

Airmen and Mental Health

Company Grade Officers' Perspective on Mental Health Care in the United States Air Force

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ABSTRACT

Current mental wellness capabilities within the United States Air Force are extensive and well publicized; yet, the service continues to face severe problems ensuring at-risk Airmen seek and receive help. This alarming trend is primarily the result of cultural stigmas; poor guidance and support from commanders; and a mental health system disproportionately focused on reactive treatment options vice preventative care. Cultural norms within the Air Force have created a perception that negative consequences will ensue for Airmen who seek behavioral health assistance. In fact, a recent survey of Squadron Officer School Captains revealed that over 80 percent believe a negative stigma exists when personnel seek a mental wellness expert's help. To remedy this situation, Air Force leadership should openly discuss the importance of seeking professional mental health assistance and establish procedural fixes protecting Airmen's ability to continue duty after admitting a need for help.

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PURPOSE

Twenty-four members of Squadron Officer School, Class 13E, were selected to provide the perspective of United States Air Force (USAF) Company Grade Officers (CGOs) on the service's current mental healthcare system. Divided into three teams, these CGOs explored the unique aspects of Air Force culture and mission that influence an Airman's pursuit of mental health treatment. The USAF is entering its thirteenth year of sustained combat operations and the need for timely, accessible, and effective mental healthcare is vital to sustaining the service's combat capability. The team uncovered a myriad of organizational programs available to Airmen needing help; however, cultural, legal, and procedural roadblocks stop many at-risk personnel from using these resources. This paper represents the most pertinent solutions to accelerate change within the USAF's culture by improving the overall perception of mental wellness.

In early 2009, A1C Doe (name changed to protect privacy), an Explosive Ordnance Disposal technician, arrived on his first deployment to Helmand Province, Afghanistan. Within a week, he engaged the enemy in his first firefight while supporting US Army Special Forces. During the first four months of his deployment, A1C Doe watched his team leader disable and destroy more than one hundred improvised explosive devices. Everything changed when the device A1C Doe's team leader was attempting to disable detonated, killing him instantly. A1C Doe was standing behind him at the time of the blast, and was the first to reach his fallen comrade. Later that year now-SrA Doe, deployed to Iraq in support of US Army units in an area known for frequent bombings against public spaces. While there, he repeatedly conducted post-blast assessments on mass-casualty sites. One day between missions, SrA Doe and his new team leader were grabbing lunch, when their base was attacked by rocket fire. The attack hit the chow hall, causing the structure to collapse and knock SrA Doe unconscious. Following his Iraq deployment, SrA Doe PCSed to Korea for a one-year short tour and then received his follow-on assignment of choice. At the follow-on, now-SSgt Doe deployed to southern-Afghanistan in support of US Army operations again. Only after this third combat deployment did SSgt Doe seek mental health treatment for the moderate to severe Post-Traumatic Stress Disorder (PTSD) symptoms he was experiencing.

SSgt Doe did not seek help earlier because there was "always something on the horizon;" he did not want to be pulled from his duties, an overseas PCS, a follow-on tour to a Personnel Reliability Program (PRP) base, or another deployment. In short, he wanted to continue to do his job. Once SSgt Doe decided to seek help, he discovered an Air Force mental health system largely ill equipped to handle his unique needs. The personnel charged with his care had not experienced similar situations or, more importantly, treated other personnel with his particular blend of combat stressors. After switching healthcare providers, SSgt Doe committed to completing his prescribed treatment regime because he wanted to ensure that his PRP and deployable statuses would return to normal, not because he felt that he was "getting better". Now-TSgt Doe is a singular example from a career-field that makes up a tiny portion of the USAF; however, his example highlights two significant questions facing the current mental healthcare system. How can the USAF embolden personnel to seek mental healthcare when required, and how can it ensure injured Airmen receive effective treatment?

PART I: INTRODUCING THE PROBLEM

“I stopped drinking and tried dealing with it on my own and I failed...I’m sorry I let you down. I was really hoping for some crazy, noble, heroic death. I love you and there’s nothing you or anyone could do. This is my decision. I’m sorry I wasn’t strong enough.”

- United States Marine’s Suicide Note

Airmen of all ranks, positions, and assignments face intense stress. Whether these stressors develop from a turbulent home life, a combat deployment, or ever-present home-station operational and support requirements, the Air Force must provide effectual treatment options to maintain a viable, combat ready force. Unfortunately, the USAF’s comprehensive mental wellness program is sidelined by cultural stigmas, poor guidance and support from commanders, and a disproportionate focus on reactive treatment vice preventative care. Elements of the service’s culture have created stigmas labeling Airmen who seek mental wellness care as weak, detrimental to the unit’s mission, or as malingerers. Additionally, perceptions exist that the command structure singles out Airmen who seek help, leading to the loss of specialty status, clearances, and access, which can negatively affect a member’s career progression. Finally, the current mental wellness program relies on reactive care provided by professionals well removed from the Airmen themselves, further decreasing the likelihood of self-identification. As a whole, these problems indicate a mental healthcare system that is broken. Consequently, the Air Force must accelerate cultural change by addressing stigmas, retributive policy, and reactive care. Together, changes to these issues could reverse the trend of rising mental wellness issues; a trend best evidenced by recent increases in the Air Force’s suicide rates.

Suicide Rates...An Indicator

Perhaps the simplest, but most emotional, method to evaluate the effectiveness of the mental wellness system is by examining the Air Force’s suicide rate. Tracking these rates over the past decade is disconcerting, as the steady increase implies a decline in the USAF’s overall mental wellness. Since 2009, an average of one Airman every week has committed suicide, with 2010 and 2012 reflecting double-digit percentage increases over previous years.¹ Department of Defense research suggests that in 2010 a military member died by suicide every 36 hours.²

“Particularly frustrating and confusing is the fact that the military suicide rate has steadily risen to an all-time high since the start of combat operations in Afghanistan and Iraq, in sharp contrast to historical trends for decreased military suicide rates during times of war, raising questions about the potential effect of combat exposure on suicide risk.”³

¹ Svan, Jennifer, “Air Force Suicide Rate Highest in 17 Years,” *Starts and Stripes*, 22 December 2010, <http://www.stripes.com/news/air-force-suicide-rate-highest-in-17-years-1.129579>.

& Burns, Robert, “Air Force Suicides Up 16% in 2012,” *Standard-Examiner in The Associated Press*, 14 January 2013, <http://www.standard.net/stories/2013/01/14/air-force-suicides-16-2012>.

² Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, “The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives,” (Washington, DC: Department of Defense, 2010).

³ Bryan, C. J., A. M. Hernandez, S. Allison & T. Clemans, “Combat Exposure and Suicide Risk in Two Samples of Military Personnel,” *Journal of clinical psychology* 69, no. 1 (2013): 64-77.

Three distinct mental health variables increase suicide risk: *perceived burdensomeness*, *thwarted belongingness* and *acquired capability*.⁴ *Perceived burdensomeness*, one's belief that he or she is a burden on others, and *thwarted belongingness*, the loss of meaningful connections with others, are emotions that a strong support network within the Air Force can counter. However, military members, especially those who have experienced combat, are extremely vulnerable to developing *acquired capability*, an individual's desensitization to painful experiences and the fear of death. Research shows that repeated and/or prolonged exposure to combat may elevate an individual's suicide risk by increasing *acquired capability*, especially if other suicide-risk factors exist.⁵ A series of independent clinical studies had similar findings, concluding that while combat does not directly increase suicide risk, it does affect upstream variables that can lead to suicide, including depression and relationship strain.⁶ Since Airmen have continually deployed over the past decade, a large percentage may be at increased risk of *acquired capability* and associated behavioral health risk factors.

The USAF's nearly instantaneous global reach further challenges traditional post-combat decompression cycles for Airmen because many specialties now engage in combat via remote-split operations from their home-station. Daily combat exposure has become routine for several career fields, including Unmanned Aerial System Operators, Intelligence Analysts, and Cyber Warfare Experts. For these Airmen in particular, the line between peacetime and wartime operations is often blurred, with little-to-no break in between. Following a routine deployment, these individuals often have a short reconstitution period before immediate and repeated exposure to combat, albeit from afar.⁷ Hence, combat does not end when they return home; it just changes form. This cycle of nonstop warfare may steadily increase an individual's mental health risks, especially without significant decompression periods.

PTSD, Emotional Injuries, and Mental Health Disorders

Unfortunately, the Air Force's startlingly high suicide rates only capture the extreme cases and a tiny percentage of personnel with mental health injuries and disorders. Most combat veterans do not commit suicide; however, studies show that warfare affects people emotionally and behaviorally, increasing their risks of long-term mental injury. Indeed, the true number of undiagnosed Airmen struggling with mental health injuries, such as Post-Traumatic Stress Disorder (PTSD) and alcoholism, is much harder to determine. Studies examining personnel who have deployed suggest that between 20 and 50 percent of service members show symptoms of psychological problems. Alarming, of those who meet the most stringent qualifiers for psychological problems, only 40 percent receive care.⁸ The Air Force's missions involving military operations at deployed locations and from garrison serve to prolong combat exposure, increasing mental health risks from depression to suicide. These statistics are disturbing, but

⁴ Ibid., 65.

⁵ Ibid., 65-7.

⁶ Ibid.

⁷ One of the authors of this study returned from a one-year individual augmentee deployment and flew a combat sortie before his CTO expired. This is not uncommon due to manning shortages, especially in the RPA community.

⁸ Department of Defense Task Force on Mental Health, "An Achievable Vision: Report of the Department of Defense Task Force on Mental Health," (Falls Church, VA: Defense Health Board, June 2007) <http://www.health.mil/dhb/mhtf/mhtf-report-final.pdf>.

they fall short of capturing non-combat related incidents, since traumatic events do not occur solely in deployed environments.

PTSD, emotional injuries, and mental health disorders strike many victims during non-combat related incidents.⁹ Stress caused by workplace accidents, violence, sexual assault, or natural disasters often leads to mental health injuries and PTSD in Airmen performing non-combat activities. The trauma these Airmen feel is no less significant than personnel downrange, and they are just as likely to experience relapses due to PTSD triggers, treatment discontinuation, or changes in mental health providers. Additionally, Airmen may feel increasingly isolated when experiencing stress at home, especially when prompted by various recurring trigger events. Personnel are often prone to misconceptions that PTSD can only occur during combat operations or that their ordeal does not warrant additional care. These misconceptions thwart self-diagnosis, the primary means of entry into the Air Force's mental healthcare system. Stresses arising from family life, career dissatisfaction, etc. can also increase while in garrison; thus Air Force mental healthcare programs must be available to Airmen whenever and wherever needed.

Finally, coping with the military's unique challenges, including deployments, long hours, and regular moves may lead to instances of *burnout* in both Air Force personnel and their families. *Burnout* is "a syndrome of emotional exhaustion, depersonalization, and a lack of a sense of personal accomplishment that occurs in response to chronic exposure to occupational stressors."¹⁰ Individuals afflicted by *burnout* may exhibit depression, depersonalization, and social withdrawal, predictors for an array of mental health concerns including depression, PTSD and suicide. While combat stressors receive significant attention in clinical analyses, Dr. Craig J. Brian, a leading expert in the field, argues that peacetime chronic stressors can also pose a significant *burnout* threat.¹¹ Coupling a stressful deployment with high tempo operations at home can increase the chance of inducing *burnout*, thus raising mental health risk factors. In direct correlation to vulnerabilities for suicide risk, *burnout* increases *perceived burdensomeness* and *thwarted belongingness*. Individuals struggling with *burnout* perceive less accomplishment at work, feeling that their job is unimportant, unappreciated, or ineffective; therefore, they may identify themselves as a burden on others in the unit. Similarly, these individuals often experience depersonalization, causing them to become indifferent to others' feelings and withdraw from social interaction. Essentially military members experiencing *burnout* are at extremely high-risk of suicide, because they may have already established *acquired capability* during combat operations. As the Air Force withdraws from Afghanistan and seeks to reconstitute its forces, identifying, treating, and healing mentally wounded members is a critical issue with long-term strategic implications for Airmen, their families, and the nation.

⁹ Stergiopoulos, E., A. Cimo, C. Cheng, S. Bonato, & C. Dewa, "Interventions to Improve Work Outcomes in Work-Related PTSD: A Systematic Review," *BMC Public Health* 11, no. 1 (2011): 838.

¹⁰ Interview with Dr. Craig J. Brain, University of Utah, National Center for Veterans Studies, Squadron Officers College, Maxwell AFB, AL, Class 13E, phone interview by co-author, Capt Timothy Finley, 20 August 2013.

¹¹ *Ibid.*

PART II: RESEARCH FINDINGS

“There’s quite a bit of effort put into addressing stigma. But the fact remains that it is still a big problem. The problem isn’t the specific treatments, but the fact that individuals aren’t seeking care or are dropping out.”

- Dr. Charles Hoge, Psychiatrist, Walter Reed¹²

Perhaps the most widely reported reason service members avoid seeking or volunteering for mental health assistance are perceptions of negative social stigmas accompanying these services. In a recent survey of Air Force Captains at Squadron Officers School, 82 percent reported that they believe a negative stigma exists when personnel seek mental wellness help and 75 percent admitted that they were uncomfortable seeking mental or behavioral health assistance.¹³ In general, stigmas fall into two categories: public stigmas and self-stigmas. Public stigmas are “beliefs held by the general public about the attributes of those with mental illness that can consequently lead to prejudice and discrimination.”¹⁴ In other words, members who need support may opt out of requesting help for fear of external repercussions and perceptions. Survey data and anecdotal evidence demonstrate that public stigmas against Mental Health exist across the DoD; so, to affect positive change the USAF must suppress these misconceptions.¹⁵ Self-stigmas are individuals’ personal beliefs about mental illness, which cause them to avoid treatment because of feelings of shame and inadequacy.¹⁶ Often interrelated, these feelings stem from deep-seated personal beliefs and may be harder to change organizationally. DoD surveys regarding one’s personal belief that seeking treatment makes one seem “weak” substantiate that these misconceptions, like public stigmas, exist within the military.¹⁷

USAF Culture and Stigmas

According to Momen, Strychacz, and Viirre, the military culture propagates a stigma that seeking mental help is a sign of weakness. Essentially, military culture ingrains toughness, mission centeredness, and self- and group-based sufficiency as cornerstones of combat readiness.¹⁸ These physicians argue that in a profession where physical and mental strength are a prerequisite, weaknesses, including one’s mental capability and decision-making skills, can cripple a team’s ability to accomplish its mission. Unfortunately, there is an enduring perception that accepting or requesting support to deal with emotional health is a greater detriment to the mission than fixing a potentially crippling mental injury. In fact, military members often fail to

¹² Dao, James & Andrew W. Lehren, “Baffling Rise in Suicides Plagues the U.S. Military,” *The New York Times*, 15 May 2013, http://www.nytimes.com/2013/05/16/us/baffling-rise-in-suicides-plagues-us-military.html?pagewanted=all&_r=1&.

¹³ SOS Class 13E responded to this survey of 742 Captains from across the USAF, 648 chose to respond. Details of the survey’s data and methodology are located in this document’s annex.

¹⁴ Momen, Nausheen, Chris P. Strychacz, & Erik Viirre, “Perceived Stigma and Barriers to Mental Health Care in Marines Attending the Combat Operational Stress Control Program,” *Military Medicine* 117, no. 10 (2012): 1143

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid. According to a 2004 study, “many soldiers and Marines believed that receiving mental health services would cause them to be seen as weak (65%), be treated differently by unit leaders (63%), lose confidence of their peers (59%), or be blamed for their problems (50%).”

¹⁸ Ibid.

recognize that emotional wounds are similar to physical ailments. For example, a broken leg is a temporary limitation a teammate can overcome and does not reflect negatively on one's "character;" however, dealing with chronic depression is often viewed as an indicator of a teammate's overall ability to deal with military stressors.¹⁹ More specifically, personnel rarely equate seeking support for emotional wellbeing with rehabilitating a mental injury or expanding one's emotional intelligence. Whether unit members actually perceive seeking mental help as a weakness, the associated negative stigma builds on misnomers that emotional health is different from physical health and that emotional problems signify a permanent inability to accomplish the mission.

In addition to stigmas that equate mental health injuries with individual weakness, a University of Maryland study notes that mental health treatment "violates military norms of group cohesion and individualistic coping."²⁰ Preconceived notions of bravery and strength compliment idealized dedication and commitment to one's military team or "family." However, these preconceived notions increase the risk that members suffering emotional wounds may fear their unit will abandon or ostracize them for seeking help. In cases involving post-deployment stress, *burnout*, or PTSD, individuals often assume other unit-members are the only people who understand their feelings. Therefore, in asking for professional help, Airmen often fear they may risk a stable support network. The University of Maryland's study examined this risk, concluding that group-centric motivations for requesting support did not minimize stigmas associated with seeking help for mental wellness and that "contact is a significant factor associated with less perceived weakness."²¹ These findings suggest that members will endure the same stigmas regardless of their motivation for seeking help and that service-wide responses geared toward reducing stigmas may have the greatest long-term impact on mental health wellness.

Wingman Concept

In the past decade, most Air Force career fields have deployed as individual augmentees, rather than with their squadron. This practice makes seeking mutual support within home units harder, because individuals rarely share common combat experiences. In Army units and Air Force squadrons that deploy together, personnel develop as a team with shared common experiences. These shared experiences make it easier for personnel to normalize and conduct peer counseling when they return. Deploying as an individual isolates an Airmen's combat experience; exposes them to significant home-unit upheaval when they return; and increases risk of hidden resentment from co-workers who inevitably absorbed the deployer's workload in their absence.²² While every service has deployed individual personnel, the past decade has witnessed a tremendous increase in Air Force individual augmentees, without an associated culture shift that encourages personnel to self-identify when they need help coping with combat experiences.

Creating a culture that identifies and meets Airmen's needs, to include encouraging people to seek professional behavioral help when needed, is a key aspect of the "Wingman Concept". If negative stigmas associated with behavioral healthcare prevent personnel from seeking help within the USAF, as anecdotal and quantitative data indicate, the Air Force's

¹⁹ Hipes, Crosby, "The Stigma of Mental Health Treatment in the Military: An Experimental Approach," *Current Research in Social Psychology*, 20 December 2011, http://www.uiowa.edu/~grpproc/crisp/crisp18_5.pdf, 1.

²⁰ *Ibid.*, 1.

²¹ *Ibid.*, 7.

²² Armed Forces Crossroads, Supporting the Military Community, www.afcrossroads.com.

Wingman Concept is not functioning properly. As such, to increase the likelihood of self-identifying, the service must decrease the perceived risk of team abandonment. Once the “gold standard” for military suicide prevention, the Air Force’s movement away from relationship-oriented seminars to computer-based training has weakened Wingmen and their ability to positively support mental health illness.²³ Indeed, peer interventions indicate a highly functioning Wingman culture, promote emotional wellness’ normalization, and outwardly show acceptance for suffering Airmen. Reestablishing a network of concerned coworkers, friends and family, who support their Airmen and intervene when emotional wounds surface, is the strongest potential deterrent to the Air Force’s eroding mental health wellness. Overtly inclusive, demonstrating mutual support, and aiding in stigma elimination, reestablishing a strong Wingman culture is critical in overcoming *burnout, perceived burdensomeness, and thwarted belongingness*.

Retributive Policy

The perceived impact on an individual Airman’s career is the single-most unique barrier to Airmen seeking help when compared to the other services.

Many disparate occupational specialties within the Air Force, including Aircrew, Intelligence, Space Operators, Missileers, Security Forces, and personnel working with nuclear weapons, require special qualifications and certifications to perform their daily duties. Failure to meet requirements associated with these special trusts force commanders to remove personnel from duty and is often reserved for substandard performance.²⁴ When commanders remove Airmen for medical reasons, there are usually external indications (i.e. crutches, a cast, pregnancy, etc.) of the condition and no negative connotation associated with the action. However, anecdotal evidence suggests that personnel who are restricted from duty for mental health issues often face negative social stigmas, exacerbated by perceived impacts to the individual’s career and unit operations. Commanders are charged with the ongoing responsibility of assessing a subordinates’ ability to perform; however, this constant evaluation may stifle members’ willingness to seek mental health treatment.

²³ Interview with Dr. Craig J. Brain, University of Utah, National Center for Veterans Studies, Squadron Officers College, Maxwell AFB, AL, Class 13E, phone interview by co-author, Capt Timothy Finley, 20 August 2013.

²⁴ Occasionally, negative career impacts for seeking mental health assistance are beyond a commander’s ability to control. These usually involve regular background investigations, to include the Personnel Reliability Program (PRP), Special Access Programs, and Top Secret / SCI clearances. For example, security clearance investigations use a SF86 worksheet (Appendix B) to check individuals’ backgrounds. This worksheet includes a question on mental health. While Executive Order 12968, *Access to Classified Information*, clearly states that behavioral health counseling is not reason enough to revoke or deny a security clearance, anecdotal evidence suggests that some personnel avoid seeking mental help because they fear repercussions to their clearance. The US Army’s Personnel Security website attempts to address this fear, stating that, “99.98 percent of cases with psychological concerns obtained/retained their security clearance eligibility. Most cases that resulted in a denial or revocation had other issues in addition to psychological concerns.” However, military members have repeatedly demonstrated that they fear asking for emotional wellbeing support because they believe answering “yes” to this question will lead to denial, suspension or possible loss of a security clearance (Army PERSEC, 2013).

"I had a friend that saw a psychiatrist because his girlfriend had broken up with him. His girlfriend cheated on him while she was deployed with another unit member. Once he found out and the relationship ended, he utilized Military One Source and was referred to a psychiatrist. Once the commander found out about my friend's sessions, he immediately removed the Airmen's ability to bear arms. Because Security Forces Airmen are required to carry firearms in their daily duties, the only eligible job for my friend was working at the Visitor's Center. This halted his career progress to become a seasoned patrolman and upgrade to Desk Sergeant."

Air Force commanders play a critical role in setting unit culture and determining how seeking emotional wellness support affects an individual's career. However, interviews with multiple graduated squadron commanders reveal that they only receive general guidance with regard to mental health information, little-to-no formal training on mental health care, and they are not equipped with appropriate responses to help hurting Airmen.²⁵ In fact, current training only consists of information on suicide prevention and commander directed evaluations. There is no required or consistent training for commanders on what is or is not in their authority regarding clearances, how to negate social stigmas within a group when a member seeks support, or how to ensure there are no unintentional, or unnecessary career implications, even though leadership has access to parts of subordinates' sensitive mental health records. Considering the range of responsibilities inherent in command, the lack of mandatory training for mental health related issues represents a significant gap in the current system.

DoD 6025.18-R, Paragraph C8.2; 45 CFR 164.502(b), 164.514(d), makes exceptions to the Health Insurance Portability and Accountability Act (HIPAA) that allow commanders to receive protected health information on subordinates.²⁶ The DoD has attempted to protect personnel who self-diagnose and voluntarily seek behavioral help, "[to] dispel the stigma of seeking mental health care and/or substance misuse education services."²⁷ Unfortunately, this guidance is caveated in the following guidance:

*"Healthcare providers shall follow a presumption that they are not to notify a Service member's commander when the Service member obtains mental health care or substance abuse education services. ... Unless this presumption is overcome by one of the notification standards listed in Enclosure 2 of this Instruction, there shall be no command notification."*²⁸

Mandatory reporting items from Enclosure 2 include: harm to self, harm to others, harm to mission, special personnel (to include those enrolled in the Personnel Reliability Program), in-patient care, acute medical conditions interfering with duty, substance abuse treatment programs, command-directed mental health evaluations, and other special circumstances.²⁹ The unique

²⁵ Interview with a colonel, Air War College, Maxwell AFB, interview by Michelle Woodie, 26 August 2013.

²⁶ TRICARE Management Activity, "Military Command Exception," <http://www.tricare.mil/tma/privacy/Military-Command-Exception.aspx>.

²⁷ Stanley, Clifford L., Under Secretary of Defense for Personnel and Readiness, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," *Department of Defense Instruction Number 6490.08*, (Washington DC: Department of Defense, 17 August 2011), <http://www.dtic.mil/whs/directives/corres/pdf/649008p.pdf>.

²⁸ TRICARE Management Activity.

²⁹ Stanley, Clifford L., Under Secretary of Defense for Personnel and Readiness, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," *Department of Defense*

nature of Air Force operations, especially the large number of personnel on flight status or in other special programs, means that caveats to confidential reporting affect a far greater percentage of USAF personnel than members of other services. Although the DoD caveats the notification standards as responsible for releasing “the minimum necessary for assuring proper execution of the military mission,”³⁰ commanders have wide discretion in how they choose to use this information. Their choices in these situations often drive unit perceptions of negative impacts on a member’s career.

Commanders have a great deal of flexibility over how they respond when a member seeks Mental Health’s help; however, DoDI 6490.08, Enclosure 2, Paragraph 3 encourages them to reward positive behavior. “Commanders must also reduce stigma through positive regard for those who seek mental health assistance to restore and maintain their mission readiness, just as they would view someone seeking treatment for any other medical issue.”³¹ While flexibility is important, misunderstanding or “kneejerk” responses to Airmen’s problems may unintentionally negate a unit’s strong Wingman culture and ruin the individual Airman’s career. Thus, establishing mental health training for commanders and ensuring USAF leadership maintains consistent messaging are imperative to correcting these stigmas.

Unfortunately, the consequences of adverse impacts of one individual can perpetuate this stigma. In 2010, Airmen First Class (A1C) Snuffy (name changed to protect privacy) told his fellow airmen in confidence that he was contemplating suicide, but had not yet formulated a plan. He was exceptionally frustrated with his career in the intelligence field and consequently his performance suffered. A1C Snuffy, often socially isolated himself from his peers, and because he was not performing at work, he felt ostracized from his coworkers. However, never during this time was the integrity of classified material an issue or perceived as something he could not handle. After the group commander learned of A1C Snuffy’s suicidal feelings, he decided to take away the Airman’s badge for 45 days and did not allow him to work in classified areas. The commander refused to notify the US Office of Personnel Management (OPM) of his decision, because he did not want to administratively affect the individual’s clearance. Unfortunately, the other airmen and NCOs within A1C Snuffy’s workplace noticed his absence and knew of the circumstances since they were the ones he talked to first. This created the perception that A1C Snuffy was being punished for reporting seeking help. A few months later, another Airman from the same unit was having issues following the death of a friend in Afghanistan. She was very concerned that if she asked for help from the Chaplain she would also lose access to the vault, citing A1C Snuffy as her example.

Two problems are clear in A1C Snuffy’s experience. First, the commander further isolated the hurting Airman from his peers and his co-workers, even though he did not appear to present any risk to classified information. By further isolating A1C Snuffy, the commander inadvertently raised his risk of suicide because his supervisors and fellow Airmen were unable to interact with him during the day. Second, because the unit was extremely small, A1C Snuffy’s banishment from work created the perception that anyone who asked for emotional help was at risk of losing their clearance and/or access to their workspace. Clearly, if the USAF wishes to change its culture, it is imperative that commanders consistently apply USAF guidance to enable effective cultural messaging that seeking help is wise.

Instruction Number 6490.08, (Washington DC: Department of Defense, 17 August 2011), <http://www.dtic.mil/whs/directives/corres/pdf/649008p.pdf>.

³⁰ TRICARE Management Activity.

³¹ Stanley, 6.

Senior leadership plays a critical role in changing cultural perceptions of mental health assistance. A study conducted by the University of Maryland found that military officers tended to perceive subjects as more weak for requesting support than did junior enlisted soldiers.³² According to Crosby Hipes, this finding implies the significant role leadership plays in carrying on stigmas or “preserving group norms.”³³ The Armed Forces Network has recently featured Army senior leaders publicly testifying, via the “Real Warriors, Real Battles, Real Strength” campaign. Targeted to directly counter the University of Maryland’s findings, this effort features senior officers and high-ranking enlisted leaders, including Sergeant Major of the Army Raymond Chandler, who sought mental health assistance. The program’s consistent theme is that seeking help is not a sign of weakness; rather, it shows self-awareness and is not punishable. Unfortunately, Air Force senior leaders do not participate in this program and there is not a similar USAF effort to establish openness about behavioral health. Stigmas against seeking emotional assistance are deep-rooted in Air Force culture, so leadership must establish long-term, consistent and directed messaging to overcome perceived command barriers and cultural norms. Encouraging USAF senior leaders and officers to publicly admit their use of mental health wellness will improve Wingman culture by emphasizing normalization of emotional health care.

Reactive Care

“The system works, but only for the people that use it.”³⁴

- USAF Captain & Primary Mental Health Care Provider

As with all branches of medicine, there are large and varied methods and practices that mental health providers use to provide patients with tailored care. In order to help facilitate mental health care and develop treatment options, the US military has created a suite of mental wellness options, ranging from board certified psychiatrists, to chaplains, to trained counselors available in person or by phone. Well publicized in print and online, during “wingman” and safety stand down days, and familiar to unit First Sergeants, every Airman should know these services exist. Unfortunately, despite varied and well-publicized treatment options, the USAF’s at-risk Airmen are not seeking help and mechanisms do not exist to allow the mental healthcare system to proactively engage at-risk Airmen.³⁵

Air Force mental health’s greatest challenge is that caregivers are limited to reactive care, because providers cannot administer treatment until individuals ask for help. Most Airmen must voluntarily seek assistance from the Mental Health clinic, Chaplains, Military OneSource or other programs, because caregivers cannot seek out hurting personnel in their workspaces.³⁶

³² Hipes, 8.

³³ Ibid., 8.

³⁴ Interview with a captain and licensed USAF mental health care provider, Squadron Officers College, Maxwell AFB, AL, Class 13E, interview by co-author, Capt. Benjamin C. Jamison, 18 August 2013.

³⁵ Jones, N., H. Burdett, S. Wessely, & N. Greenberg, “The Subjective Utility of Early Psychosocial Interventions Following Combat Deployment,” *Occupational Medicine* 61, no. 2 (2011): 102-107.

A British study of troops undergoing mandatory post-deployment decompression therapy found that 80% of participants were either ambivalent or did not want to attend the training. However, 91% of participants reported that the training was helpful in coping with post-deployment stress after they complete it. Respondents that desired to participate in the training reported even higher levels of perceived helpfulness.

³⁶ Ibid.

While commanders retain the ability to order a commander-directed mental health evaluation (CDE), this action usually requires legal support and documented justification. In other words, the CDE is a reactionary tool commanders use when behavioral problems surface, not preventative medicine. While a CDE may help an individual deal with emotional issues, mental health treatment is empirically more effective when individuals choose help on their own.³⁷ In an attempt to encourage service members to self-diagnose, the United States Department of Veterans Affairs (VA) maintains a robust website with a variety of tools available to personnel seeking help or information about mental health.³⁸ This website provides questionnaires and information on suicide prevention, substance abuse, military sexual trauma, depression, PTSD, anxiety, bipolar, schizophrenia, and mental health recovery. By answering a short survey, at-risk Airmen can check their systems against common military mental health ailments, receiving instantaneous recommendations on whether they should seek help and directions to different treatment avenues, including Military OneSource and the National Resource Directory. While the VA website contains a wealth of knowledge and tools, it is not well advertised at the squadron level. Determining the extent that Airmen utilize this resource will require further study; however, there are ample resources to encourage at-risk Airmen to seek counsel.

Falling outside the umbrella of formalized care, Air Force Chaplains offer Airmen a unique service that is completely confidential. Specializing in “spiritual care,” Chaplains allow Airmen to process experiences in an environment designed to promote “healthy interpersonal relationships, responsible living, and the ability to respond effectively to stress, hardship, and tragedy.”³⁹ Unlike any other mental health resource in the military, Chaplains guarantee privileged communication and total confidentiality.⁴⁰ Additionally, Chaplains can meet Airmen “where they are,” rather than waiting for them to self-identify by walking into a clinic. The Army and Marine Corps capitalize on this unique blend of privileges; assigning Chaplains to battalion-level combat units as members of the Battalion Battle Staff rather than in centralized commands. By placing Chaplains at the squadron-level rather than at the base’s chapel, Chaplains can provide personnel with a unit-level confidant to build mental health resiliency with zero negative stigmas and/or career risks.⁴¹ Unfortunately, Chaplains do not specialize in mental healthcare, and this informal care avenue cannot always meet Airmen’s unique needs.

Military OneSource, an online tool equivalent to a civilian Employee Assistance Program, is available to Airmen seeking specialized assistance for mental health, family advocacy, and a variety of other issues. For more than a decade, Military OneSource has offered free treatment from licensed mental health providers either in-person or by phone to military members. Designed to handle non-medical, short-term issues that do not require formal medical diagnosis, OneSource’s clients are usually limited to 12 counseling sessions in a 6-month period. While Military OneSource encourages providers to diagnose military members, it does not

³⁷ Ibid.

³⁸ United States Department of Veterans Affairs, Mental Health, <http://www.mentalhealth.va.gov/gethelp.asp>.

³⁹ Air Force Policy Directive 52-1, “Chaplain, Chaplain Service,” (Washington DC: Department of the Air Force, HQ USAF/HCX, Certified by Maj Gen Charles C. Baldwin, 2 October 2006) http://static.e-publishing.af.mil/production/1/af_hc/publication/afpd52-1/afpd52-1.pdf.

⁴⁰ Air Force Instruction 52-101, “Chaplain, Planning and Organizing,” (Washington DC: Department of the Air Force, HQ USAF/HCX, Certified by Maj Gen, Lorraine K. Potter, 10 May 2005) http://static.e-publishing.af.mil/production/1/af_hc/publication/afi52-101/afi52-101.pdf.

⁴¹ Assignment levels for Army Chaplains (i.e. at the Bn-level) are in the Religious Support Handbook for the Unit Ministry Team and the Army’s Command Battle Staff Handbook, page 129. The handbook notes that a Bn Chaplain’s duties include, “Works with the S1 and the battalion surgeon in the battalion mental health program to include training unit leaders in the preventive aspects of stress on soldiers.”

require a diagnosis as part of the evaluation. If an Airman's issues remain unresolved following these sessions, the OneSource provider can refer him or her to Tricare for continuing treatment. However, to continue receiving military funded treatment, members must visit a military Mental Health Clinic.⁴²

Once an Airman decides to formally seek Mental Health's help, he or she meets with a licensed mental health care provider for diagnosis and to begin a treatment routine. Anecdotal evidence and survey data indicate that this step, getting personnel to voluntarily visit the Mental Health Clinic, remains the greatest challenge in stemming the service-wide rise in mental health sickness and injuries. After "walking through the door," an Airman's treatment is confidential, unless they meet one of the several classifications mentioned in the commander's section of this document.⁴³ Regardless of whether this treatment is effective, studies indicate that personnel continue to fear seeking help, and mental health remains a critical concern across the DoD. Responding to these issues, Congress enacted measures that attempt to identify at-risk personnel returning from combat deployments without stigmatizing them.

Congress, in conjunction with the DoD and the VA, developed new legislation and guidance for mental health care in recent years. The 2010 National Defense Authorization Act provided guidance for reforming the military's pre and post-deployment mental health assessment.⁴⁴ The legislation, which is meant to identify, standardize, and treat at-risk personnel, requires all service-members who deploy in support of contingency operations to meet with a mental health care provider two months prior to deploying and three separate times after returning home.⁴⁵ Like their British counterparts, many of these personnel might normally deny their need for treatment; however, research shows that receiving mental health training and guaranteeing a member's ability to speak, in person, with a mental health care provider offers tangible post-deployment behavioral benefits.⁴⁶ The 2013 National Defense Authorization Act expanded the 2010 legislation further, including guidance on sharing information between the DoD and the VA, on developing peer support counseling programs and addressing the unique challenges military culture presents to service members in need of mental health care.⁴⁷

The USAF, in conjunction with the DoD and the VA, maintains a multitude of avenues for Airmen seeking mental and emotional healthcare. Formal treatment options are well defined, while Air Force squadron-level programs only exist as individual units' creations, lacking

⁴² Military One Source, <http://www.militaryonesource.mil/>.

& Interview with Dr. Timothy Reger, D.Min, LPC, BCPC, BCPC and Military OneSource Provider, Squadron Officers College, Maxwell AFB, AL, Class 13E, phone interview by co-author, Capt Chad Reger, 18 August 2013 and 31 August 2013.

⁴³ Interview with a captain and licensed USAF mental health care provider, Squadron Officers College, Maxwell AFB, AL, Class 13E, interview by co-author, Capt. Benjamin C. Jamison, 18 August 2013.

⁴⁴ Public Law 111-84, "National Defense Authorization Act for Fiscal Year 2010," (Washington DC: 111th Congress, 28 October 2009) http://www.intelligence.senate.gov/pdfs/military_act_2009.pdf.

⁴⁵ Rice, Charles L., M.D. President, Uniformed Services University of the Health Sciences Performing the Duties of Assistant Secretary of Defense (Health Affairs), memorandum for the Assistant Secretary of the Army, Assistant Secretary of the Navy, Assistant Secretary of the Air Force, Director, Joint Staff, 19 July 2010.

Section 708 of the 2010 National Defense Authorization states that member will meet "person-to-person" with a health care provider four times in the their deployment cycle. First in the two months prior to their deployment and then three times after their return. They must meet in the first 3 to 6 months after they return, again between 7 and 12 months after their return and finally between 16 and 24 months from their return.

⁴⁶ Ibid.

⁴⁷ National Defense Authorization Act for Fiscal Year 2013, (Washington DC: One Hundred Twelfth Congress of the United States, at the Second Session, 3 January 2012) <http://www.gpo.gov/fdsys/pkg/BILLS-112hr4310enr/pdf/BILLS-112hr4310enr.pdf>.

normalization or standardization. Hampered by an inability to “reach out” to Airmen and forced to wait on personnel to voluntarily seek treatment, the system is almost totally reactive. Unlike other Air Force healthcare subsets, the only formalized preventative mental healthcare in existence is “resiliency days,” which focus on suicide prevention. In light of the reactive nature of the Air Force’s mental healthcare, implementation of a more proactive system is required. Without it, individuals will continue struggling to fix emotional injuries that may have been prevented with early treatment. In short, treatment is available, but identifying at-risk Airmen and getting them “through the door,” remains problematic.

PART III: RECOMMENDATIONS

While this study identifies multiple shortcomings in the Air Force’s comprehensive mental wellness program, the authors have formulated a three-pronged approach to comprehensively address and rectify systemic shortcomings and inadequacies in the current construct. The following courses of action (COA) provide command, unit, and policy recommendations intended to normalize mental healthcare perceptions; honestly and aggressively pursue negative stigmas; reevaluate retributive measures (both functional and inferred); establish formal commander training programs; foster a spirit of open emotional healthcare discussions; and, tangibly tweak treatment mechanisms to emphasize preventative care. Each section submits tangible recommendations intended to provide senior leadership with a range of COAs that, if implemented together, promise to enhance mental healthcare across the Air Force.

Destroying Stigma

If the USAF does not address the cultural biases and negative stigmas against seeking mental health assistance that currently permeate its ranks, no service-wide fixes will mitigate rising suicide and negative behavioral health trends. To truly address the expanding mental health challenges, personnel must attack stigmas at all levels. The Air Force must work to normalize cultural views on seeking mental health assistance by eliminating overt and inferred negative stigmas, biases and preconceptions for all USAF personnel. Until Mental Health treatment and behavioral maintenance are perceived as entirely benevolent, benign operations, wellness options will remain reactionary and stigmatized.

Because cultural change is incredibly challenging, the USAF should directly engage junior enlisted and commissioned personnel, dispelling mental health misconceptions and preventing negative stigmas from flourishing. The Air Force’s Sexual Assault Prevention and Response (SAPR) program is a valid benchmark for establishing a systematic approach to changing culture; a similar squadron-level program of mental health wellness training should be initiated service wide. Ironically, less than a decade ago, the Air Force maintained the “gold-standard of suicide prevention programs,”⁴⁸ where units promoted Wingmen concepts via round-table discussions and face-to-face education. However, this training’s shift to computer-based instruction has negated the program’s previous effectiveness. As Dr. Craig Bryan noted, the Air Force should reestablish peer-to-peer training for suicide prevention and widen the program to

⁴⁸ Interview with Dr. Craig J. Brain, University of Utah, National Center for Veterans Studies, Squadron Officers College, Maxwell AFB, AL, Class 13E, phone interview by co-author, Capt Timothy Finley, 20 August 2013.

include behavioral health wellness at large.⁴⁹ In a guided, free-flow, peer-based conversation, Airmen are safe to discuss emotional health issues without danger of retribution. By placing junior Airmen in this environment, the Air Force can normalize mental health issues and nurture cultural change at the peer level. By reestablishing a strong and effective Wingman culture, the USAF can affect far greater change because support and peer approval often catalyze difficult social decisions. Rather than attempting to fight through emotional adversity alone, Airmen can leverage the strength of peer influence to normalize treatment and maintenance.

Front-line supervision plays a vital role in changing cultural stigmas, especially outside structured discussion forums. By refusing to allow negative banter in workspaces' daily discourse, Sergeants and Captains can provide immediate and powerful feedback when junior Airmen voice negative, detrimental ideas and preconceptions about mental health treatment. Airmen at all levels should be directly and assertively corrected by their supervisors the instant they besmirch personnel for seeking treatment or support, especially when these slights are couched in innuendo and doublespeak. The result of this intervention and mentorship is two-fold, because it promotes a culture more conducive to seeking and receiving emotional support and, more importantly, encourages suffering individuals to seek treatment. By interjecting in and disrupting negative conversations, front-line supervisors indirectly encourage observers who are quietly considering help. Once hurting personnel realize that peers and direct supervision support their needs, the likelihood that affected Airmen will seek professional support is dramatically increased. Daily workspace discussions promoting Wingmanship and support may be the key ingredient in curing stigmas surrounding mental injuries.

Senior leaders can also affect Air Force-wide stigmas by adopting the Army's example of openly sharing their experiences with mental and emotional wellness. Since studies repeatedly show that junior officers believe behavioral assistance negatively influences their careers, senior leaders' testimonies may have tremendous influence over cultural stigmas within the Air Force, especially preconceived notions held by the officer corps. If senior leadership demonstrates the courage to overcome established negative paradigms and surmount insidious culture, then junior members will follow suit. Commanders can approach mental health with commonplace regularity in a matter-of-fact timbre, which will encourage personnel who lack confidence to seek assistance. Furthermore, by initiating this dialog with middle-tier leaders, USAF senior leaders can create an environment that destroys stigmas. Senior leaders and commanders play a critical role in setting organizational culture, by openly discussing their emotional health experiences they can affect positive change across the Air Force.

Commanders' Influence

Senior leadership cannot simply tell anecdotes of personal mental health experiences and expect revolutionary cultural change. Rather, they must articulate the organization's mental health vision, set expectations for commanders and drive the Air Force's conversation by exerting decision-making influence. A conscious effort to mitigate biases and influence mental health stigmas' impact on positional or promotional appointments is critical. Senior leaders must demonstrate to subordinates and commanders that seeking mental health assistance will not preclude them from positional or promotional considerations. As demonstrated throughout this study, commanders' actions are often viewed as retributive and current policies cater to knee-jerk reactions, based on the individual leader's perceived risk. Whether a commander chooses to

⁴⁹ Ibid.

seize an access badge, remove someone from flight status, or suspend an Airman's ability to carry weapons, these reactions foster a perception of hypocrisy when compared to the "no effect on your career" environment that encourages personnel to seek care.

Senior leaders should institute several changes to standardize USAF policy and rectify commanders' arbitrary responses when personnel seek emotional treatment. First, the USAF should perform a blanket reevaluation of mental health policies, ensuring they are *truly* non-punitive and non-retribution. More often than not, retribution is subversive and incognito, often one or two times removed from the immediate action. Second, senior leadership should clearly articulate their behavioral health expectations to the total force, setting organizational expectations of how members who voluntarily seek treatment should be treated. Third, commanders should receive dedicated training on effectively dealing with members who seek mental health assistance. By combining these actions, senior leaders can drive cultural change, build commanders who are better equipped to help hurting Airmen and standardize USAF expectations of mental health wellness. To drive culture change, leadership must initiate open, frank discussions while establishing organizational goals and formal commander's training.

Healthcare Changes

While the Air Force's current mental wellness system is robust, it faces a severe challenge in getting personnel to voluntarily seek help. The USAF can take two steps to empower mental health providers and shift to an active behavioral healthcare system. First, integrating Chaplains into squadrons will allow Airmen to discreetly access confidential help whenever they need it. Additionally, putting Chaplains at the unit level allows them to be much more proactive in getting to know Airmen, which helps them recognize subtle indicators of emotional distress and establish trusting relationships with more personnel. Second, the Air Force should reexamine the Mental Health clinic. While offering centralized and discrete treatment, embedding Mental Health in normal medical departments (i.e., public health and flight medicine) would place providers within established healthcare systems, allowing them to create relationships with personnel during yearly physical examines, schedule discrete appointments and quietly monitor members' post-deployment health. Like embedding Chaplains at the unit-level, this action allows discrete treatment, normalizes visits with Mental Health professionals as part of Airmen's yearly health assessments and transitions the current system to a more proactive approach.

CLOSING

As the United States withdraws from over a decade of constant combat, the Air Force faces a crisis in its ability to identify and treat personnel who need mental health treatment. Plagued by cultural stigmas, arbitrary command signals, and a reactive mental healthcare system, double-digit suicide rates and multiple DoD-wide surveys indicate that personnel are scared to seek treatment. To address these issues, the USAF can implement several institutional changes to eliminate cultural stigmas within the service, ranging from organizational changes to establishing formal commander's training. While Air Force implementation of these recommendations is uncertain, research indicates that the Air Force must examine strategies to reduce stigmas associated with mental wellness. Mental and emotional injuries have similar effects as physical wounds encountered during combat and traumatic events; as such, the Air

Force is morally obligated to explore methods for helping Airmen overcome these challenges.

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Appendix A

Survey Appendix

Figure 1 – Survey template

This survey is intended to gather your opinions about CGOs willingness to use Mental Health services provided by the Air Force. Your participation in the survey is voluntary but will help leadership to ensure Airmen are willing to access the help they may need and support others in doing so.

Demographic Data (Check all that apply):

Flight Status PRP SCI I have deployed

Using the following scale, please rate your level of agreement with the following statements:

1 - Strongly Disagree 2 - Disagree 3 - Agree 4 - Strongly Agree

- I believe CGOs feel comfortable seeking mental/behavioral health.
1 2 3 4
- I can appropriately respond if/when an Airman shows signs that something is wrong.
1 2 3 4
- I know the Air Force's policy on suicide resiliency.
1 2 3 4
- The Air Force adequately supports survivors, family members, and co-workers of suicide attempts/victims.
1 2 3 4
- Mental health services are adequately available to AF members in need.
1 2 3 4
- The AF culture, in my unit, encourages individuals to seek mental health services when needed.
1 2 3 4
- The AF culture, as a whole, encourages individuals to seek mental health services when needed.
1 2 3 4
- The AF has provided CGOs with sufficient mental health/wellness training.
1 2 3 4
- I know someone who I believe needed or needs to seek mental health/wellness services, but has not done so.
1 2 3 4
- CGOs believe a negative stigma exists when personnel seek mental wellness professionals' help.
1 2 3 4

In 3 words, describe the generic individual that seeks mental health services:

Check any perceptions CGOs hold that would inhibit motivation to seek mental health/wellness services:

- It is too embarrassing Believe the problem will solve itself Will be blamed for having the problem
- There is not enough confidentiality It will harm one's career Might be seen as weak
- Members of the unit might lose confidence in the officer My unit leadership might treat the officer differently
- Other reasons not listed _____

Are you aware of the following services? Please indicate (circle) whether they are confidential or not:

Mental Health Office:	Yes	No	;	Confidential	Not Confidential
Chaplain:	Yes	No	;	Confidential	Not Confidential
Military One Source:	Yes	No	;	Confidential	Not Confidential
Military Family Life Counselors:	Yes	No	;	Confidential	Not Confidential

Figure 2 – Survey data for all participants

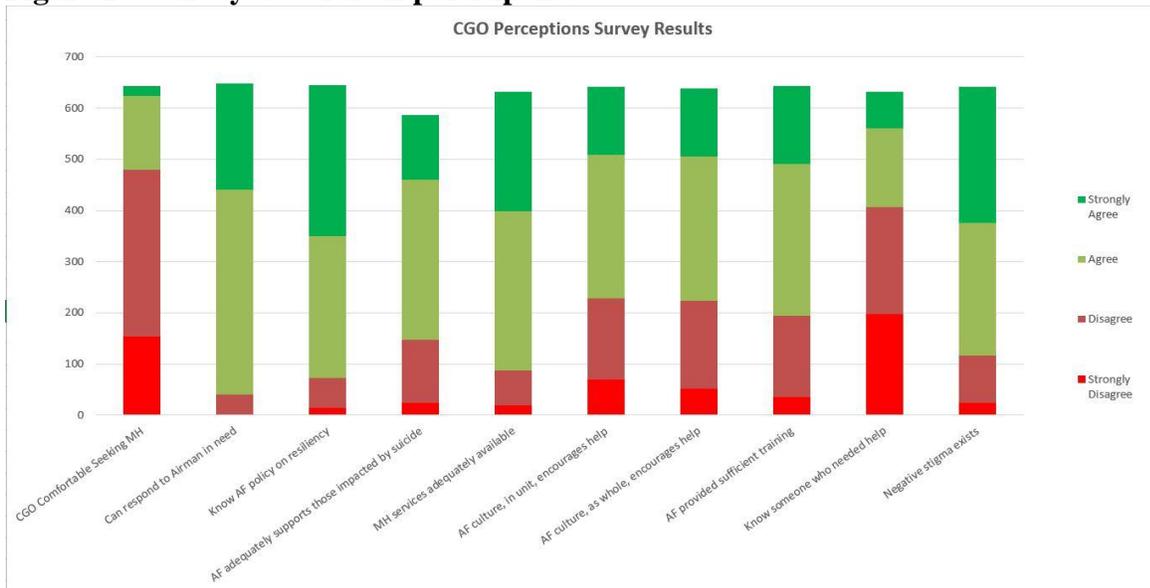


Figure 3 – Survey data for flight status participants

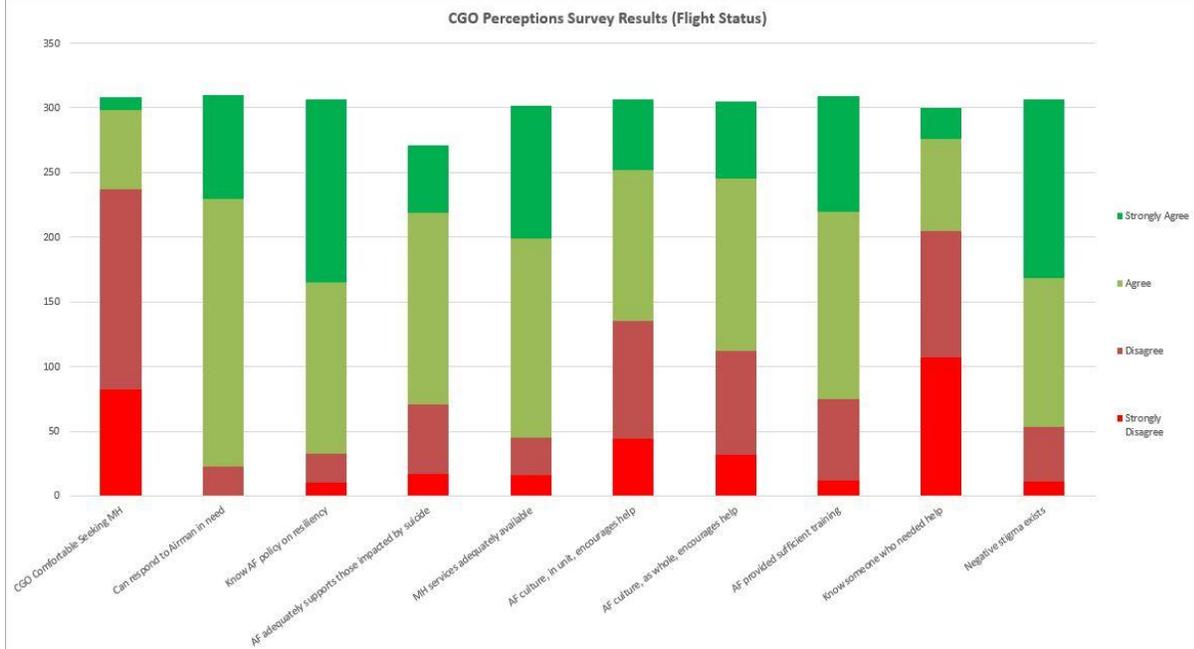
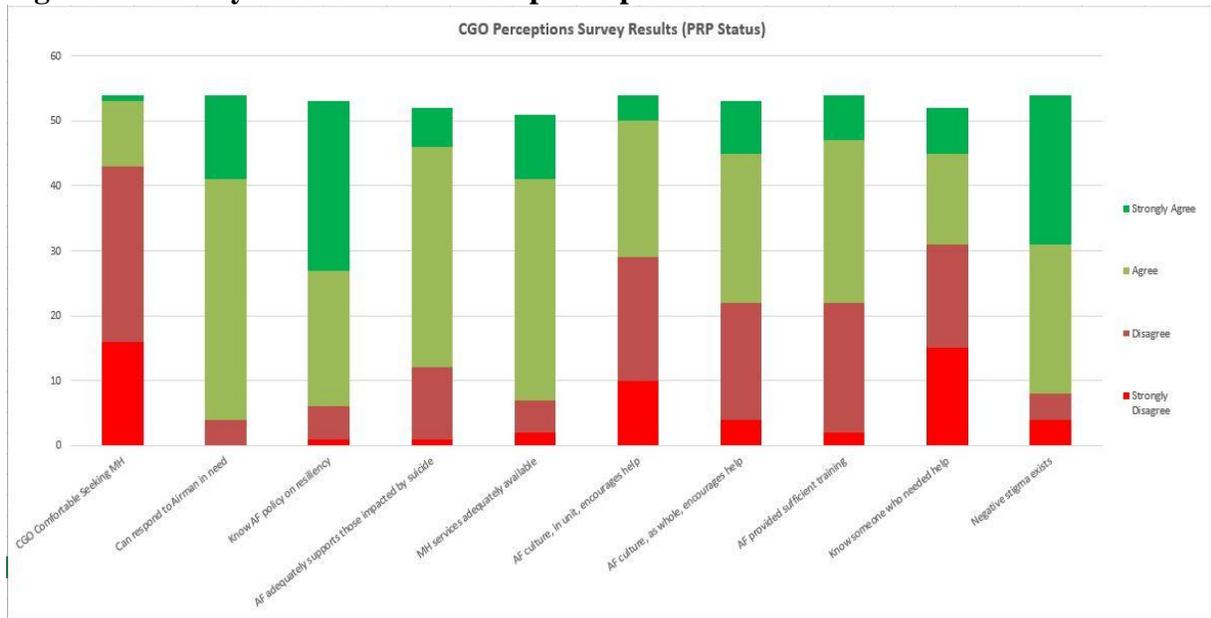


Figure 4 – Survey data for PRP status participants



Appendix B

Squadron Officer School Demographics

Start: 2013-08-12 **Grad:** 2013-10-04

NOTE: 696 out of **742** students have updated/confirmed their personal information.

Please take this into consideration when viewing the statistics.

Summary	Gender	Married	SOS by Correspondence	Race
Class size: 742 Avg age: 30	M: 612 F: 130	Y: 499 UNKNOWN: 1 N: 242 Accompanied 89	622 Attended ASBC 542	White: 607 African American: 56 Asian: 29 Multi: 11 Unknown: 33 American Indian: 1 Hawaiian or Pacific: 5
Education	Service Component	Commissioning Source	MAJCOM	AFSC Breakdown
MASTERS DEGREE: 314 BACHELORS: 8 REGISTERED NURSE: 4 UNKNOWN: 33 JURIS DOCTORATE: 8 MASTERS: 5 OTHER: 9 BACHELORS DEGREE: 361	CIVILIAN: 2 ANG: 21 AF ACTIVE: 699 AFRES: 20	USAFA: 172 OTS-COT: 25 ROTC: 370 AMS: 41 UNKNOWN: 2 OTS-BOT: 109 OTHER: 23	PACAF: 52 ACC: 158 USAFA: 4 AFCEE: 1 AETC: 81 AFELM: 1 AFDW: 6 HAF: 1 AFGSC: 52 AFRC: 11 AMC: 113 AFMC: 56 AFSOC: 56 -----: 11 OSD (AFELM): 1 AFSPC: 58 AFOTEC: 3 AFOSI: 3 AFCAA: 1 AFMSA: 1 UNKNOWN: 15 AIA: 1 AFPAA: 1 AFELM: 1 USSOUTHCOM: 1 AFPC: 2 USAFE: 39 AFISRA: 13	Acquisitions/Finance: 93 Bomber: 11 Chaplain Corps: 4 Communications: 29 Fighter: 34 Helicopter: 14 Intel: 39 JAG Corps: 9 Logistics/Mx: 45 Medical: 42 Missing/Invalid: 14 Mobility: 104 Operations (Other): 139 Pilot (Other): 61 Pilot (RPA): 19 Space/Missile: 24 Special Duty: 6 Special Investigations: 4 Support: 45 Weather: 4 All Others: 2 NON-LINE TOTAL: 55

Appendix C

SF86 Appendix

Standard Form 86
 Revised December 2010
 U.S. Office of Personnel Management
 5 CFR Parts 731, 732, and 736

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

Form approved:
 OMB No. 3206 0005

Section 21 - Psychological and Emotional Health

Mental health counseling in and of itself **is not a reason** to revoke or deny eligibility for access to classified information or for a sensitive position, suitability or fitness to obtain or retain Federal employment, fitness to obtain or retain contract employment, or eligibility for physical or logical access to federally controlled facilities or information systems.

21.1 In the last seven (7) years, have you consulted with a health care professional regarding an emotional or mental health condition or were you hospitalized for such a condition? Answer 'No' if the counseling was for any of the following reasons and was not court-ordered:

- strictly marital, family, grief not related to violence by you; or
- strictly related to adjustments from service in a military combat environment

Please respond to this question with the following additional instruction: Victims of sexual assault who have consulted with the health care professional regarding an emotional or mental health condition during this period strictly in relation to the sexual assault are instructed to answer No.

Complete the following if you responded "Yes" to having consulted with a health care professional regarding a mental or emotional health condition or were hospitalized for such a condition.

Entry #1		
Provide the dates of counseling or treatment. From Date (Month/Year) <input type="text"/> <input type="checkbox"/> Est. To Date (Month/Year) <input type="text"/> <input type="checkbox"/> Est. <input type="checkbox"/> Present	Provide the name of the health care professional. <input type="text"/>	Provide the telephone number of the health care professional. <input type="checkbox"/> International or DSN phone number <input type="checkbox"/> Day <input type="checkbox"/> Night Telephone number <input type="text"/> Extension <input type="text"/>
Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/> Country <input type="text"/>		
Provide the name of agency/organization/facility where counseling/treatment was provided. <input type="text"/> <input type="checkbox"/> Same as above		
Provide the address of agency/organization/facility provider. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) <input type="checkbox"/> Same as above Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/> Country <input type="text"/>		
Were you EVER admitted as an inpatient to the agency/organization where counseling/treatment was provided? <input type="checkbox"/> YES <input type="checkbox"/> NO You responded "YES" to having been admitted as an inpatient to the agency/organization where counseling/treatment was provided, was the admission voluntary or involuntary? <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary Explanation <input type="text"/>		
Entry #2		
Provide the dates of counseling or treatment. From Date (Month/Year) <input type="text"/> <input type="checkbox"/> Est. To Date (Month/Year) <input type="text"/> <input type="checkbox"/> Est. <input type="checkbox"/> Present	Provide the name of the health care professional. <input type="text"/>	Provide the telephone number of the health care professional. <input type="checkbox"/> International or DSN phone number <input type="checkbox"/> Day <input type="checkbox"/> Night Telephone number <input type="text"/> Extension <input type="text"/>
Provide the address of the health care professional. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/> Country <input type="text"/>		
Provide the name of agency/organization/facility where counseling/treatment was provided. <input type="text"/> <input type="checkbox"/> Same as above		
Provide the address of agency/organization/facility provider. (Provide City and Country if outside the United States; otherwise, provide City, State and Zip Code) <input type="checkbox"/> Same as above Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/> Country <input type="text"/>		
Were you EVER admitted as an inpatient to the agency/organization where counseling/treatment was provided? <input type="checkbox"/> YES <input type="checkbox"/> NO You responded "YES" to having been admitted as an inpatient to the agency/organization where counseling/treatment was provided, was the admission voluntary or involuntary? <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary Explanation <input type="text"/>		

Enter your Social Security Number before going to the next page