



Qualitative Study Examining Perceived Stigma and Barriers to Mental Health Care Among Student Veterans

RESEARCH

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ABSTRACT

Student veterans experience barriers when seeking and receiving mental health care. This qualitative study aimed to better understand how those barriers affect access to mental health care from the perspective of student veterans. Semi-structured interviews were conducted regarding the lived experience of student veterans and their perceptions of self-stigma and barriers to care. A deductive thematic analysis guided by phenomenological theory was applied. Analysis clarified several distinctive themes that provide implications for future psychosocial support and treatment interventions.

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With the introduction of the Post-9/11 GI Bill, which expanded education benefits for United States (US) military service members, enrollment by veterans in both undergraduate and graduate studies increased from approximately 500,000 in 2009 to around 1,000,000 in 2019 (US Department of Veterans Affairs, 2019). Student veterans (SVs) make up roughly 6% of the US undergraduate population (US Department of Veterans Affairs, 2020). While they experience many of the same academic and logistical challenges as their civilian counterparts, SVs also contend with unique mental health challenges that affect their wellbeing and functioning (McCaslin et al., 2014; see also Canfield & Weiss, 2015; Glover-Graf et al., 2010; Grossbard et al., 2014). An analysis of peer-reviewed studies found that SVs experience increased rates of health risk behaviors, psychological symptoms, and difficulties adjusting to school compared to their non-veteran student peers (Barry et al., 2014). Further, in a non-random national sample, approximately 35% of SVs experienced severe anxiety, 24% experienced severe depression, and 46% experienced significant symptoms of posttraumatic stress disorder (Rudd et al., 2011). Of particular concern, suicidal ideation among SVs is reported to be significantly higher than among non-veteran students (Rudd et al., 2011).

Compounding psychological distress, SVs differ demographically from their non-veteran student peers, which may impact their ability to navigate the transition from the military to a college setting (Wurster et al., 2013). Specifically, compared to their peers, SVs are older, carry more work responsibilities, and occupy family roles, such as being a parent or spouse (Livingston et al., 2011). According to the US Department of Veteran Affairs (2020), most SVs are 24–40 years of age, with only 15% falling within the 18–24 age range of typical college students. Roughly 47% of SVs are married and have children, with 15% identifying as single parents. Additionally, approximately two-thirds are first-generation college students. Further, SVs are twice as likely as their non-veteran peers to have an off-campus job while attending school. Amplifying these demographic differences, SVs also report that they stand apart due to their military experiences and find it difficult to relate to other students on campus, often preferring the company of other veterans (Borsari et al., 2017; Darcy & Powers, 2013). Finally, transitioning from the hierarchical military environment to an unstructured college environment with its own set of values and priorities may prove challenging and affect their sense of belonging in campus life (Arminio et al., 2018; Messina, 2014; Mobbs & Bonanno, 2018). Thus, acclimation to civilian and college life may necessitate not just a reconceptualization of their occupation but also a renegotiation of their identity and beliefs (Rumann & Hamrick, 2010).

Despite the need for treatment and support, SVs experience unique barriers to seeking and receiving mental health care. Some of these barriers include stigma, a perceived lack of support, and limited access to resources (Norman et al., 2015). Compared to their civilian peers, SVs tend to endorse low levels of positive attitudes toward mental health services (Currier et al., 2017). A study examining campus services among SVs with traumatic injuries found that even in the face of impaired physical and psychological functioning, less than 19% of the sample utilized counseling services (Elnitsky et al., 2018).

BARRIERS TO SEEKING AND RECEIVING CARE

Stigma is a well-documented barrier to care and has several definitions, given that research in this area is highly multidisciplinary (Link & Phelan, 2001). Nonetheless, it primarily involves labeling the differences of others, associating negative attributes and stereotypes with those differences, and separating “us” from “them.” “They” are believed to be inherently different from “us” in a way that fosters exclusion, discrimination, and loss of status. Stigma can be demonstrated at individual, interpersonal, and structural levels (Link & Phelan, 2001). In the present study, we define stigma as the internalization of negative attitudes, stereotypes, and prejudices about mental illness toward the self. Self-stigma is the internalization of public stigma, negative attitudes, and discrimination against a group of people by the larger population (Corrigan, 2010; Corrigan & Rao, 2012).

Stigma has a host of adverse sequelae. Studies show that some individuals internalize negative attitudes toward mental illness (i.e., self-stigma) while experiencing discrimination from others for their mental illness (i.e., interpersonal discrimination) and being subject to legislation that restricts their access to mental health care (i.e., structural discrimination) (Corrigan, 2004; Rüsch et al., 2005). This, in turn, has several implications for help-seeking behavior. Theoretical models of help-seeking suggest that it is largely influenced by beliefs about mental health and its treatments (Mojtabai et al., 2002). Thus, it is not surprising that several laboratory and population-level studies have found that public stigma is inversely related to help-seeking for mental health, treatment adherence, and healthcare utilization (Cooper et al., 2003; Leaf et al., 1987; Phelan et al., 2000; Rüsch et al., 2005).

A review by Vogt (2011) found that stigma was a significant barrier to care among military service members and veterans. A study by Cheney et al. (2018) on veterans' barriers to mental healthcare access at the US Department

of Veterans Affairs (VA) found that stigma reinforces the belief that help-seeking indicates weakness or failure, which is influenced in part by military attitudes and socialization fortifying ideas around self-reliance. As a result, veterans' motivation to access healthcare may be reduced. Consistent with Cheney's 2018 study of VA use among a random sample of female veterans from Operation Enduring Freedom/Operation Iraqi Freedom, Newins (2019) found stigma to be a reliable barrier to treatment. Further, a study by Blais and Renshaw (2013) found that, when accounting for perceptions of stigma from others, self-stigma was the most salient predictor of intentions to seek mental health services among National Guard and Reserve members. While self-stigma has been minimally examined among SVs to date, a study found that self-reliance and emotional control, which are both prized in military culture, were mediating variables in the relationship between traditional masculine ideologies and self-stigma among SVs (Currier et al., 2017). Finally, stigma and other barriers to care have been reported twice as much by military personnel who experience mental health problems, suggesting that those in most need of services may perceive the most significant challenges in accessing care (Hoge et al., 2004).

METHOD

Building off the research presented here, the primary aim of this qualitative study was to better understand mental health care access from the perspective of SVs. To expand knowledge within the domains of stigma and barriers to care, this study sought to gather data to inform future psychosocial support and treatment interventions to meet the needs of this population.

PARTICIPANTS

Participants for the study were recruited between August and December 2020. The inclusion criteria for the sample of SVs included those enrolled in an academic institution (part- or full-time), identified as a military service veteran regardless of deployment or combat status, and were 18 years of age or older. The study protocol was reviewed and granted exempt status by the Teachers College, Columbia University Institutional Review Board (IRB) in August 2020 (20–385).

SVs ($n = 12$) were passively recruited through an invitation to participate in key informant interviews by providing their email address at the end of a survey inquiring about stigma and barriers to care. The study recruited SV participants through the VA's Veterans Integration to Academic Leadership (VITAL) program and emails and flyers to national SV organizations, collegiate SV organizations, and collegiate mental health clinics across all 50 states.

Of those who volunteered to participate in the key informant interview ($n = 12$), five (42%) completed the interview (see Table 1 below). The mean participant was 32.40 years old ($SD = 2.70$), identified predominantly as White (80%) and heterosexual (60%), with an even distribution between men and women. Overall, the sample was primarily composed of those not in a relationship (60%), with 60% holding an associate's or bachelor's degree. All were full-time students, and many were employed (60%). The majority served in the Army (60%), were from the mid-level enlisted ranks (80%), had deployed at least once (80%), and were currently receiving mental health services (60%). All those with previous use of mental health services (80%) had obtained them through the VA.

	MEAN	RANGE	SD
Age	32.40	28–35	2.70
Gender Identity	Male	Female	Non-Binary
	2 (40%)	2 (40%)	1 (20%)
Race	White	Middle Eastern	Other
	4 (80%)	1 (20%)	0 (0%)
Sexuality	Heterosexual	Bisexual	Other
	3 (60%)	2 (40%)	0 (0%)
Relationship Status	Married	Single	Separated
	2 (40%)	2 (40%)	1 (20%)
Highest Education	High School	Bachelors	Associates
	2 (40%)	2 (40%)	1 (20%)
Employment Status	Part-Time	Unemployed	Other
	3 (60%)	2 (40%)	0 (0%)
Student Status	Full-time	Part-Time	
	5 (100%)	0 (0%)	
Previous Military Branch	Army	Navy	Air Force
	3 (60%)	1 (20%)	1 (20%)
Rank at Discharge	E-5-7	E-1-4	Other
	4 (80%)	1 (20%)	0 (0%)
Deployment History	Twice	Once	None
	2 (40%)	2 (40%)	1 (20%)
Current Mental Health Utilization	Yes	No	
	3 (60%)	2 (40%)	
Past Mental Health Utilization	VA	Other	
	4 (80%)	1 (20%)	
Where Received Previous Treatment ($n = 4$)	VA	Other	
	4 (100%)	0 (0%)	
N = 5			

Table 1 Participant Demographic Information.

MEASURE

A semi-structured interview guide was developed with 20 pre-determined questions, including five engagement questions, 13 exploration questions, and two exit questions, which allowed for emergent dialogue between the interviewer and interviewee (Doody & Noonan, 2013). The engagement questions probed the participant's general experiences as an SV, levels of subjective psychological distress, and seeking and receiving support. The exploration questions were developed to investigate the constructs of stigma and barriers to care using a survey previously used with college students and veterans (Britt, 2000, Britt et al., 2008; Hoge et al., 2004). Exit questions prompted about the impact of the transition from the military on SV's mental health care and left space for open comments. Each semi-structured interview was approximately 45 minutes in length.

PROCEDURE

In alignment with the National Institute of Health's best practices approach for qualitative work, a consent team was assembled and uniformly trained in qualitative work (Dowding, 2013). Specifically, the audio files were transcribed by a two-person team and subsequently coded in NVivo by a team of five to establish the data's reliability and validity. The team included individuals with military, SV, and clinical expertise to avoid false consensus. A team-based codebook development approach was used (MacQueen et al., 1998). The team coded each interview independently in accordance with a co-created rulebook, holding bi-monthly meetings (from January to June 2021) until consensus was reached. The team continued to generate codes with each new transcript, identifying and defining dominant codes and sub-codes, which were stored in a dynamic codebook. This was repeated until saturation (when no new codes emerged from the data) was reached. Finally, qualitative data were analyzed using deductive thematic analysis guided by phenomenological theory (Braun & Clarke, 2006; Groenewald, 2004). Deductive thematic analysis was selected to identify and organize patterns in the data, driven by a specific theoretical interest—in this case, stigma and barriers to care (Braun & Clarke, 2006). Then, codes were

analyzed through a phenomenological lens. Phenomenology was used as it assumes that humans hold their own truth, and therefore, facts are conceptualized as phenomena (Groenewald, 2004). This theory was used as a guide, as it seeks to shed light on a subject's lived experience in specific settings. In this study the phenomena examined were the barriers affecting access to mental health care, with descriptions (e.g., attitudes, beliefs) coming from veterans in collegiate spaces (the setting). Themes, thus, encapsulated the meaning conveyed through the SVs' lived experience (the phenomena). Finally, NVivo was used to calculate inter-coder reliability (ICR), assessing the consistency of coding across the team of independent coders (MacPhail et al., 2016). Cohen's Kappa was used as the statistic to measure the degree of agreement between coders in which .60 to .80 indicates high agreement, and .80 to 1 is a very high agreement (Cohen, 1960; Burla et al., 2008; MacPhail et al., 2016). Accordingly, all the transcripts were recoded until an ICR of 60% or above was established using the final codebook at the sentence level. Table 2 (below) illustrates the Cohen's Kappa for each parent code in the final codebook.

RESULTS

The thematic analysis revealed a complex and nuanced view of perceived barriers to care, including stigma, by SVs. Themes surrounding stigma and barriers to care will be discussed as well as additional emergent themes that were critical to our understanding of these two constructs. Participant quotes are provided below to elucidate themes for each parent code.

EXPERIENCES AS A STUDENT VETERAN

As participants described their lived experiences as SVs, negative and positive aspects emerged. Negative experiences included feeling overwhelmed, confused, and intimidated by the collegiate setting. Notably, SVs could not easily utilize academic resources, such as tutoring and study groups, since other priorities, such as work or children, competed for their time and attention.

PARENT CODE	PARTICIPANT #1	PARTICIPANT #2	PARTICIPANT #3	PARTICIPANT #4	PARTICIPANT #5	AVERAGE OVERALL
Experiences as a student veteran	.95	.82	.91	.86	.77	.86
How managed distress	.87	.81	.71	.86	.66	.78
Reaching out for support	.84	.63	.67	.83	1.00	.79
Stigma	.74	.84	.74	.83	.92	.81
Barriers to care	.78	.68	.69	.68	.83	.73
Transition affected access to care	.98	1.00	.82	.70	.80	.86

Table 2 Cohen's Kappa for Parent Codes.

Because you have financial responsibilities also. You're trying to balance that life plus going to college, and ... [T]here's a lot more involvement as being a student veteran than just being ... a normal traditional student.

At the same time, SVs also described positive experiences, stating that the collegiate space was a time of increased freedom, self-reflection, enlightenment, and autonomy. They noted an ability to leverage skills acquired during military service and maturity that comes with age to fully engage in the collegiate space.

For me, I think the biggest benefit for being a student veteran is I have better discipline than I did when I was 18 and went to college ... I have a much better understanding of time, and I'm more mature.

Overwhelmingly, SVs described differences between themselves and their non-veteran peers and professors within the collegiate space. These differences included age, life experiences (e.g., work, family), values (e.g., discipline), and political views.

I find that I don't have a lot in common with many of [my peers], and it's been difficult to create a peer network. I guess there's a lot of cultural differences between the generations about respect and timeliness and things like that. It has been a little bit difficult getting acclimated.

These differences led to difficulties feeling connected to or understood by others, which sometimes manifested in self-censure.

In some of the classes, you're challenged on what you think, or you're challenging. You're constantly challenging that teacher on what they think. Especially in the philosophy classes, especially in today's political climate, you find yourself at odds with the instructor sometimes ... Sometimes you feel like you can't speak out because you'll be punished for your beliefs.

Finally, SVs noted positive distinctions between the military and their current scholastic environment. For example, some offered that collegiate life allowed them to use independent critical thinking skills instead of following orders within the military chain of command.

[T]he military actively discourages you from thinking critically. Then when you get into college, it's like, [this is the] time to think critically ... time to be rewarded for expressing yourself and expressing ideas.

Other SVs stated that the physical stability of being a student—living in one place for an extended period—allowed them to connect with resources and community, which was not previously possible due to changes in duty stations during their time in military service.

You're not going on underways or deployments. You're not being constantly uprooted. There's a lot more stability. I found a VA that I really like, and I have rapport with my doctors. I'm able to stay there instead of moving in 3 years—like having my permanent change of station. Having to go through the entire process again, and finding a new doctor that I get along with, and like new referrals, or ... I'd say the stability of not moving constantly and having more time in the day has been instrumental in making me feel like I can seek help.

MANAGING DISTRESS

SVs managed psychological distress through three primary avenues: engaging in social support from family, friends, and peers, utilizing mental health services, and most predominantly, self-care. Reported self-care activities included working out, meditation, sleeping, eating, journaling, doing things that brought them pleasure, and spiritual practices.

I work out and try and do my meditation every day. If it gets too much, I also talk with my Veteran friends online, very often. Then, if it gets too bad, I reach out to my counselor.

Other SVs found it more difficult to skillfully cope and, instead, withdrew and self-isolated as a way to manage distress.

I isolated myself. I withdrew from my relationship. I still maintained it, but it kind of took a downturn into a not-healthy place. I really, really just isolated myself.

REACHING OUT FOR SUPPORT

SVs reached out for support for their distress when triggered by psychological symptoms (i.e., emotional distress) and external events. Many sought help to remain connected to others and when symptoms became functionally impairing (e.g., interpersonal disputes, behavioral dysregulation).

Once it got to the point where I could no longer maintain my physical composure with people, is when I went and sought treatment.

Environmental triggers included reaching out upon the anniversary of a friend's or loved one's death, housing

instability, financial difficulties, and times of political unrest. Others reached out when transitioning back to school, graduating from school, or finding a job.

This time last year, I was having issues with some anniversary deaths, because it was 10 years since a lot of my friends died in a combat. I was having trouble doing that and my schoolwork and everything. I just kind of felt overwhelmed.

Additionally, SVs reached out for support when their significant others encouraged them to do so, emphasizing that being held accountable by a partner directly affected by their mental distress was a decisive factor in their decision to seek help.

I pretty much left the VA and only sought care from civilian providers and paid—unwillingly paid—out of pocket for care because at that point my boyfriend, who's now my husband, was like, "You need to get care. This is not an option."

STIGMA

SVs highlighted the ways in which they did not access care due to self-stigma. First, their belief in self-reliance informed a "mission mindset" regarding school, which urged them to push aside their emotional distress and not seek support until they completed their degree. This belief was ingrained and highly valued in the military, which often requires time-limited operational missions, but became problematic in a collegiate environment, which necessitated years of sustained effort. They also expressed a disdain for labels associated with seeking help, such as being considered a "victim." Others noted their mental health challenges were not as "bad" compared to the needs of other veterans. Many were concerned that seeking help would result in being placed on medication, which was highly undesired. Additionally, shame frequently accompanied their experience of psychological distress.

I was too proud to accept help. I just was like, "No I can do this on my own," and "I should be stronger than this. Look at what I did in the military. [I was] sure that I could handle this by myself.

Second, disclosing their experience of psychological distress could affect their reputation. Specifically, when SVs perceived disclosure would have a negative effect (e.g., seen as weak), they selectively disclosed to those they felt would be more receptive and supportive.

I think it depends on the person. People that have been to therapy, they are very positive about it. Then people, especially those who are very recently separated [from the military] ... they still kind of like give you the side-eye and look at you like you're crazy. You end up not discussing that with those people.

Third, peers, as well as other important people in the lives of SVs, had a mixed reaction to the news that they experienced distress and/or were seeking help, with some being unprepared to provide support (e.g., did not know about resources or what to say) upon disclosure. Conversely, partners and friends who supported the SVs' desire to seek help played an influential role in accessing care.

That's very important to have that spouse or that very close friend who'll say, "No, you need to go to your counselor. Like, you're starting to go off the deep end. Let's prevent this."

BARRIERS TO CARE

SVs shared several barriers to seeking and receiving care. Many were knowledgeable of or had previously sought psychological services through formal avenues of care, such as Veteran Affairs Medical Centers (VAMCs), Veterans Clinics, campus counseling centers, campus veterans liaisons/service offices, campus crisis hotlines, medical doctors, and civilian providers. Others received informal support from other veterans they met through video games, teachers, family, partners, or other significant people in their lives. However, despite awareness of and previous experience with support services, not all could be easily accessed when needed.

I was having a hard time getting connected with the VA mental health care. I have a VA liaison at my university, and I was able to reach out to him.

Second, telehealth offerings assisted in removing traveling as a barrier to care, noting that location, accessibility, transportation options, and time for travel affected access to care. Specifically, a lack of disability access (e.g., parking, sidewalk ramps) was noted as a barrier to care.

I'm very lucky that I have reliable transportation. I have my own vehicle, but that's a cost that not everyone can take. I definitely can see how people would defer going and getting help [if they didn't have one]. [Mental health services] do feel like very far out of the way. Unless you have an online option.

Third, SVs provided a complex view of scheduling as a potential barrier to care. Specifically, it was a barrier depending on the service provider.

Non-VA care, so private medical or like public systems, have been fairly easy [appointments] to get. The VA has been terrible.

For example, VAMCs require a disability rating and diagnosis to qualify for one-on-one therapy. Within this system, SVs found it was easier to obtain an appointment for ongoing care and crisis support but more difficult to obtain an initial appointment. In contrast, initial appointments at Veterans Clinics, campus counseling centers, and private providers were easier to obtain.

Getting your initial appointment, it's one or two ways. Like, if you have your counselor set up, it's kind of easier to get an appointment, even though you might be booked a week or two out. But getting your initial one through the VA, it takes a little bit.

Fourth, time to seek and receive support was contingent on personal finances, such as having a job with paid time off or flexible work hours. Likewise, it was influenced by the number of responsibilities juggled, including family and work.

We have all personally had to take the time, and sacrifice the money, to be able to seek our treatment.

Fifth, the financial burden associated with obtaining care was noted as a barrier. Costs included private provider fees, travel costs, insurance co-pays, and time off from work without pay. Specifically, personal finances impacted the ability to choose between care options. For example, mental health services are free at the VA, but if a consistent or more conveniently located community provider was preferred, there is an associated cost. Notably no/low-cost options included campus counseling centers, VAMCs, and Veterans Clinics.

When I was paying the 30 dollars, it was because I wanted to stick with a particular provider. I was willing to pay that 30-dollar visit fee to stay with him.

Sixth, SVs had distinct experiences with trusting mental health professionals. Overwhelmingly, having a connection with the provider was critical to feeling understood and building trust. Some felt that providers at the VA better understood their military background compared to campus or private practice providers.

It's kind of mostly the military background because the military is a shared experience. There's a certain level of trust. When I was talking with the school's counselor, he wanted to help me and tried to understand, but I was spending more time explaining myself than actually ... him helping me.

Others cited how difficult it was to trust someone they did not know or believed they would only work with for a brief period of time, referencing provider turnover. These factors also played a role in their ability to connect, and therefore trust, mental health professionals.

Overall, my personal experience is I just don't want to go deal with a counselor who is going to turn around and leave again. That is a downside to being at a VA counselor.

Seventh, SVs told us why they thought that mental healthcare does or does not work. Many shared that their perceptions were based on either their own or other veteran peers' experience accessing care. When referring to personal experiences, access to care was impacted by a variety of factors, including their readiness to receive care, connection to the provider, and continuity of care (or lack thereof).

I think you have to find the right provider, and sometimes it takes a few providers. I've gone through a lot of them, and I've gone through a lot of different medications. It's been very frustrating."

Finally, SVs who identified as women discussed unique barriers around accessing care. Specifically, they shared feeling underrepresented in the VA patient population and perceiving a lack of provider knowledge surrounding women's health issues.

My VA providers were not very welcoming. They told me, as a woman, that they didn't know how to deal with me and my unique stressors. I had one provider tell me he did not know how to treat me or handle me as a female veteran with my issues. Literally [he] said, "issues."

MILITARY TO STUDENT TRANSITION

Themes emerged on how transitioning from the military to student life impacted the SVs ability to seek or receive mental health support. Many noted that their transition out of the military afforded more freedom, including not operating within the chain of command (i.e., permission for

time off), having more time and physical stability (i.e., no deployments or permanent changes in station), and access to campus resources.

It has made me more willing to receive [mental health services] because I don't have my chain of command questioning me. I have more free time now that I'm not working 12-hour days and things like that.

FACILITATORS TO CARE

Finally, while facilitators to care were not a direct line of inquiry in this study, it is notable that SVs indicated a variety of internal and external facilitators to their mental healthcare. Internal facilitators included a readiness or openness to accept help, perceptions that mental health is as important as physical health, and a military service-related connection to their provider. External facilitators included adequate mental health literacy, accessibility of services (e.g., telehealth, convenient location), insurance coverage or low/no fee options, and self-directed treatment modalities.

I've been really lucky in that respect where [mental healthcare] was obviously covered for me as an active-duty service member. And then once I was out, because I was medically discharged, I only paid like \$30 a session. Or, it was at the VA, where it was obviously free. Now that I'm insured by my husband and his military plan, it's back to being free. I've been very fortunate in that.

DISCUSSION

These findings highlight attitudes regarding stigma and barriers to mental healthcare among a sample of SVs. Taken together, they suggest that tailored treatment interventions may help bridge the treatment gap between those who need and those who receive care in this population. Specific implications for the support and treatment of SVs accessing mental healthcare, as well as recommendations, when appropriate, follow below.

STIGMA

First, participants often espoused entrenched negative perceptions of mental health treatment. Similar to Nash's study (2009), SVs in this sample believed these attitudes and beliefs were imbued while in military service, where help-seeking was seen as a weakness (i.e., stigma), and self-reliance was prized. These perceptions were reinforced by negative personal experiences or by the experience

of veteran peers who were challenged when accessing mental health services (e.g., barriers to care via provider connection, travel, costs). This finding mirrors literature that suggests that those who experience skepticism about treatment and providers were significantly associated with a lower probability of seeking services from other healthcare professionals (Kim et al., 2011; Vogt et al., 2014).

Second and relatedly, participants disclosed how negative impressions of mental healthcare services were reinforced when they felt misunderstood by providers. Evidence suggests that many community-based providers are not culturally competent or aware of the unique needs of this population (Tanielian, 2014). The sentiments of SVs reflected these findings, indicating that, while many civilian providers meant well, they did not always understand the unique lived experiences of their patients. For example, providers were unaware of terms (e.g., duty station), acronyms (e.g., MOS), or dynamics (e.g., chain of command). Conversely, SVs perceived a strong treatment alliance with providers who demonstrated awareness of military culture, including customs and values. This facilitated trust, treatment buy-in, and treatment retention, which echo findings from a recent independent committee regarding VA mental health services (National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services, 2018).

Third, participants described the disadvantages of holding multiple stigmatizing identities when accessing mental healthcare. For example, an individual may be a veteran, hold a diagnosed mental health disorder, and be a member of an underrepresented group. Specifically, participant narratives suggested that those identifying as women may selectively disclose their status as a veteran based on their perception of how their intersecting identities would be received by their provider. This aligns with research suggesting that, while the stigma against mental illness is an important deterrent to help-seeking, other gender-specific attitudes may also influence access to care (Strong et al., 2018). Importantly, women veterans may encounter beliefs that they did not engage in combat-related roles; thus, they do not require mental health services (Street et al., 2009). Consequently, their symptoms and experiences may be misunderstood or marginalized by providers and accompanied by self-stigma regarding how deserving they are of help (Mattocks et al., 2012).

Fourth, participants highlighted that SVs enter academia with a unique set of experiences shaped by their time in the military that sets them apart in the collegiate space. Specifically, they noted a divergence in political leanings and ethical beliefs from those of their professors and fellow students. This finding aligns with evidence suggesting that

veterans are more likely to be politically conservative and that college professors tend to hold negative views of the military (Bacevich, 2013). Perceiving their status as “other” had a deleterious impact on their sense of belonging in the classroom, leading them to engage in self-censorship, citing a concern that they would be punished for their perspectives. At present, the impact of this divergence is minimally discussed in the SV mental health literature.

BARRIERS

First, while continuity of care is universally significant for quality healthcare management, it seems particularly important for this population, with participants reporting impacts of interrupted care. Specifically, SVs discussed interrupted treatment during the military to civilian transition, a period of time in which they are required to switch insurers, healthcare systems, and providers. Also, they discussed mental health provider turnover rates when receiving treatment within the VA system, a documented barrier to care, which is impacted by a prevalence of burnout among its psychiatrists (Garcia et al., 2015). This latter point was the most frequently reported deterrent for seeking treatment at the VA, noting that a lack of continuity of care by a single provider triggered setbacks in their recovery as well as confidence in mental health treatment.

Second, cost is a well-documented barrier to mental healthcare in the US (Mojtabai, 2005). While offering no or low-cost options may be critical to this population’s access to care, participants elucidated that cost should be addressed in the context of other barriers. For example, SVs acknowledged their awareness of the VA as a no-cost option for mental healthcare. However, perceptions surrounding difficulties scheduling initial appointments, traveling to VAMCs, and high turnover of providers made seeking and receiving services within that system less desirable. Participants also perceived that mental health treatment at the VA would lead to being placed on medication, which was highly undesired. Thus, they were willing to pay more for services if they were accessible (i.e., travel, scheduling) or when they felt a connection to the provider (i.e., alliance, trust) if they were insured or had the option for private pay. Therefore, while cost was a formidable barrier to care, it was not the sole barrier impeding SVs from utilizing services within this sample. Future studies may consider the cost of care in this context.

Third, of all the reported barriers, the most common were associated with accessing mental health services within the VA. Such barriers included being enrolled in the VA system (e.g., application, screening, disability rating), enduring issues scheduling appointments, and maintaining continuity of care with providers. Although the VA is a primary source of mental healthcare for many veterans, the barriers mentioned above often prevent participants from utilizing

these resources and greatly diminish their confidence in the VA healthcare system (Cheney et al., 2018).

Fourth, in the context of barriers, participants discussed the importance of having a partner or trusted friend as a source of accountability when seeking or receiving mental health services, which resonates with findings that suggest having a spouse promotes one’s own mental health care (Reczek et al., 2020). Some SVs sought care following a partner or friend’s effort to make them aware of how their behavior or mood affected social life and functioning in the home. However, it is not clear from this study what prompted others to be a source of support and accountability. Nevertheless, a partner or trusted friend can be a positive resource for spurring mental health-seeking behaviors.

Finally, often those who are most in need of care are unable to reach out for help. In response, it may be imperative to position mental health services in places where SVs live and work. Instead of requiring them to come to a designated location or through a specific care system, it may be prudent to adjust delivery systems to approach SVs more directly. For example, telehealth options were noted by participants as a facilitator to care. Likewise, providing services on college campuses instead of medical settings may help to alleviate the stigma associated with seeking care. On this point, more research is needed, as there is little empirical evidence supporting the effectiveness of those services to date (Albright et al., 2017). Future studies may further explore this paradigm shift to proactively meet the needs of this population.

LIMITATIONS AND RECOMMENDATIONS FOR FUTURE DIRECTIONS

This study focused on exploring critical gaps in knowledge around stigma and barriers to care for SVs. However, there are several limitations to the current study. First, this study was conducted during the COVID-19 pandemic. Thus, many students were taking classes remotely on their respective campuses, which may have influenced their awareness of services as well as their perception of and access to mental health care on campus. Second, the data collected were retrospective and self-reported and, therefore, susceptible to threats to validity. Third, the respondents who self-selected to participate in the study were not randomly sampled, which may render the sample non-representative of the population of SVs in terms of their military experiences, adjustment to college life, perceptions of psychological treatment, stigma, barriers to care, or mental health outcomes. Fourth, though the sample generated sufficient data for phenomenological analysis, the study relies on a small pool of participants to represent the perceptions of the disproportionately larger population of SVs (Marich, 2010).

RECOMMENDATIONS FOR FUTURE DIRECTIONS

Building on this work, future research and psychological services targeted for SVs should integrate the following recommendations (see [Table 3](#)).

First, given that stigma has been found to be a significant barrier to care, it is recommended that interventions for SVs utilize non-stigmatizing language when possible. For example, using the idiom “distress” may be more inclusive and less stigmatizing than labeling individuals with a mental health “disorder” or “illness.” Future research should assess the treatment effects of such interventions, as they have been preliminarily identified as an effective, strength-based engagement strategy ([Markel et al., 2010](#)).

Second, leveraging SV preferences for providers with awareness of military and veteran life, it is recommended that campus providers are equipped with training and education to practice cultural humility, sensitivity, and awareness to foster an alliance built on trust as well as a sense of belonging within the dyad. In turn, this may lead to increased treatment satisfaction and reduced treatment dropout rates.

Third, to ensure that psychosocial support and treatment interventions meet the needs of all SVs, it is recommended that treatment developers and providers recognize and purposely integrate the heterogeneity of identities (e.g., gender, sexuality, family roles) and lived experiences (e.g., work history, leadership skills) within the SV community, promoting inclusion and equity in health services.

1. Utilize non-stigmatizing language when providing psychoeducation and support services
2. Equip providers with knowledge and skills to practice with military/veteran cultural sensitivity and humility
3. Recognize the heterogeneity of identities among SVs to promote inclusion and equity in services
4. Promote continuity of care within systems and between providers
5. Research cost in the context of other barriers to care
6. Assess the impact of programs that target SV mental health on perceptions of stigma and barriers to care
7. Further examine specific barriers to care among SVs
8. Integrate self-directed care and peer mentorship into support services
9. Explore engagement strategies for campus-based mental health services
10. Proactively position inclusive, accessible, non-stigmatizing services on campus

Table 3 Recommendations for Future Research and Support Services.

Fourth, it is recommended that continuity of care should be a focus when implementing short and long-term treatments for this population, utilizing best practices for multidisciplinary treatment and warm-handoffs.

Fifth, it may behoove future studies to consider cost in the context of other barriers to care, such as accessibility, connection with the provider, and continuity of care.

Sixth, the VITAL program was established to support the mental health needs of SVs transitioning from military to student life; future research may assess the impact of this and similar programs on perceptions of stigma and barriers to care.

Seventh, while much of the existing literature focuses on mental health stigma, our study found that barriers to care played a large role in mental health access. Future research may examine these barriers to better understand why they exist as well as strategies to overcome them.

Eighth, findings suggested that SVs desire both self-reliance and connectedness. Thus, future treatment interventions may integrate aspects of self-directed care (e.g., strength-based approaches) as well as offer support from those who have a shared lived experience (e.g., peer mentors).

Ninth, research shows that SVs who receive mental health treatment are more likely to maximize their academic potential and attain their educational goals ([Mattocks et al., 2013](#)). Therefore, gaining a better understanding of and improving engagement strategies for campus mental health services may lead to better outcomes.

Tenth, recognizing that barriers to help-seeking exist in this and many other populations, it is recommended that future studies explore the effects of a paradigm shift in which providers meet SVs where they are, proactively positioning inclusive, non-stigmatizing mental health services accessibility to bridge the treatment gap of those SVs who need and receive care. Notably, a two-site clinical trial is currently underway to assess a three-session version of Interpersonal Counseling as a psychosocial intervention for SVs experiencing psychological distress at Teachers College, Columbia University. The intervention is provided by trained and clinically supervised Peer Mentors via telehealth at VA sites in New York and Utah.

ETHICS AND CONSENT

The research represented in this study was reviewed and granted exempt status by the Teachers College, Columbia University Institutional Review Board (IRB) in August 2020 (20-385).

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COMPETING INTERESTS

The authors have no competing interests to declare.

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