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Impacts of Stigma on Female Service Members

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Impacts of Stigma on Female Service Members

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Abstract

There are a variety of factors that prevent people from seeking mental health treatment. The stigma associated with mental health disorders or seeking treatment is a primary deterrent. This stigma is particularly impactful within the armed forces when they are assessed for fitness for duty. Because most research examines stigma's impact on male military members, this study aims to identify the type of stigma that creates the most significant barrier to female service members seeking mental health treatment. Results indicate that stigmatizing perceptions of service members significantly impact female service members holding negative views towards seeking treatment.

Keywords: stigma, military, treatment barrier

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Impacts of Stigma on Female Service Members

Chapter 1

Stigma

The need for mental health treatment within the military community has become apparent. One particularly sobering statistic is that the rise of suicide rates among this population has grown steadily since the terrorist attack on the United States on September 11, 2001. A study in 2021 showed that since 9/11, 30,177 active-duty personnel and veterans have died by suicide (Suitt, 2021). This amount is astonishing compared to the 7,057 military personnel killed in combat during this same time. Although there is a clear need for intervention, current research exploring why suicide rates are at an all-time high for this population is lacking, even more so for female service members. Although suicide prevention programs are being implemented, these programs are often informed by research primarily focusing on middle-aged men or take a gender-neutral approach (Monteith et al., 2022). This is particularly concerning because the rate of suicides among female service members has increased at twice the rate of their male counterparts since 2015 (Gorn, n.d.).

Service members in the United States Armed Forces often suffer severe mental health problems from combat and non-combat-related experiences. (Blais & Renshaw, 2014). When deployed, they often encounter traumatic experiences such as ambushes, vehicle rollover accidents, improvised explosive devices (IED), losing a fellow service member, personal injuries, and other events that cause mental scarring. An estimated 30% of the veterans that served in Iraq and Afghanistan alone suffer from either a traumatic brain injury (TBI) or post-traumatic stress disorder PTSD (Martin, 2013). These same service members often fail to receive mental health services to help cope with the trauma they experienced and the mental health

problems they have developed, such as TBI, PTSD, depression, suicidal ideations, and anxiety (Tanielian & Jaycox, 2008). Although these concerns impact all those serving in the military, female service members have additional barriers to overcome. A study by the International Peace Institute suggests that stigma is a common reason women struggle with feeling accepted within the military (Vermeij, 2020).

Perceived Stigma

Perceived stigma from others (also called *public stigma* or *general stigma*) is defined as an individual's concern about being seen in a negative light for having a mental health condition (Britt et al., 2014). It is the assumption that others perceive or act negatively toward individuals with mental health conditions or those seeking treatment (Blais, 2016). It involves 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.

Self-Stigma

On the other hand, s*elf-stigma* is defined as a concern in seeing oneself in a negative light for having a mental health condition. Manos et al. (2009) describe self-stigma as the negative attitudes or thoughts about mental illness or mental health treatment held by the individual with the mental health condition.

Lannin et al. (2016) found that self-stigma was associated with a decreased probability of seeking mental health information. People may avoid information that validates their mental health concerns in order to reduce the self-stigma potentially associated with having a mental health disorder (Lannin et al., 2013). This suggests that self-stigma is a perceived threat, reducing individuals' likelihood of seeking information that addresses their mental health concerns. However, they also found that attitudes toward counseling mediated the effects of self-

stigma on the decision to read online information. As a result, Lannin's (2016) mediation model provided preliminary evidence that self-stigma influences decisions to seek mental health and counseling information through its negative association with attitudes toward counseling, particularly, for those in the highest distress.

Held and Owens (2013) explained how public stigma and self-stigma were related to individuals' attitudes toward seeking mental health treatment. This study found that the relationship between public stigma and attitudes toward seeking mental health treatment was fully mediated by self-stigma. Furthermore, higher public stigma indirectly predicted more negative attitudes toward seeking mental health treatment because of self-stigma.

Stigmatizing Perceptions of Service Members

Within the military, Britt et al. (2014) found that perceived stigma from others could be separated into two different factors. One reflects a concern that getting treatment would harm the soldier's career (perceived stigma for career), and the other is a concern that soldiers would be viewed and treated differently by fellow soldiers (perceived stigma for treatment by others). However, Brown and Bruce (2016) claimed that career worry about seeking treatment is a construct independent of self-stigma and public stigma. Career worry was shown to be the strongest predictor of unwillingness to seek treatment in those with no treatment history. Thus, some veterans/service members may not perceive seeking mental health treatment negatively as much as they fear it may impact their careers.

Blais and Renshaw (2014) evaluated how anticipated enacted stigma perceived by unit leaders and self-stigma influenced soldiers seeking help from a mental health professional. The study found that anticipated enacted stigma and self-stigma lowered soldiers' likelihood of seeking treatment. However, of the two, self-stigma had the greatest impact on soldiers seeking

treatment, suggesting that reducing self-stigma would be the most effective way to increase a service member's willingness to seek treatment.

In addition to these traditional sources of stigma, there is another form of stigma based on the results of two qualitative studies conducted with military personnel (Zinzow et al., 2013). In focus groups with soldiers who sought treatment while on active duty, soldiers expressed concerns about the operational readiness of soldiers seeking treatment, which impeded treatment-seeking (Britt et al., 2015). These concerns are referred to as *stigmatizing perceptions of service members* (Britt et al., 2015), congruent with the modified labeling theory of Link (1987). This theory states that all individuals develop conceptions of mental illness and perceptions of how people generally view those with mental illness. These perceptions can create a stigma that harms the self-esteem of individuals (Link et al., 2001) and is likely to interfere with individuals getting needed treatment. (Britt et al., 2015). Examples of these perceptions are that the soldier is no longer fit for duty, cannot lead due to mental illness, or are a weak link in the unit, posing a risk to others' safety during deployment.

Summary

Various forms of stigma have been cited as barriers to treatment-seeking within the military community (Boyd, 2003; Britt, 2015; Goldsmith et al., 2002; Hoge et al., 2004a; Lannin et al., 2016). However, no study has explained the relationship between the different types of stigmas and help-seeking behaviors for the female service member population. This study aims to investigate how stigma creates a barrier to female service members seeking mental health treatment.

Hypotheses

1. As female service members stigmatizing beliefs increase, as does their negative views towards seeking treatment.
2. Self-stigma, perceived stigma, and stigmatizing perceptions of service members will predict the beliefs about seeking mental health treatment.

Chapter 2

Methods

Participants and Procedure

The study used archival data to review the impact of stigma on the United States Army female service members and veteran population. Data was gathered from female participants between 18–65 years of age. Participants were recruited from closed Facebook groups exclusive to veterans and service members. Posts were made in the specified Facebook groups containing a brief study description and a link to the survey's website. Once an individual clicked on the link, they were brought to a screen with a consent form explaining that participation in the study was voluntary and completely anonymous (see appendix A).

Materials

Demographic Questionnaire

The demographics collected included sex, age, educational level, ethnicity, veteran status, length of time served, the branch of service, service component, rank/grade, and combat experience. There were 97 participants, all of whom identified as female. 95 were officers and two were enlisted. Of the participants who disclosed their ethnicity, 90 identified as White, three as African American, and 3 as Asian. The average age of the population was 31 years, average years of education was 17, and average years in service was 9. Seventy-three participants were currently serving on activity duty at the time of the study, 20 were in the reserves or national

guard, and 4 were retired or separated from the military. Thirty-one participants endorsed having experienced combat.

Self-Report Questionnaires

Self-stigma was assessed with the Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006). The SSOSH rating scale assesses an individual's stigma toward themselves for seeking help. A 5-point Likert-type scale ranging from *strongly disagree* to *strongly agree* was used. All responses from this scale were added to provide a composite score. Sample items include, "I would feel inadequate if I went to a therapist for psychological help" and "My self-confidence would NOT be threatened if I sought professional help." The SSOSH showed good reliability in its first study (.91). Three subsequent studies cross-validated the reliability (.86 to .90; test-retest, .72) and showed evidence of construct, criterion, and predictive validity (Vogel et al., 2006). The SSOSH also predicted attitudes about and intent to seek mental health services.

Perceived stigma from others was assessed using the Mental Health Treatment Stigma questionnaire (Hoge et al., 2004b). The Mental Health Treatment Stigma questionnaire contains 13 items that assess perceived barriers to treatment in service members, including perceived stigma from others. This measure offers five possible responses ranging from *strongly disagree* to *strongly agree*, with *agree* and *strongly agree* combined as a positive response. All responses from this scale were added to provide a composite score. Sample items include "People would like me less if they knew I was receiving help for a mental health problem" and "I would be seen as weak."

Stigmatizing perceptions of service members seeking treatment were assessed using the Perceptions of Stigmatization by Others for Seeking Help scale (short form; PSOSH; Vogel et al., 2006). PSOSH short form is a five-item rating scale that assesses how an individual perceives

how others will view them for seeking help. Instructions ask the participant to imagine an emotional or personal issue and then rate responses that reflect possible reactions from others they might have if they were to seek treatment. All responses from this scale were added to provide a composite score. Sample items include “See you as seriously disturbed” and “Think you pose a risk to others.” Five samples were used in the development of the PSOSH scale. Concurrent validity was shown through moderate associations with three stigma measures during the third sampling. In the fourth sample, test-retest reliability was calculated (.82). In the final sample, the reliability ($\alpha = .78$) and validity were examined with the sample experiencing symptoms of psychological distress.

Mental health beliefs and negative views about mental health treatment were measured with the Endorsed and Anticipated Stigma Inventory (Vogt et al., 2014). The Endorsed and Anticipated Stigma Inventory is a 40-item rating scale used to assess beliefs about mental illness and mental health treatment among military personnel and veterans. Answers are rated on a 5-point Likert-type response format, ranging from *strongly disagree* to *strongly agree*. All responses from this scale were added to provide a composite score. Sample items include “People with mental health problems cannot be counted on” and “Most people with mental health problems are just faking their symptoms.” The reliability of this measure was shown with internal consistency estimates for all scales exceeding .80. Correlations among endorsed or anticipated stigma scales did not exceed .70, suggesting that each scale addresses unique content (Kline, 2005).

Chapter 3

Results

Correlation

A correlation of the scales' scores was conducted to ensure that there was indeed a relationship between the scales; results suggested that they were. Mental health beliefs and negative views about mental health treatment correlated significantly with self-stigma $r = (95) = .328$, $p = .001$, perceived stigma $r = (95) = .687$, $p = < .001$, and stigmatizing perceptions of service members who seek treatment, $r = (95) = .786$, $p = < .001$. This suggests that increased levels of all three stigma types are related to negative beliefs about receiving mental health treatment.

A correlation was also conducted to view potential intercorrelations between the three stigma variables. Self-stigma was correlated with stigmatizing perceptions of service members who seek treatment $r = (95) = .217$, $p = < .05$. Stigmatizing perceptions of service members who seek treatment was also correlated with perceived stigma $r = (95) = .755$, $p = < .001$. A correlation of all available study variables was run to view potential intercorrelations (see Table 1).

Multiple Regression

Multiple linear regression was carried out to determine the effect of perceived stigma, self-stigma, and stigmatizing perceptions of service members on treatment-seeking behavior, each of which did not violate normality assumptions. This was a statistically significant model $R^2 = .67$, $F(1, 97) = 62$, $P = < .001$, indicating that these results were unlikely to have arisen by chance. The adjusted R squared indicated that 65.7 % of the variance in treatment-seeking behavior can be explained by variances in the three predictor variables. Collinearity was satisfactory at values between 0.414 and 0.948. Heteroscedasticity was not problematic. The analysis suggested that stigmatizing perceptions of service members ($\beta = .57$) were the most influential predictor, then perceived stigma ($\beta = .24$) and self-stigma ($\beta = .18$) was the least

influential predictor in the model. A multiple linear regression was run to analyze the effect all available variables had on treatment seeking. No further significant results were found related to this study.

Chapter 4

Discussion

Key Findings

The hypotheses of this study were partially supported. The first hypothesis was that female army veterans and service members hold stigmatizing beliefs about receiving mental health treatment. Results supported that as service members stigmatized beliefs about having a mental health condition increase, so do their negative views toward seeking treatment. This suggests that these veterans and service members are not likely to seek treatment themselves which is congruent with previous research (Britt et al., 2015; Skopp et al., 2012).

The second hypothesis was that self-stigma, perceived stigma, and stigmatizing perceptions of service members would predict the beliefs about seeking mental health treatment. The findings from the second hypothesis were supported in that perceptions of stigmatization from other army service members have the greatest influence in preventing service members from seeking mental health treatment.

The supportive findings of Hypothesis 2 suggest that perceived stigmatization from other soldiers had a greater impact on seeking mental health treatment than their own stigmatized views of treatment seeking. This idea corresponds to the findings of Britt et al. (2015) and Link's (1987) modified labeling theory of stigma, which suggests that the stigmatizing views of fellow soldiers are likely to become relevant to the individual's sense of self when the soldier develops

a mental health condition. Therefore, stigmatized views from other soldiers will likely create a barrier for soldiers seeking mental health treatment.

Many previous studies (Adler et al., 2015; Britt et al., 2015; Kim et al., 2011; Pietrzak et al., 2009; Skopp et al., 2012) concluded that perceived stigma does not differentiate those seeking treatment from those who do not; however, the current study found that perceived stigma is a contributing factor to treatment seeking in army veterans and current service members. Furthermore, perceived stigma also has a greater effect on treatment-seeking than self-stigma. Thus, the previous theory that self-stigma may be more important to consider than perceived stigma (because of the internalized nature of the stigma) should be reexamined in the context of the female military population. This discrepancy between this current study and previous research suggests a delineating factor between the female military population, the military population as a whole, and civilian populations regarding the impact of public stigma on treatment-seeking.

Finally, the results from the current study indicating that self-stigma towards treatment seeking is associated with negative views toward seeking treatment are consistent with the findings by Skopp et al. (2012), whose study found both self and public stigma prevented individuals from seeking mental health treatment. It is also consistent with Britt et al. (2015), whose study found that self-stigma from treatment-seeking is uniquely related to treatment dropout in the military population. These findings reiterate that stigma perceptions impact treatment-seeking behavior. In the current study, stigmatizing perceptions of service members who seek treatment, perceived stigma, and self-stigma from treatment seeking emerged as unique predictors of treatment seeking. Perceived stigma, having a stronger correlation to negative views on seeking treatment, contradicts previous research that states that self-stigma may be

more important to consider than prior conceptualizations of perceived stigma because of the internalized nature of the stigma. This discrepancy may be a result of the collectivist nature of the military population verse the individualist nature of civilians in the United States. Soldiers are viewed as part of a unit comprised of "brothers and sisters in arms." Their mental health impacts the individual and the unit as a whole due to safety concerns during deployment.

Limitations

No information on whether or not the participants in the study had sought treatment in the past or had a previously diagnosed mental health condition is a notable limitation. This factor could have potentially influenced the perceptions held towards treatment seeking independent of, or in addition to, stigma. Previous research, such as seen in Skopp (2012), shows that soldiers who had seen a mental health provider scored lower in self-stigma than those who had not.

Areas for Future Research

Further studies should focus on interventions to increase unit support of female service members who need mental health treatment. This study's findings suggest that the stigmatizing perceptions held by female army veterans and current service members, who may wish to seek treatment, should be a target for these interventions. Once in treatment, it is recommended that practitioners address perceived stigma and self-stigma perceptions to prevent dropout. Cognitive behavioral strategies may effectively reduce these perceptions, such as challenging maladaptive beliefs and supporting individuals to engage in community and social activities suggested by Holmes and River, 1998. Thus, a combined intervention to address stigma through encouraging treatment and mental health interventions may most effectively decrease the divide between mental health needs and treatment-seeking behavior. This combination of intervention and treatment could also reduce the common forms of stigma in the military environment and

increase treatment-seeking in female military members. This would not only create a healthier work environment for service members but would increase the well-being of service members while working to decrease suicidality.

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Table 1

Correlation Coefficients for Study Variables.

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Treatment seeking											
2. Self stigma	0.328**										
3. Service member stigma	0.786**	0.217*									
4. Perceived stigma	0.687**	0.121	0.755**								
5. Age	-0.208*	-0.139	-0.223*	-0.185							
6. Rank	-0.016	0.071	0.004	0.171	0.078						
7. Marital	-0.012	-0.125	-0.019	0.099	-0.144	0.049					
8. Ethnicity	0.050	-0.047	0.047	0.051	-0.145	0.014	-0.122				
9. Education	-0.188	-0.082	-0.225*	-0.182	0.258*	0.064	-0.150	-0.177			
10. Military status	-0.067	-0.014	0.034	0.073	0.028	0.030	-0.144	0.218*	0.028		
11. Combat	-0.048	0.038	-0.002	-0.024	-0.472**	-0.166	-0.021	-0.017	-0.108	0.226*	
12. Years of service	-0.163	-0.089	-0.150	-0.052	0.797**	0.068	-0.116	-0.148	0.190	0.030	-0.570**

•• $p < 0.01$ level (2-tailed); * $p < 0.05$; $N = 97$

Appendix A

Informed Consent

Informed Consent for Participation

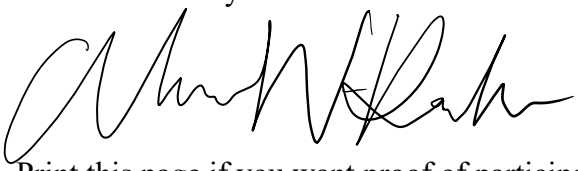
Dear Research Participant:

Your participation in a research project is requested. You must have served or are currently serving in the U.S Army and must be between 18 and 65 years old.
The title of the study is *Stigma and Mental Health Perceptions in Army Service Members.* The research is being conducted by Alisha Weatherly-Kershaw, a graduate student in the Psychology Department at Barry University who is seeking information that will be useful in the field of Psychology. The aim of the research is to see if stigma influences service members seeking mental health treatment. In accordance with the aim, the following procedure will be used: a demographic questionnaire, 10-item Self-Stigma of Seeking Help Scale, Mental Health Treatment Stigma Questionnaire, Perceptions of Stigmatization by Others for Seeking Help Scale (short form), and Endorsed and Anticipated Stigma Inventory will be administered on the subsequent pages. I anticipate the number of participants to be 300.
If you decide to participate in this research, you will be asked to do the following: complete the surveys, which should last about 15 minutes.
Your consent to be a research participant is strictly voluntary, and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects.
While any risks to participants are unlikely, it is possible that questions about stigmatization and having a mental health disorder could provoke feelings of anxiety or depression. If you feel that questions of this nature may invoke negative feelings, it is advised that you do not continue with this study. If you do wish to continue the study and begin to feel any psychological distress, you should discontinue the survey. If you do experience any psychological distress, you may also contact Warm Lines at (888) 448-9777 or the National Suicide Prevention Lifeline at (800) 273-TALK (8255), a support hotline for those who are in need to speak with someone as well as the national crisis line will also be provided.
Although there are no direct benefits to you, your participation will contribute to research in psychology. You may print a copy of this cover letter as proof of your participation.
As a research participant, the information you provide is anonymous; that is no names or other identifiers will be collected. Psychdata.com allows researchers to suppress the delivery of IP addresses during the downloading of data, and in this study, no IP address will be delivered to the researcher. However, Psychdata.com does collect IP addresses for its own purposes. If you have concerns about this, you should review the privacy policy of Psychdata.com before you begin. Data collected by the researcher will be kept for five years in encrypted files and then will be kept in the encrypted files indefinitely.
By completing and submitting this electronic survey, you are acknowledging that you are at least 18 years old and that you voluntarily agree to participate in the study.
If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Alisha Weatherly-Kershaw, at alisha.christensen@mymail.barry.edu, my

supervisor, Dr. David Feldman, at (305) 899-3478 or dfeldman@barry.edu, or the Institutional Review Board point of contact, Jasmine Trana, at (305) 899-3020 or jtrana@barry.edu.

Thank you for your participation.

Sincerely,
Alisha Weatherly-Kershaw



Print this page if you want proof of participation.

Appendix B

Self-Stigma of Seeking Help Scale

Items
1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Appendix C

Mental Health Treatment Stigma Questionnaire

Items
I do not trust mental health professionals.
My unit leadership might treat me differently.[a]
It would be too embarrassing.[a]
People would like me less if they knew I was receiving help for a mental health problem.[a]
There would be difficulty getting time off work for treatment.[a]
I would be seen as weak.[a]
I do not have adequate transportation.
It would harm my career.[a]
Members of my unit would have less confidence in me.[a]
I do not know where to get help.
My leaders would blame me for the problem.[a]
Mental health care costs too much money.
I would hide from others that I had seen a mental health treatment provider.[a]
It is difficult to schedule an appointment.[a]
I would feel inadequate if I went to a therapist for a mental health problem.[a]
Mental health care does not work.

Note. [a]Items included in the mental health treatment stigma factor.

Appendix D

Perception of Stigmatization by Others for Seeking Help

INSTRUCTIONS: Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would _____ _.

1 = Not at all 2 = A little 3 = Some 4 = A lot 5 = A great deal

1. React negatively to you

2. Think bad things of you

3. See you as seriously disturbed

4. Think of you in a less favorable way

5. Think you posed a risk to others

Scoring: add items 1-5.

Appendix E

Endorsed and Anticipated Stigma Inventory

Items

Beliefs About Mental Illness

1. People with mental health problems cannot be counted on.
2. People with mental health problems often use their health problems as an excuse.
3. Most people with mental health problems are just faking their symptoms.
4. I don't feel comfortable around people with mental health problems.
5. It would be difficult to have a normal relationship with someone with mental health problems.
6. Most people with mental health problems are violent or dangerous.
7. People with mental health problems require too much attention.
8. People with mental health problems can't take care of themselves.

Beliefs About Mental Health Treatment

1. Medications for mental health problems are ineffective.
2. Mental health treatment just makes things worse.
3. Mental health providers don't really care about their patients.
4. Mental health treatment generally does not work.
5. Therapy/counseling does not really help for mental health problems.
6. People who seek mental health treatment are often required to undergo treatments they don't want.
7. Medications for mental health problems have too many negative side effects.
8. Mental health providers often make inaccurate assumptions about patients based on their group membership (e.g., race, sex, etc.).

Beliefs About Treatment Seeking

1. A problem would have to be really bad for me to be willing to seek mental health care.
2. I would feel uncomfortable talking about my problems with a mental health provider.
3. If I had a mental health problem, I would prefer to deal with it myself rather than to seek treatment.
4. Most mental health problems can be dealt with without seeking professional help.
5. Seeing a mental health provider would make me feel weak.
6. I would think less of myself if I were to seek mental health treatment.
7. If I were to seek mental health treatment, I would feel stupid for not being able to fix the problem on my own.
8. I wouldn't want to share personal information with a mental health provider.

Concerns About Stigma From Loved Ones

If I had a mental health problem and friends and family knew about it, they would . . .

1. . . . think less of me.
2. . . . see me as weak.
3. . . . feel uncomfortable around me.
4. . . . not want to be around me.

5..... think I was faking.
6..... Be afraid that I might be violent or dangerous.
7..... think that I could not be trusted.
8..... avoid talking to me.

Endorsed and Anticipated Stigma Inventory

Items

Concerns About Stigma in the Workplace

If I had a mental health problem and people at work knew about it . . .

1. My coworkers would think I am not capable of doing my job.
2. People at work would not want to be around me.
3. My career/job options would be limited.
4. Coworkers would feel uncomfortable around me.
5. A Supervisor might give me less desirable work.
6. A Supervisor might treat me unfairly.
7. People at work would think I was faking.
8. Co-workers would avoid talking to me.