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RESEARCH

Veterans' Transition Out of the Military and Knowledge of Mental Health Disorders

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There is a need for research to understand veteran's mental health and how they use resources, like the Veteran's Affairs and non-profit organizations. This study serves to further our understanding about veterans' knowledge on this subject. This study adds to the literature by conducting semi-structured interviews with 15 veterans who had deployed on either United States military bases or ships, or peace-keeping missions, overseas after 9/11. The interviews were audio-recorded, transcribed, and thoroughly analyzed using a narrative approach. Five important themes emerged from the interviews: prevalence of mental health disorders, knowledge of disorders and resources, barriers to seeking help, types of resources available, and motivations to seek help. Although this study aimed to explicitly understand knowledge, the inductive research process produced four other themes that became pivotal in understanding why veterans were skeptical to seek help.

Keywords: Military; Mental Health; Knowledge; Resources; Prevalence; Stigma

Introduction

The last day the United States drafted individuals for military service was January 27, 1973 at the close of the Vietnam War. Since then, men and woman have voluntarily joined our country's military in order to willingly fight and defend the homeland and its citizens from outside invasion and terrorism. Although there can be many different reasons for joining the military, be they patriotic, economic, educational, or personal, it is certain that individuals undergo a major transformation after enlistment, during their service, and upon returning to civilian life. Many make this sacrifice with a sense of pride to protect America's freedoms, but often face substantial challenges and problems when they return to civilian life.

Research suggests that veterans face many problems (e.g., drug and alcohol addiction, entry into jail or prison, trouble finding jobs, homelessness, etc.) that are often tied directly to their service (Beckham, Feldman & Kirb, 1998; Fontana & Rosenheck, 2005; Hoge, Auchterlonie & Milliken, 2006; Teachman, 2007), which leads several members to experience post-traumatic stress disorder (PTSD), but only few end up seeking mental health resources for their care (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004). Although mental health disorders do not only effect service men and women, research indicates that it is extremely prevalent among this population (Helzer, Robins & Envoy, 1987; Hoge et al., 2004). This study will explore three interrelated themes by investigating veterans' 1) perceived knowledge of mental health disorders, 2) awareness of mental health resources, and 3) access to mental health resources upon discharge from the military.

Prior research has explored the extent that mental illnesses afflict our military men and women along with the various treatment resources available (Booth-Kewley, Larson, Highfill-McRoy, Garland & Gaskin, 2010; Bryant, 1979; Freeman & Roca, 2001; Teachman & Tedrow, 2008). However, very little research has been collected to gauge the knowledge of service men and women to notice the signs and symptoms of mental health disorders or whether they are aware of resources they or their friends and family can utilize to get help once the illness is recognized. This study fills a gap in the literature by conducting semi-structured interviews with 15 veterans who had deployed on either United States military bases or ships, or peace-keeping missions, overseas after 9/11 to explore mental health knowledge of resources and barriers related to seeking help for mental health disorders.

Mental health and war

War has played an important role in human society and culture. The use of violence has become a central way to mitigate differences between conflicting nations, cultures,

and groups (i.e., gangs, tribes, etc.), and to deal with corrupt governments. This can be seen in ancient history during Biblical times, among the Romans and Greeks, and many others until present day. Military members who enter these conflicts, regardless of era, are exposed to scenes many civilians will never have to come to terms with.

Because of this, many veterans develop symptoms related to mental illness. Prior to the creation of the Diagnostic and Statistical Manual of Mental Disorders (DSM), doctors were aware of these symptoms although they did not have a medical name for it yet. "Generations before PTSD was diagnosed, doctors used terms such as 'nervous disease' in the medical pension files of veterans" (Pizarro, Silver & Prause, 2006). There is evidence of the toll military service takes on individuals in numerous manuscripts and journals from many wars in history including, but not limited to, the Revolutionary War, the Civil War, and both World Wars.

Some veterans are diagnosed with a single mental illness. However, it is much more likely that they will have co-morbid disorders, meaning more than one, such as depression and anxiety (Helzer, Robins & McEvoy, 1987; Kulka et al., 1990; True, Goldberg & Eisen, 1988). In addition to mental health disorders, veterans may also develop substance abuse disorders resulting in co-occurring mental illness and substance abuse (CMISA). For example, Vietnam veterans were shown to have high rates of both PTSD and addiction to alcohol and drugs (Kulka et al., 1990; McGuire, Rosenheck & Kasprow, 2003; True et al., 1988).

In addition to the impact that mental illnesses and CMISA have on veterans, they can also impact family members. For example, interpersonal violence with significant partners has been documented in elevated rates among Vietnam veterans (Beckham, Feldman & Kirby, 1998; Byrne & Riggs, 1996). Family problems can also contribute to higher levels of homelessness among veterans. Studies have found that homelessness is twice as common among the veteran population than the general population (Cunningham, Henry & Lyons, 2007).

Although awareness for mental health has certainly improved since the Vietnam era, much is still unknown by the population about symptoms and the frequency. This knowledge can be empowering and should be taught to a population such as veterans, where the likelihood of developing mental health disorders is high. This could, potentially, increase their likelihood to seek help, although other barriers may be at work. Numerous veterans enlisted in, and been discharged from, the military during the OIF/OEF era. Even now, there are many service members still stationed overseas. Since 9/11, over 2.77 million service members have been deployed including 590,000 with two deployments and 528,000 service members with three or more deployments (Wenger, O'Connell & Cottrell, 2018). Recent military procedures in Iraq and Afghanistan (OIF/OEF) represent the longest ground combat operations involving American forces since the Vietnam era. Although Vietnam and Korea are thought to be among the bloodiest conflicts for United States military, United States service members who served in the wars in Afghanistan and Iraq faced long and often multiple deployments and a constant risk of injury and death (O'Bryant & Waterhouse, 2008).

Veterans experienced tumultuous environments that can have devastating effects on their psyche. Some were deployed several times. Many are exposed to traumatic injury and experiences, and more of the wounded have survived than any previous era (Kang & Hyams, 2005). Depending on military branch and service job, some experienced high-intensity guerrilla warfare and there was a chronic threat of roadside bombs and improvised explosive devices (IED's) (Friedman, 2005; National Center for Post-Traumatic Stress Disorder (US) & Walter Reed Army Medical Center, 2004). As of September 2019, more than 6,700 personnel have been killed during OIF and OEF, and nearly 53,000 members of the military have been wounded (Congressional Research Services, 2019). Such traumatic experiences not only affect personnel immediately, but can continue to affect them well into their time as veterans.

Just as research suggested negative health outcomes for Vietnam veterans, research conducted within the past 15 years on the conflicts in Iraq and Afghanistan discovered similar findings. Researchers have reported substantial evidence describing negative effects of combat on the mental health of military personnel since 9/11 (Ahern, Worthen, Masters, Lippman, Ozer & Moos, 2015; Isaacson, Weeks, Pasquina, Webster, Beck & Bloebaum, 2010; Seal, Bertenthal, Miner, Sen & Marmar, 2007; Teachman, 2011). The National Defense Council (2009) estimates 25–40 percent of returning veterans have wounds that are less visible such as mental illnesses and traumatic brain injury (TBI). The number of troops suffering from head injuries (i.e., TBI) caused by combat is just as alarming as other disorders like PTSD and anxiety. A recent study found that 20% of infantry troops on the frontline suffered concussions during combat ("Troops risk", 2006). Hoge and colleagues (2008) surveyed army infantry troops finding that 15 percent of the 2,525 experienced TBI symptoms in the three to four months after returning home. TBI has also been known to cause symptoms associated with PTSD and anxiety. These symptoms include loss of consciousness, altered mental state, decreased attention, being less motivated, irritability, depression, anxiety, fatigue, headaches, memory loss or disturbance in memory, disrupted sleep, and behavioral problems (Hoge et al., 2008).

In yet another study, approximately 17% of veterans returning from Iraq were diagnosed with a serious mental disorder, two times higher than pre-deployment levels (Hoge et al., 2004). Results from a study done by Seal et al. (2007) show that 25% of the OIF/OEF veterans studied received at least one mental illness diagnoses. Of those, 44% received one diagnoses, 29% received two diagnoses, and 27% received three or more diagnoses. Of the 102,632 veterans studied, 13% was diagnosed with PTSD, making it the most common mental disorder diagnoses (Seal et al., 2007).

A crucial part of understanding mental health knowledge among veterans is to combat the growing suicide rate. According to Sederer (2011), the suicide rate among veterans is at a three-decade high. This can be the result of both mental health disorders and a need to relieve the pain these disorders cause. A shocking fact is that more people are dying from suicide than combat among the post 9/11 veteran population (Sederer, 2011).

Just like with the Vietnam veterans, these tumultuous environments and ill effects of the mental health, do not only affect veterans. Perhaps because of these traumatic experiences, service men and women have said relationships with family members and friends are often disrupted. This, coupled with changes in character by both the service member and their loved ones, often leads to difficulties when it is time to transition (Hoge, McGurk, Thomas, Cox, Engel, & Castro, 2008; Milliken, Auchterlonie, & Hoge, 2007; Teachman, 2007). In addition to the conflict with family and friends, the symptoms associated with combat-related injuries can also lead to anti-social behavior that can draw the attention of the police (e.g., drug use, increased aggression), and may result in arrest and incarceration upon homecoming (Freeman & Roca, 2001; Lasko, Gurvits, Kuhne, Orr & Pitman, 1999; Sherman, Sautter, Jackson, Lyons & Han, 2006).

Life course perspective

Life Course Perspective and Homecoming Theory are used as theoretical frameworks for this study. The Life Course Perspective focuses on the importance of time, context, process, and meaning on human development and family life (Bengtson & Allen, 1993). The premise for Life Course Perspective focuses on four main areas: trajectories, pathways, transitions, and turning points. Theoretically, an individual has a set trajectory in life, which is determined early in life by several pathways. Pathways are influenced by factors such as parental involvement, social networks, and human agency. Transitions occur when an individual alters the pathway they are on, either by their own choice or outside influence. A *turning point* is defined as a point (i.e., an event or experience) in time, which has the potential to alter a person's current life course trajectory (Bengtson & Allen, 1993).

There is growing evidence that military service is linked to a number of subsequent life course outcomes, including education, income, marital status, and health, making joining the military a turning point (Angrist, 1990, 1998; MacLean & Elder, 2007; Segal & Segal, 2004; Teachman, 2007, 2008, 2010; Whyman et al., 2011; Wilmoth & London, 2013). Reasons for enlisting in the military can vary from one individual to the next. Research suggests that factors such as, "patriotism, propinquity to military installations, family history, and desire for travel and adventure" influence the decision to join the military (Eighmey, 2006; Elder et al., 2010; Kleykamp, 2006; Woodruff et al., 2006). Whatever the reason for enlistment, there is no denying entrance into the military affects a person's future (e.g., their trajectory).

The reason military involvement is considered such a crucial turning point is explained through research. Much of it suggests that the military is a unique institution that provides individuals with a range of opportunities that are not normally available in a civilian environment. First, the military provides stable employment opportunities and good benefits for young people that are hard to rival (Teachman & Tedrow, 2014). Second, the military provides young recruits with a structured, disciplined lifestyle and a source of self-esteem and pride (Eighmey, 2006). Bryant (1979) argued, "rigid norms and severe sanctions are dually necessary for members of the military to do things they would not otherwise do and to make the military efficient (Stacer & Solinas-Saunders, 2015, pp. 201)." Third, the military offers a sense of social belonging that is not easily attained (Spence et al., 2013). The last component of military life that is difficult to match in a civilian occupation is the opportunity for travel and adventure (Eighmey, 2006; Woodruff et al., 2006).

An argument can be made for the military acting as a positive turning point. This argument is focused on criminal desistance in delinquent youth. It thus appears that successful cessation from crime occurs when proximate causes of crime are affected. According to Caspi and Moffit (1995), a central component in the desistance process is the "knifing off" (i.e., the removal) of individual delinquents from their immediate environment and creating a potentially new future. "Institutions like the military have this knifing-off potential, as does marriage, although the knifing-off effect of marriage may not be as dramatic" (Laub & Sampson, 2001, pp. 49). Although entering the military may result in criminal desistance for youth, it may serve as a negative turning point upon departure from the military.

Fontana and Rosenheck (2005) found that "pre-military experiences and behavior exert the largest effects on post-military antisocial behavior (pp. 208)." Still more studies allude to these pre-existing risk factors (i.e., early anti-social behavior and social adversity) which can ultimately affect a veteran's likelihood to become violent (Teachman & Tedrow, 2014; Spence et al., 2013; Bryant, 1979). Although evidence supports the connection between pre-existing risk factors and experiences to post-military anti-social behavior and violence, the experiences and traumas experienced while in service can have devastating effects, which can follow veterans for their whole lives, beyond their active time in the military. Mental health disorders and symptoms after deployment, such as PTSD, alcohol and drug misuse, and lack of anger management are often cited as potential facilitators of the link between combat experience and subsequent violence (Eighmey, 2006; Woodruff et al., 2006; Bengtson & Allen, 1993; MacLean & Elder, 2007; Angrist, 1990). Some recent research has even suggested that trauma and combat exposure, coupled with PTSD symptoms, substance abuse, and post deployment adjustment problems, may increase the likelihood of incarceration for veterans (e.g., supportive of the Violent Veteran Model; McGuire et al., 2003; Saxon et al., 2001; Yager, Laufer, & Gallops, 1984).

Ultimately, the link between military service, combat-related mental health problems (particularly PTSD) and involvement in the criminal justice system remains uncertain, as it appears that other risky behavior, such as drug and alcohol abuse, likely plays an important role (White, Mulvey, Fox & Choate, 2012). However, an argument can be made that entry into, and exit from, the military can ultimately effect a person's future, sometimes for the better, and other times, for the worse.

Homecoming theory

Since 2011 the Iraq war has come to an end and the US military presence overseas has been decreasing. More veterans than ever are transitioning back into civilian life and it is crucial to understand and encourage a healthy homecoming transition (Ahern, Worthen, Masters, Lippman, Ozer & Moos, 2015). Homecoming theory was developed after World War II and identifies the challenges retiring veterans face when transitioning from military service. Schuetz (1945) claims that the premise for homecoming theory revolves around an individual (in this case, a service member) who is separated from his or her social network by both time and space. Both the service member and those in his or her social network experience varying situations while separated from each other. These unique experiences alter both the military member and the members of his or her social network, which creates a sense of unfamiliarity between both parties upon return by the service member. This unfamiliarity produces shock and rough waters during homecoming, which makes re-establishing connections difficult on both sides.

The separation between family and service members upon enlistment has unmeasurable consequences on mental health, especially during the transition back to civilian life. A related study found that many veterans who showed no signs of mental health disorder symptoms immediately after their return from service were diagnosed with a mental disorder upon rescreening some months later (Milliken, Auchterlonie & Hoge, 2007). There is evidence that veterans from preceding wars who had complications in the switch to civilian life faced increased risk of long-term problems that include homelessness and early mortality (Mares & Rosenheck, 2004; Boscarino, 2006; Schinka, Schinka, Casey, Kasprow & Bossarte, 2012), indicating that these transition problems are a long-term concern. Recent studies estimate that up to 40% of returning service members are in need of treatment for mental health issues (Department of Defense Task Force on Mental Health, 2007), and that many suffer co-occurring disorders (Seal, Bertenthal, Miner, Sen & Marmar, 2007).

Given the substantial burden of health problems (both physical and mental) in recent Afghanistan and Iraq veterans, the potential for long-term impacts is worrisome and support for the transition process is necessary. While research indicates that a successful transition is critical for veterans' long-term well-being, the nature of the transition experience and readjustment needs have not been examined in-depth among Afghanistan and Iraq veterans.

Integrated behavior model

Using an inductive approach, the Integrated Behavior Model (IBM) began to shape the topics expressed in the interviews. IBM describes five determinants for behavior. A person must be motivated and have knowledge to perform a behavior, and the behavior must be important to the individual. If the first three determinants are met, social norms must align with the behavior and there must be minimal barriers in place making the behavior easy to perform. The last determinant conveys that a behavior will become habitual if the individual carries it out multiple times, reducing the importance for motivation as the first determinant (Montano & Kasprzyk, 2015).

The authors anticipated that the themes and concepts put forth in the Life Course Perspective, Homecoming Theory, and Integrated Behavioral Model would be reiterated during the interviews conducted for this research study. In accordance with the Life Course Perspective it is hypothesized that respondents will emphasize the effect separation from the military has on their life. Additionally, it is predicted that Homecoming Theory will explain the change a service member experienced while active in the military and how that affected his or her transition to the civilian world. Furthermore, through the inductive process, Integrated Behavioral Model became relevant to understand the themes of knowledge, barriers/social norms, and motivations.

Methods

Recruitment and ethics

The participants in this study were recruited, in partnership with Upstate Warrior Solutions (UWS), Clemson University Veteran Center, and Clemson Paralympic Soccer. Information about the study was circulated on social media, and a flyer was distributed on Clemson University's campus. The three recruitment partners agreed to assist in recruitment by locating and contacting potential participants. They sent contact information of all interested potential participants. Potential participants were contacted by phone and read a verbal recruitment script, which was approved by the University's Institutional Review Board (IRB).

Summary of qualitative method

In-depth semi-structured interviews were the primary method of data collection. This methodology was employed due to the sensitive nature of researching mental illness, especially within veteran populations. This technique has shown significant gains when researching sensitive subjects with less than willing populations (McNamara, 1999). Although survey methods can be employed to research sensitive topics, in-depth interviews are able to reach a deeper understanding of information put forth by participants. Confidential interviews were conducted over several months at UWS. In the event participants could not meet in-person, a telephone interview was offered.

A guided interview instrument was developed with input from UWS. This guide was structured into five sub-sections: 1) background in the military, 2) knowledge of mental

health disorders, 3) knowledge of mental health resources prior to enlistment, during enlistment, and after discharge, 4) personal experience with mental health disorders and resources, and 5) demographics. These questions and categories were designed to explore the three main key themes of this research project: 1) knowledge of mental health disorders, 2) awareness of mental health resources, and 3) access to mental health resources upon discharge from the military.

Questions regarding respondent's background in the military asked about the state of enlistment, length of service, length since separation from the military, whether the participant deployed, and if so, where, as well as whether he or she saw combat during their service. The next section, knowledge of mental health disorders, included questions that gauged the participants' perception about receiving help while in the military (e.g. any barriers), their knowledge about specific disorders (i.e., PTSD, anxiety, depression, etc.), and their ability to notice mental disorders in themselves or others. The third section explored the participants' knowledge of resources by directly asking if they knew of any resources or resource centers before they joined the military, during their service, and after they were discharged. The brief section on a participant's personal experience asked them if they have been diagnosed with a mental health disorder, and whether they received treatment and why. The final section included demographic questions regarding age, gender, ethnicity, marital status, student status, religion, and income.

The interview guide was utilized to keep conversations on topic and maintain a logical flow, but participants were encouraged to complete their thoughts, give examples, and further elaborate before moving to the next question. Several unguided follow-up questions and probes were asked dependent on participant's responses. However, to ensure confidentiality, no identifying information (i.e., names and unique numbers, dates, or geographic identifiers below the state level) was collected using the Safe Harbor method (El Emam, 2011). During the interviews, hand written notes were taken and audio recording devices were utilized to analyze participant answers. Once the interviews were completed the interviews were transcribed verbatim.

Upon review of the interviews, key themes and characteristics mentioned in each session were noted. A color-coded guide was created to identify and analyze common themes throughout the participant interviews. Employing a narrative approach, the stories told by interview participants were utilized to provide insights about lived experiences. In the analytic process, main narrative themes were generated through the accounts participants gave about their lives. With these themes, the goal was to create a better understanding of veteran knowledge and experiences as they relate to mental health.

Sample characteristics

Sixteen participants were recruited for the study, but one was excluded for not fitting the inclusion criteria; therefore, 15 interviews were utilized in the analysis. The sample included respondents of diverse military backgrounds (see **Table 1** – Sample Characteristics). Participants in the sample served in the Navy, the Marines, the Army, the Army Reserves, the National Guard, and the Air Force. Each enlisted in the states in which they lived, which included South Carolina, Florida, Mississippi, Michigan, Illinois, Arkansas, New York, Pennsylvania, Tennessee, and Minnesota, and the majority currently resides in South Carolina. The average number of years the participants served was nine years and eight months with the shortest time being three years, and the longest time being 20 years. The average amount of time since their separation from the military was three years and eleven months. Their military grades varied from E4 to E7, and the military rank varies by branch. All participants had a family history of service within the military, although some weren't within two generations; however, some had fathers, brothers, and sisters who enlisted. All participants did deploy during their service, although the locations varied, as well as the amount of combat experienced first-hand.

The average age for the sample was 32.6 years, with the youngest being 25 and the oldest being 48. All participants reported being Caucasian, although one did identify with a Hispanic ethnicity. An overwhelming majority of participants within this study were male and college students, while only 13% (2 out of 15) were female and 20% (3 out of 15) were non-students. Of the participants who were not current college students, the highest level of education attained was a Bachelor's degree. Half of the participants were married.

Table 1: Sample Characteristics.

Age	Gender	Branch	Rank	Years Served	Years Since Separation
32	Male	Navy	E5	6	3
37	Male	Air Force	E4	5.5	6
31	Male	Marines	E4	4	8
43	Male	Army	E7	20	6
38	Male	Air Force	E6	12.5	4.5
30	Male	Air Force	E5	8	2
25	Female	Navy	E4	3	3
48	Male	Marines	E6	18	5
42	Male	National Guard	E6	20	1.7
26	Female	Navy	E4	10	7
33	Male	Marines	E7	4.5	5
32	Male	National Guard	E5	7	3
28	Male	Army	E4	9	4.5
30	Male	Air Force	E6	3	2
35	Male	Army Reserves	E4	12	6

Results

Through the interviews five main themes emerged. The themes included 1) prevalence for mental health disorders, 2) increasing knowledge of disorders and resources once separated from the military, 3) barriers which inhibit access to resources, 4) various types of resources available, and 5) motivations to seek help for mental health disorders.

The first theme that emerged focused on the perceived prevalence of mental health disorders. When asked about the likelihood of developing a mental health disorder upon exiting the military, many of the respondents indicated that the transition process could make the prevalence higher. A 32-year-old male Navy veteran said:

> You might have a difficult time adjusting back, you know, back to the civilian world. I mean, you know, not to say, I don't know, if they'd be like having a mental issue, they could just be having a hard time adjusting and I mean, that could lead you down a road you know, in your head that could go somewhere bad. So, I think that maybe it could be more prevalent after the military.

A second theme that organically emerged from the data revolved around knowledge of mental health disorders and resources that are available. While it is possible for a veteran to be knowledgeable about disorders and not resources, or vice versa, our results indicated a large majority of participants had little to no perceived knowledge about mental health disorders and mental health resources prior to enlistment. Most agreed that, once enlisted in the military, that knowledge increased slightly. Some participants said that they perceived their knowledge as increasing the most upon discharge from the military, mostly in part because of their participation with non-profit organizations and universities. A 30-year-old male Air Force veteran stated: "I've been made more aware since I came to university and the Veterans Association has made me aware of a lot but before that, not really."

The third theme that emerged identified barriers that come into play when veterans want to seek out help. Although there are certainly barriers related to receiving help for mental health disorders for anyone suffering, an argument can be made about the culture of the military and the creation of more barriers for those who have joined the military. The barrier most talked about was the geographical proximity to resources like the Department of Veterans Affairs (VA) or non-profits, and access to quality mental health counselors. A 32-year-old male National Guard veteran stated:

> I mean, I'd like to think it's easy, but you know at the same time I mean I guess it depends on where you live too, I mean there's not really a VA on every corner. I mean, we're lucky to have one [close by] and there's some small places [further away]. If one is disconnected from all that I don't think they would really know about it. It's not as easy as it should be.

A fourth theme dove into the notion that there are varying types of resources available for veterans in the civilian world. While exiting the military, exiting service members had to undergo a Transition Assistance Program (TAP). However, the majority of the curricula for these classes were focused on professional development, not mental health resources. A 28-year-old male Army veteran stated:

> On your way out of the military, you go to classes called TAP. I can't remember what the acronym stands for but everybody getting out of any branch of the military goes to the class and it's kind of a week of them talking about resume building, resources, resources as far as VA healthcare, GI Bill educational benefits. I say it's mainly more targeted for how to apply for jobs and how to convert your skills required in the military to things that private companies would want to hire you for. But it's also, I mean, they spend some time on resources available to you.

After transitioning into the civilian population, veterans have limited options for resources on mental health outside the VA. There was a perceived notion by all participants that the VA is inept in their ability to care for physical ails, let alone mental disorders. This has led to many not utilizing the counselors within the VA system. A 38-year-old male Air Force veteran recounted his struggle:

> I have attempted multiple times in the past to seek assistance. I have an appointment this week. I've had difficult experiences with it. The last time I sought assistance the psychiatrist continued to miss appointments before dumping me as a patient which left me with a little bit of heartburn about seeking assistance, because I could never get someone to sit down and talk with me. Hopefully that will change with this next experience, but again it's the Veteran's Administration. So that's a whole other crazy situation.

The last theme highlighted motivations participants had to seek help. Some had not been diagnosed with a mental illness, but said they felt they would not seek help even if they had been. Others spoke about their families, and felt a push to seek help because they perceived themselves as a threat to their significant others and kids. A 31-year-old male Marine Corps veteran stated:

> "I haven't been diagnosed with a disorder, but I'd be pretty likely to seek help if I was. I've got a couple kids, I don't want to mess them up."

These quotes, along with many other interview answers, showcase many issues related to military veterans seeking help for mental health disorders. While there is extensive research being conducted and resources being put into by the Department of Veteran Affairs and the Department of

Defense (see National Institute of Medicine, 2014; Porter, Bananno, Frasco, Dursa & Boyko, 2017), there needs to be more effort in addressing the extensive cultural, medical, and geographical barriers that keep many from seeking help to live a mentally healthy life after the military.

Discussion

The results presented above have serious implications for the culture of the military and the atmosphere surrounding mental health. Although this study aimed to gauge the knowledge that veterans held in regard to mental health disorders and resources, many other issues influenced the likelihood of service men and women to seek help. Although the United States currently has an all-volunteer military, does not minimize the fact that mental health disorders affect veterans at a much higher rate than many other populations (Helzer, Robins & Envoy, 1987; Hoge et al., 2004). Service members are removed from their social support systems, trained in the most demanding ways imaginable, and transferred to unfamiliar locations far from home. They are required to see and do things many people in the civilian world will never have to do, which takes an unimaginable toll on even the "strongest" in the military.

The training service members undergo before being deployed changes their physical bodies, mental capacity, and emotional state. This practice of rigorous training leaves little room for what they view as weakness, whether it is physical or mental. Some service members who are deployed see their peers, commanders, and friends killed by violent means and those images can haunt and plague them causing irreversible effects to their mental psyche (Killgore, Cotting, Cox, McGurk, Vo, Castro & Hoge, 2008). The need for counseling is essential, although there are many barriers, which stop veterans from seeking help.

Many service members undergo training programs upon separation; however, these programs spend an insufficient amount of time educating individuals on mental health disorders and resources. The participants in this study attributed their increased knowledge to becoming involved in universities and non-profits like UWS. The military spends so much time and effort to change a recruit from a functioning member of society into a warrior, but focuses very few resources on the transition process. One day an individual could be in the middle of a firefight and explosions, and the next they could be sitting in their living room with their kids and wife. The need for a smoother and more complete transition process is necessary to improve service members' perceived capabilities of reintegrating into the civilian world once again.

Veterans have few options to receive help for mental health disorders. The main source of counseling comes from the VA, and many participants suggested there are severe problems related to the caliber of training psychiatrists have when dealing with individuals with a military background. Many of the psychiatrists do not have the same background as their patients, which creates a distrust in the patient that they are not being heard or understood. Also, one participant suggested that counselors do not try to get to the root of the problem, but simply write prescriptions for anxiety or depression without conducting actual counseling sessions. Not only does this effect the occurrence of addiction to drugs and alcohol for veterans, but also creates a significant barrier for seeking help.

An aspect for many individuals that broke down the barriers established for seeking help for mental health disorders was having social support from family and friends. Being able to come home to a strong network of individuals pushing a veteran to receive help seemed to be the main reason many participants believed they would seek help. Having children in the home was the main concern for participants who had been diagnosed with a mental illness and seemed to overcome the barriers expressed above. An implication of military service, however, is a loss of social connection with family and friends. Several participants who were deployed numerous times on lengthy deployments, lost contact with wives, girlfriends, children, and friends. This leaves little for social support upon their transition process, and for many participants affected their willingness to seek help for mental illnesses.

These barriers and lack of support for the transition process calls for policy and cultural changes related to mental health for the military, the VA, and veteran social networks. If the perception of the VA as incompetent could be changed and the social networks for veterans increased, maybe veterans would also be more likely to seek help.

Theoretical implications

Both Life Course Perspective and Homecoming theory can be used to explain the phenomena that have been explored during these interviews and could be avenues for future researchers to explore on the subject. However, the determinants proposed in IBM became more influential to explain the main themes uncovered by respondents. Although many participants talked about why they joined the military, how their experience changed them while serving, and about their rocky transition process, the determinants (intention, knowledge, barriers, saliency, and consistency) outlined in IBM became prevalent upon analysis of the data gathered during the interviews.

IBM touches on features neither the Life Course Perspective nor Homecoming Theory do. IBM describes five elements necessary for a behavior to occur: intention to perform the behavior, knowledge and skill to carry out the behavior, limited environmental constraints and acceptable social norms, the behavior must be significant, and excessive performance of the behavior may make it habitual (Montano, & Kasprzyk, 2015). During the interviews, participants brought up four out of five of the above notions: intention, knowledge, barriers/social norms, and saliency. First, the theory says that a behavior will occur if the individual has the intent and knowledge to perform said behavior. A 30-year-old male Air Force veteran stated: "If I felt like I was having issues I would seek them out. I just don't feel like I need to at this period

in my life, but I do know that it's there. I know plenty of resources now that I could go to if I needed."

Second, social norms and lack of barriers was touched on. Examples of social norms include stigma and lack of social support. Barriers illustrated in the interviews include medical incompetence, transportation, and geographical access. A 32-year-old male Navy veteran stated:

> There could be logistical issues, someone might not be close to a facility that can help them, they might not have transportation, there might be scheduling conflicts. I know, oftentimes with the Veterans Administration, there can be month long gaps between a request for assistance and the actual fulfilling of that request.

Lastly, the behavior is likely to occur if it is important to the individual. This came about in the interviews when it came to seeking help because of having close family ties. As discussed previously, having children was an important factor. Another familial tie was having a significant other who showed substantial interest in helping the service member receive help. A 42-year-old male National Guard veteran stated:

> My wife has learned my triggers. She sees it in my face when things are not going well for me. She's even, at home, I have a service dog, and if my service dog is in another room, my wife has gone and gotten her. She gives me a lot of support to deal with my PTSD.

Study limitations and further research

This exploratory study provides insights into veterans' knowledge of mental health disorders, but is not without limitations. First, interview participants were self-selected. This is important because participants who self-select are inherently different from those who do not participate. Second, participants were recruited through non-profit organizations near a large university and the VA. This is an important limitation, because access to resources are geographically dependent and thus, can influence a participant's knowledge. Additionally, participants were recruited from an organization that is dedicated to providing resources to veterans, which makes this group unique in its knowledge and access to resources. Although this particular sample may have had more current knowledge on mental health and the resources associated with treatment, the interview process and questionnaire was retrospective in nature. Because of this, the participants' current knowledge did not affect the validity of this research project. However, future research should explore more diverse veteran populations. Last, although 16 participants were recruited, only 15 were eligible to complete the study. Of the 15 who completed the study, only a small portion were women. This is generally representative of the military population with 14.5% in the active duty forces, and 18% in the reservists and National Guard (CNN, 2013). However, it would be beneficial to compare gendered perceived knowledge of resources and disorders, which would require a larger sample of women.

Although the sample was diverse in terms of military background there was very little variability between races or ethnicity. Therefore, it is important to conduct more research on this topic in other areas of the country and with a larger, more diverse sample. Another interesting aspect for further research revolves around the difference between enlisted service members and commissioned officers. The differences between basic training and officer school could reveal interesting information about the inclusion of information about mental health disorders and resources. It will be important for future research to also use other research methods beyond those used in this project, such as focus groups or surveys, to explore the issues identified here in greater detail.

Conclusion

Many factors affect a veterans' willingness to seek help regarding mental health disorders. The five that came to light in this study were 1) prevalence for mental health disorders, 2) increasing knowledge of disorders and resources once separated from the military, 3) barriers which inhibit access to resources, 4) various types of resources available, and 5) motivations to seek help for mental health disorders. Although this study sought to understand knowledge related to mental health disorders and resources, it uncovered many other aspects. With the prevalence of these barriers, and the low likelihood that veterans will seek out, and actually receive help, the possibility that these service men and women will face significant challenged in their transition out of military life is high. Mental health disorders and symptoms can affect them shortly after transitioning or they can continue to affect them for the rest of their life. Regardless of time, there is a high likelihood that the reason these disorders developed is due to the person's participation in the military, which is a huge sacrifice to keep our homeland safe.

Further research in each of these areas could be fuel for policy and cultural changes, which may help the military population receive treatment and stay healthy, both physically and mentally. It is imperative to give our veterans a fighting chance for success upon returning from deployment. Veterans and their families need the help of sound research and activism grounded in research to overcome the stigma and barriers to care faced by persons with mental illness. This study attempted to help identify these barriers by learning what knowledge veterans currently have about mental health disorders and resources available.

Competing Interests

The authors have no competing interests to declare.

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