

## Self-Stigma Fully Mediates the Association of Anticipated Enacted Stigma and Help-Seeking Intentions in National Guard Service Members

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Higher self-stigma and anticipated enacted stigma from unit leaders are linked with lower intentions to seek help from a mental health professional in service members. Research in civilians suggests that the association between stigma perceived from others (e.g., anticipated enacted stigma) and help-seeking is fully mediated by self-stigma, but this has yet to be tested in military samples. The current study explored whether self-stigma mediated the association of anticipated enacted stigma from unit leaders and help-seeking intentions from a mental health professional in 138 Iraq/Afghanistan service members. Self-stigma and anticipated enacted stigma were positively correlated with one another and negatively associated with help-seeking intentions from a mental health professional. Test of direct and indirect effects using bootstrapping revealed that the direct effect of anticipated enacted stigma on help-seeking intentions was no longer significant after accounting for self-stigma. Stigma reduction interventions to facilitate help-seeking in this population are discussed.

*Keywords:* PTSD, self-stigma, anticipated enacted stigma, help-seeking, military

Posttraumatic stress disorder (PTSD), depression, and anxiety following deployments to combat theaters are common mental health concerns for service members who have deployed to Iraq/Afghanistan (Hoge et al., 2004; Seal et al., 2009). Prior research shows that many service members and veterans do not follow through with referrals to mental health treatment, will not receive minimally adequate care, or will discontinue mental health treatment prior to making adequate treatment gains (Garcia, Kelley, Rentz, & Lee, 2011; Harpaz-Rotem & Rosenheck, 2011; Hoerster et al., 2012; John-

ston & Dipp, 2009; Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2010). Stigma for seeking treatment is identified as a possible barrier to care, but the majority of studies examining stigma in military service members do not link the experience of stigma to seeking mental health care (Vogt, 2011).

There are multiple types of stigma that might impact treatment seeking. Two potentially influential forms of stigma are *anticipated enacted stigma* and *self-stigma*. Anticipated enacted stigma is the belief held by the service member that they will experience hostility, discrimination, or negativity from others if their treatment seeking is made known. Self-stigma is the negative attitudes held by service members about themselves for seeking or needing treatment. Anticipated enacted stigma is associated with lower intentions to seek mental health care from a mental health professional in service members who deployed to Iraq or Afghanistan (Blais & Renshaw, 2013), treatment avoidance in VA-enrolled Iraq and Afghanistan veterans (Mittal et al., 2013), and fewer visits to a mental health professional in veterans aged 65 and older (Blais, Tsai, Southwick, &

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Pietrzak, 2014). Self-stigma is linked with lower intentions to seek mental health treatment from a medical or psychological provider (Blais & Renshaw, 2013).

Stigma theory suggests that stigma perceived from others (e.g., anticipated enacted stigma) may lead to an internalization of these attitudes, resulting in self-stigma (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Indeed, longitudinal research demonstrates that stigma perceived from others results in greater self-stigma over time (Vogel, Bitman, Hammer, & Wade, 2013). Moreover, research in civilian samples suggests that the association of stigma perceived from others and help-seeking intentions or behaviors is fully mediated by self-stigma (Ludwikowski, Vogel, & Armstrong, 2009; Vogel, Shechtman, & Wade, 2010; Vogel, Wade, & Hackler, 2007). To our knowledge, this association has yet to be tested in military samples. It is critical to examine the association of stigma with regard to help-seeking specifically in military service members as military service members live in a unique culture focused on stoicism and warrior ethos (Skopp et al., 2012). Thus, full reliance on extrapolating findings from civilian samples to military samples may obscure our understanding of stigma and help-seeking.

Prior research conducted as part of a larger study composed of participants in the current investigation found that both self-stigma and anticipated enacted stigma, specifically from unit leaders, were negatively associated with help-seeking intentions from a mental health professional. Anticipated enacted stigma from unit members and family/friends were unrelated to help-seeking intentions from a mental health professional (Blais & Renshaw, 2013). The purpose of the present brief report was to evaluate whether self-stigma mediates the association of anticipated enacted stigma from unit leaders and help-seeking intentions from a mental health professional. We examined these associations in the context of a broader model of help-seeking, the behavioral model of health services use (Andersen, 1995). This model specifies three primary characteristics that impact help-seeking: *predisposing* factors, *enabling* factors, and *need* factors. In this study, we wanted to examine the associations of anticipated enacted stigma and self-stigma with help-seeking intentions while accounting for predisposing, enabling, and need characteristics

related to mental health care utilization. We examined age, religious affiliation, gender, race, and education as predisposing factors; marital status, prior history of treatment utilization, and income as enabling factors; and PTSD symptoms, depressive symptoms, anxiety symptoms, and overall combat exposure as need factors.

The current study focused on recently returned National Guard service members, because they may not have easy access to mental health care following deployment given their reserve status. Consistent with theory and previous research in civilians, it was hypothesized that self-stigma would fully mediate the association between anticipated enacted stigma from unit leaders and help-seeking intentions.

## Method

### Participants

Participants were 138 Utah National Guard/Reserve Iraq/Afghanistan service members. The average length of time being home from deployment was 3.84 months ( $SD = 2.41$ ). The sample was predominantly male (91.3%), White (87.7%), married (58.0%), and Latter Day Saints Church members (68.5%). Participants were mostly Marines (54.7%) or Army (41.4%). Most participants had received some college education (73.6%), with an annual income  $< \$50,000/\text{year}$  (75.6%). The mean age was 27.06 years ( $SD = 7.11$ ), and the average number of deployments was 1.47 ( $SD = 0.67$ ). The majority (79.2%) reported no history of mental health treatment.

### Measures

**Stigma.** Self-stigma for seeking mental health treatment was assessed using the 10-item Self-Stigma of Seeking Help Scale (Vogel, Wade, & Haake, 2006). Participants rated their agreement with each statement using a Likert scale of 1 (*strongly disagree*) to 5 (*strongly agree*). Total scores were derived by summing all 10 items after five items were reverse scored. Scores range from 10 to 50. Higher scores indicated higher self-stigma. A sample item includes, "I would feel inadequate if I went to a therapist for psychological help." The Self-Stigma of Seeking Help Scale showed high internal consistency and good test-retest reli-

ability in the norm sample (Vogel et al., 2006). Internal consistency was also high in the current sample (Cronbach's alpha = .85).

Anticipated enacted stigma from unit leader was assessed using the five-item Perceptions of Stigmatization by Others for Seeking Help Scale (Vogel, Wade, & Ascheman, 2009). Items asked participants to rate their agreement with each statement regarding how they would feel that their unit leaders would respond to them if they sought psychological help. Participants rated their agreement with each statement, using a Likert scale of 1 (*strongly disagree*) to 5 (*strongly agree*). Total scores were derived by summing all five items and higher scores indicated higher anticipated enacted stigma from unit leader. Scores range from 5 to 25. A sample item includes, "If you sought mental health services for difficult negative emotions or psychological problems, to what degree do you believe your unit leader would react negatively to you?" Cronbach's alpha and test-retest reliability in the norm sample were .91 and .82, respectively (Vogel, Wade, & Ascheman, 2009). Cronbach's alpha in the current sample was .94.

**Help-seeking intentions.** Likelihood of seeking help from a mental health professional was assessed via a single item from the General Help-Seeking Questionnaire (Wilson, Deane, Ciarrochi, & Rickwood, 2005), which uses a Likert scale from 1 (*extremely unlikely*) to 7 (*extremely likely*). The item asks, "If you were having difficult negative emotions or psychological problems, how likely is it that you would seek help from a mental health professional (e.g., counselor, psychologist, psychiatrist)?" The scale was designed to allow researchers to select which items to use in their investigations (i.e., not all items need to be used in each investigation). Cronbach's alpha and test-retest reliability of the full scale in the norm sample were .70 and .86, respectively.

**Predisposing, enabling, and need factors.** Predisposing (i.e., age, religious affiliation, gender, race, education) and enabling (i.e., marital status, prior history of treatment utilization, income) characteristics were assessed using a demographic questionnaire designed for the current study. Need characteristics related to psychological distress were assessed using the PTSD Checklist – Military (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993) and the Depression Anxiety Stress Scale – Short Form

(DASS-SF; Lovibond & Lovibond, 1995). The 17 items on the PCL-M were summed for a total score. The depression (DASS-SF-D) and anxiety (DASS-SF-A) short-form subscales each contained 7 items, and items were summed for a depression and anxiety subscale score. Higher scores on all three need measures indicated greater distress. Cronbach's alpha in the current sample for the PCL-M, DASS-SF-D, and DASS-SF-A were high, .95, .92 and .84, respectively. Last, combat exposure was assessed using the Deployment Risk and Resiliency Inventory—Combat subscale (King et al., 2006), a dichotomously scored 15-item inventory assessing exposure to certain combat scenarios. Items are summed for a total score, and higher scores indicate greater combat exposure. Cronbach's alpha for the Deployment Risk and Resiliency Inventory—Combat subscale in the current sample was .82.

## Procedures

The current study is part of a larger investigation on postdeployment adjustment in National Guard/Reserve Members. The George E. Whalen VA Human Subjects Subcommittee and the Institutional Review Board at the University of Utah approved all study methods. Service members from different war eras ( $n \sim 240$ ) present during three postdeployment health assessments and Yellow Ribbon events were informed of the study by the principal investigator, who was present at each event. Interested service members were given a waiver of documentation of informed consent and study assessments. Participants who completed study measures were provided with \$15 for participation. One hundred sixty-five service members completed study questionnaires, and 138 reported that they returned from deployment within the last year. These 138 service members are the focus of the current study.

## Analytic Plan

Associations of predisposing, need, and enabling characteristics with help-seeking intentions from a mental health professional were examined using  $t$  tests, bivariate correlations, or negative binomial regression (appropriate for use with count variables, including combat exposure). All variables that demonstrated a significant association with help-seeking were in-

cluded in the final model. Mediation testing using bootstrapping methods with 5,000 samplings and macros proposed by Preacher and Hayes (2008) was utilized to examine the mediation of the association between anticipated enacted stigma and help-seeking intentions from a mental health professional by self-stigma, controlling for relevant predisposing, enabling, and need characteristics. Given the different scalars associated with our variables of interest, variables representing relevant predisposing, need, and enabling characteristics, as well as anticipated enacted stigma and self-stigma scores, were transformed to standardized scores in mediation tests to allow for easier interpretation of output.

### Results

The mean score for help-seeking intentions was 3.28 ( $SD = 1.89$ ), for self-stigma was 27.91 ( $SD = 7.94$ ), and for anticipated enacted stigma from unit leaders was 12.90 ( $SD = 6.44$ ). The observed score for help-seeking intentions is nearly the exact midpoint of the scale, which ranges from 1 (*extremely unlikely*) to 7 (*extremely likely*). The average score for self-stigma was nearly identical to one of the norm development sample's average score (i.e.,  $M = 27.3$ ,  $SD = 6.6$ ) on this scale (Vogel et al., 2006), and the average score for anticipated enacted stigma from unit leaders was slightly higher than the norm sample score ( $M = 11.30$ ,  $SD = 3.66$ ), which was composed of a nonclinical sample of undergraduate students (Vogel et al., 2009). Self-stigma and anticipated enacted stigma from unit leaders were positively correlated with each other ( $r = .33$ ,  $p = .001$ ). Consistent with hypotheses, self-stigma ( $r = -.43$ ,  $p = .001$ ) and anticipated enacted stigma from unit leaders ( $r = -.20$ ,  $p < .05$ ) were negatively correlated with help-seeking intentions from a mental health professional. The predisposing characteristic of age ( $r = .19$ ,  $p < .05$ ) and the enabling characteristics of being married,  $t(135) = 2.91$ ,  $p < .01$ , history of prior mental health care utilization,  $t(127) = 3.46$ ,  $p = .001$ , and having an income greater than \$50,000,  $t(124) = 2.24$ ,  $p < .05$ , were associated with help-seeking intentions from a mental health professional. Education, race, religion (member of Latter Day Saints Church vs. non-member), combat exposure, PTSD symptoms,

depressive symptoms, and anxiety symptoms were all unrelated to help-seeking intentions from a mental health professional (all  $ps > .05$ ).

In order to test the indirect effect of anticipated enacted stigma from unit leaders on help-seeking intentions from a mental health professional via self-stigma, we used bootstrapping methods recommended by Preacher and Hayes (2008). Including predisposing and enabling characteristics of age, history of mental health treatment, income, and marital status as covariates, the overall model was significant,  $F(6, 111) = 7.48$ ,  $p < .001$ ;  $R^2 = .29$ . The direct effect of self-stigma on help-seeking intentions from a mental health professional was significant ( $b = -.60$ ,  $p < .001$ ), whereas the direct effect of AES from unit leaders was nonsignificant ( $b = -.20$ ,  $p = .23$ ). However, the indirect effect of AES from unit leaders on help-seeking intentions via self-stigma was significant ( $b = -.21$ ; 95% CI =  $[-.41, -.07]$ ). Thus, the effect of anticipated enacted stigma on help-seeking intentions was fully mediated by self-stigma. Of note, the only predisposing and enabling characteristics that maintained significant associations with help-seeking intentions in this model were history of mental health treatment and marital status, with those who had prior mental health treatment ( $b = 1.26$ ,  $p < .01$ ) and those who were married ( $b = 0.70$ ,  $p < .05$ ) being more likely to seek help.

### Discussion

The direct association between anticipated enacted stigma with help-seeking intentions in National Guard service members was no longer significant after accounting for the effects of self-stigma. These results have important implications for interventions aimed at increasing help-seeking intentions in returning service members. To be most effective, such interventions should primarily focus on addressing and reducing self-stigma. Interventions focused on self-stigma reduction are typically more feasible than interventions focused on perceived stigma reduction, because self-stigma interventions are directed at altering individual beliefs, rather than altering societal or cultural beliefs.

Direct therapy interventions may be helpful in reducing the self-stigma associated with seeking treatment following deployment; however, relying on direct therapy interventions will likely be dif-

difficult as such interventions require military service members to present for care. Our findings suggest that stigma will prevent them from even seeking care. Use of alternate methods of treating veterans is needed. Preliminary findings from a randomized clinical trial incorporating a seven-session cognitive-behavioral therapy Web-based intervention for PTSD and depression showed that veterans who received the intervention reported clinically significant reductions in PTSD and depression after treatment (Hobfoll, Blais, Stevens, Walte, & Gengler, 2014). Veterans were able to complete this online treatment in the privacy of their own home and at their leisure. Providing veterans with more flexible and confidential treatments may circumvent the self-stigma that stops them from seeking treatment from a mental health professional in a formal care setting.

Our findings showed that married military service members and those who reported a history of mental health care utilization were more likely to report a willingness to seek help from a mental health professional. Thus, self-stigma reduction interventions may be most beneficial if targeted toward unmarried service members who do not have a history of mental health care utilization.

The average scores on the self-stigma and anticipated enacted stigma measures in the current sample was very similar or slightly higher than scores on these measures in the norm samples (Vogel et al., 2006; Vogel et al., 2009), which were composed of undergraduate civilian students. One might anticipate that veterans would score higher on these measures than their civilian counterparts given the pressure from military culture to be mentally and physically fit. To our knowledge, this is the first dataset to use these measures of stigma. Additional research using more diverse samples of military veterans may be useful in understanding how veterans perform on this assessment.

Although our findings suggest that it is important to focus on reducing self-stigma, efforts should also be made to reduce anticipated enacted stigma for seeking treatment. Coping phrases such as “suck it up and drive on” (Johnson, 2009) are common within the military. Such phrases do not promote openness to or acceptance of seeking treatment despite high rates of exposure to traumatic events during their military deployment (Hoge et al., 2004). Given that the majority of veterans are likely to experience traumatic events, normalizing a posttraumatic stress reaction and

promoting the efficacy of treatment may facilitate help-seeking. Messages of acceptance for experiencing distress and promotion of help-seeking will likely be most effective if these messages come from military leaders and those who assist wounded veterans (e.g., medics).

Limitations of this study include the cross-sectional design, which prevents drawing causal inferences. Sampling methods were nonprobability-based, which resulted in a predominantly male, White, and religiously homogenous sample. Finally, our outcome was limited to *intentions* to seek mental health care—additional research is needed to determine if these same associations would be detected when investigating barriers to actual utilization.

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