

Marine Culture and Mental Health Help-Seeking: Stigma, Barriers, Resilience, and Culturally Responsive Interventions

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Abstract

Common favorable attributes within the marine culture include readiness, self-reliance, discipline, unit cohesion, and mission accomplishment. These attributes enhance the soldiers ability to adapt under pressure but can also delay or complicate the need for professional mental health intervention due to the perception of such help as weak, perceived loss of control, or possibly a threat to trust and career standing. This narrative examines the mental health stigma and barriers to mental health care in the Marine population and other closely related military groups while focusing on Marine-specific areas related to identifying and seeking out mental health help. In addition, a culturally responsive clinical framework with an emphasis on solution-focused practices, narrative methods, attention to military identity, and collaboration with leaders, chaplains, families, and community resources are explored. Changing the hesitation of Marines to seek mental health requires trustworthiness in the system, supportive leadership, accessibility to care, effective messaging, framing help seeking as a strength, responsibility, and readiness. There is a limited amount of research on the Marine population in this areas and future research should examine subgroup differences, confidentiality perceptions, intervention effectiveness, and the transferability of findings across branches and international military contexts.

Keywords: Marines, military culture, mental health stigma, help-seeking, resilience, spirituality, solution-focused counseling

Military service creates a unique cultural context for understanding clinical mental health. Within the United States Marine Corps, expectations surrounding endurance, self-discipline, loyalty, readiness, and responsibility to the unit a strong sense of identity and belonging. However, these same attributes may shape how Marines interpret problems, decide whether a problem warrants attention, and impact the evaluation of personal or occupational risks of seeking help. A Marine may recognize that support is available while still believing that using support could change the perspective that peers or leaders have about the his or her abilities. As a result, just having services available does not ensure that care will be utilized, trusted, or maintained.

With this in mind, there is research pointing to the need for culturally responsive ways to encourage help-seeking. Mental health stigma has repeatedly been associated with a service members reduced willingness to use services, and perceived public stigma may play a particularly influential when someone overestimates the degree that others may judge treatment seeking (Kulesza et al., 2015). Another important component related to this area is leadership.

In a study of military members and veterans, negative leadership experiences were associated with stronger internalized stigma and lower likelihood of help-seeking, whereas supportive leadership was associated with a greater likelihood of help-seeking (McGuffin et al., 2021).

These findings point out that help-seeking is occurs within relationships, command climates, organizational policies, and expectations about confidentiality and professional consequences.

This review is a practice focused synthesis on Marine culture, stigma, barriers to seeking mental health help, resources, and resilience. Because most literature combines branches of active-duty personnel, veterans, and international defense populations the review intentionally avoids assuming that all military findings apply only to Marines. Instead, broader scoped studies are used to make clinical considerations and explore casual factors related to military servicemen and women not seeking mental health help while highlighting the continued need for branch-specific evidence. The central argument is that culturally responsive care should preserve the strengths embedded in Marine identity while reducing the interpersonal, structural, and internal barriers that can hinder seeking mental health help.

Scope and Approach

This is a narrative rather than systematic review used to explore foundational and contemporary scholarship on military mental health stigma, help-seeking, leadership, resilience, family relationships, and clinical engagement. A narrative review is the best approach for identifying research across several areas and applying findings into counseling practice. However, this approach does not provide a research strategy, formal study, or meta-analysis which occurs in a systematic review. The conclusions are meant to assist with forming a clinically informed synthesis and a base for future identifying future research needs in this population.

Terminology is used carefully throughout the review. Marine refers specifically to a current or former member of the United States Marine Corps. Service member refers more broadly to military personnel in any branch of the military. Veteran is not considered an interchangeable designation with active-duty Marine because veterans and currently serving personnel may differ in access to assistance, command influence, occupational risk, and approach to accessing mental health care. In addition, international defense personnel procedures may also show variance in relationship to policy, cultural norms, health care access, and legality related areas. This distinction is essential for an article intended for an international audience.

Military Culture, Strength, and Mental Health

Military culture does not lend itself to be entirely protective or entirely harmful in relationship to mental health. Values such as cohesion, purpose, sacrifice, adaptability, and mutual responsibility foster purpose, endurance, resistance, and meaning. Training may increase confidence under pressure and create a shared purpose used to respond to various challenges. Being a part of a unit in the military also fosters social support that is unmatched outside the military. Although there is a temptation to view some of these areas as risk factors, caution should be used with this label just because these specific variables can encourage complications to help-seeking.

Specifically, narrowly defining these areas that are seen as strengths by the military causes problems. For example, in this culture, there is a tendency to identify strength only with emotional control, independent problem solving, or silent endurance and consequently mental health symptoms may be minimized until there are disruptions in everyday functioning. Marines may specifically distinguish between problems viewed as a natural consequence of their line of work or a reflection of a personal failure. This distinction can impact full disclosure. For example, someone may be comfortable discussing sleep disruption, irritability, or concentration problems while feeling uncomfortable with mental health verbiage that feels inconsistent with his or her military identity.

In addition, gender specific expectations may play a role in these areas. Qualitative research with male veterans seeking posttraumatic stress disorder care identified stigma, distrust, reluctance to revisit trauma, and traditional masculine expectations as barriers to seeking and engaging treatment even while their significant others encouraged treatment initiation (Silvestrini & Chen, 2023). Those findings cannot be generalized automatically to all Marines or to women, but these findings show how identity standards and close relationships may shape the path to care. A culturally responsive clinician should therefore ask how the service member defines strength, responsibility, privacy, and readiness rather than assuming that military culture has a single meaning.

Recognizing Mental Health Distress Early

Early recognition matters because mental health concerns often first appear as changes in the way a military member is functioning rather than as requests for mental health help. Potential signs of the need for mental health help include persistent sadness or irritability, shifts in mood, excessive worry, social withdrawal, changes in sleep or appetite, anger, reduced concentration, declining work performance, substance use, hopelessness, and suicidal thinking. Considered alone, these signs are not diagnostic but the clinical importance is based on duration, intensity, context, functional impact, safety, and departure from the military members daily patterns.

In military settings, some indicators can be misread as discipline, fatigue, conflict, or attitude problems. For example, sleep disruption may be normalized because of duty obligations. Increased alcohol use may be thought of as part of the social routine. Irritability may be seen as a leadership or relationship issue rather than a possible mental health need like trauma, depression, anxiety, grief, or moral distress. For this reason, education is needed to assist service members with connecting symptoms to changes in readiness, relationships, judgment, and daily functioning without implying that the service member needs a diagnosis every time a concern in one of these areas presents itself.

Gatekeepers can support early recognition of mental health needs if appropriately trained. In fact, leaders, peers, chaplains, medical personnel, counselors, spouses, and family members may notice changes before an individual seeks care. Their role is not to diagnose but to recognize changes, respond without humiliation, clarify available options, and facilitate timely evaluation when needed. Immediate safety concerns, including suicidal intent, psychosis, severe impairment, or risk to others, require urgent assessment through local emergency and military procedures.

Forms of Stigma

Public and Perceived Public Stigma

Public stigma includes the negative stereotypes, prejudice, or discriminatory responses directed toward people with mental health concerns or those who use are actively in treatment. Perceived public stigma is what an individual believes other people think, which may be more negative than the views peers actually hold. In a sample of young adult veterans, higher perceived public stigma was associated with lower mental health service utilization, even though many participants who expected negative judgment reported that they would not judge another veteran similarly (Kulesza et al., 2015). This mismatch suggests that perceived norms may be an important intervention target.

Within a Marine context, anticipated reactions from peers and leaders play a large role in seeking mental health help because the trust a member achieves within the command is crucial to identity and functioning. A Marine may fear being viewed as unreliable, weak, unsafe, or less deployable if he or she seeks mental health help. Even if these concerns about perception are inaccurate, behavior can be influenced. As a result, anti-stigma efforts are needed and should go beyond stating that treatment is acceptable. Credible peers and leaders should communicate specific norms, explain how assistance can support functioning, and correct assumptions about seeking mental health help.

Self-Stigma

Self-stigma occurs when individuals internalize negative beliefs and apply these to themselves. For example, a Marine who believes that competent people should solve personal problems independently may experience shame when mental health symptoms persist. Self-stigma can reduce self-efficacy, cause limited thinking, and create an internal conflict between seeking relief and protecting identity. McGuffin et al. (2021) found that internalized stigma helped explain relationships between leadership experiences and help-seeking, illustrating how organizational experiences can become personal beliefs.

Clinicians should address self-stigma without arguing against the client's values. A more effective approach may be to explore how responsibility, courage, preparation, and commitment to others can support treatment engagement. The goal is not to replace Marine identity with perceived clinical readiness but rather to expand the meaning of strength so that seeking help, building skills, and seeking help early are perceived as acts of strength rather than signs of failure.

Institutional and Structural Stigma

Institutional stigma is most noted in policies, practices, or organizational climates that portray a risk or disadvantage associated with receiving mental health care. Concerns about confidentiality, documentation, fitness determinations, security clearances, career advancement, deployment status, and command notification can be rationalized as reasonable based on the institutional climate, even when the service member's feared outcomes are unlikely. If messages about these areas are vague or inconsistent, reassurance alone may not restore trust.

Structural barriers also include scheduling, transportation, geographic access, fragmented referrals, long wait times, limited culturally competent providers, and difficulty obtaining privacy. These areas play a role in the stigma attached with seeking mental health care. A Marine who is already uncertain about seeking care may interpret a complicated referral process or lack of private appointment options as confirmation that treatment is unsafe or impractical. Effective systems must therefore reduce friction as well as stigma.

Common Barriers to Help-Seeking

Preference for Self-Reliance

A desire to handle problems independently is a primary barrier to seeking mental health treatment and one of the most understandable barriers because the marine culture values resourcefulness. Even though self-management can work when there are mild and temporary circumstances that a service member can use strategies to cope. The problem arises when handling mental health concerns independently becomes the only acceptable response even as safety, relationships, work performance, or health deteriorate. Counselors can respect self-reliance by presenting treatment as collaborative consultation and by identifying what the Marine has already successfully attempted, what has helped, and what additional resources might strengthen current efforts.

Fear of Career and Relational Consequences

Military members may worry that disclosure of a mental health concern will reduce leaders' confidence, cause a change in assignments, impact advancement, or change peers' perceptions and behaviors. Research with active-duty Air Force nursing personnel found substantial concerns that unit members might lose confidence, leaders might treat the individual differently, mental health care could harm a career, or the military member would be seen as weak (Hernandez et al., 2016). Although these findings are not Marine-specific, this research demonstrates that anticipated work related consequences are prominent even among military health professionals.

Counselors should avoid dismissing these concerns as mere stigma. Instead, clinicians should explain confidentiality and its limits in plain language, identify what circumstances may create a need for disclosure, separate common concerns from imminent safety risks, and encourage clients to ask questions before sharing specific detail. When clinicians do not know the possible outcomes of a policy, they should consult appropriate legal, ethical, and military resources rather than providing false reassurance to a service member.

Leadership Climate

Leadership can either reduce or create more barriers to seeking mental health help. Supportive leaders normalize appropriate care, respond consistently, protect dignity, and avoid treating meeting mental health needs as a character flaw. Destructive leadership may increase fear, public stigma, and self-stigma. McGuffin et al. (2021) found meaningful relationships among leadership experiences reduced stigma and encouraged mental help-seeking across military and veteran participants. Although causality cannot be assumed from this cross-sectional study, the findings support leadership development as part of mental health promotion.

Leader training should include concrete behavioral expectations rather than general encouragement. Leaders need guidance on responding to disclosure, avoiding public discussion of private information, facilitating appointments, recognizing urgent risk, and maintaining appropriate role boundaries. They should also understand that a referral is not treatment and that leadership support cannot replace qualified clinical mental health care.

Access, Convenience, and Trust

Practical barriers can be especially impactful for younger personnel who often do not have reliable transportation, may be stationed in remote areas, or may want privacy from coworkers or family members. Tele-mental health may reduce travel and increase scheduling flexibility, but it does not eliminate concerns about confidentiality, internet access, private space, licensure, emergencies, or continuity of care. Similarly, online counseling formats may provide useful stress-management tools but should accompany thorough assessment practices when symptoms are severe or persistent.

Trust for mental health treatment among Marines depends on more than availability. Marines may evaluate whether providers understand military language, hierarchy, operational demands, deployment cycles, family pressures, and the difference between military branches. A clinician does not need to have served to practice competently, but humility is essential. Providers should ask rather than assume, acknowledge limits in their knowledge, and avoid romanticizing or pathologizing military service.

Differences within Marine and Military Populations

Military populations are heterogeneous. Rank, age, gender, education, race and ethnicity, family status, occupational specialty, combat exposure, disability, location, sexual orientation, religious background, and prior treatment experiences may influence help-seeking. An international perspective adds further variation in military organization, health coverage, legal protections, cultural expectations, and the meaning of service. Broad statements about “the military” can obscure these differences. Specifically there are possible differences in concerns among women, younger Marines, college-educated Marines, and those with or without combat experience. These patterns should be used to guide clinical inquiry and not viewed as causal research information. Clinicians might ask whether supervisory response, transportation, cost, confidentiality, cultural fit, or treatment preferences are especially important to the individual rather than assuming priorities based on the military member’s demographic characteristics.

In addition, combat status should not be used as a quick approach for determining mental health need. Distress may arise from combat, military sexual trauma, harassment, accidents, grief, moral injury, family separation, relocation, occupational demands, or experiences unrelated to service. Silvestrini and Chen (2023) emphasized the need for trauma services that recognize noncombat and military sexual trauma. A narrow focus on combat may silence clients whose experiences do not match the more common military narratives.

Resilience as a Dynamic Process

Resilience should not be looked at as the absence of distress but is better understood as a dynamic process involving adaptation, access to resources, meaning, relationships, skills, and environmental support. A resilient Marine can experience significant symptoms and still benefit from mental health care. Conversely, labeling a person resilient should never be used to minimize suffering or justify withholding support.

Research among Air Force nursing personnel found that greater stigma concerns were associated with higher perceived stress and lower resilience (Hernandez et al., 2016). This relationship does not establish a causal relationship, but it suggests that stigma reduction and resilience promotion should work together. Systems that make mental health help-seeking safer facilitate a stronger capacity for the military member to utilize mental health support, while resilience-oriented interventions may increase confidence to use the available support. Some resilience factors are explored below.

Spirituality and Meaning

Spirituality may provide meaning, hope, identity, ritual, moral orientation, community, and a way to interpret suffering. Chaplains can offer readily available support to service members and may be viewed as less stigmatizing than formal mental health services. However, not every Marine incorporates spirituality as a part of his or her life and spirituality is not protective for everyone. Spiritual struggles, moral conflict, anger toward God, shame, or exclusion from a faith community can intensify distress depending on the service members experiences with such concepts.

Clinicians should use client-led spiritual assessment rather than presuming belief or prescribing religious practices. Clinician questions may explore whether faith, values, prayer, worship, nature, service, or community currently helps; whether spiritual concerns contribute to distress; and whether collaboration with a chaplain or faith leader is desired. Collaboration should occur with consent and with attention to role clarity, confidentiality, and the limits of each discipline.

Support Networks and Core Relationships

Peers, partners, relatives, and trusted leaders can encourage treatment, notice changes, provide transportation, support routines, and reduce isolation. Close relationships may also be strained by irritability, emotional withdrawal, relocation, deployment, grief, or uncertainty about how to help. In fact, significant others were described as potential facilitators of care in qualitative research with male veterans (Silvestrini & Chen, 2023).

Family-inclusive practice may therefore be useful when the Marine desires it and when participation is clinically and ethically appropriate.

However, family involvement must not be assumed. Some clients need private care, and some relationships are unsafe, coercive, or conflictual. Clinicians should assess consent, safety, and the client's goals before involving others. When appropriate, family sessions can clarify symptoms, reduce blame, develop communication plans, and identify specific supportive behaviors.

Resourcefulness and Flexibility

Resourcefulness involves identifying options, using available strengths, and navigating systems effectively. Flexibility includes adjusting coping strategies when circumstances change. Both qualities align well with military problem solving, but implementing these areas should not be framed as requirements to adapt to all situations. Sometimes the resilient response is to seek protection, use formal channels, request accommodation, or challenge a barrier.

Counselors can strengthen flexibility and resourcefulness by helping clients distinguish between controllable and uncontrollable factors, rehearse multiple responses, anticipate setbacks, and identify the smallest feasible next step. This approach respects autonomy while reducing all-or-nothing thinking about treatment. A Marine may not be ready for long-term psychotherapy but may be willing to consult a primary care provider, chaplain, peer support program, embedded behavioral health professional, or confidential community clinician.

A Culturally Responsive Clinical Framework

Begin With Cultural Humility and Transparency

The first task is to establish credibility without pretending expertise the clinician does not possess. Providers should ask about branch, current status, rank or role when relevant, occupational specialty, deployment history, family context, and the client's own understanding of Marine culture. They should also explain confidentiality, documentation, consultation, and emergency procedures before inviting detailed disclosure. Transparency is a clinical intervention because uncertainty about information sharing can prevent honest participation.

Use Solution-Focused Practices

Solution-focused counseling emphasizes preferred outcomes, exceptions, existing coping, incremental change, and client-defined progress. These features may fit clients who value efficiency, action, and observable results. Questions can identify how the Marine has kept the problem from becoming worse, when symptoms are less intense, who notices improvement, and what a one-point change would look like in daily life. Scaling questions can make progress concrete without reducing complex experiences to a single score.

The miracle question may be useful when adapted to the client's language and tolerance for hypothetical work. Rather than asking for an unrealistic future disconnected from military realities, the clinician might ask: "If this concern became manageable overnight, what would be the first small difference in your morning, your workday, or your relationships?" The answer can reveal functional goals and early indicators of change. Solution-focused practice should not bypass trauma, grief, discrimination, or safety concerns; it should provide a structured way to identify agency while acknowledging reality.

Integrate Narrative Methods

Narrative approaches can help client's separate identity from problems and examine the stories that define strength, failure, loyalty, or worth. A Marine might externalize "the pressure to handle everything alone" rather than describing the self as defective. The counselor can explore when that pressure has been useful, when it has become costly, and what alternative stories are supported by the client's actions. This process respects military identity while creating room for a broader account of courage and responsibility.

Narrative work is especially relevant when shame or moral conflict dominates the client's meaning-making. The clinician can identify values revealed by distress, acknowledge cultural and institutional contexts, and document preferred identity statements in language chosen by the client. Care is needed to avoid imposing a heroic recovery narrative or suggesting that every painful experience must produce growth.

Coordinate Care without Diluting Confidentiality

Effective support may involve collaboration among behavioral health clinicians, primary care providers, chaplains, leaders, family members, peer programs, and community agencies. Coordination should be purposeful rather than automatic. The client should understand who will receive information, what will be shared, why sharing is important, and any other options that exist. Releases of information should be specific and time limited when possible.

For international readers, care pathways will vary substantially. Local laws, military regulations, public health systems, insurance arrangements, and professional scopes of practice should help inform decisions related to this area. The hope is to identify easy to use, credible, and transparent options for service members.

Implications for Counselors, Leaders, and Organizations

Counselors should analyze several angles when working with this group including symptoms and barriers to care. Asking “What could make using support difficult or risky for you?” may help to identify concerns that are missed by regular assessments and intakes. Clinicians should assist with developing treatment goals that match the client’s values, use military-informed language without stereotyping, and provide clear information about privacy and documentation. Treatment planning should include clinical as well as practical areas such as scheduling, transportation, telehealth privacy, family responsibilities, and anticipated command reactions.

Leaders shape norms through everyday actions. They can communicate that early support protects people and missions, respond privately and consistently to disclosures, and ensure that appointment attendance is not publicly stigmatized. Leaders should receive training that distinguishes routine stress, clinical concerns, and emergencies, while reinforcing that they are neither therapists nor diagnosticians. Organizational accountability is necessary when informal practices contradict formal anti-stigma messages.

Organizations should reduce unnecessary friction in access. Useful strategies may include embedded services, multiple entry points, peer navigation, confidential consultation options, telehealth when appropriate, clear policy education, and transition support between military and civilian systems. Current reviews suggest that education, peer support, leadership engagement, integrated care, tele-mental health, and targeted anti-stigma initiatives may improve engagement, although effects vary and require continued evaluation (Atkins & Joseph, 2026; Rasheed et al., 2026).

Implications for International Practice

The international relevance of this topic lies in the interaction between military cultures and local systems. Many armed forces value cohesion, discipline, endurance, and operational reliability, but the meaning of disclosure differs across nations. Some militaries rely primarily on military clinicians, while others use public or contracted services. Legal protections, command access to health information, religious diversity, veteran status, and public attitudes toward service can alter both stigma and access.

International journals and researchers should resist exporting U.S.-specific assumptions without testing these. Measures of stigma, masculinity, unit climate, spirituality, and resilience require cultural verification. Researchers should report branch, nation, service status, rank composition, gender distribution, deployment context, and care system characteristics so readers can judge transferability. Cross-national studies could identify which barriers are common across military cultures and which are products of specific policies or health systems.

Limitations and Future Research

The primary limitation of this review is the scarcity of research focused exclusively on active-duty Marines. Much of the relevant evidence comes from mixed-service samples, veterans, other branches, or international defense personnel. These groups offer important insights but should not be treated as equivalent. The narrative method also introduces selection risk because the review does not claim exhaustive coverage or formal quality appraisal.

Future studies should use Marine-specific samples and examine differences by age, rank, gender, occupational specialty, family status, education, location, combat exposure, and prior treatment. Longitudinal work is needed to clarify whether leadership climate and stigma predict later service use, whether treatment experiences change stigma, and which organizational interventions produce sustained effects. Research should also distinguish perceived career risk from documented occupational outcomes and examine how accurately personnel understand confidentiality policies.

Intervention research should compare peer-led education, leader training, embedded care, telehealth, chaplain collaboration, family-inclusive approaches, and culturally adapted counseling. Outcomes should include not only attitudes but actual initiation, continuity, clinical improvement, trust, and occupational functioning. Qualitative studies can deepen understanding of how Marines describe strength, privacy, readiness, and acceptable support in their own words. International comparative research is particularly important for identifying culturally specific and cross-cutting pathways to care.

Conclusion

Marines may encounter mental health care within a culture that offers both substantial strengths and meaningful barriers. Cohesion, discipline, purpose, spirituality, flexibility, and close relationships can support resilience. Yet norms of self-reliance, anticipated judgment, leadership climate, confidentiality concerns, structural obstacles, and fears about career consequences can delay help-seeking. These influences should not be reduced to individual reluctance.

Culturally responsive practice views support as compatible with responsibility, readiness, and strength while remaining honest about the realities of military systems. Counselors can contribute through transparent confidentiality discussions, respectful assessment, solution-focused and narrative methods, and coordination with trusted supports. Leaders and organizations must also create conditions in which seeking help is practically accessible and socially safe. Advancing this work will require Marine-specific and international research that distinguishes among branches, service statuses, and care systems while preserving the voices of those who serve.

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