Preliminary Evidence of Differences Between Stigma Source Versus Type With Individual Functioning Variables in National Guard/Reserve Troops

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Preliminary Evidence of Differences Between Stigma Source Versus Type With Individual Functioning Variables in National Guard/Reserve Troops

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University of Utah

Extant military studies show that stigma has a variable association with seeking mental health treatment and mental health distress. Previous studies used a general measure of stigma that does not differentiate between stigma source or type. Stigma source can be either self-perceived or perceived from others, and stigma type can include stigma for disorder or stigma for help-seeking. Civilian literature demonstrates that self-stigma is more detrimental to individual functioning than stigma perceived from others, and prior studies in National Guard service members (NGSMs) show that self-stigma and stigma perceived from unit leaders were associated with lower help-seeking intentions relative to stigma perceived from unit members or family members. No military study has simultaneously explored the associations of demographic and distress variables with various stigma types and sources. To determine if prior mixed findings were due to the use of a general measure of stigma, NGSMs (n = 163) completed demographic and distress measures, as well as stigma source (e.g., self, leader) and type (i.e., general, disorder, help-seeking) assessments. General stigma was positively associated with all stigma types and sources as well as a college education. Disorder stigma was positively associated with stigma from nonmilitary sources, and self-stigma for help-seeking was negatively associated with help-seeking intentions. Likelihood of deploying again was positively associated with disorder and help-seeking stigma when perceived from someone in authority. Given the unique associations observed, future studies should utilize specific measures of stigma when examining factors related to postdeployment functioning.

Keywords: National Guard, stigma, PTSD, help-seeking, military

Stigma is posited to be a barrier to mental health care in U.S. military service members (Vogt, 2011). Findings from studies exploring the association of stigma with help-seeking in U.S. Veterans, however, are mixed. Some studies observed stigma to be unrelated to actual mental health care utilization in Veterans Administration (VA)-enrolled and non-VA enrolled veterans (Adler, Britt, Riviere, Kim, & Thomas, 2015; Hoerster et al., 2012), higher in veterans already engaged in VA mental health care (Rosen et al., 2011), or lower in a nationally representative sample of older veterans who sought mental health care (Blais, Tsai, Southwick, & Pietrzak, 2015). Together, these mixed results have called into question whether stigma is a true barrier to care despite widely held beliefs that the military culture discourages service members from seeking mental health care or admitting that they are experiencing postde-
ployment distress (e.g., Barrett, 1996; Jakupcak, Blais, Grossbard, Garcia, & Okishi, 2014). These extant military studies further contradict a large body of civilian literature showing that stigma is a prominent barrier to help-seeking (e.g., Barney, Griffiths, Jorm, & Christensen, 2006; Fung, Tsang, & Corrigan, 2008; Pederson & Vogel, 2007; Vogel, Wade, & Haake, 2006; Vogel, Wade, & Hackler, 2007). One possible explanation for previously observed mixed findings in military samples was the use of a general measure of stigma that does not differentiate between different stigma types and sources.

Goffman (1963) posits that there are several variations of stigma, namely those that are visible (e.g., race, physical disability) and those that are less visible (e.g., “invisible wounds of war” Tanielian & Jaycox, 2008; political, or religious affiliation). Corrigan, Watson, and Barr (2006) emphasize the importance of distinguishing between possible stigma sources, including stigma from the self (i.e., self-stigma) and stigma perceived from others (e.g., perceived stigma, anticipated stigma, enacted stigma, public stigma). Self-stigma refers to the negative thoughts or beliefs about mental illness or mental health treatment held by the individual with the mental health condition (Manos, Rusch, Kanter, & Clifford, 2009). Perceived stigma refers to the belief that others think or act negatively toward individuals with mental health conditions or those that seek treatment. General stigma does not specify stigma source or type, but rather collapses stigma concerns into a single construct. Table 1 includes additional definitions of these stigma constructs and various terms used to describe each stigma type.

The mixed findings observed by Blais et al. (2015), Hoerster et al. (2012), and Rosen et al. (2011) all used the same measure of general stigma, the Perceived Barriers to Care Scale (PBCS; Britt, 2000). The PBCS asks service members/veterans to rate their (1) concerns that others may respond or react negatively toward them if they sought mental health treatment (i.e., other perceived stigma for help-seeking) or had a mental health disorder (i.e., other perceived stigma for disorder), and (2) concerns that they would think negatively of themselves if they had sought mental health treatment (i.e., self-stigma for help-seeking) or had a mental health disorder (i.e., self-stigma for disorder). The PBCS does not differentiate between stigma types (e.g., disorder, help-seeking) or sources (e.g., self, other). As such, the discrepant findings observed across studies in military service members/veterans between stigma and individual outcomes (e.g., Blais et al., 2015; Hoerster et al., 2012; Rosen et al., 2011) may be

<table>
<thead>
<tr>
<th>Stigma term</th>
<th>Stigma definition</th>
<th>Possible stigma sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated enacted stigma for disorder</td>
<td>The expectation that others will think or act negatively toward individuals with the mental health condition</td>
<td>Unit leader, unit members, romantic partners, family, friends, society</td>
</tr>
<tr>
<td>Anticipated enacted stigma for help-seeking</td>
<td>The expectation that others will think or act negatively toward individuals that seek treatment for a mental health disorder</td>
<td>Unit leader, unit members, romantic partners, family, friends, society</td>
</tr>
<tr>
<td>Self-stigma for disorder</td>
<td>The negative thoughts or beliefs about mental illness held by the individual with the mental health condition</td>
<td>Self</td>
</tr>
<tr>
<td>Self-stigma for help-seeking</td>
<td>The negative thoughts or beliefs about mental health treatment held by the individual who seeks mental health treatment</td>
<td>Self</td>
</tr>
<tr>
<td>General stigma</td>
<td>The perception that having a mental health disorder or seeking treatment for a mental health disorder will cause others to think less of an individual if s/he has a mental health condition or seeks treatment</td>
<td>Self, unit leader, unit members, romantic partners, family, friends</td>
</tr>
</tbody>
</table>
due to the general measure of stigma that does not differentiate between unique stigma experiences.

There is preliminary evidence that differentiating between disorder and help-seeking stigma has clinical utility. That is, civilian data shows that disorder stigma and help-seeking stigma were differentially related to social inadequacy, shame, and self-blame (Tucker et al., 2013). Blais and colleagues (2013, 2014) found that self-stigma and anticipated enacted stigma (AES) from unit leaders for help-seeking was negatively associated with formal help-seeking intentions, but AES from family and unit members for help-seeking was unrelated to formal help-seeking intentions. AES from family/friends for help-seeking, however, was negatively associated with informal (e.g., social support) help-seeking intentions (Blais, Renshaw, & Jakupcak, 2014). Finally, Mittal et al. (2013) found that VA-enrolled veterans who reported higher anticipated stigma for posttraumatic stress disorder (PTSD) were more likely to report prior treatment avoidance. These differences suggest that in order to reduce shame or social inadequacy, to facilitate help-seeking, or to encourage social support seeking, unique interventions that specifically target stigma source and type will be needed for these individual outcomes. To date, no study has systematically studied possible differences between stigma source or type at the same time or in the same sample.

The purpose of the current study was to examine whether the association of demographic (i.e., age, race, history of prior treatment, or mental health diagnosis), military (i.e., total number of deployments, perceived likelihood of deploying again), and distress characteristics (i.e., PTSD, depression, general anxiety) as well as help-seeking variables differed based on stigma type versus source. Such information can be used to develop targeted strategies to reduce stigma. For example, if self-stigma for help-seeking is the only stigma variable associated with help-seeking, it will be critical for interventions to focus on reducing individuals’ own negative beliefs about seeking treatment. Alternatively, if stigma for help-seeking that is perceived from unit leaders is the only stigma variable related to help-seeking, it will be critical for interventions to focus on altering perceptions of unit leaders’ reaction to help-seeking.

Method

Participants

Participants were 163 NGSMs who had deployed to Iraq and Afghanistan. The average length of time being home from deployment was 9.59 months ($SD = 16.20$). The average age was 27.89 ($SD = 7.12$) and number of deployments was 1.43 ($SD = 0.67$). The sample was predominantly male (93.9%), White (86.1%), and married (58.9%). NGSMs were mostly Marines (56.8%) or Army (36.8%). Most participants received some college education (75.0%) and had an annual income < $50,000/year (76.4%). The majority (79.6%) reported that they had never received mental health treatment nor received a mental health diagnosis prior to deployment (93.2%). A minority sought mental health treatment during deployment (4.3%) or sought help following deployment (15.3%). The majority crossed the suggested threshold of 30 for PTSD ($n = 85; 54.5%;$ Bliese et al., 2008), and a minority reported at least mild depression ($n = 26; 16.9%$) or anxiety ($n = 21; 13.7%$; see Table 2 for average scores and standard deviations).

Procedure

NGSMs ($n \sim 240$) attending three postdeployment health assessments or Yellow Ribbon events were informed of the study by the principal investigator. NGSMs who were interested in participating were given a study packet that included a waiver of documentation of informed consent and study questionnaires. Participants received $15 compensation. Of the $\sim 240$ NGSMs present at the events, 68.8% ($n = 163$) NGSMs returned packets with complete data. These NGSMs comprise the current study. The Institutional Review Board at the University of Utah and its affiliated VA Human Subjects Subcommittee approved all study methods.

Measures

Table 1 defines the different types and sources of stigma.

Self-stigma. Self-stigma for having a mental health disorder and for seeking mental health
Table 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>M (SD)</th>
<th>1</th>
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<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
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</thead>
<tbody>
<tr>
<td>1. General stigma</td>
<td>9.08 (6.65)</td>
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<tr>
<td>2. SS for problem</td>
<td>31.86 (7.51)</td>
<td>0.39***</td>
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<tr>
<td>3. SS for HS</td>
<td>28.18 (7.70)</td>
<td>0.36***</td>
<td>0.55***</td>
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<tr>
<td>4. AES for problem—</td>
<td>14.04 (6.14)</td>
<td>0.69***</td>
<td>0.37***</td>
<td>0.33***</td>
<td>—</td>
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<td>Leader</td>
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<tr>
<td>5. AES for HS—Leader</td>
<td>12.75 (6.26)</td>
<td>0.62***</td>
<td>0.32***</td>
<td>0.31***</td>
<td>0.87***</td>
<td>—</td>
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<tr>
<td>6. AES for problem—</td>
<td>12.09 (5.55)</td>
<td>0.53***</td>
<td>0.25***</td>
<td>0.14</td>
<td>0.64***</td>
<td>0.52***</td>
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<td>Member</td>
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<tr>
<td>7. AES for HS—Member</td>
<td>11.17 (5.43)</td>
<td>0.49***</td>
<td>0.22**</td>
<td>0.20*</td>
<td>0.57***</td>
<td>0.55***</td>
<td>0.92***</td>
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<tr>
<td>8. AES for problem—</td>
<td>8.89 (4.60)</td>
<td>0.45***</td>
<td>0.11</td>
<td>0.05</td>
<td>0.42***</td>
<td>0.45***</td>
<td>0.48***</td>
<td>0.42***</td>
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<tr>
<td>Family/friend</td>
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<tr>
<td>9. AES for HS—Family/friend</td>
<td>8.21 (4.51)</td>
<td>0.36***</td>
<td>0.08</td>
<td>0.08</td>
<td>0.37***</td>
<td>0.44***</td>
<td>0.45***</td>
<td>0.43***</td>
<td>0.89***</td>
<td>—</td>
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<tr>
<td>10. PTSD</td>
<td>35.19 (14.06)</td>
<td>0.05</td>
<td>-0.01</td>
<td>0.04</td>
<td>0.09</td>
<td>0.05</td>
<td>0.04</td>
<td>0.04</td>
<td>0.20*</td>
<td>0.16*</td>
<td>—</td>
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</tr>
<tr>
<td>11. DASS-D</td>
<td>4.69 (5.41)</td>
<td>0.15</td>
<td>0.22**</td>
<td>0.12</td>
<td>0.21**</td>
<td>0.14</td>
<td>0.07</td>
<td>0.03</td>
<td>0.16</td>
<td>0.11</td>
<td>0.64***</td>
<td>—</td>
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</tr>
<tr>
<td>12. DASS-A</td>
<td>3.05 (3.94)</td>
<td>0.13</td>
<td>0.11</td>
<td>0.17*</td>
<td>0.19*</td>
<td>0.15</td>
<td>-0.01</td>
<td>-0.06</td>
<td>0.20*</td>
<td>0.10</td>
<td>0.60***</td>
<td>0.69***</td>
<td>—</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13. Age</td>
<td>28.00 (7.14)</td>
<td>0.10</td>
<td>-0.11</td>
<td>-0.18*</td>
<td>-0.07</td>
<td>-0.05</td>
<td>0.21**</td>
<td>0.19*</td>
<td>0.20*</td>
<td>0.21*</td>
<td>-0.06</td>
<td>-0.03</td>
<td>-0.02</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Likelihood of deploying again</td>
<td>3.46 (1.34)</td>
<td>-0.06</td>
<td>-0.02</td>
<td>0.06</td>
<td>-0.18*</td>
<td>-0.17*</td>
<td>-0.05</td>
<td>-0.06</td>
<td>-0.12</td>
<td>-0.08</td>
<td>-0.14</td>
<td>-0.12</td>
<td>0.01</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. HS—Mental health professional</td>
<td>3.18 (1.86)</td>
<td>-0.05</td>
<td>-0.04</td>
<td>-0.41***</td>
<td>-0.09</td>
<td>-0.13</td>
<td>0.02</td>
<td>-0.01</td>
<td>0.06</td>
<td>0.03</td>
<td>0.03</td>
<td>0.05</td>
<td>-0.07</td>
<td>0.13</td>
<td>-0.12</td>
<td>—</td>
</tr>
<tr>
<td>16. HS—Doctor</td>
<td>2.69 (1.69)</td>
<td>0.01</td>
<td>-0.07</td>
<td>-0.24**</td>
<td>-0.05</td>
<td>-0.08</td>
<td>0.02</td>
<td>0.04</td>
<td>0.07</td>
<td>0.07</td>
<td>0.03</td>
<td>0.05</td>
<td>0.16*</td>
<td>-0.16*</td>
<td>0.59***</td>
<td>—</td>
</tr>
</tbody>
</table>

Note. SS = self-stigma; HS = help-seeking; AES = anticipated enacted stigma; PTSD = posttraumatic stress disorder; DASS-D = Depression Anxiety Stress Scale—Depression subscale; DASS-A = Depression Anxiety Stress Scale—Anxiety subscale.

*p ≤ .05. **p ≤ .01. ***p ≤ .001.
treatment was assessed using the 10-item *Self-Stigma of Seeking Help* (SSOSH; Vogel et al., 2006) scale. Participants completed this scale twice: the first time to assess self-stigma for seeking help and the second time to assess self-stigma for having a mental health problem (instructions were altered for the second administration to instruct NGSMs to respond to stigma for having a mental health problem in place of seeking help). A sample item from the SSOSH for problem includes: “I would feel inadequate if I had difficult negative emotions or psychological problems.” A sample item from the SSOSH for help-seeking includes: “I would feel inadequate if I went to a therapist for psychological help.” Participants indicated their agreement with each statement using a Likert scale of 1 (strongly disagree) to 5 (strongly agree). Items were summed for a total score after five items were reverse scored. Higher scores reflected greater self-stigma for either having a mental health disorder or seeking treatment. The SSOSH showed high internal consistency and good test–retest reliability in the norm sample (Vogel et al., 2006). Cronbach’s alphas for the six administrations in the current sample were very high, range = .90–.95.

**General stigma.** Perceptions of general stigma were assessed using the 6-item *Perceived Stigma and Barriers to Care Scale—Stigma subscale* (Britt, 2000). Response options to these items were scored from 0 (completely disagree) to 7 (completely agree). Items were summed for a total score and higher scores indicated greater general stigma. Scores ranged from 0–24. Cronbach’s alpha in the current sample was high, .90.

**Help-seeking intentions.** Likelihood of seeking help was assessed using items from the *General Help-Seeking Questionnaire* (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005). Participants are asked to rate how likely they are to seek help from informal sources (e.g., romantic partner, family members, friends) and formal help sources (e.g., mental health professional, medical doctor) using a Likert scale from 1 (extremely unlikely) to 7 (extremely likely). 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).

**Distress characteristics.** The *PTSD Checklist—Military* (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993) was used to assess PTSD symptoms experienced within the past month. Participants were asked to rate how much each symptom bothered them using a Likert scale from 1 (not at all) to 5 (extremely). Items were summed for a total score. Cronbach’s alpha in the current sample was .95. Several cutoffs for PTSD have been suggested. For the purpose of this study, we selected a cutoff of 30 on the PCL-M to denote problematic PTSD symptoms, which has a sensitivity
index of .78 and specificity index of .88 (Bliese et al., 2008).

The Depression Anxiety Stress Scale—Short Form—Depression and Anxiety subscale (Lovi-bond & Lovibond, 1995) was used to assess depression and anxiety. Participants were asked to rate how much each depressive or anxiety symptom bothered them over the last week using a Likert scale of 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time). Scores are summed for a total score and a positive screen for probable depression or anxiety is reflected by a score of 10 or higher. Internal reliability and test–retest reliability in the norm sample was high (Antony, Bieling, Cox, Enns, & Swinson, 1998; Lovibond & Lovibond, 1995). Cronbach’s alpha for the depression subscale in the current sample was .93. Cronbach’s alpha for the anxiety subscale in the current sample was .85.

Demographic and military characteristics. Demographic characteristics were assessed using a questionnaire designed for this study. The questionnaire assessed age, gender (male/female), history of previous mental health treatment (yes/no), history of diagnosis prior to deployment (yes/no), perceived likelihood of deploying again (Likert scale from 1, not at all likely, to 5, most certainly), education (some college/no college), and total number of deployments.

Analytic Plan

Measures of stigma, distress, help-seeking intentions, likelihood of deploying again, and age were assessed as continuous variables. Associations of stigma source (e.g., general, self, military, nonmilitary) and type (disorder, help-seeking) with age, likelihood of deploying again, help-seeking intentions, PTSD, depression, and anxiety were assessed using bivariate correlations. The associations of stigma source and type with history of previous mental health treatment (yes/no), history of diagnosis prior to deployment (yes/no), and education (some college/no college) were assessed using analyses of variance (ANOVA). The association of stigma with total number of deployments was assessed using negative binomial regression, which is appropriate for count variables (total number of deployments). Because of low power, the associations of gender (female n = 3; male n = 162) and stigma could not be assessed. As this is a preliminary study, no alpha corrections were employed.

Results

Intercorrelations

Correlations among stigma source and type variables are shown in Table 2. Correlations between general stigma and stigma sources and types were mostly medium-to-large in effect size ($r$ values = .36–.69). Correlations among nongeneral sources and types of stigma were mostly small-to-large in effect size, suggesting that these are related but not isomorphic constructs. Correlations within source and type of stigma (e.g., self-stigma for problem with self-stigma for help-seeking) were large in effect size (range: $r$ values = .55–.92), further suggesting that these are related but not isomorphic constructs.

General stigma. General stigma was higher among those with at least some college education but unrelated to all other variables (see Tables 2–3).

Stigma for mental illness. Self-stigma for having a mental illness was positively related to depression with a small effect size (see Table 2). AES from leaders for having a mental illness was positively associated with depression and anxiety with small effect sizes, and negatively related to perceived likelihood of deploying again, also with a small effect size (see Table 2). AES from unit members for having a mental illness was positively associated with age with a small effect size, and it was also higher among those with some college and those with a history of seeking help (see Tables 2–3). AES from family and friends was positively associated with PTSD, anxiety, and age with small effect sizes, and it was also higher among those with a history of mental health treatment (see Tables 2–3). Number of deployments was unrelated to any stigma variable (all $p$ values > .05).

Stigma for seeking treatment. Self-stigma for seeking treatment was positively associated with anxiety and negatively associated with age and intentions to seek help from a mental health professional or medical doctor with small-to-medium effect sizes (see Table 2). Self-stigma for seeking treatment was also higher among white Veterans (see Table 3). AES from unit
### Table 3
**Associations of Stigmas With History of Mental Health Diagnosis or Treatment, Education, and Race**

<table>
<thead>
<tr>
<th></th>
<th>General stigma</th>
<th>SS-Problem</th>
<th>SS-HS</th>
<th>AES Problem-Leader</th>
<th>AES HS-Leader</th>
<th>AES problem-Unit member</th>
<th>AES HS-Unit member</th>
<th>AES problem-Family/friend</th>
<th>AES HS-Family/friend</th>
<th>Race</th>
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<tbody>
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<td>MH diagnosis</td>
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<tr>
<td>Yes</td>
<td>$r(158) = 1.64$</td>
<td>$r(149) = .02$</td>
<td>$r(150) = -1.21$</td>
<td>$r(147) = 1.53$</td>
<td>$r(146) = .59$</td>
<td>$r(149) = 1.89$</td>
<td>$r(148) = 2.19^*$</td>
<td>$r(148) = 1.26$</td>
<td>$r(148) = .91$</td>
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<td>$13.91 (6.17)$</td>
<td>$12.73 (6.31)$</td>
<td>$11.91 (5.47)$</td>
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<td>$r(148) = 1.11$</td>
<td>$r(147) = .50$</td>
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<td>$13.84 (6.14)$</td>
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*Note. SS = self-stigma; HS = help-seeking; AES = anticipated enacted stigma; MH = mental health.*
to perceived belief that civilians would not understand or appreciate their military distress or their need for treatment for completing duties that are military-related. Indeed, cultural competence literature shows that similarities among individuals can foster a sense of understanding or ease when interacting with these similar others (see Sue et al., 1998). Recent research in military service members corroborates this experience; psychologically distressed veterans were more receptive to prompts to get mental health care when the prompts came from military service members relative to civilians (Clark-Hitt, Smith, & Broderick, 2012). Unfortunately, military veterans’ or NGSMs potential discomfort discussing military trauma with nonmilitary individuals may be reasonable. Tanielian and colleagues (2014) found that civilian mental health care workers demonstrated less military cultural competence relative to their military or government-employed mental health care workers counterparts. As such, veterans or NGSMs may be more comfortable or feel more able to connect to individuals who have more familiarity with military culture and experience, thus perceiving less PTSD stigma from fellow military personnel.

PTSD was associated with nonmilitary stigma, depression was associated with self-stigma for problem and AES for problem from unit leaders, and anxiety symptoms were related to self-stigma for problem, AES for help-seeking from unit leaders and from family/friends. Depression and stigma for problem may be related to NGSMs’ own negative evaluation and their perceived negative evaluation by an authority as part of the two elements of the cognitive triad (see Beck, 1967): negative views of the self and the future. As military authorities can determine fitness for duty, fears that a military authority may not deem them fit for duty due to depression can create feelings of sadness or low self-worth. The variable association of anxiety with these forms of stigma, mostly stigma for help-seeking, may reflect apprehension that the more visible act of help-seeking will result in negative evaluations by those who have some control over their military career and by those who are most important to them outside of the military, that is, their family and friends. Though the content of therapy sessions is confidential, if a veteran is seen entering a mental health clinic, a reasonable assumption is that they are in distress and need help—thus making their wound more visible. These differences in the associations of distress symptoms with stigma types and sources suggest that different interventions would be needed for specific symptoms. That is, reducing stigma for a problem will be important for those experiencing PTSD and depression, but reducing stigma for help-seeking will be more beneficial for those experiencing anxiety symptoms. Moreover, such interventions will need to focus on altering the beliefs systems associated with different groups (e.g., military vs. nonmilitary) to be effective.

Self-stigma for help-seeking was the only variable associated with race, such that NGSMs identifying as white reported higher self-stigma. This finding differs from prior studies showing that racial minorities tend to report higher mental health stigma than their white counterparts (Conner, Koeske, & Brown, 2009; Sirey, Franklin, McKenzie, Ghosth, & Raue, 2014). As this is a preliminary study and the study sample is small and the number of nonwhite NGSMs was low, additional research is necessary to understand this group difference. Prior studies have shown higher rates of mental health care utilization in both groups in civilian and military research (Di Leone et al., 2013), which suggests race and self-stigma or race and help-seeking is influenced by other variables across samples.

Prior mental health treatment was positively associated with AES for problem from unit members and family and AES for help-seeking from family. This finding is somewhat unusual as stigma reduction techniques typically employ increasing contact or proximity to stigmatized others or stigmatized behavior (e.g., seeking therapy). Evidence of prior mental health care may serve as a negative mark against military service members, thus, history of treatment could be viewed as a sign of weakness. However, one might then expect that stigma from a unit leader would also be associated with prior help-seeking. The need for fitness for duty is unique to military service members compared with civilians, and this pressure may result in differing experiences across these groups, particularly in NGSMs who frequently straddle the military and civilian world.

Prior mental health diagnosis was positively associated with AES for help-seeking from unit members, but unrelated to all other variables.
Within military culture, one might anticipate that a prior diagnosis would be associated with stigma from all military sources. As this is the first study to look at these differentiations in stigma across type and group, additional research will be needed to further explore these preliminary findings. It is possible that the small sample size and high number of statistical tests run as part of this study produced this single finding.

Self-stigma for help-seeking was negatively associated with intentions to seek help from either a mental health professional or medical doctor. Stigma for disorder variables and stigma perceived from others were not associated with intentions to seek help. Such findings are consistent with Goffman’s (1963) proposal that visible, versus invisible, stigmatizing conditions may be more problematic for individual functioning. Indeed, it might be easier to conceal mental health distress relative to concealing help-seeking. Moreover, by seeking help, “invisible wounds of war” (see Tanielian et al., 2008) become visible to others, such as mental health workers. Such findings are also consistent with civilian research, which demonstrates that self-stigma is a stronger correlate of help-seeking than perceived from others (e.g., Barney et al., 2006; Fung et al., 2008; Pederson & Vogel, 2007; Vogel et al., 2006; Vogel et al., 2007). This pattern of association suggests differential validity of stigma type and source, and is consistent with civilian research that demonstrated factorial validity disentangling stigma for disorder and stigma for help-seeking (Tucker et al., 2013). Importantly, these findings suggest that efforts to reduce stigma for help-seeking should focus efforts on the individual seeking help by altering any negative cognitions they have about help-seeking. Indeed, negative cognitions about mental health care are lower among those who have sought treatment (Blais et al., 2015). Focusing on the utility and effectiveness of treatment as well as increasing awareness of actual rates of help-seeking are three ways to decrease individual beliefs.

Perceived likelihood of deploying again was associated with perceived stigma for disorder and help-seeking from a unit leader, but it was not correlated with any other stigma variable. NGSMs may see unit leaders as a source of stigma as these individuals have the ability to impact the type of deployment a NGSM might have, if they are deployed again. If NGSMs wish to deploy again, they may fear that their unit leaders would think less of them if they experienced distress secondary to carrying out their duties, and therefore, their unit leader may not recommend them for redeployment. Additional information is needed to further understand this association as several variables may relate to the possibility of deploying again, including age, psychological distress, or rank.

Age had a variable relationship with stigma. Older age was negatively associated with self-stigma for help-seeking but positively associated with AES for problems from unit members and family/friends and AES for help-seeking from unit members. Prior research in civilian samples demonstrates that older age is typically associated with lower stigma (Yap, MacKinnon, Reavley, & Jorm, 2014), which contradicts these latter associations. Within the military population, stigma might increase with age as a function of exposure to military culture and assimilation to military values. Additionally, stigma might increase with age as a function of higher rank and corresponding responsibility. That is, as service members age, they are likely to have higher rank, which may result in the belief that leaders should not experience distress or need help. Indeed, Hoge et al. (2004) observed that many service members believed that those in a position of authority should not experience distress or need psychiatric treatment.

Limitations of the study include the use of a convenience sample utilizing a cross-sectional study. No statements about causality can be made. Our sample was relatively homogenous with regard to race, gender, and ethnicity, and data on mission type during deployment was not collected. All data was based on self-report, and we were not able to address actual help-seeking behavior. As this study was an exploratory study, the sample was generally small. The small effect sizes noted in the aforementioned correlations among stigma and individual characteristics may have been unduly influenced by the sample size. The associations among the various stigma types and sources were medium-to-large in effect size, which might suggest some homogeneity within sources and/or types. A larger sample would facilitate the use of more sophisticated statistical tests, such as confirmatory factor analysis on
stigma variables. Finally, this study was limited to NGSMs, and the associations detected may differ in an active duty sample. In particular, participation in the military as a full-time source of employment may create unique pressures specific to stigma experiences that differ among those in the reserve component.

This study examined help-seeking intentions from a mental health professional and medical doctor. Information on actual current mental health care use was collected; however, the number of military service members actually receiving treatment was too small to facilitate statistical testing. Additional sources of help that veterans can complete in their own home (i.e., Vets Prevail; Hobfoll, Blais, Stevens, Walt, & Gengler, 2016) or with greater privacy (e.g., Military OneSource) were not examined. Future research should examine the association of stigma with these nontraditional forms of help.

In summary, the current study demonstrates preliminary evidence of differential validity for stigma source and stigma type in NGSMs. The continued use of a general measure of stigma may be most useful for studies not specifically exploring stigma phenomena as a main effect. This study also demonstrates that when trying to understand factors related to help-seeking in veterans and NGSMs, self-stigma is more important to consider than stigma perceived from others. Future research should assess these stigma variables with actual help-seeking behavior.

References


Call for Papers for a Special Section of the Journal of Family Psychology

Military Deployment Communication: New Findings and Conceptual Frameworks

Editors: Steven L. Sayers and Galena Rhoades

The Journal of Family Psychology invites manuscripts for a special section on military deployment communication.

The ability of military service members to maintain regular communication with their intimate partners and spouses during their deployment to a combat has increased dramatically in the last decade. Researchers have begun to expand beyond investigating the role of written communication for couples experiencing this type of separation. Only recently have studies been conducted on the impact of modern communication (e.g., Skype and instant messaging) on the job of the service member and the functioning of both service member and spouse. The literature in this area, however, lacks an accepted conceptual framework for understanding these modes of communication. Furthermore, there has not been an exploration of the reasons why inquiry in this area is important. For instance, what individual- and couple-based outcomes are important to examine and why, and what implications do these findings have for military policy, training, and deployment preparation for military families?

The intent of this special section is to bring together empirical papers that contribute to the developing conceptual frameworks of deployment communication and a broader consideration of the impact of deployment communication on the psychological health and well-being of military families. Papers that contribute new findings and advance the development of this important area of research will be considered for publication.

The deadline for receipt of papers for this special section is August 1, 2016.

Questions regarding the special section should be addressed to the section editors, Steven L. Sayers (steven.sayers@va.gov) and Galena Rhoades (grhoades@du.edu). Please follow the journal’s Instructions to Authors found elsewhere in this journal for information about how to prepare an article. Manuscripts must be submitted electronically through the Manuscript Submission Web Portal of the Journal of Family Psychology (http://www.apa.org/pubs/journals/fam/?tab=4).

Please be sure to specify in the cover letter that the submission is intended for the special section on Military Deployment Communication. All papers will be initially screened by the editors, and papers that fit within the scope of this special section will be sent out for blind peer review.