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Conducting Qualitative Research on Stigmatizing Conditions with Military Populations

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Abstract

This article addresses the conduct of qualitative research regarding sensitive or stigmatizing topics with military populations, and provides suggestions for implementing culturally responsive and effective data collection with these groups. Given high rates of underreporting of sensitive and stigmatizing conditions in the military, qualitative methods have potential to shed light on phenomena that are not well understood. Drawing on a study of U.S. Army National Guard personnel by civilian anthropologists, we present lessons learned and argue that the value of similar studies can be maximized by culturally responsive research design.

Keywords

Alcoholism; Stress; Psychological; Post Traumatic Stress; Post Traumatic Stress Disorder; National Guard

Introduction

Qualitative research has the potential to generate nuanced findings and inform evidence-based approaches in behavioral health policy and practice. Culturally responsive study design maximizes the methodological benefits of qualitative approaches, especially when addressing sensitive or potentially stigmatizing topics. Given high rates of underreporting of stigmatizing yet highly prevalent mental health conditions among military populations, qualitative research has potential to shed light on phenomena that are not well understood. This article identifies potential challenges for civilian researchers conducting qualitative research with military populations and provides methodological suggestions for managing these challenges. Our findings draw on a study whose goal is to identify, explore and thereafter provide guidelines for eliminating individual, social, and structural barriers to

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treatment for substance use disorders (SUD) and Post-Traumatic Stress Disorder among U.S. National Guard[1] service members returning from deployment in Afghanistan and Iraq and other hazardous duty zones.

Researching Stigma in Military Cohorts

Stigma is socially and institutionally produced (Kleinman and Hall-Clifford 2009); therefore, determining whether and how a topic is stigmatizing for a given population requires investigators to consider sociocultural context. Although some issues may entail equivalent stigma for military and civilian populations, certain topics may cause more sensitivity among military cohorts. Such concerns include alcohol abuse or dependency (Santiago et al., 2010), illicit drug use, and mental illness, including post-traumatic stress disorder (PTSD) – health concerns that are underreported in military populations (Kline et al., 2010). Military personnel are also exposed to occupationally specific hazards whose disclosure may also be significantly sensitive or stigmatizing – including military sexual trauma, combat-related trauma, and "moral injury" (Litz et al., 2009) associated with witnessing or participating in acts that transgress cultural norms.

Military members may be reluctant to disclose behaviors or experiences that contravene subcultural expectations for wellness and psychological resilience (Meredith et al., 2011). The overarching "cultural climate of the military" (Visco 2009, 242) is widely held to stigmatize mental health concerns, and military personnel report feeling more uncomfortable discussing psychological problems than medical problems (Greene-Shortridge et al. 2007, 157). Military workers may also anticipate that disclosing symptoms of mental illness will compromise prospects for promotion and job retention. Despite the attempts of the U.S. military to destigmatize mental health problems (c.f. Bryan and Morrow, 2011), members frequently do not seek services when in need (Acosta et al., 2014): Hoge et al (2004) found that military personnel whose psychiatric symptoms are most severe following combat exposure experience the greatest stigma regarding mental health treatment. We argue that in order to be culturally responsive, research addressing these topics among military populations must be designed and carried out with awareness of the cultural and policy inputs to stigma.

The Civil-Military Gap

Compounding the challenge of researching sensitive subject matter is the "civil-military gap" (Feaver & Kohn, 2001), a concept that military sociologists have described since the Vietnam era. While some literatures cite institutional separations between civilian and military worlds as the source of this gap, differences between these sectors' respective sub-cultures has been attested since at least the middle of the twentieth century (c.f. Coates &

[1]A number of attributes distinguish the National Guard from active duty branches of the U.S. military. The Army National Guard is one of seven reserve components (U.S. Congress, 2005); along with the Air National Guard, it has additional responsibilities for emergency and security services for each state within which it operates (Kapp & Toreon, 2014). Many National Guard members balance civilian duties with military roles. They receive less extensive military training, are less immersed in military culture (La Bash et al., 2009); they have higher rates of mortality (Goldberg, 2010) than full-time soldiers and they are more likely to be diagnosed with PTSD following deployment (Milliken, Auchterlonie, & Hoge 2007). As "citizen-soldiers," National Guard personnel may experience greater independence from military institutions, oversight, and culture than members of other military branches; however, Vest (2012) has suggested that National Guard members with combat experience are more fully socialized into military culture and institutions.

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Pellegrin, 1965, p. 397). The cultural gap between military personnel and civilians may be widening in the post-Vietnam era, owing to the changing composition of the military services. As the military historian Robert L. Goldich (2011) argues, since the end of the draft, members of the U.S. military are volunteers, more likely to be careerists, more highly professionalized, and more apt to share the values of the military prior to enlisting. As a result, Goldich suggests some military personnel may be conditioned to perceive themselves as significantly different from civilians; anthropologist Catherine Lutz has argued that in the post-9/11 era, military personnel perceive themselves as "supercitizens" (2001, p. 326).

The civil-military gap has been described in accounts of civilian mental health care provision to veterans, where treatment is hindered by disparities in culture and worldview (c.f. Young, 1995). As anthropologist Kenneth MacLeish observes in his study of a military community, personnel often perceive the civilian health professionals from whom they seek care with a measure of mistrust or alienation, and experience frustration with care providers:

> Civilian and civilian clinicians simply don't understand what war is like, and it is only on contact with the civilian world that the experience of soldiering is made to seem crazy. (…) 'Combat is fun,' a recently retired soldier who had done tours in Iraq and Afghanistan told me (…) Combat isn't what gives you PTSD, he asserted. 'Being subliminally told by a twenty-seven-year-old woman therapist that 'you were in a terrible situation' and you should feel bad about what you did is what gives you PTSD!'" (MacLeish, 2013, p. 122)

As this quote implies, discussing sensitive and stigmatizing topics requires a careful approach. For this older male veteran with extensive combat experience, the apparent youth, inexperience, female gender, prescriptivism, and naïveté of a civilian interlocutor generated a dynamic that precluded trust. Though research and care provision settings are not equivalent in structure or purpose, we suggest that civilian researchers interviewing military personnel regarding combat or other stressful and traumatic experiences may encounter a similarly sensitive dynamic. When rapport between interviewer and respondent comprises a key element of study design, it is important to manage the kind of discordance that MacLeish's respondent describes as alienating.

Any individual participating in a study may hesitate when requested to disclose personal information. However, the institutional positioning of military personnel experiencing symptoms that may indicate a mental, emotional, or behavioral health diagnosis adds another layer of complexity to this reluctance. Military personnel face a "double bind" insofar as they may feel threatened by disclosing sensitive information both to civilians and to other military members. The role of both social stigma and military policy regarding mental health diagnoses may also make service members unwilling to risk compromising their fitness for service assessment, as well as self-image and sense of group belonging, by disclosing such problems to other members of the military. Military communities are also likely to observe an informal – but powerful – "code of silence" (Pershing, 2003). As a result of this conditioning, military personnel may be reluctant to speak about sensitive issues to outsiders. In order to gain the trust of study participants in a military population, researchers pursuing research on sensitive subjects should be aware of this "double bind." Researchers are also ethically obliged to design culturally appropriate data collection

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procedures to elicit and secure information that may be compromising in the context of military employment.

Silence and secrecy have an established function in military history, as evidenced by the Vietnam-era warning that "Charlie [*sic*] is listening" and the belatedly celebrated success of the Navajo Code Talkers. There is a longstanding recognition within military cultures that wars can be won or lost on the basis of information interception (Durrett, 2009). It is our impression that the culture of "don't ask, don't tell" extends beyond the now-obsolete military policy requirement to protect information regarding sexual preference via silence. Silences can afford cover for diverse kinds of perceived risk or harm, and indirect speech or euphemistic references may provide more acceptable ways to discuss topics that are stigmatized, painful, or otherwise discrepant with the individual or collective self-image of military personnel. As a result, some experiences of war and their sequelae may remain "unknowable" (McGarry, 2011) to outsiders. However, we believe it is possible for civilian researchers working with military populations to elicit high-quality responses using surveys, life histories, semi-structured interviews, and other qualitative data collection methods – as successful studies on alcohol use and high-risk sexual behavior in different branches of the military demonstrate (c.f. G. Ames, Cunradi, Moore, & Duke, 2009; G. Ames, Cunradi, Moore, & Stern, 2007; G. M. Ames & Cunradi, 2004/2005). In the following section, we identify and discuss methods that improve the cultural responsiveness of such research.

Methods

Study Design

Our findings draw on a mixed-methods study of barriers to mental health treatment for National Guard personnel with symptoms of substance use disorder and post-traumatic stress disorder. We first interviewed 16 key informants in order to refine our draft screeners and interview guides. We then administered brief screens for substance use disorders and PTSD to 928 National Guard members in Hawaii and New Mexico, 448 and 480 per state, respectively; from those, we selected 100 who reported numerous symptoms of either substance use disorders or PTSD (or both) for a semi-structured in-person interview on their experiences with and perceptions of barriers to treatment. At the time of this writing, we have completed all phases of data collection.

With this focus on alcohol/drug abuse and dependency and post-traumatic stress disorder, our study requested respondents to disclose potentially sensitive content. The sensitivity of survey and interview questions was increased given the occupational status of the study population: virtually all of our respondents were still enlisted in the service at time of research participation, and were therefore subject to military policy and fitness criteria. They were also dependent on military health care providers, military-associated diagnoses, and insurance benefits.

Culturally responsive practices—Culturally responsive practices should be built into every stage of research on sensitive or stigmatizing topics. With military populations, this can be best accomplished when researchers are familiar with military regulations, terminology, and culture. Even if study team members are participating in an isolated

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portion of a project – such as scheduling, administering surveys, or coding interviews – this knowledge can contribute to better results, including higher response rates and more nuanced data analysis. Practices for becoming more conversant with military culture that we recommend include subscribing to publications and listservs issued by relevant military offices, reading publications targeted to civilians with military family members, and keeping track of news and research related to the military, veterans' affairs, and SUD and PTSD prevalence and treatment in military populations. Investigators with no prior experience of military research may consider pilot studies. We also recommend designing participatory research protocols to involve military personnel and/or veterans as co-investigators, consultants, or project staff.

Surveying—Study data collection took part in two stages. The first stage entailed distributing a screener survey to members of units with combat experience. This typically took place at public National Guard-affiliated events such as physical health assessments (PHA) where respondents could be recruited in person. Survey-eligible respondents included individuals with combat or hazardous duty deployments. Members of the survey team informed potential respondents about the content of the survey, stating that respondents were free to decline to complete a survey and to skip questions.

To ensure confidentiality, the survey instrument was printed as a booklet containing a separate piece of paper for contact details; respondents were informed they were free to leave this sheet blank. Though the research team was not able to provide complete privacy to survey participants, who could be observed completing the surveys in public spaces, we requested that respondents keep their answers private. Upon collecting the survey instruments, team members removed the page containing contact details from each survey booklet and stored the documents separately. Individuals completing surveys were notified that some respondents would be contacted later for a face-to-face interview, which was also voluntary and confidential.

Recruiting interview respondents—We recruited interview participants via initial telephone contact, following up in some cases with emails and/or text messages to accommodate respondent preference. In all communication with prospective participants, the recruiter emphasized the voluntary and confidential nature of the research. Knowing that military personnel are likely to have been surveyed about mental health and substance abuse concerns by many different agencies, the recruiter stated clearly that the project was led by independent civilian researchers. In making contact with potential respondents, team members also described our previous research efforts and explained their utility. We further recommend that individual investigators also maintain an online presence and/or a dedicated web page with information on the study. This permits prospective study participants to review researcher and institutional credentials.

Interviewing—Our research team members carried out semi-structured interviews with respondents, traveling to meet with respondents in their home towns or other convenient locations. We recommend in-person interviews to interviewing by telephone or via videoconferencing software, and suggest that interviews be conducted by researchers who

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verbally and nonverbally convey professionalism and trustworthiness. We do not advise hiring students or commercial interviewers.

Choice of interview venue is part of establishing trust and protecting respondent confidentiality. Our study team typically arranged interviews at locations away from military facilities and in areas where the content of the conversation cannot easily be overheard, including cafes and other food service venues, hotel lobbies or meeting rooms, and private offices at military bases (in the case of key informants). We suggest that meeting respondents in their homes, in hotel rooms, or in an automobile is generally not good practice, and that interviewers should be mindful of requirements for professionalism and their own safety. On site, we asked respondents where they wish to sit, as some military personnel feel less comfortable with their back to a window or a door.

The design and discussion of informed consent protocols provides another opportunity to establish rapport with respondents. Our team used an elaborated consent process that was explanatory, provided many openings for questions, and reflected awareness of the potential sensitivity of some subjects. We requested check marks instead of initials or signatures on consent forms and requested that the respondent to refrain from using names in the taped portion of the interview. We offered to cease tape-recording at any time and/or to write notes by hand instead of recording.

The ordering of interview prompts should proceed from less sensitive to more sensitive prompts. Our interview schedule began with questions regarding the respondent's occupational and personal background, then addressed deployment experience, post-deployment experience, PTSD, alcohol and drug use, and treatment-seeking. The interview schedule closed with an opportunity for the respondent to summarize and conclude. We suggest that interview prompts be worded in straightforward and non-technical language, especially when addressing potentially sensitive topics. For example, the first version of our interview schedule contained the question: "Some soldiers party pretty hard after they come back from deployment. Was this something that happened to you?" Noting that this question could convey tacit disapproval of drug or alcohol use, the research team later revised this question to replace the term "party." The revised prompt read "Some soldiers start drinking a lot and some use either prescription or recreational drugs after they come back from deployment (…)." The below interview excerpt reflects the change in phrasing; as the interview participant's statements suggest, direct language need not be stigmatizing.

Interviewer Some soldiers start drinking a lot, and some use either prescription or recreational drugs, after they come back from deployment. Was this something that happened to you?

Respondent Oh, absolutely. (…) I got drunk last night (…) When I got back from Iraq, I think I only had four or three months left before I got out. I was using a lot. I drank a lot. It got me into a lot of trouble too.

Interviewer Do you want to talk about the trouble, or?

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Respondent Yeah, absolutely. I could definitely talk about the trouble. [Interview August 9 2015]

Though the members of research team invested time into becoming more knowledgeable about military culture, we refrained from presenting ourselves as experts. Instead, we requested that respondents explain their experiences in a descriptive lay register, reflecting the practice of cultural humility (Tervalon & Murray-Garcia, 1998). In this way, respondents were able to assume a position of expertise with respect to researchers, which could also afford them a sense of autonomy and agency in the interview process. Congruent with this approach, we recommend that even when researchers are experienced in working with military populations, they proactively request respondents to clarify and elaborate their statements. As the below interview excerpt suggests, this is a way to establish rapport as well as to enrich the informational content of the interview.

Interviewer IRR, what is that?

Respondent Inactive Reserve. Inactive Ready Reserve is what it's called. When you sign up for active duty, you sign up for eight years completely. Everybody signs up for eight years. You may have to actually do, say, three or four or five or six years actually on active duty, then you get transferred to the IRR for that last two years.

Interviewer I did not know that. I'm picking up the acronyms, but I'm still--

Respondent Oh, yeah. There's a lot of them [laughter]. There's a dictionary full of acronyms just for the Army, let alone the different branches. Yeah, it's crazy. [Interview September 23, 2015]

Upon completing their responses, survey and interview respondents received a list of medical and therapy contacts that the research team had developed with input from the medical department of the relevant military base. Research team members also provided their contact information and remained available to respondents in the event of follow-up questions or concerns.

Results

Though literature often suggests that military personnel are reluctant to describe potentially stigmatizing mental health concerns (c.f. McFarling et al. 2011), our study team found that many respondents were forthcoming, discursive, and eager to share personal experiences. Indeed, respondents often expressed their gratitude at being able to communicate experiences that they believed were both personally important and institutionally under-recognized. Such accounts often broadened the analytic scope of our team's research: in light of the comments and concerns that respondents identified, the study team added questions and thematic codes to the interview schedule and the codebook to ensure that issues we had not identified in our initial research design were captured and analyzed consistently.

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Situating symptoms

Our respondents' commentaries on their post-deployment experience often contributed new understanding regarding the subjective experience of traumatic and stressful experiences and their sequelae. For example, midway through interviewing we noted that many respondents spontaneously described symptoms of sleep disturbance, though our interview schedule did not contain questions addressing sleep. Quantitative analysis of our survey data revealed that sleep problems represented the second highest rated item on the 17-item PCL-M (M = 2.05, SD = 1.24) (Moore et al. 2015). Believing that sleep problems were likely to be associated with other PTSD symptoms and that discussion of this less stigmatized symptom could facilitate discussion of more sensitive subjects, we added new questions and follow-up questions to the interview schedule, as illustrated in the below interview excerpt. This amplification of study design is uniquely facilitated by inductive research design and qualitative methods.

Interviewer So then, the next question is, you said you have trouble sleeping now. When did that start? Was that out in the field, or when you came back?

Respondent It was prior to my first deployment. But when I was getting deployed the second time, I never told them that. I never told them that I might be having this problem. But for me, I think I do have PTSD. Like I said, after the first deployment, it was hard to sleep. I would wake up at 11:00 at night, then I would wake up at like 2:00, then I would wake up at 2:30, then I would wake up at like 4:30, and I'm like, "Oh, man."

Interviewer So, it's hard to feel rested the next morning if it was interrupted like that. I can tell you, sleep problems are one of the most common things I've heard people talk about. (…) How about the - I don't know what you want to call it - but there's a term called hypervigilance, which means you're always on alert as if you're almost back in Iraq, scanning for IED's on the road and stuff like that. So, when you're driving do you still feel like you have to be at the ready?

Respondent I have that. Sometimes I see trash on the side of the road or sometimes I see a tire - like one of those tires that come off the diesel - I see that on the side of the road, or either a box or a plastic bag or something like that. It's not unusual out here for people to leave trash. [Interview November 21, 2014]

While the above example illustrates the utility of the standard diagnostic criteria for post-traumatic stress disorder among military servicepeople, our respondents also helped us recognize that in some cases, behaviors that civilian health care providers construe as pathological are normative and adaptive in combat settings. For example, although many respondents described experiencing hypervigilance after deployment, and sometimes suggested that this had contributed to interpersonal and other problems, one individual with a lengthy career in the National Guard explicated the positive meaning and value that he associated with his hypervigilance.

Interviewer Here is a naive question. (…) Is there some training you could envision that before people go through demobilization, they get the heads up? "Look, this is what's going

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to happen. You are going to continue to be hypervigilant, here are the five things you need to know to ratchet it down or turn it down." (…)

Respondent But with that, I mean, your hypervigilance though, I believe it comes with all your years of training. You just don't get rid of it because it's – you're so in tune with it, it's taken years and years and years and years to get to that level. You've honed it, you've perfected it. Everything down to your muscle memory to the way your weapon feels into your hand (…). You've honed that skill so fine. It's like a knife. Once that knife gets dull, you just sit there and you sharpen that knife again. [Interview April 7, 2015]

Illuminating policy loopholes

Respondent commentaries illuminated shortfalls in military protocol and practice that are described in official policy as sufficient and effective. As our respondents' comments suggested, the absence of soldiers' perspectives in the design and evaluation of military policies can conceal programmatic failings, and in this way, qualitative research can supply helpful correctives to policies that fail to respond to the real needs of military personnel or produce perverse outcomes. For example, some respondents identified that while mental health treatment facilities and services were available to them during deployment, that these settings failed to provide adequate privacy and confidentiality, making them inaccessible to individuals who associated mental health problems with stigma:

Interviewer Well, when you were deployed in this last NATO mission, did you hear about any attempts by the military to find out whether the soldiers had PTSD or were suffering?

Respondent They told me when I was at mob station - because I went to seek counseling because I was trying to prepare myself for these things - and they assured me that all I have to do is go over there and seek help, and it's available. But when I got out there, it wasn't that easy. I thought it was just an open door where I could just walk in and nobody would say a thing. I could sit down, but no, you have to go to sick hall [laughter].

Interviewer Okay, in front of other people?

Respondent Yeah, and sign up and saying, "I need to talk." For a soldier, as me, who's supposed to show no fear and all that, for these younger ones, I avoided that. [Interview November 11, 2014]

Another respondent, an intelligence analyst with two experiences of overseas deployment, noted that the logistical realities of some military deployments are at cross-purposes with individual privacy; as he stated, military groups are designed to function "like an incredibly small town" where people keep close track of one another's whereabouts. Under circumstances such as he described, stigma may therefore effectively prevent personnel from securing help confidentially:

Respondent (…) You get to talk to a chaplain a couple of times, whatever, if you're religious, and you can't sleep you go to the medical people, the psychiatrist guys will talk to you for a while to make sure you're not going crazy. If you go talk to one of them there's stigma everywhere.

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Interviewer People know that you're talking to the chaplain?

Respondent Yes, usually.

Interviewer How would they know?

Respondent It's, consider it like an incredibly small town. A town of 70 or less. (…) You live and sleep and shower and eat and everything together. Anywhere you go they know. And besides it's pounded into everybody's brain, no matter what, to know where that other person is at any time. So even if you wanted to try to hide that you're going to go talk to somebody or had to go to sick call for something or whatever, you're stressed out – you couldn't, because somebody had to know where you were anyway. (…)

Interviewer Tell me about that stigma.

Respondent The military in both branches are trying to combat that, minimize it. And it seems to be working to a point, but no matter what, there's still always going to be that perceived stigma. (…) Because if you're joking around with your buddies or something like that, you know you go into a room full of soldiers (…) I'll give you a scenario: "Hey this guy went over to talk to that guy because he's getting too stressed out, oh that guy's a bitch." [Interview July 22, 2014]

This example suggests that both physical circumstances of military service, cultural stigma surrounding mental health diagnoses, and a lack of institutional responsiveness to mental health stigma may prevent individuals from seeking help, thereby exacerbating the seriousness of mental health concerns and the stigma they engender. Respondents identified other ways in which current military policy and practice defeats the military's stated intention to destigmatize and treat mental health concerns of its personnel. For example, while some respondents noted that the lack of demobilization practices during the First Gulf War had challenged their efforts to seek treatment following deployment, other respondents criticized the way that demobilizations coincided with post-deployment health reporting and stated that they felt disincentivized to report health problems when demobilizing. If widespread, this dynamic could cause substantial underrepresentation of the prevalence of post- mental health and other diagnoses among military personnel post-deployment. In the below interview excerpt, a 32-year-old respondent with deployment experience to Iraq as a line leader in the Marine Corps Reserves commented on the perverse incentive for personnel not to disclose mental health symptoms during demobilization:

Interviewer Do you know what happens to soldiers who have PTSD during demobilization? Are you aware if they're properly diagnosed? If so, are they referred to treatment? And do they want to go into treatment when they're in demob? 'Cause I realize they're on their way home. What's your take on that?

Respondent So with demob, they are interviewed for it. (…) At this point, these guys haven't been home in a year or more, so they will say whatever they need to get done, to get that checkbox off of the clearing list. So I don't think that they would be opposed to talking about it; it's just that they want to get the hell out of there. [Interview July 22, 2014]

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This critique was affirmed by a senior officer with extensive experience in both the active-duty military and the National Guard. This respondent described the insufficiency of the current protocol for demobilization. As his comments suggest, this individual believed that assessing returning military personnel for PTSD symptoms immediately upon their return is counterproductive, given that individuals may be unable to identity whether their behavior patterns are symptomatic of underlying mental health difficulties.

Interviewer Now in terms of the demobilization process, how candid do you think people are when they're asked about if they're experiencing any of the symptoms of PTSD?

Respondent I think it really depends on the individual and it depends on the unit that they're in. (…) If you're in a combat outfit, most of them probably won't admit to something like that. (…)

Interviewer So why is that?

Respondent Because (…) they're all A-type personalities and you're just like, "F---, I got the job done, let me go home. And I can tell you why I'm getting up at 2:00 in the morning." Because at that time it seems normal. You know what I mean? (…) You have a new normal, but you don't know that you're coming back to and you've got to get a new normal.

Interviewer Yeah.

Respondent So you're over there for one year in this high stress environment (…) And you think that that's normal, so then you come back and you're getting up and you're like, "I used to do this anyway. I'll just go get some water and go back to sleep." So when you're going through the demob, a lot of times you don't realize. (…) You kind of bury those indicators like you're not sleeping regular, you're still doing all kinds of that stuff. [Interview August 10, 2015]

Such experience-near accounts of military service add depth, nuance, and essential detail to processes and procedures that are typically represented in the neutral, obfuscating language of official policy. Our study privileged this type of data in view of the opportunities that narratives afford for robust, dimensional accounts of respondents' experiences with trauma and mental health concerns – an approach whose benefits has long been recognized in the medical anthropological literature (c.f. Kleinman 1988). One respondent commented explicitly on the methodological issue that this article engages: the epistemological and practical limitations of quantitative approaches, particularly those that bear on mental health concerns. As the respondent notes, the inevitable difficulties of combat deployment complicate assessments of whether someone is experiencing levels of stress that could be considered clinically significant. Indeed, as he pointed out, a soldier's wellness cannot be established by straightforward questioning – of the sort that a questionnaire or survey might feature – and requires time and interpersonal investment.

Interviewer Do you know are there any procedures in place to determine whether a soldier or soldiers are suffering from [PTSD]? Are there any procedures in place to diagnose and pull out those that might need help, when you're on deployment?

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Respondent Yes, (…) there are a couple of procedures, I'm not 100% familiar with them. There's things that, you know the average soldier and then the line leaders like me are taught to look for. And then they get referred to either like medical section or the Chaplain section, something like that to go for behavioral health. (…)

Interviewer And for example if you were doing that, what would you ask a soldier? If you thought that he was, or you heard that he was stressed?

Respondent It's kind of hard to go and just outright ask an individual, depending on the circumstances. If you're, like say, on an Afghanistan deployment, you know, 'Are you stressed?' Well, no shit! You're getting shot at from time to time; you're running around in 100 degree weather without armor. You're dealing with a country and a population that's stone age for the most part, and they know a different language at that, and then you've got a million responsibilities to do a day, and your wife or your girlfriend or your boyfriend or whatever may or may not be having a kid or some kind of stress, yes, you're king of stress, so just outright asking them like that, that's useless. It's looking for actions, keys, triggers, that you have to be ready. If the person laughs a lot and jokes a lot and whether it's dark humor, or regular you know knock-knock kind of joke, whatever the case may be, whatever their standard is, you know if they're usually very active, you know they go to the gym after work, or they hang out with a group of guys behind the building or something like that, playing cards talking, whatever their norm is, when they start deviating from that, you know they don't laugh so much, they're pissed off or sad, you know they avoid people, they spend more time by themselves, or they're snappish or angry, their anger outbursts become more, or they just completely isolate themselves and you never see them, or just they start speaking in a different way, that baseline can only be accrued over time, so you have to spend a little bit of time around this person. [Interview July 22, 2014; emphasis added]

We agree with this respondent that attempts to understand well-being in the military are inherently subtle and nuanced. We further agree that such efforts require triangulation and an understanding of the potential for stigma to impede disclosure of mental health symptoms. Finally, we concur with the respondents's expressed belief that such evaluations must be situated in a sociocultural context and afforded adequate time. Qualitative research principles have the potential to inform studies with these methodological advantages.

Conclusion

Our findings suggest that qualitative methods offer important advantages for the study of sensitive and stigmatizing conditions among military personnel. As this study presentation suggests, open-ended interviews permit respondents to lead interviewers narratively into accounts of experiences and perceptions that would otherwise be inaccessible. Qualitative methods allowed the study team to gain a more fine-grained understanding of the experience of PTSD and SUD concerns that respondents reported, and to hypothesize how the subcultural significance of such symptoms among military members might impact reporting rates. Our approach also allowed us to situate respondents' experiences analytically within the contexts of military culture and policy.

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Civilian researchers should consider the potential for the "civil-military gap" to impede their data collection, and should design and implement culturally responsive practices that accommodate the needs and preferences of military respondents as possible. However, we also find that military respondents often appreciate the opportunity to describe their experiences in a setting that affords them respect and autonomy in self-disclosure. We assess that the quality of the interview responses we collected indicates that the practices we have described above have the intended effect of promoting disclosure of health-relevant experiences and behaviors, including those that may be considered sensitive and stigmatizing. However, this impression cannot be corroborated by the study participants themselves, given that the research design did not include an evaluation portion. We suggest that qualitative researchers working with military populations should seek ways to elicit respondent perspectives on the research methods.

Future research has the potential to assess and contrast the efficacy of disparate qualitative methods among diverse military populations. We further note that, given the significance of stigma and sensitivity as barriers to health-care seeking by military personnel of widely divergent backgrounds, that qualitative studies of the social construction and enactment of stigma in military settings could have great benefit to populations that are occupationally at high risk for both mental health diagnoses and stigma. In this way, qualitative research on stigma among military personnel has the potential not only to generate a deeper and more nuanced understanding of under-theorized experiences, but also to improve interventions targeting these populations.

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