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Our Stigmatized American Heroes: Examining How Veterans with PTSD Communicatively Manage Stigma

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OUR STIGMATIZED AMERICAN HEROES: EXAMINING HOW VETERANS

WITH PTSD COMMUNICATIVELY MANAGE STIGMA

BY

RIKKI A. ROSCOE

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OUR STIGMATIZED AMERICAN HEROES: EXAMINING HOW VETERANS

WITH PTSD COMMUNICATIVELY MANAGE STIGMA

RIKKI A. ROSCOE

This thesis is approved as a creditable and independent investigation by a

candidate for the Master of Arts degree and is acceptable for meeting the thesis

requirements for this degree. Acceptance of this does not imply that the conclusions

reached by the candidate are necessarily the conclusions of the major department.

Jennifer Anderson, Ph.D.
Thesis Advisor   Date

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Dean, Graduate School   Date

This thesis is dedicated to my brother, Ramsey, who is a veteran of Operation Iraqi Freedom. Ramsey went to "go play army" in Iraq and Kuwait from 2009-2010. His service continuously motivated me throughout this project. Ramsey, you are my forever hero.

This thesis is also dedicated to all the men and women in uniform - past, present, and future. Without the sacrifices of those who have served for the Stars and Stripes, I would not have the privilege of attaining a degree and conducting this research in the first place. I thank you for your bravery, hard work, and dedication to our great country.

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"If I have seen further it is by standing on the shoulders of Giants." – Isaac Newton

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ABSTRACT

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WITH PTSD COMMUNICATIVELY MANAGE STIGMA

RIKKI A. ROSCOE

2019

Mental health conditions are arguably the most prominent disabling medical condition that military service members endure. Veterans with combat-related PTSD often refrain from seeking mental health treatment due to the stigma attached. Concealing PTSD or attempting to cope without professional help can lead to extreme and life-threatening consequences including depression, substance abuse, and suicide. Attaining a better understanding of stigma management strategies is important because it has the ability to help veterans better manage stigma in the future. Thus, the current study uses stigma management communication theory (Meisenbach, 2010) to uncover the ways in which veterans with PTSD communicatively manage their stigmatized identity. In addition, this study uses Smith's (2007) stigma communication framework to evaluate the military discourse and public discourse surrounding veterans with PTSD.

In-depth one-on-one interviews were conducted with 10 United States veterans to dig deep into the personal experiences of those who have developed combat-related PTSD and learn more about how veterans communicatively manage mental health stigma. The results show that veterans with PTSD manage stigma using all six major strategies of stigma management communication. Further, all elements of stigma communication were represented in military and public discourse. Interestingly, veterans sometimes managed stigma by blending contradictory strategies together. In addition,

three new stigma management communication strategies appeared. Not only do these results offer advancement for communication theory, but they could aid in the development of military training, military policy, mental health assessments, interventions, and destigmatizing campaigns.

CHAPTER 1

Introduction

Approximately four million United States military members have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) (National Academies of Sciences, 2018). These veterans returned home with the weight of the war on their shoulders, complicating their reintegration into civilian life. A soldier may be removed from the war zone, but their thoughts continue to linger there. In fact, a survey of 819 American veterans who fought in the war zones of Iraq and Afghanistan reported that "six-in-ten (62%) thought about their war experiences at least once a week or more, with 33 percent reporting that they thought about it every single day" (Pew Research Center, 2014). Too often, United States veterans face a lifetime of consequences due to the injuries they sustained fighting for their country.

Mental health conditions are arguably the most prominent disabling medical condition that military service members endure (Hoge, Auchterlonie, & Milliken, 2006). Combat-related posttraumatic stress disorder (PTSD) is a mental health condition that causes major distress and life disruption (National Institute of Mental Health, 2016). Several studies have shown that there is a stigma associated with mental illness in the military and that the fear of stigmatization acts a barrier to veterans seeking the mental health treatment that they need (Hernandez, Morgan, & Parshall, 2016; Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; Hoge et al., 2006; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Kulesza, Pederson, Corrigan, & Marshall, 2015; Mittal, Drummond, Blevins, Curren, Corrigan, & Sullivan, 2013). Veterans perceive that if they seek treatment for their mental health problems, they will be regarded as weak,

dangerous, or crazy (Mittal et al., 2013). Military service members are taught to be self-reliant and prioritize the needs of the unit over themselves (True, Rigg, & Butler, 2014), and therefore fear that a diagnosis of PTSD will lead to their colleagues losing trust in them and ultimately put their career in danger (Hoge et al., 2004; Hoge et al., 2006). The very soldiers that put their lives on the line to protect their country fear they will be blamed for the mental illness they develop doing so because they knew the risks involved when signing up for service (Mittal et al., 2013). With all of this anticipated backlash in mind, veterans sometimes choose to rely on their own resilience to cope, rather than seeking professional health treatment (Hernandez et al., 2016; Mittal et al., 2013).

Concealing mental illness or attempting to cope without professional help can lead to extreme and life-threatening consequences including severe depression, substance abuse, and suicide (Hoge et al., 2006). Within a major evaluation of the Department of Veterans Affairs' mental health services, the National Academies of Sciences (2018) provided scientific evidence that veterans were not only being diagnosed with mental illnesses at a higher rate than the general population but were also experiencing the mental health-related outcomes, like suicide, more frequently. In 2014, a total of 7,403 United States veterans took their own life, which accounted for 18% of all the suicides that took place on American soil (Veterans Affairs, 2016). These statistics show just how strongly stigma messages can affect military service members who suffer from mental illness. These statistics also demonstrate an urgent need for more research about the stigma that exists in the military.

Scholars have examined various communication problems within the military context surrounding family communication (Chernichky-Karcher & Wilson, 2017;

Hinojosa, Hinojosa, & Hognas, 2012; Knobloch, Ebata, McGlaughlin, & Theiss, 2013; Knoblock & Wilson, 2015) and health communication (Smith, 2015). Yet, it appears that the communication surrounding the stigmatization of military personnel who suffer from mental illness remains largely untouched by communication scholars. Thus, the purpose of this study is to better understand if/how military veterans communicatively manage mental health stigma. Attaining a better understanding of coping mechanisms and stigma management is important because it has the ability to help veterans better manage their stigma in the future and potentially save their lives.

In this chapter, I begin by providing a brief background of the problem regarding stigma surrounding mental health problems in the military context. I will then introduce the important concepts of this study within the statement of the problem before explaining the value of the study. I will conclude the chapter by defining important terms and phrases that will provide clarity in reading the review of the literature in chapter 2.

Background of the Problem

To better understand the background of the problem, we must establish an understanding of the following concepts: stigma, military stigma, stigma communication, and stigma management communication. All of these concepts play a part in the stigmatization of veterans who suffer from mental illness. This section provides a brief overview of the concepts that will be discussed more deeply in the literature review.

Stigma. Erving Goffman (1963) laid the foundation for the ancient concept of stigma, describing it as an undesirable attribute that differentiates an individual in such a way that they are deeply discredited and viewed as tainted, handicapped, and less than fully human. Individuals are often stigmatized when they hinder effective group function

(Smith, 2007). For example, Link & Phelan (2001) explained that when individuals are given a marked identity, it indicates that they are outside of what is considered normal or acceptable within society and creates a separation of "us" and "them". While stigma has many different functions, it often leads to the isolation of stigmatized individuals due to their undesirable characteristics (Link & Phelan, 2001). Stigma exists around countless topics and groups, but this study focuses specifically on stigma surrounding veterans with PTSD.

Military stigma. Military stigma is based upon "military enculturation that seeking mental health services would be discrediting or embarrassing, cause harm to career progression, or cause peers and/or supervisors to lose confidence in members ability to perform assigned duties" (Hernandez et al., 2016, p. 191). Scholars have pointed out that military culture sets a standard for how soldiers should act. For example, military service members rely on one another to ensure that missions are completed properly, and therefore, must remain mentally, technically, and physically prepared to execute duties when called upon (Hernandez et al., 2016). Additionally, soldiers are expected to remain stoic, invincible, and self-reliant and therefore, the stigma associated with mental health services continues to exist within the military context (Mittal et al., 2013; True et al., 2014). Military culture is important to understand because it gives us insight into why there is a stigma associated with veterans who have mental health conditions.

Stigma communication. Smith (2007) developed stigma communication framework to better understand how stigma messages are communicated. Thus, 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). These messages contain specific content including marks, labels, responsibility, and peril. In other words, a stigmatized individual may be marked as different from society, may be negatively labeled, thought to be a threat to society, or assigned personal responsibility for having a specific stigma attribute. Smith (2007) argued that stigma messages are powerful because of their ability to create stigma attitudes, to encourage the sharing of these attitudes, and to signal protective action tendencies (Smith, 2007).

It is important to include literature on stigma communication in this study. Elements of sigma messages (e.g., marks, labels, social peril, and personal responsibility) appear in past studies regarding veterans with PTSD, even though the researchers were not specifically testing for stigma communication theory (Hoge et al., 2004; Hoge et al., 2006; Mittal et al., 2013). Including a review of the stigmatizing messages that are communicated about veterans with PTSD will help us to better understand the background of the problem, as well as better understand the process in which veterans manage and cope with these stigmatizing messages.

Stigma management communication theory. Stigma management communication theory was proposed by Meisenbach (2010) in an attempt to better understand the existing stigma management strategies that are available for those who suffer from stigma. Meisenbach (2010) explains that stigma management occurs as a reaction to receiving a stigmatizing message and these responses fall into one of the following four quadrants: accept self/accept public, challenge self/accept public, accept self/challenge public, challenge self/challenge public (Meisenbach, 2010).

Stigma management communication theory has been used by many communication scholars to learn more about stigma management in a variety of contexts including depression in college students (Reichert, 2012), marginalized family members (Dorrance-Hall, 2016), burn survivors and relational partners (Noltensmeyer & Meisenbach, 2016) and men pursuing foreskin restoration (Hartelt, 2018). Yet, no one has used the theory to analyze veterans who suffer from PTSD.

In summary, several studies have shown that military service members perceive that they are stigmatized (Hoge et al., 2004, Hoge et al., 2006; Kulesza et al., 2015; Mittal et al., 2013). Studies have barely broken the surface in explaining what specific stigma messages are used when communicating about veterans with PTSD (Roscoe & Anderson, 2019). Further, we do not have an understanding of how veterans with PTSD communicatively respond to and/or manage stigma. It is necessary and important to learn more about communicative stigma management strategies in an attempt to help military members cope with the stigmatization of mental illness. In the long run, a better understanding may help suffering veterans get the treatment that they need and help them avoid the severe and sometimes life-ending consequences of PTSD.

Statement of the Problem

Ultimately, what is at stake is the well-being of military veterans. Being on the receiving end of stigmatizing messages has numerous consequences. To better understand these consequences, this section will examine the general consequences of stigma, as well as a narrowed focus on the consequence of stigma in the United States military.

Consequences of stigma. Stigma messages can have serious effects on the stigmatized individuals. Link and Phelan (2001) believed that stigmatization can lead to a "dramatic and possibly underestimated impact on life chances" in terms of careers, earnings, social ties, housing, criminal involvement, health, and life itself (p. 382). Link and Phelan (2001) made this claim because linking people to undesirable characteristics constructs a rationale to de-value, reject, and exclude them, thus leading to status loss and discrimination. In fact, Link and Phelan (2001) argue that status loss is an immediate consequence of labeling, making a person less attractive to get involved with whether it's socializing, participation in community activities, or partnering for business ventures. In addition, other scholars have argued that stigmatization can lead to experience prejudice, stereotyping, neglect, thus lowering self-esteem (Crocker, Major, & Steele, 1998; Miller & Major, 2000). These consequences can haunt any stigmatized group or individual. However, there are more specific consequences that arise when looking at military service members as a stigmatized group.

Consequences of stigma in the U.S military. There is a strong stigma attached to military service members seeking mental health care (National Academies of Sciences, 2018), and the resulting consequences are alarming. One of the negative effects derives from how stigma acts as a significant barrier to seeking mental health treatment (Kim et al., 2010). Individuals are discouraged from seeking mental health treatment when they perceive that they are going to be stigmatized for doing so, thus creating a sociocultural barrier (National Academies of Sciences, 2018).

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" (p. 1338). Moreover, Boudewyns et al. (2015) argued that individuals may avoid a topic all together if they except fear or rejection as a result of talking about a taboo topic. Additionally, the more that people perceive that an issue is stigmatized, the less likely they are to talk about it - both publicly and/or privately (Boudewyns et al., 2015).

Veterans are suffering, yet many are not seeking help due to the strong stigma associated with it. 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 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. This is demonstrated in a study of 812 veterans which found that veterans were less likely to take part in mental health treatments if they perceived greater levels of public stigma (Kulesza et al., 2015). This same study also found that 44 percent of participants perceived they would be judged poorly by others for seeking mental health treatment. Additionally, 26-44% of military service members agreed that apprehensions of stigma prevented them from seeking mental health treatment in a meta-analysis of 15 studies (Sharp, Fear, Rona, Wessely, Greenberg, Jones, & Goodwin, 2015).

In some cases, discouragement of seeking mental health services came from a veterans very own supervisor or commander. One study explained that not only were

veterans discouraged from reporting medical issues but "any behaviors that demonstrated weakness for not sucking it up and driving on were severely chastised" (National Academies of Sciences, 2018, p. 283). In another study of 1,939 military personnel, of the ones who screened positive for a mental health disorder, 23 percent marked "my commander or supervisor might respect me less" as a barrier to seeking treatment and 7.8 percent marked "my commander or supervisor has asked us not to get treatment" (Hoge et al., 2004, p. 23).

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 member's 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, have more difficulty with social relationships and more (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). Ultimately, this research shows that veterans return home from war, but continue to battle for their lives. More needs to be done to help veterans win their battle against mental health stigma.

Purpose of the Study

Little is known about the stigma management strategies that are used by military service members who are stigmatized for having PTSD. Thus, the purpose of this study is to better understand if/how military veterans communicatively manage mental health

stigma. Meisenbach (2010) argued that stigma management communication and its strategies call for applied research that can assist those managing stigma, stating that "as scholars work with this theory, new propositions, strategies, and applications will be developed that can be used to improve the lives of individuals as they interact with moments of stigmatized identity" (p. 289). Therefore, I argue that attaining a better understanding of stigma management communication in the military context could help combat the issue of stigma and potentially save lives. Each day, 20 veterans take their own lives in America (Veteran's Affairs, 2016). More needs to be done to change this statistic.

This study has the potential to help more than just veterans who suffer from PTSD. As previously discussed, mental health stigma results in negative health effects for the stigmatized, and such effects are not limited to only veterans who suffer from PTSD but those who suffer from depression, anxiety disorders, obsessive-compulsive disorders, phobias, and other mental illnesses. In fact, research conducted by National Institute of Mental Health (2016) showed that mental illnesses are common, affecting one in six U.S. adults and tallying up a total of 44.7 million total cases in 2016. It is my hope that this study can help the vast amount of people who suffer from mental illnesses.

In addition to better understanding how individuals manage communicative stigma, this study answers a call to test and advance the theory of stigma management communication. Meisenbach (2010) argued that testing stigma management communication theory using qualitative methods such as in-depth interviews (which this study aims to do) will not only grow the understanding of stigma management processes and experiences.

Furthermore, Meisenbach (2010) added that additional research using stigma management communication theory may offer insight into how stigmatized individuals use multiple management strategies or even strategies that contradict one another. For example, this study may demonstrate that veterans use more than one strategy to cope with stigmatizing messages. In addition, it is possible that veterans use a strategy that is not clearly defined in stigma management communication framework.

Definitions

Language is not without ambiguity, as people perceive and understands words differently. Thus, it is important to provide specific definitions before digging into the previous literature surrounding mental health stigma in the military context. This section, therefore, provides definitions of important words or phrases for maximum clarity.

Stigma. This study uses Smith's (2007) definition of stigma: "a simplified, standardized image of the disgrace of certain people that is held by a community at large" (p. 464). It is argued that stigma is a powerful phenomenon that places value on varying social identities (Dovidio, Major, & Crocker, 2000). Goffman (1963) described that individuals are deeply discredited when they have certain stigma characteristics or attributes. In addition, a stigmatized individual's social identity is often devalued, spoiled, or flawed in the eyes of the other (Crocker et al., 1998).

Military stigma. Hernandez et al. (2016) described that military stigma is based upon "military enculturation that seeking mental health services would be discrediting or embarrassing, cause harm to career progression, or cause peers and/or supervisors to lose confidence in members ability to perform assigned duties" (p. 191). Military service members may encounter military stigma during interactions friends, family, colleagues

and employers due to their mental illness or need to seek treatment (National Academies of Sciences, 2018).

Stigma communication. 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). Communicative stigma messages work to "distinguish people, categorize distinguished people as a separate social entity, imply a responsibility for receiving placement within this distinguished group and their associated peril, and link this distinguished group to physical and social peril" (Smith, 2007, p. 462). Smith (2007) explains that the specific content of stigma messages (e.g., marks, labels, assign responsibility, and link the individual to social peril) evoke different emotional reactions such as disgust, fear, or anger.

Stigma management communication theory. Stigma management communication theory was proposed by Meisenbach (2010) in an attempt to improve the understanding of stigma management and suggest options for individuals who experience stigma and suffer from its consequences. Stigma management occurs as a result of experiencing communicative stigma and these responses fall into one of the following four quadrants: accept self/accept public, challenge self/accept public, accept self/challenge public, challenge self/challenge public (Meisenbach, 2010). Six major strategies for stigma management are derived from these quadrants, including: accepting, avoiding, evading responsibility, reducing offensiveness, denying, and ignoring/displaying (Meisenbach, 2010).

Posttraumatic stress disorder. Posttraumatic stress disorder (PTSD) is described as a "psychiatric disorder that can occur in people who have experienced or

witnessed a traumatic event" (American Psychiatric Association, 2017). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association (2017) explained that individuals who suffer from PTSD experience continuous, intense, and disturbing thoughts or feelings associated with their traumatic experience, even long after the event has passed. The symptoms of PTSD fall into four categories including:

(a) intrusive thoughts such as repeated, involuntary memories, distressing dreams, or flashbacks, (b) avoiding reminders such as people, places, activities, objects and situations that bring on distressing memories, (c) negative thoughts and feelings such as distorted beliefs about oneself or others, ongoing fear, horror, anger, guilt or shame, lack of interest in previously enjoyed activities, feeling detached from others, and (d) arousal and reactive symptoms such as irritability, angry outbursts, behaving recklessly or self-destructive, easily startled, or problems concentrating or sleeping" (American Psychiatric Association, 2017, para. 5).

Military service members develop PTSD from unique war experiences including exposure to roadside bombs, handling human remains, and being responsible for killing another human (Greene-Shortridge, Britt, & Castro, 2007). These war-related demands, stressors, conflicts, and traumatizing and/or devastating events have lasting effects on a veteran (National Center for Post-Traumatic Stress Disorder, 2004).

United States military. The United States military is comprised of five branches including: Air Force (the nation's source of air and space power), Army (the dominant land power), Coast Guard (protects domestic waterways), Marine Corps (known was the

rapid-reaction force), and Navy (accomplishes missions primarily by sea, but also by air and land) (Military.com Editors, 2018). Each of the five branches also have a Reserve category and the Army and Air Force have National Guard branches. The difference between the Reserve and National Guard is that the Reserves report to the federal government, while the National Guard belongs to individual states (Veterans Anonymous, 2017). Reserve and National Guard are complimentary branches that consist of men and women who work civilian jobs but can be called to full-time military duty (Military 2018). Military people are split into three general categories including active duty (full-time soldiers and sailors), reserve & guard forces (works a civilian job, but can be called to full-time military duty), and veterans and retirees (past military members) (Military, 2018). In this paper, military service members and military personnel are inclusive phrases that will be used to refer to all members of the United States military. When referring to someone as a veteran, I am referencing to "a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable" (Veterans Anonymous, 2018, para. 1).

In conclusion, this chapter has introduced how communicative stigma surrounds veterans who suffer from PTSD. In review, the purpose of this study is to better understand if/how military veterans communicatively manage their stigmatized identity. A better understanding of coping mechanisms and stigma management is important because it could help veterans better manage their stigma in the future and potentially save lives. To learn more about this issue, chapter two will include a review of the prior literature regarding stigma in the military context. Chapter three will serve as the proposed methodological section and will prepare me to begin studying this phenomenon.

CHAPTER 2

Literature Review

Mental health problems are deemed as some of the most disabling medical conditions that affect military service members (Hoge et al., 2006), and yet soldiers are reluctant to seek help because of the perceived stigma that surrounds mental health (Hernandez et al., 2016; Hoge et al., 2004; Hoge et al., 2006; Kim et al., 2010; Kulesza et al., 2015; Mittal et al., 2013; Sharp et al., 2015; True et al., 2014). Concealed and/or untreated mental illnesses can have immediate and ongoing consequences including difficulty with relationships, physical discomfort, substance abuse, severe depression, and suicide (Hoge et al., 2006; National Center of PTSD, 2004; West et al., 2001; Wilk et al., 2010). To avoid these life-threatening consequences, more research must be done.

Communication scholars have not yet examined how stigma surrounding mental health is communicated and managed in the military. Therefore, the purpose of this study is to understand how U.S. military members experience and communicatively manage mental health stigma. Specifically, this study uses Smith's (2007) stigma communication framework to learn how stigma is communicated in the military and the public and uses Meisenbach's (2010) stigma management communication theory to analyze how veterans with mental illness communicatively manage stigma. Before explaining the methodology of this study, it is important to review the previous literature that surrounds this problem.

Communicating in the Military Context

Military deployment does not just have a stressful impact on the service member who has been called to duty; the effects branch out to all of the family and close friends who remain in the United States during the military service member's deployment.

Because of this, communication scholarship surrounding the military focuses largely on

family communication. The Defense Manpower Data Center (2009) found that out of

247,367 military service members of OEF or OIF, 56% (140,546) of them were married.

Of these married military personnel, 85% (96,976) of them had children. In addition,

16% (15,832) of the personnel in the study were single parents and had at least one child.

These numbers show the massive number of people who are impacted by military service

deployment.

Interpersonal communication with family members and close friends can be

difficult during a military service member's deployment and upon their return when they

are being reintegrated back into their normal daily routines. A study that used narratives

of men's deployment experiences found that "operational security, technical problems,

miscommunication, or having nothing new to say lead to a gap between veteran's

deployment experiences and their family members' understanding of their deployment"

(Hinojosa et al., 2012, p. 193). These strains can lead to negative effects on the kids

within the family (Chernichky-Karcher & Wilson, 2017). Chernichky-Karcher & Wilson

(2017) explained that children are left to worry about their deployed parent's safety while

experiencing changes in family rules, routines, and responsibilities. In addition, children

may feel the need to provide emotional support for their at-home parent or caretaker and

at times, are exposed to inappropriate disclosures regarding their parent's military

experiences (Chernichky-Karcher & Wilson, 2017). Overall, a variety of factors such as

selective disclosure and deployment experiences and sporadic communication with

family members lead to disruptive family relations during the reintegration period

(Hinojosa et al., 2012).

Military couples also face unique communicative issues due to military deployment, such as how generalized anxiety and relational uncertainty lead to topic avoidance (Knobloch et al., 2013). To learn more about what topics are avoided between military couples, 1,220 returning service members described issues they avoid discussing upon reunion (Knobloch et al., 2013). Knobloch et al. (2013) found three topic avoidance themes pertained to deployment: danger and experiences during employment (e.g., threats to safety, warzone experiences, events that occurred during the separation), confidential military information (e.g., mission intelligence not to be shared with civilians), and faithfulness and fidelity during deployment (e.g., the possibility of affairs). In addition, there were five themes that pertained to reintegration issues: household stressors (e.g., assortment of challenges of running a household while readjusting), the returning service members feelings and emotions (e.g., feelings of anxiety, sadness, fear, or distress), the possibility of future deployment, financial troubles (e.g., adhering to a budget and making ends meet) and references to politics, world events, and news coverage related to military (Knobloch et al., 2013). Knobloch et al. (2013) suggested that these themes offer practitioners a starting point to prepare military couples for the issues that may be face-threatening to talk about during reintegration.

On top of family strain, military service members face the risk of physical and psychological injuries when they are deployed to war. The United States Census (2015) found that in 2014, there were 3.8 million veterans who had a disability that was connected to military service. The vast number of disabled veterans creates a need for continuous scholarship that examines health communication problems that arise in terms of patient/physician care practices. For example, one study examined patient-centered

communication and access for veterans in hopes to find better ways to communicate about healthcare with veterans who have disabilities (Smith, 2015). More specifically, Smith (2015) used surveys to compare disabled veterans and non-disabled veterans to determine if there were significant differences in terms of patient-centered communication experiences and access to care. It was found that:

veterans with disabilities were significantly less likely to say that a physician listened to their concerns, explained care so that they understood, treated them with respect, spent enough time with them, and were less likely to get necessary care or experience a delay in getting care than veterans without disabilities (Smith, 2015, p. 454).

Overall, being a veteran with a disability increased the likelihood of poor care, and Smith (2015) concluded that physicians must consider the unique strengths and limitations presented by disabled veterans.

In another study, 5,000 veterans were surveyed to assessed which media is most helpful in providing health risk communication messages to veterans (Schneiderman, Lincoln, Curbow, & Kang, 2004). Overall, veterans found their primary care providers to be the most helpful in accessing health information, and veteran's affairs doctors were regarded as the least helpful (Schneiderman et al., 2004). Schneiderman et al. (2004) suggested that the internet is an increasingly important channel for delivering health risk information to veterans, as the study indicated high internet use among veterans.

This brief discussion of health communication-related problems in the military context shows the wide range of opportunity for scholarship. Overall, communication problems are inevitable when considering how military service members are separated

from their families to risk their lives on the war front and face numerous opportunities for injury. This study has the potential to contribute to the existing health and family communication scholarship by inspiring workshops and support groups for the veterans who are stigmatized for having PTSD, and for military families and health care providers who seek to help and support veterans who have PTSD.

While a variety of communicative issues have been examined, I believe there is one important problem that has been largely overlooked by communication scholars. Research shows that stigma exists around military service members who have mental illness and that this stigma leads them to avoid seeking treatment (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). This issue, however, has not been examined from a communication standpoint. There is an opportunity to learn more about the specific words and phrases that are used to communicate stigma about veterans with PTSD and further, to learn more about how veterans communicatively manage these stigmatizing messages. This study fills that gap.

Stigma

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 "immortality" 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 bore such a mark was to be discredited, scorned and avoided (Neuberg et al., 2000). Although it is much less common to physically burn and cut individuals, the concept of stigma still exists in modern times and has been a vastly popular topic of

study. Well-known sociologist Erving Goffman (1963) laid the foundation for sigma research in his seminal work titled *Stigma: Notes on the Management of Spoiled Identity*. Within his text, Goffman (1963) described stigma as an "attribute that is deeply discrediting" which ultimately leads to the individual being regarded as spoiled, handicapped, and less than fully human (p. 3).

It is argued that stigmatizing others can serve many functions within a society such as (a) self-esteem enhancement through downward comparison of the stigmatized individual, (b) control enhancement due to the outcome of the stigmatized individual being treated differently, being avoided, segregated, or marginalized, and (c) anxiety buffering through the social rejection of a stigmatized individual who is viewed as threatening (Dovidio et al., 2000). With this in mind, people will often stigmatize those who are seen as hindering the effective functioning of groups. For example, Smith (2007) argued that in order to protect effective group functioning, people associated with threats to group success need to be marked and labeled as a separate social entity. Similarly, Link & Phelan (2001) explained that individuals are given marked identity, it indicates that they are outside of what is considered normal or acceptable within society, which leads to the process in which stigmatized individuals are isolated due to their undesirable characteristics. Ultimately, the elements of the stigma process (e.g., marking and labeling) become the rationale for believing the stigmatized person is fundamentally different, and thus create a separation of "us" and "them" (Link & Phelan, 2001, p. 370).

Stigma is defined differently within the disciplines of sociology, psychology, and communication. Within their study of the prevalence of military stigma, Acosta et al., (2014) reported a total of 98 distinct definitions of stigma. Therefore, it is important to

note that my study defines stigma under a communication perspective where stigma is regarded as a "simplified, standardized image of the disgrace of certain people that is held in common by a community at large" (Smith, 2007, p. 464). This definition is necessary because my study uses stigma communication and stigma management communication theory framework to assess the process of stigmatizing Veterans who suffer from PTSD.

  Military stigma. Military culture sets standards for how soldiers should act. Hernandez et al. (2016) argued that service members are expected to "maintain a high level of mental, technical, and physical preparedness, so that they can perform duties when called upon" and in addition, are "highly dependent on other members of their units to ensure mission execution and completion" (p. 190). These expectations lead soldiers to act a certain way. It is argued that military culture promotes "stoicism, self-reliance, and prioritizing the needs of the unit over the needs of the individual" (True et al., 2014, p. 4). Likewise, Mittal et al. (2013) suggested that military culture promotes invincibility among soldiers, and acknowledging mental illness is likely to be regarded as a sign of weakness that may pose a threat to their careers. In fact, a study by the National Academies of Sciences (2018) stated that veterans were severely chastised and discouraged from reporting any medical issues that showed weakness. In that same study, veterans expressed that they had a hard time believing they could share their concerns regarding mental health without receiving backlash, even after leaving active duty (National Academies of Sciences, 2018).

  Ultimately, these intense standards lead to military stigma, which is based upon "military enculturation that seeking mental health services would be discrediting or

embarrassing, cause harm to career progression, or cause peers or supervisors to have decreased confidence in members ability to perform assigned duties" (Hernandez et al., 2016, p. 191). Acosta et al. (2014) explained that military stigma operates within social contexts (personal relationships), institutional contexts (the policies and systems one operates under), and public contexts (the culture and norms in which one operates). The major consequence of military stigma is that it acts as a barrier to 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).

In summary, military culture sets standards for how soldier should act (Hernandez et al., 2016; Mittal et al., 2013; True et al., 2014). Having an understanding of military culture helps us understand the root of stigma in the military and better understand the problem being examined in this study. The next section explains how military stigma can be communicated not only in the military context but throughout society as a whole.

Communicating Stigma

Stigma messages are shared between members of a community and therefore rely heavily on communication. Smith (2007) developed stigma communication framework to better understand the role communication plays in stigmatizing an individual. 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 rapidly gains attention, encourages stereotyping, validates emotional reactions in response to a stigmatized individual, and creates a separation between stigmatized groups and the rest of society (Smith, 2007). 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 (Smith, 2007, p. 463).

Therefore, a stigmatized individual could be marked as different than society, may be negatively labeled, thought to be a threat to society, or assigned personal responsibility for having a specific stigma attribute. Smith (2007) explained that the specific content of stigma communication messages "induce affective and cognitive responses to create stigma attitudes, to generate protective action tendencies, and to encourage the sharing of these messages with others" (p. 477). Stigma messages often lead to split-second judgments and thus appear to be operating preconsciously (Link & Phelan, 2001). Further, different qualities of stigma messages evoke feelings of fear and disgust and encourage 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 veteran who suffer from PTSD.

Marking. Marking someone includes using cues that evoke quick recognition and instinctive response (Smith, 2007). In addition, Mackie & Smith (2002) explained that stigma marks can evoke disgust and result in a tendency to avoid or reject the marked target. A mark that cannot be easily concealed provides greater opportunity to be recognized (Smith, 2007). For example, Anderson & Bresnahan (2012) 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 (Anderson & Bresnahan, 2012). In contrast, there are many stigmatized groups and diseases, such as mental illness, that are unique in that they are not visible to the human eye and can be concealed. Stigma communication within the military context has not been studied enough to know if veterans who suffer from PTSD are marked, but this study intends to find out.

  Labeling. Stigmatized groups are often given labels that bring consideration to the group's stigma, suggest that they are a separate social entity, and differentiates them from those who are considered normal (Smith, 2007). There are several labels used to distinguish veterans suffering from PTSD. One study that explored stigma related to PTSD among treatment-seeking OED/OIF combat veterans through the use of focus groups found that the participants clearly believed that society stigmatizes veterans with PTSD and were aware of labels 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, p. 88). Of these labels, being "violent, dangerous, and crazy" were perceived as the most dominant among the treatment-seeking veterans with combat-related PTSD (Mittal et al., 2013, p. 88-89). Other studies have found that non-treatment-seeking service members conceal their illness due to the fear of different labels. For example, 63% returning active duty who military members from Iraq and Afghanistan who had the symptoms of mental illness thought they would be perceived as weak if they sought help (Hoge et al., 2004).

A recent study by Roscoe and Anderson (2019) indicated that both veterans and non-veterans perceived that negative labels were used to communicate stigma about veterans with PTSD. However, the study extended beyond label association to consider if participants believed the labels were accurate in describing veterans with PTSD. For example, five labels (dangerous, unreliable, weird, crazy, and weak) were perceived as inaccurate descriptions of veterans with PTSD, yet some of these were rated highly in terms of association (e.g., 53% of participants reported being exposed to the label dangerous). This shows that even if people have heard certain stigmatizing labels associated with veterans with PTSD, they do not necessarily think the labels are accurate.

Link to social peril. Individuals are linked to social peril when messages highlight 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 and provoke fear and anxiety and thus lead to stigmatization.

Studies have demonstrated that veterans who suffer from PTSD are linked to social peril, and military culture may be to blame. Simmons & Yoder (2013) described "mental stability and toughness are unwritten requirements for surviving in the military environment" (p. 18). 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, their unit members would have less confidence in them (59%), felt that they would be treated differently by others (63%), and felt that it would

harm their careers (50%). Another 2012 study of 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).

  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) where participants expressed that society held them accountable for their mental illness because "they volunteered for military service, and therefore, knowingly put themselves at risk" (p. 89). 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). In contrast, in a study of 164 veterans and non-veterans conducted by Roscoe and Anderson (2019) showed that participants rarely held veterans personally responsible for developing or overcoming PTSD.

  In review, using stigma communication framework developed by Smith (2007) helps to identify what specific messages are stigmatizing toward veterans who suffer from PTSD. Stigma communication messages exist in the form of marks, labels, links to social peril, and the assigning of responsibility (Smith 2007). Therefore, stigmatizing messages may contain one or more of the following: negative labeling of veterans suffering from PTSD, linking these veterans to peril, and ascribing personal responsibility for obtaining the illness. An understanding of these stigma messages is important because in some cases these labels are the beginning of the end of a suffering soldier's life. Moreover, a better understanding of stigma management can help veterans who are stigmatized for having PTSD.

Stigma Management Communication Theory

Keeping the negative consequences of stigmatizing veterans in mind, I argue that we need to better understand and further develop stigma management strategies that help stigmatized individuals cope. It is argued that although stigmas differ in a variety of important ways that will likely affect the coping strategy that is used (e.g., some stigmas are visible, while others are concealable), there are similarities across stigmas in how people cope with them (Crocker et al., 1998). Mesienbach (2010) developed stigma communication management theory to improve the understanding of stigma management and shine a light on the options available for those who suffer from stigmatizing experiences and the consequences that spring from these experiences. Meisenbach's (2010) framework includes four major quadrants where an individual may: accept self/accept public, challenge self/accept public, accept self/challenge public, challenge self/challenge public. Six major strategies for stigma management are derived from these quadrants, including: accepting, avoiding, evading responsibility, reducing offensiveness, denying, and ignoring/displaying (Meisenbach, 2010).

Accepting. Individuals may manage stigma by accepting it as a part of their identities. Meisenbach (2010) states that stigmatized individuals may accept public expectations regarding the stigma and accept that it applies to them in displaying a variety of behaviors. For instance, when stigma is accepted, an individual may engage in passive acceptance where they have a "no comment" stance or the individual may openly display the stigmatized attributes and adhere to societies beliefs of the stigma (Meisenbach, 2010, p. 278-279). Openly displaying the stigmatized attribute may even help the stigmatized individual achieve a certain goal (Miller & Major, 2000). For

example, instead of concealing it PTSD, a veteran may openly share his or her symptoms with medical professionals in order to receive the treatment they need.

Meisenbach (2010) also argued that individuals that accept the stigma may feel the need to apologize for it. In this case, a military service member may feel the need to apologize to his or her unit for attaining a mental health illness or apologize to their loved ones for being "dangerous." In addition, when accepting stigma, an individual may use self-deprecating humor to help cope (Meisenbach, 2010). For example, a veteran suffering from PTSD may joke that he's the "crazy uncle" at his niece's birthday party. Lastly, a stigmatized individual may assert blame on their stigma when experiencing a negative outcome, such as a veteran blaming their PTSD diagnosis for not getting a job.

Acceptance was used as a management strategy in a study of treatment-seeking veterans which found that some of the participants accepted the accuracy of the labels dangerous and weak (Mittal et al., 2013). For example, one participant stated, "I think we're dangerous to a certain degree because sometimes our anger does begin to overcloud our judgment," and another participant stated, "it was my weakness, my fault" in terms of developing PTSD (Mittal et al., 2013, p. 89). Sometimes, when individuals accept and internalize a stigma, they isolate themselves from society (Smith, 2007), thinking it is the easiest way to live with the blame they bestow upon themselves (Goffman, 1963). This isolation sometimes leads to bonding, which is a sub strategy of accepting in which stigmatized individuals socialize and/or bond with one another (Meisenbach, 2010). LeBel (2008) noted that as a way to cope with their own stigma, an individual may provide mentoring or peer support for others who endure stigma. This is demonstrated in a study where veterans who suffered from PTSD "contrasted feeling

misunderstood with the sense of understanding and fellowship they felt with other veterans who had experienced similar combat situations" (Mittal et al., 2013, p. 89). Further, participants proclaimed that fellow veterans in treatment for PTSD as those "most likely to understand them, and thus, the people they were more likely to trust with their feelings" (Mittal et al., 2013, p. 89). Additional benefits from affiliating oneself selectively with members of the same stigmatized group include validation of beliefs and attitudes, mutual need gratification, mutual understanding, and social support (Miller & Major, 2000).

Avoiding. Someone may manage stigma by avoiding it. Avoiding happens when the stigmatized individuals accept that the stigma exists within society, but deny the stigma applies to them (Meisenbach, 2010). Meisenbach (2010) describes several different behaviors in which an individual avoids stigma including hiding the stigma attribute, avoiding stigmatizing situations, distancing self from the stigma, eliminating the stigma behavior or attribute, and making favorable social comparisons. When avoiding stigma, individuals may try to hide the stigma attributes (Meisenbach, 2010). Other scholars refer to this strategy as secrecy (Link & Phelan, 2001) or concealment (Goffman, 1963). This is very common in the military when service members recognize that they have symptoms of PTSD, yet try to conceal it (Hoge et al., 2006).

Meisenbach (2010) describes that an individual may also manage stigma by avoiding stigmatized situations, meaning they intentionally avoid situations, behaviors, and discussions that might involve public attribution of the stigma. In this situation, a military service member who suffers from PTSD may avoid situations where loud noises (e.g., watching a movie or playing a video game) may trigger a flashback or outburst.

Miller and Major (2000) described that total avoidance may be impossible (e.g., a veteran may be unable to escape fireworks exploding on the Fourth of July), thus leaving the stigmatized individual to consider the risks and negative consequences associated with certain situations.

Moreover, in an attempt to avoid stigma, an individual may attempt to stop or eliminate the stigma attribute (Meisenbach, 2010). Lebel (2008) explains that individuals will deem themselves as ex-stigmatized when they eliminate their stigma attribute. Miller and Major (2000) explain that an obese individual may diet to lose weight or someone may undergo cosmetic surgery to eliminate the evidence of aging. However, there are stigmatized groups that may not be able to eliminate their stigma attribute (e.g., mental illness, terminal illness, obesity), thus they may attempt to distance themselves from the stigma (Meisenbach, 2010). For example, in a study conducted by Noltensmeyer and Meisenbach (2016), burn victims engaged in avoidance by hiding their scars (the stigmatized attribute) under their clothes. The participant felt uncomfortable completely revealing her marked body to her husband and preferred to hide as much as possible with clothes (Noltensmeyer & Meisenbach, 2016). In addition, the elimination strategy may not be feasible for some veterans who have PTSD, because treatment to eliminate their mental illness may not be successful.

Finally, individuals may avoid stigma by making favorable comparisons between themselves and others. Further, "individuals find a group or individual that is enough like them that the connection is meaningful, and discursively make clear that this other is somehow lesser than they are" (Meisenbach, 2010, p. 282). For example, a veteran suffering from PTSD my claim their mental illness is not as bad as someone who is

suffering from schizophrenia. In fact, in a study conducted by Mittal et al., (2013), treatment-seeking veterans reported they would rather be diagnosed with PTSD than schizophrenia, because PTSD "doesn't sound as bad as schizophrenia" and "PTSD is the lesser of two evils" (p. 90).

Evading responsibility. Meisenbach (2010) describes that an individual evades responsibility when they acknowledge that the stigma is applicable to them but tries to change societies understanding of the stigma by deferring control away from the stigmatized individual by claiming provocation, defeasibility, and/or unintentionality. A veteran may evade responsibility through defeasibility by claiming that during the war, they were just doing what they were told to do and cannot control the PTSD they experience because of it. Thus, this stigma management strategy focuses on changing public opinion about the characteristics of the stigma (Meisenbach, 2010).

Reducing offensiveness. Individuals work to reduce offensiveness of stigma when they accept that it applies to them but want to change how the stigma is perceived by others (Meisenbach, 2010). Likewise, Miller and Major (2000) described that stigmatized groups social devaluation can be eliminated, pointing to efforts that had previously been made to eliminate the prejudice of others including the "black is beautiful" and "gay pride" movements (p. 256). In Meisenbach's (2010) stigma management communication framework, reducing offensiveness is broken into subcategories including bolstering/refocusing, minimizing, and transcending. Bolstering and refocusing involves shifting the focus from the stigmatized part of an individual's identity to a non-stigmatizing part (Ashforth & Kreiner, 1999; Meisenbach, 2010). For example, instead of focusing on veterans having PTSD, one may discuss how they are

brave for their service, focusing on the heroic qualities of the person rather than the mental illness.

Minimization is a process in which an individual works to reduce the offensiveness of a stigma by highlighting how the stigma attribute does not inconvenience or harm others (Meisenbach, 2010). In Hartelt's (2018) study, participants minimized stigma and defended their pursuit of foreskin restoration by stating, "it's not about you, it's about me" (p. 54). Minimizing the stigma attribute is similar to the idea of compensation. Miller and Major (2000) described that compensation is a "coping response in which a stigmatized individual alters their behavior so that they can achieve their interaction goals despite the fact the person with whom they are interacting may be prejudiced against them" (p. 253). Some goals of compensation include gaining access to resources that are controlled by another individual (such as a job) or being accepted by another (Miller & Major, 2000). Hypothetically, a veteran with PTSD may minimize stigma by showing they are dependable in the workplace.

Transcendence is another strategy of reducing offensiveness where an individual "calls attention to how the stigma attribute can be a means that leads to a valuable end" (Meisenbach, 2010, p. 283). As a result, the individual acknowledges that stigma applies to them, but works to reduce its sting by identifying a higher purpose. Transcendence was a strategy used by several participants in a study of men who were pursuing foreskin restoration (Hartelt, 2018), where men expressed that their journey was difficult and long but the end result would be worth it (Hartelt, 2018, p. 55). In addition, men referred to being "whole" or "restored" at the end of their journey, which represents what Ashforth and Kreiner (1999) would call a badge of honor. Ashforth and Kreiner (1999) explained

that stigma resembles a badge of honor when it is reframed to have a positive value and demonstrates a higher end. Veterans may wear a tangible badge an honor on their sleeve. However, the injuries that veterans acquire, including mental illness, could represent a hypothetical badge of honor, showing that their sacrifice was for the greater good of the country.

Denying. Denial happens when individuals both challenge society's understanding of a stigma and challenge that it applies to themselves (Meisenbach, 2010). There are both simple and logical denials. Individuals engage in simple denial when they simply state that there simply is no stigma. For example, Hartelt (2018) pointed out that participants in his study of men who experienced stigma for seeking foreskin restoration used simple denials as a response. For instance, in their one-on-one interviews, participants stated that foreskin restoration is "not some fetish thing" or "not something weird," and undergoing foreskin restoration "doesn't mean your nasty; doesn't mean you're dirty (p. 57). Meisenbach (2010) considers simple denials as a straightforward approach that denies the stigma exists and also denies that it is applicable.

Logical denials come in several different forms and are more complicated than simple denials. Meisenbach (2010) described that an individual may use logical denial by "denying the stigma's acceptability by questioning the credibility of those promoting stigma, providing specific evidence that refutes stigma, and/or showing how some stigma communicators are engaging in logical fallacies" (p. 284). These three sub strategies (discredit discreditors, provide evidence/info, and highlight logical fallacies) rely on rhetorical argumentation techniques (Meisenbach, 2010).

Ignoring/displaying. Stigma is ignored when individuals challenge public perceptions by ignoring moments of stigmatization and continue to display the stigma (Meisenbach, 2010). Although this strategy may seem similar to acceptance strategies, Meisenbach (2010) argued that choosing to ignore and display stigma stems from a desire to challenge rather than accept society's perceptions of the stigma. Ignoring and displaying as stigma management is demonstrated in a study by Noltensmeyer and Meisenbach (2016) where a burn victim chose to wear a swimming suit, displaying her burns and using "fake confidence" to "deal with the looks and the pointing and the whispers" (p. 186).

Another participant from the same study also chose to ignore/display a burn he had received on his face, noting that he never had a difficult time with it because not hiding the burn relieved him of the burden (Noltensmeyer & Meisenbach, 2016). Meisenbach (2010) pointed out that this strategy encourages close contact between stigmatized and non-stigmatized individuals. This close contact may lessen the perception of stigma (Corrigan & Penn, 1999).

Rationale and Research Questions

Ultimately, what is at stake is the well-being of military veterans. It is unfortunate that military service members who suffer from PTSD are stigmatized by society and that veterans are reluctant to seek treatment for their mental illness due to their fear of being stigmatized (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). Many veterans fear being labeled as weak, dangerous, violent, crazy, or unfit for their job and consequently choose to attempt to cope without treatment, relying instead on their own

resilience (Mittal et al., 2013). This can lead to detrimental consequences such as substance abuse, major depression and even suicide (Hoge et al. 2006; Veteran Affairs, 2016; West et al., 2011).

A better understanding of how veterans with PTSD respond to and/or manage stigma communication messages is needed. It is necessary and important to learn more about stigma management strategies in an attempt to help military service members get the help they need to cope with not only their mental illness but the stigmatization of such illness. The research questions seek to uncover a rich understanding of how veterans with PTSD communicatively manage and cope with stigma. This study uses Smith's (2007) stigma communication framework to learn how stigma is communicated in the military and the public and uses Meisenbach's (2010) stigma management communication theory to analyze how veterans with mental illness communicatively manage stigma. Therefore, the following research question guides this study:

RQ1: Which stigma management communication strategies are used by veterans who are stigmatized for having PTSD?

As previously discussed, stigma communication management theory suggests that people fall into four quadrants when it comes to managing stigma: accept self/accept public, challenge self/accept public, accept self/challenge public, challenge self/challenge public (Meisenbach, 2010). These quadrants are then broken down into subcategories including accepting, avoiding, evading responsibility, reducing offensiveness, denying, and ignoring/displaying (Meisenbach, 2010). With that being said, it is possible that unique strategies will appear that do not coincide with one of the proposed strategies within stigma management communication. If management strategies that are outside of

the theory appear in this study, it is important to understand what they are. Thus, I propose the following research question:

RQ2: How, if at all, do veterans with PTSD use stigma management communication strategies that do not appear in Meisenbach's (2010) theory of stigma management communication?

In addition to testing stigma management communication theory (Meisenbach, 2010), this study provides an opportunity to learn more about the general discourse surrounding veterans who have PTSD. Previous studies have credited military culture as a major factor in creating the stigma that surrounds veterans who have mental health issues (Hernandez et al., 2016; Hoge et al., 2004; Mittal et al., 2013; True et al., 2014). This claim can be further evaluated by attaining first-hand accounts of the communication regarding mental health in the military.

Further, much of the previous literature has focused on how veterans perceive stigma specifically within the *military* context (Hernandez et al., 2016; Hoge et al., 2004; Mittal et al., 2013). On the contrary, little scholarship explores veteran's perceptions of *public* stigma, or the stigma that exists outside of the military context (e.g., friends, family, media, politicians, the general public, etc.). One recent study by Roscoe and Anderson (2019) explored perceptions of the stigma surrounding veterans with PTSD and found differences between the perceptions of veterans and the perceptions of civilians. For example, 40% of veterans associated the label weak with veterans who have PTSD, while only 16.3% of civilians made that association (Roscoe & Anderson, 2019). These differences could exist because discourse about stigma in the military is different than that of the public. This study has the ability to help us understand these differences.

Meisenbach's (2010) stigma management communication theory and Smith's (2007)

stigma communication theory is helpful in evaluating how *military* discourse differs from

public discourse, and thus leads veterans to have different perceptions of the stigma

surrounding PTSD than civilians. Thus, I present the exploration and comparison of the

following research questions:

RQ3: How do participants describe *military* discourse about PTSD?

RQ4: How do participants describe *public* discourse about PTSD?

CHAPTER 3

Methodology

Procedure

The previously discussed research questions were answered using naturalistic

qualitative design. Qualitative research methods are described as "an array of interpretive

techniques which seek to describe, decode, translate, and otherwise come to terms with

meaning…" (Frey, Botan, & Kreps, 2000, p. 262). Therefore, using qualitative methods

helped me dig deep into the personal experiences of veterans who have experienced

moments of stigma due to their diagnosis of PTSD and better understand how they cope

and manage stigma.

Naturalistic in-depth one-on-one interviews were necessary because PTSD can be

a sensitive topic to discuss. In a one-on-one situation, participants may feel more

comfortable disclosing sensitive and personal information (Frey et al, 2000), and

therefore, the information attained may be more accurate. It is important that participants

are willing to share their experiences, as the goal of in-depth interviews is to better

understand another person's point of view on a particular phenomenon (Frey et al., 2000).

The interviews took place face-to-face in a secluded room within a University library,

and over the telephone which allowed the researcher an easier way to reach participants

who have the desired characteristics.

Sample

The goal of this study was to better understand how veterans manage and cope

with stigmatizing discourse regarding mental health issues. In total, 10 military veterans

who self-reported firsthand, personal experience with PTSD were interviewed for this

study. All of the participants were citizens of the United States and ranged from 24 to 52 years old, with a median age of 32. The sample included one female and nine males, which is representative of U.S. veterans' gender. In 2016, there were around 1.6 million female veterans in the United States, accounting for approximately 10% of all veterans (Statista, 2016). Further, the sample was 80% white and 20% Hispanic or Latino. Finally, 50% of the sample represented the Army and the other 50% represented the Marine Corporation.

As a result of established inclusion criteria, all participants self-reported service in modern wars (e.g., OIF and OEF) post-9/11. These criteria allow for consistency with the previous military-related literature. Further, combat-related PTSD has become a more recognized health condition over time (Friedman, 2018), and therefore I argue that veterans of different wars have different experiences with the stigma that surrounds mental health problems.

Sampling

The goal was to recruit participants that can act as informants on the issue. This provided unique insight on how veterans with PTSD manage communicated stigma messages (Frey et al., 2000). These participants were recruited using nonrandom, purposive, volunteer, and snowball sampling. Nonrandom purposive sampling entails selecting purposeful respondents on the basis of a certain characteristic (Frey et al., 2000), and in this study, the characteristic is being a veteran who has experienced PTSD. This study also used volunteer sampling, meaning participants choose to participate in the study (Frey et al., 2000). Participants who volunteer typically have "greater intellectual ability, interest, motivation, need for approval, and sociability" (Frey et al., 2000, p. 132).

This means that the volunteers have information that they are interested and willing to share about the topic. In addition, having volunteer participants indicates they are more comfortable discussing a topic that can be sensitive, such as experiences with PTSD. Lastly, there were elements of snowball sampling because participants were encouraged to share the study with others who contain the desired characteristic of having been medically diagnosed with PTSD.

The sampling techniques were used on two platforms. One way that participants were recruited for this study was by sending an email to members of a Veteran support group at a large Midwestern university explaining the project and inviting them to participate. Another way was through a recruitment message on a private PTSD support group for military veterans on Facebook, with the approval of the group administrator. As previously mentioned, participants were encouraged to share this project with others who would be interested in participating. A total of 25 people responded to the recruitment survey. I was given contact information to follow up with 14 of these people. From there, 10 total interviews were conducted.

Instrumentation/Operationalization

The University's institutional review approved the interview study and participants consent was obtained. A confidential location and time was established with the face-to-face interviewee and the remaining participants who were interviewed via telephone were able to choose a time that was convenient for them. Allowing the participant to choose the time and location can increase comfort level, as Lindlof & Taylor (2002) mentioned the best interview results are attained when the participant feels relaxed, rather than highly energized or fatigued.

Once a comfortable location (e.g., secluded room in a University library) and/or time were established, the interviews commenced and were audio-recorded. I wanted the interviews to resemble guided conversations, and therefore, semi-structured interviews were beneficial to the study. Semi-structured interviews use outlined questions that are organized in advance but allow the researcher to improvise and develop probing questions on the spot (Frey et al., 2000). Therefore, questions were rephrased, broken up into smaller question units, or altered in other ways in order to achieve the goals set out by the researcher (Lindlof & Taylor, 2002, p. 195). This format allowed me to dig deeper into the issue and forge new territory in which was not anticipated. The order of questions followed a funnel format, proceeding from broad, open questions to closed questions that seek specific information (Frey et al., 2000, p. 277). By starting with open, non-directive questions, the participants were given a better opportunity to talk freely about themselves and their scene (Lindlof & Taylor, 2002). The interview questions appear in Appendix B.

Analysis

I conducted the interviews and transcribed them. Lindlof and Taylor (2002) explained that when the researchers conduct the transcription themselves, it allows them to listen more closely to the conversation and pick up on themes, issues, or contradictions that may not have been noticed in real time. I then analyzed the data using theoretically driven qualitative thematic analysis. To do this, I started by thoroughly reading all of the transcripts to experience total immersion and to attain a broad sense of the data (Baxter and Babbie, 2003). I then used the constant comparative method to conduct open coding. The constant comparative method involved examining each piece of data and determining how it was the same or different from the categories (Cresswell, 1994; Frey

et al., 2000). Coding categories were developed using concepts from stigma communication (Smith, 2007) and stigma management communication (Meisenbach, 2010).

The constant comparative method was used until saturation was reached. Cresswell (1994) explained that saturation occurs when no new categories need to be created to account for the data and new cases do not add any new information to the current categories. Once the thematic analysis was complete, I conduct member-checking, which is the process of seeking feedback from participants about the credibility of my findings (Baxter & Babbie, 2003). To do this, I emailed my findings to each of my participants, so they could ensure I represented their contributions accurately. Participants reflected that the results were accurate. This concluded thematic analysis.

CHAPTER 4

Results

This chapter paints a picture of how veterans with PTSD experience and manage

stigma by presenting the results from the thematic analysis of 10 one-on-one interview

transcripts. For clarity, participants will be referenced by a randomly assigned number (1-

10). The thematic analysis was guided by four research questions:

RQ1: Which stigma management communication strategies are used by veterans

who are stigmatized for having PTSD?

RQ2: How, if at all, do veterans with PTSD use stigma management

communication strategies that do not appear in Meisenbach's (2010) theory of

stigma management communication?

RQ3: How do participants describe *military* discourse about PTSD?

RQ4: How do participants describe *public* discourse about PTSD?

The results of each research question are presented in the following sections*: Stigma

Management Communication Strategies* (RQ1), *New Stigma Management*

Communication Strategies (RQ2), *Communicating Stigma in the Military* (RQ3), and

Communicating Stigma in Society (RQ4).

Stigma Management Communication Strategies

RQ1 asked which stigma management communication strategies are used by

veterans who are stigmatized for having PTSD. In review, stigma management

communication framework was developed by Meisenbach (2010) to improve the

understanding of stigma management and outline the available options for those who

suffer from stigmatizing identities. In this study, participants managed stigma by using

strategies of accepting, avoiding, reducing offensiveness, and ignoring/displaying

strategies. Further, participants sometimes blended stigma management communication

strategies (e.g., participants evaded responsibility and engaged in denial at the same

time).

Accepting. Stigmatized individuals may accept public expectations of stigma and

its applicability to themselves, and therefore, incorporate it into their sense of self

(Meisenbach, 2010). Participants in this study accepted the stigma that surrounds PTSD

by *openly displaying and/or disclosing* their stigmatized attributes. Some participants

disclosed about their experiences with having PTSD. For example, participant 9 stated,

"there is a stigma for mental health" and admitted that he "truly believed that you suck it

up and drive on" while he was leading soldiers until he was having serious mental health

problems himself. He disclosed that PTSD starts to weigh on a person, describing that

"it's like a bottle of champagne. You just keep shaking it up until you pop the cork and

it's everywhere. You don't know how to get it back in the bottle." Participant 9's

comment "you suck it up and drive on" is identical to research by the National

Academies of Sciences (2018) where military personnel were "chastised" for "not

sucking it up and driving on" (p. 283).

Stigmatized individuals may also use *humor to ease comfort* as a way of

indicating to others that he or she accepts the stigma's existence (Meisenbach, 2010).

Participant 4 described humor as a response to a situation in which he experienced PTSD

symptoms. The participant shared a story where he found himself "jammed" between two

elderly women in a Walmart aisle and became anxious and had to leave. When

recounting this experience, the participant said, "I joked about it. I laughed about it. I felt

silly because I was in Walmart. I'm not going to get stuck with an icepick at Walmart and have an old lady jump me." The participant went to work and told the story as a joke and described that "half of the people at [his] workplace thought it was just hilarious that [he] got anxious at Walmart and had to leave." Meisenbach (2010) described that humor can reduce tension and allow for easier interactions between stigmatized and non-stigmatized individuals.

Participant 7 also described using humor as a response to negative communication about veterans with PTSD, such as comments like, "I don't know what to say around you," "it's like walking on eggshells," or "I don't know what to do because I don't want to trigger you." In response, participant 7 thinks it is "hilarious" and he laughs, stating "I think the most important part of dealing with certain phrases that people are saying is to keep a sense of humor because if you don't you'll literally go psycho."

As another form of acceptance, some participants *blame the stigma for the negative outcomes* that they have experienced. Meisenbach (2010) explains that this strategy can be used as a source of comfort and can be used to protect self-esteem. The negative outcome that participants described was that employers do not want to hire veterans who have PTSD. For instance, participant 4 described that employers "don't want to hire someone with PTSD because they don't know what happened [in regard to war experiences] and when that switch is triggered, when the animal is let out of the cage, they don't know what's going to happen." Similarly, participant 10 suggested employers are "skeptical" of veterans with PTSD, especially if the job involves firearms. "I know some [employers] are nervous to hire somebody who has PTSD or a veteran in general because they're going to snap, or they have a chemical imbalance in their brain," he

stated. Further, participant 10 argued this happens because society is "branding anyone with mental health as somebody that's a liability."

Those who accept a stigma's existence and internalize the stigma are likely to *isolate themselves* (Meisenbach, 2010). Participant 8 shared that there were times when he locked himself in his room because he "just wanted to be alone" and "did not want to be around anyone." Participant 9 isolates himself more than most people he knows and describes himself as a "lone wolf." Likewise, when asked if he ever felt pressure to isolate himself due to his PTSD symptoms, participant 10 responded, "every day." Meisenbach (2010) explained that this coping strategy "is minimally discursive in its nature since it involves limiting communication with others, yet this includes a lack of communication as a discursive strategy" (p. 280). Therefore, veterans may seek comfort from being stigmatized for having PTSD by isolating themselves.

One of the more prominent ways participants managed stigma in this study was through the acceptance sub strategy of *bonding*. Here, stigmatized individuals socialize with other stigmatized individuals (Meisenbach, 2010), as this provides mentorship and peer support (Lebel, 2008). Participants expressed ease and comfort in talking about PTSD with other servicemembers and veterans. For example, participant 3 described that it is more meaningful to talk to past unit members because of the bond they have. Participant 1 described this bond exists because "you have a brothership where you can talk to the person, and they understand you, and you understand them." Likewise, participant 8 expressed that it is easier to talk to other veterans because they have had the same experiences and can better relate to one another compared to civilians, who do not understand.

Avoiding. Avoidance strategies stem from stigmatized individuals accepting the existence of a particular stigma but challenging that the stigma applies to themselves specifically (Meisenbach, 2010). One way an individual may attempt to avoid stigma is by *hiding the stigma attribute*. Meisenbach (2010) explained this strategy is also known as "secrecy" or what Goffman (1963) described as restricting the display of stigma failings. Participants expressed situations in which veterans will hide their PTSD (the stigma attribute) while actively serving. In fact, hiding the stigma attribute appeared to be a useful stigma management strategy among higher ranked military personnel holding leadership positions because they feel pressure to take charge and be leaders. For instance, participant 5 described concealing PTSD symptoms because he was newly assigned to a leadership position where he was trying to earn respect and establish himself as a leader. He shared a situation in which he lost a soldier and felt the need to "be a leader" and tell the 115 people in his command he was "doing fine," when in reality, he described:

> Hell no. I wasn't doing fine. I had no idea what I was doing. I felt terrible. I had
> just lost one of my best soldiers. He was an E5. He was the same age as me. I had
> his family asking me what I did to prevent it and what I did to cause it. I felt a
> tremendous amount of pressure, but I was just in that go, go, go, 'I'm doing fine,
> worry about other people.'

Likewise, participant 9 also described feeling pressure to conceal his PTSD as a leader, stating:

> Trying to be a leader of people who are being asked to go kill other human
> beings, it takes a certain level of mental focus, of mental strength, and when you

start to lose that edge, and you start to not be able to do your job because of those

things… I think that's the stigma behind it.

This same argument appeared in previous research by Hernandez et al. (2016) who

argued that service members are expected to "maintain a high level of mental, technical,

and physical preparedness, so that they can perform duties when called upon" and are

"highly dependent on other members of their units to endure mission execution and

completion" (p. 190). As a leader, participant 9 felt pressure to conceal symptoms of

PTSD because he did not want others to think he had lost his edge as a leader. In fact,

when asked if he felt he needed to appear tougher in a leadership position, participant 9

responded:

Absolutely. I don't think, on the enlisted side, I don't think they realize quite how

much pressure there is. I was a 25-year-old kid in charge of 40 guys in North-

West Bagdad. All of them had more experience than me. My platoon Sargent was

probably 25 years old, most of his non-commissioned officers were middle 30's

or upper 20's so they'd been doing it for a while. So, to keep it together, there

could be no chinks in my armor. I had zero choice but to try to be strong.

Military personnel in leadership positions are not the only ones who conceal or

hide their stigma attribute (PTSD), and military culture may partially be to blame. Often,

military servicemembers refrained from talking about PTSD, as participant 10 stated

"during active duty, discussing PTSD wasn't something anyone wanted to get into too

much detail about. There was a risk of losing your contract or getting kicked out of the

military." Other participants hid PTSD because they felt the need to put feelings aside

and go to work (P2, P4, P7).

Participants also discussed hiding PTSD after returning from war and transitioning to civilian life. For example, participant 9 described never talking about his PTSD in the early months after returning from war:

> When I was traveling down to the eternally black abyss, I didn't want anybody to know. My ego was still holding onto what the human ego holds onto. I didn't want anyone to know that I was suffering, because of the stigma. Some of the symptoms are embarrassing. Everyone wants to be a well-wired circuit, you know?

Another participant (6) expressed feeling pressure to conceal PTSD while working in law enforcement. He argued that there are questions about whether or not someone with PTSD should be allowed to carry a gun, explaining that "if the diagnosis is public and out there, anything that happens could bring up questions. They're going to automatically say, 'Oh, well of course, he has PTSD'." Additionally, participant 10 admitted to concealing his PTSD because he does not want to "be seen as a threat." Lastly, participant 7 conceals his PTSD symptoms and refuses to seek medical help due to his belief that people need to be tougher, as he articulated, "I'll conceal whatever I need to conceal that I feel necessary in order to portray or be viewed as a legitimate stone." This revelation from participant 7 about wanted to be portrayed as a "stone" helps to solidify scholars' argument that military culture promotes "stoicism," "invincibility," and "self-reliance" (Hernandez et al., 2016; Mittal et al., 2013; National Academies of Sciences, 2018, p. 283; True et al., 2014, p. 4).

Overall, the concealment of PTSD during and after military service is consistent with the results of a study by the National Academies of Sciences (2018) wherein

veterans expressed they had a hard time believing they could share their concerns

regarding mental health without receiving backlash, even after leaving active duty. More

importantly, these examples of participants hiding their PTSD, and refusing to seek help

to avoid stigmatizing reactions, reiterates the major argument made by several scholars

that soldiers are reluctant to seek help for PTSD because of the perceived stigma

(Hernandez et al., 2016; Hoge et al., 2004; Hoge et al., 2006; Kim et al., 2010; Kulesza et

al., 2015; Mittal et al., 2013; Sharp et al., 2015; True et al., 2014).

PTSD diagnosis led one participant (6) to *attempt to stop or eliminate the stigma*

attribute, which is another avoidance sub strategy where a stigmatized person takes

corrective action to proclaim them self ex-stigmatized (Meisenbach, 2010). Participant 6

accepts that some of the negative communication about PTSD is accurate and this has

made him "work harder and harder to address [his] situation because [his] ultimate goal is

to get rid of the diagnosis." This strategy may not be useful for veterans who are having a

hard time overcoming PTSD, just as Meisenbach (2010) referenced this strategy is not

feasible for those who have been diagnosed with uncurable cancer.

A stigmatized person may *avoid stigmatizing situations*, an avoidance sub

strategy where an individual "discursively and physically chooses to avoid situations,

behaviors, and discussions that might involve public attribution of this stigma to them"

(Meisenbach, 2010, p. 281). Further, Meisenbach (2010) explains the individual may

avoid areas in which the stigma becomes visible. Participant 1 described avoiding a

stigmatizing situation that triggers his PTSD, claiming you will not find him at a street

dance (a social gathering in which people dance in the street to a live band) because the

environment triggers his combat mode. The same participant shared that a friend of his refused to spend time at a park with his family because there were too many people.

In response to negative communication about PTSD, one participant (8) stated, "I'll walk away… I'm quick to temper so I try to avoid that kind of conversation. If people are bashing I have to walk away." Further, hearing negative communication infuriates participant 8, as he admits, "this is going to sound crazy, but I can see myself hurting them, and that's the point and time I have to walk away." Although he feels frustrated by the negative communication, he chooses to avoid physical altercations. Similarly, participant 6 also stated there are times he just ignores negative comments because he is not going to fight over them. Another participant (2) described how she used to try to have a conversation with someone who was using negative communication about veterans with PTSD, but now she chooses to leave it alone:

> They are convinced that we are horrible humans and we're robots and monsters because we have PTSD. That's your opinion. I don't know where you got that from, but you can keep it. Its ignorance is bliss. I feel indifferent about it now because everyone has an opinion.

An avoider may deny a stigma applies to them as individuals by *making favorable comparisons* between themselves and others (Meisenbach, 2010; Miller & Major; 2000). One example of this strategy in use is participant 1 mentioning that even though he has PTSD, he is "lucky" to have all his limbs and that he does not mind his dreams whereas others may wake up sweating and breathing heavy. Here, the participant is accepting that he has PTSD (the stigmatized attribute) but is denying the stigma applies to him because he has not lost limbs and does not react negatively to nightmares. Some participants'

favorable comparisons served as grounds for not seeking help for their mental illness. For example, participant 3 never sought professional help because he "didn't want to be one of those guys." He stated, "I didn't think I was bad at all," and he did not want to "waste time with a doctor." He argued his problems did not seem as big and mental health professionals "could go help someone who has it worse." Participant 5, who also was never medically diagnosed, admitted to experiencing PTSD symptoms but they were "nowhere near the symptoms [he's] seen outwardly displayed by soldiers who have spent a lot of time in combat."

Making these kinds of comparisons ties in closely with people abusing the diagnosis of PTSD or what participant 10 referred to as "malingering." Malingering was described as "people trying to get additional disability payments by getting stuff on their record, claiming that they have something like PTSD." Other participants described situations in which veterans were abusing the diagnosis of PTSD, such as "faking it" to get out of work or to be medically discharged (P3, P4, P9). Participant 10 stated, "Malingering was always thrown around when it came to PTSD," and described that veterans did not think they did enough *compared* to others, such as killing people. He continued to detail a scenario where "so-and-so did way more than you'll ever do, so you shouldn't try to claim PTSD because you haven't done any of that" and "you don't have a right to talk about [PTSD] because you didn't get blown up." This suggests veterans with PTSD make favorable comparisons to others to determine whether their problems are serious or legitimate enough or if they will be considered what other participants have referred to as a "malingerer" or "shit bag." Participant 9 described how soldiers, at times, looked at other soldiers getting help and think, "okay, we're dealing with some shit too,

but we are still out there and doing it." Similarly, participant 5 recalled people saying, "You just need to get over it, we all went through something and we're all here right now," or "it could have been worse."

Reducing offensiveness. Reducing the offensiveness of a stigma happens when individuals accept the stigma applies to them but work to change how the stigma is perceived by others (Meisenbach, 2010). *Minimization* is a sub strategy where individuals highlight how the stigma attribute does not inconvenience or harm others. Participant 1 pointed out the CEO of Triple Canopy, the largest government contracting company in the United States, has PTSD and managed to become a multi-million-dollar company owner. Further, participant 1 argued that PTSD does not hold him back from living a normal life, such as being a parent and coaching his kid's sports teams. Lastly, participant 10 described running his own business and working with firearms while living with PTSD and participant 9 described succeeding in college. Ultimately, by showing that they still have jobs, success in school and/or a family, participants are showing they are not an inconvenience or harm to those around them even though they have PTSD.

Ignoring/displaying the stigma. The strategy of ignoring moments of stigma communication and displaying the stigma stems from a desire to challenge the stigma rather than passively accepting the stigma (Meisenbach, 2010). In this case, the stigmatized individual ignores stigma communication and continue to display the stigma attribute. Meisenbach (2010) explained that this strategy is similar to passive acceptance or displaying strategies but ignoring/displaying stems from a "desire to challenge" rather than passively accept public stigma perceptions (p. 284). This strategy is demonstrated by

participant 4 when telling himself and his fellow Marines that "you know who you are," stating:

> I didn't join the marine corps to prove myself to you. I didn't join the marine corps to prove myself to the next guy down the road, I joined for myself. These people that are making these negative connotations, negative comments, they don't know me. There's nothing that they are going to be able to say to take that away from me. I guess I ignore it. I don't think about it. There's not much to what they are saying.

Ignoring and displaying was also described by participant 3 who admits he concealed his PTSD symptoms for a while and then "quit caring about the stigma because if I give in to the stigma then it's just feeding the beast. And it's a lot better to just not do that, you have to feel what you feel, and it gets better." These participants are actively ignoring the stigma communication they encounter and choose to remain true to themselves despite having PTSD.

Blended strategies. At times, participants in this study blended stigma management communication strategies. Blended strategies were also used by participants in Hartelt's (2018) study, which found men managing stigma about pursuing foreskin restoration shift in and out of strategies, even within the same encounter. Hartelt (2018) referred to this phenomenon as "testing the water" and argued that testing the water is a practical strategy for others managing stigma related to taboo topics. The results of the current study support Hartelt's (2018) argument, as participants in this study tested the water as they attempted to manage stigma over the taboo topic of mental health.

Evading responsibility and denying. Two strategies most commonly blended together by participants in this study were provocation (sub strategy of evading responsibility) and discrediting the discreditor (sub strategy of denying). Provocation allows people to distance themselves from stigma because they assign responsibility for the stigma to something beyond their control (Meisenbach, 2010). In addition, individuals may discredit the discreditors by questioning the credibility of those promoting the stigma (Meisenbach, 2010).

Participants in this study expressed that veterans with PTSD are misunderstood because many people do not understand what they went through during deployment. For instance, participant 6 stated civilians "don't have any real understanding of veterans and what they've gone through." Similarly, participant 2 claimed there is "not an in-depth understanding of what we go through," and participant 7 believes "civilians have a hard time actually understanding what post-traumatic stress is." When participants point to war experiences that lead to PTSD, they are evading responsibility through provocation. At the same time, arguing that members of society do not understand what these war experiences were like for veterans discredits the discreditors. The argument that surfaces in these comments is civilians who stigmatize PTSD should not be taken seriously because they simply do not understand. The blending of these strategies is also demonstrated in the reaction participant 1 has when civilians make comments along the lines of, "oh my god, they [veterans with PTSD] are crazy," as he responds:

> If you knew what [veterans] went through you would shut the hell up. Or if you
>
> want to know what they went through, why don't you join the army and come
>
> back and see what life's like. Walk in our shoes. If you understood that person

and what they went through, you would be trying to help that person, or giving

them a dollar, or be there for them to talk to, or just leave them alone.

Further, participant 1 argued civilians "don't want to know what I know, don't want to

see what I've seen, and don't want to feel what I feel." Again, the participant is pointing

to his unique experiences (which civilians have not experienced) that contributed to

attaining PTSD. Interestingly, these blended strategies come from contradicting

quadrants, as evading responsibility resides in accepting that the stigma applies to

self/challenging public understanding of stigma whereas denying resides in challenging

that stigma applies to the self/challenging the public understanding of stigma (represented

in Table 2).

Acceptance and denying. In one instance, a participant blended passive

acceptance (sub strategy of accepting) and discrediting the discreditor (sub strategy of

denying). In response to negative communication about PTSD, one participant (4) stated:

I just keep my mouth shut. You don't need to pick a fight about it, you don't need

to stand up because you're not going to change someone's mind by being

aggressive. They're never going to understand. You're not going to make them

understand in a quick little 5-minute argument. In my head, you just keep

walking. There's nothing to do with it. You know how you are. They know how

you are. That's just how it goes.

Individuals engage in passive acceptance when they present a "no comment"

stance. Therefore, by stating "I just keep my mouth shut," the participant is engaging in

passive acceptance. However, he continues to explain that people are never going to

understand PTSD, and therefore discredits the discreditors.

These blended strategies come from polar opposite quadrants, as acceptance resides in accepting the stigma applies to self/accepting the public understanding of stigma. On the other hand, denying resides in challenging that the stigma applies to oneself/challenging the public understanding of stigma (represented in Table 2). When a stigmatized individual intertwines, synthesizes, and/or shifts between multiple strategies in one communication exchange, they could be feeling conflicted as to whether they accept or challenge the stigma internally and/or publicly. Ultimately, the stigmatized individual ends up presenting an ambiguous message in response to stigma.

New Stigma Management Communication Strategies

This section presents the results of RQ2, which asked how, if at all, veterans with PTSD use stigma management communication strategies that do not appear in Meisenbach's (2010) theory of stigma management communication. The first strategy presents the difference between denying a stigmatized attribute (PTSD) versus denying the stigma that surrounds the stigmatized attribute. The next strategy presents how stigmatized individuals will accept stigma on behalf of a group, rather than themselves. Lastly, forced and unintentional disclosure is discussed.

Denial of stigma attribute versus denial of stigma. In many cases, participants denied having the stigma attribute (PTSD as mental health condition) rather than the stigma attached to the stigma attribute. The act of denying that the stigmatized attribute exists is not captured in the original conceptualization of stigma management communication (Meisenbach, 2010). When describing simple denials, Meisenbach (2010) explains how the individual "simply states that there is no stigma" and that "this

straightforward response challenges both the existence of the stigma and its applicability to the individual" (p. 284). Again, denial of the stigma attribute is not mentioned.

I argue that participants are still managing their stigmatized identity by denying stigma—not by addressing the existence of stigma about PTSD, but by denying the existence of the attribute that would evoke that stigma. This situation is demonstrated by participant 9 who denied his PTSD diagnosis because he did not want to have that label. He recalled saying, "no, I don't have PTSD" because he "didn't want to be anything but 100%." He did not want to acknowledge the "demoralizing" experience and thought he could "just get through it."

Other participants challenged the medical explanation of PTSD, as participant 4 described, "People call it a sickness, and it's not. It's not a disease, there's nothing wrong with these individuals. It's just a mindset for them." In addition, two participants discussed their distaste for the word "disorder." For example, participant 8 explained:

> I don't consider it a disorder and I think the VA is trying to change that: post-traumatic stress disorder to just post-traumatic stress. I think there is a big stigma that comes from that word. A lot of veterans don't want to be classified as 'I have a disorder.'

By challenging the medical definition of PTSD, I argue that participants are working to deny the stigma. Meisenbach (2010) described that denial strategies are "primarily proactive in nature and represent what other scholars refer to as social activism, challenging, and public education techniques" (p. 283-284). Participant 7 has been very active in his advocacy for eliminating "disorder" from "post-traumatic stress disorder"

and he has transitioned his usage from "PTSD" to "PTS." The participant explained that

he prefers "PTS" because:

> calling it a disorder is incorrect in my opinion but that's just my personal opinion.
>
> I understand that there's scientists or doctors that have their certain way of doing
>
> things, but I think calling it a disorder, for one, is completely incorrect and it's
>
> kind of degrading. We should stop calling it a disorder because it's not a disorder.
>
> That's a negative connotation and that automatically puts you in a circle that
>
> segregates you.

When participants challenge the medical explanation and definition of the stigma

attribute, they are working to deny the presence of the stigmatized attribute, rather than

the actual stigma.

Further, some veterans deny stigma by claiming that PTSD does not exist

altogether, again denying the stigmatized attribute rather than the stigma itself. For

example, participant 3 had a friend who had lost his legs tell him that PTSD was not real.

Similarly, participant 6 recalled military service members referring to PTSD as "non-

existent" and "made-up."

Acceptance on behalf of others in the stigmatized group. Many participants

engaged in a situation in which they accepted the status quo of the stigma and accepted

that it applies to other people of their same stigmatized group, yet they were ambiguous

as to whether they accepted or challenged the application of the stigma to themselves. For

example, participant 8 stated:

> There are veterans out there that, you know, are violent. I'm not going to lie.
>
> There are some out there that are absolutely… I mean I would even call them

crazy. They've just completely gone off the scale. There's no bringing them back

down, and medication only does so much. Yeah, I would agree with the civilian

population and other people. Yeah, some of it's true.

Further, the participant urged that people shouldn't "blanket the whole group of veterans"

because "we're not all like that, there's just a few that have really serious problems." The

participant, who openly admitted to having the stigmatized attribute of PTSD, accepts the

status quo of the stigma and accepts the applicability to some veterans with PTSD, but is

ambiguous as to whether he accepts this stigma in terms of his own identity.

Another participant (6) simply stated that some of the negative communication

about veterans with PTSD is accurate, but sometimes it is not. Again, this participant

does not take a stance on their own potentially stigmatized identity. Likewise, participant

1 accepted the stigma on behalf of the stigmatized group by agreeing that "some people

have their demons that they cannot control." Ultimately, I argue that these participants

are still managing stigma, but doing so by accepting the status quo and the applicability

to the stigmatized group. This differs from Meisenbach's (2010) stigma management

communication strategy of accepting since the applicability is applied to a group, rather

than the self.

Forced disclosure and unintentional disclosure. Hartelt (2018) described that

some participants in his study were forced to disclose their practice of foreskin

restoration because they were "found out." One participant from the current study

described a situation that aligns closely with forced disclosure, as he did not seek

diagnosis or treatment from a health professional for several years. A PTSD diagnosis

came about when he was visiting the doctor for a different health matter, one his wife

convinced him to go in for. When participant 6 was officially diagnosed with PTSD, he felt "angry" about it and "wished it never happened" because he views it as a weakness in himself. I argue that this situation aligns with forced disclosure of a concealable stigma because the participant did not seek this diagnosis and described working hard to rid of his stigmatized attribute (PTSD). In this case, the disclosure of PTSD to others was not necessarily forced, but it was an unintentional discovery of his own PTSD that the participant did not want to happen.

Communicating Stigma in the Military

This section addresses RQ3, which asked how participants describe *military* discourse about PTSD. Much of the military discourse described by participants in this study is consistent with previous research on military stigma, which argues the culture of the military stigmatizes mental health problems (Hernandez et al., 2006; National Academies of Sciences, 2018). Major themes that emerged are 1) military stigma about mental illness, 2) changes in military perceptions of mental illness, 3) stigma communication about PTSD, 4) the importance of comradery between military service members, and 5) how the diagnosis of PTSD is sometimes abused.

Military stigma about mental illness. Military stigma is based upon "military enculturation that seeking mental health services would be discrediting or embarrassing, cause harm to career progression, or cause peers and/or supervisors to lose confidence in members' ability to perform assigned duties" (Hernandez et al., 2016, p. 191). Veterans in the current study described that military stigma was much stronger in the earlier operations following the 9/11/2001 terrorist attacks. Toward the beginning of the wars in Iraq and Afghanistan, no one wanted to talk about mental health problems like PTSD, as

participant 6 claimed, "Early on, nobody wanted to discuss it at all," and participant 9

stated, "I don't really remember PTSD being a talked-about term when I was first

serving." Similarly, participant 8 stated, "No one really did talk about it. It's kind of one

of those things, especially when you're in and still deploying and training, you don't have

time to talk about it." Participant 2 described that they had to put symptoms of PTSD

aside because they did not have the ability to say, "I need to go to the doctor" while

overseas. Instead, they just had to keep going. Participant 7 stated:

> When you're in the military you're not allowed to worry about your feelings. You
>
> get over feelings. You don't put those things… you don't have them, basically.
>
> You put them aside because you have to take care of what you have to take care
>
> of.

Sometimes the motivation to put feelings aside and keep moving forward came

from higher ranked military personnel, as participant 4 shared that his commanding

officer urged that "it didn't matter what's going on at home, doesn't matter what's going

on in your life, when you show up to work, you bottle everything up into a cargo pocket,

and you go to work." Participant 4's experience with his commanding officer aligns with

research published by the National Academies of Sciences (2018) which showed veterans

were severely chastised and discouraged from reporting any medical issues that showed

weakness. In a culture that promotes "prioritizing the needs of the unit over the needs of

the individual" (True et al., 2014, p. 4), a soldier is apt to brush feelings aside if a

commanding officer tells him to do so. For example, in a study of 1,939 military

members, of those who screened positive for a mental health disorder, 23 percent marked

"my commander or supervisor might respect me less" as a barrier to seeking treatment

and 7.8 percent marked "my commander or supervisor has asked us not to get treatment" (Hoge et al., 2004, p. 23).

The lack of communication about mental health problems described by previous participants and feeling the need to put feelings aside to get work done are examples of the ways military culture sets a standard for how military personnel should act. True et al. (2014) argued military culture promotes "stoicism." Stoicism is defined as "the endurance of pain or hardship without the display of feelings without complaint" (Dictionary.com). Through not being allowed to worry about feelings, not having feelings, and putting feelings away to get work done, as participant 7 described, soldiers can and must achieve this standard of stoicism. One could argue that another way to remain stoic is not to speak of their mental health problems at all.

Along the same line, previous research by Mittal et al. (2013) argued military culture promotes "invincibility" among soldiers, and acknowledging being anything less than invincible, such as experiencing mental health problems, is likely to be regarded as a sign of weakness that may pose a threat to the soldier's career. The career threat to which Mittal et al. (2013) refer is consistent with several comments made by participants in this study, who described that career woes are another reason veterans stay silent about their mental health problems. For instance, participant 8 described the consequences of talking about PTSD while being an active member of the military, arguing that if one starts talking about mental health problems, then "they are just going to yank you. You're not going to… nothing more is going to be said about… you're just going to kind of disappear from your unit. What happens to you, happens to you." Participant 1 also described how soldiers fear demotion and recalled his own demotion experience:

They are afraid that if they say or go up to a commander or platoon Sargent and say, 'Hey, I've been having nightmares. I think I need to see someone…' They don't want to do that because some of them are afraid, 'If I go see someone, they're going to pull my rank or knock me down in rank. They won't let me go from E4 to E5.' They wanted to go up in rank. 'They're going to make me non-deployable.' I had so much stuff wrong with me that they said, 'You know what, you're not going to ranger school. You're not getting your next rank.'

These perceptions and experiences align with previous work on military stigma (Hernandez et al., 2016). Further, the threat that a soldier is going to be "yanked" if they expose any sign of mental health problems, or act anything less than "stoic" or "invincible," becomes enough of a reason for soldiers to conceal their symptoms and struggles and avoid talking about it.

Participants still had a hard time talking about PTSD even after losing unit members to suicide. Participant 8 argued, "It's not until people start offing themselves that it really hits home and then, you know, when people commit suicide, it brings that conversation up of mental health, but no one wants to go there." This participant offered that he had lost 13 buddies since 2010, six of whom took their own lives within the first 90 days of returning home. He explained, "Again, it's something that no one wanted to talk about. And when it happened, everyone just kind of said, 'yeah, we need to talk about this stuff,' but no one actually did." Participant 5 described that the issue of suicide among veterans with PTSD is "rampant" and "numbing," stating:

We go to these memorials and there's no emotion. There's no sadness. There's no happiness. There's no celebration of life. It's just going through the motions. It's

like, 'Oh, we have to do another memorial.' Read some bible verses. Sing a song.

Listen to the speeches. Play taps. Salute them one last time.

Participants said there were some attempts made by the military to check for

PTSD and to prevent suicide. Participant 8 described pre-deployment and post-

deployment health assessments and mandatory classes on suicide, mental health

awareness, and buddy awareness. However, he described it as a "check in the box."

Similarly, participant 10 described the military had a "very standardized, cookie-cutter

approach" in terms of safety debriefings and annual training but "everyone knew that that

training was just for the sake of saying they [the military] were doing it." Here,

participants are describing that there was an effort being made from the military to

prevent suicide, but soldiers did not perceive it as authentic.

Changes in military perceptions of mental illness. Participants described

negative discourse about PTSD in the military and suggested military stigma was

stronger in the early years of OIF and OEF. However, they also pointed toward a positive

shift and detailed their perceptions of the military attempting to fix problems surrounding

mental health stigma. For instance, participant 7 explained a shift from PTSD being

recognized as a weakness to now being recognized as a serious health concern.

Participant 4 described that when he first started hearing about the issue of PTSD, he was

an "18- or 19-year-old boot" and would hear people say an individual who had PTSD

was just a "weak individual." Now, they've [the military] realized, "it's an issue, it's a

sickness, it's a lack of support from the government" The participant claims mental

illness in the military is regarded as a big issue now.

Similarly, at the time of participant 2's deployment (2006-2008), she did not view the military as supportive of those who developed PTSD, because seeking help was never encouraged and mental health problems were seen as a weakness most of the time. Now, the participant argues PTSD is talked about more openly because they [the military] realize the seriousness of the situation – a situation the participant refers to as "horrid." Participant 7 detailed a major effort by the military to increase awareness of PTSD:

In 2007, there was a large push from the military to, and this is obviously my point of view- I could be 100% wrong, in 2007 there was a large push from the military to increase awareness for PTS [PTSD], and they didn't know what they were doing. Like anything, you know, the first time human-beings tried to map the human genome and DNA, we didn't know what we were doing the first couple years, we were just beginning it. Do you know what I mean? That's how it was in the military. That's how a lot of things are there. But they did try. They were trying to reach out. They were trying to justify a purple heart for if you were in an IED (improvised explosive device) and you didn't exactly receive a life, limb, or eyesight injury, but they were trying to justify a purple heart for you and I think they actually did give purple hearts for IED injuries that were not life, limb, or eyesight. So, they were trying to create awareness there.

Awareness may be a good start, but participant 5 claimed awareness is not enough to fix the problem. When asked how he wished the topic of PTSD was talked about, participant 5 responded:

I wish it was more than raising awareness. I wish it was more educational as to how to help. Some of the groups, like 22 for 22, does a good job of raising

awareness, but if you ask someone, 'Hey, have you heard of 22 for 22?' and they

say, 'Yes' and then you ask them, 'so I was talking to my buddy, he went to Iraq

6 years ago, and he is becoming more distant. I've been trying to spend more time

with him, but he tends to get down this time of year. What do you think I should

do to reach out to him?' and they'll respond, 'I don't know.' Like yeah, I did

some pushups, but I don't know how to actually address this issue.

The problem participant 5 describes is even though there is awareness about veteran

suicide, people still do not know how to react to a suicidal situation, and that is unhelpful.

Participant 5 continued to explain a new technique he is seeing in the military that

is "not necessarily telling people how to prevent suicide" but is instead "teaching people

how to have good communication skills." The military is starting to teach soldiers about

active listening, eye contact, reading body language, and being able to hold someone's

attention. Further, soldiers learn techniques to assess nonverbals and be able to "see

inside or behind the curtains that [a veteran struggling with PTSD] is putting up."

Participant 5 argued that by teaching these "building blocks in communication skills,"

people now "understand how to have that direct conversation, they know the nonverbal

cues they need to look out for, you learn how to analyze a whole situation outside of what

the person is saying."

Further, participant 5 said the military is recognizing soldiers when they employ

these communication skills. Participant 5 shared a story about how a soldier (who had

just gone through this communication training) was able to convince a suicidal soldier to

seek professional help. The soldier who helped was recognized in front of others, so they

saw someone else being rewarded for it, saying, "Hey, we want to thank you and reach

out to you and let you know you are doing a fantastic job," "you did the right thing," and "your actions were honorable and respectful." Ultimately, what participant 5 wants to do in his leadership position is reframe what resilience means in the military. Currently, he argues that "no one talks about the people who get help and they'll never talk about it because they don't want to seem weak" and they "don't want people to know they got to that point." Instead, participant 5 wants to show other veterans that soldiers who sought treatment for their PTSD are more resilient because of it and that "they were strong enough to go forward and get help."

Overall, there is more support for PTSD now than ever, as some participants argued the military is now recognizing better ways to deal with mental health problems and is looking out for soldiers. For example, participant 5 argued the military is trying to take more of a family approach when they say, "Hey, these are your brothers and sisters, we need to take care of each other." Further, he argued that the younger soldiers have been taught nothing but, "you need to deal with these issues, you need to talk to people, and understand you have resources available to you." Further, participant 4 (who holds a leadership position) argued that brushing problems aside and driving on is incorrect, stating this approach "isn't right because that's not how it works." Participant 4 stated, "You have to make sure everything is okay. Make sure they weren't having issues at home. If they are having mental issues, they need to be taken care of." In regard to how the military deals with PTSD and mental health stigma, participant 5 described that in the end, there are a lot of areas that still need improvement, but the issue is "finally coming to light. We're opening up curtains and exposing issues."

Stigma communication about PTSD. Participant 6 described that even though there has been a positive shift from negative to positive in regard to the discourse about PTSD and support for PTSD in the military, there are still many people who consider PTSD a weakness. In fact, some of the participants in this study stigmatized themselves or other veterans with PTSD by using stigmatizing labels, holding veterans personally responsible for seeking help, and/or eliminating the stigma. For example, participant 7 chooses not to seek professional help for PTSD, despite "freaking out because [he] thinks about picking up [his] battle buddies' brains off the floor every day." This act of recognizing symptoms of PTSD but deciding to not seek help also presented itself in a study of 303,905 soldiers by Hoge et al. (2006) where 78% of participants acknowledged having some mental health problems, but fewer than 45% were interested in receiving help. Instead of seeking help, participant 7 conceals symptoms of PTSD due to the belief that people need to be tougher:

> We need to be tougher. We need to be tougher people. Just man in general. I'm not saying man as gender, I'm saying man as the human race. We need to be tougher people. We need to stop being such Jell-O. Stop worrying about people being offended or hurting their feelings all the time you know? We just need to be tougher people so like, yes, I hid it. Or I'll conceal whatever I need to conceal that I feel necessary in order to portray or be viewed as a legitimate stone. You know? I don't think we need to be fluid and beatable right now. I think what we need is fixed people.

Further, participant 7 argued that, ultimately, it comes down to whether or not the veteran is willing to stand up and move forward past their PTSD, stating, "Are you going to stand

there and let it kick your ass or are you going to get up and do something about it?" Here, the participant is alluding to the veteran's personal responsibility to get help and overcome PTSD. Personal responsibility is a stigma communication attribute where a stigmatized individual is assigned responsibility for attaining their stigmatized condition and/or has control over eliminating the stigma (Smith, 2007).

Other participants combined personal responsibility with labeling. Labeling is another stigma communication attribute in which stigmatized groups are given labels to bring consideration to the group's stigma and differentiates them from those who are considered normal (Smith, 2007). In this case, those who are unwilling to take on the personal responsibility of seeking help and instead choosing to take their own lives are labeled as "weak." For instance, participant 4 admitted to finding weakness in veterans who choose suicide over seeking help, admitting, "Personally, even myself, I do think there is a touch, even my friends who kill themselves, I do see a touch of weakness there, because they couldn't ask for help. They couldn't turn around and try to figure out how to get help." Similarly, participant 1 stated that:

> If you've got a problem and you know it, you're going to go and try and get help before you take your own life. The way I look at it, if you're not going to go get help it means you're weak. You're not weak, but I don't know… If you need help, go get it.

Participant 6 engaged in self-stigma (Corrigan & Rao, 2012) by labeling himself as weak for being diagnosed with PTSD and wished the diagnosis never happened. When asked why he felt that way, he responded, "Because I am an old timer and to me, it's kind of a weakness." Further, when asked if he still views the diagnosis as a weakness, he

admitted, "I do. Yes. In me. I don't hold others to the same standard that I hold myself though. That's a little wrong, but that's the way it is." Even though the participant denies stigmatizing other veterans with the same condition, he admits to stigmatizing himself as being weak.

Importance of comradery between veterans. One area where participants perceive the support of PTSD in the military is through veteran-to-veteran interactions and relationships. If with nobody else, participants expressed ease and comfort in talking about PTSD with fellow military servicemembers. Participants referred to this special relationship between servicemembers as a "brotherhood," "brother-ship," "comradery," and/or "bond." Participants explained that other veterans hold a better understanding of the experiences of war and that military servicemembers hold a certain level of respect for one another. For example, one participant mentioned there are only two people he will ever talk to about PTSD. "One was with me in the marines, and the other one is a really close friend of mine who was in the marines, but not in my unit," he stated. When asked why he chose to talk to them about PTSD, the participant responded:

> We experienced everything together, so we can kind of, we know what each other is talking about; what the feeling was like at that point in time. And we've both dealt with the same stuff outside of the marine corps for the most part. We can connect in a certain way and we feel comfortable and trust each other. We were in the same job, different unit, different deployment, but for some reason, we can converse at that level.

Likewise, participant 3 prefers talking to people in his unit because it is more meaningful due to the strong bond they share, describing comradery with everybody that is hard to break:

> It's just a bond. I still talk to a lot of people who were in my first unit, even my second one. And that's just because we had that bond. I think we kind of support each other… If I had a good friend from high school, I probably still wouldn't take it as much as someone who has been by my side through the hard times. I think they know what to say, it's just not as meaningful as another veteran – even if it's the same exact words.

Another participant (1) described this special bond as "brotherhood." He recalled how he and other members of his unit "talked until two in the morning, drinking beer and just chit-chatting about what we did, who we lost, and what went good." He continued:

> You have the brothership where you can talk to that person and they understand you and you understand them. I know what that person went through that was with me and how this firefight when down or the patrol went down. I remember it. They remember it.

Participant 4 said this type of "brotherhood" relationship extends across military branches, as he explained:

> They may have been a cryptologist in the navy and you were an infantryman in the army, but they kind of have a certain understanding. Like, "hey you know what, there's a lot of craziness that goes on being on the frontlines." And I think, every veteran has a certain respect for other veterans and I think it kind of stands out there.

In addition, participant 4 argued that even new service members understood the relationship, explaining that even if you take a brand-new individual in the service who is serving with somebody with PTSD, such as a Sergeant, the new individual is just going to know that "it's a salty service member who's been through some shit but knows what's going on." The Sergeant is still a part of "the family" even though he has seen issues and has issues. Further, participant 4 explained there are instances where he may not even know the other military member, but there's still a bond there. "You see people with tattoos that say, "I've got your six," participant 4 explained. "So, it's always that, 'I'm your brother, I'm your sister, we've got your back. You can come to us.'" He explained that he has seen servicemembers saying, 'please come talk to me whether it's at lunch or at night' or 'hey, come to the bar just to get it off your chest.' Participant 1 also expressed his willingness to talk to other veterans who may be having a hard time, even if he doesn't know them personally:

> If they say, 'hey, you know I was here, I saw this, I'm just having a bad day can I talk to you?' 'Psh, yeah, sure!' I know that tone, I know what happened there. 'Let's just sit down here on the bench and talk.' If that makes you feel better to go on with your day, you know? I mean I have no problem talking to other vets.

This special relationship between military service members provides an outlet to discuss taboo topics such as PTSD. Participants described how many military service members do want to talk about PTSD but find comfort talking with one another about the signs and symptoms of PTSD and what can be done to fix it. Participant 7 expressed that PTSD can be "very, very confusing" from a veteran's perspective, and he sees a lot of comments such as, "I don't know what to do about this," or, "I don't know if I should say

this." Participant 6 stated that the biggest thing he talks about with other veterans in terms of PTSD are all the negatives that come from it, such as "the suicidal tendencies, the inability to manage finances, the alcoholism, the self-medication, the over-medication, the side effects." In addition, military servicemembers will reach out to give support to others. Participant 4 stated he would check in on a buddy to see if he needed anything or if there was anything he could help him with. Further, members will also reach out to seek support, such as how participant 3 calls up his buddies (former unit members) when he is having a rough time, and they share their PTSD experiences with one another.

Abusing the diagnosis of PTSD. Many participants in this study brought up cases when the diagnosis of PTSD is sometimes abused. Participants described how some veterans use PTSD as an excuse for "for any important behavior" (P6), "getting out of work or to get medically discharged" (P3), and "to do bad things" (P8). For example, participant 3 saw soldiers using PTSD as an excuse, acting completely different outside of work or outside of certain people. Explaining further, participant 3 described a situation in which another military member would jump and act scared when grenades were going off during work but would act fine when they were off work in the barracks, stating that, "In the barracks where artillery was going off all the time, and the explosions would set off car alarms, but you wouldn't see him jump then and they [explosions] were clearly just as loud." Participant 3 is describing that the actions of this soldier did not seem authentic.

Participant 4 described a situation in which he compared a military service member to a close friend of his who had just committed suicide:

He was taking time off to go see the wizard, to go talk to the psychologist, he'd

take time off from work and was on all sorts of meds and wouldn't talk to

anybody. In the back of my mind, I always kind of knew he was faking it because

he didn't have any of these experiences as my buddy [name removed] to correlate

along with it. It's wrong to judge, but at the same time, as an employer in a sense,

it was tough to say, 'you don't have anything wrong,' if there really was.

Some participants brought up the argument that PTSD is not real. Participant 3

recalled a former military servicemember directly telling him that PTSD was not real, and

this was coming from someone who had lost his legs. When recalling words or phrases

military servicemembers used in regard to PTSD, participant 6 mentioned "non-existent"

and "made-up." The participant continued to explain that there are men and women

getting diagnosed because of anxiety that accrued due to almost having been deployed. "I

feel like the level has been brought down so low, the bar, that it has now become an easy

way to get paid for some people and that takes away from the men and women who are

truly suffering and have issues." This frustration was also voiced by participant 7, who

stated:

I just want to get off my chest and also the soldier who are considered combat

arms, when you have somebody who says, 'Oh, I have PTSD and I've gotten a

purple heart because I was in this accident," or whatever, when they say that they

have PTSD and they go get a certain claim from, you know like saying, "Oh I was

in, I get 50% disability because I have PTSD". That's, in my opinion, that's

horseshit. I'm amongst the very few that believe that it doesn't matter what your

MOS (military occupational specialty) is or what your job was in the military or

what you saw - if you go to a combat zone, everyone is going to have a certain

degree of PTS [PTSD]. If you don't realize that and you try to slice money off the

federal government because of it, you're basically a shit bag and you're a part of

the problem and not the solution.

In addition, one participant argued that in the past ten years, PTSD has almost become a

badge of honor, which participant 6 describes as "scary" because it is "almost like guys

have to say they have PTSD. It's almost like if you don't you're downplaying what you

did."

Communicating Stigma in Society

This section answers RQ4, which asked how participants describe *public*

discourse about PTSD. Participants in this study perceived much of society's views of

PTSD are negative, but they recognize there are those who view it from a positive

perspective, such as those who want to fix this issue. Some common themes include 1)

stigma communication in society, 2) civilians are perceived as misinformed and do not

understand veterans with PTSD, and 3) media have had a negative impact on society's

perception of the issue.

Stigma communication in society. Some of the public discourse described by

participants was stigmatizing according to Smith's (2007) theory of stigma

communication. As a review, according to stigma communication framework, stigma is

communicated through four attributes: labeling, marking, linking to social peril, and

assigning personal responsibility (Smith, 2007). Many of the veterans in this study

described stigmatizing content that aligns with the stigma communication attribute of

being linked to social peril. Individuals' stigmatizing identities are linked to social peril when messages highlight the danger that the stigmatized group poses to society.

Many participants highlighted how society sees them as a threat. For example, participant 6 described how society still considers veterans with PTSD "broken" and "untrustworthy," stating, "There's still a big push out there that anyone who has PTSD, you have to watch them or be careful of them. They're either weak-minded or they're violent or they're both. They think we are all flawed. It's a blanketed thing." Likewise, participant 1 described trust as an issue, stating that "you have to earn people's trust. You're not going to walk into a store and pull a gun and go nuts. I mean you need to just, I wouldn't say blend in but carry on with normal life." Participant 4 described the way people recognize when you're not blending in, because as a veteran who is trying to integrate into society, "you may be at work and start to have problems and think you need to keep yourself safe and watch your back" but "others recognize this and see it as an issue, think there is something wrong with you." Participant 1 also explained:

They [civilians] hear PTSD and they think, 'Oh, this person is crazy in the head. Be careful of them. You don't know what they're going to do to.' A lot of people think of triggers. Like, 'what triggers that person?' or 'what do they listen to for music? or 'what are their hobbies now?' And when you say that frickin' PTSD they think, 'what do they dream of? How do they sleep? What do they eat?' It's just dumb stuff like that. But yeah, one of the bigger things is 'what kind of dreams do you have?' or 'they're crazy' and that's why people go to get help because everyone thinks they are crazy and have nightmares.

Participant 7 also mentioned triggers, stating civilians feel like they are "walking on eggshells" because they do not want to trigger a veteran who has PTSD. Participant 4 described that society does not want to talk about PTSD because they think of veterans with PTSD as diseased animals. Other labels or phrases cited by participants include PTSD is "a sickness" or "an issue," and people who have PTSD are "blackouts," "crazy," "psycho," and are on "all these medications." Participants argued that a lot of these perceptions are derived from misinformation and/or misunderstanding about veterans who have PTSD.

Misinformation and lack of understanding about veterans with PTSD. On top of feeling stigmatized by the public, many participants expressed that civilians are misinformed about combat-related PTSD and there is a lack of understanding from society in general. Participant 2 described that there is not an in-depth understanding of what veterans with PTSD go through, stating, "People don't understand how to deal with us, or the different types [of PTSD], or finding an information bank to help people understand how to cope with a loved one that may have it." Similarly, participant 8 offered, "I don't think there is enough awareness. I mean, mental health stigma, you see it on the news every once in a while, but there's not a lot of information out there." In addition, participant 6 stated:

> A lot of civilians don't have any real understanding of veterans and what they've gone through. It makes them [civilians] think that they're [veterans] crazy and dangerous. That, in effect, hurts the veteran who is having issues because, in their mind, they know they are not crazy or dangerous which makes them even more off balance.

This lack of understanding and misinformation described by participants leads to veterans being apprehensive about talking about PTSD with civilians, as participant 1 described he will discuss PTSD with others who have PTSD but does not want to talk to "people that don't understand." Similarly, participant 8 stated that he has a hard time "correlating" to whoever he is talking to most of the time and that it is hard for them to "correlate" to him. Participant 2 described how she stopped discussing PTSD all together with her own family because her mother "had no idea how to deal with someone with PTSD" and would tell the participant, "Oh, you'll get over it. It's just a phase." Other family members told the participant she was just "faking it." The communication apprehension described by participants relates to the argument made by Boudewyns et al. (2015) that individuals may avoid a topic altogether if they expect fear or rejection as a result of talking about the taboo topic.

While participants expressed frustration over civilians being uninformed about PTSD and not understanding veteran's experiences, they also recognized that civilians will never understand and probably do not want to understand. For example, participant 6 stated, "If you didn't serve you have no… you're not allowed to say you understand. Because you don't." Further, participant 1 stated, "You don't want to know what I know, you don't want to see what I have seen, you don't want to feel what I feel." One participant described the closest that a civilian may get to understanding the experiences of a veteran with PTSD is someone who experienced the terrorist attacks of September 11, 2001 firsthand and survived.

Ultimately, participant 3 argued misunderstanding of PTSD exists in society because part of the story is missing:

You have to walk in their shoes. You have to try to understand them. It's like

judging a book by its cover, really. You don't really know what they are going

through. They could just be going through a rough time, and it happens to

everybody, but some people just go off the deep end and that's how the bad

reputation gets started. No one is going to read a story on someone who just did

okay.

Participant 3 continued to explain that the problem is that this "misinformed" reputation

is blanketed over all veterans but not everyone is the same, stating, "In the military, it's

so diverse…You have people from all different walks of life… Everyone's different so

you don't have a good idea of what they feel, like you haven't walked in their shoes for a

mile." Participant 3 was not the only one to discuss the media's role in how society

develops their perception of veterans with PTSD. This theme is discussed further in the

next section.

      Media portrayal of veterans with PTSD. In a recent study by Roscoe and

Anderson (2019), over 80% of participants reported having been exposed to stigmatizing

messages about veterans with PTSD through media (e.g., TV, movies, radio, and social

media). Likewise, many of the participants in the current study called out the media for

painting a bad image of veterans who have PTSD and perpetuating stigma. As participant

3 stated, "Veterans who have PTSD kind of have a bad rep," and further, "Everyone has

heard news stories on how someone who may have had PTSD killed themselves in a

parking lot or steals a car and runs some people over on a highway." Similarly,

participant 2 claimed:

Everyone has a TV nowadays. They turn on the TV and hear of one veteran that may have done something horrible or shot their family or someone else, or gone on a spree, whatever it may be, even from the White House jumper who even actually got into the White House who was an Iraq Veteran. Due to those things we have a blanketed notion that all veterans are a hazard.

Other participants offered similar hypothetical situations in which veterans with PTSD are poorly portrayed, including participant 4 who said, "If a marine beat up his wife and he had PTSD, that's all they're going to say. He was a marine with PTSD that beat his wife to death. That's going to be the story. There's not going to be any context as to what was happening." Participant 6 also claimed the media only share negative stories, such as "the guy who went crazy and killed his whole family or something in a drunken rage. That's the kind of story that was put out there. Anything short of that was never put out there." Participant 1 described how media "amped" how society viewed PTSD, making people think "it's so bad to have PTSD, oh my God, they're psycho." The nature of the words expressed in participants' hypothetical media coverage such as "crazy," "psycho," or being viewed as a "hazard" is stigmatizing under Smiths (2007) theory of stigma communication.

Overall, participants in this study perceived the media poorly portrays veterans and PTSD, which gives them a bad reputation in society (e.g., they are hazardous, psycho, crazy, murderers, etc.). This adds to the literature suggesting media share partial responsibility for perpetuating the stigma surrounding veterans who have PTSD (Roscoe & Anderson, 2018). This is a problem in relation to the findings of previous research that

reported veterans were less likely to partake in mental health treatments if they perceived greater levels of public stigma (Kulesza et al., 2015).

In review, this chapter presented the results of 10 one-on-one interviews with veterans who have experienced PTSD personally. These participants described managing mental health stigma using all six strategies outlined in Meisenbach's (2010) theory of stigma management communication: accepting, avoiding, evading responsibility (blended with another strategy), denying, reducing offensiveness, and ignoring/displaying. In addition, three new management strategies were presented: 1) denying a stigmatized attribute versus denying stigma about the attribute, 2) stigmatized individuals accepting stigma on behalf of a group rather than themselves, and 3) forced and unintentional disclosure. Participants revealed there is a strong stigma surrounding mental health in the military but described a positive shift in the increasing support for PTSD. Participants also perceive a strong stigma from society due to civilians' lack of understanding about war and PTSD experiences and poor portrayal of veterans in the media.

CHAPTER 5

Discussion

This chapter provides an in-depth discussion about each research question, the theoretical and practical implications from the results of this study, paths for future research, and this study's limitations. First, I briefly discuss how participants experienced communicated stigma about PTSD, as this provides a better understanding of how and why veterans engage in stigma management communication. Next, there is discussion about the stigma management communication strategies used by veterans with PTSD, the strategies that are blended together, and the new strategies that emerged. Finally, I discuss how participants described the discourse about veterans with PTSD in the military and in society, and further, how these findings highlight how mental health stigma becomes a barrier to seeking treatment.

Stigma Communication about Veterans with PTSD

Few participants in this study described being 'marked' by PTSD, but many participants described labels and how those labels can link them to social peril. Additionally, some participants engaged in self-stigmatization (Corrigan & Rao, 2012), by assuming personal responsibility for PTSD. Since concealable stigmas, like mental illness, are more difficult to 'mark' in comparison to a visible stigma such as burns on skin (Noltensmeyer & Meisenbach, 2016), it is understandable that few participants described this aspect of stigma communication. Participants in this study shared labels for veterans with PTSD (used by civilians and military service members) that are consistent with previous research (Mittal et al., 2013). Although these labels remain *associated with*

veterans with PTSD, that does not necessarily indicate that they are perceived as *accurate*.

Roscoe and Anderson (2019) observed that both civilians and veterans considered most stigmatizing labels about veterans with PTSD to be *inaccurate* (Roscoe & Anderson, 2019). However, compared with veterans, civilians were more likely to perceive some labels (i.e., those that suggest social peril like "unstable" or "dangerous") as *accurate*. This may explain why, in this study, all 10 participants believed that civilians view veterans with PTSD as a threat to society in some way, such as being linked to social peril (Smith, 2007). Whether civilians truly believe veterans with PTSD pose a threat to society or not, veterans' perceptions of this belief are important to recognize, because they shape veterans' beliefs about PTSD and how to respond to it. For example, participants in this study exhibited moments of self-stigmatization (Corrigan & Rao, 2012) when they expressed that they (individually, or veterans as a group) were personally responsible for acquiring and/ or managing PTSD.

These findings provide many avenues for future research on stigma communication in relation to veterans with PTSD. First, given the suggested discrepancies between label association and perceptions of label accuracy, future research can probe the relationship between label association and label accuracy, as well as the effects of these variables on mental health stigma. It may be that stigmatization through labels only occurs when labels are perceived as accurate. In terms of marking concealable stigmas, future research could continue to explore how people can be 'marked' discursively, and the effect of such marking on stigma disclosures. Finally, the findings

regarding links to social peril and personal responsibility offer important insights for creating campaigns to PTSD among veterans.

If future research confirms that civilians believe that veterans with PTSD pose a threat to society, campaigns could focus on providing information about PTSD and humanizing veterans with PTSD by depicting them as "normal" and non-threatening. This would also help to address some participants' beliefs that civilians simply do not (or cannot) understand their experiences and that this lack of understanding often comes from a lack of interaction with military members. In addition, if future research confirms the inaccuracy of veterans' perceptions of public stigma toward veterans with PTSD, campaigns could focus on correcting that misunderstanding in order to lessen the stigma. Third, if future research confirms that veterans hold themselves (individually and as a group) responsible for this condition, campaigns could focus on challenging that belief.

Stigma communication theory by Smith (2007) can be used to further assess how stigma is communicated about veterans with PTSD in many contexts. First, many participants described a shift in how military culture views PTSD, shifting from unaccepting/avoiding to accepting/acknowledging. It would be valuable to do interviews with veterans who served in the last 5 years to get their perspective of how mental health stigma is regarded in the military and if there is support for PTSD. This would help to solidify that military culture is changing, as well as the standards set by military culture (e.g., stoicism, invincibility, putting feelings aside and driving on, feeling embarrassed about seeking help, the thought that seeking help would mean letting down your unit, etc.).

Veterans with PTSD and Stigma Management Communication

RQ1 asked which stigma management strategies are used by veterans who are stigmatized for having PTSD. In review, stigma management communication theory posits that people use different strategies to communicatively manage moments of stigmatized identity (Meisenbach, 2010). In this study, all six major strategies were used by veterans with PTSD to manage stigma about PTSD: *accepting* (including the sub strategies of passive acceptance, display/disclose, use humor to ease comfort, blame stigma for negative outcomes, isolate self, and bond with stigmatized), *avoiding* (including the sub strategies of hide/deny stigma attribute, avoid stigma situations, stop stigma behavior, and make favorable social comparisons), *evading responsibility* (including the sub strategy of provocation), *reducing offensiveness*(including the sub strategy of minimization), *denying* (including the sub strategy of discrediting the discreditors), and *ignoring/displaying*. Therefore, in terms of sub strategies, participants engaged in 13 of the 20 sub strategies.

Interestingly, there were several instances in which participants blended contradictory strategies together and shifted in and out of different strategies within the same communication encounter. Thus, this study extends Meisenbach's (2010) theoretical model and responds to her call to engage in research that will offer insights into how individuals who experience stigma use multiple strategies or even strategies that contradict one another.

Participants in this study blended the contradictory sub strategies of evading responsibility and denying and accepting/denying. Here, participants engaged in "testing the water" or what Hartelt (2018) describes as shifting in and out of strategies, even in the

same encounter (p. 73). Veterans with PTSD test the water when it comes to managing their stigma over a taboo topic (mental health problems) just as the men seeking foreskin restoration had to do in Hartelt's (2018) study. Testing the water seems to be a natural way in which stigmatized individuals manage their stigma when they are unsure of other's feelings about the stigma/stigmatized attribute or are unsure about their own feelings about it. Therefore, stigma management communication should expand to account for these combinations and shifts of strategies.

New strategies. RQ2 asked how, if at all, do veterans with PTSD use stigma management communication strategies that do not appear in Meisenbach's (2010) theory of stigma communication management. First, similar to Hartelt (2018), I argue that stigma management communication should better account for forced disclosure and/or unintentional disclosure. In her framework, Meisenbach (2010) discussed disclosure of a disability without "explicit statement" of the stigmatized, which serves as forced disclosure although not explicitly stated (p.274). Hartelt (2018) described that "forced disclosure is unique with concealable because a person has to actively hide their sigma attribute to avoid being found out, and when faced with being found out, must make a decision with disclosure" (p. 76). In this study, participant 6 was unintentionally "found out" about having PTSD when he went to the doctor for a reason other than mental health. Further, it is possible that veterans with PTSD face forced or unintentional disclosure due to frequent training and health screenings.

A new strategy unique to this study was acceptance on behalf of others in the stigmatized group. In this situation, participants accept the status quo of the stigma and accept that it applies to other people in their same stigmatized group, yet they were

ambiguous as to whether they accepted or challenged the application of the stigma to their self. For example, participant 8 admitted that some veterans are "violent" and "crazy," without mentioning himself. Admittedly, this situation may be outside the scope of stigma management communication, a theory that was created to help individuals manage their own stigmatized identity. However, it is possible that stigmatized individuals are more comfortable accepting stigma on behalf of a group, rather than their individual identity. Therefore, stigmatized individuals may strategically leave themselves out when communicatively managing stigma in protection of their own identity and self-esteem. More research should be done to understand this phenomenon.

Another new strategy that warrants more examination is the denial of the stigmatized attribute (in this case, PTSD as a mental health condition) rather than the stigma attached to the stigmatized attribute. For example, one participant denied the diagnosis of PTSD, because he did not want that label associated with him. In terms of denial strategies, Meisenbach (2010) explains that an "individual simply states that there is no stigma" and that "this straightforward response challenges both the existence of the stigma and its applicability to the individual (p. 284). There is no mention of denying the stigmatized attribute itself. In this study, participants denied their own diagnosis of PTSD (the stigmatize attribute), they denied the medical explanation of PTSD (e.g., arguing PTSD is not a sickness, disease or disorder), and some denied that PTSD even exists (e.g., a soldier who had lost his legs argued PTSD simply does not exist). Ultimately, I argue that participants are still managing their stigmatized identity by denying stigma – not by addressing the stigma itself, but by denying the existence of the attribute that would evoke the stigma.

Future research related to stigma management communication. First, stigma management communication theory proved to be successful in determining how veterans manage mental health stigma regarding combat-related PTSD. Therefore, stigma management communication theory could be useful in assessing how members of other stigmatized mental illnesses manage stigma. Mental illness stigma is a major problem in society today, and therefore, future research that examines how other groups communicatively manage stigma about mental illnesses (e.g., those dealing with substance abuse, eating disorders, depression, anxiety disorders, obsessive-compulsive disorder, bipolar disorder, etc.) could pave the way for a framework tailored specifically to mental health stigma management communication.

Additionally, this study examined the way mental health stigma about veterans with PTSD is managed in a broad sense. Future research should examine how mental health stigma operates and how the stigma is managed by veterans in more narrow contexts such as 1) during deployment, 2) in comparison between higher ranked and lower ranked soldiers, 3) within the workplace/hiring process (post-deployment), 4) civilians that have no connection with the military, 5) in the home with family, and 6) while attaining a degree from a higher-education institution. These studies and their potential implications are discussed in the following sub sections.

Stigma management during deployment. Deployment is a unique time for military service members. During deployment, soldiers are in a high-stress situation in which they are located in a foreign country away from home, have little contact with loved ones, and are often in life-threatening situations. Further, soldiers are operating directly under military culture (Hernandez et al, 2006), where soldiers are expected to be

reliant on themselves and are criticized for showing weakness. In this environment, I argue that the stigma soldiers would experience would come from themselves (self-stigma) and from other military members, and therefore, their management of the stigma would differ. For example, participants in this study described that no one talked about mental health problems when they were deployed, because they were afraid of harming or losing their careers and were expected to remain tough and brush problems aside. Thus, veterans who were experiencing PTSD symptoms during deployment may have engaged in avoidance and denial strategies. A study that focuses on soldiers in the deployment experience could help the military organization better prepare soldiers for the deployment experience. Additionally, awareness of these management strategies could help mental health professionals better uncover mental illnesses in soldiers who refrain from opening up about PTSD, because they are avoiding or denying the stigma.

Stigma management among higher and lower ranked soldiers. I previously suggested that higher ranked military personnel holding leadership positions may feel more pressure (in comparison to lower-ranked soldiers) to take charge, to maintain mental focus and strength, to earn respect, to establish themselves as leaders, and to suck it up and driving on. These higher ranked soldiers are in charge of soldiers' lives and have to deal with the consequences of losing a soldier, as participant 5 described a family asking him what he did to prevent their loved one's death and participant 3 described a situation in how it is difficult to "feel okay" after someone loses limbs because he missed a hidden explosive.

Due to the pressure that comes along with being a leader of other soldiers, higher ranked soldiers may use unique stigma management communication strategies. For

example, I argued that the sub strategy *hiding the stigma attribute* (an avoidance strategy) may be common among higher ranked soldiers holding leadership positions because they do not want their soldiers to know they are having a hard time or "losing their edge" as participant 9 explained or they may feel that someone has to remain strong when everyone else is struggling with the loss of a unit member, as participant 5 mentioned. Research in this area could have practical implications when it comes to training these higher-ranked individuals and assessing their mental health.

Stigma management in the post-deployment workplace/hiring process. Many participants argued that employers are skeptical of hiring veterans with PTSD. For example, participant 4 described that employers are afraid of what will happen when "when the animal is let out of the cage" and participant 10 described that employers are nervous about hiring veterans because they are going to "snap." Fortunately, statistics from the Department of Labor (2019) shared that the veteran unemployment rate dropped to 3.7% in 2017, which is the lowest annual rate since 2001. However, according to the Bureau of Labor Statistics Labor, Rolen (2017) reports there are states with dramatically higher unemployment rates among veterans such as District of Columbia (7.6%), Illinois (6.7%), Oregon (6.3%), and Minnesota (5.8%). These numbers, in addition to comments made by participants in this study, show a need for more research that analyzes how stigma operates and is managed within the workplace or hiring process. Further, research that focuses on combat-related PTSD in an organizational context could give us insight into larger societal problems such as illegal discrimination in the hiring process and homelessness among veterans.

Stigma management in the family household. As discussed in my literature review, post-deployment reintegration is a difficult process for veterans and poses many challenges with it comes to communicating with family members (Chernichky-Karcher & Wilson, 2017; Hinojosa et al., 2012; Knobloch et al., 2013; Knobloch & Wilson, 2015). While combat-related PTSD can be concealable, there are symptoms that family members may notice. Participant 5 described that "when something changes a soldier's mental state, appreciation for life, or personality, no one is going to like that, especially their loved ones who just want their loved one back." In other words, the person who comes back from a war may not be the same person they were before the war, which can be a confusing situation that is hard for military families to manage and could ultimately evoke stigma. In addition, it is possible that family members may need to engage in stigma management communication on behalf of the veteran with PTSD in their family, just as relational partners of burn victims did in a study by (Noltensmeyer & Meisenbach, 2016).

The results of the current study suggested that participants may engage in the stigma management communication sub strategy of *avoiding stigmatizing situations* when it came to managing stigma from family members, as participant 2 stopped communicating about PTSD all together with her own family because her mother had "no idea how to deal with someone with PTSD." Further, several participants described that they did not talk about their mental health problems for a long time after deployment. Ultimately, stigma management communication framework could be used to advance family communication research by assessing how families can overcome the

communicative challenges that are present when a veteran with PTSD is reintegrating into civilian life.

Stigma management in higher-education. More than one participant expressed having a hard time in the classroom post-deployment. For example, participant 9 stated, "I'll be in class and I'm thinking about Iraq and Afghanistan and I'm not paying attention to the class. That's something I want to conceal. I don't really tell people I'm a veteran." Here, the participant is alluding to *hiding the stigma* attribute in the classroom by concealing that his mind is somewhere else. Physically, he may be sitting in the classroom, but mentally, he is at war. Future research could focus on the stigma management strategies veterans use in the classroom post-deployment and analyze how that affects their learning.

This research could be beneficial in helping veterans succeed in the classroom. While the money is there to support veterans pursuing degrees, the support in the classroom at universities is lacking. Take the GI Bill for example, which refers to any Department of Veterans Affairs education benefit earned by members of Active Duty, Selected Reserve and National Guard Armed Forces (Military Editors, 2019). Marcus (2017) reports that at nearly a third of the 20 two-year schools that enrolled at least 100 veterans receiving GI Bill benefits and who are eligible for degrees, none of them got one. Further, even the ones with the highest veterans' success rates managed to graduate only one-in-five. Ultimately, I argue that more can be done to help veterans succeed in the classroom and graduate with a degree, such as learning more about what makes veterans most comfortable in a classroom setting and what teaching strategies will keep them most engaged in the content being taught.

Veterans with PTSD and the United States Military

This study examined how participants describe *military* discourse (RQ3) and *public* discourse (RQ4) about veterans with combat-related PTSD. Participants described much of the discourse about veterans with PTSD in the *military* and in the *public* was stigmatizing. However, participants suggested a positive shift in which there is now more support for PTSD in the military. On the other hand, while participants recognized there are some civilians who support veterans and want to help those with PTSD, the public discourse about veterans with PTSD needs improvement.

The responses to RQ3 and RQ4 have the ability to improve the quality of life for veterans who have experienced stigma for developing PTSD. For example, this study outlined several ways in which military culture perpetuates mental health stigma. A major argument made by previous scholars is that stigma acts as a barrier to veterans seeking the mental health treatment they need (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). This argument holds true according to the results of this study, as participants described the delay of seeking professional help for PTSD or refrained from seeking help all together due to the stigma attached to it. The following sections 1) examine how the results of this study support pre-existing arguments made about how stigma acts as a barrier to seeking care and 2) present new ways that stigma becomes a barrier.

Pre-existing arguments about stigma as a barrier to care. This study backed pre-existing arguments made about ways communicated stigma becomes a barrier for veterans seeking mental health treatment such as 1) military culture/stigma, 2)

stigmatizing labels, 3) society viewing veterans as a threat, and 4) poor media portrayal of veterans with PTSD.

   Military culture and stigma. This study confirmed that military culture promotes mental health stigma. All 10 participants discussed military stigma at one point or another during their interviews, solidifying scholars' argument that military service members are reluctant to seek mental health treatment due to the stigma attached (Hernandez et al., 2016; Hoge et al., 2004; Hoge et al., 2006; Kim et al., 2010; Kulesza et al., 2015; Mittal et al., 2013; Sharp et al., 2015; True et al., 2014). In review, participants described that military service members A) did not want to talk about health problems, B) were afraid of harming or losing their careers, and C) were expected to remain tough and brush problems aside. These aspects of military stigma led veterans to delay seeking the help they need (sometimes for years at a time) or led them to not seek treatment at all. These results support the argument that military culture is partially to blame when it comes to perpetuating stigma surrounding mental health. It comes as no surprise that veterans are wary of coming forward to talk about and seek treatment for mental health problems when the military culture has traditionally preached and promoted stoicism, self-reliance, and invincibility. (Hernandez et al., 2006; Mittal et al., 2013; True et al., 2014).

   Stigmatizing labels. Veterans are aware of several different PTSD-related labels that exist in the military and within society. Labels have been presented in previous studies (Mittal et al, 2013; Roscoe & Anderson, 2019), however, this study gave new insight on the label "weak." Being regarded as "weak" due to mental health problems was a reoccurring concern among participants, as 7 out of 10 participants discussed weakness or a similar term such as "pussy," "pussy willow," or "Jell-O." Ultimately, the

results of this study combined with previous research (Academies of Sciences, 2018; Hoge et al., 2004; Mittal et al., 2013) suggest that being stigmatized as "weak" for having PTSD is a major concern among veterans with PTSD that sometimes leads to the avoidance of seeking help. The stigma surrounding weakness operates in many contexts, as veterans stigmatize themselves as weak for having PTSD, stigmatize other veterans who have PTSD as weak, and perceive that others will stigmatize them as weak for experiencing PTSD.

Interestingly, previous research suggests that veterans perceive that they are stigmatized for being "weak" more than they really are. For example, in a recent study of veterans and civilians by Roscoe and Anderson (2019), 40% of veterans associated the label "weak" with veterans with PTSD, whereas only 16.3% of civilians did. In fact, out of 10 labels, "weak" was the ranked the third lowest label associated with veterans with PTSD among civilians, ranking only above "unfit to raise kids" (15.5%) and "robotic" (14.7%). Further, in an unpublished study by Roscoe and Anderson, participants were asked, "How would you described veterans with PTSD?" Civilians responded with 392 units of data (e.g., traumatized, aggressive, broken, scarred, tortured, fragile), most of which was stigmatizing content according to Smith's (2007) theory of stigma communication. However, not one time did a civilian use the label "weak" to describe a veteran with PTSD. According to these data, most civilians do not perceive veterans with PTSD as weak, yet veterans perceive that others view them as weak. This data could fuel interventions focusing on changing veterans' inaccurate perceptions about the label "weak."

Civilians viewing veterans as a threat. All 10 participants described that veterans with PTSD are viewed as a threat in some way. As previously discussed in the stigma communication section, veterans perceive that civilians view them as a threat in society (e.g., veterans with PTSD are "violent," "unstable," "dangerous," etc.). Previous research has also suggested that civilians stigmatize veterans as a threat (Roscoe & Anderson, 2019). In the military context, veterans with PTSD may fear they are letting down their unit members by suffering from PTSD, as found in previous research (Hoge et al., 2004; Momen et al., 2012; Simmons & Yoder, 2013). More research should be done to better understand the consequences of perceived social peril in society and in the military.

Poor media portrayal of veterans with PTSD. Several participants in this study call out the media for painting a bad image of veterans who have PTSD and consequently, perpetuating mental health stigma. This aligns with previous research by Roscoe and Anderson (2019) where over 80% participants (veterans and civilians) reported to having been exposed to stigmatizing messages about veterans with PTSD through media (e.g., TV, movies, radio, and social media). Overall, the participants in this study perceived that the media poorly portrays veterans and PTSD which gives them a bad reputation in society (e.g., they're hazardous, psycho, crazy, murders, etc.). Participant 6 argued that media only shares the negative stories about veterans with PTSD and participant 1 described that these stories have "amped" how society views PTSD and perpetuates stigma. This is a problem because previous research by Kulesza et al. (2015) found that veterans were less likely to partake in mental health treatment if they perceived greater levels of public stigma.

There has been examination as to how various media have the ability to influence society. For example, cultivation theory by Gerbner and Gross (1976) suggests that television is responsible for shaping, or 'cultivating' viewers conceptions of social reality (University of Twente, 2017). Further, "massive television exposure by viewers over time subtly shapes the perception of social reality for individuals and, ultimately, for our culture as a whole" (University of Twente, 2017, para 3). With cultivation theory in mind, one may argue that repeated exposure to the "dangerous," "diseased animal" veterans' identity in movies or in the news could cultivate the idea that this identity is the reality within our society. Further, this identity cultivation is confusing for veterans, as participant 6 described that media makes civilians think veterans with PTSD are crazy and dangerous, and that "in effect, hurts the veteran who is having issues because in their mind they know they are not crazy or dangerous, which makes them even more off balance."

Currently, the argument focuses on how media portrayal of veterans with PTSD affects civilians' perceptions. However, I am interested in learning more about how media portrayal affects veterans' perception of their own identity. More could be done to learn about the effect media has on veterans in terms of self-stigmatization and how the media may contribute to veterans not seeking treatment for mental health issues.

New arguments about stigma as a barrier to care. This study revealed two new ways in which communicated stigma becomes a barrier for veterans seeking mental health treatment, including 1) making favorable comparisons and 2) the fear of being stigmatized for abusing the diagnosis of PTSD.

Making favorable comparisons. First, making favorable comparisons between the self and other veterans with PTSD can serve as grounds for not seeking help. Some participants made favorable comparisons in regard to the degree in which they experienced PTSD symptoms. For example, participant 3 never sought professional help because his own PTSD symptoms were not as bad compared to other veterans, and consequently, thought mental health professionals could help those who had it worse than he did. Along the same line, participants compared their war experiences to other veterans' experiences – which could lead to developing PTSD (e.g., getting blown up, having to kill another human, etc.). In this case, the comparison may be favorable in that their experiences are not as bad as others; however, the comparison can lead to a veteran thinking they did not have bad enough experiences to make their mental health problems serious enough to seek mental health treatment, or they may feel they are unworthy of seeking help.

Ultimately, even though veterans may make favorable comparisons that "discursively makes it clear that the other is somehow lesser than they are" (Meisenbach, 2013, P. 282), these comparisons can lead to negative outcomes where veterans do not seek the help they need. In other words, making favorable comparisons, a stigma management communication strategy of avoidance, may act as a quick fix (e.g., self-esteem boost because others are worse off), but this strategy can lead to worse consequences down the road (e.g., if the veteran does not seek treatment and ends up committing suicide).

Fear of being stigmatized as abusing the diagnosis of PTSD. Secondly, this study revealed that that fear of being stigmatized as someone who is "faking" PTSD or

abusing the diagnosis in some way scares veterans out of seeking mental health treatment. In this study, 8 out of 10 participants referred to veterans abusing the diagnosis of PTSD in various ways (e.g., faking symptoms to get out of work or to get medically discharged, get disability payments, use it as an excuse for poor behavior, etc.). Consequently, veterans who are truly suffering from mental health problems refuse to seek help to avoid being stigmatized. Participant 6 voiced frustration over the abuse of PTSD diagnosis because it "takes away from the men and women who are truly suffering and have issues." Similarly, participant 7 described that people who abuse diagnosis of PTSD are "shit bags" and "a part of the problem and not the solution."

This issue is difficult to navigate because mental illness is not always visible, whereas there is physical evidence of an injury such as losing a limb. One participant described having a hard time distinguishing if a fellow unit member was being honest about experiencing PTSD symptoms. This is a unique challenge that is faced by all people with mental illness and all mental health practitioners, as it is difficult to discern the veracity and severity of a patient's mental illness.

Limitations

This study has some limitations that warrant discussion. First, this study called for a population who has had experiences with a sensitive health issue. More specifically, this study required U.S. veterans who self-reported experiencing PTSD or who have been medically diagnosed with PTSD, and therefore, recruitment of this hard-to-reach population was difficult. Thankfully, having permission to post on an online support group for combat-related PTSD helped expedite purposive and volunteer recruitment. It is possible that purposive and volunteer sampling lead to self-selection bias where

participants who hold strong opinions that are not representative of the whole population (Frey et al., 2000). This could be the case when veterans volunteer to talk about a taboo topic, such as mental illness.

In addition, snowball sampling was used, as participants were encouraged to refer others that may be interested in participating in the study. If participants took it upon themselves to recruit other like-individuals, there is a possibility of the diffusion effect, which is when participants communicate with other potential participants about the study, sharing what is asked in the interview (Frey et al., 2000). This is not ideal because interviewees will have an idea of what will be asked in the interview ahead of time. This then allows them to think through the responses ahead of time and edit what they want to say, thus their responses during the interview may not be as natural. Even though purposive, volunteer and snowball sampling have their limitations, I believe these were the best option for this study, as Frey et al. (2000) argued these sampling methods are best suited for hard to reach populations with sensitive topics, such as mental illness.

Since PTSD is a taboo topic, especially in the military (Hoge et al., 2004; Kim et al., 2010; Kulesza et al., 2015), it is possible that the participants had a difficult time discussing it. It is possible that discussing a sensitive topic in an in-depth interview for 45-60 minutes could lead to maturation. Frey et al. (2000) described maturation as "internal changes that occur within people over the course of a study that explains their behavior" (p. 123). For example, participants may grow tired, resentful, or impatient which ultimately influences their responses (Frey et al., 2000). I did my best to eliminate the threat of maturation by building rapport with each participant and using a funnel format (asking general questions first and moving to deeper and narrower questions

toward the end), and by using a veteran of OIF as key informant who gave insight into language use that my participants could relate to and easily understand. I believe rapport was built with participants, as participant 9 described wanting to meet for a one-on-one interview so he could gauge my "vibe", stating "if I would have felt a negative vibe from you, I probably would have walked out." Further, when talking about how people communicate about PTSD, participant 4 stated, "there are people such as yourself, who view it [PTSD] in a positive sense… that they want to fix this issue. They know that something is wrong." Finally, several participants thanked me for looking into the issue of veterans and mental health stigma. Overall, I am satisfied with the depth of interviews and impressed with the participant's willingness to share about their experiences with war, mental illness, and stigma.

Another limitation is the representativeness of the sample. Having 10 participants is adequate for qualitative research, however, one must be cautious when interpreting the results and making generalizations because the sample size is not necessarily representative of the entire population. In addition, my study is limited to veterans of the U.S. military, and therefore, I cannot speak to what veterans of other nations militaries experience in regard to mental health stigma. However, this could be a direction for future research. In terms of analysis, I was able to reach saturation and performed member checking to improve the validity of the results. With that being said, this study still could have benefited from an additional coder to ensure intercoder reliability.

Conclusion

Mental health problems are deemed as some of the most disabling medical conditions that affect military service members (Hoge et al., 2006), and yet soldiers are

reluctant to seek help because of the perceived stigma that surrounds mental health (Hernandez et al., 2016; Hoge et al., 2004; Hoge et al., 2006; Kim et al., 2010; Kulesza et al., 2015; Mittal et al., 2013; Sharp et al., 2015; True et al., 2014). Concealed and/or untreated mental illnesses can have immediate and ongoing consequences including difficulty with relationships, physical discomfort, substance abuse, severe depression, and suicide (Hoge et al., 2006; National Center of PTSD, 2004; West et al., 2001; Wilk et al., 2010). To avoid these life-threatening consequences, more research needed to be done on the stigma that surrounds combat-related PTSD. Therefore, this study sought to better understand how stigma is communicated about veterans with PTSD and how veterans manage this stigma.

The results of 10 one-on-one interviews with veterans who have personally experienced PTSD demonstrate that stigma is prominent in the military context and within society. Stigma is communicated through labeling, marking, linking to social peril and assigning personal responsibility (Smith, 2007). These results are important because they give us a better understanding of exactly how veterans are stigmatized in these contexts. Veterans, in response, manage this stigma by using all six strategies (e.g., accepting, avoiding, evading responsibility, reducing offensiveness, denying, and ignoring/displaying) of Meisenbach's (2010) theory of stigma communication management.

These results are important because A) we now have an idea of how veterans react to and manage the stigma which can help us develop destigmatizing campaigns, interventions, changes in military policy, etc. and B) we have specific avenues for advancing stigma management communication theory as a viable way to qualitatively

analyze how stigmatized groups manage stigma. Further, the results presented theoretical

implications in regard to blended management strategies and new strategies that could be

implemented into the theory.

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APPENDIX A

Table 2 Stigma management communication strategies

	Accept that stigma applies to self	Challenge that stigma applies to self
Accept public understanding of stigma (status quo)	I. Accepting —Passive (silent) acceptance —Display/Disclose stigma —Apologize —Use humor to ease comfort —Blame stigma for negative outcomes —Isolate self —Bond with stigmatized	II. Avoiding —Hide/deny stigma attribute —Avoid stigma situations —Stop stigma behavior —Distance self from stigma —Make favorable social comparison

Challenge public understanding of stigma (change)	III. Evading responsibility for
	—Provocation
	—Defeasibility
	—Unintentional
	IV. Reducing offensiveness of
	—Bolster/refocus
	—Minimize
	—Transcend/reframe
		V. Denying
		—Simply
		—Logically
		    —Discredit discreditors
		    —Provide evidence/info
		    —Highlight logical fallacies
		VI. Ignoring/Displaying

Table reproduced from Meisenbach (2010) p. 278.

APPENDIX B

Interview Protocol

1) Tell me a little about your deployment experience.

   - Where did you deploy?

   - What was your length of service?

   - What specific operation were you part of?

   - What was your job or role?

   - What was your specific rank?

2) How did/do military service people talk about veterans and mental illnesses, such

   as PTSD?

   - What are some things that you've heard from fellow military service

     members?

   - Was/is the communication surrounding mental health negative or positive?

   - Do you remember at words or phrases related to PTSD?

   - Did you feel the military culture was supportive of those who developed

     PTSD?

   - Is seeking help encouraged? Why do you think that is?

   - Did you perceive any black lash from the public (friends, family, doctors,

     community members, etc.) for seeking treatment?

Now that we've discussed how military service members talk about mental illness, let's

think about how society, or the general public, talks about these issues.

3) How does society talk about veterans who are dealing with PTSD?

- Do you perceive the communication surrounding veterans with PTSD is negative or positive?

- Do you recall any specific words or phrases related to PTSD?

- What are the differences in how civilians and veterans (or current service members) talk about the issue of veterans with PTSD?

The ways that military service members and civilians talk about PTSD sends a "message" about PTSD among veterans. The way people talk about this issue shows their perceptions of it.

4) Tell me what you think of these messages that are out there about veterans with PTSD.

- Do you feel that the messages are stigmatizing? Why?

- The messages reflect perceptions of PTSD. Are the perceptions accurate?

  i. Do those perceptions apply to veterans with PTSD, as a group? Why or why not?

  ii. Do those perceptions apply to you, personally? Why or why not?

Now let's turn to your experiences with PTSD and communication about it.

5) Tell me about when you started experiencing symptoms of PTSD.

- Were you medically diagnosed/or did you self-identify the symptoms?

- If you weren't medically diagnosed, how come?

- How long ago was it?

- How did you feel?

- What was your response?

- How do you feel about having been diagnosed with PTSD?

6) Do you ever talk to people about PTSD?

- If no, why not?

- If yes, what kinds of things do you talk about?

    i. Do you talk about your own diagnosis or experiences?

    ii. How often do you talk about PTSD? Why?

    iii. Who do you talk to? Why?

    iv. Who do you avoid? Why?

7) How do you respond to moments of negative communication about veterans with PTSD?

- How does it make you feel?

- Who do you talk to about this? Who is most comforting?

- Has stigma put pressure on you to conceal the illness?

- Has stigma put pressure on you to isolate yourself?

8) How do you wish the topic of veterans with PTSD was talked about?

- How would you want people talk about it?

- If someone wanted to support you, what could they say in response to negative or stigmatizing messages?