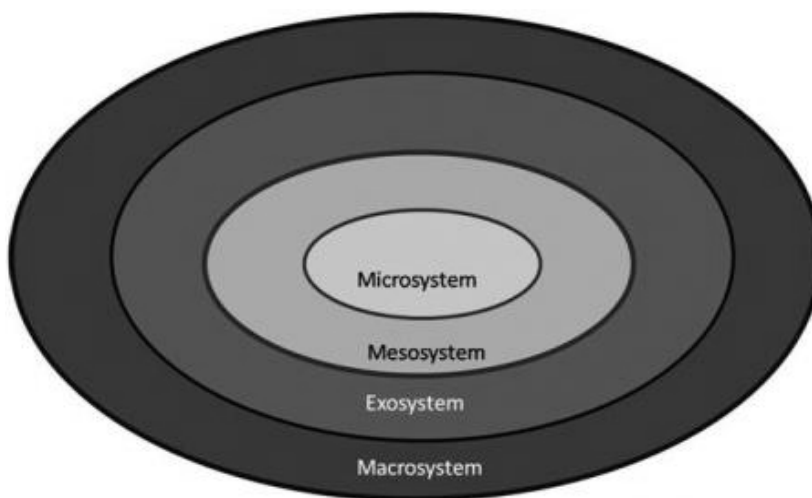


Figure 1. Process-Person-Context Model.

There are multiple concepts and precepts to understand in order to use this theory for the present study. First, ontogenetic development and social development are closely linked, such that an individual's development is affected by their environment. An individual grows, adapts, and makes decisions through interactions within their microsystem and mesosystem. Also, an individual's ability to adapt to a situation is measured through their ability to maintain behaviors without direction from others. And, lastly, if one individual in a dyad changes, most likely the other individual will also change (Bronfenbrenner, 1986).

For the purpose of the present study, the ecological systems theory will guide the researcher to explore how Service members and spouses of Service members' mental health counseling service seeking behaviors are affected by their environment. Specifically, the researcher will examine whether the direct interactions with others in one's microsystem affects his or her utilization of mental health counseling services. Possible examples within an individual's microsystem include direct interactions with spouses, family members, other Service members, other military families, commanders, etc. The researcher will further examine whether the interactions between an individual's microsystem and mesosystem influence his or her utilization of mental health counseling services. An example of this includes whether an individual's decision making process regarding accessing mental health counseling services, is affected by knowing how another Service member was treated by their commander or other Service members after seeking mental health counseling services. The exosystem encompasses the policies and guidelines surrounding the mental health counseling services. Examples include the type of information (e.g., alcohol related problems, suicidal ideation) staff members are mandated to report to the command, the type of records that must be maintained, and information that is allowed to remain confidential. The macrosystem is the military culture, and includes the

messages Service members and spouses of Service members receive about accessing mental health counseling services. Through an ecological systems theory lens, the researcher will be able to explore the impact a participant's environment has on his or her service seeking behavior with mental health counseling services.

Purpose of the Study

Through the current study the researcher explored Service members and spouses of Service members' mental health counseling service seeking behaviors. To the researcher's knowledge, there has not been any published qualitative research studies conducted with *both* Service members and spouses of Service member's regarding their service seeking behaviors with mental health counseling services. This study sought to understand the causal factors which facilitate or inhibit Service members and/or spouses of Service member's willingness to seek mental health counseling services. More specifically, the researcher analyzed the data through the ecological systems lens. In doing so, the results of this study have added to the gaps in the existing literature by identifying how the causal factors to seek or not seek mental health counseling services are interactional in nature and exert influences on multiple levels of the ecological system simultaneously. Additionally, this study provides policy makers and service providers with important feedback to help them refine and strengthen the mental health counseling services in order to enhance Service members and spouses of Service members' experiences with these services. Overall, it is hoped that through this feedback the quality of life for Service members and spouses of Service members will be improved.

Research Question

The research question being studied is:

1. What factors facilitate and/or inhibit Service members and spouses of Service member's intent to seek mental health counseling services?

CHAPTER 2: LITERATURE REVIEW

In this chapter, research on the military culture, combat exposure and mental health, availability and utilization of mental health counseling services, the importance of including military spouses in current research, and barriers to accessing and utilizing mental health counseling services will be reviewed. Previous research suggests there is a relationship between combat exposure and mental health disorders, which has led to mental health concerns for Service members and affected attrition rates in the military. Previous research also suggests a discrepancy between the mental health counseling services available to Service members and the mental health counseling services actually utilized by Service members. Consistent findings about the barriers to seeking mental health counseling services have been reported. However, these studies on mental health counseling services have only been conducted with Service members. There is currently minimal literature that focuses on spouses of Service members and their mental health counseling service seeking behaviors. Nevertheless, studies have suggested that spouses play an important role in influencing close family member's treatment seeking and treatment compliance; along with the fact that spouses play a pivotal role in reenlistment of their Service member partner. Studies have highlighted the importance of spouses being included in treatment due to the negative implications associated with living with Service members after deployment, especially when the Service member has a mental health diagnosis. Studies also suggested that spouses are more willing to seek mental health counseling services compared to Service members, and, at the same time, another study identified perceived barriers to care and the affects of stigma on spouses.

Military Culture

To better understand the literature presented in this review, it is important to be aware of

the complexities of the military culture and recognize how military culture and warrior ethos impacts military Service members and spouses of Service members. Military culture includes three distinctive qualities which are communal life, hierarchy, and discipline and control.

Communal life represents a life that is dedicated to the military through upholding the values of the military. For military personnel, a distinction is *not* made between military life and personal life, suggesting that a Service member's service to the military becomes a way of life (Soeters, Winslow, & Weibull, 2006). Reports have stated that the military can be considered a "greedy" institution by requiring 24/7 commitment and only offering a fixed pay structure (Segal, 1986; Soeters et al., 2006). Hierarchy refers to the bureaucratic nature of the military and authors have classified the military as a coercive bureaucracy suggesting unbalanced power between the ranks of military personnel. Discipline and control in the military fosters the importance of compliance with rules and the acceptance of authority and order (Soeters et al., 2006). The context of the military culture is important to know in order to better understand Service members and spouses of Service members' service seeking behaviors with mental health counseling services.

Moreover, the lifestyle of an Active Duty military family is quite different than the lifestyle of a civilian family. The characteristics of a military lifestyle include risk of injury or death of the Service member, frequent moves, separations of the Service member from his or her family, and residence in foreign countries (Segal, 1986). It is imperative to recognize that Active Duty military families live a different lifestyle and are faced with different stressors on a daily basis. Lastly, Service members are trained based on the mentality of warrior ethos. Warrior ethos embodies what is expected of a Service member and what Service members can expect of other Service members. Service members are trained to put the mission first and to never quit, accept defeat, or leave a soldier behind. Warrior ethos represents the strength Service members must

uphold and the ethos helps guide the Service member to be able to maintain courage through chaos and disorder. Of most importance, warrior ethos is a sacred trust built between Service members in a unit. Without this trust it is difficult and challenging for Service members to uphold the values of the ethos (Coker, 2007). Due to the warrior ethos, the use of mental health counseling services may impact how that Service member is trusted by fellow Service members, which may in turn affect their decision to receive help.

Combat Exposure and Mental Health

As more Service members are being deployed to active combat zones, studies have indicated an increase in the number of Service members experiencing mental health problems after returning from deployment (Hoge et al., 2004; Milliken et al., 2007; Sareen et al., 2007). Milliken et al. (2007) conducted a longitudinal quantitative follow up study to the Hoge et al. (2006) study to examine whether the number of Service members returning from Iraq with a mental health disorder had been underestimated. The 88,235 participants were screened for a mental health disorder immediately after returning from deployment by completing the Post-Deployment Health Assessment (PDHA) *and* three to six months after deployment by completing the Post-Deployment Health Re-Assessment (PDHRA), as well as briefly being interviewed by a trained clinician. For the purpose of this review, only the data for the Active Duty Service members will be examined, which included 56,350 participants. Results indicated that mental health concerns substantially increased between the two assessments. The presence of PTSD increased from 11.8% to 16.7%, depression increased from 4.7% to 10.3%, and overall mental health risk increased from 17% to 27.1% (Milliken et al., 2007). These findings suggest that previous studies underestimated the presence of mental health disorders among Service members when *only* assessing Service members immediately after deployment. The under

diagnosis of mental health disorders in Service members can lead to numerous problems, such as negative effects on the Service members career and increased relationship problems with the Service members spouse (Milliken et al., 2007).

Availability and Utilization of Mental Health Counseling Services

The military has made an effort to provide military families with a variety of programs and services, including mental health counseling services, to help the Service members and their families cope with the negative effects of the deployment cycle and improve their quality of life (e.g. U.S. Department of Defense, 2009; see quality of life review). However, according to Milliken et al. (2007), despite the increasing rates of mental health diagnoses, the DoD does not have adequate resources in terms of mental health care for Service members. This finding acknowledges that there are mental health counseling services available to Service members, but that these services are *not* meeting the Service members' needs. It was also reported by the Defense Health Board Task Force on Mental Health (2007) that these mental health services tend to be overcrowded with Service members, insufficiently staffed, and lacking in the resources needed to provide adequate mental health care.

The DoD issued their second quadrennial quality of life review to report recent research findings about the current programs and services available to Service members and their families (U.S. Department of Defense, 2009). While an abundance of information was provided on various programs and services related to recreational activities, child support, financial stress, and community, there was little information provided about counseling services. The military has tried to improve their counseling services available to Service members and their families by offering counseling through both Military OneSource, which has been available since 2004, and through the Military and Family Life Consultant Program (MFLC), which more recently became

available in 2006. Both services are available at no cost to the Service members and their families and are confidential, unless a “duty-to-warn” situation arises (U.S. Department of Defense, 2009).

While there are only a few studies in the public domain about the utilization of mental health counseling services by spouses of Service members (notable exception is Mansfield et al., 2010), studies have examined the utilization rates of mental health counseling services by Service members (e.g. Cully et al., 2008; Hoge et al., 2006; Hoge et al., 2004; Milliken et al., 2007). For example, the retrospective study of 410,923 newly diagnosed patients with depression, anxiety, or PTSD at the Veteran’s Health Administration (VA) outpatient facilities explored the utilization of psychotherapy for patients at the VA (Cully et al., 2008). The study was specifically conducted to determine the length of time between the Service member being diagnosed with a mental health disorder and initial treatment, as well as the total number of mental health sessions attended. Results indicated that 49% of the patients had at least one mental health encounter within the 12 months following their diagnosis. Of those patients that had a mental health encounter, 22% attended at least one session of psychotherapy. Of the 22% of patients that attended psychotherapy, 54% attended one to two sessions, 27% attended three to seven session, and 19% attended eight or more sessions. Eight or more sessions was defined as extended exposure to treatment. However, the majority (almost 95%) of psychotherapy patients attended less than eight sessions (Cully et al., 2008). Similar findings were reported in the Hoge et al. (2004) study which suggested that of the U.S. military personnel that met the strict definition criteria for a mental health disorder, 38% to 45% expressed interest in receiving mental health care, and only 23% to 40% actually received professional mental health care. It is apparent that Service members are not fully utilizing the mental health counseling services that

are available; however, the rationale related to the Service member's reluctance to seek services is unclear.

In their study of 303,905 Army soldiers and Marines, Hoge et al. (2006) explored the utilization rates of mental health services, based on the Service member's deployment location, immediately following the Service member's return home. Participants completed the self-administered Post-Deployment Health Assessment (PDHA), which assessed Service member's mental health, psychosocial issues, deployment-related exposures, and deployment-related health concerns, and Service members were interviewed by health care professionals as well. Surprisingly, results suggested that over 50% of Operation Iraqi Freedom (OIF) Service members referred through the PDHA screening process actually received mental health care. Similarly, 48.2% of Operation Enduring Freedom (OEF) Service members and 51.4% of Service members deployed to other locations utilized mental health care after being referred through the PDHA screening process. These findings were unexpected since a large percentage of Service members that received mental health care did not have a mental health diagnosis (Hoge et al., 2006). Unfortunately, the scope of the study did not identify factors that contributed to Service members' utilization of mental health counseling services.

Milliken et al. (2007) conducted a follow up study to the Hoge et al. (2006) study cited above to determine if there was a relationship between time point of mental health screening and utilization of mental health services. The 56,350 Active Duty participants were screened immediately after deployment by completing the Post-Deployment Health Assessment (PDHA) and three to six months after deployment by completing the Post-Deployment Health Re-Assessment (PDHRA). Results suggested that Service members were more likely to utilize mental health counseling services after completing the PDHRA. Findings indicated that the

largest percentage of Service members accessed mental health counseling services within 30 days after completing the PDHRA assessment. Also, for the Service members that received a referral to seek mental health services, the utilization rates of mental health counseling services increased by about 20% between the two assessments (Milliken et al., 2007). These findings suggest that Service members may be more willing to utilize mental health counseling services three to six months after deployment due to the level of mental health distress being experienced.

According to this review, multiple factors seem to be associated with whether a Service member accesses and utilizes mental health counseling services. Some of these factors include location of Service member's deployment, severity of mental health disorder, co-morbidity of disorders, receiving a mental health diagnosis by a mental health professional, and the length of time after deployment before completing screening assessments. Although illuminating, it seems there may be other factors that contribute to a Service member's decision to either utilize or not utilize mental health counseling services. Overall, there is an inconsistency of utilization of mental health counseling services by Service members. It is apparent that thus far, a stronger focus has been placed on studying the utilization of mental health counseling services rather than examining the factors that facilitate or inhibit Service members' service seeking behaviors. Understanding these factors may help explain the inconsistencies reported for Service members' utilization of mental health counseling services. The present study was conducted to address this gap by exploring Service members' service seeking behaviors with mental health counseling services from those that have and have not accessed mental health counseling services.

Military Spouses

As previously mentioned, empirically based research studies have primarily focused on Service members utilization rates of mental health counseling services and it is unfortunate that

researchers have excluded military spouses in these studies. Studies have been conducted with spouses of Service members but these studies *did not* explore Service member spouses' mental health counseling service seeking behaviors (notable exceptions Eaton et al., 2008; Mansfield et al., 2010). It is important to recognize the significant role spouses play in Service member's lives, especially when it comes to their well-being. In this section, various reasons for why spouses should be included in the research will be explored. These are: (1) spouses' influence on retention rates of Service members, (2) spouses' influence on Service members' treatment seeking and treatment compliance, (3) the effects of deployment on spouses (e.g., caregiver burden or "secondary traumatization"), and (4) spouses' willingness to seek treatment.

Retention

It is important to note the influence spouses can have on the retention rates of Service members. Military families are unique in that the Service member *and* his or her spouse are immersed within the military culture, which can affect retention, especially when there is work-family conflict. Work-family conflict is an imbalance of three factors (time, strain, and behavior) that makes it difficult for the responsibilities within both domains (work and family) to be fulfilled. Typically, the time devoted, strain produced, and behavior required in one domain makes it tough to fulfill the requirements of the other domains, thus causing conflict (Greenhaus & Beutell, 1985). Numerous aspects of military life should be considered, such as frequency of moves, length and frequency of deployments, frequency of training exercises, communication during deployments, and social support for family members during deployments, in order to determine the possibility of work-family conflict (U.S. Army Surgeon General, 2003). When these aspects of military life are negatively perceived by a Service member's spouse, this can lead to conflict, lack of support for the Service member's career, and in turn may affect

reenlistment of a Service member.

According to Weiss et al. (2003) spouses play a pivotal role in the decision-making process associated with retention. A spouse's dissatisfaction with military life may impact the spouse Service member's decision-making process regarding reenlistment (Weiss et al., 2003). Similar findings were reported by Segal (1986) in a study on the relationship between military life and family. Numerous demands due to the military lifestyle were reported (e.g., risk of Service member injury or death, relocations, duty related separations, and foreign residence), and findings suggested that the combination of these demands may lead to negative outcomes for family members, thus resulting in lower retention rates of Service members. Moreover, as reported by Bell, Schumm, and Martin (2001), other aspects of military life, such as a spouse's opinion about pay and benefits and a spouse's satisfaction with life disruptions, must be examined in addition to length and frequency of deployments, to predict retention rates of Service members.

Orthner and Rose (2003) suggested various assets to help reduce the amount of strain experienced by family members due to military separations, thus increasing the likelihood of reenlistment of the Service member. Assets were divided into six categories, which were Army related, family, personal, financial, social, and leader-support. Causal inferences were drawn, suggesting that the more assets the family possessed, the better family members were able to adjust to duty related separations (Orthner & Rose, 2003). It seems these identified assets helped minimize the effects of duty related separations on the Service member's spouse, which may positively influence a spouse's perception of the Service member's career. Because spouses' experiences with mental health counseling services have rarely been studied, it is unknown how their experiences may impact the retention rates of Service members. It seems probable that if

spouses have unsatisfactory experiences, then this would lead to lower retention rates for Service members.

Treatment Seeking and Treatment Compliance

Pescosolido and Boyer (1999) suggest that the utilization of mental health services is not only an individual decision, but a decision influenced by one's social environment as well. According to the authors, individuals are more likely to seek mental health services if their family members have a positive attitude towards utilizing mental health services or if they have utilized mental health services themselves. Thus, it has been suggested that spouses have an important influence on other family member's treatment seeking and treatment compliance (Pescosolido, & Boyer, 1999).

The Effects of Deployment on Spouses

An additional concern is the mental health of military spouses. Given the current rates of deployment, it is important to consider the possible effects the deployment cycle has on spouses. Studies have indicated that military spouses have experienced caregiver burden or "secondary traumatization" after their Service member returned home from deployment. Moreover, one recent study identified the impact of Service members' deployments to Iraq and Afghanistan on spouses.

Caregiver burden is the stress caregivers (e.g., spouses) experience when caring for their loved one with a mental health disorder. This care giving role can have a significant impact on one's well-being, suggesting that the individual with a mental health diagnosis is not the only person affected by the disorder (Hoffmann & Mitchell, 1998). For example, in a quantitative study of 71 Vietnam combat veterans and their partners, Calhoun, Beckham, and Bosworth (2002) explored the caregiver burden and psychological adjustment for partners of veterans with

and without PTSD. Results indicated that partners of veterans with PTSD experienced greater burden, poorer psychological adjustment, and were more likely to experience depression, anxiety, hostility, and obsessive-compulsive symptoms (Calhoun et al., 2002). Similar findings were also reported for caregiver burden in a study that compared the level of burden of wives of war veterans that were and were not diagnosed with PTSD and post-concussion syndrome (PC). Results suggested that the wives of war veterans with PTSD and PC were more likely to experience symptoms of depression, anxiety, paranoid ideation, and obsessive-compulsive problems when compared to the control group (Ben Arzi et al., 2000). While some PTSD treatment programs include support for the veteran's partner, Calhoun et al. (2002) suggested that there is a need to develop programs that include partners in treatment *and* provides partners with interventions to help reduce caregiver burden. Because caregivers are also being affected by a Service member's mental health diagnosis, it is imperative that spouses' mental health counseling service seeking behaviors are examined.

“Secondary traumatization” is a term developed to describe the phenomenon that close family members or friends may experience due to their regular interaction with someone that has encountered traumatic events or situations. This term has also been described as “trauma transmission” due to the traumatized individual sharing too much information with others, re-telling stories countless times, or family members' continuous exposure to the traumatized individual (Figley, 1993). It has been suggested that family members may become indirect victims of the trauma. This phenomenon has been examined in spouses and children of Holocaust survivors (Baranowsky, Young, Johnson-Douglas, Williams-Keller, & McCarrey, 1998; van IJzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003), Vietnam War veterans (Maloney, 1988; Rosenheck & Nathan, 1985), and Lebanon War veterans (Solomon et al.,

1992; Waysman, Mikulincer, Solomon, & Weisenberg, 1993).

Both empirical studies and reports have been written to describe the effects of living with a traumatized Service member on spouses and other family members. Effective treatment modalities to use when working with spouses of Service members and other family members were provided as well. For example, a quantitative study was conducted with 60 wives of war veterans diagnosed with PTSD, post-concussion syndrome (PC), or no psychological or physical diagnosis to determine caregiver burden, spousal distress, spousal psychological separation from the veteran, and whether there were differences across these three groups. Participants completed three measures: (1) the Caregiver Burden Inventory (CBI) to identify level of burden experienced, (2) the Symptom Checklist-90R to identify level of emotional distress, and (3) the Psychological Separation Inventory to assess the spouses' ability to remain autonomous while still caring for their veteran. For the purposes of this review, the wives of veterans diagnosed with PTSD and PC will be referred to as the diagnosed group and the wives of veterans that received no diagnosis will be referred to as the non-diagnosed group. Results indicated that, overall, the diagnosed group experienced higher levels of caregiver burden, with emotional burden being significantly higher for the wives of PC veterans than the wives of PTSD veterans. Significant findings were also reported for emotional distress when comparing the diagnosed group and the non-diagnosed group, suggesting that the diagnosed group experienced more psychiatric symptomatology compared to the non-diagnosed group. It was further reported that the level of emotional distress is positively correlated with caregiver burden, which suggests the higher the sense of burden experienced, the more severe the level of distress reported. Finally, findings suggested that the diagnosed group experienced a greater level of difficulty maintaining their autonomy and identity while caring for their veteran, and the more burden and distressed

experienced, the more difficult it was for the wife to separate her life from her veterans life (Ben Arzi et al., 2000).

Rosenheck and Thomson (1986) recognized that in the treatment of Vietnam veterans it is important to incorporate the veteran, as well as the veteran's spouse and/or other family members. The authors suggested that a combination of both individual and family therapy needs to be implemented in order for therapy to be effective. If spouses and other family members are not incorporated in the treatment process, spouses may become over involved in their partner's emotional life or may be traumatized by their partner's behaviors; children may replicate their veteran parent's experiences in play, experience violent nightmares, or mimic symptoms their veteran parent is exhibiting (Ben Arzi et al., 2000; Rosenheck & Thomson, 1986).

An interesting finding reported from the study conducted with patients seeking outpatient treatment in Veterans Health Administration (VA) facilities was that married Service members either took a longer amount of time to seek treatment after receiving a mental health diagnosis or failed to make contact for an initial treatment appointment compared to unmarried Service members, who were more likely to seek mental health services after receiving a mental health diagnosis (Cully et al., 2008). On one hand, it could be inferred from this finding that Service members may rely on their spouse as a strong support system and feel that seeking professional mental health treatment is unnecessary. On the other hand, other researchers have reported that the presence of a mental health disorder places stress and strain on the spouse, the marriage, and other family members, thus highlighting the importance that Service members, spouses of Service members, and possibly other family members utilize mental health counseling services (Calhoun et al., 2002; Jordan et al., 1992).

Lastly, Eaton et al. (2008) conducted a study with 940 Army spouses to determine the

prevalence of self-reported mental health concerns by spouses of Service members deployed to Iraq and Afghanistan while seeking primary care, to determine the proportion of spouses with mental health concerns that were not receiving services, and to identify perceived barriers to care. Participants completed the Patient Health Questionnaire (PHQ) to assess for symptoms of major depressive disorder and generalized anxiety disorder within the past month. Participants also completed the Two-Item Conjoint Screen to measure alcohol use and abuse. Participants were further assessed through questioning to determine if they were currently experiencing stress, emotional, alcohol or family problems and at what level (e.g., mild, moderate or severe) as well as whether or not they were interested in receiving help. Finally, participants were asked about their use of mental health services and their perceptions of barriers to care and stigma (Eaton et al., 2008).

Results indicated that 16.9% of the spouses were currently experiencing moderate to severe emotional, alcohol, or family problems, 19.3% of the spouses were currently interested in receiving help for stress, emotional, alcohol, or family problems, and 21.7% of the spouses reported that stress and emotional problems negatively impacted their quality of work or performance in other activities. Results from the PHQ suggested that 12.2% of spouses screened positive for major depressive disorder and 17.4% of spouses screened positive for generalized anxiety disorder. Of the spouses that screened positive for a mental health problem (n=74), 68% received mental health care for their problems. Moreover, spouses that screened positive for mental health problems were assessed for perceived barriers to care and stigma. Results indicated the most commonly reported barriers were practical reasons, such as difficulty getting time off from work, finding childcare, and getting an appointment, and cost. Factors related to stigma were also reported, such as the spouse would be seen as weak, it would be too embarrassing, and

it would harm their partner's career (Eaton et al., 2008). Together these studies illustrate that family functioning may be negatively impacted if the Service member's spouses are not included in treatment.

Willingness to Seek Care

Lastly, the Task Force (2007) has reported that the military is not providing family members with sufficient mental health care. This is of great concern due to the impact war has on spousal and family relationships. It was suggested that there is a greater willingness for spouses to seek mental health care compared to their Service member partner. However, currently, spouses are unable to initiate mental health treatment since mental health care for family members is *only* available through the civilian Tri-care insurance network. It has been reported by spouses of Service members that the system does not have adequate resources, and is "inconvenient and cumbersome" (Task Force, 2007, p. 49). The findings reported by the Task Force (2007) are consistent with the findings reported in the Eaton et al. (2008) study conducted with Army spouses. Specifically, findings in this study indicated that almost 70% of the spouses that screened positive for a mental health disorder and reported significant functional impairment sought mental health care (Eaton et al., 2008).

Moreover, a recent retrospective quantitative study was conducted with 250,636 Army wives who received outpatient services between 2003 and 2006. Only wives of Active Duty spouses that have been in the service for at least five years as of January 1, 2007 were included in the study. Researchers obtained the wives mental health history, the number and length of their spouse's deployments to Iraq or Afghanistan between 2003 and 2006, the spouses rank and time in the service, and the wives mental health diagnoses. Analyses compared wives of Service members that were not deployed, wives of Service members that were deployed for one to 11

months, and wives of Service members that were deployed for more than 11 months. Results indicated that longer deployments were associated with more mental health diagnoses, and 34.7% of the wives in the study had at least one mental health diagnosis. Of the wives whose spouses were deployed during the study period, 36.6% (63,091 wives) had at least one mental health diagnosis, compared to 30.5% (23,799 wives) of the wives of non-deployed spouses. Wives of deployed spouses were also more likely to use mental health services compared to wives of non-deployed spouses; specifically, rates of usage of mental health services were 19% higher for wives of spouses that were deployed for one to 11 months, and 27% higher for wives of spouses that were deployed for more than 11 months (Mansfield et al., 2010). It is important to recognize that the Service members' spouses are also impacted by deployment and it is imperative to understand their service seeking behaviors with mental health counseling services. The purpose of this current study was to capture Service members *and* spouses of Service members overall service seeking behaviors with mental health counseling services.

Barriers to Utilizing Mental Health Counseling Services

Due to the inconsistency of the utilization rates of mental health and counseling service by Service members, it is essential to understand what inhibits Service members from accessing services, or continuing to access services for ongoing treatment. It is apparent that the military has attempted to provide Service members with adequate mental health counseling services. However, the possible barriers that inhibit Service members from accessing these services are unclear.

Hoge et al. (2004) conducted a quantitative study to explore the effects of combat exposure on Service members and the perceived barriers to care that inhibit Service members from accessing mental health counseling services. Participants were asked to rate statements of

perceived barriers that may affect their decision to utilize mental health or counseling services. Response choices ranged from strongly disagree to strongly agree on a 5-point likert scale. Results indicated that participants that met the criteria for a mental health disorder were twice as likely to report fear of stigmatization and apprehension regarding how one would be perceived by peers and leadership as a barrier to accessing mental health counseling services compared to Service members that did not meet the criteria for a mental health disorder. Other barriers that were reported by participants that met the criteria for a mental health disorder were being viewed as weak, difficulty getting time off of work for treatment, and the possibility that utilizing services would harm ones career. Similar barriers were reported for participants that did not meet the criteria for a mental health disorder, however, the percentage of Service members reporting being affected by these barriers was not as high (Hoge et al., 2004). These findings suggest that perceived barriers to care are amplified for Service members with a mental health diagnosis.

In their study of 8,441 Canadian Service members, Sareen et al. (2007) studied the prevalence of mental health disorders related to mission type, as well as the perceived need for mental health care after deployment, and the perceived barriers to care. Participants completed the Composite International Diagnostic Interview (CIDI) to determine the prevalence of mental health disorders and the Perceived Need for Care Questionnaire (PNCQ) to determine if Service members' needs for mental health counseling services had been met, partially met, or unmet. Participants that indicated partially met and unmet needs indicated the perceived barriers to care by choosing the barriers that affected their utilization of mental health counseling services from an existing list of possible barriers to care. Results suggested that across all mental health disorders, individuals who had a perceived need for care reported that they did not have their needs met or their needs were only partially met. The two most commonly chosen barriers to

care were “other” and “did not have confidence in the military health, administrative, or social services” (p. 849). Because 82.6% of the participants that felt their needs were only partially met or were not met chose “other” as a perceived barrier to care, it seems the study did not capture the most prevalent barriers to care (Sareen et al., 2007).

The longitudinal study conducted by Milliken et al. (2007) explored the mental health needs of Service members returning from deployment. Even though perceived barriers to care were not specifically screened for, issues related to perceived barriers to care were discussed in the comment section. Results indicated that Service members may not truthfully complete the PDHRA due to the stigma associated with being diagnosed with a mental health disorder. Also, Service members commonly reported alcohol related issues, but they did not receive treatment due to concerns related to confidentiality. Current military policies state that receiving treatment for alcohol related issues, even when self-referred, leads to direct involvement of the Service member’s commander and the Service member’s career may be negatively impacted. Particularly since alcohol related problems have been found to be co-morbid with PTSD and relationship issues, it is important for Service members struggling with alcohol related problems to access and utilize mental health counseling services. It was suggested that the military policies need to be *flexible* so Service members can receive alcohol-related treatment confidentially before formally involving the Service member’s commander (Milliken et al., 2007). It seems some of the military’s current policies may in and of itself be a perceived barrier to care for Service members, which in turn, could lead to redeployed Service members experiencing mental health issues and increased levels of family and relationship distress.

Johnson et al. (2007) reviewed both empirical studies and non-empirical literature (e.g., medical reports, informal surveys, etc.) to identify perceived barriers to care for Service

members and their families. The identified barriers to care were divided into three broad categories, including: (1) availability (e.g., unable to get time off from work, lack of knowledge regarding where to get help, and lack of military culture training for behavioral health professionals), (2) acceptability (e.g., stigma, career being negatively affected, lack of confidentiality, and perception of poor quality services), and (3) accessibility (e.g., difficulty scheduling appointments, overlapping hours with workdays, lack of follow through after being referred, lack of transportation, and limited hours,). Another significant barrier reported that was not identified within the three categories was that Service members do not seek mental health services because it will not be “well received up the chain of command” (Johnson et al., 2007, p. 50).

Although the above studies have identified perceived barriers to care, the designs were quantitative, which limited Service members responses and did not capture the factors that impacted their service seeking behaviors with mental health counseling services. A qualitative study would allow Service members to identify their personal barriers to care without being restricted to an already created list of possible barriers to care, as well as allow Service members to elaborate on the factors that facilitated and/or inhibited their behaviors.

Conclusion

The existing quantitative studies have reported the prevalence rates of mental health disorders among services members, the availability and utilization rates of mental health counseling services, and the perceived barriers to receiving mental health care. The research has primarily been conducted with Service members, with limited research conducted with military spouses of Service members’ and the factors that facilitate or inhibit their service seeking behaviors. The current study was conducted to address the gaps in the existing literature.

Through this qualitative study, the researcher will explore both Service members and spouses of Service members' mental health counseling service seeking behaviors.

CHAPTER 3: METHODS

Design of the Study

The current study is an extension of the Military Family Needs Assessment, a qualitative study that was originally conducted by Dr. Angela Huebner and her research team. In the original study focus groups were conducted to gather feedback from military families on current educational programs and support services from those who have and have not accessed these services. The research team was interested in determining what is and is not working in regards to these services, as well as participant's adjustment to deployment. The current study used this data to explore Service members and spouses of Service members' mental health counseling service seeking behaviors.

The focus groups consisted of no more than 10 participants, lasted no longer than 90 minutes, and were facilitated by two moderators. Participants interested in partaking in the study could do so voluntarily. Each participant completed a brief demographics form before the start of the focus groups (see Appendix B). The moderators asked the participants to respond to a series of six questions (see Appendix C). The focus groups were free flowing and each participant was given an opportunity to share his or her opinion and experience. The focus groups allowed for richer, in-depth descriptions of military Service members and spouses of Service members experiences. The interactions amongst participants provided the researcher with information that may not have been attained through one-on-one interviews because the participants may have been more reluctant to talk about their experiences. Also, the focus groups allowed the moderators to ask follow up questions to better understand and clarify participants' experiences.

Study Participants

The original study consisted of military Service members and their families. Each branch

of the military was represented, and included Active Duty, National Guard, and Reserve. The participants were selected to participate in the study based on snowball and convenience sampling. Participants were provided with informed consent forms prior to partaking in the study and participants were informed that they could withdrawal from the study at any time without penalty (see Appendix A). Focus group participants were recruited through invitations received by representatives of the Office of the Secretary of Defense. Specific installations were targeted based on geographic and service diversity, representing all branches of service. Participants in the focus groups were from an instillation in the South, an instillation in the Mid-Atlantic, and several Outside the Continental United States (OCONUS) installations.

The study included a total of 108 participants in the focus groups from 22 different groups. The focus group participants ranged in age from 19 to 54 years, with 70.4% females and 29.6% males. Military service branch of the focus group participants was reported as follows: 25% Army, 28.7% Navy, 9.3% Air Force, 16.7% Marines, 19.5% National Guard/Reserve, and 0.9% who did not report. Focus group participants included 29.6% Service members, 64.8% spouses of Service members, 4.6% who were both a Service member and spouse of a Service member, and 0.9% who did not report. Ethnicity of the focus group participants was reported as follows: 57.4% Caucasian/White, 17.6% African American, 10.2% Hispanic, 11.1% Asian/Pacific Islander, 2.8% “Other”, and 0.9% as unreported.

The current study only included Active Duty focus group participants because of the distinct differences among Active Duty, National Guard, and Reserve. These differences would make it difficult to develop themes to accurately represent the participant’s experiences from all military affiliations. Moreover, the literature presented throughout this report only represents experiences of Active Duty Service members and spouses of Active Duty Service members.

While some of the experiences may be similar between Active Duty, National Guard, and Reserve, literature on the National Guard and Reserve was not specifically researched.

The current study included 76 participants from 15 different focus groups that were conducted in the same geographical location. The focus group participants ranged in age from 20 to 54 years, with 90.8% females and 9.2% males. Military service branch of the focus group participants was reported as follows: 26.3% Army, 9.2% Navy, 15.8% Air Force, and 28.9% Marines, and 19.7% who did not report. Focus group participants included 5.3% Service members, 86.8% spouses of Service members, 6.6% who were both a Service member and spouse of a Service member, and 1.3% who did not report. Ethnicity of the focus group participants was reported as follows: 60.5% Caucasian/White, 5.3% African American, 13.2% Hispanic, 15.8% Asian/Pacific Islander, 3.9% "Other", and 1.3% as unreported.

Procedures

In the original study, the consent process took place prior to the start of the focus groups. The moderators verbally described to the participants the study, participant expectations, risks, benefits, and confidentiality. The participants also received an informed consent form which expanded on what was verbally stated by the moderators. If the participants had any questions, the moderators answered them at this time. After all questions were answered, participants were asked to initial a box on the informed consent form, which indicated that the participants had been informed about the study and agreed to participation. The participants only initialed the consent form rather than using separate written and signed consent forms because the researchers believed this increased the level of participant's anonymity in the process thus increasing comfort with disclosing thoughts and experiences. A copy of the consent form was given to the participants to take home. The consent form was also used as a cover sheet to a brief

demographic form the participants were asked to complete prior to the start of the focus groups (Huebner, Alidoosti, Brickel, & Wade, 2010).

After consent had been obtained from all participants and the brief demographic form was completed, the focus groups began. The focus groups were audio taped and were facilitated by two moderators. The study took place in convenient locations for the participants, either on the military base or near the military base in a military facility. The audio recordings were transcribed and the demographic information was entered into SPSS. After the audio files had been transcribed and checked for accuracy, the files were deleted. Participant's first names on the transcripts were replaced with an identification number. This identification number was the same number placed at the top of participant's demographic form. The demographic forms and the code book were stored separately in locked cabinets. The electronic data was stored on a password protected computer hard drive. Only the researchers had access to this information (Huebner et al., 2010).

A secondary analysis was conducted on the data collected in the focus groups from the original study to determine the participants' service seeking behaviors with mental health counseling services. For the present study, focus groups from the original study were selected based on criterion sampling. Criterion sampling was used to ensure participants being included in the study met a specific criterion (Creswell, 2007). There was only one criterion that needed to be met for inclusion in the present study, which was all the participants in the focus groups had to be part of an Active Duty military family. Although the mental health needs of Service members from the National Guard and Reserve components are also compelling (Milliken et al., 2007), given their geographic dispersion, their physical ability to access mental counseling health services may be so disparate from those residing closer to military installations to warrant an

independent study. Also, due to this specific criterion for the current study, only Active Duty literature was represented throughout the report.

Analyses

The present study sought to explore Service members and spouses of Service members' service seeking behaviors with mental health counseling services. The transcripts of the focus groups were analyzed using the thematic analysis method outlined by Braun and Clarke (2006). The researcher's analysis was guided by the six phases of thematic analysis, which are: (1) familiarizing oneself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. The researcher also used the computer program ATLAS.ti for qualitative data to assist in the organization of data analysis (Scientific Software, 2012).

The first phase of analysis began with the researcher becoming immersed in the data set by reading the transcripts multiple times in order to develop an understanding of the information. During the immersion phase, the researcher wrote down ideas and possible codes while reading and re-reading the transcripts. Next, the researcher generated initial codes from the data. Coding was data-driven since the researcher developed themes based on the relevant responses in the focus groups related to the research questions. During the initial phase of coding, the researcher coded for all potential themes, coded liberally to help maintain the context of the extract, and used multiple codes for an extract when necessary. After the transcripts had been coded, the researcher then sorted through the different codes for potential themes. The researcher developed a thematic map to help identify the relationship between codes, between themes, and between different levels of themes.

The researcher then reviewed the themes for refinement by eliminating themes,

combining themes, and separating themes. Two levels of reviewing and refining occurred during this phase. Level one involved reviewing all the extracts coded in each theme to determine if a coherent pattern existed. Level two involved determining whether the themes accurately represent the data set. After the themes had been reviewed and refined, the researcher then defined and refined the themes to identify what each theme represented. At this point, possible sub-themes within each theme were also identified. The sixth and final phase involved the researcher developing a concise and comprehensive story of the data through a within and across analysis of the themes. In order to establish credibility and trustworthiness throughout the process, the Thesis Committee Chair, Dr. Angela Huebner, was employed as a second coder and reviewed the themes and codes developed by the researcher. A second coder helped ensure the themes developed by the researcher accurately and meaningfully represented the participants' service seeking behaviors with mental health counseling services.

CHAPTER 4: MANUSCRIPT

Abstract

While previous research has explored the relationship between combat exposure and mental health disorders, the effects of mental health disorders on attrition rates of Service members, the discrepancy between mental health counseling services available and utilized by Service members, and barriers to seeking mental health counseling services, the majority of studies thus far have only been conducted with Service members and have been quantitative in nature. While researchers have begun to explore the experience of deployment on Service member spouses, little research has focused specifically on their service seeking behavior regarding accessing mental health services. This is unfortunate given that multiple studies have indicated the importance of including Service member's spouses in future research. This qualitative study included both Service members and spouses of Service member's in an attempt to capture their mental health counseling service seeking behaviors. Thematic analysis was employed to develop a model of mental health seeking behavior among Service members and their spouses. The resulting model is unique in that it attempts to account for the influence of multiple contextual and ecological factors. Limitations of the study, future research and clinical implications are also discussed.

Service Seeking Behaviors among Service Members and Spouses of Service Members:
Facilitating and Inhibitory Factors

Molly A. Brickel

Introduction

The Department of Defense (DoD) provides care and support to Service members each year through funding received from the United States Federal Government. In the budget proposal for the 2010 fiscal year, one of the DoD's primary objectives was "providing the necessary resources to support the troops in the field" (U.S. Department of Defense, 2009, p. 1). The budget requested \$533.8 billion for military support services, which is a four percent increase from the 2009 fiscal report. This year the DoD has also requested \$177.5 billion to use towards support services, which is a \$13 billion increase from the 2009 fiscal report (U.S. Department of Defense, 2009). It is apparent that the DoD is committed to providing needed care and support for Service members and their families in order to strengthen and improve the Armed Forces. These supports have been provided across a wide variety of areas, including funding for college, filing taxes, mental health counseling services, and most everything in between. The support of interest in the present study is that of mental health counseling services.

Research conducted in recent years reveals a great deal about the impact of deployment and its associated stressors on Service members and their spouses. For example, numerous research studies have reported that a spouse's satisfaction or dissatisfaction with aspects of the military lifestyle (e.g., length and frequency of deployment, relocations, financial benefits, etc.) impacts a Service member's likelihood to reenlist (Bell, Schumm, and Martin, 2001; Orthner and Rose, 2003; Segal, 1986; Weiss et al., 2003). Research has also explored the effects that deployment itself has on Service members' spouses and the likelihood that spouses will seek

mental health counseling services. Findings indicated that prolonged and frequent deployments were associated with an increased risk of mental health diagnoses among spouses and spouses of deployed Service members were also more likely to use mental health services compared to spouses of non-deployed Service members (Bell et al., 2001; Eaton et al., 2008; Mansfield et al., 2010; Orthner and Rose, 2003; Pescosolido & Boyer, 1999; Segal, 1986; Weiss et al., 2003). Multiple researchers have further reported that the impact of Service members returning home from deployment has led to spouses experiencing caregiver burden or “secondary traumatization” (Ben Arzi et al., 2000; Calhoun et al., 2002; Cully et al., 2002). Lastly, a recent study conducted by Eaton et al. (2008) identified the prevalence of self-reported mental health problems among Army spouses, the proportion of spouses that did not seek mental health care, and perceived barriers to care and the impact of stigma on Army spouses seeking mental health counseling services. Given these findings regarding the impact of deployment on Service members’ spouses, it is apparent that more needs to be known about the process and experience of seeking treatment.

While there is minimal research and literature that includes Service members *and* Service members’ spouses service seeking behaviors with mental health counseling services, research has been conducted with Service members that have served or that are currently serving in the Global War on Terrorism and whom have been deployed to active combat zones. Studies suggest that Service members who witness atrocities and are exposed to combat are more likely to experience mental health problems compared to those who do not (Hoge et al., 2006; Hoge et al., 2004; Sareen et al., 2007; Seal et al., 2007). It has also been suggested that there is a relationship between combat exposure and the prevalence of post-traumatic stress disorder (PTSD). Currently, PTSD is one of the most commonly diagnosed mental health disorders among Service

members (Hoge et al., 2006; Seal et al., 2007).

Given the prevalence of diagnosable mental health issues for this population (Milliken et al., 2007; Seal et al., 2007), Service members are routinely screened for mental health disorders immediately after deployment and three to six months thereafter. Screening consists of a self-report questionnaire and a secondary assessment completed by trained clinicians (Milliken et al., 2007). Despite this two part screening process, some suggest that the number of Service members diagnosed with a mental health disorder is still underestimated (Rona et al., 2005). Given current high operation tempo, this may mean that Service members are being redeployed without addressing their existing mental health concerns. Additionally, it has also been reported that only a small percentage of Service members that met the criteria for a mental health diagnosis actually receive help (Hoge et al., 2004; Hoge et al., 2006). Other studies suggest that despite the advertised availability of mental health support services, , they may not be readily accessible to Service members and their families (Johnson et al., 2007; Milliken et al., 2007; Task Force, 2007). Given the commitment to provide mental health services to Service members and their families, why are so few actually receiving help?

Previous studies of this issue, conducted primarily with Service members (as opposed to both Service members and their spouses) are revealing. For example, several studies have suggested that fear of stigmatization by others is by far the most frequently reported reason Service members give for not seeking mental health services (Hoge et al., 2004; Milliken et al., 2007). Other cited reasons are related to issue of access, availability and perceived acceptability of use (Johnson et al, 2007, Mililiken et al, 2007, Task Force, 2007). Additional consideration must be given to the prevalence of the comorbid diagnoses that often occur with mental health diagnoses. For example, alcohol and misuse of other substances is often co-morbid with PTSD

and relationship issues (Hoge et al., 2004; Milliken et al., 2007). Given the zero tolerance policy of the military for drug use, presentation for treatment could lead to discharge (Milliken et al., 2007). In summary, as evidenced by these studies, the problem may not be a lack of mental health counseling services per se, but rather that the perceived cost of obtaining treatment is too high. Despite these perceived costs, findings suggest that Service members are almost four times more likely to accept treatment if *they* referred themselves to mental health care as opposed to being referred by a military mental health professional. Unfortunately, those Service members diagnosed with a mental health disorder who did present for treatment consistently stated that their needs were not met or only partially met (Sareen et al., 2007).

Identifying and treating mental health issues among Service members is clearly important to ensure the mental well-being of those serving our country. It is also important given that there appears to be a significant relationship between diagnosis of a mental health disorder and attrition rates in the military. For example, Hoge et al. (2006) reported that Service members who met the criteria for a mental health disorder were almost one and a half times more likely to leave the service during the year following their deployment compared to the Service members that did not meet the criteria. Furthermore, the Hoge et al. (2005) study reported that of the 45% of Service members hospitalized with a mental health diagnosis upon returning from a combat deployment left the military within six months of their hospitalization. Of note is the fact that of that 45%, 17% were involuntarily discharged, suggesting they were deemed to be inconducive for further military service (Hoge et al., 2005). In sum, these findings illustrate the negative impact mental health diagnoses and hospitalizations for mental health disorders can have on a Service member's career (Hoge et al., 2006; Hoge et al., 2005).

Summary

Previous studies have documented the relationship between combat exposure, mental health, and attrition from the military (Hoge et al., 2006; Hoge et al., 2004; Sareen et al., 2007; Seal et al., 2007). The utilization rates of mental health counseling services by military Service members have been identified, along with possible barriers affecting Service members' willingness or ability to receive mental health care (Hoge et al., 2006; Hoge et al., 2004; Johnson et al., 2007; Milliken et al., 2007; Sareen et al., 2007). Mansfield et al. (2010) explored the prevalence of spouses' use of mental health services, suggesting that rates of usage of mental health counseling services were 19% higher for wives of spouses that were deployed for one to 11 months, and 27% higher for wives of spouses that were deployed for more than 11 months when compared to wives of non-deployed spouses. In a study conducted with Army spouses during a routine primary care visit, Eaton et al. (2008) reported that almost 70% of the spouses that screened positive for a mental health disorder and reported significant functional impairment sought mental health care. While these studies have documented the mental health status of Service members' spouses and even the usage rates of services among Service members' spouses, the studies fall short in that they do not provide insight into the actual decision making process to seek mental health services, or into the factors that facilitate and/or inhibit use of mental health services themselves.

To address this issue, this in-depth qualitative study was conducted to explore the service seeking behaviors with mental health counseling services of *both* Service members and spouses of Service members. This qualitative methodology allowed the researcher to obtain a more nuanced view of their service seeking behaviors with mental health services, views that are not possible to explore with quantitative methodologies. This study builds on previous research to

begin to explore the multiple and often simultaneous influences that impact a Service member or spouse's motivation and ability to access mental health services. To this end, the ecological model framework (Bronfenbrenner, 1986) provided a useful lens for thinking about their processes. This study may provide policy makers and service providers with a clearer understanding of the multitude of factors impacting the use of the mental health counseling services among Service members and their spouses, thus helping them to refine and strengthen the mental health counseling services provided.

Methods

The current study is based on data collected in the Spring of 2010 as part of the Military Family Needs Assessment, a study conducted at the request of the Department of Defense to gather feedback from military families on current educational programs and support services from those who have and have not accessed these services (Huebner, Alidoosti, Brickel, & Wade, 2010). In total 22 focus groups were conducted with 108 participants at various geographic locations representing all four branches of military service (Army, Navy, Air Force, Marines). The current study focuses only on the data related to Service members and spouses of Service members' service seeking behaviors with mental health counseling services. It was also limited to those Service members and spouses residing in the Active Duty components of the military. Although the mental health needs of Service members from the National Guard and Reserve components are also compelling (Milliken et al., 2007), given their geographic dispersion, their physical ability to access mental counseling health services may be so disparate from those residing closer to military installations to warrant an independent study.

In all, 108 participants were recruited through invitations received from representatives of the Office of the Secretary of Defense using snowball and convenience sampling. The invitations

were sent directly from the Office of the Secretary of Defense to installation representatives who were then responsible for participant recruitment. Participation was voluntary and no compensation was given. The 90-minute, digitally-recorded focus groups consisted of no more than 10 participants and were facilitated by two moderators. The moderators asked the participants to respond to a series of six questions regarding current educational programs and support services. For the purpose of this study, the researcher was only interested in focusing on the participant's answers to the mental health questions. The focus groups were free flowing and each participant was given an opportunity to share his or her opinion and experience. Participants completed a brief demographic form prior to the initiation of the focus group.

The audio recordings were transcribed verbatim and demographic information was entered into SPSS. Focus groups were chosen for inclusion in the present analysis based on two main criteria. First, as mentioned previously, all the participants in the focus groups had to have been part of an Active Duty military family. Second, in order to ensure enough "data" on the topic of interest, the majority of the participants in the focus groups must have spoken about their specific service seeking behaviors with mental health counseling services in some depth.

The transcripts were analyzed using thematic analysis method as outlined by Braun and Clarke (2006). Accordingly, the researchers (1) spent time becoming familiar with the data, (2) generated initial codes, (3) searched for themes, (4) reviewed themes across transcripts, (5) defined and named themes, and (6) produced the report. ATLAS.ti (Scientific Software, 2012) was used to assist in the organization of data analysis. In order to establish credibility and trustworthiness, the Thesis Committee Chair, Dr. Angela Huebner, was a second coder and reviewed the themes and codes developed by the researcher.

Results

Demographics

The current study included 76 participants from 15 different focus groups that were conducted in the same geographical location. The focus group participants ranged in age from 20 to 54 years, with 90.8% females and 9.2% males. Military service branch of the focus group participants was reported as follows: 26.3% Army, 9.2% Navy, 15.8% Air Force, and 28.9% Marines, and 19.7% who did not report. Focus group participants included 5.3% Service members, 86.8% spouses of Service members, 6.6% who were both a Service member and spouse of a Service member, and 1.3% who did not report. Ethnicity of the focus group participants was reported as follows: 60.5% Caucasian/White, 5.3% African American, 13.2% Hispanic, 15.8% Asian/Pacific Islander, 3.9% “Other”, and 1.3% as unreported.

Factors Influencing Intent to Seek Treatment

The model presented in Figure 1 illustrates the factors which seem to facilitate and/or inhibit Service members and/or spouses of Service member’s willingness to seek mental health counseling services. These factors seem to operate at multiple levels of our participants’ ecological environments. For presentation purposes, these factors have been designed to a particular ecological niche (e.g., microsystem, mesosystem, exosystem, and macrosystem). It is important to note however that these factors are interactional in nature and can therefore exert influences at multiple levels simultaneously.

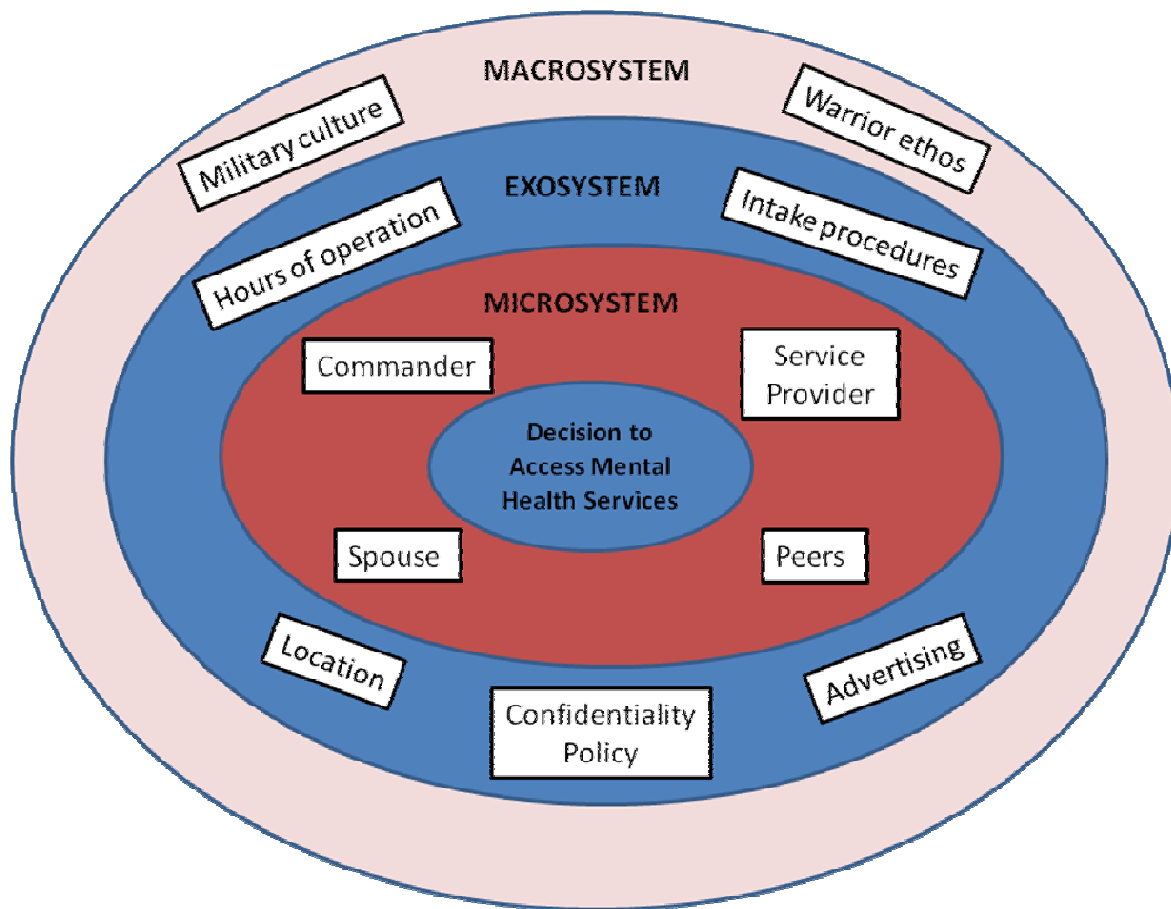


Figure 2. Factors Influencing Intent to Seek Treatment.

Context: Microsystem Influences

Microsystem Influences

Microsystem influences included people with whom our study participants had direct interaction. As revealed by the participants, four primary relationships seemed pivotal in the decision to seek mental health counseling services: 1) spouses, 2) peers, 3) commanders, and 4) service providers. It seemed to be that the others' perceptions of the services were highly influential in participants' decision to seek mental health counseling services.

Spouse Factors

It is important to note that participants interviewed in the focus groups included both Service members and spouses of Service members. As reported by participants, both Service

member's and spouses of Service members play an essential role in the decision making process regarding seeking mental health counseling services.

Spouses of Service members described "forcing" their spouse to seek mental health counseling services because of their own concerns about presenting mental health issues. Both spouses and Service members said their hesitation about seeking services stemmed from their concern that it would get back to their command, go on their personnel record, affect their job status and/or security clearance, and/or impact the way they were perceived by others. Service members themselves were cited as a barrier to spouses' access to mental health treatment because they controlled the flow of information about those services. Some spouses stated that they were given information about support services on a "need to know basis" based on the Service member's perception of what they thought was relevant.

... I have a wonderful husband, you know, I cannot complain about my husband, but I can tell you what he can be a barrier to me. He gets busy all day long, sees e-mails coming through, and I'll hear about things that are happening on base maybe a week later because he is so busy trying to perform the function of his job. And it's not, you know, intentionally holding information back from me, but it's not important to him, which would be important to me. We have these arguments all the time why didn't you tell me? So, getting information to spouses is always, always a problem. (Service Member Spouse)

In some cases, the perception by spouses was that their Service members intentionally withheld information because they feared the backlash and stigma associated with accessing mental health services, and they wanted to avoid any possibility of their spouse becoming involved with gossip or drama regarding mental health counseling service all of which could negatively impact the Service members' career.

Participant 1: We also find cases where the military spouse is intentionally not telling their spouse anything or giving them inaccurate, wrong information. (Service Member Spouse)

Interviewer: So what's the fear there? Why would they do something like that? Why don't they want their spouses in the loop?

Participant 1: A control issue. (Service Member Spouse)

Participant 2: Bad reputation for the FRG; they assume that their wives are going to get involved in drama and gossip and it will affect them on the boat. (Service Member Spouse)

In addition, seasoned Service member's spouses expressed that they felt there are a lack of supports that are available to them since the military assumes that because they have been affiliated with the military for so long they do not need support or automatically know where to go to find support.

...so I feel like a lot of people assume that because my husband has been in for 16 years, too, that I should know it all. This was our first deployment, and you can ask them I have struggled really right on through and again there is stuff I could read on-line, but as far as tangible on the ground, you know, real resources that I was willing to use, I really never really connected with any of them. (Service Member Spouse)

Contradictory perspectives were also expressed by Service member spouses regarding the acceptability of seeking marriage counseling. Some participants stated that they believed it was acceptable to seek services to help their marriage because they would be perceived as a good husband or wife.

I think for like the family services, marriage counseling, that type of deal, there's really no stigma involved with that at all. You're perceived as being a good family member, a good husband, good father whatever, but you're seeking to get, you know, that type of counseling if that's what you need. So, that is stressed with it's real. They really want you to do that. For as far as like mental health or anything maybe dealing with post-

deployment issues, there are to me there's still that stigma is there and it's prevalent, it's there. (Service Member)

Other participants stated that their military spouse was unwilling to seek marriage counseling due to the fear it would negatively impact their career.

At one point my husband and I were having difficulties, and I wanted to go see a marriage counselor and his concern was that because of his security clearance any kind of counseling that he went to could essentially bump him out of his job. And that was no military related, no war related, that was just if you don't do this, I'm going to kill you kind of deal on my part. (Service Member Spouse)

Peer Factors

Participants stated that they were more likely to seek mental health counseling services if peer's normalized the importance of seeking services, if they were reassured that seeking services would not affect their job status or career, and if they directly knew someone that utilized services and they were not treated differently by peers.

The only thing that in my experiences with friends, you know, who spouses had this type of issue, the only thing that has finally convinced them to seek help is knowing someone personally that has done the same. The only thing. (Service Member Spouse)

Inhibitory peer factors included the fear of being viewed differently, being judged, having their abilities questioned, and stigma.

I've got to tell you they are talking a good game, but bottom line upfront it don't matter what you go in to seek services for they're going to look at you twice from that point forward. (Service Member)

Commander Factors

Participants discussed the influential role of their commanders in their decision making process to access mental health services. Participants whose commanders talked about the

acceptability of seeking mental health counseling services as well as admitted to using mental health counseling services reported that they were more open to seeking treatment themselves.

If the first sergeant says, hey, I just went to a marriage retreat and it was the best thing I ever did for me and my wife, you're going to have five or six soldiers that are going, wow, first sergeant is going to do it and then I'll do it. If first sergeant says man, I'm not going to that stupid marriage retreat; they're going to waste my weekend. None of those soldiers are going to go and that's where you see the strong FRG programs versus the weak FRG programs. It's commander's intent. (Service Member Spouse)

Participants talked about “being ordered” to seek treatment as a reason for attendance. It seems that the perception of being told to go seek mental health counseling services (thus eliminating their own role in the decision) allowed the Service member to access services without the appearance of weakness (e.g., “I didn’t want or need to go; I was made to go”).

In my case if my, you know, if the command would have said there's something kind of going on, you know what, go over and see somebody. If it would have been kind of like an order, but really not because they said they can't order you, but if it would have come like...Hey, go see somebody, I would have been, oh, okay and would have just done it and not said, well, you can't make me, you kind of, you know, you're trained to go, okay, and then you probably would have, you know, I probably would have. (Service Member)

Service Provider Factors

Participants identified factors related to service providers themselves that inhibit them from seeking mental health counseling services, such as providers being rude on the phone, being transferred multiple times before connected to a provider that can help, providers being unable to answer questions, services not being up to date, disorganization of the services, and lack of communication between the different services offered.

Quote 1: The problem is that we've just completely it seems like across the Army, not just ACS, is that we've lost touch with what customer service is, and I think they feel like

they're giving out all these benefits and services, but they don't have to service them like their customers and they are and part of the problem is that somebody will call and you'll get somebody who is just rude as all heck to you at the front desk or they transfer you around to two different departments before you actually figure out where they, where you need to go. And I think that right off the bat is a problem. (Service Member Spouse)

Quote 2: I think a lot of the times that's where the shut off is for people is they call a front desk and got somebody who just didn't know what they were doing or whatever and then that was it. We were done from that point. (Service Member Spouse)

Another factor participants discussed was service providers not being knowledgeable on the military culture, military language, nature of military life, and the military community.

The only thing that I can think of is going in and seeking services and the people you are seeking services not knowledgeable on what you're seeking services about. Not understanding the culture or the acronyms or, you know, not understanding just the culture itself, you know, and not really immersing them. If you're going to speak about the Navy or the Marine Corps, then understand the situation you're speaking about, you know, find out about what that family goes through or what the deployment does to that family, you know, and understand the facets around that. Don't just put yourself in this is the little sliver that I'm going to be doing, you know, and you have wonderful people that do that, but you will, I notice at different bases that I have gone to you will have this individuals that, well, this is my job and my job only. And don't really pay attention to all the facts that surround. And I think that's the only disadvantage at centers and places that I have gone to. (Service Member Spouse)

Intervening Factors: Exosystem and Macrosystem Influences

Exosystem Influences

Exosystem influences included the policies and guidelines of mental health counseling services on and off installation. Policies and guidelines of the organizations that impact Service members and spouses of Service members seeking mental health counseling services on

installation are: 1) advertising, 2) confidentiality, 3) intake procedures, 4) hours of operation, and 5) location.

Advertising

Despite a plethora of presentations, classes, newspapers, flyers, and marquee signs on installations about the availability of mental health services, participants continued to state that they were unaware of what services were available. Some participants reported that they had heard of the services available but they did not know their functions so they did not utilize these services.

...I mean, I've heard about it (MOS – example of mental health service). I have a magnet on my fridge...it is everywhere you turn like you see the sign for it, but it doesn't mean anything to me. (Service Member Spouse)

Confidentiality

Participants expressed that they were afraid and intimidated to access mental health counseling services because of their fear that that provider would put that information on their record and that it would become available to their commander, thus potentially negatively impacting their career and reputation with peers.

Quote 1: I also think that it has to do with a lot of people like say my husband went in and said something that he's having problems or something like that, I think he feels that somebody will use that against him. It might affect his job. Yeah, his career or the reputation around his Marines. (Service Member Spouse)

Quote 2: Also if he goes to someone I think, too, I think if they go to someone and say I'm having trouble, I need help, then that someone is going to tell someone else who is going to tell someone else. It's going to go from a private issue to something that's public. (Service Member Spouse)

Intake Procedures

Participants stated another inhibitory factor that impacts their decision to seek mental

health counseling services is the intake process and order of questions asked over the phone by service providers at counseling centers to evaluate potential clients. Participants emphasized that this first encounter and experience is crucial in determining whether or not to support services are sought.

I came back pretty much alone more or less and I remember my first phone call over here [referring to a counseling center on base] the first question I was asked was do you feel like killing yourself? I was will, whoa, I do not want to be involved in any of this crazy stuff. I was like, I'll try later. (Service Member)

Hours of Operation

Participants stated that due to current policies Service members are encouraged to access mental health counseling services during the duty day which negatively impacts their likelihood of seeking services because Service members do not want their command or colleagues to question where they are going.

My husband has used a couple of the things and he just, like, he was saying he went during work hours too and so maybe instead have it where he can go at a time where nobody is going to know where he is at, you know? Because if he doesn't want someone to know what's going on that way they're not going to ask questions about where he's at and what he's doing when he's not around. (Service Member Spouse)

Participants also expressed that services are understaffed which in turn impacts the hours that services are offered, thus limiting flexibility around their work schedule.

Location

Participants reported that mental health counseling services located in a central area on the installation inhibited their willingness to seek services, whereas services located in a remote area on the installation increased their willingness to seek services. Participants stated that they were concerned about how easily others could observe them walking into a counseling center.

So that is a huge thing is the stigma that you don't want to be seen walking into the Fleet and Family Support Center. (Service Member)

Moreover, participants reported both pros and cons of accessing mental health counseling services off installation. Participants stated that accessing mental health counseling services in the community (rather than those on the installation) was sometimes preferable because the information does not go on the Service member's record and they felt protected by confidentiality. Moreover, participants reported that they felt more comfortable talking with a therapist not affiliated with the military because they felt they were not being judged.

I would definitely recommend or I've personally used Tri-Care counseling services. So, there is addition to Marine and Family Services or Fleet and Family Services, which was nice. It was private, off-base, not affiliated with the military, and we spent a year with a private counselor, and it was fantastic. Never went in anybody's record, I never paid a dime, and so kudos to the Marine Corps and DoD for that because that saved my marriage so, yeah. (Service Member)

Other pros participants identified in regards to accessing mental health counseling services off installation were the therapist had knowledge of the military culture and language, the therapist was not directly affiliated with the military, it was easy to set up sessions, and the sessions did not have to be paid for through the Service member's Tri-Care insurance.

So, I thought about coming here on base at one time, but then I thought about that stigma with having to worry about who is going to find out especially for my wife because she's the active duty one. So, we outsourced, you know, we got the information, Military One Source somebody that we can use that there's nothing that our commands or whatever can go. So, once we started going through that comparing it to something we have been through before and that feeling it's a lot better. The civilian that we went through they had to go through some basic classes to get knowledge of the military to make sure they understand because a lot of times you can't bring in somebody that doesn't understand the nature of military life or the community within, you know, so the person that we talked to

did their classes and went through whatever courses, you know, through the key volunteer programs here on base and, you know, they got knowledge, they got knowledge and then they started doing their practice of being an outsource person so. (Service Member Spouse)

Finally, participants stated that they were hesitant to use off installation therapy services because they felt the services were still too closely affiliated with the military. Furthermore, participants stated that in order to find out information about off installation services the website was time consuming, overwhelming, and not user friendly. Some participants reported that when they called to find out about off installation services, the first referral source was back to a counseling service provided by the military, which in turn led to the participant not accessing services. Lastly, participants stated that they feared their confidentiality would not be protected and their command would find out they were accessing mental health counseling services.

I mean if you want to know something about a car wash, a pet spa, they do everything. They will find it for you, but a lot of times their first referral is right back into the military system. (Service Member Spouse)

Macrosystem Influences

Macrosystem influences included the participant's perception of the military culture and warrior ethos. Identified factors that influenced Service members and Service members spouses seeking mental health counseling services are: 1) length of time Service member has been in military and 2) the changing military culture.

Length of Time in Service

Participants indicated that the length of time the Service member has been in the military impacted their perception of the acceptability of using mental health counseling services. It seems that Service members that began their career during the "warrior mentality" period found it less acceptable to seek mental health counseling services compared to Service members that

began their career during the military's current mentality that suggests it is acceptable and expected that Service members seek mental health counseling services if needed. This became evident when participants stated that "newer" Service members are more likely to seek mental health counseling services since the military is working on changing the culture to encourage Service members to seek support when needed.

... a lot of the newer, younger Marines are, they just have a different mindset where I think it's okay for them to seek help and seek services where I still think you have that older, salty crowd that is of the old mindset where everything is okay, there's nothing wrong with us. They're supposed to be tough, they're supposed to be strong, they're not supposed to admit weakness. (Service Member Spouse)

Participants stated that Service members that have been in the military longer and are a higher rank are worried about loss of respect from Service members of a lower rank if they seek support services. Participants stated that "warrior ethos" (e.g., defined as a sacred trust built between Service members in a unit where each member is expected to be strong and courageous in order to remain composed through chaos and disorder (Coker, 2007)) impacted their willingness to seek support services due to being trained to be mentally tough and strong, to handle issues on their own, and that seeking support is seen as a sign of weakness.

What prevented me from coming in for a while was that stigma that, okay, you're a Navy leader, you're in a certain position. It's almost like it's a sign of weakness when it shouldn't be or it's like now there's a perceived chink in your armor. So, everybody you're competing against now has either something on you or a leg up on you that they can, you know, use to jockey for position or whatever to, you know, sway the balance of you or them being in charge or you or them being selected for something there's always the thought of that that would be used against you. Well, he went to, you know, counseling. What if we put him in charge here, and he has a meltdown or a flashback or, you know, crazy thoughts that they think about? (Service Member)

Moreover, participants expressed that spouses of Services members of a higher rank and have been in the military for a longer period of time feel they cannot access support services because this could negatively impact their spouse Service member's career.

... that stigma of using any program even as a spouse of a senior NCO officer is very detrimental even to your spouse's career, you know, if I use the service. So that also prevents a lot of people from it. (Service Member Spouse)

Military Culture

Participants also discussed how the changing military culture encourages Service members as well as spouses of Service members to seek mental health counseling services. Participants said that the change in military culture supports Service members to immediately take care of mental health issues instead of ignoring the issues and allowing them to negatively impact their work.

I do see it slightly changing just because of the new Navy where the Navy is there now they want you to get the help because you could get back on track versus getting off, so off track that it's too late. So, the Navy is shifting to where it's not going to be frowned upon if you go and get that access. (Service Member)

Summary

Based on this proposed model, it is apparent that Service members and spouses of Service members' service seeking behaviors with mental health counseling services are affected by multiple influences. Through this analysis it became evident that in order to capture and understand participant's meaning making regarding their beliefs about mental health counseling services, and in turn their behavior regarding whether services were sought, each level of the model needed to be considered.

Discussion

Proposed Model

The proposed model presented in this paper explores the interactions of multiple contextual levels illustrating Service members and spouses of Service members' service seeking behaviors with mental health counseling services. During data analysis, it became evident that beliefs about mental health counseling services drive behavior and the participant's beliefs were impacted by various conditions. This model illustrates the factors influencing the process by which decisions are made and these decisions seem to be reflected in the meaning the Services members and Service member's spouses make about the factors that are present in each level of the model. This model is multi-systemic in that the behaviors of the Services members and spouses of Service members cannot be understood by solely looking at one level of the model because multiple factors impact one's beliefs and decisions about mental health counseling services. From an ecological perspective, it appears that certain factors at each level support Service members and spouses of Service members to seek mental health counseling services whereas other factors inhibit Service members and spouses of Service members to seek mental health counseling services.

Existing Literature and Proposed Model

The existing literature examined the utilization of mental health counseling services by Service members linearly and did not entertain the idea of multiple factors impacting the utilization of these services. The importance of exploring more than one factor in determining Service member's utilization of services was underscored by Sareen et al.'s (2007) finding that 82.6% of the participants chose "other" as a perceived barrier to care.

Many of the results reported in the current study were consistent with the existing research; however, the existing quantitative research limited the Service member's response options regarding mental health counseling services and thus was not representative of their full experience. For example, numerous quantitative studies indicated that Service members did not access mental health counseling services due to one specific reason, such as stigma, lack of confidentiality, or fear that accessing services would affect their career. While all these factors are certainly influential, our proposed model illustrates that these factors only represent part of what is going on for the Services members. For instance, Service members might have a fear of stigma *and* they may also be receiving messages from their commander that it is not okay to seek services, therefore making them less likely to utilize mental health counseling services. On the other hand, Service members could have a fear that their confidentiality will not be protected, but willingly seek mental health counseling services due to knowing another Service member that had a great experience seeking services. These two examples illustrate how it is difficult to say that only one factor impacts Service member's decisions to seek or not seek mental health counseling services.

This current study adds to the existing literature as well since the majority of the previous studies conducted were quantitative. As previously stated, quantitative studies have been conducted on the effects of combat exposure with military Service members, attrition rates of Service members due to mental health issues, utilization rates of mental health services by Service members, and barriers to accessing mental health care for Service members (Hoge et al., 2006; Hoge et al., 2004; Johnson et al., 2007; Milliken et al., 2007; Sareen et al., 2007; Seal et al., 2007); however, these studies limited participant's responses and did not always pinpoint the existing barriers to accessing mental health counseling services for Service members (Sareen et

al., 2007). The results from the current study not only identified factors that both influenced and inhibited Service members to seek mental health counseling services but also presented in-depth explanations for each factor. Through the qualitative design of the study, influences regarding willingness to seek mental health counseling services were explained on multiple levels of the participants' ecological environment.

The present study also adds to the limited research with Service member's spouses since their mental health counseling service seeking behaviors has thus far been understudied (notable exceptions Eaton et al., 2008; Mansfield et al., 2010), and previous research has suggested the importance of including Service member spouses in future research studies. Studies suggested that spouses play an important role in influencing close family member's treatment seeking and treatment compliance as well as reenlistment. The results of the present study indicated that spouses play an essential role in the decision making process for Service members to seek mental health counseling services. This finding is consistent with the previous literature (e.g., Pescosolido & Boyer, 1999); however, the results elaborate on the spouses' experiences and the struggles they faced to get their Service member spouse to seek mental health counseling services. It is evident that without the described pressure placed on Service members by their spouses to seek services, the Service member most likely would not have accessed mental health counseling services. Also, the present findings suggest that Service members themselves could be barriers to their spouse seeking mental health counseling services for a variety of reasons ranging from stigma to control issues to the fear that their job status or career would be negatively affected. This finding is a unique contribution to the literature and it further illustrates the difficulty Service member's spouses endure to seek mental health counseling services.

Clinical Implications and Future Research

Researchers may expand on the current study in numerous ways. The qualitative study was conducted as a secondary analysis to the original study that gathered feedback from military families on current educational programs and support services from those who have and have not accessed these services. The purpose of the study was to determine what is and is not working in regards to these services, as well as participant's adjustment to deployment. This secondary analysis has identified preliminary results regarding Service members and spouses of Service member's service seeking behaviors with mental health counseling. A future study that focuses solely on Service members and spouses of Service member's service seeking behaviors with mental health counseling services would be beneficial, especially since the questions in the original study included a wider range of topics. Moreover, since there is limited research with spouses of Service members and mental health counseling services, future studies with this population may expand our understanding of the multiple factors that impact spouses seeking mental health counseling services. It would also be beneficial for future research to be conducted throughout the United States so more than one geographic location is represented in the study. Lastly, in the present study focus groups were held throughout the duty day which made it difficult for Service members to attend. In a future study it would be important to consider holding focus groups both during the day and in the evening so a greater number of Service members could partake in the study.

It is essential for service providers to be aware of the multiple factors that impact Service members and spouses of Service members' service seeking behaviors with mental health counseling services. Service providers need to understand how difficult it is for Service members to seek mental health counseling services. It is imperative for providers to be cognizant of this

sense of vulnerability experienced by the Service members and spouses of Service members and be mindful of their interactions. For example, the providers at the mental health counseling centers need to be warm and welcoming both in person and over the phone and it is crucial that these providers understand the military culture. It is hoped that this information can be used to guide service providers to provide better support to Service members and their spouses and thus improve Service members and Service members spouse's experiences with mental health counseling services.

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Appendix A

Consent Form

OVERVIEW

The Military Family Needs Assessment (MFNA) is being conducted by Virginia Tech. The project is in partnership with CSREES, Families, 4-H, & Nutrition and the Department of Defense, Military Community & Family Policy. The overall goal is to explore your experience with educational programs and support networks for military youth and families.

PURPOSE

We hope to gather feedback from both those who have accessed various educational programs and support services as well as from those who have not. The goal is to hear directly from you about what is working and what is not. This information will help policy makers and service providers deliver programs that are both helpful and accessible. It is hoped that such programs will improve your quality of life and overall adjustment to deployment and reintegration, thus improving overall family and Service member readiness.

PROCESS

You will be asked to participate in a “Listening Session,” with 8-10 others. You will be asked to talk about your experience of any educational programs, support networks and services within the military community. At the end of the session, you will be asked to complete a brief questionnaire about yourself. The Listening Session will run approximately an hour and will be audio-recorded. The questionnaire can be completed within 10 minutes. This is an entirely voluntary study. You may refuse to answer any questions at anytime. You may also choose to end the process altogether with no penalties. The entire process should take no more than 60 minutes.

CONFIDENTIALITY

It is important to know that the audiotape will be transcribed. Your name will be replaced with a code number to protect your identity. The audiotapes will be destroyed. The same code will be given to your questionnaire. Once the information from the questionnaire has been coded, the original questionnaire will be destroyed. Only the researchers will have access to the study information.

[] By initialing this box I indicate that I have been informed about the Military Family Needs Assessment (MFNA). I understand what my participation entails. I consent to taking part in the study as it was described to me by the researcher(s) and as it is presented above.

For more information, please contact Dr. Angela J. Huebner, Associate Professor, Department of Human Development at Virginia Tech at 703-538-9491 or at ahuebner@vt.edu.

Appendix B

Demographic Information

1. Are you the Service Member or spouse?:

Service Member Spouse of Service Member

2. Gender:

Female Male

3. Age: _____

4. Race/Ethnicity:

Caucasian/White

African American

Hispanic

Asian/Pacific Islander

Other (please specify): _____

5. Marital or relationship status:

Single

Living together in committed relationship (not married)

Married

Separated

Divorced (not remarried)

Widowed (not remarried)

6. How many years have you been with your spouse/partner? _____

7. Number of child/children: _____

8. Age of Children: _____

9. Where does your family live?

On installation Off installation Within 30 minute drive of installation

10. Service Member's present pay grade (please check one):

E1-E4 (Junior Enlisted)

E5-E9 (Senior Enlisted)

W1-W5 (Warrant Officer)

O1-O3 (Junior Officer)

O4 or above (Senior Officer)

Don't Know

11. What is your highest level of education?

- Grade school
- Some high school
- High school grad (or GED)
- Trade/vocational school after high school
- Some college
- Completed community college/two-year degree
- Four year college/university graduate
- Graduate school/professional school

12. Military service branch: _____

13. Number of deployments (since 2001): _____

14. Current deployment status:

- Pre-deployment
- Currently deployed
- Post-deployment/Reunion
- Never been deployed

Appendix C

Military Family Needs Assessment

Topic Areas

1. Where do you get information about resources available to support you and your family?
 - a. When you need information or help outside you friends/family, where do you go?
2. What programs/services are you (your spouse; children) currently using? Are they provided by the military? By your community? Online?
 - a. How are these programs/services useful to you and/or your family?
 - b. Which of these programs are more valuable to you and/or your family?
3. What is missing and/or could be improved about these programs/services? From the military? By your community? What barriers exist to accessing resources (either concrete barriers or stigma issues)?
 - a. What needs do you have that are not being met by the military? By your community?
 - b. What, if any, limits your ability to access resources in your community? In the military?
 - c. What could civilian communities do better to support military families?
4. What has been your experience with Military OneSource?
5. What are the challenges that your children face? Are you aware of resources that can help, either in your community or in the military?
6. If you were in charge for a day, what would you do to help military families like yours in terms of programs and services?

Appendix D

IRB Approval Letters



VirginiaTech

Office of Research Compliance
Institutional Review Board
2000 Kraft Drive, Suite 2000 (0497)
Blacksburg, Virginia 24060
540/231-4806 Fax 540/231-0959
e-mail: irb@vt.edu
Website: www.irb.vt.edu

MEMORANDUM

DATE: March 7, 2011

TO: Angela J. Huebner, Molly Brickel

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires October 26, 2013)

PROTOCOL TITLE: Exploring Service Members and Spouses of Service Members Experiences with Mental Health and Counseling Services

IRB NUMBER: 11-234

Effective March 7, 2011, the Virginia Tech IRB Administrator, Carmen T. Green, approved the new protocol for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at <http://www.irb.vt.edu/pages/responsibilities.htm> (please review before the commencement of your research).

PROTOCOL INFORMATION:

Approved as: **Expedited, under 45 CFR 46.110 category(ies) 5**

Protocol Approval Date: **3/7/2011**

Protocol Expiration Date: **3/6/2012**

Continuing Review Due Date*: **2/21/2012**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals / work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

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VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

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MEMORANDUM

DATE: February 8, 2012

TO: Angela J. Huebner, Molly Brickel

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires May 31, 2014)

PROTOCOL TITLE: Exploring Service Members and Spouses of Service Members Experiences with Mental Health and Counseling Services

IRB NUMBER: 11-234

Effective March 7, 2012, the Virginia Tech IRB Chair, Dr. David M. Moore, approved the continuation request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at <http://www.irb.vt.edu/pages/responsibilities.htm> (please review before the commencement of your research).

PROTOCOL INFORMATION:

Approved as: **Expedited, under 45 CFR 46.110 category(ies) 5**

Protocol Approval Date: **3/7/2012 (protocol's initial approval date: 3/7/2011)**

Protocol Expiration Date: **3/6/2013**

Continuing Review Due Date*: **2/20/2013**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals / work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

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