CHAPTER 3

Family Impact of Military Mental Health Stigma

A Narrative Ethical Analysis

Susanne W. Gibbons and Edmund (Randy) Howe

ABSTRACT

Our past lessons from war trauma have taught us that mental health-care stigma and other issues surrounding mental health-seeking behaviors can negatively impact the healing trajectory and long-term function for service members and their families. It can take years to decades before a service member seeks professional help for psychological distress, if he or she seeks it at all. Unfortunately, signs of personal and family problems can be subtle, and consequences, such as suicide, tragic. In this chapter, we consider the story one military health-care provider submitted in response to a study solicitation that read: *Please provide your personal story telling me about any psychological distress you may have experienced after returning from deployment and your personal challenges accessing care and/or remaining in treatment.* This story is analyzed to explore the moral implications of his experience for the military and for other service members. The main points to be highlighted are that altruism can leave altruists more vulnerable, military mental health stigma may exacerbate this risk, and military families may profoundly be affected.

INTRODUCTION

Health-care providers may have trouble finding the right words when patients are hurting. In these situations, when there are no words, silence may be better than speaking. Considering the problems health-care providers have at times when addressing their patient's distress, we wonder how difficult it might be for them to reveal their own pain and suffering. For military health-care providers who experience the horrors of war and often suffer quietly, remaining silent might be preferable to facing real or perceived mental health stigma from acknowledging they have a problem and seeking help. Perhaps this type of silence is a testimony to the culture they are a part of and the bond they share that comes about from the military brotherhood and the mission. This might explain why only one military health-care provider submitted a narrative in response to a study solicitation that read: *Please provide your personal story telling me about any psychological distress you may have experienced after returning from deployment and your personal challenges accessing care and/or remaining in treatment.*

The goal of this chapter is to use narrative ethical analysis, which is to interpret and gain insight from the story of this one participant who had the courage to reveal what was for him almost too awful for words; to compel, involve, and teach us about life as a health-care provider in the armed services; and to consider how the military health system might better meet the needs of all service members. Although one case study is useful from a pedagogical standpoint, it is not generalizable. Yet the lessons included in this manuscript may still be immensely valuable. Individuals in similar circumstances, facing similar challenges, may be able to apply some of the lessons learned. We begin by describing how the military is addressing mental health stigma and barriers to care, by presenting background on military mental health stigma and the impact of recent conflicts on military members and their families to develop the context for the analysis. Then, the research study design and methods are briefly described. After that, the narrative of one participant is presented, highlighting themes from his experiences using hermeneutic phenomenology, which means to contextually interpret the hidden and explicit meanings behind his story (Moustakas, 1994; Van Manen, 1990). The moral implications of the participant's actions and perceptions are also addressed. The main points that are highlighted are that altruism can leave altruists more vulnerable, military mental health stigma may exacerbate this risk, and military families may be profoundly affected.

BACKGROUND ON MILITARY MENTAL HEALTH-CARE STIGMA AND PERCEIVED BARRIERS TO CARE

Mental health stigma is of particular concern to the military because, together, individual and social stigmatizing beliefs and behaviors influence service members' willingness to seek professional help (Mojtabai, 2010; Vogel, Wade, &

Haake, 2006; Vogt, 2011). These stigmatizing beliefs can be adopted in a couple of ways. Individuals can enter the military with these beliefs or acquire them from the organization. Service members in need of mental health care can hopefully depend on support from family, friends, and leadership to guide them toward care that is accessible and affordable and offers the necessary privacy (Britt, Wright, & Moore, 2012; Warner, Appenzeller, Mullen, Warner, & Grieger, 2008; Wright et al., 2009). Privacy is often not guaranteed in the military because of mission needs. Those with mental health symptoms, who are most at risk, present the greatest concern since they are more likely to fail to seek treatment (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Visco, 2009). In recent years, the military services have focused on dispelling the “myth” that a mental health problem means “weakness” and have encouraged service members to openly acknowledge the need for help so that service members look after one another (Gibbons, Migliore, Greiner, Convoy, & DeLeon, 2014).

All service members, regardless of occupation, are exposed to a similar set of values that include obedience; service; mission first; and never failing, quitting, or leaving another service member behind (Defense Health Board, 2015; Rondeau, 2011). Military health-care providers experience psychological problems similar to those seen in combat troops where stress, emotional instability, and family conflict are prominent upon return home (Jones et al., 2008; Kolkow, Spira, Morse, & Grieger, 2007; Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2009; Smith et al., 2008, Thomas et al., 2010). Even though over 75% of combat veterans recognize these problems, only 40% are interested in receiving help (Brown, Creel, Engel, Herrell, & Hoge, 2011). If not treated early, when treatment is necessary, significant posttraumatic stress symptomatology, poorer psychosocial functioning, and other psychological disorders can persist chronically or surface years later, resulting in long-term psychological distress (Gibbons, Hickling, & Watts, 2012; Kulka et al., 1990). It can take years to decades before a service member seeks professional help for psychological distress, if he or she seeks it at all. Our past lessons from war trauma have taught us that mental health-care stigma and other issues surrounding mental health-seeking behaviors can also negatively impact the healing trajectory and long-term function for service members and their families. Even if service members can get better over time, which many do, early intervention can profoundly help their families. An example that follows most sadly makes this point.

Unfortunately, signs of family problems can be subtle, and consequences, such as suicide, tragic (Nock et al., 2014; Sareen, 2014). Furthermore, the lives of military children are intertwined with those of their parents to such an extent that it is believed that health risks for these children often reflect those of their families (Cozza, 2015). Even though the literature has predominantly focused on

service members, concern also has been raised that mental health problems are not adequately treated among military family members (Chandra et al., 2010; Lester et al., 2013). In the general community, there is evidence that adolescents, in particular, underutilize mental health services because of stigma, concerns about confidentiality, lack of accessibility, and because of the preference to rely on themselves only (Gulliver, Griffiths, & Christensen, 2010). The exaggerated belief that one must be self-reliant in all circumstances might also be more pronounced among military families, than others with teenagers, where a strong desire to solve problems without outside support is a point of exceptional pride, and thus in this context, seeking help is a hurdle to overcome (Becker, Swenson, Esposito-Smythers, Cataldo, & Spirito, 2014). A further contributory factor to these obstacles is cultural indoctrination that occurs in the military. Military members and their families experience a system of spoken and written beliefs, values, language, manners, customs, courtesies, traditions, and expected behaviors that shape who they are and how they handle themselves (Hall, 2011).

The maladaptive goal of always being self-reliant, and never owning up to a feeling such as fear, might be best understood through the following narrative account of one service member's experience of mental health stigma and access to care, seen through the eyes of an altruistic military physician who ignored his own needs. His story is marked by personal tragedy and by what the ancient Greeks referred to as *peripeteia*, the sudden change of fortune from good to bad and a turning point in a person's life (Bruner, 1990; Bury, 1982).

THE STUDY

The story for this analysis is from a study with the overarching goal of better understanding barriers to care experienced by military health-care providers. Narrative stories are representations of events and experiences, communicated by the teller, that reflect the narrator's culture, institutions, and political environments (Reissman, 2008). While these stories can serve many purposes, in this study, the written narratives of military health-care providers were bound around a single concept—military mental health stigma and perceived access to care—to better understand how these individuals may perceive or misperceive their past experiences, understand or misunderstand what these mean, and how they came about. This study was approved by the Uniformed Services University of the Health Sciences Institutional Review Board. Solicitations were through social networking sites, list serves for communities of service members, and pro bono mental health-care providers. Consent to publish ideas and verbatim segments of the narrative without participants' name or other identifying information was obtained through written consent. The military health-care providers invited to

participate were asked to e-mail their narratives directly to the principal investigator. The narrative of one service member is presented in the next section. While reading and considering the story and the researcher's interpretations, the reader is encouraged to make his or her own additional interpretations of what may underlie this writer's narrative, but not be explicitly expressed, in trying to capture and infer some of the most significant underlying considerations (Van Manen, 1990).

NARRATIVE

I deployed to Saudi and Bosnia without hesitation early in my career. I knew deploying was part of being a soldier physician but was not prepared for the effects on myself and my family. I observed inequities in poor leadership support of our troops, lack of continuity in medical care from Garrison to Overseas and back, and unwillingness of Unit and Medical Commands to involve families in soldier mental health evaluation and treatment. My eyes were opened to what our troops and their families were going through; I decided they deserved better advocacy and stayed on active duty rather than join a civilian practice after seven years. I saw career soldiers with destroyed joints and spines still soldiering on, waiting until retirement to begin taking care of their health. They truly sacrificed all for the Army and their careers. When they suffered from what they witnessed while deployed, we sent them "to the rear," and administratively discharged them. Returning from deployment, I found my family had endured injuries and my relationship with my boys was changed, more distant. Events had occurred needing a husband and father for best resolution, and I wasn't there. In Bosnia, I witnessed families who had been torn apart by war, women and children in refugee camps devoid of males, as they had been killed en masse. All of this, unbeknownst to me, was taking a great toll on my own psyche over the years. I internalized all I saw and worked harder and harder to reverse it, to prevent it, by advocating intensely for Soldiers, Airmen, Sailors, Marines, and Coasties and their Families. I, and my fellow care givers, could not see the toll it was exacting on myself and my family members. Especially, with the Medical Corps, we do not follow the mantra, "Physician, heal thyself."

Ironically, and sadly, as my 20th year approached, while in my first Medical Command, at the pinnacle of my career, my youngest son succumbed to suicide days after being seen in one of our military clinics for depression, anxiety, and suicidal ideation. He was turned away with an inadequate standard of care, given an antidepressant but not allowed to see mental health providers as "We only have enough for Active Duty, not family members." He left the clinic and immediately began plans for death by shotgun to the heart 14 days later. As I sought to

explore and identify what happened, why we didn't respond when he came to us for help "one last time," I began to see why we've been so ineffective in dealing with suicide, posttraumatic stress disorder (PTSD), and mental health evaluation and treatment for troops and family members over the past 20 years. The more I spoke out in alarm, the more I was ostracized and alienated. Being patronized (ironically), downplaying my concerns, was bringing out PTSD I had harbored for 20 years, unrecognized and untreated. I realized I, too, was in denial all this time, not able to deal with my stress and anxiety, especially regarding ability to effectively advocate for Service Members and Families.

I began to think of suicide myself. I asked for help and saw military mental health personnel (psychologist and psychiatrist). They responded automatically, ironically, with anti-depressants, before a true evaluation was complete, just as happened with my son. While I was able to access mental health consultants, being Active Duty, sadly, these sessions were ineffective where real issues were ignored. After six months I realized I was unable to get effective care from within the military system. The culture of the military makes us ineffective and reluctant to address deep-seated issues causing PTSD. They were unable to assist me in identifying long-term stress while advocating for military families against all odds throughout my life and career. Fears I lived with while deployed, carrying a 9-mm pistol, gas mask, and wearing Kevlar, even though I'd not been in live-fire combat, were unresolved and contributing to continued intensity and drive, taking its toll. I recognized my inability to receive help from within the system, so sought mental health care outside the Tricare Network. I found a civilian psychologist who specialized in men's grief therapy, but who didn't take Tricare, a "non-Network Provider." The request to be referred out was denied, despite being written by my Primary Care Manager Provider who agreed therapy from within was ineffective. I appealed, reminding decision makers adequate care for me was unavailable within the military Tricare sphere, and was finally allowed to see this person. Work with him was transformational and allowed me to begin to see the chronic stress I'd developed over my career, both while deployed and while back in Garrison supporting those deployed, especially during Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). (I volunteered to deploy but was in high-level positions disallowing deployment.)

The suicide of my son at 20 years of age while in the hands of the very health-care system I was part of exponentially deepened and drew out my PTSD. I realized it was time for me to separate from the military if I was to address my conditions in a timely manner. The Veterans Administration (VA) separation psych evaluation confirmed chronic PTSD from intense anxiety and passionate advocacy for military Service Members and their Families, as well as my fellow medical employees, exponentially heightened with the recent traumatic suicide

of my son. The Retirement VA Claim indicates moderate PTSD with disability. I continue to work on depression, PTSD, guilt, and anxiety through various modalities as a retiree.

HERMENEUTIC PHENOMENOLOGY: INTERPRETATION OF THE MEMORY OF LIVED EXPERIENCE

Stories such as this one express the perception of the narrator who in this case is the actor in his own story. He involves us personally by revealing private and sensitive details of his life, deepening our ability to try to make additional interpretive sense out of what we read. Through the narrator's self-reflection, the story acquires hermeneutic significance as he goes beyond simple description when he attaches meanings to people, actions, events, and objects (Van Manen, 1990). This is like phenomenology in that it seeks to capture the essence of a person's subjective experience but is hermeneutic because it allows one to imagine multiple meanings in light of current history and context contributing to these perspectives. Through this exceptional explanatory endeavor, the narrator carefully and skillfully crafts his story to share events in his life, and we use this technique so that we can better understand his personal experience with military mental health stigma and trouble accessing and remaining in mental health care.

As a phenomenologic research method oriented to a more subtle study of the intentions and latent meanings and driving factors behind what people perceive, this is a process that allows us to look behind appearances or "the told" so that the narrator's intention and meaning is more fully understood (Moustakas, 1994). The hermeneutic goal is to understand the author better than the author may understand himself. This is a cyclical process for the researcher who reads the texts, writes reflectively, and interprets and then does this again, until all possibilities have been fully considered. For the reader, who in this case is a dialogic partner by virtue of listening and thinking about the story, hermeneutics happens when we find ourselves in the world, along with the narrator and his story, trying to use our own intuition to understand (Malpas, 2014). Through this reflective process, the researcher analyzes underlying conditions, historical events, and other details and nuances of phenomena to go beyond the pure description of experience. The hermeneutic assumption is that we can never know exact meaning since all we have is interpretation, but we can create meaning and possibly a deeper sense of understanding.

According to Brody and Clark (2014), narrative ethics is inherently hermeneutic. Similar to phenomenologic interpretation where there is an attempt to get beneath the surface subjective experience, the researcher goes through a process of listening to what the text is saying. The researcher frees himself/herself

of fixed perspectives so that new questions can be asked and a new gestalt is possible. The interpretive process is existential phenomenology in that the analyst sees the phenomena through a particular lens that embraces the view that being human involves shared feelings and responses, which includes being responsive to others. Narrative ethical analysis is dialogical, accepting and imagining multiple points of view, and considering how these are acted out and responded to, the whole time recognizing the narrator's basic good intentions (Frank, 2014). The ultimate goal of this is to discern what we can do better. Thus in the ethical analysis that follows, we are also interpreting segments of the narrative from an ethical perspective because the narrator has convinced us that despite his best effort to do the right thing for himself and others, something got in the way.

ETHICAL ANALYSIS OF NARRATIVE

This story of sacrifice, advocacy, biographical disruption, and transformation is written in a way that allows us to appreciate the particular life of a "soldier physician" while illuminating the universal experience of life's unintended tragedy. The story helps generate new understanding and start dialogues—particularly with regard to care for self, care for family, and care for country in the context and value system associated with being a service member (Frank, 2014). The military health-care provider's story is resequenced so that we can appreciate how his altruistic journey led to his vulnerability. First, he speaks of a health-care provider's role and responsibility in the military as a noncombatant who wore Kevlar, carried a 9-millimeter pistol and a gas mask, and although he was never involved in live fire, still experienced fear. Then, he describes the physical distance caused by deployment as an expected part of his job, and he acknowledges not being prepared for the emotional impact on his family and the changed relationships with his wife and his sons, who were emotionally distant when he returned home. Finally, he portrays his participation in military missions and commitment to the armed service members and to his country, but admits to being unaware of "the toll it was exacting on" him and on his fellow caregivers who served beside him. He tells us that in the Medical Corps, they do not follow the mantra "physician heal thyself." Through the first section of his narrative account, we sense the ambivalence he must have felt over where to place his allegiance since he clearly wanted to do the right thing, but as is often the case when considering ethical implications, his moral decision making at earlier points in his life, to remain in the military and to advocate for fellow service members and their families led to "trouble"—a complicating factor in the story (Bruner, 1990).

Virtue Ethics: Good Character

Our physician narrator sought to do the responsible and right thing for those he served. As a moral agent, he exemplifies goodness of character. His story describes a virtuous person who has lived his life in a way that contributes to the good of others. People are drawn to medicine, nursing, and other helping professions because the practice contributes to individual as well as the greater societal good (Grace, 2014). In the military, people self-select by joining and serving their country, and then often and when possible, they further self-select their occupation. For this military health-care provider, the self-selection process came at a price. Despite the best intentions, even virtuous individuals who live life in a way that contributes to the good of others can get lost along the way because some choices have risks that might lead to sadness, helplessness, and even tragedy as seen in this case (Frank, 2014). Helping others carries its own risk and also sometimes serves as a defense mechanism that obscures an individual's ability to see his or her own need for help.

Narrative Analysis: How Not Why

To interpret and understand the meaning of choices and decisions made by our military physician narrator, we need to see what Montello (2014) refers to as the “topography” or structure of what was important to him, his “mattering map.” The structure of this narrative can be understood by considering several key pieces. First, the analyst determines the prominent voice and central character, which involves identifying whose perspective is presented, what is presented, and how this is accomplished. Then, the plot or circumstances that led to writing the story are considered. Finally, a possible or actual resolution to the problem faced by the main character in the story is addressed. By providing this type of structure, it is easier to illuminate details and seemingly trivial aspects within the narration and gain greater insight into the author's intent.

First: Who Is Speaking? Learning by Being a Soldier

The military physician who narrates is at the center of the story. He shares an insider's perspective on deployment and on leadership inequities, with regard to how service members with physical and mental health issues are handled. He offers his perspective on the suffering of service members and the effect on their families and also the suffering of people living in the war-torn countries where he served. He chose not to “join a civilian practice after seven years,” but instead “soldiered on” to intensely advocate for “Soldiers, Airmen, Sailors, Marines, and [Coast Guard personnel] and their Families.” His perspective is

one of self-sacrifice and altruism; however, this sacrifice made him vulnerable, increasing his risk for developing mental health problems and negatively impacting his role as a father and husband.

We learn a lot about the narrator's mattering map when he speaks of his recently deceased son, another character in the story. We wonder what his son would have said about his father's occupation, the military culture, and whether or not these elements in the story influenced the son's emotional distress and his not seeking help. It is unclear who did not respond "one last time" when his son "came to [us] for help." As he wrote this, it is unclear whether he is referring to himself or to others. We imagine that his son perhaps came with a veiled or indirect plea for help—to the physician narrator, his wife, or other family members—or sought informal help from the broader community, of which he was also a part. This last highly speculative point illustrates this hermeneutic phenomenologic approach of seeking to illustrate hidden realities for our understanding. If the narrator was referring to himself as the one who did not respond, he might be at risk for profound survival guilt and is perhaps attempting to deflect or dilute the unbearable self-blame. There appear to be other factors contributing to the story, perhaps the broader military family for whom the narrator physician sacrificed his mental health, being pushed to the brink of what he could take, as he "began to think of suicide [himself]." He says that his own "distress was exponentially heightened" with the suicide of his son.

We recognize the narrator's vulnerability and his central emotion, chronic distress, from decades of advocacy role and military responsibilities. By not addressing his own mental health needs and by not being present for his own family, he finds himself in an extreme state of despair. We feel the unbelievable pain and grief in this narration. If our narrator had cared for himself, would his son have killed himself? We will never know, since all we have is "mimesis" or what we can imagine, and the physician narrator's imagination of how the death of his son was impacted by his military service and then how his son was improperly handled by the military health system who missed the fact that he was suicidal. However, those affected by mental health problems may distort facts, and this may be the case with our physician narrator. Mental illness increases perceptions of stigma and makes it harder for those who really need help to reach out for help, a phenomenon that is not unique to the military, but might be intensified by the military culture (Pietrzak et al., 2009; Visco, 2009).

Second: Feeling the Importance to Share!

Learning by Being a Patient

The story can be interpreted as a part of this physician's healing journey from decades of "anxiety and passionate advocacy for military members and their families" and from resulting distress compounded by the recent traumatic suicide

of his son by “shotgun to the heart.” This sudden tragic event is similar to what Brody has described as a loss that ruptures a person’s life story, and the plea that is heard, “My story is broken, please help me fix it” is reflected in the words of this service member, who sacrificed so much to ensure advocacy for his fellow soldiers (Brody & Clark, 2014). The physician narrator has become one of the service members who “suffered from what they witnessed while deployed . . . [being] ‘sent to the rear,’ and administratively discharged.” Perhaps he is suffering from survivor guilt, that he did not do enough or that he did not recognize the signs in his own son. Because of the devastating loss of his son, everything he had consciously denied, or internalized, all of the unresolved issues “contributing to [his] intensity and drive,” bubbled to the surface. He becomes a patient in the military health system.

As a patient, the narrator says that his eyes were opened to how mental health issues are handled by military mental health-care personnel who he says “responded automatically . . . with [an] anti-depressant” when he experienced thoughts of suicide. We know that this is often a treatment for PTSD but he seems to dismiss this, illustrating the possibility that his own emotional impairment has gotten in the way of his ability to perceive accurately. We listen to his concern that the “culture of the military makes [military health-care providers] ineffective and reluctant to address deep-seated issues causing PTSD” and that this might also be the reason why no one was able to help him see the impact of his “long-term stress while advocating for military families against all odds throughout [his] life and career.” He has insight regarding what went on and how he got to where he is; however, considering from a hermeneutic standpoint, his thinking might reflect a new position, one of distrust and loss of faith in the military health-care system that led to his “inability to receive help from within the system so [he] sought mental health care outside the Tricare Network.” The concurrent magnification of distress and suspicion are possibly symptoms of his current predicament. He is having trouble moving forward with his life. And this may, in part, be a function of his misperceptions, which may include his seeing himself as more blocked or helpless than he truly is.

Third: Resolution—Learning by Being a Casualty

We see him as one of many military members in similar circumstances, enduring hardships as a part of their military duty and accumulating stress in the process. We wonder if his impression of military health care and his interpretation of events surrounding his experience of mental health stigma and accessing and remaining in treatment reflect his deep, raw emotional wound from the suicide of his son, and the temporary inability to get on with his life. Early in

his narrative, he speaks of “career soldiers with destroyed joints and spines still soldiering on, waiting until retirement to begin taking care of their health . . . truly [sacrificing] all for the Army and their careers.” We wonder if this is how many other military members may feel, who respond all too often when called upon, to tend to the needs of others. Perhaps, they slowly become a casualty of the system, during active duty or possibly even after service, since this seems to be how the physician narrator feels his military career evolved. His wounds are not physical, they are emotional. He was at the “pinnacle of his career” when his son committed suicide and then his entire world collapsed.

The narrative reflects the physician’s attempts at restoring integrity and wholeness to his life. He continues in search of resolution since his story has not come to an end, but he is progressing with his life. The meaning and purpose that he seeks is perhaps being found as he “continue(s) to work on depression, PTSD, guilt, and anxiety through various modalities as a retiree.” He continues to search for this through other avenues, including this story, to advocate for military members and their families; however, it is possible that he questions his own efficacy at this point. Perhaps he is in the process of forgiving himself. He seems to recognize the limitations of individuals/patients themselves and of mental health providers within the military health system and the limitations of the system itself. Despite recently instituted peer support programs to empower and sensitize service members to their own mental health needs, our narrator was unable to be effective in this regard (Gibbons et al., 2014). He knows that he was an insider and perhaps also ignored the obvious in his own patients, as he ignored his own needs for decades. Eventually, he will hopefully come to terms with his internal dissonance and conflict about his military career and his son’s suicide in order to find peace. The time has come for him to take care of his own health and well-being.

CONCLUSION

The military physician who provided us with his story had the courage to break the silence in this study about individual and social stigmatizing beliefs and behaviors that are imposed by the self and the organization, and as he believes, may be perpetuated by the very people who are supposed to be eliminating them. He wants us to see the size and complexity of the problem and its reach—not only to soldiers but also to military families and our military-connected youth who are negatively impacted with depression and suicidal ideation (Cederbaum et al., 2014; Mansfield, Kaufman, Engel, & Gaynes, 2011). This physician’s study participation exemplifies moral courage since he stepped outside of the military culture, deliberately and carefully constructing his narrative, to include elements

for us, as dialogical partners, for reflection and action. He is courageous because of his admirable initiative to help others as he continues to advocate for his peers by drawing us into his story. He continues to move forward in his role as advocate, also perhaps as a means to seek resolution, possibly because the meaning and purpose in his life have always been tied to his health-care and military roles.

This interpretive exploration of a single case can be best understood in the current context of military life and operations. The problem may begin at the individual level. The price of altruism combined with culture and stigma is a cost known to many service members but may not be as well recognized by those of us who have not traveled this road. Systems may change, but change is slow. The success of current antistigma campaigns and efforts by military leadership and military health system personnel depend on culture change. This story teaches us that the personal cost of military service can be great, but that systems and individuals should have the capacity to do better. Change is going to take time and, for this reason, we all need to be maximally sensitive to subtle signs of distress and work to improve the lives of service members and their families.

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