Out with The Old, In with The New: A Nuanced Approach to Self-Stigma Among Veterans

Derrick Alan Kranke, Shant Barmak, & Aram Dobalian

Abstract

Application of the prominent Corrigan and Watson (2002) self-stigma model to treatment modalities among civilians with mental illness, has been linked to the development of efficacious interventions and positive outcomes. Few intervention studies to reduce veteran self-stigma exist, but even fewer studies apply the Corrigan and Watson (2002) model to the veteran experience. Applying this model to veterans, may yield additional insight into factors driving self-stigma. In addition, contextual factors such as identity development, military cultural values, and familial concerns are shown in recent research to impact stigma, but have not yet been accounted for collectively in veteran self-stigma processes. Therefore, the purpose of this article is to apply the Corrigan and Watson (2002) model with nuanced contextual factors to develop a model that explicates the veteran self-stigma process. The authors conducted a constant-comparative method between the Corrigan and Watson (2002) self-stigma model and a variation of a stigma model among military personnel with mental illness. The corresponding similarities, differences, and any unaccounted factors, were applied collectively to the context of veterans and help-seeking. The model developed from this study suggests the veteran self-stigma process contains three components: 1) resistance, 2) differentiate, and 3) protect. The newly generated proposed model, is meant to disseminate novel issues that compound the effects of veteran self-stigma. Future research should assess the adequacy of this model, if it is consistent with the lived experience of veterans, and should develop interventions that target the corresponding issues within each component.

Keywords: Veterans, self-stigma, mental illness, identity, social work, psychology, military science

Introduction

Prior studies have found that 50%-82% of the recent generation of veterans (Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn) with mental health concerns do not access healthcare because of stigma (Kulesza et al., 2015; Nelson et al., 2014). Heightened suicide rates are commonly associated with stigma, which among veterans, continues to be higher than that of any other group, holding steadily at 21 suicides per day (www.va.gov, 2018). Statistics show that veterans and active duty military service members are 66% more likely to commit suicide than non-military civilians (McCarthy et al., 2009). A diagnosis of mental illness, when associated with negative reactions such as stereotyping and prejudice, results in being assigned an undesirable social status (Goffman, 2009; Hinshaw, 2009; Link & Phelan, 2001). Individuals in society are taught at an early age not to embrace feelings of differentness, but veterans may have a heightened sense of disregarding feelings of differentness (Kranke, Weiss, and Brown, 2017). Difference can accentuate feelings of exclusion and dissonance among veterans and civilians, since relationships are commonly based on feelings of similarity.

Presently, there are approximately 22 million veterans in the US, 1.2 million of whom receive mental health treatment (www.va.gov, 2018). A report by the National Council for Behavioral Health (2012) showed that the incurred cost of Post-9/11 veterans with mental illnesses who do not seek treatment, is almost four-fold the cost for veterans who do seek psychiatric treatment; non-

treatment can lead to other issues, which may require a greater amount of treatment and health cost. Furthermore, over $1 billion would be saved in treatment costs if every veteran with a psychiatric disorder sought mental health services. In sum, stigma is a contributing factor that substantially increases health care costs over time for veterans, limiting the availability of funds for other services to enhance veteran well-being.

For purposes of this study, the word **veterans** refers to those American military personnel who served in either the Air Force, Army, Coast Guard, Navy, Marines, or Military Reserves. The term **mental illness** refers to either Bipolar Disorder, Depression, Schizophrenia, or Post Traumatic Stress Disorder (PTSD). The word **treatment** refers to either medication, mental health counseling, or both.

Stigma can manifest in several ways (Corrigan, 2005): **public-stigma** refers to the attitudes and behaviors of the public to oppress and discriminate against individuals that possess attributes of differentness. In comparison, **self-stigma** is defined as the internalization of rejection for having a mental illness. Individuals self-stigmatize to protect themselves from the shame of repeated instances of rejection. They fear being denied meaningful housing, employment, education, and social opportunities because of their illness (Corrigan, 2005; Hinshaw, 2009). Individuals who feel ashamed may react by being secretive about their condition or need for treatment, engage in risky behaviors such as substance use or self-harming tendencies to take away from attention related to dealing with shame, and/or disengage from treatment and meaningful opportunities because they do not feel worthy or have low self-esteem (Corrigan & Kleinlein, 2005). The effects of self-stigma will perpetuate unless the individual targets his/her source of shame (Corrigan & Kleinlein, 2005).

Furthermore, self-stigma is highly associated with "personal perceptions of group identification and stereotype legitimacy" (Dickstein et al., 2010, p. 229). Veteran populations are vulnerable to self-stigmatizing, as they tend to strongly identify with their peers, and may share values that may increase the legitimacy of a stereotype (i.e., asking for help is a sign of weakness), which could diminish their self-efficacy. Cognitive techniques have the potential to reduce veteran self-stigma because they allow for reappraising the legitimacy of stereotypes. Despite the promise of the approach to utilize cognitive techniques, minimal research proposes strategies to reduce self-stigma among veterans (Bonfils et al., 2018; Dickstein et al., 2010; Mittal et al, 2013).

Framework

When adults experience self-stigma, the literature contends that the person with the mental illness accepts notions of stigmatizing images, which diminish his or her self-esteem and reduce confidence in the future (Corrigan, 1998). The most recognized adult self-stigma model suggests three components (Corrigan & Watson, 2002). The first component is stereotype, wherein people with mental illness are exposed to negative beliefs about the self. They either apply the label to themselves, and experience negative effects, or they do not apply the label to themselves and have no consequences.

The second component is prejudice; here, the stigmatized individual agrees with the stereotype and emotionally internalizes it as a negative perception. It also exacerbates feelings of shame because the individual believes the stereotype and negative perceptions about the self. The third component is self-discrimination, and refers to the way the individual behaves in response to the prejudice. These discriminatory acts could include isolation or social withdrawal. (Corrigan & Watson, 2002)

The Corrigan & Watson (2002) adult self-stigma model \has been applied to numerous groups of individuals, both adults and adolescents, who possess attributes of differentness. The successful application of this model to adults with mental illness, has led to the development of interventions

that improved long-term outcomes, such as self-esteem and self-efficacy. While self-stigma has not been completely eradicated, those intervention studies inclusive of aspects of Corrigan and Watson (2002), show marked improvement in stigma reduction efforts when compared with other self-stigma approaches. For instance, narrative enhancement and cognitive therapy is an evidence-based practice based on aspects of the model; this approach utilizes cognitive restructuring to change negative thoughts or stereotypes about one's self (Roe et al., 2013; Yanos et al., 2012), and is essential to identity transformation (Rhodes & Jakes, 2009), which can lead to higher self-esteem and consequently, more-positive outcomes in housing, employment, education, and social opportunities. In the model's application to adolescents, issues pertaining to identity development, reintegration in public settings, and family concerns impacted the overall trajectory of the self-stigma process (Kranke, Floersch, Kranke & Munson, 2011).

Existing literature on self-stigma interventions among veterans

The body of literature on interventions to reduce the effects of self-stigma effects among veterans is limited (Cornish et al., 2014; Dickstein et al. 2010; Lucksted et al., 2011; Mittal et al., 2013). Recent research (Kranke et al., 2017) indicates that combat veterans willingly and independently engage in thought restructuring—a form of cognitive restructuring—to reduce negative thoughts, provide emotional support to their fellow veterans, and participate in a process that enhanced feelings of normalization related to some of the trauma they may have experienced while in combat. This study (Kranke et al., 2017) was limited in its generalizability because it was qualitative and focused on a self-selected group of veterans who participated in a disaster relief organization. However, the findings of this preliminary study demonstrate the importance of building on this knowledge base to improve outcomes of veterans who self-stigmatize.

As research indicates, treatment is critical to positive long-term outcomes and successful reintegration at the individual, family, and community levels (Elnitsky et al., 2017). However, there appears to be an additional gap in the explication of the self-stigma process among veterans. No research has applied the prominent framework of self-stigma by Corrigan and Watson (2002), who developed the first self-stigma model among adults with mental illness. Conversely, Greene-Shortridge, Britt, and Castro (2007), developed a variation of a self-stigma model among veterans that consists of being socially distant from others with mental illness, and denial of having a mental illness in order to maintain control of self; however, both models (Corrigan & Watson, 2002; Greene-Shortridge et al., 2007) lack inclusion of certain contextual factors to the veteran experience, particularly related to barriers in identity development (Demers, 2011), adherence to military cultural values (Kim et al., 2010), and family issues (Sayer et al., 2014).

In addition, Mittal et al.'s (2013) study assessing the perceptions of treatment-seeking combat veterans found that most participants resisted the mental illness stereotype. For instance, respondents said "I don't think that we're violent or I don't think PTSD people are violent. I just think they're trained (p. 89)." Another veteran noted, "I guess they stigmatize us as crazy, and that's a liability because I'm not a liability. I'm not just going to go off on somebody without provocation or anything. . . I don't like being labeled (p. 89)." Mittal et al.'s (2013) findings have significant implications for the application of the Corrigan and Watson (2002) self-stigma model, as "acceptance of public stereotypes is a prerequisite for the development of self-stigma. The fact that participants resisted the legitimacy of stereotypes may decrease their chances to develop self-stigma" (Mittal et al., 2013, p. 90). While this may be the case with regard to self-stigma, it certainly does not suggest these veterans may not need any less treatment than those who resist the legitimacy of stereotypes.

Contextual factors promoting self-stigma among veterans

Veterans may be reluctant to engage in mental health treatment because of a desire to conform to the perceived military cultural value of self-reliance. While serving in the military, veterans were taught to embrace attitudes such as discipline, mental toughness, self-based sufficiency and that they can "tough out" problems in the military (Kim et al., 2010). In addition, seeking treatment may be interpreted as showing signs of weakness to unit leaders if they seek help (Kim et al., 2010). Furthermore, there is a fear among some veterans that they should not seek services out of concern about certain career tracks (Mittal et al., 2013). Values and coping mechanisms learned while serving may be contradictory to civilian life. Moreover, these contrasting belief systems complicate the healing process for many veterans.

Identity development is an additional consideration impacting veteran self-stigma. The military tends to "tear down" cadets during boot camp and reconstruct a new sense of self that affirms military cultural values. Many who join the service do so between the ages of 18-22, which is considered as late adolescence by Kroger (2007). That developmental stage entails identity formation—i.e., where do I fit in the world; which set of peers do I belong with; what career will I choose? Servicemembers will base much of their reconstructed adult identity on those interactions and values acquired in the military (Demers, 2011; Rumann & Hamrick, 2010). Simply put, veterans are "caught between who they knew themselves to be in the military and who they are now that they are in the civilian world" (Demers, 2011, p. 174). In addition, societal views of military personnel as "national heroes" tend to dissipate, as veterans are mainstreamed with the rest of the society (Fontana & Rosenheck, 1994). Veterans may also have difficulty reintegrating into civilian life, including "renegotiating his or her role in the family, in terms of one's relationship with their children, parental or spousal responsibilities, and being comfortable in one's family and household" (Sayers et al., 2009, p. e7). This sense of vulnerability and discomfort, could contribute to isolation and helplessness—conditions commonly associated with self-stigma.

Besides concern about one's self, self-stigma can impair the functioning of family members. Family members of those in the military may similarly experience psychological effects related to the servicemember's deployment and return to civilian life. Findings illustrate that military-connected adolescents report significantly higher levels of suicidal ideation, being bullied, and substance use when compared to students who are not military-connected (Kranke, Barmak, Weiss & Dobalian, in press; Gilreath et al., 2016). In addition, military families have higher instances of domestic violence and rates of divorce when compared with non-military families (Lester & Flake, 2013; Sayer et al., 2014). Additional stressors, can have negative long-term impact and carryover of its effects suffered by other family members.

Purpose

Identifying components of self-stigma processes is valuable, as research shows that interventions that target the specific components of the process are longer lasting and more efficacious (Boyd-Ritsher et al., 2003). However, the research on self-stigma seems to neglect factors related to identify development, military cultural values, and familial concerns. Generating a model by applying the prominent Corrigan and Watson (2002) framework, along with identified contextual factors, could provide additional insight to the process among veterans, and in turn could enhance the impact of interventions (Dickstein et al., 2010). An empirical self-stigma model of veterans exists (Greene-Shortridge et al., 2007), but it does not rely on cognitive processes or the additional contextual factors noted in this introduction. Therefore, the objective of this study is to enhance the components of the existing model in explicating the self-stigma process among military veterans.

Methods

The first step in the development of our proposed self-stigma model was to apply the constructs of the extant Corrigan and Watson (2002) model: stereotype, prejudice and discrimination. We focused on the characteristics and attributes associated with each component and identified which of those attributes might be relevant to the Veteran population. Then, we conducted a literature review of articles (See Table 1 below) in PsycINFO and PubMed that contained aspects of "self-stigma" and "models" among "veterans." We identified few articles that applied aspects of a self-stigma model to veterans, but noted a variation of a veteran self-stigma model created by Greene-Shortridge et al. (2007), and recurring themes of factors that reduced stigma from the literature search.

Table 1.
Results of literature review

Search Terms	Database	# of initial hits	Criteria for Reduction	# of useful hits
"self-stigma", "veterans"	PsycINFO	54	Excluded dissertations /theses, titles not containing "veterans," and veterans not focus	20
"self-stigma", "model", "veterans"	PsycINFO	14	Excluded redundancies	2
"self-stigma", "veterans"	PubMed	25	Excluded redundancies, titles not containing "veterans," and veterans not focus	2
"self-stigma", "model", "veterans"	PubMed	6	Excluded redundancies, titles not containing "veterans," and veterans not focus	0

Next, we conducted a constant comparative method (Boeije, 2002) between the Greene-Shortridge et al. (2007) model and the Corrigan and Watson (2002) model to identify similarities and differences (See Table 2 next page). This led us to identify contextual factors, such as identify development, military cultural values, and family concerns noted in recent research (Kulesza et al., 2015; Kim et al., 2010; Smith & True, 2014) as factors impacting stigma, but were not accounted for in either model. Finally, we noted connections between themes or patterns and how those contextual factors would impact the self-stigma process. Accordingly, we suggest that the Corrigan and Watson (2002) model should be expanded to encompass contextual factors to help explicate why some veterans are self-stigmatizing.

Table 2
Comparison of self-stigma models and processes

Self-stigma model	Corrigan & Watson (civilians)	Greene-Shortridge et al. (veterans)	Differences between existing models	Proposed Kranke et al. model (veterans)
Initial response	Stereotype: Apply label to self Label based upon what is heard by public	Social distance from others who have mental health problems	Willingness to apply label to self related to group identification	Resistance to label since cause of mental illness not their own doing
Emotional response	Prejudice: Agreement with negative belief about self	Do not agree with belief Deny need for health care because of desiring control over condition Illness not of their doing	Civilians agree with negative belief whereas veterans resist	A unique sense of differentness because military cultural values related to help-seeking and identity/ developmental milestones achieved while serving
Behavioral response	Discriminate: Self-discriminate by withdrawing from opportunities because of negative belief of self	Withdraw from care because of logistics and perceived barriers (i.e., cultural competence)	Civilians likely to seek treatment in a quiet manner whereas veterans disengage from treatment	Protect social capital and keep problems within military family because of perceptions among fellow military families and officers

Reliability

        To determine the reliability and appropriateness of the model, the lead author consulted separately with a VA researcher, who has a background in sociology and qualitative expertise with veterans and homelessness. This was the first iteration of the proposed self-stigma model. When there was disagreement about the components or characteristics within each component, discussion of additional factors that need to be accounted for in able to be applicable to the larger veteran population ensued.

Results

Self-stigma model

        The authors propose the following components and underlying reasons for behaviors to explicate the self-stigma process among veterans. Dissimilar to the Corrigan and Watson (2002) framework, *resistance* is the first component of the process. The veteran response to apply the label to the self is largely dependent upon the feeling of us vs. them. Veterans who have PTSD may not associate themselves with either civilians or the label of mental illness (Mittal et al., 2013). Veterans

may believe that their situation and contextual factors vary from those of a civilian with mental illness. Veterans may feel that they were a victim of a traumatic event not of their own doing, or are responding rationally to a set of experiences that have been put upon them (Greene-Shortridge et al., 2007; Kranke et al., 2017). This resistance may enhance the propensity of the effects of self-stigma by downplaying symptoms and attributing them to something other than a mental illness.

The second component of the veteran self-stigma process is *differentiate*. Most veterans value the sense of self, and the identity they reconstructed while in the military (Demers, 2011). Military values were instilled in veterans, and are applied in their everyday lives to succeed and thrive in the toughest of conditions (Kim et al., 2010). While reintegrating into civilian societal settings, these veterans may cling to that sense of military identity because it has shaped/differentiated them into their current sense of self. This may be buttressed by the pride in what they accomplished and the friendships they formed. In many cases with having a mental illness, veterans may feel that getting help or not being self-reliant alters their sense of military identity. This part of the process creates confusion because society presents a different ideology and perspective about mental illness. Furthermore, veterans may not have the same social support network with similar others (i.e., peers from military), which impacts their ability to cope. Ultimately, these veterans have a reduced sense of self-efficacy because of the mental illness, which in turn may impact their daily functioning.

The third component, *protect*, implies that veterans avoid treatment for their mental illness because of their military values to protect. First, they are protecting their social capital, or resources and networks directly related to increased opportunities in education, employment, housing and social relationships (Kranke et al., 2017). Social capital for them is already diminished because of not having their same support network. Second, they are protecting their family from negative perceptions that other military families may have of them not being able to pick themselves up by the bootstrap and solve problems on their own. Third, they are protecting their loss in status because they may think the mental illness, when combined with being a veteran in society, is a "double stigma."

Case example

Hypothetically, a veteran from a recent generation of war (Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn) could return to society and experience symptoms related to mental health unlike any they have previously experienced. He/she may "resist" symptoms, or the need for treatment because of military cultural values instilled in them that promote feelings of self-reliance, toughness, and unwillingness to ask for help.

Next, the veteran will "differentiate" their mental illness from civilians who also experience mental illness because of contextual factors and their valued military identity. They may think that mental health treatment specialists lack cultural competence because they cannot identify with their experience of serving. Their motivation for underutilizing treatment is attributed to the clinging of their military identity. They may believe in utilizing other mechanisms to address their mental health concerns because their typical methods of coping successfully led them to overcome situations in the past, and these methods are differentiated from others who have not served.

Third, the veteran will engage or behave in a way to "protect" themselves and their families by not utilizing treatment for fear of losing career and social opportunities, in addition to negative perceptions of fellow military families. By not addressing their mental health concerns, the self-stigma process will perpetuate, veterans will be less likely to access mental health care, and the veteran may consider suicide, isolation, or substance use, among others.

Discussion

The goal of this article is to enhance knowledge about the veteran self-stigma process because of the implications and potential costs of self-stigma to Veterans, their families, society and particularly, to the fields of social work, psychology, public health, and military medicine, among others. This is an understudied topic, with the potential to have a lasting impact on some veterans and their families. If self-stigma among veterans is reduced, it improves the health and well-being of these veterans and their families, and the resulting savings in health care costs would allow those funds to advance other societal goals for veterans.

The application of the Corrigan and Watson (2002) model of self-stigma to veterans had parallels that are present with civilians who self-stigmatize: First, we propose the veteran experience is illuminated by the three temporal components pertaining to the immediate response to a mental illness label and how that manifests from cognition to a behavioral response. In addition, the model accounts for aspects of self-stigma related to group identity and stereotype legitimacy; most veterans have pride in staying connected to fellow veterans and therefore uphold values related to a "warrior mindset" acquired while serving in the military. In sum, they do not want to deviate from their peers. Even though civilians and veterans may have very different circumstances that lead to self-stigmatizing, the application of the Corrigan and Watson (2002) model can be appropriate in predicting and explaining the experience among veterans.

Implications for practice and research

Our proposed self-stigma model contains three interrelated components, and not addressing an early aspect within a component, such as labels within the *resistance* component, could cause other components in the self-stigma experience to propagate. Prior research (Corrigan & Watson, 2002; Kranke et al., 2011) shows that individuals do not need to experience all three components of the process to be considered as self-stigmatized. Therefore, interventions to reduce self-stigma can be effective by focusing on one aspect (i.e., component). For instance, intervening with the first self-stigma component, resistance, by normalizing a veteran's mental illness and educating him/her on the prevalence of veterans who have a mental illness, could reduce the likelihood that subsequent components could surface.

Since the Corrigan and Watson (2002) model has been instrumental in developing evidence-based practices among civilians, such as narrative enhancement and cognitive restructuring, social workers should consider implementing these same techniques with veterans. It is imperative that the delivery of these interventions be inclusive of the contextual factors identified in this model to control for extraneous variables. Furthermore, cognitive restructuring, when practiced and utilized sufficiently, can be done independently. Recent research (Kranke et al., 2017), illustrates how combat veterans engage in thought restructuring—a form of cognitive restructuring—without the guidance of a clinician. This finding is not meant to undermine the value of being guided by a clinician, but rather, to illustrate that veterans are capable of, and buy into, the help-seeking process to reduce negative thoughts.

Future research should assess the adequacy of this model, and, if it is consistent with the lived experience of veterans, seek to develop interventions that target the corresponding issues within each component of the model. Since preliminary work (Kranke et al., 2017; Dickstein et al., 2010) suggests positive results, the next steps may be to conduct a study with a quasi- or an experimental design. It is vital that self-stigma be addressed on a grander scale because the actual number of veterans who experience self-stigma may be way beyond the subset of those who report self-stigma.

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Derrick Kranke
Health Science Specialist
Veterans Emergency Management Evaluation Center (VEMEC),
U.S. Department of Veterans Affairs
derrick.kranke@va.gov

Shant Barmak
Psychologist
Private Practice, San Diego, CA

Aram Dobalian
Director, VEMEC, U.S. Department of Veterans Affairs
Director, School of Public Health, University of Memphis