

Mental Health Stigma in the U.S. Military

By

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ABSTRACT. Predominant military ideology, which perpetuates hegemonic masculinity by purporting emotional and physical discipline at all times, is not conducive to fostering a culture that readily accepts mental health diagnoses resulting in increased stigma and barriers to care. Prevention tactics, institutional changes, military ethos, statistical data on yearly suicide rates by service members, and perceived barriers to care were compiled and analyzed. A review of related scholarship found that particular demographics increase the risk that service members and veterans sustain mental health disorders. Additionally, a service member's intersecting identities play a role in the compounding levels of mental taxation they face, which is discussed specifically for women and people of color.

INTRODUCTION

The final draft for the U.S. military took place in December 1972, just before the end of the Vietnam War. Since then, America's Armed Forces have remained an all-volunteer force (Denning, Meisnere and Warner 2014). Despite the voluntary nature of our military system, many service members experience involuntary psychological trauma. This paper provides an overview of the military structure and its dominant cultural norms to outline the trauma that can manifest from such organization and ethos. In this paper, I focus on hegemonic masculinity as a cultural influence in the military context, with a brief contextual summary of the perceptions and stigmatization of people with mental health disorders (PWMHD). After examining the interaction between the characteristics of hegemonic masculinity and the military as a social institution, I analyze the compounding mental health effects these ideals have on two groups: women and people of color. These analyses lead to a broader discussion of mental healthcare as a necessity for military personnel, concentrating on access to care and the mental health needs of the enlisted and veterans. This paper seeks to provide civilians insight into the lives of military personnel and the struggles they face to access mental health care.

MILITARY STRUCTURE, CULTURE, AND TRAUMA

It is essential to understand the military's structure and the culture it promotes to grasp the institution's control over its personnel. There are five branches of service in the United States military: Army, Navy, Marine Corps, Air Force, and Coast Guard; each of these branches contains a reserve and active component. Active members are full-time service members engaged in both combat and non-combat situations. Members in the reserves serve part-time (generally, two weeks per year); they are tasked with being equipped to fill an active duty position immediately in the case of a national emergency. A concrete hierarchical system is imperative for the military as a means of control and regulation. Thus, the military works based on a system of ranks of which there are three: enlisted (e.g., private, corporal, sergeant, seaman, etc.), officers (e.g., lieutenants, captains, majors, colonels, etc.), and warrant officer. Enlisted services members perform the day-to-day and managerial tasks that keep the military up and running. They fix equipment, patrol the streets, manage paperwork, etc. Officers derive their authority from the President and are confirmed by the U.S. Senate. These members are responsible for commanding, directing, and coordinating their units to achieve a given operation. Alternatively, warrant officers do not hold the authority to instruct units. Instead, they are tasked with possessing technical expertise in a specified area (e.g., maintenance, computers, aircraft, etc.) (Denning, Meisnere and Warner 2014).

As gathered from the overview depicted above, a chain of command and organization is critical for an institution as substantial as the military. Undoubtedly, such order aids in carrying out successful missions and mitigates confusion concerning lines of authority and responsibility. In addition to this universal value denoting organizational efficiency, each branch has a prescribed set of values. For the Army, these include loyalty, duty, respect, selfless service, honor, integrity, and personal courage. For the Navy and Marine Corps: honor, courage, and commitment. The Air Force recognizes integrity first, service before self, and excellence in all they do. Finally, the Coast Guard outlines honor, respect, and devotion to duty in their core values (Denning, Meisnere and Warner 2014). While all of these values work toward carrying out successful operations and ensuring institutional organization and upkeep, they simultaneously encourage normative views of courage (e.g., feats of physical strength and stoicism) to be carried out. That is, they perpetuate notions of hegemonic masculinity; they encourage this predominantly male profession to carry out roles that are characteristic of logical, intelligent, and unemotional thinking. In turn, these characteristics are used to rationalize male authority and control. For personnel who identify as masculine, honoring notions of hegemonic masculinity fosters a rigid way of performing identity. Of course, the personnel that makes up the U.S. military go far beyond strictly men whose identity aligns with their gender assigned at birth based on sex. In turn, in embodying the values ascribed to the branch of service they're engaged in, all service members must internalize and perform, at least in part, society's patriarchal ideals that protect and promote hegemonic masculinity.

HEGEMONIC MASCULINITY IN THE MILITARY CONTEXT

One team of researchers stated, “Service members are expected to be disciplined in their actions and words and to maintain control of their emotions and their physical selves at all times” (Denning, Meisner and Warner 2014:10). Expecting anyone to maintain control of their emotions “at all times” is a weighty demand; further, expecting such discipline from service members who, on a daily basis, endure grief, loss, hyperactive pumps of adrenaline, a lack of sleep, uncertainty, and more, is extremely dangerous as it has the potential to foster an environment where suppressing one’s true emotions is looked down upon in favor of upholding a facade of uniformity and a narrow understanding of bravery.

As understood in the context of the United States’ military agenda, bravery is tied to invulnerability, self-reliance, and success that is largely bound to physical strength. This specific notion of bravery is imposed on service members by the military institution. One former Royal Marine, Aldo Kane, said that the thing he takes away from the corps is not the technical skills but rather the Commando Spirit, “courage, determination, selflessness, cheerfulness in the face of adversity” (Men’s Health UK 2020) to which his peer, Jason Fox (Special Forces veteran) explains that members are, in essence, brainwashed by this spirit. Fox goes on to say that the military tries to build a culture around the Commando Spirit that engrains these values into the minds of military personnel so that in the midst of a challenge, members can rely on this spirit they have tucked away in their back pocket and think to themselves, ‘all I need right now is a bit of courage.’ The institution drills this into members’ heads by not only repeating it time and time again but also by plastering it on signage in spaces frequently visited by the enlisted (Men’s Health UK 2020). Highlighting the grave disregard the military has permitted for psychological disorders, one team of researchers notes, “The military has a mission-first approach, and the mental health of their service members is an afterthought. In fact, the DoD [Department of Defense] did not begin keeping a record of service member suicides until after 9/11” (Games and Theargood 2021). Despite the institution’s neglectful stance, it’s also important to note civilians’ role in shaping how bravery is perceived within the military culture.

The Invisible Wounds of War Project found the following societal stigmas create barriers to care: “my friends and family would respect me less; my spouse or partner would not want me to get treatment; my co-workers would have less confidence in me if they found out; my commander or supervisor has asked us not to get treatment; my commander or supervisor might respect me less” (Acosta et al. 2014). Of course, each of these barriers had varying response rates, but the sheer fact that service members held these concerns implies that society has a much more significant role to play in perpetuating stigma among people with mental health disorders than we may recognize. Civilians understand little about the intricacies of service members’ daily life; what is understood comes largely from military propaganda and sensationalized slogans such as “land of the free because of the brave.” This skewed understanding of the military and its personnel lead civilians to falsely accept and preserve a military ethos that asserts members should pride themselves on their mental toughness, resilience,

strength, and self-reliance. When bravery is discussed in the military context, these adjectives resonate with what is considered the cultural norm. As members are inducted into this social institution, these descriptors are automatically ascribed to their person; any deviation from these norms, such as seeking help, would thus imply weakness (Charrys 2021). In this way, the conservation of these cultural norms, all characteristic of hegemonic masculinity, are upheld not only by the military institution but also by civilians' understandings of mental health and bravery in the military context, as well as their perceptions of military personnel as soldiers whose duty it is to fight for our country versus citizens who also experience emotional turmoil and mental taxation.

PERCEPTIONS AND STIGMATIZATION OF PEOPLE WITH MENTAL HEALTH DISORDERS

Negative connotations of mental illness and the devaluation of people with mental health disorders begin early in life. Once someone is officially labeled as having a psychological condition, the label becomes personally relevant, and the individual enduring social prejudice may internalize the negative societal associations with the label (Acosta et al. 2014). Some studies suggest that the military's firm emphasis on fulfilling one's military duties influences the stigmatization and discrimination of people with mental health disorders (Gibbs et al. 2011; Barrett 2011). Stigma is created in multiple contexts. Four key contexts include the public, institutional, social, and individual contexts. A service member's social context encompasses the primary relationships they have with other people (e.g., command leadership, peers, and family). The institutional context is cultivated via the policies and systems under and through which they operate, and their public context is comprised of the military norms and culture that service members navigate daily (Acosta et al. 2014). Each of these contexts may produce a different outcome for the individual experiencing the stigmatization. Four immediate outcomes have been empirically linked to stigma-- coping mechanisms (e.g., withdrawing), interpersonal consequences (e.g., fluctuations in self-esteem), attitudes toward treatment-seeking, and intentions to seek treatment. In thinking of these contexts, it is important to note the dynamic nature of stigma-- stigma can fluctuate daily, even hourly, based on changes in context and relationships (Acosta et al. 2014).

Stigma affects service members differently. Military demographics particularly favor young men, thus, research has shown that men receive greater stigma associated with treatment-seeking behavior than women do (Vogel, Wade and Hackler 2007) because they are expected to be stoic, self-reliant, and controlled (Hammen and Peters 1978). Conversely, women in the military suffer disproportionately from military sexual trauma and assault, increasing the risk that they sustain psychological disorders and increasing their probability of seeking mental health care (Turchik and Wilson 2010). People of color serving in the military also face unique circumstances concerning stigmatization as many have spoken out on the deep-seated racist culture they encounter upon entering

the military. Despite bringing attention to this toxic environment, many people of color in the military feel they have nowhere to report these occurrences as the military's judicial system lacks a category for hate crimes (Stafford et al. 2021). Understanding why there are discrepancies in perceptions of people with mental health disorders is vital. Variation in stigmatization occurs because it focuses on the recipient rather than the perpetrator of the discrimination; this validates the idea that there is something wrong with the population or individuals being discriminated against rather than those enabling the stigma (Acosta et al. 2014).

WOMEN IN THE MILITARY

Previously discussed characteristics of hegemonic masculinity and mental health stigma contribute to 70% of military personnel nursing concerns about being labeled as having a mental health disorder (Charrys 2021). Due to the military's large male population, young men are especially susceptible to obstructive beliefs regarding mental health and treatment-seeking behavior (Vogt 2011). However, women in the military endure their own unique, compounding discrimination and stigmatization based on the hypermasculine ideals purported by the military institution. Hypermasculinity is defined as "an extreme form of masculinity based on beliefs of polarized gender roles, the endorsement of stereotypical gender roles, a high value placed on control, power, and competition, toleration of pain, and mandatory heterosexuality" (Hunter 2007). For women in the service, this manifests primarily in the form of Military Sexual Trauma (MST), which refers to "any instance of experiencing sexual assault or threatening sexual harassment during the duration of the service members' service period and is associated with increased odds of a mental health diagnosis" (Charrys 2021). One paper cited that "The reported rates of sexual assault in the military are as high or higher than those reported by civilians, but taking into account that the rates only include sexual assaults that took place during one's military service, the rates are very high" (Turchik and Wilson 2010). Turchik and Wilson (2010) went on to clarify that while 18% to 25% of American women report experiencing either an attempted rape or completed rape in their lifetimes, between 9.5% and 33% of women report experiencing an attempted or completed rape while serving in the military. Another study found that 43% of all female service members and 12.5% of all male service members have reported an incident of MST (Katz et al. 2012).

The military works as a total institution. That is, the military is a place of work and residence that is cut off from the broader society; it has its own code of conduct, legal system, police, courts, education, research facilities, and medical system (Turchik and Wilson 2010). Along with these, the military also has its own set of norms and values that are engrained into recruits during their training. As mentioned previously, many of these norms are distinguishable by their representation of hypermasculinity which, despite being in place to train service members to be effective, may contribute to the promotion of sexual violence (Turchik and Wilson 2010). Sexualized and violent

language, the general acceptance of violence, the learned ability to objectify others, and consuming obedience to the chain of command along with the structure of the military as a male-dominated institution in which men assume a greater number of leadership roles, all shape service members' beliefs that sexist and violent behavior is acceptable. The military uniquely nurtures violence; in some ways, the emphasis on violence is outright, like killing in combat zones. In other ways, this emphasis is much more discrete, such as within common slang used among military personnel. Regardless, rationalizing the government's use of violence as a means to an end may increase the number of individuals who then legitimize this technique for themselves, ultimately increasing the risk of sexual victimization within the military context (Turchik and Wilson 2010).

Hypermasculinity adds to the decreased extent to which the military is an inviting environment for women; it has also been shown to increase the likelihood that men hold rape-supportive attitudes and commit acts of sexual aggression (Turchik and Wilson 2010). Studies have also found that institutions that profess hypermasculine values typically have higher sexual harassment and assault rates than other organizations (Turchik and Wilson 2010). The hypermasculine values embodied by this institution thus, compound the vulnerability of women serving in the military. These values increase the likelihood that women sustain military sexual trauma, thereby also increasing the risk women in the military face in combatting mental health disorders.

SERVICE MEMBERS OF COLOR

Like female service members, people of color serving in the military may also be at a heightened risk of experiencing compounding factors that further drive them to suppress mental health issues. A study on Americans' public opinion towards the military based on differences in race stated that some historically marginalized communities view the military as more of an egalitarian organization than society at large. In turn, for people of color, the military is often regarded as a means for achieving a "way out/up;" it provides stable food, housing, education, and the possibility for upward economic mobility and workplace promotions that are not commonly available for those without higher education in civilian society (Leal 2005). Thus, for people of color who rely on the military for opportunities unlikely to be provided in civilian society, there is a greater pressure to uphold a facade that aligns with the military ethos.

The No Child Left Behind Act of 2001 gave U.S. military recruiters the same access to high school students as college recruiters, including access to the personal contact information of high schoolers around the country. The United States remains the only Western Nation to allow military recruiters such access to the educational system (Miralao 2020). Though military recruiters have equal access to students across geographical lines within the U.S., they utilize this information disproportionately. Military recruiters use this information to exploit students based on their financial and social situations. One study found that recruiters made ten times as many school visits to a

predominantly low-income school as they did to a nearby affluent one. At the more affluent high school, where only 5% of students were eligible for free or reduced-price lunch, recruiters visited a total of four times throughout the 2011-2012 academic year. In a nearby low-income school, where nearly half of the student body qualified for free or reduced lunch, U.S. Army recruiters made more than ten times as many visits during the same year (Kershner and Harding 2015).

The previously stated findings capture the inequality present in military recruitment in high schools around the nation. The military may have proved critical to “leveling the playing field” for all Americans in the late 1960s when Black men were first fully integrated into the armed forces (Wilcox, Wang and Mincy 2021). Still, after 60 years, more societal progress is necessary. Black men are significantly overrepresented in the armed forces compared to the civilian labor force (Reeves and Nzau 2020); however, when they enter the force and experience discrimination, they often find few parameters in place to bring justice to their experiences. Numerous interviewees spanning across all branches of the military have described “a deep-rooted culture of racism discrimination that stubbornly festers, despite repeated efforts to eradicate it” (Stafford et al. 2021). Additionally, there is no distinct classification for hate crimes within the military’s judicial system, making it nearly impossible to quantify such occurrences. Finally, despite processing more than 750 complaints regarding discrimination by race or ethnicity in the 2020 fiscal year alone, people of color serving in the military commonly face court-martial panels composed of all-white service members, which some experts argue leads to harsher punishments (Stafford et al. 2021).

Prevailing characteristics of hegemonic masculinity within the military context can complicate any service member’s experience. Facing racial discrimination while simultaneously being bombarded with messages to remain valiant and in control of one’s emotions constitutes an environment defined by toxicity. Further, despite any harm brought on by one’s surroundings, said environment may feel inescapable given the unique opportunities for service members of color, which may be unavailable in civilian society. As a society branded with notions of meritocracy, the considerable lack of resources service members of color possess amid instances of racial injustice is preposterous.

MENTAL HEALTHCARE NEEDS AND ACCESS TO CARE

The current process utilized by the military to assess the psychological health of their service members includes three main categories: universal screening, psychological health integration, and self-assessment procedures. Universal psychological health screenings of service members occur at four different stages of a member’s military experience: entrance into the armed forces (“accession”), pre-deployment, post-deployment, and reintegration. Additionally, the Department of Defense (DoD) is working to improve early recognition and intervention strategies by implementing structural interventions to support psychological health integration. The DoD seeks to achieve this goal through three primary efforts: Re-Engineering Systems of Primary

Care Treatment in the Military (RESPECT–Mil), embedded mental health providers, the Patient-Centered Medical Home, and self-assessment (Denning, Meisnere and Warner 2014).

RESPECT–Mil provides primary care-based screening, assessment, treatment, and referral of active-duty personnel diagnosed with PTSD or depression. Since the integration of this service in early 2007, it has provided screening for depression and PTSD at every visit to a primary care provider and further evaluation for those who test positive. “Embedded mental health providers” is an effort by the DoD to bring psychological health professionals closer to service members to decrease accessibility dilemmas. This effort also strives to improve communication between psychological health care professionals and operational unit leaders. In 2008, the DoD adopted the Patient-Centered Medical Home (PCMH). This team-based model provides “continuous, accessible, family-centered, comprehensive, compassionate, and culturally sensitive health care in order to achieve the best possible health outcomes” (Denning, Meisnere and Warner 2014).

Self-assessment is the final tool relied on by the military to improve preventative care and early intervention. There are two main self-assessment tools. Military Pathways is a series of questions that creates a holistic picture of how an individual is feeling and aids in determining whether or not that service member could benefit from speaking with a professional. Military Pathways is free, anonymous, and available over the phone, online, and at select in-person special events. Depression, PTSD, generalized anxiety disorder, alcohol use, and bipolar disorder are all addressed via the questionnaire. After an individual completes a self-assessment, they are provided with referral information, including services provided by the DoD and Veterans Affairs. Clinical practice guidelines are the other primary method of self-assessment. These guidelines are developed and updated by representatives from the DoD and VA; they “document evidence-based procedures for screening, assessment, diagnosis, and treatment of adults who are seen in any DOD or VA clinical setting” (Denning, Meisnere and Warner 2014). Although these clinical guidelines are better implemented than not, it should be noted that the representatives working to create and enforce them know that these guidelines alone cannot ensure that service members receive optimal evidence-based care (Denning, Meisnere and Warner 2014).

The disturbing reality is that these measures alone are not sufficiently supporting military personnel in their process of acquiring psychological help. The DoD’s Annual Suicide Report for the 2020 calendar year confirmed that 580 service members died by suicide. The report also verified that the suicide rate for the Active Component statistically increased from CY 2015 to CY 2020 (U.S. Department of Defense 2021). Many factors affect treatment-seeking accessibility; therefore, the Department of Defense, Veterans Affairs, and military leaders must use several different tactics to encourage treatment-seeking behavior and psychological health care retention. The RAND Corporation, a nonprofit organization that conducts research on the armed forces, also promotes the simultaneous implementation and use of various tactics as a way to mitigate criticisms of one approach; implementing numerous complementary

practices that all attack different barriers to care would facilitate structural change more permanently (Acosta et al. 2014). Methods must cater to reducing mental health stigma in the military, changing military norms that encourage self-reliance, emotional control, and narrow definitions of power and bravery. They must also fight misperceptions about the effectiveness of care, which often lead service members to believe their families and friends can help more than service providers. Along with these approaches, military peer and leadership support need to be addressed-- military personnel in every branch and at every ranked level need to be educated about mental illness, symptoms, and available resources, including logistical and administrative resources such as transportation, cost, and provider availability (Acosta et al. 2014).

Stigmatization within the military culture is systemic and directly related to martial traditions, which, in turn, influence the attitudes and beliefs that service members hold regarding mental health. The culture upheld by the military thereby inhibits service members from seeking professional help (Charrys 2021). If the military environment is not conducive to normalizing the pursuit of mental health services, access to care will always be obstructed. Access to mental health care should be as readily available and accessible as access to physicians. If a service member sustains a physical injury, they are immediately ushered to see a doctor; the process should be no different for so-called "invisible wounds of war." Many scholars invested in bringing the issue of mental health care in the military to the forefront of society's attention demand that, should the military wish to prove their belief in the importance of mental health, they need to begin by increasing the number of employed psychologists as well as the salaries of these professionals. Lieutenant D'Arienzo, a Doctor of Psychology, calls attention to the discrepancy in pay between military physicians and psychologists, noting that the overall salary for a Navy-employed psychologist is nearly half that of a Navy physician (Dingfelder 2009).

In addition to the insufficient number of employed mental health professionals and the unsatisfactory salaries they receive, one task force commissioned by the Department of Defense in 2007 found two other prominent barriers to care. The Task Force on Mental Health found that the cohort of professionals employed is not sufficiently accessible to service members. And significant gaps remain in the continuum of care which inhibit the enlisted and their families from accessing mental health care during peace and conflict. The primary recommendations of this task force were for the military to ensure they participate in cultivating a culture of support for psychological health and provide a full continuum of care for military personnel (including sufficient resources). The task force also encourages military leaders to act as advocates for not only mental health broadly but specifically for their units' mental health (Denning, Meisnere and Warner 2014).

An evaluation of access to mental health care in the DoD in 2020 found that the DoD did not consistently meet access to care criteria for active duty service members according to law and applicable DoD policies. The evaluation also resulted in a finding that states an average of 53% of all active-duty service members and their families identified as needing mental health care and who were referred to a specific health care system did not end up receiving care. The Military Health System claimed not to know

why this gap in care occurred. The evaluation noted that the Department of Health Agency failed to publish consistent and clear access to care policies and did not have visibility of patients who endured a failed attempt at obtaining mental health appointments in the purchased care system. Both of these inadequacies contributed to the DoD's inability to meet access to care standards (Inspector General U.S. Department of Defense 2020). Based on this evaluation, fourteen recommendations were made to the Assistant Secretary of Defense for Health Affairs and the Defense Health Agency (DHA) director to improve access to mental health care. Of these, seven recommendations were resolved, including the DHA director agreeing to update the "TRICARE Policy for Access to Care" 2011 Memorandum and to remove the eight-visit limit for outpatient mental health care. The DHA director denied the suggestion to develop standardized mental health care access measures for both active duty service members and their families. Subsequently, the proposal to track the reasons referrals went unused was dismissed. This recommendation was denied on the basis that it would require invasive questioning of service members, thereby increasing treatment-seeking stigma (Inspector General U.S. Department of Defense 2020).

While the DoD's commitment to increasing mental health care accessibility and awareness is commendable, it should continue to seek alternative actions that could evade the stigma surrounding mental health, which was noted above as a significant reason particular recommendations were not implemented. One of these potential solutions was reintroduced into Congress in June 2021 as the Brandon Act (Stewart 2021). The Brandon Act was named after a Navy Seal trainee, Brandon Caserta, who committed suicide in 2018 after enduring perpetual hazing and bullying. Brandon's parents, select policymakers, and individuals from the military community and civilian force alike are pushing Congress to enact this piece of legislation that would allow a service member of any branch to casually mention the Brandon Act. Mentioning this act would trigger a confidential referral for mental health treatment and enable service members to receive care without notifying their command. The chain of command in the military is understandably necessary for organizational success. However, bypassing the bureaucracy is sometimes required; a week before Brandon died, he slipped a note seeking help under his Command Officer's door, which went ignored (Favakeh 2021). Due to the secrecy engrossed in the Brandon Act, the measure would not abrade the mental health stigma that is systemic within the military culture. However, it would provide confidentiality and assure service members that they would be free of questions and repercussions-- both of which allow for the potential to develop standardized mental health care access measures which could contribute to structural and systemic changes within the military.

CONCLUSION

Given the unique structure and makeup of the military, we know that particular demographic factors (i.e., younger age, male sex, and non-white race) are related to increased stigma and barriers to care (Pietrzak et al. 2009). Additionally, a service

member's intersecting identities play a role in the compounding levels of mental taxation they face, as discussed for people of color and women in the military. In turn, these compounding levels of mental strain heighten the risk that particular individuals will sustain a mental health disorder.

When defining mental health stigma in the military context, certain unique characteristics of the organization must be addressed. The primary point of interest is the function of the military as a total institution. Service members' home and work lives are far less separated than their civilian counterparts. The military's broad governance over its personnel, including service members' access to military mental health service providers, may inflate the perception that leadership will find out if a service member is diagnosed with a mental health disorder compared to those working in the civilian sector (Acosta et al. 2014). The norms and values of unit culture and military culture, more broadly, influence service members' public context in a unique way. The context that military personnel must navigate on a daily basis is construed based on notions of a shared mission, leaving no soldier behind, the commando spirit, and a plethora of other verbal and written messages engrained into the minds of soldiers during recruitment and training.

As examined throughout this paper, predominant military ideology is not conducive to fostering a culture that readily accepts mental health diagnoses. The military must normalize the use of mental health services for service members within every branch of service and regardless of a service member's rank. Failing to normalize such services will continue to result in the inability of service members to properly use and gain access to psychological help (Games and Theargood 2021). Service members who wish to pursue counseling or any other type of mental health care need to be met with unwavering support rather than scrutinized for seeking help-- the lives of our service members depend on this shift in awareness.

The military must funnel more money into providing higher quality and quantity of psychological services. There need to be easily accessible, concrete data on how much the armed forces spend on psychological services compared to the amount spent on staffing physicians to promote accountability and transparency. Further, tracking what aspects of mental health care provided by the military are most helpful to veterans and the enlisted will aid in creating a more comprehensive and proactive response to mental health disorders. Barriers to care need to be tracked by the military, despite the stigma that may loom among the forces, to ensure no veterans, service members, or their families fail to access or receive the psychological services they need. Certainly, the military must create a more inclusive environment for individuals with intersecting, historically marginalized identities. This paper does not provide comprehensive solutions to precisely how the military should restructure its allocation of money and other resources to fulfill these needs. However, it does provide insight into the mental health stigma faced by service members and veterans in an effort to bridge the gap between the intricacies understood by military personnel and their families, and civilian society.

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