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Civilian and Veteran Perceptions of Communicated Stigma about Veterans with PTSD

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Abstract
Mental health problems are considered some of the most common and disabling medical conditions that affect military service members. Veterans with PTSD need mental health services but are often reluctant to seek them due to perceived stigma. In this study, we used Smith’s (2007) stigma communication framework to analyze veterans’ and civilians’ perceptions of combat-related PTSD. Findings from our study indicate that, although participants were exposed to stigma communication about veterans with PTSD, most stigmatizing labels were considered inaccurate. Further, participants perceived that discourse about veterans infrequently implied that veterans were personally responsible for developing and overcoming PTSD. These findings indicate that perhaps efforts to destigmatize mental health issues, and PTSD among veterans specifically, have been successful.

Introduction
Approximately four million United States service members took part in the wars in Afghanistan and Iraq (National Academies of Sciences, 2018). Many American veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) bring home the burdens of war and face a lifetime of consequences due to war zone-related injuries, both physical and psychological (Drake, 2014). Posttraumatic stress disorder (PTSD) is a common mental health condition that causes major distress and can disrupt an individuals’ everyday life (National Institute of Mental Health, 2016). Each year, out of 100 veterans, 11-20 who served in OIF/OEF develop PTSD (Veterans Affairs, 2016a). Veterans with mental illness experience negative outcomes, like suicide, at a higher rate than civilians (National Academies of Sciences, 2018).

About 60% of military veterans with mental health issues do not seek help (Sharp, Fear, Rona, Wessely, Greenberg, Jones, & Goodwin, 2015), often due to perceived stigmas associated with both PTSD and mental health services (Mittal, Drummond, Blevins, Curren, Corrigan, & Sullivan, 2013). The stigma communication framework (Smith, 2007) explicates features of communication that generate and sustain stigma. This framework can pinpoint specific message characteristics that generate and sustain stigma (Anderson & Bresnahan, 2013; Malterud & Anderson, 2017). However, it is not clear how those perceptions of stigma may differ between civilians and veterans, since previous studies typically focus only on veterans’ perceptions of PTSD stigma (Acosta, Becker, Cerulley, Fisher, Martin, Vardavas, Slaughter, & Schell, 2014;
Hernandez, Morgan, & Parshall, 2016; Mittal et al., 2013; Sharp et al., 2015; True, Rigg, & Butler, 2014). Therefore, the current study uses the Smith’s (2007) stigma communication framework to a) understand the features of messages that stigmatize veterans with PTSD and b) determine how perceptions of this stigma differ between veterans and civilians.

Stigma and PTSD

This study focuses on the communicative stigma surrounding veterans with posttraumatic stress disorder (PTSD). A recent meta-analysis of 15 studies of military personnel showed that 26-44% of participants agreed that concerns of stigmatization prevented them from seeking mental health treatment (Sharp et al., 2015). Clearly, stigma negatively impacts the experiences of veterans with PTSD, but stigma is not a new experience. Stigma is an ancient concept that has withstood the test of time. In fact, the Greeks are credited with marking slaves, criminals, and traitors with cuts and burns to signify their “immorality” or “lack of fitness” for regular society (Goffman, 1963; Neuberg, Smith, & Asher, 2000, p. 31). These marks were referred to as stigma, and an individual that bared such a mark was to be discredited, scorned, and avoided (Neuberg et al., 2000). Goffman (1963) laid the foundation for modern stigma research and described stigma as an “attribute that is deeply discrediting” (p. 3) which ultimately leads to the individual being regarded as spoiled, handicapped, and less than fully human. For veterans with PTSD, their mental illness—or the seeking of mental health services—can be perceived as that discrediting mark, and therefore generate stigma.

Stigma and the U.S. Military

Studies of military veterans with mental health concerns suggest that these veterans continue to perceive a stigma associated with seeking mental health services (Acosta et al., 2014; Hernandez et al., 2016; Mittal et al., 2013; True et al., 2014). Acosta et al. (2014) explain that the stigma veterans experience related to seeking mental health services operates in many different settings. Veterans and service members experience this stigma in the social context (relationships with friends, family, unit members, command leadership), the institutional context (policies, systems), and the public context (military culture) (Acosta et al., 2014). Indeed, True et al. (2014) argued that stigma associated with mental health services continues to exist in the military because of “cultural norms of stoicism, self-reliance, and prioritizing the needs of the unit over the needs of the individual” (p. 4).

The norms and culture of the military stigmatize mental health conditions and deter veterans from seeking mental health services (Hernandez et al., 2016; Mittal et al., 2013; True et al., 2014). Hernandez et al. (2016) noted that seeking mental health services could be discrediting or embarrassing, could cause harm to career progression, or could cause peers or superiors to have decreased confidence in the service member’s ability to perform assigned duties. Mittal et al. (2013) suggested that fear of stigmatized labels may be related to the military culture that promotes invincibility among soldiers. Furthermore, they argue that acknowledging mental illness is likely to be regarded as a sign of weakness and may pose a threat to service members’ careers (Mittal et al., 2013).

Previous research suggests that the mental health stigma that exists in the military also extends to civilians. Ryan (2016) described that there is a lack of understanding and awareness from peers (friends, family, community members) when it comes to PTSD and the displayed
symptoms. This lack of awareness and understanding about PTSD can cause mistrust, avoidance, and strengthen the stigma against veterans who are affected by PTSD (Ryan, 2016). A study conducted by the Pew Research Center (2011), that included 2,003 civilians, found that the civilian respondents largely disapproved of the recent combat efforts in Afghanistan and Iraq. Further, civilian participants believed that over half the post 9/11 veterans suffer from PTSD, which is much higher than the 10-20% prevalence rate reported for PTSD (Pew Research Center, 2011). Schreger and Kimble (2016) also found that civilians hold a moderate sized implicit bias of mental instability in veterans. These studies suggest that civilians may hold negative perceptions of veterans, particularly those with mental illnesses like PTSD. However, they do not establish the extent to which civilians stigmatize veterans with PTSD, nor how that level of stigma compares to veterans’ own stigmatizing beliefs. The current study addresses that gap by measuring perceptions of stigma about veterans with PTSD among both civilians and veterans.

**Effects of stigma.** Stigma related to mental illness among veterans causes detrimental effects. One of the negative effects derives from how stigma acts as significant barrier to seeking treatment for mental illness in the military (Kim, Thomas, Wilk, Castro, & Hoge, 2010). A large-scale study of 303,905 soldiers and Marines conducted by Hoge et al. (2006) found that 17% of those who deployed to Iraq and 11% of those who deployed to Afghanistan developed a mental health disorder such as anxiety, major depression, PTSD, or substance abuse. Even more alarming is that 78% of the participants acknowledged having some mental health problems, but fewer than 45% were interested in receiving help (Hoge et al., 2006). Too often, military service members avoid accessing mental health services or cease mental health treatment due to the perceived stigma associated with these services.

Boudewyns, Himelboim, Hansen, and Southwell (2015) explained that the fear of stigma can create an atmosphere of silence and denial, in which openly talking about the stigmatized disease becomes difficult to do. In fact, people may avoid the taboo topic all together because they expect or fear rejection (Boudewyns et al., 2015). Additionally, the more people believe that an issue is stigmatized, the less likely they are to talk about the issue both privately (e.g., family, friends, healthcare providers) and publicly such as on social media (Boudewyns et al., 2015). The fact that returning veterans with mental health problems are reluctant to seek help due to fear of stigmatization is highly concerning. If mental health disorders are concealed, it can have immediate and ongoing consequences for a military service members health (Hernandez et al., 2016). Several studies have found that military service members who do not seek help for their mental health disorders are at increased risk of substance abuse, physical discomfort, and have more difficulty with social relationships (Hoge et al., 2006; National Center of PTSD, 2004; Wilk, Bliese, Kim, Thomas, McGurk, & Hoge, 2010). These factors can lead to isolation, depression, and reduced self-esteem, which puts them at increased risk for suicide (West, Yanos, Smith, Roe, & Lysaker, 2011).

In 2014, more than 7,400 United States veterans took their own lives, accounting for 18% of all suicides in America (Veteran Affairs, 2016b). Further, 70% of the veterans who took their own lives were not regular users of Veteran Affairs services (Veterans Affairs, 2016b). As established above, the reluctance to seek treatment for mental illness (which can ultimately lead to suicide) can be at least partially explained by the stigma surrounding mental illness, especially among veterans. Although there is evidence that service members perceive stigma related to seeking mental health services, and that the effects of this stigma are devastating, few studies have examined the specific discourses that enable and perpetuate this stigma.
Communicating Stigma

One way to examine the nature of stigma around mental health among U.S. military service members and veterans is to examine how this stigma is shared. Stigma messages are shared between members of a community and therefore rely heavily on communication (Smith, Zhu, & Quesnell, 2016). Smith (2007) developed the stigma communication framework to better understand the role communication plays in generating and perpetuating stigma. Stigma communication is defined as “the messages spread through communities to teach their members to recognize the disgraced and react accordingly” (Smith, 2007, p. 464). Stigma communication messages include content that gains attention quickly, encourages stereotyping, justifies emotional reactions, and creates separation between stigmatized groups and society to protect the community at large (Smith, 2007). Further, stigma communication messages contain the following attributes:

They provide content cues (a) to distinguished people and (b) to categorize these distinguished people as a separate social entity. In addition, stigma messages include content cues (c) to link this distinguished group to physical and social peril, and (d) to imply a responsibility to blame on the part of the stigmatized for their membership in the stigmatized group or their linked peril (p. 463).

To make sense of these attributes, a stigmatized individual could be marked as different than society, may be negatively labeled, thought to be a threat to society, and/or assigned personal responsibility for having a specific stigma attribute. Smith (2007) explained that the specific content of stigma communication messages produces stigma attitudes, protective action tendencies, and desire to share the messages with others. Additionally, stigma messages often lead to split-second judgements and thus appear to be operating preconsciously (Link & Phelan, 2001). Different qualities of stigma messages evoke different emotions, such as disgust or fear, and activate relevant stigma attitudes which are then shared between individuals within a network (Smith, 2007). The four stigma communication attributes of marking, labeling, link to peril, and assigning responsibility are valuable in helping to assess the specific messages that are stigmatizing toward veterans with PTSD.

Marking. Marking someone involves using cues that evoke quick recognition and instinctive responses (Smith, 2007). Stigma marks can evoke disgust and result in a tendency to avoid or reject the marked target (Mackie & Smith, 2002). Marks can be visible or concealed. A mark that cannot be easily concealed provides greater opportunity to be recognized (Smith, 2007). One mark that cannot be concealed is how one looks physically. For example, within their study, Anderson and Bresnanahan (2013) argued that body-size stigma is a strong form of stigma because the “mark” of body size is always present and the visible mark makes it easy to engage in stigma communication about body size. In contrast, there are many stigmatized groups and diseases, such as the LGBTQ community, mental illness, and AIDS, that are unique in that the stigma characteristics are not visible and can be concealed (Corrigan & Mathews, 2003; Crawford, 1996; McLaughlin, Bell, & Stringer, 2004). Concealed stigmas are not visibly apparent and require self-disclosure, meaning individuals could conceal the part of their identity that is stigmatized (Ragins, 2008). When a stigmatized identity can be concealed, as is often the case for PTSD and other mental illnesses, it is necessary to closely examine communication about that stigma, since discursive marking may be the main or only way that a person with that attribute could be stigmatized through marking.
Labeling. Stigmatized groups are often given labels that bring attention to the group’s stigma, suggest that they are a separate social entity, and differentiate them from those who are considered normal (Smith, 2007). Link and Phelan (2001) explained that labels work to link a person to a set of undesirable characteristics which demonstrate that the stigmatized individual is different. There are several labels used to distinguish veterans with PTSD. Mittal et al. (2013) conducted focus groups with treatment-seeking combat veterans to understand their experiences with stigma. Participants in this study clearly believed that society stigmatizes veterans with PTSD. The participants generated many labels they believed were associated with PTSD among veterans, including “crazy,” “violent,” “weird,” “depressed,” “nonsocial,” “weak,” “numb,” “shell-shocked,” “cold-hearted,” “unfit to raise kids,” “unreliable,” “distant,” “robot,” “unstable,” “on guard,” “pissed off at the world” (Mittal et al., 2013). Of these labels, being “violent,” “dangerous,” or “crazy” were perceived as the most dominant among the treatment-seeking veterans with combat-related PTSD (Mittal et al., 2013). In another study, 63% of active duty military members who met the criteria for a mental disorder after returning from combat duty in Iraq or Afghanistan felt that if they sought help, they would be labeled as weak (Hoge et al., 2004). Clearly, military service members and veterans perceive that stigmatizing labels are associated with mental illness and seeking mental health treatment. However, previous research has not established the extent to which civilians associate these labels with veterans with PTSD, nor how those perceptions compare with veterans’ perceptions. The current study addresses these issues by including both civilians and veterans in the sample.

Linking to social peril. In addition to labeling, stigma communication messages link individuals to social peril by highlighting the danger that the stigmatized group poses to society (Smith, 2007). Stangor and Crandall (2000) argued that groups are stigmatized when they pose threats that are both tangible (e.g. health, safety, or wealth) and symbolic (e.g. beliefs, values, or ideology). Both kinds of threats are viewed as unwelcome, as they provoke fear and/or anxiety and thus lead to stigmatization. Studies have demonstrated that veterans with PTSD are linked to social peril and, as previously discussed, military culture may be to blame (Hernandez et al., 2016; Mittal et al., 2013). Service members are highly dependent on other members of their units to ensure mission execution and completion (Hernandez et al., 2016). Additionally, Simmons and Yoder (2013) described that, “mental stability and toughness are unwritten requirements for surviving in the military environment” (p. 18.)

Due to cultural norms in the military, service members may feel pressure to conceal their mental health issues so that unit members do not view them as a threat to their unit. A study of returning OIF/OEF combat veterans conducted by Hoge et al. (2004) found that veterans felt that if they sought help, they would be treated differently by others (63%), their unit members would have less confidence in them (59%) and felt that it would harm their careers (50%). Another study on the prevalence of stigma among U.S. Marines found that 48.9% of participants feared that their commands would lose trust in them if they sought out mental health services (Momen, Strychacz, & Virre, 2012). Not only are service members viewed as a threat to the community that is their military unit, but it is possible that society views them as a threat upon their arrival back home from war. However, previous studies have not specifically examined the extent to which civilians perceive veterans with PTSD as a threat or associate them with social peril. By using the stigma communication framework to understand civilian perceptions of veterans with PTSD, the current study addresses that gap.

Assigning responsibility. Within the stigma communication process, it may be argued that an individual has chosen their stigmatized condition and/or has control over eliminating the
stigma (Smith, 2007). Personal responsibility was an emerging theme in the study conducted by Mittal et al. (2013), for the participants felt that the public blamed them for their illness, because they volunteered for military service, and therefore, knowingly put themselves at risk. However, it should be noted that this study observed military service members’ perceptions of civilian beliefs, rather than a direct measure of civilian beliefs about veterans with PTSD. Another study found that 51% of combat veterans returning from OIF/OEF felt they would be blamed for their illness if they sought help (Hoge et al., 2004). Again, Hoge et al.’s (2004) study examined veterans’ perceptions of civilian beliefs but did not directly measure civilians’ beliefs about veterans with PTSD. Given these findings, it is reasonable to expect that communication about veterans with PTSD may assign veterans personal responsibility for their condition as a way to stigmatize that condition. However, it is not clear how civilians and veterans may differ in terms of stigmatizing veterans by assigning them personal responsibility for PTSD.

**Study Rationale**

The stigma communication framework developed by Smith (2007) helps to identify the specific characteristics of messages that are stigmatizing toward veterans with PTSD. Stigma communication messages contain one or more of the following elements: marks, labels, links to social peril, and the assigning of responsibility (Smith 2007). Therefore, stigmatizing messages may contain one or more of the following: discursive marking of veterans with PTSD, negative labeling of veterans with PTSD, linking these veterans to social peril, and/or assigning personal responsibility for obtaining the illness. Since stigma can act as a barrier to veterans seeking mental health treatment (Acosta et al., 2014; Hernandez et al., 2016; Hoge et al., 2004; Hoge et al., 2006; Kim et al., 2010; Mittal et al., 2013; Sharp et al., 2015; True et al., 2014), it is necessary and important to learn more about stigma communication messages in attempt to break this barrier and get military service members the help they need to cope with their illness.

The proposed research questions seek to uncover a better understanding of communication about veterans with PTSD. Because previous studies have established specific labels associated with veterans with PTSD (Hoge et al., 2006; Mittal et al., 2013), we were first interested in which of those labels our participants—who included both veterans and non-veterans—perceived to be associated with veterans with PTSD. Further, previous studies have established that veterans believe they are stigmatized by civilians (Hoge et al., 2006; Mittal et al., 2013), that civilians lack understanding and awareness of PTSD (Ryan, 2006), and that civilians may mistrust veterans with PTSD (Ryan, 2006; Schreger & Kimble, 2006). However, we have not identified previous research that a) directly measures civilians’ stigma toward veterans with PTSD or b) compares civilians’ stigma beliefs with veterans’ stigma beliefs regarding veterans with PTSD. The first four research questions explore this topic:

- **RQ1:** Which previously established stigmatizing labels do participants associate with veterans with PTSD?

- **RQ2:** In what context (self, family, friends, media, military, other) do participants report being exposed to these labels?

- **RQ3:** To what extent do participants perceive these labels to be accurate descriptions of veterans with PTSD?

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RQ4: Do veterans and civilians differ in (a) their perception of labels associated with veterans with PTSD, (b) the context where they are exposed to the labels, and (c) their perception of the labels’ accuracy?

Next, we were interested in determining the extent to which participants perceived that public discourse about veterans with PTSD was stigmatizing. To that end, we asked participants to think about “the way that people talk about veterans with PTSD” and rate the extent to which that discourse contained each element of stigma communication: marking, labeling, linking to social peril, and assigning personal responsibility. The remaining research questions deal with these perceptions of stigma communication, and how they differ between veterans and civilians.

RQ5: To what extent do participants perceive that public discourse about veterans contains each element of stigma communication: (a) marking, (b) labeling, (c) linking to social peril, and (d) assigning personal responsibility?

RQ6: How do veterans and civilians compare in terms of the extent to which they perceive that public discourse about veterans contains each element of stigma communication: (a) marking, (b) labeling, (c) linking to social peril, and (d) assigning personal responsibility?

Method

Participants

Participants were recruited using nonrandom, purposive sampling as well as convenience sampling. Our convenience sample was draw from students at a large Midwestern university who were recruited via an e-mail message describing the project with a link to an online survey. Additionally, we used purposive sampling to ensure that our sample included participants who had served in the military or who had a family member that served in the military. We used this approach, because we were interested in determining whether perceptions of stigma communication about veterans with PTSD differed based on a person’s experience with military service, directly and/or indirectly. Thus, we sought permission from group administrators to post the link to this survey in private Facebook groups that operate as support groups for those supporting a veteran experiencing PTSD. Once we gained permission to post, we shared the link to the survey on that Facebook page. We also encouraged participants to share the link with their social networks, so our sampling procedure also included snowball sampling.

Participants were required to be age eighteen or older and reside within the United States. A total of N = 169 participants provided responses. Our sample was predominantly female (60.4%) and White (92.9%). The average age of the respondents was 29.69 years (SD = 12.01 years). Further, 62.1% of the participants were single, 27.4% were married, 3.6% were divorced or separated, one participant was a widower, and 5.9% reported their relationship status as “other.” In terms of education, 91.1% of participants were currently enrolled in a college or university or had graduated with some type of collegiate degree, while the remaining participants had graduated from high school or the equivalent.
While participants were not required to be a current or past military service member to complete the survey, purposive sampling was used to ensure some of the participants contained the characteristic of being a military service member so that we could compare military personnel perspectives versus non-military personnel perspectives. Most of the participants in this sample (87%) had a family member who currently or previously served in the military. In addition, 40 (23.7%) of the respondents were current or past U.S. military personnel with the majority of those participants (67.6%) having been enlisted in the Army. Finally, of the respondents who said they were a current or past U.S. military service member, 12 (30%) reported being diagnosed with, and subsequently seeking treatment for, PTSD.

Procedure

The study used utilized an anonymous online survey with closed- and open-ended items. The survey had a total of 26 questions and was approved by the university human subjects review board. The survey started by collecting demographic information (age, gender, race, relationship status, military status). Next, participants provided open-ended responses to the following questions: “What words would you use to describe a veteran?” and, “What words would you use to describe a veteran with posttraumatic stress disorder?” Participants then preceded to complete the quantitative measures described below; only results from the quantitative portion of the survey are reported here.

Instrumentation

To determine the participants’ perceptions of stigmatizing labels for veterans with PTSD, we developed our own measures. Our measures were most closely based on research from Mittal et al. (2013) which used an inductive approach, through focus groups with veterans, to determine the most common stigmatizing labels that veterans associated with PTSD. The labels that emerged from that study closely mirrored findings about stigmatizing labels across the literature and seemed to have the most comprehensive list. Thus, we drew from that list to create our own measures 1) whether participants associated a label with veterans with PTSD, 2) through which channels they were exposed to the labels, and 3) the accuracy of the labels.

**Labels for veterans with PTSD.** We selected 15 labels identified in previous research (Mittal et al., 2013) as stigmatizing labels used for veterans with PTSD: crazy, unsocial, unfit to raise kids, dangerous, numb, robotic, weak, cold-hearted, unstable, weird, unreliable, on-guard, depressed, distant, and angry. Participants were instructed to “select all of the following words that you have used or heard used to describe a veteran with PTSD.”

**Context of stigmatizing labels.** Participants were asked to select all the contexts where they have heard any of the 15 labels for veterans with PTSD used. The options for contexts included: myself, family members, friends or colleagues, media (television, movies, newspaper, etc.), military service members, or other (with the option to describe).

**Accuracy of stigmatizing labels.** In an effort to keep the survey length reasonable, we only asked participants to rate the accuracy of ten one-word labels: crazy, weak, dangerous, unreliable, weird, unsocial, unstable, distant, angry, and depressed. These ten labels were also chosen because they were the most common across research on this topic (Acosta et al., 2014; Hernandez et al., 2016; Mittal et al., 2013). Participants used a 5-point Likert-type response scale.
(1 = Strongly Disagree to 5 = Strongly Agree) to indicate their agreement with the accuracy of the label.

**Stigma communication elements.** For each stigma communication element, we created a four-item scale that measured the extent to which participants perceived that element was present in communication about veterans with PTSD. The content of the items was based on Smith’s (2007) stigma communication model, as well as previous research that has measured perceptions of stigma content in messages (Malterud & Anderson, 2016).

All items on each scale used the stem “The way people TALK about veterans with PTSD makes it seem like…” Example items from the marking scale include “Veterans with PTSD are not normal” and “Veterans with PTSD do not belong.” Example items from the labeling scale include “There are negative labels associated with being a veteran with PTSD” and “Veterans with PTSD are called names.” Example items from the social peril scale include “Veterans with PTSD are a threat to society” and “Veterans with PTSD are dangerous.” Finally, example items from the personal responsibility scale include, “It is the Veteran’s fault for developing PTSD, because they signed up for military service” and “There are ways for Veterans to overcome PTSD by themselves.” Participants used 5-point Likert-type response scales (1 = Strongly Disagree to 5 = Strongly disagree) for each item. Each scale was reliable (marking, α = .81; labeling α = .74; social peril, α .86; and personal responsibility, α = .88).

**Results**

Research question 1 asked which previously established stigmatizing labels the participants associated with veterans with PTSD. Table 1 displays the percent of veterans, civilians, and the entire sample, who selected each label as one they had heard or used in reference to veterans with PTSD. The most commonly used label was “depressed”; the least commonly used label was “robotic.”

<table>
<thead>
<tr>
<th>Label</th>
<th>% of Veterans</th>
<th>% of Civilians</th>
<th>% of Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed</td>
<td>90.0%</td>
<td>86.8%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Distant</td>
<td>75.0%</td>
<td>74.4%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Unstable</td>
<td>70.0%</td>
<td>69.8%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Angry*</td>
<td>75.0%</td>
<td>55.8%</td>
<td>60.4%</td>
</tr>
<tr>
<td>On Guard*</td>
<td>75.0%</td>
<td>55.0%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Dangerous</td>
<td>57.5%</td>
<td>52.7%</td>
<td>53.8%</td>
</tr>
<tr>
<td>Numb</td>
<td>57.5%</td>
<td>46.5%</td>
<td>49.1%</td>
</tr>
<tr>
<td>Unsocial</td>
<td>42.5%</td>
<td>37.2%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Crazy</td>
<td>47.5%</td>
<td>34.9%</td>
<td>37.9%</td>
</tr>
<tr>
<td>Cold-hearted*</td>
<td>45.0%</td>
<td>21.7%</td>
<td>27.2%</td>
</tr>
<tr>
<td>Weak*</td>
<td>40.0%</td>
<td>16.3%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Unreliable</td>
<td>32.5%</td>
<td>18.6%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Weird</td>
<td>25.0%</td>
<td>20.2%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Unfit to raise kids</td>
<td>25.0%</td>
<td>15.5%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Robotic</td>
<td>17.5%</td>
<td>14.7%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

*Indicates significant differences in percentage of veterans and civilians reporting known use of these labels

**Table 1. Percent of Participants Associating Established Labels with Veterans with PTSD**

Note: N = 169
Research question 2 asked in what context participants reported being exposed to these labels. Table 2 displays the percent of veterans, civilians, and the entire sample, who selected each communication channel as one where they were exposed to these labels. The most commonly reported channel was media (including TV, movies, radio, and social media). The least common channel (after “other”) among civilians was “self”; the least common channel (after “other”) among veterans was “family.”

Table 2. Percent of Participants Reporting Channels of Exposure to Stigmatizing Labels

<table>
<thead>
<tr>
<th>Channel</th>
<th>% of Veterans</th>
<th>% of Civilians</th>
<th>% of Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media</td>
<td>77.5%</td>
<td>82.9%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Friends</td>
<td>55.0%</td>
<td>55.8%</td>
<td>55.6%</td>
</tr>
<tr>
<td>Family</td>
<td>22.5%</td>
<td>27.9%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Military*</td>
<td>45.0%</td>
<td>18.6%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Self</td>
<td>32.5%</td>
<td>19.4%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Other channel</td>
<td>2.5%</td>
<td>3.9%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Note: N = 169
*Indicates significant differences in percentage of veterans and civilians reporting channels where labels are used

Research question 3 asked about participants’ perceptions of these labels as accurate. Table 3 displays the accuracy ratings from veterans, civilians, and the entire sample. The “depressed” label was rated the most accurate overall, $M = 3.75$ ($SD = 1.01$). The “weak” label was rated the least accurate overall, $M = 1.38$ ($SD = .69$). We used one-sample t-tests to determine whether accuracy ratings fell significantly above or below the scale midpoint. Accuracy ratings were significantly above the midpoint for the “depressed” label, $t (164) = 9.57, p < .001$ and the “distant” label, $t (164) = 5.30, p < .001$. Accuracy ratings were significantly below the midpoint for the “crazy” label, $t (164) = -23.08, p < .001$; the “weak” label, $t (165) = -30.16, p < .001$; the “dangerous” label, $t (164) = -4.93, p < .001$; the “unreliable” label, $t (163) = -10.87, p < .001$; and the “weird” label, $t (163) = -18.58, p < .001$.

Table 3. Ratings of Perceived Accuracy of Labels for Veterans with PTSD

<table>
<thead>
<tr>
<th>Label</th>
<th>Veterans’ Ratings $M(SD)$</th>
<th>Civilians’ Ratings $M(SD)$</th>
<th>Sample Ratings $M(SD)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed $^b$</td>
<td>3.63 (1.15)</td>
<td>3.79 (1.97)</td>
<td>3.75 (1.01)</td>
</tr>
<tr>
<td>Distant $^b$</td>
<td>3.53 (1.13)</td>
<td>3.43 (1.10)</td>
<td>3.45 (1.10)</td>
</tr>
<tr>
<td>Angry</td>
<td>3.16 (1.10)</td>
<td>2.99 (1.10)</td>
<td>3.03 (1.10)</td>
</tr>
<tr>
<td>Unstable*</td>
<td>2.70 (1.18)</td>
<td>3.10 (1.03)</td>
<td>3.01 (1.08)</td>
</tr>
<tr>
<td>Unsocial</td>
<td>2.89 (1.25)</td>
<td>2.95 (1.10)</td>
<td>2.94 (1.13)</td>
</tr>
<tr>
<td>Dangerous $^*,a$</td>
<td>2.29 (1.04)</td>
<td>2.69 (1.05)</td>
<td>2.59 (1.06)</td>
</tr>
<tr>
<td>Unreliable $^*,a$</td>
<td>1.78 (.71)</td>
<td>2.32 (.97)</td>
<td>2.20 (.94)</td>
</tr>
<tr>
<td>Weird $^a$</td>
<td>1.73 (.93)</td>
<td>1.68 (.89)</td>
<td>1.69 (.90)</td>
</tr>
<tr>
<td>Crazy $^a$</td>
<td>1.53 (.76)</td>
<td>1.60 (.79)</td>
<td>1.58 (.79)</td>
</tr>
<tr>
<td>Weak $^a$</td>
<td>1.32 (.66)</td>
<td>1.40 (.70)</td>
<td>1.38 (.69)</td>
</tr>
</tbody>
</table>

Note: N = 169; accuracy rating scale: 1 = strongly disagree to 5 = strongly agree
*Indicates significant differences in ratings of label accuracy by veterans and civilians
$^a$ Indicates ratings are significantly below the scale midpoint
$^b$ Indicates ratings are significantly above the scale midpoint
The findings for veterans and civilians, as subgroups, mirrored the findings for the entire sample. Among veterans, accuracy ratings were significantly above the midpoint for the “depressed” label, \( t(37) = 3.39, p = .002 \) and the “distant” label, \( t(37) = 2.86, p = .007 \). Among veterans, accuracy ratings were significantly below the midpoint for the “crazy” label, \( t(37) = -11.93, p < .001 \); the “weak” label, \( t(37) = -15.69, p < .001 \); the “dangerous” label, \( t(37) = -4.22, p < .001 \); the “unreliable” label, \( t(36) = -10.39, p < .001 \); and the “weird” label, \( t(36) = -8.29, p < .001 \). Among civilians, accuracy ratings were significantly above the midpoint for the “depressed” label, \( t(126) = 9.19, p < .001 \) and the “distant” label, \( t(126) = 4.46, p < .001 \). Among civilians, accuracy ratings were significantly below the midpoint for the “crazy” label, \( t(126) = -19.76, p < .001 \); the “weak” label, \( t(127) = -25.79, p < .001 \); the “dangerous” label, \( t(126) = -3.38, p < .001 \); the “unreliable” label, \( t(126) = -7.89, p < .001 \); and the “weird” label, \( t(126) = -16.59, p < .001 \).

Research question 4 asked about differences by veteran status (veteran v. civilian) in perceptions of labels associated with veterans with PTSD, channels of usage, and perceptions of label accuracy. We used chi-square tests to determine whether there were differences in which labels were chosen and which channels were used, based on veteran status (veteran v. civilian). Tables 1, 2, and 3 indicate where differences in these variables occurred. Specifically, in terms of perceptions of which labels are associated with veterans with PTSD, four labels were selected more often by veterans than civilians. Veterans were more likely than civilians to select the labels of “weak,” \( \chi^2 (1, 169) = 10.05, p = .002 \); “cold-hearted,” \( \chi^2 (1, 169) = 8.36, p = .004 \); “on guard,” \( \chi^2 (1, 169) = 5.06, p = .024 \); and “angry,” \( \chi^2 (1, 169) = 4.69, p = .030 \). Veterans were more likely than civilians to report hearing the labels through the military, \( \chi^2 (1, 169) = 11.39, p = .001 \); no other significant differences emerged. Finally, we used one-way ANOVAs to determine whether ratings of accuracy differed by veteran status. In three cases, civilians rated the accuracy of a label higher than veterans. Compared to veterans, civilians rated the accuracy of these labels significantly higher: “dangerous,” \( F(1, 163) = 4.16, p = .043 \); “unreliable,” \( F(1, 16) = 9.92, p = .002 \); and “unstable,” \( F(1, 161) = 4.03, p = .046 \).

Research question 5 asked about the extent to which participants perceive the presence of each stigma communication element in public discourse about veterans with PTSD. Participants’ ratings of each stigma communication element are presented in Table 4; separated into veteran, civilian, and full sample ratings.

<table>
<thead>
<tr>
<th>Stigma Communication Element</th>
<th>Veterans’ Ratings M(SD)</th>
<th>Civilians’ Ratings M(SD)</th>
<th>Sample Ratings M(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Label b</td>
<td>3.72 (.77)</td>
<td>3.61 (.73)</td>
<td>3.65 (.74)</td>
</tr>
<tr>
<td>Mark</td>
<td>3.29 (.99)</td>
<td>3.08 (.84)</td>
<td>3.13 (.88)</td>
</tr>
<tr>
<td>Peril</td>
<td>2.96 (.99)</td>
<td>2.93 (.94)</td>
<td>2.94 (.95)</td>
</tr>
<tr>
<td>Personal Responsibility a</td>
<td>2.83 (1.17)</td>
<td>2.50 (1.09)</td>
<td>2.58 (1.11)</td>
</tr>
</tbody>
</table>

Note: \( N = 169 \); rating scale for presence of stigma communication element: 1 = strongly disagree to 5 = strongly agree

a Indicates ratings are significantly below the scale midpoint

b Indicates ratings are significantly above the scale midpoint

To determine the participants’ perceptions of a significant presence (or absence) of each stigma communication element, we used one-sample t-tests to determine whether the ratings were significantly different from the midpoint of the scale. The only element that participants

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rated significantly above the midpoint of the scale was “labeling,” \( t (164) = 11.03, p < .001 \). The only element that participants rated significantly below the midpoint of the scale was “responsibility,” \( t (163) = -4.87, p < .001 \). The findings for veterans and civilians, as subgroups, mirrored the findings for the entire sample. Among veterans, the only element rated significantly above the midpoint of the scale was “labeling,” \( t (37) = 5.72, p < .001 \). Among civilians, the only element rated significantly above the midpoint of the scale was “labeling,” \( t (126) = 9.42, p < .001 \), the only element rated significantly below the midpoint of the scale was “responsibility,” \( t (125) = -5.15, p < .001 \).

Research question 6 asked whether there would be differences by veteran status (veteran v. civilian) in perceptions of the presence of stigma communication elements in discourse about veterans with PTSD. We used one-way ANOVAs to answer this question. We did not observe any significant differences by veteran status in perceptions of stigma communication elements.

**Discussion**

The results from this study paint a more nuanced picture of the stigma communication surrounding veterans with PTSD. First, in answering RQ1, RQ3, RQ4, RQ5, and RQ6, our results indicate that participants—both civilians and veterans—perceive that communication about veterans with PTSD functions to label (Smith, 2007) PTSD among veterans as a stigma. This result is consistent with previous research (Hoge et al., 2004; Mittal et al., 2013). However, our study extends beyond this to consider the extent to which participants perceived that certain labels accurately described veterans with PTSD. Examining the extent to which participants perceive the stigmatizing labels to be accurate links and refines the theoretical paths of stigma communication (Smith, 2007) with stigma management communication (Meisenbach, 2010) and provides a novel extension.

In the stigma communication framework, Smith (2007) outlines elements of messages that are capable of producing stigma—such as labeling—and the effects of those messages on publics who are willing to stigmatize. However, it is possible for a person/audience to be exposed to a stigmatizing message, recognize that it contains stigma (Malterud & Anderson, 2017), and not have a stigmatizing reaction. For example, in our study, over 80% of participants reported being exposed to stigmatizing messages about PTSD through various media (RQ2). But, that finding does not explain the context of those messages (e.g., news reports that attempt to lessen the stigma still count as instances of exposure to stigma through media), the audiences’ perceptions of those messages (e.g., did the audience perceive them as accurate or valid?), or the audiences’ reactions (e.g., did they accept the stigma or resist it?).

In fact, audiences exposed to stigma communication may disbelieve the claims, reject the idea that those claims should generate stigma, or reject the idea that the proposed stigma applies to the target group. Those reactions reflect some of the strategies used to communicatively manage stigma (Meisenbach, 2010). In stigma management communication theory, Meisenbach (2010) outlines six strategies that stigmatized individuals may use to communicatively manage stigma, based on whether they accept the public’s understanding of the stigma and whether they believe it applies to them. Accuracy ratings for stigmatizing labels (RQ3, RQ4) can act as an indirect measure of the extent to which participants accept the public stigma and/or its applicability to individual veterans with PTSD. Thus, even though an audience member does not belong to the stigmatized group, they may still engage in stigma management communication. First, they can still engage in the process of determining the acceptability and applicability of the
stigma for the stigmatized group. Second, their communication about this issue can perpetuate the stigma (Smith, 2007) or fight against it (Meisenbach, 2010) in a novel way: as an ally.

Perceptions of Label Accuracy: Accepting the Stigma

Two labels (depressed and distant) had accuracy ratings above the midpoint of the scale, indicating that these stigmatizing labels were perceived to be accurate descriptions of veterans with PTSD. Using the stigma management communication framework (Meisenbach, 2010), these perceptions would be classified as “accepting the public understanding of the stigma” (p. 278). This may further indicate that, not only do participants accept the public understanding of the stigma, they may also accept that it applies to veterans with PTSD. That there were no differences in accuracy ratings for these labels between veterans and civilians may also indicate that veterans have internalized this stigma (West et al., 2011).

Internalizing the stigma is another strategy consistent with the stigma management communication framework (Meisenbach, 2010) that connects with stigma communication (Smith, 2007). Specifically, a stigmatized person who internalizes the stigma likely uses language that reflects that; i.e., the stigmatized person uses stigma communication about him or herself. The use of stigma communication among those who are stigmatized is not well-understood. For example, is there an association between the level of self-stigma and the extent to which a person engages in stigma communication about that issue? Or, are there functions of stigma communication (e.g., personal responsibility) that are more likely to appear in the language of the stigmatized, compared to the stigmatizer? Additionally, do stigmatizing messages from the stigmatized generate different responses than those from stigmatizers?

In this study, self-stigmatization by veterans may be indicated by findings such as 40% of veterans, compared to just 16.3% of civilians, associating the label “weak” with veterans with PTSD (RQ4). As previously mentioned, it is argued that stigma associated with mental health services continues to exist in the military because of cultural norms or stoicism, invincibility, self-reliance, and prioritizing the unit over oneself (Mittal et al., 2013; True et al., 2014). Further, seeking mental health services is likely to be regarded as weakness and could be discrediting, embarrassing, cause harm to career progression and more (Hernandez et al., 2016; Mittal et al., 2013). It could be argued that military enculturation does affect the way veterans think they should act and the stigma stems from this very issue.

Perceptions of Label Accuracy: Challenging the Stigma

In contrast to labels that participants rated as accurate, five labels (dangerous, unreliable, weird, crazy, and weak) had accuracy ratings below the midpoint of the scale, indicating that these stigmatizing labels were perceived to be inaccurate descriptions of veterans with PTSD (RQ3). What is more, although the label “dangerous” was perceived to be inaccurate, more than half (53%) of the participants reported being exposed to this label (RQ1). Using the stigma management communication framework (Meisenbach, 2010), these perceptions would be classified as at least “challenging the public understanding of stigma” and possibly also “challenging that stigma applies to self” (p. 278). Although, recall, there may also be a sense that the stigma does not apply to the group (rather than the self) that the message attempts to stigmatize; i.e., audiences may be acting as ‘allies.’

These findings are extremely important, because they indicate that veterans’ perceptions of public stigma may not be entirely accurate (e.g., society does not stigmatize them as harshly...
as they perceive or even as much as they stigmatize themselves). Indeed, in rating the presence of stigmatizing elements in communication about veterans with PTSD (RQ5, RQ6), participants in this study indicated that such communication rarely holds veterans personally responsible for developing or overcoming PTSD. This contrasts with results from a previous study of treatment-seeking veterans (Mittal et al., 2013). Mittal and colleagues found that veterans felt the public blamed them for their illness, because they voluntarily for military service and, therefore, knowingly put themselves at risk. Our study suggests discrepancies between veterans’ perceptions of public opinion and actual public opinion toward PTSD. Perhaps if veterans could become aware of this discrepancy—using campaign approaches much like the Social Norms Approach (Berkowitz, 2005) to correct commonly-held misperceptions—their self-stigmatization might decrease, and they might seek treatment.

Anti-stigma health communication campaigns, such as those using the social norms approach, could incorporate this study’s model for measuring perceptions of stigma communication elements’ accuracy. Such measures could be used for pre- and posttests to evaluate programs designed to decrease stigma toward a group or behavior. Lower perceptions of the stigma’s accuracy would indicate a successful anti-stigma campaign. Extending that idea, one could also measure the extent to which an audience accepts/challenges the public understanding of the stigma and accepts/challenges its applicability to the group (Meisenbach, 2010). Movement along those continua could also serve as meaningful indicators of the impact of an anti-stigma campaign. Anti-stigma campaigns could also take a step further to equip audiences to serve as allies for stigmatized groups. Messages that model stigma management communication strategies for allies could achieve that goal. Finally, the use of these strategies among allies could also be measured, to better understand if, when, and how the strategies are used.

Limitations

Despite the potential benefits of measuring stigma communication variables, such measurement is not without difficulties. For example, it is difficult to measure exposure to stigma communication about a given topic, because participants may not recall every comment that they have personally spoken or that they have heard others speak about veterans with PTSD. In addition, since this survey was open to individuals who have no association with the military, it is possible that they had never previously thought about or paid attention to the issue of stigma in the military. For example, a portion of our sample were college students, who may not have enough life experience to be exposed to these ideas. Still, 87% of the sample reported having a military family member, so a large majority of our participants likely had some opportunities for crossing paths with this topic. On the other hand, twelve participants self-identified as veterans with PTSD. Clearly, their perspectives on this issue may be unique, but due to low statistical power, we could not examine differences between veterans with PTSD and civilians. Future studies could include a more balanced sample of veterans in general, veterans with PTSD, and civilians and make comparisons between their perspectives.

Conclusion

Veterans with PTSD need mental health services but are often reluctant to seek them due to perceived stigma (Acosta et al., 2014; Hernandez et al., 2016; Hoge et al., 2004; Hoge et al., 2006; Kim et al., 2010; Mittal et al., 2013; Sharp et al., 2015; True et al., 2014). Findings from

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our study indicate that, although participants were exposed to stigma communication about veterans with PTSD, most stigmatizing labels were considered inaccurate. Furthermore, participants perceived that discourse about veterans infrequently implied that veterans were personally responsible for developing and overcoming PTSD. These findings are hopeful, because they indicate that perhaps efforts to destigmatize mental health issues, and PTSD among veterans specifically, have been successful. We suggest building on this success by providing allies with models for how to challenge these stigmas through communication.

References

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