5-2022

Stigma as a Barrier to Military Mental Health Services

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ABSTRACT

A psychiatric disorder is perhaps an uncomfortable topic that isn't discussed enough in the military. However, the nature of the profession (i.e., the possibility of combat exposure) increases the risk of mental health disorders in the military. Despite the increasing awareness of the effects of untreated mental health conditions, a treatment gap still exists within the military culture. The present study aims to describe the prevalence of stigma in the military, as well as examine related factors, such as leadership behaviors and the associations between endorsed and anticipated stigma and treatment seeking intentions. Utilizing a questionnaire, this study investigated the extent to which stigma exists in a sample of U.S Army active-duty soldiers. The goal of this study was to identify the factors that contributed to their reluctance to seek care. By understanding the dynamics of treatment seeking behaviors and the gaps associated with care, future policy changes can be made that focus on normalizing mental health treatment in the military.

Stigma as a Barrier to Military Mental Health Services

A Thesis

Presented to

The Faculty of the School of Social Work

Abilene Christian University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Science in Social Work

By

Alicea Gray

May 2022

This thesis, directed and approved by the committee for the thesis candidate Alicea Gray, has been accepted by the Office of Graduate Programs of Abilene Christian University in partial fulfillment of the requirements for the degree

Master of Science in Social Work

Assistant Provost for Residential Graduate Programs

Date

May 4, 2022

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I dedicate my clinical research project to all my fellow military buddies serving our country. Thank you for your bravery, strength, and commitment in protecting America's freedom.

ACKNOWLEDGMENTS

First and foremost, I would like to thank my committee, who worked with me over the last year to make this research possible. As my chair, Dr. Alan Lipps, went above and beyond to ensure I was supported through the entire process. His time, dedication and unwavering commitment contributed to the success of my research. Dr. Malcom Scott's expertise was essential in the development of my research and greatly appreciated. I would like to thank CPT Maria Bibilioni for the words of encouragement throughout my graduate experience. Her kind words inspired me to keep pushing through the struggle and reminded me of my end goal.

Finally, I would like to thank my friends, Kaleena, Kevin and Mike for being there for me throughout the entire process. I couldn't have completed this project without their presence in my life. I am truly grateful to have friends who refused to see me give up and constantly reminded me of my purpose in life. I love you guys.

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CHAPTER I

INTRODUCTION

The military is known for courageous men and women who fight for their country. However, service members commonly face many hidden problems during their time in service. Military life includes deploying to hostile environments. For many, returning home is a pleasant experience; however, this isn't the case for all military members. Service members often experience unforeseen challenges upon arriving home from a long deployment. Likewise, deployment creates such stress for family members who are left at home, and absence of the military member results in changes to family dynamics. These variables can make reintegration a complex event for many service members returning home from deployment (Pessoa dos Santos et al., 2021).

In addition to the common stressors associated with returning home from deployment, being exposed to war and experiencing trauma, make service members more likely to be affected by drugs, alcohol, and other mental health problems (Forbes et al., 2019). Existing literature confirms that mental health issues, such as posttraumatic stress disorder (PTSD), anxiety disorders, and major depressive disorder are commonly associated with work-related stressors and deployments to a combat zone (Dickstein et al., 2010; Olson et al., 2018; Parnell et al., 2018). In 2015, the Department of Defense (DOD) conducted a behavioral health survey to assess the health related behaviors associated with the military population (Beckman et al., 2018). The data collected

indicated that 21% of active duty military members met criteria for a major depressive disorder, 14% met criteria for a generalized anxiety disorder, 9% met criteria for a post-traumatic stress disorder, 47% reported aggressive behaviors and 12% considered suicide since joining the military (Beckman et al., 2018). Furthermore, in the past year 26% sought mental health care; however, 36% who needed care refused to receive professional help, and 35% identified stigma as the main reason for the refusal of treatment (Beckman et al., 2018).

Although the prevalence rates of mental health disorders are high in the military, researchers have found that many members are reluctant to seek professional help due to the stigmas associated with mental health care. In 2015, Britt, Cheung, Jennings, Pury and Zinzow conducted a study that examined the impact stigma that's associated with mental health care has on the military population. Their research implied that various types of stigma were strongly associated to the treatment seeking process (Britt, et al., 2015). Similar to findings, McEnany and Schereiber found that stigma is considered one of the primary barriers to care for military members (2015). Furthermore, possible combat exposure for military personnel increases the risk of a psychiatric illness, however, "stigma creates an unconscious predisposition against seeking care" (McEnany et al., 2015, p. 55).

Based on existing literature, apprehension to seek treatment in the military is influenced by the many stigmas associated with mental health services (Ajzen et al., 2007). There are several factors that contribute to the resistance of care for military members. Therefore, the aim for this study will be to investigate the extent to which stigma exists in a sample of active-duty soldiers. Furthermore, this study will evaluate the

associations between leadership ratings and stigma rating scores. Ultimately, this study will assess the associations between endorsed and anticipated stigma and treatment seeking intentions related to mental health treatment.

CHAPTER II

LITERATURE REVIEW

The Foundation of Mental Health Stigma

Interest in research of the concept stigma has resulted in an evolution of definitions (Link & Phelan, 2001). One relatively early definition of stigma defined it as a personal characteristic that shames the stigmatized individual (Goffman, 1986). Goffman observed that stigma involves a relationship between the personal attribute and a stereotype that ultimately leads to diminished social status (Corrigan et al., 2014; Link & Phelan, 2001; Schreiber et. al., 2015). To distinguish stigma from other social phenomena, Link and Phelan (2001) proposed four elements of stigma. These included: (a) that stigma is a label for an outgroup; (b) that the label illuminates differences in the outgroup that carry a negative connotation; (c) that these differences separate groups into *us* and *them;* and (d) that this separation leads to discrimination. Corrigan et al. (2014) further refined the Link and Phelan (2001) elements of stigma using a grid to organize different types of stigma by the manner in which stereotypes, prejudice, and discrimination operate. In so doing, the types *structural*, *public*, *self* and *label avoidance* were differentiated.

- *Structural stigma* exists on a macro level and emerges when laws, policies, or practices of larger institutions intentionally or unintentionally limit opportunities for people with mental illnesses (Hatzenbuehler, 2018; Link & Hatzenbuehler, 2016).

- *Public* (also called *social*) *stigma* exists on a macro or mezzo level and is the process by which stereotypes are used to label a particular group possessing a particular attribute (e.g., mental illness). At the public level, discrimination occurs when members of the stigmatized group cannot obtain, or have trouble obtaining, employment, adequate housing, quality healthcare, etc. (Corrigan et al., 2014; Corrigan et al., 2016; Corrigan & Bink, 2015).
- *Self-stigma* exists on a micro level and occurs when an individual absorbs the negative stereotypes society has placed on mental illness, resulting in a decrease in self-esteem or treatment avoidance (Drapalski et al., 2013).
- *Label avoidance* exists when an individual is aware that those who are labeled as belonging to a stigmatized group are discriminated against and avoids the label (e.g., by not seeking treatment) (Corrigan et al., 2014)

Structural Stigma

Structural stigma refers to the "social and institutional policies and practices that undermine opportunities of people with mental illness" (Corrigan et al., 2014, p. 43). Research shows that the public's opinion has great influence over policy decisions; therefore, public stigma is strongly related to structural stigma. As legislators represent the public, and the public largely does not support increased funding for mental health and mental illness (MHMI) related policies and services (Conley, 2021; Corrigan et al., 2004). legislators structurally stigmatize MHMI in a variety of ways (Corrigan et al., 2004). These methods can include introducing and voting for bills that promote stigma or voting against funding or legislation that are supportive of the interests of the MHMI population (Conley, 2021; Corrigan et al., 2004). Legislators may also choose to ignore

the voices of stigmatized constituents (Hatzenbuehler & Link, 2014; Link et al., 1991; Link & Hatzenbuehler, 2016).

Public Stigma

In the social cognitive paradigm Corrigan and Watson (2002) described for understanding stigma, mental illness-related public stigma is defined as public labeling of (i.e., assigning a stereotype to), and subsequent discrimination against, people with mental illnesses. Acting as socially constructed knowledge structures, stereotypes are an efficient mechanism for transmitting widely-held beliefs about a group of people (e.g., those with mental illnesses). The mental illness stereotype includes the beliefs that persons with mental illnesses are dangerous, incompetent, and characterologically flawed (Corrigan & Watson, 2002). Prejudice is an attitude that is a combination of stereotype endorsement and negative emotional reactions (e.g., fear, anger). Discrimination occurs when prejudice produces a behavioral action that adversely affects a member, or members, of a stereotyped group (i.e., those with a mental illness). Therefore, public stigma occurs when a stereotype is generally accepted by a population and that population engages in discriminatory behavior toward the stereotyped group.

Public stigma has an important influence on discrimination against persons suffering from mental illness as it influences the context in which healthcare, employment, and housing services are provided (Parcesepe & Cabassa, 2013). Public discrimination against mentally ill people can include poor quality of healthcare, refusing to rent to a person because of a mental illness, or refusal to employ people because of mental illness (Parcesepe & Cabassa, 2013). That quality of healthcare for persons diagnosed with a mental illness is inferior to that received by those not diagnosed with

such an illness is well documented (Temple et al., 2021). Similarly, employment discrimination against those with mental illnesses persists with studies showing that the unemployment rate for people diagnosed with psychiatric disorders is three to five times higher than it is for those without such diagnoses (Cook et al., 2005). One study reported that 61% of mentally disabled working age adults are unemployed, while only 20% of working-age adults in the general population are unemployed (Cook et al., 2005).

One model used to explain and help disentangle the contributions of multiple variables involved in public stigma is called the *etiology and effects of stigma* (EES) model (Parcesepe & Cabassa, 2013). The EES model proposes that sociodemographic variables (e.g., age, race, education, etc.) of both the individual with a mental illness and those in the community who might either offer support to, or ostracize the individual with a mental illness, will influence cognitive processes related to the mental illness (e.g., causal attributions, moral judgments, etc.). The cognitive processes of attributions (e.g., is this biological, characterological, stress-related, etc.) and judgments (is this a mental or physical problem? How severe is this?) inform stigmatizing beliefs. Stigmatizing beliefs (e.g., that a person with schizophrenia is dangerous) are associated with discriminatory actions (i.e., measured as social distancing).

Though a complete review of the Parcesepe and Cabassa (2013) systematic review of public stigma studies would be to lengthy to report here, this study found limited support for the EES model. Most notably, a substantial number of Americans prefer to distance themselves from people diagnosed with mental disorders. Higher levels of education and being female were associated with less desire to socially distance. Attributions (e.g., bad character, absence of discipline) correlated significantly with

social distance. Stigmatizing beliefs were strongly associated with a desire to socially distance (i.e., stay away). More specifically, the belief that those possessing the label *mental illness* are dangerous was inversely related to willingness to socially engage with a diagnosed individual. Furthermore, the results of the study showed that the public believes mental illness and dangerousness are inextricably intertwined.

Self-Stigma

Self-stigma (also referred to as *internalized stigma*) includes the processes that make up public stigma except that these processes are internalized. When an individual becomes a member of a stereotyped group (e.g., is diagnosed with a mental disorder), and that individual believes the stereotype, the stigma is internalized (Ben-Zeev et al., 2010; Corrigan, 2002; Corrigan et al., 2006). Prejudice is directed inward resulting in a loss of self-esteem and self-efficacy (Corrigan et al., 2006). According to Corrigan (2012) and his colleagues, self-stigma occurs when an individual (1) becomes generally aware of negative public stereotypes about mental illness through everyday exposure in society (awareness), then (2) overtly or tacitly accepts that these negative public stereotypes are legitimate or true (agreement). When the stereotype-endorsing person experiences mental health problems, is diagnosed with a mental illness, or interacts with the mental health care system, the mental illness label becomes personally salient. This can lead to (3) agreement that the stereotype applies, and (4) subsequent decrease in self-esteem, lowered sense of worth to society, and lowered life expectations. Numerous studies document the deleterious psychological outcomes of internalized (self) stigma (Drapalski et al., 2021; Oexle et al., 2017; Oexle et al., 2018). Behavioral responses to internalized stigma can include avolition and impaired quality of life (Corrigan et al., 2006; Corrigan

& Rao, 2012). As Corrigan, Druss, and Perlick (2014) report, more than 100 studies documented that self-stigma is associated with reluctance or refusal to seek mental healthcare.

Corrigan et al. (2009) described a phenomenon that often occurs as a result of self-stigma. This phenomenon, called *why try* occurs as a result of stigmatizing beliefs. Stigmatizing beliefs are influenced by causal attributions (i.e., what causes the mental illness?) and internal evaluations (i.e., how serious is this mental illness?). As discussed above, these stigmatizing beliefs can influence some to conclude that they are unworthy of treatment or that treatment is hopeless. In other words, when the perceived benefits of treatment are outweighed by the imagined costs of treatment (e.g., a waste of time) the person develops a *why-try* attitude (Corrigan et al., 2009). Importantly, not all members of a stereotyped group will endorse the stereotype, neither will they internalize the stigma. Many actually develop a righteous form of anger and use that energy for empowerment (Corrigan et al., 2006; Corrigan et al., 2009). Additionally. self-stigma is more likely to decrease when service members have a positive experience with mental health services or are encouraged by others to seek treatment (Skopp et al., 2012).

Label Avoidance

Although label avoidance isn't a form of stigma, it's still considered a major aspect that composes the concept of stigma. Additionally, label avoidance links the stereotypes associated with stigma to delay treatment seeking behaviors (Corrigan & Wassel, 2008). Denying and avoiding are two components of label avoidance that impact treatment behaviors. To reject the notion of stigma, an individual may deny their status and avoid the institutions (i.e., mental health care) that brand them (Corrigan, 2004). In

other words, psychiatric labels create a separation between individuals with a mental health illness and those without a disorder.

There is significant evidence that indicate labels, (e.g., mental health disorders), can strongly influence the behaviors of individuals. Labels can cause an individual to negatively react, develop defense mechanism or adapt to their mental health disorder; potentially leading to major consequences that may interfere with their daily lives (Link, 1982). Hypothetically, behaviors as such may force an individual to choose between the risk of being labeled or receiving quality care. Essentially, the stigma associated with psychiatric disorders can lead to label avoidance and decrease treatment adherence (Corrigan, 2004).

Mental Health Stigma in the Military Context

As described above, mental health stigma is a complex social cognitive phenomenon that manifests at different system levels (i.e., micro, mezzo, macro) and has different types (self, public, structural, label-avoidance) that roughly correspond to different system levels. As military culture exists as a culture within a culture, the different levels and types of stigmas are influenced by military culture and the larger cultural context. In the military context, for example, structural stigma is influenced by military specific regulations and policies and regulations and policies of the larger socio-political context. The following discussion will focus on the policies, values, traditions, and other military-specific variables that combine to produce mental-illness stigma ultimately leading to barriers to provision of, or utilization of, mental healthcare services. The following bullet points offer brief definitions of the different forms of stigma that exist in the military, and are followed by a more in-depth explanation of each.

- Structural stigma consists of the military policies, creeds, traditions, and principles that create and reinforce public stigma, self-stigma, and label avoidance. The *tough warrior mentality*, for example, is built into the policies, creeds, and traditions that define the structure of the military (Ganz et al., 2021).
- Public (or social) stigma is the process through which other service members or leaders have endorsed MHMI stereotypes (i.e., people with mental illness are lazy, incompetent, and dangerous) and publicly discriminate against people diagnosed with, or receiving services for, MHMI issues (Coleman et al., 2017).
- Self-stigma in the military context occurs when a military service member, because of exposure to public stigma, accepts the stereotypical beliefs about mental health disorders, subsequently experiences a mental illness or needs mental healthcare, and applies the stereotype to themselves (e.g., I am weak, lazy, incompetent, and dangerous to myself or others) (Britt et al., 2020; Mohatt et al., 2017).

Military Culture and Structural Stigma

There is substantial evidence that shows a strong correlation between the culture of the military and structural stigma. Since its inception, the military culture has been built on toughness. The toughness requirement for service members is transmitted through the "unspoken beliefs, values, language, custom courtesies, traditions and expected behaviors" of military ranks (Gibbons et al., 2014, p. 368). These values and beliefs are instilled in service members from the beginning of their career and embedded in the military creeds which were created to empower and shape the *tough warrior* identity (Gibbons et al., 2014). Through daily repetitious recitation of creeds, military

service people internalize this belief system that insists on duty, toughness, and self-discipline (Ganz et al., 2021).

In the US Army, for example, reciting the Soldier's Creed is a mandatory activity during every formation. Within the creed, are the four-warrior ethos, which signify a soldier's commitment to service and their duty to uphold a warrior image. The phrase "I will always place the mission first" is the first verse and implies that the mission is always top priority. Therefore, built into the military is the expectation that service members put aside their own health and welfare to ensure the mission's success. Secondly, the phrase "I'll never accept defeat" implants the belief that being defeated is synonymous with failure as a warrior. The third statement, "I will never quit," indoctrinates soldiers to believe that the mission is most important and that giving up is not an option. In a 2006 article written by former US Army officer Robert Fisk (2006), the author quoted from a letter he received from a veteran whose son was serving in Baghdad. The letter expressed concerns about changes to the US Army Creed. Fisk quoted the father's letter as follows:

> The Warrior Creed . . . allows no end to any conflict accept total destruction of the 'enemy'. It allows no defeat . . . and does not allow one ever to stop fighting (lending itself to the idea of the 'long war'). It says nothing about following orders, it says nothing about obeying laws or showing restraint. It says nothing about dishonorable actions.

There is no doubt that the creeds of the military were created, by military brass, to empower service members. However, as illustrated in the above quotation, these very core values make no provision for anything other than placing the mission first and

destroying enemies (Fisk, 2006). Not a lot of imagination is necessary to see the conflict between the military creed and asking for help because one is experiencing mental illness symptoms (Ganz et al., 2021). Creeds are very similar to stereotypes in that both creeds and stereotypes contain potent beliefs and values about a specific population of people. In the military creeds, the core belief is that military people are tough and self-reliant. In the mental patient stereotype, the core belief is that mental patients are weak, lazy, dangerous and incompetent. Therefore, military creeds stigmatize mental illness through promoting a structure where anything other than mental toughness is intolerable.

There is not one specific person who created the creeds, but rather multiple people from different branches of the military who helped in the development of these doctrines. To be specific, each creed is written differently for each branch of the military, however the purpose and meaning behind them are rather similar. For instance, all branches stress the importance of physical strength, mental toughness and mission's success, which appeals to the hegemonic ideals of the warrior persona. Additionally, the military relies heavily on the masculine ideology of toughness, which clearly is demonstrated throughout their creeds. However, reinforcing the warrior mentality and self-sacrifice can portray underlining messages, such as emotional control and self-reliance (Prody, 2015).

Given the military emphasis on mental toughness, never accepting defeat, and never giving up, it seems only logical that military personnel would want to avoid being perceived of as weak, lazy, incompetent, or dangerous to self or others. Yet, these are the beliefs about mentally ill people embedded in the mental illness stereotype. As previously discussed, high stress levels, and exposure to traumatic events commonly experienced by military personnel put them at high-risk for developing mental illnesses. The presence of

public stigma toward mental illness creates label avoidance whereby those that might benefit from psychiatric, psychological, or psychotherapeutic services are reluctant to seek those services.

Numerous studies reviewed indicate that the tough mentality can become problematic to help seeking behaviors in the military. In 2019, Britt, Sawhney and Wilson (2020) conducted a study with 349 active-duty infantry soldiers in the U.S Army. Their study examined whether the unit's climate supported receiving mental health treatment and attitudes of mental health services. Britt et al.'s (2020) sample was predominately male (84%), majority white (51%), mostly enlisted (71%) and less than half (48%) have been deployed to Iraq or Afghanistan. Their findings indicated that military members are discouraged from seeking treatment because the *mental patient* stereotype is incompatible with the more desirable mentally tough image embedded in military culture.

Berger et al. (2021) focused on the positive and negative effects that the military lifestyle may have on mental health services. After sampling a total of 129 active-duty personnel in the U.S. Air Force, Army, Marine Corps and Navy, the authors concluded that the majority of participants believed that seeking mental health treatment contradicts military values. In addition, the sacrifice to the mission and their comrades is of utmost importance and mental health treatment makes service members feel as if they are "unfit" for duty and disloyal to their commitment to others (Ganz et al., 2021). After enduring a deployment and achieving mission success, service members feel a sense of pride, simultaneously proving to be the warrior the military trained them to be. However, at the same time it was found that, rather than seeking treatment, the majority of service

members tended to self-medicate to avoid being labeled and ridiculed by others (Ganz et al., 2021).

Military Leadership and Public Stigma

In the military, public stigma related to mental illness, or treatment for mental illness, exists when a significant segment of the military population endorses the mental illness (or mental patient) stereotype and engages in discriminatory actions toward a group of people who have been identified as being mentally ill. Such discriminatory actions can include name calling, physical violence, ostracism, or any other action that reduces the status of anybody identified as possessing the stigmatized label. In the military, as in the broader social context, public stigma removes power from the stigmatized group creating a power differential (Gibbons et al., 2014).

Leadership in the military context is defined as the process of "influencing people by providing purpose, direction, and motivation to accomplish the mission and improve the organization" (Department of the Army, 2019). In the Army, "leaders must consistently demonstrate good character and inspire others to do the same" (Department of the Army, 2019, 2-1). Ideally, all military leaders adhere to the core values of their respective branch, are humble, and have empathy for those under their command. Because leaders are responsible for training and motivating their subordinates to perform the duties of soldiers, they directly and indirectly influence their coping strategies, attitudes, values, beliefs, and behaviors (Britt et al., 2004). Furthermore, evidence supports that leaders and unit members are directly linked to social stigma and heavily sway the ideas of those suffering from a mental illness.

The military hierarchy consists of two types of leaders, non-commissioned officers (NCOs) and commissioned officers, both of which play a pertinent role in the military. Military officers are known as organizational leaders who are responsible for the planning and execution of military operations, as well as ensuring the welfare of NCOs and lower enlisted members (Sharma & Pearsall, 2016). NCOs play a more predominant role in the lives of junior enlisted, as they serve as first line supervisors in the military rank structure. Additionally, they are in charge of the development and well-being of their subordinates and are responsible for leading them in the execution of combat and non-combative missions (Sharma & Pearsall, 2016). Since NCOs have a more personal relationship with their subordinates, more than likely they carry a more influential role than military officers. NCOs guide and set the tone for junior enlisted, therefore they significantly impact the behaviors and attitudes of their subordinates (Sharma & Pearsall, 2016).

Military leaders contribute to the mission's success, unit's morale and the well-being of their subordinates (Squires & Peach, 2020). Constructive military leaders are viewed as confident role models that gain a high level of trust and promote healthy working relationship with their soldiers (Portela et al., 2015; Stanciulescu & Beldiman, 2019). Furthermore, rather than endorsing the *mental patient* stereotype, leaders who lead by example care about the mental and physical welfare of their subordinates and promote treatment seeking behaviors when necessary (Greenberg & Jones, 2011). As a prior military leader, myself, my soldiers trusted my ability to lead because I was approachable, displayed compassion and empathy while creating an encouraging work environment that recognized their job performance. It is clear that supportive leaders

have the ability to inspire and positively influence their subordinates, which is imperative in the development of all service members.

The Army Doctrine Publication No. 6-22 (Department of the Army, 2019) uses the term *toxic* "when describing leaders who have engaged in what the Army now refers to as counterproductive leadership" (8-7). Toxic leadership sabotages unit cohesion, mission success and negatively effects the motivation and well-being of subordinates (Fors Brandebo et al., 2019). While leaders have responsibility for conditioning soldiers to tolerate operational stress, and for working closely with providers of religious, behavioral, or psychological care, toxic leaders can interfere with soldiers' receipt of such care. Toxic leaders may behave in ways that are aggressive, manipulative, passive or derailing. Therefore, rather than looking out for the physical and psychological welfare of those in their charge, toxic leaders can obstruct the growth of, and contribute to the stress of, their subordinates (Doody et al., 2021; Fors Brandebo et al., 2019). Furthermore, toxic leaders can influence the attitudes of their subordinates, therefore it is likely that toxic leadership contributes to reluctance to seek help due to the lack of support from, or direct discrimination from, such leaders.

Military members are constantly under a great deal of stress, which is defined as a physical or mental reaction caused by life changes or events (Patil & Shahapure, 2021). In 2019, the military was considered the most stressful career in the United States (Career Cast Statistics, 2019). Military stressors, such as deployments, training exercises, permanent changes of duty stations, and work-related stressors, if not adequately managed, can consequently lead to a decline in health for service members (Patil & Shahapure, 2021; Pflanz & Sonnek, 2002). Military leadership is charged with the

responsibility of preparing soldiers to cope with operational stress (Department of the Army, 2019).

Extensive research has found a direct association between destructive leadership and chronic stress (Fosse et al., 2019). Severe stress in the military triggered by leadership may lead to misbehaviors, a decline in job performance and create a barrier to mental health treatment (Fosse et al., 2019). Despite the large number of stressors accompanied in the military and mental health concerns associated with those stressors, only 30–40% of service members will consider pursuing treatment (Hoge et al., 2006). Castro et al. (2014) examined the perceived barriers related to mental health care and the motives behind services members who refrain from asking for help. Shockingly, it was discovered that out of the 6,201 participants who met the criteria for a mental health disorder in the military, 65% reported fears of being perceived as weak, 63% specified the worries of being treated differently by leadership, 41% described feelings of embarrassment, and 51% expressed fears of being blamed by leadership for the problem (Hoge et al., 2004). These results clearly indicate that military personnel are aware of the public stigma (i.e., the combined effect of the stereotype, application of the stereotype to a group of labeled people, and discrimination against that group), and a significant number of military personnel fear being stigmatized (or labeled) by leadership.

Considering the number of stressors associated with the military population, it is imperative to understand the impact leadership styles have on treatment seeking behaviors. A recent study sampled 232 participants with an average of nine years in the military and found that leadership styles are associated with social and self-stigma (McGuffin et al., 2021). Their findings are consistent with the research that explored the

positive and negative effects of constructive and destructive leadership and mental health stigma. Their results discovered that constructive leadership decreases self-stigma by encouraging help-seeking behaviors; therefore, junior enlisted are less likely to develop negative attributes of oneself and more inclined to seek treatment (McGuffin et al., 2021). Conversely, destructive leaders endorse the mental patient stereotype and communicate their beliefs to their subordinates. Subordinates of destructive leaders are likely to internalize these beliefs should they develop a mental illness believing themselves to be weak and incompetent (McGuffin et al., 2021). Overall, both leadership styles are related to the attitudes and beliefs of mental health treatment and play predominate help-seeking behaviors.

Self-Stigma and the Effects of Military Treatment Avoidance

In a culture of toughness, accepting the *mental patient* label would be highly undesirable. The *mental patient* stereotype carries the message that mental patients are weak, dangerous, and incompetent (Ben-Zeev et al., 2010). This stereotype is practically the opposite of the three ethos of the Soldier's Creed. Internalizing the stigma undoubtedly would create an identity conflict in addition to the other problems associated with self-stigma (Ganz et al., 2021; Lunasco et al., 2010). Consequently, within the military culture, label avoidance makes sense. Seeking treatment for a mental illness within a culture that structurally and publicly stigmatizes mental illness will likely place the member seeking treatment at risk of ostracism and ridicule. Perhaps worse, once the service member accepts that a mental condition requiring treatment exists, the potential for self-stigma arises. Self-stigma, combined with the mental illness, can result in the *why-try* phenomenon, ultimately lowering the service member's chances for recovery.

Label avoidance is the process in which an individual denies or minimizes their symptoms of a mental health disorder to avoid the stigma or negative consequences associated with seeking treatment (Ben-Zeev et al., 2012). Although some service members may desire mental health treatment, they choose to avoid it due to the fear of being labeled or rejected or losing their social status with others (Skopp et al., 2012). People who suffer from a mental biological disorder, such as schizophrenia, are less likely to be perceived as "weak" rather than individuals who suffer from a mental disorder caused by trauma or other significant life changes (Dickstein et al., 2010). A major consequence of self-stigma is that many individuals would rather tolerate the symptoms of the illness that address the problem through treatment (Dickstein et al., 2010).

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) describes PTSD as a psychiatric condition caused by traumatic or life-threatening events (American Psychiatric Association, 2013). Symptoms of PTSD include severe psychic numbing (e.g., dissociation, depression), anxiety (experienced as hyperarousal and hypervigilance), anger, despair, and hopelessness (Koenig, 2018). Commonly, environmental stimuli can trigger traumatic memories in the person suffering from PTSD producing what is commonly called a *flashback*. During the flashback, the person suffering from PTSD reexperiences the fullness of emotions experienced during the initial traumatic event. Left untreated, disorders such as PTSD can cause severe consequences for active duty members, such as substance abuse, divorce, intimate partner violence, employment problems, homelessness, and increased risk for suicide (Koenig, 2018).

Exposure to combat and combat-related injuries increases the likelihood that military members will engage in binge drinking or drug abuse (Jeffery et al., 2014; Teeters et al., 2017). One study reported that, in the fiscal year 2008, prescriptions, such as opioid-based pain relievers have been abused by 11% of the total military population (Jeffery et al., 2014). Opioid use rose significantly among military members, with those diagnosed with a mental health disorder receiving the largest share of prescriptions (23.8%) and those diagnosed with a substance abuse disorder accounted for 11.4% of opioid prescriptions (Jeffery et al., 2014). In addition, 32.3% did not have an active prescription in the fiscal year 2010 (Jeffery et al., 2014). These data suggest that pain-numbing medications are commonly used by military members.

Though the military has a zero-tolerance policy on drug use, self-medicating otherwise-untreated mental illnesses with alcohol or other drugs is a commonly used coping strategy for some military personnel (Ganz et al., 2021). One study reported that heavy episodic drinking, illicit drugs, and cigarette use are strongly associated with the stressors in the military (Bray et al., 1999). In a study investigating military individuals who had successfully committed suicide, 25% had a substance abuse diagnosis (Pruitt et al., 2019). The most prevalent types of substance use problems among military members include alcohol, illicit drugs and cigarette smoking and is strongly linked to combat exposure and military stressors (Bray et al., 1999).

Overuse of alcohol is associated with a number of health-related and social problems. Approximately 31% of driving-related fatalities are linked with alcohol-impaired drivers. Alcohol use among military members is associated with increased risk for domestic violence (Teeters et al., 2017). The National Institute on Alcohol Abuse and

Alcoholism (NIAAA) reports that approximately 195,000 people die each year as a direct consequence of overuse of alcohol (*Alcohol Facts and Statistics,* National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2022). Among military members, specifically, studies demonstrate that alcohol use increases risk of interpersonal violence, poorer health, and mortality (Teeters et al., 2017). Substance and alcohol abuse strongly correlate with the physical and mental well-being of service members.

Domestic violence is the violent behavior, aggression or abuse committed against an intimate partner or adult family member, which is considered to be a more personal and severe case of abuse (Williamson, 2012). Challenges encountered upon returning home are related to parenting, family routines and responsibilities, finances, communication and bonding with loved ones, which may increase the risk for domestic violence (Lutgendorf et al., 2012; Williamson, 2012). In a review of literature involving domestic violence in military families, it was found that mental illnesses, such as depression is associated with domestic violence (Williamson, 2012). Shockingly, another study reports that 28% of men diagnosed with PTSD were perpetrators of domestic violence (Trevillion et al., 2015).

Suicide is the worst outcome that stems from mental illness and considering the majority of evidence examined, mental disorders increases that risk (Black et al., 2011; Pruitt et al., 2019). While it is a tough reality for the military, the suicide mortality rate for military members has increased over time. In 2020, there were 580 deaths by suicide among service members, which is a 16% increase from 2019 (Orvis, 2021). Nearly 50% of service members who died by suicide in 2015 had at least one mental disorder, which implies that mental health stigma plays a very influential role in suicide rates (Pruitt et

al., 2019). Mental health issues are often invisible wounds, making difficult the recognition of the degree of suffering and the signs of impending suicide. Common stressors associated with suicide are relationship problems, financial issues, military punishment and substance abuse dependency (Pruitt et al., 2019).

The military lifestyle is mentally and physically exhausting. Multiple tours of duty, being away from loved ones, and work-related stressors combine to create a very heavy load that all members of the military must carry. Unfortunately, this load often exceeds the load-carrying capacity of otherwise normal individuals, and mental illnesses result. While it is evident that mental illnesses often manifest themselves across a large section of the military, many military personnel are reluctant to seek treatment. Unfortunately, the military culture does not promote an environment that encourages mental health treatment (Ganz et al., 2021).

With mental disorders such as PTSD being strongly associated with war and other stressors associated with military life, the techniques for assessing, diagnosing, and rendering treatment are needed to enhance the mental effectiveness of military members. However, statistics show that approximately 36% of military members seek mental health services and very few actually complete the treatment process (Beckman et al., 2018; Gibbons et al., 2014). Despite the availability of treatment, many members refrain from seeking treatment due to the fear of losing the respect of leadership, career consequences and being judged by their subordinates (Nash et al., 2009; Skopp et al., 2012). Existing research confirms that apprehension to seek treatment in the military is influenced by the many stigmas associated with mental health services (Stecker et al., 2010).

Conclusion

The importance of early treatment amongst the mentally ill is crucial for those suffering with a mental disorder and reducing the rates of domestic violence, substance abuse and suicides in the military (Black et al., 2011; Bradley & Redfering, 1978; Trevillion et al., 2015). However, the many forms of stigma associated with mental illnesses prevent many members of the military from seeking such treatment. Fear of being labeled a mental patient, fear of being ostracized for having a mental illness, and fear of being assaulted for being labeled as a member of a stereotyped population are all very real fears. To address stigma in the military, interventions are needed to correct the beliefs of those throughout the various levels of the military. Structural stigma is best addressed at the various levels of policy generation. Public stigma is best addressed by changing inaccurate beliefs about the mental illness and mental patient stereotypes throughout the broader military culture. Self-stigma will be reduced as structural and public stigma are reduced. Self-stigma can also be reduced by interventions developed specifically to reduce the internalization of the stereotypical beliefs. This study will evaluate the degree to which interventions designed to reduce self-stigma are effective.

CHAPTER III

METHODOLOGY

The purpose of this study is to examine perceived stigma as a predictor for military members accessing mental health care. As discussed above, such stigmas can include structural stigma, public stigma, self (internalized) stigma, and label avoidance. Findings from this study will educate and bring awareness for military members to better understand the role stigma has on help-seeking behaviors. The primary aim for this study is to assist future researchers in developing intervention strategies designed to reduce self-stigma or label avoidance.

Research Questions

The present study will explore the prevalence of mental health stigma in the military. To accomplish this goal, the data collected will address the following research questions:

1. Can leadership behaviors influence mental health stigma?
2. What is the extent of perceived stigma experienced by participants?
3. What is the extent of participants' attitudes towards a psychiatric disorder?

These research questions were chosen due to the vast number of military members who refrain from seeking the appropriate psychiatric care necessary to improve their quality of life. With suicide being a major risk factor for untreated mental disorders, these questions

are fundamental to answer to enhance the knowledge of mental health disorders, help-seeking behaviors, self-helping tactics and the support of others who need treatment.

Data Collection

Approval was obtained from the Institutional Review Board (IRB) prior to collecting data for this study. To examine the impact stigma has on the access to care for the military population, this research design focused on collecting data from an Army unit located in Fort Bragg, NC. The company consists of 52 active-duty service members. Therefore, the desired sample size was 52 participants. Through email, a questionnaire was distributed electronically, using Qualtrix, to an active-duty Army 1SG, who then forwarded the questionnaire by email, inviting his company to respond to the online questionnaire. To meet criteria for this study, respondents must be serving as an active-duty member and have at least one year time in service. Participants who chose to respond to the questionnaire had seven days to complete it before it closes. The informed consent statement was attached to the email and was reviewed by participants prior to completing the questionnaire.

Measures

Screening Questionnaire

A screening questionnaire was developed for the current study, which included two “yes or no” questions. The participants were asked about their military status and time in service to ensure the inclusion criteria were met. The questionnaire took approximately one minute to complete.

Demographic Questionnaire

A demographic questionnaire was developed for the current study, which included 6 questions. The participants were asked their sex, age bracket, ethnicity, military pay grade, time in service and number of deployments. The questionnaire consists of three multiple choice questions and three fill-in-the-blank questions and took approximately one minute to complete.

Walter Reed Army Institute of Research Leadership Scale (WRAIR-LS)

The WRAIR-LS, Short Form is a scale commonly used in the military to assess three elements of leadership: supportive, destructive, and advocacy (Adler, Cabrera, Lopez & Thomas, 2018). The scale rates the positive and negative behaviors of leadership from the subordinate's perspective (Adler, et al., 2018). There are various forms of the scale, but the four-item version takes the least amount of time to complete, thus benefitting the participants. The respondents rate the behaviors of their leadership in terms of frequency, ranging from 1 "never" to 5 "always". The validity of the scale has been proven to be an effective method to measure leadership behaviors in the military (Adler et al., 2018).

Endorsed and Anticipated Stigma Survey (EASI)

The EASI is recognized as an efficient scale and is commonly used amongst the military population to assess various dimensions of stigma-related beliefs (Vogt et al., 2014). The EASI consists of a 40-item endorsed stigma scale that takes approximately 10 minutes to complete (Vogt et al., 2014). This questionnaire focuses on five components "beliefs about mental illness, beliefs about mental health treatment, beliefs about treatment-seeking, concerns about stigma from loved ones and concerns about stigma in

the workplace" (Vogt et al., 2014, p. 107). Using a Likert-type format, the respondents select their level of agreement ranging from 1 (strongly agree) to 5 (strongly disagree) to each statement. Evidence has proven that the validity and reliability of the EASI scale is beneficial for measuring endorsed and anticipated stigma among the military population.

The General Help-Seeking Questionnaire (GHSQ)

The GHSQ was developed to evaluate a person's likelihood of acknowledging their mental illness and indeed seek treatment from different sources of care (Ciarrochi et al., 2005). The scale assesses individuals by asking participants to respond to the phrase, "If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?" The respondents then use a number value to select their level of agreement ranging from 1 (extremely unlikely) to 9 (extremely likely). This scale has proven to be a reliability and validity of measures for help-seeking behaviors and emotional competence (Ciarrochi et al., 2005).

Data Analysis

Qualtrix responses were downloaded as an SPSS (.sav) data file. Unnecessary variables inserted by Qualtrix were deleted. Items 3, 4, 7, and 8 on the WRAIR were reverse coded so that ratings on all WRAIR items reflect more positive assessment of CFO leadership. A total of 26 responses were received. Total scores for the WRAIR, and the EASI subscales were computed by summing the relevant items. One participant failed to complete all of the GHSQ items, and those missing values were replaced with the median of all responses to the GHSQ items. EASI responses were recoded into a binary

category dividing responses into either 1 (neutral to strongly disagree) or 2 (agree or strongly agree).

To test hypotheses about predicted relationships between stigma and leadership, a series of regression analyses were performed. Bootstrapping, using the wild method with 2000 resamples, was performed to correct for bias associated with a small sample. Because the wild method requires unstandardized residuals for each predictor and response pair, residuals were obtained and saved using a preliminary regression analysis. In this preliminary analysis, each of the EASI subscales were used as the predictor variable and the WRAIR total score was used as the response variable. Using the wild bootstrapping method, separate regression analyses were executed using the WRAIR total score as the predictor variable and each of the EASI subscales as a response variable.

To test hypotheses about predicted relationships between stigma and healthcare seeking intentions, a similar series of regression analyses were executed using the GHSQ subscale (i.e., personal emotional problems, suicidal thoughts) totals as response variables and each EASI subscale total as predictor variables. Custom tables, showing counts and percentages of responses to the binary coded EASI items, were produced using the SPSS Custom Table interface. The number of responses within each binary category (neutral to strongly disagree or agree or strongly agree) were tabulated and row percentages were computed.

CHAPTER IV

RESULTS

Table 1 shows a comparison of mean scores on the outcome measures by age range. The majority of participants marked the 18- to 20-year-old age range with all participants being 40 years old or younger. Only one participant was in the 31–40 age range. No significant differences between the age range variables were observed.

Table 1

Scale and Subscale Means by Age Range

Variable Labels	18–20 $n = 19$	21–30 $n = 6$	31–40 $n = 1$	Total $N = 26$
EASI: Beliefs About Mental Illness	16.9	17.7	19.0	17.9
EASI: Beliefs About Mental Illness Treatment	20.8	22.7	29.0	24.2
EASI: Beliefs About Mental Illness Treatment Seeking	24.5	22.0	13.0	19.8
EASI: Concerns About Stigma from a Loved One	16.1	15.5	9.0	13.5
EASI: Concerns About Stigma in the Workplace	21.4	21.2	8.0	16.9
GHSQ Personal or Emotional Problem	12.9	13.3	17.0	14.4
GHSQ Suicidal Thoughts	13.3	13.2	16.0	14.2
WRAIR Total Score	26.6	25.3	26.0	26.0

Table 2 presents mean values on the outcome measures by racial group. A majority of participants were African American with one participant in the Asian category and one participant who chose the "prefer not to specify" option. No statistically significant scale by racial category mean differences were observed.

Table 2

Outcome Means by Participant Ethnicities

	White / Caucasian *n* = 9	Asian *n* = 1	African American *n* = 11	Hispanic *n* = 4	Other *n* = 1
EASI Beliefs About Mental Illness Total	17.11	18	17.64	14.75	22
EASI Beliefs About Mental Illness Treatment Total	20.56	21	22	22	24
EASI Beliefs About Treatment Seeking Total	23.67	24	21.91	26.75	25
EASI Concerns About Stigma From Loved Ones Total	17.33	17	14.18	17.5	8
EASI Concerns About Stigma in the Workplace Total	24.37	17	19.09	21.5	12
Total WRAIR Score (items 3, 4, 6, & 7 reverse coded)	26.33	28	26.64	23.5	32
GHSQ Personal-Emotional Problems Total	13.11	15	13.36	12.5	12
GHSQ Suicidal Thoughts Total	13.22	17	13.27	13.5	12

Of those who completed the survey, 21 (80.8%) were male and five (19.2%) were female. Table 3 shows the means on the outcome variables by gender. No statistically differences in means by gender were observed. Of those who answered the question about number of deployments, eight (30.8%) responded that they had been deployed one time. Three (11.5%) responded that they had been deployed two times, and a single participant marked either three, four, or six or more deployments.

Table 3

Outcome Means by Participant Gender

Outcome Variable Scale	Male $n = 21$	Female $n = 5$
EASI Beliefs About Mental Illness Total	17.0	18.0
EASI Beliefs About Mental Illness Treatment Total	21.4	22.0
EASI Beliefs About Treatment Seeking Total	22.3	28.2
EASI Concerns About Stigma From Loved Ones Total	15.7	15.6
EASI Concerns About Stigma in the Workplace Total	20.2	23.4
Total WRAIR Score (items 3, 4, 6, & 7 reverse coded)	27.1	22.8
GHSQ Personal-Emotional Problems Total	13.3	12.4
GHSQ Suicidal Thoughts Total	13.5	13.0

Table 4 presents regression data regarding the hypothesized association between leadership and stigma. As the table shows, leadership scores (higher scores = better leadership) were not significantly ($\alpha = .05$) associated with any of the stigma subscale total scores. Beliefs about mental illness treatment and concerns about stigma in the workplace both had standardized coefficients (i.e., $\beta = -.373$ and $\beta = -.356$) that were moderate and in the predicted direction (i.e., inverse). Arguably, a one-tailed test would produce probabilities less than the critical value ($\alpha = .05$) for beliefs about mental illness treatment (.061/2 = .031 and .099/2 = .0495 respectively) although a Bonferroni correction is required and will negate the significance of those one-tailed tests.

Table 4

Relationships of Leadership and Types of Stigma

EASI Stigma Type	df	Mean Square	*F*	*β*	*p**
Beliefs About Mental Illness	1, 24	18.38	0.05	0.046	.819
Beliefs About Mental Illness Treatment	1, 24	63.402	3.87	-0.373	.061
Beliefs About Treatment Seeking	1, 24	21.823	.346	-0.119	.613
Concerns About Stigma from Loved Ones	1, 24	103.30	1.83	-0.266	.197
Concerns About Stigma in the Workplace	1, 24	222.77	3.33	-0.356	.099

*Probabilities were estimated using a Bias-Corrected Bootstrap procedure with 2000 resamples

Table 5 shows the results of regression analyses using EASI subscales as predictor variables for the two GHSQ scales. As the table shows, none of the EASI subscales were significantly associated with either the personal-emotional problems or the suicidal thoughts scales of the GHSQ. Although bootstrapping with a bias correction was used in this analysis, bias values were very small.

Table 5

Bias Corrected Regression Coefficients for EASI Subscales and Totaled GHSQ Help-Seeking Intentions

EASI Subscale	*B*	Bias	SE	*p*	BC 95% CI	
					Lower	Upper
GHSQ: Personal-Emotional Problems						
EASI: Beliefs About Mental Illness	0.05	0.01	0.12	0.67	-0.20	0.37
EASI: Beliefs About Mental Illness Treatment	-0.14	-0.01	0.12	0.26	-0.33	0.08
EASI: Beliefs About Treatment Seeking	-0.09	0.00	0.06	0.13	-0.20	0.01
EASI: Concerns About Stigma from Loved Ones	-0.05	0.00	0.06	0.36	-0.16	0.06
EASI: Concerns About Stigma in the Workplace	-0.07	0.00	0.06	0.19	-0.21	0.03
GHSQ: Suicidal Thoughts						
EASI: Beliefs About Mental Illness	-0.14	-0.01	0.12	0.26	-0.33	0.08
EASI: Beliefs About Mental Illness Treatment	-0.09	0.00	0.06	0.13	-0.20	0.01
EASI: Concerns About Stigma from Loved Ones	-0.05	0.00	0.06	0.36	-0.16	0.06
EASI: Concerns About Stigma in the Workplace	-0.07	0.00	0.06	0.19	-0.21	0.03
EASI: Concerns About Stigma in the Workplace	-0.10	0.00	0.06	0.10	-0.21	0.03

Table 6 shows that there was mostly disagreement with statements consistent with the mental illness stereotype. As the table shows, a few participants (11.5%) indicted they believed people with mental health problems use those problems as an excuse and the same proportion believed having a relationship with a person with a mental illness would

be difficult. Overall, participants marked less than 5% of items indicating stigmatizing beliefs about mental illness.

Table 6

Beliefs About Mental Illness

	Neutral to Strongly Disagree		Agree or Strongly Agree	
	Count	%	Count	%
People with mental health problems cannot be counted on.	25	96.20%	1	3.80%
People with mental health problems often use their health problems as an excuse.	23	88.50%	3	11.50%
Most people with mental health problems are just faking their symptoms.	26	100.00%	0	0.00%
I don't feel comfortable around people with mental health problems.	25	96.20%	1	3.80%
It would be difficult to have a normal relationship with someone with mental health problems.	23	88.50%	3	11.50%
Most people with mental health problems are violent or dangerous.	25	96.20%	1	3.80%
People with mental health problems require too much attention.	25	96.20%	1	3.80%
People with mental health problems can't take care of themselves.	26	100.00%	0	0.00%
Beliefs About Mental Illness Total	**198**	**95.19%**	**10**	**4.81%**

Table 7 shows that there was mostly disagreement with statements consistent with the treatment for mental illness stereotype. However, nearly 35% of participants agreed or strongly agreed with the EASI item regarding side-effects of medications for mental health problems. Additionally, nearly 30% of participants agreed or strongly agreed with the statement that mental healthcare providers make inaccurate assumptions (i.e., stigmatize) about patients because of their *membership* in the *mental patient* group. Nearly 20% of participants agreed or strongly agreed that psychiatric medications are ineffective, and nearly 20% agreed or strongly agreed that those seeking mental healthcare are forced to undergo unwanted treatments.

Table 7

Beliefs About Mental Health Treatment

EASI Item Statement	Neutral to Strongly Disagree		Agree or Strongly Agree	
	Count	%	Count	%
Medications for mental health problems are ineffective.	21	80.80%	5	19.20%
Mental health treatment just makes things worse.	25	96.20%	1	3.80%
Mental health providers don't really care about their patients.	25	96.20%	1	3.80%
Mental health treatment generally does not work.	25	96.20%	1	3.80%
Therapy/counseling does not really help for mental health problems.	23	88.50%	3	11.50%
People who seek mental health treatment are often required to undergo treatments they don't want.	21	80.80%	5	19.20%
Medications for mental health problems have too many negative side effects.	17	65.40%	9	34.60%
Mental health providers often make inaccurate assumptions about patients based on their group membership (e.g., race, sex, etc.)	19	73.10%	7	26.90%
Beliefs About Mental Health Treatment Total	**176**	**84.62%**	**32**	**15.38%**

Table 8 shows that more than 65% of participants indicated a problem would have to be really bad before they would seek mental healthcare and that personally dealing with a mental health problem was preferable to seeking treatment for that problem. Nearly 40% indicated they would not share personal information with a mental health provider, and nearly 35% indicated that they would not be comfortable discussing problems with a mental healthcare provider. Nearly one-third of participants indicated they would feel stupid for not being able to handle a mental health problem on their own.

Table 8

Beliefs About Treatment Seeking

EASI Item Statement	Neutral to Strongly Disagree		Agree or Strongly Agree	
	Count	%	Count	%
A problem would have to be really bad for me to be willing to seek mental health care.	9	34.60%	17	65.40%
I would feel uncomfortable talking about my problems with a mental health provider.	17	65.40%	9	34.60%
If I had a mental health problem, I would prefer to deal with it myself rather than to seek treatment.	9	34.60%	17	65.40%
Most mental health problems can be dealt with without seeking professional help.	20	76.90%	6	23.10%
Seeing a mental health provider would make me feel weak.	19	73.10%	7	26.90%
I would think less of myself if I were to seek mental health treatment.	21	80.80%	5	19.20%
If I were to seek mental health treatment, I would feel stupid for not being able to fix the problem on my own.	17	68.00%	8	32.00%
I wouldn't want to share personal information with a mental health provider.	16	61.50%	10	38.50%
Beliefs About Treatment Seeking	**128**	**61.84%**	**79**	**38.16%**

Table 9 presents frequencies and percentages of responses to a series of questions asking how they believed friends and family would behave given the knowledge that the respondent had a mental health-related problem. According to Table 7, the two items with the highest proportions of agreement included "see me as weak" and "be afraid that I might be violent. As the table shows, only one participant indicated that they believed friends and family would not want to be near them should they have a mental-health problem. Overall, the vast majority of participants (i.e., 88%) expressed neutrality or disagreement with the EASI statements concerning mental health-related stigmatization from loved ones.

Table 9

Concerns About Stigma from Loved Ones

EASI Item Statement	Neutral to Strongly Disagree		Agree or Strongly Agree	
If I had a mental health problem and friends and family knew about it, they would…	Count	%	Count	%
think less of me.	22	84.60%	4	15.40%
see me as weak.	21	80.80%	5	19.20%
feel uncomfortable around me.	23	88.50%	3	11.50%
not want to be around me.	25	96.20%	1	3.80%
think I was faking.	23	88.50%	3	11.50%
be afraid that I might be violent	21	80.80%	5	19.20%
think that I could not be trusted	23	88.50%	3	11.50%
avoid talking to me.	24	92.30%	2	7.70%
Total	**182**	**87.50%**	**26**	**12.50%**

Forty percent (n = 10) of participants indicated that they agreed or strongly agreed that employment options would be limited if they had a mental health problem that was known about in the workplace (see Table 10). More than one third (i.e., 36%) of participants agreed that they would be assigned undesirable work, and 32% agreed that they would be treated unfairly should they have a mental health problem that was known about in the workplace. Overall, nearly one-third of participants agreed with the statements pertaining to mental-health-related stigma in the workplace

Table 10

Concerns About Stigma in the Workplace

EASI Item Statement	Neutral to Strongly Disagree		Agree or Strongly Agree	
If I had a mental health problem and people at work knew about it….	Count	%	Count	%
My coworkers would think I am not capable of doing my job.	18	72.00%	7	28.00%
People at work would not want to be around me.	21	84.00%	4	16.00%
My career/job options would be limited.	15	60.00%	10	40.00%
Coworkers would feel uncomfortable around me	19	76.00%	6	24.00%
A Supervisor might give me less desirable work.	16	64.00%	9	36.00%
A Supervisor might treat me unfairly.	17	68.00%	8	32.00%
People at work would think I was faking.	19	76.00%	6	24.00%
Co-workers would avoid talking to me.	21	84.00%	4	16.00%
Total	**146**	**73.00%**	**54**	**27.00%**

CHAPTER V

DISCUSSION

The current study explored endorsed and anticipated stigmas and their association with leadership and intentions to seek mental health care. The literature review showed that military leaders who cared more about subordinates promoted more mental healthcare seeking behaviors than leaders rated less positively (Greenberg & Jones, 2011). Other studies showed that stigma is frequently associated with refusal to seek mental healthcare treatment in active duty military members (e.g., Nash et al., 2009; Skopp et al., 2012; Stecker et al., 2010). Therefore, the aim for this study was to investigate the extent to which stigma exists in a sample of active-duty soldiers. Additionally, this study evaluated associations between leadership ratings and stigma rating scores. Finally, this study evaluated the association between endorsed and anticipated stigma and treatment seeking intentions related to mental health treatment. Ultimately, the goal of this study was to aid in the development of future evidence-based research that may serve to help in the treatment seeking process for military members.

Summary of Findings

Demographics

Demographic screenings were used in the current study to determine whether a specific gender, age group or ethnicity were more likely to be impacted by stigma. Results in the current study indicated that the majority of participants were between the ages of 18 to 20 years old, predominately male and African American. In addition, half of

the participants were deployed at least once during their military career. The findings revealed that demographics as such, were not significantly impacted by mental health stigma. Although male and females of all ages and ethnicities can be impacted by mental health stigma, it can be inferred that the non-significant results can be due to the small sample size.

Leadership

Given the role and impact leadership has on their subordinates, this research examined the relationship between leadership and factors that determine treatment seeking behaviors amongst military members. The data indicated that there was no statistically significant association between military leadership and treatment seeking beliefs. This implies that the leadership, as measured for this study does not influence mental health stigma at a greater than random chance level. However, beliefs about mental illness treatment and concerns about stigma in the workplace had standardized regression coefficients (-.373, p = .061; -0.356, p = .099) that were moderately strong and in the predicted direction. With a larger sample, these variables would likely have been statistically significant. Interestingly, the most common endorsed barrier related to stigma in the workplace was the belief that leadership might give less desired work. Barriers to care do not appear to be increased by leadership, however treatment seeking behaviors may affect occupation roles in the military.

Mental Illness and Treatment Beliefs

Stated by previous literature, the concept of stigma is one the main barriers that prevent service members from seeking treatment (Dickstein et al., 2010; Britt, et al., 2020). Furthermore, stigma was driven by fear, which impacted treatment seeking

behaviors (Nash et al., 2009; Skopp et al., 2012). Shockingly, the results for this study revealed the opposite but this could be because participants may be reluctant to admit or acknowledge stigma. In general, the majority of participants would feel accepted by others if diagnosed with a mental disorder, as well as accept others who've been diagnosed. However, nearly 30% disclosed they would feel stupid if they couldn't handle their diagnoses on their own. This indicates that participants who internalize negative stereotypes of mental illness might be more incline to think negatively towards seeking treatment. It is possible that military members who are devoted to their military image may perceive mental health disorders as a negative factor that sabotages their warrior identity.

Although beliefs of mental disorders were not statistically significant, results from this study reported that treatment seeking behaviors is a prevalent issue. Over 65% of participants agreed or strongly agreed that a problem would have to be really bad before seeking treatment. Also, more than 65% of participants revealed that they would rather deal with their mental problems on their own. It appears that participants have more negative views of seeking professional help, rather than stigmatizing beliefs of mental health disorders.

The findings for this study revealed that, despite the benefits of mental health treatment, the quality of care is clearly a concern. Over 30% of participants agreed or strongly agreed that mental health care providers make inaccurate assumptions and expressed their concerns regarding the side effects of medication. In addition, nearly 20% believed that seeking mental health care would force them to undergo unwanted treatment and take ineffective medication. Taken together, these results suggest a small

proportion of participants are more likely to refrain from treatment due to the quality of care and internalized beliefs of mental health disorders. However, these results confirm that barriers to care were not significantly associated with stigma.

Implications for Policy and Practice

In attempt to enhance treatment seeking behaviors in the military, several considerations come to mind. As described in the literature review, the tough mentality can become problematic to help seeking behaviors in the military, therefore intervention strategies focused on stigma reduction should be implemented into military policy. Helping service members cope with their mental health challenges enhances military readiness and improves the organization. Therefore, intervention strategies to improve the military's willingness to combat mental health stigma should be considered.

As indicated in the literature review, it comes as no surprise that military culture fosters an environment of mental toughness (Gibbons et al., 2014). Therefore, policy considerations should focus on developing campaigns that promote mental health treatment as a strength for the organization. Traditionally, the warrior identity is shaped through the masculine culture. Rather than changing the culture, efforts should be made to normalize mental health care. Additionally, an atmosphere that encourages help-seeking contributes to removing the labels related to mental health disorders and supports mental health care.

While normalization is imperative for the military culture, efforts that focus on psychoeducation should also be considered. The literature review stated that toxic leadership can create barriers to mental health treatment (Fosse et al., 2019). Therefore, the military should develop programs designed to educate leaders on mental health

disorders and the benefits of treatment to reduce the stigmas associated with mental health care. It's possible that psychoeducation that aims to improve attitudes towards mental health in the military could increase the likelihood of help-seeking behaviors.

The problem of mental health stigma is a growing concern in the military. The military culture is built on toughness, therefore normalizing mental health disorders and help-seeking behaviors are vital in reducing stigma. The purpose of this research was to explore the relationship between stigma and access to care. Despite the limitations, the findings of this study provided an understanding on the prevalence of mental health stigma in the military. Although the findings did not support the notion that stigma is a barrier care for military members, it is necessary to identify the concerns associated with mental health care. Therefore, improving the psychological health of those who risk their lives for our country is imperative for improving military readiness.

Implications for Research

The sample used for this study was from a single unit that was unexpectedly deployed about the same time as the online survey was made available. Because of the small sample size, statistical power to capture differences between subgroups of the sample (e.g., those with high levels of stigma and those with low levels of stigma) was inadequate. Future research efforts should attempt to obtain a larger sample so that subgroups of interest will be adequately represented.

Similarly, since the entire sample was from a single unit with a single commander, ratings of leadership style likely only reflected a single leader. A sample from multiple units under multiple leaders would help detect differences in leadership qualities. With a larger sample, from multiple leaders, the statistical sensitivity to detect

the anticipated association between leadership quality and stigma would be enhanced. Ideally, a random sample of several units would help eliminate problems due to statistical power and improve the generalizability of the findings.

Limitations

While this study sought to explore endorsed and anticipated stigmas and their association with leadership and intentions to seek mental health care, several limitations arise. First, the surveys were conducted while the unit was currently deployed overseas. Such circumstances could in fact impact the study in numerous ways. For example, service members who are deployed to hostile environments have mission essential tasks that would be considered a priority. Therefore, conducting a survey would be the least of their worries and could potentially cause them to rush their responses to the questionnaire. Additionally, future researchers should administer the questionnaire to service members in a traditional setting, under conditions that allow them to take their time and document their experience.

Another limitation to consider would be sample size for this study. The number of participants who responded to the questionnaire was significantly small, therefore the results found might not have high external validity. An appropriate sample size detects relevant differences and is essential to producing accurate results (Orthod, 2014). It's evident that the sampled participants in this study did not represent the larger population of the military. Bearing this in mind, it's difficult to determine the reliability of the outcome due to the small sample size in this study. A more diverse sample size would likely be more informative to understanding stigma, therefore, future researchers should expand their sample size by including a broader approach to the recruitment process

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APPENDIX

Institutional Review Board Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

Dear Alicea,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled

(IRB# 22-009)is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs