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An Examination of Racial and Ethnic Differences in Internalized Mental Health Stigma and Perceived Mental Health Barriers Due to Stigma Among Women Veterans

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ABSTRACT

The stigma associated with mental illness can serve as a barrier for receiving treatment. Veterans may avoid seeking care due to stigma-related negative beliefs about one's self or others. Research suggests that the stigma of mental illness can adversely impact service utilization. Although studies have shown that racial and ethnic minoritized individuals are more likely to experience poor mental health outcomes, no studies have examined how mental illness stigma differs across racial groups among women veterans. The objective of this secondary analysis is to examine how internalized mental health stigma and perceived barriers to access to care related to mental health stigma may differ across race and ethnicity in women veterans. The sample included 412 women veterans who participated in an anonymous national survey. Participants completed measures of internalized mental illness stigma (Internalized Stigma of Mental Illness Scale Brief Version [ISMI-10]) and barriers to accessing mental health care (Barriers to Access to Care Evaluation Treatment Stigma Subscale [BACE-TSS]). A multivariate analysis of covariance was conducted to examine if there were groups differences based on race/ethnicity in internalized mental health stigma and barriers to access to care due to mental health stigma while covarying for age; no significant differences were found. The implications of the present findings and future directions are discussed.

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CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

Women are the fastest growing and most diverse group within the veteran population. In 2020, women made up 10% of the veteran population; it is projected that by 2040, women will make up 18% of the veteran population (U.S. Department of Veterans Affairs, 2016). Women veterans have differing mental health experiences compared to men, and military culture can exacerbate symptoms of trauma (Greenberg et al., 2007). In addition to this, research has shown that racial and ethnic minoritized (REM) veterans have adverse mental health outcomes and underutilize healthcare services (Saha et al., 2008; De Luca et al., 2016). Despite the Department of Veterans Affairs (VA) offering specialized services for mental health, these services are still underutilized by women veterans (Frayne et al., 2018). Stigma is one factor that is salient in understanding why veterans do not seek mental health care (Vogt, 2011). With this group growing and becoming the most diverse REM group within the military, there is a need to explicate how to better serve this population. Understanding REM women veterans' perceptions of mental health stigma can provide direction for how to engage them in using mental health services.

Women Veterans' Mental Health Care Utilization

The women veteran experience is multi-faceted. In addition to women being more likely to experience interpersonal trauma, veteran women are also at risk for mental

health problems due to the risk of exposure to potentially traumatic events. More specifically, research has shown that women veterans report the highest rates of lifetime posttraumatic stress disorder (PTSD) in comparison to women non-veterans, men veterans, and men non-veterans (Lehavot et al., 2018). Results from a large national mental health study reported that more than half of all women experience a traumatic event in their life (National Center for PTSD, 2018). Although all individuals can experience traumatic events, in comparison to men, women are more likely to experience interpersonal traumas such as child abuse, sexual assault, or domestic violence, which is more likely to lead to a diagnosis of PTSD in comparison to other types of trauma (Nishith, Mechanic, & Resick, 2000; Seris et al., 2004; Silove et al., 2014). The duality of women being more likely to experience interpersonal trauma and women veterans being exposed to potentially traumatic events puts their mental health at risk. Despite this, women veterans are still underutilizing services made available to them through the Veterans Health Administration (VHA) that could be of use.

The U.S. Department of Veterans Affairs provides mental health services for PTSD depression, anxiety, and other mental health disorders. In addition to in-person services, resources such as an online self-help portal, smartphone apps, and a telehealth program are available (e.g., National Center for PTSD, 2018). While these resources provide different modalities for mental health services to be accessible, there is still a disconnect between mental health care needs and actual utilization (Vogt, 2011).

Given that women veterans are susceptible to experiencing lifetime interpersonal trauma and are at risk for exposure to potentially traumatic events and their mental health sequelae, there is a need to understand why VHA services are not being used more by

women veterans. Despite women making up the largest growing group within the veteran population, 83% of women veterans choose to receive outside health care in civilian systems (Washington et al., 2007; Westermeyer et al., 2009). The VA system has historically been regarded as one that focuses on the care of men veterans (Goldzweig et al., 2006). Women veterans' perceived stigma, or how they may be the recipient of discrimination or stereotyping, may serve as a barrier to care (Fox et al., 2015). The expanding population of women veterans highlights the need for them be able to perceive VA services as a resource that is tailored to their specific needs.

Veteran Racial and Ethnic Diversity

Research has shown that REM groups experience negative mental health outcomes by way of structural barriers to resources, prevention, and care (Andrade et al., 2014). Mental illness stigma is prevalent among minoritized populations. In adults with a mental illness, only 31% of Black and Hispanic people and 22% of Asian/Asian American/Pacific Islander (AAPI) people received mental health services in comparison to 48% of White people (American Psychological Association, 2017). With the U.S. population becoming more diverse, so has the military, which brings a sense of urgency as to how we can better serve marginalized groups. In a national sample of veterans with mental health and substance use disorders, minoritized racial and ethnic groups reported worse symptoms than White veterans (Jones et al., 2016). This reflects the predicament of differing mental health outcomes among REM veteran groups.

In addition to women becoming more populous, the military and veteran population is becoming more racially and ethnically diverse (Minority Veterans Report, 2017). In 2017, 57% of U.S. service members were White, 16% were Black, 16% were

Hispanic, 4% were Asian/Asian American, and 6% identified as "other" (U.S. Department of Veteran Affairs, 2016). Identifying differences in perceived barriers to accessing mental health treatment among REM veterans will provide direction for how to best meet their mental health needs. Minority veteran statistics report that from 2019 to 2045, non-Hispanic White veterans will decrease from representing 74% to 61% of the population. Moreover, it is projected that non-Hispanic White veterans will decrease from 62.1% to 51.33% of the women veteran population (Racial and Ethnic Minority Veterans, 2019).

Racial/Ethnic Minoritized Women Veterans

Notably, women veterans are more likely to hold minoritized racial/ethnic identities than veteran men (Grzanka, Santos, & Moradi, 2017; Cole, 2009). Furthermore, from 2000-2015, the percentage of non-White women Veterans Healthcare Administration users increased from 30% to 42% (Frayne et al., 2018). The women veteran population is also more likely to be more racially/ethnically diverse (Minority Veterans Report, 2017). Knowing that both women and racial/ethnic minorities are marginalized groups that have differing mental health experiences, there is a need to shift this focus to veterans (Tsai, Mota, & Pietrzal, 2015).

From an intersectional framework, women veterans have unique lived experiences that can be influenced by race and ethnicity. Research suggests that each of these racial/ethnic groups in the civilian population have differing mental health experiences (Villatoro, Mays, Ponce, & Aneschensel, 2018). Intersectionality provides a framework to conceptualize how the unique characteristics of these intersecting identities contribute to overall health (Seng, Lopez, Sperlich, Hamama, & Meldrum, 2012). In addition to

gender, race and ethnicity can impact how one perceives and navigates the world around them. In a 2014 national cohort study on racial/ethnic disparities in PTSD treatment, results showed that African American and Latino veterans experienced low overall rates of retention in mental health treatment (Spoont et al., 2014). Furthermore, in a cross-sectional study that examined racial and ethnic differences by gender among veterans with a diagnosis of PTSD, Asian and Pacific Islander women veterans were more likely to screen positive for PTSD (Koo et al., 2016).

Little research has been done focusing on the disparities among racially and ethnically diverse women veterans, particularly regarding how this affects health seeking behaviors. There is a need to fill this gap and better understand how to serve this growing population.

Mental Health Stigma Among Veterans

Individuals living with a mental illness are faced with the challenge of coping with symptoms and the misconceptions of living with a disorder. One factor that can serve as a barrier in seeking mental health treatment is stigma. The stigma associated with mental illness can be burdensome for those living with the disorder. Vogt's (2011) review of existing literature found that perceived stigma by others was pervasive among veterans. Furthermore, in an observational study on women veterans and VHA utilization, one of the most frequently endorsed barriers to accessing mental health services was "being seen as weak" (Tsai et al., 2015). Public stigma and self-stigma may be experienced in conjunction with the symptoms of the mental illness itself. This dual problem likely has an impact on how an individual functions in different domains of life. Public stigma includes the reactions of the general population and their attitudes towards

groups in society (Rusch et al., 2005). This can result in negative actions or discrimination towards the individual living with a disorder. Self-stigma refers to the stigmatized reactions an individual has towards themself when belonging to a stigmatized group.

Gender and sex can moderate the stigma associated with mental illness. Research on military veterans with PTSD has more recently started to focus on women veterans. In a 2018 study that examined public stigma for men and women veterans with a combat-related PTSD diagnosis, stigma was influenced by the individual's gender (Caldwell & Lauderdale, 2021). Additionally, findings indicated that women veterans felt more responsibility stigma (Caldwell & Lauderdale, 2021). It can be inferred that this may be associated with VHA utilization and is consistent with previous findings of women's mental health seeking behaviors (Weiner et al., 1988).

Stigma can exacerbate symptoms and negatively impact the likelihood of receiving treatment. In a longitudinal survey study of U.S. post-9/11 men and women veterans, higher anticipated stigma led to higher levels of self-stigma, which in turn was associated with decreased treatment seeking (Fox et al., 2018). Further research suggests that institutional and cultural attitudes within the military serve as barriers to engaging service members in mental health services (Fox et al., 2018). Public stigma within the military emphasizes strength and is associated with the desire to resolve one's problems on their own. This notion serves as an impediment for seeking mental health treatment and can affect how veterans and active duty service members perceive stigma (Held & Owens, 2013).

Stigma as a Barrier to Seeking Treatment

While many barriers exist that interfere with mental health seeking behaviors, one factor that can serve as a barrier for treatment is stigma. Service members may avoid seeking care due to negative beliefs of oneself or from others. Research has found that stigma related barriers were rated as most salient in barriers to accessing mental health care in a sample of men and women Vietnam and Iraq/Afghanistan veterans who have been diagnosed with PTSD (Ouimette et al., 2011). Findings also suggest that the stigma of mental illness can adversely impact service utilization. In a national sample of veterans with mental health and substance use disorders, REM groups reported worse experiences than White veterans with mental health care (Jones et al., 2016). Findings for the Jones et al. (2016) also showed that REM groups reported worse experiences than White identifying individuals with access and quality of health care. Additionally, a qualitative study found that barriers to mental health care fell in two categories: structural barriers and institutional and cultural attitudes associated with the military (Tanielian et al., 2016).

Similar to men veterans, women veterans underutilize mental health services (Di Leone et al., 2016; Ryan et al., 2015). Stigma as a barrier can be related to how women veterans perceive their ability to seek care. Research has identified gender differences between men and women identifying veterans and perceived stigma (Fox et al., 2015; Gallegos et al., 2015). Results from a 2015 cross-sectional study found that for women veterans, negative beliefs about treatment seeking was associated with a decrease in likelihood of utilizing mental health care services (Fox et al., 2015). Qualitative data from a study focusing on gender differences in service utilization found that in comparison to

men veterans, women veterans reported a higher frequency of concerns about treatment (Gallegos et al., 2015). Additionally, findings from a 2017 study focusing on racial and ethnic variation in veteran mental health experiences found that REM veterans with a PTSD diagnosis are less likely than White non-Hispanic veterans to persist in mental health treatment (Spoont et al., 2017). Although studies have identified gender differences and racial/ethnic differences in perceived mental health stigma, little research has been done to further explicate racial/ethnic differences among women veteran stigma in relation to health seeking behaviors.

Although studies have shown that racial and ethnic minoritized groups are more likely to have negative mental health experiences, to the author's knowledge, no studies have examined if mental illness stigma differs across racial and ethnic groups among women veterans.

The Current Study

The unique characteristics of women veterans highlight the need to understand the barriers to mental health care for this unique population. The purpose of this secondary analysis is to examine how perceived mental health barriers differ across race/ethnicity in women veterans. It is hypothesized that (1) those with minoritized racial/ethnic identities will have higher levels of internalized mental illness stigma than White/Non-Hispanic individuals, and (2) minoritized racial/ethnic identities will perceive higher levels of treatment-seeking stigma-related barriers to accessing mental health care than White/Non-Hispanic individuals. Identifying whether or not there are racial and ethnic differences in perceived barriers to seeking mental health services due to mental health stigma may inform treatment and prevention within the women veteran population.

CHAPTER TWO: METHOD

Participants

The data used for this secondary analysis was from a cross-sectional, national study of women veterans (Monteith et al., 2020). Inclusion criteria included veteran status, female sex and woman gender[1], age 18-89, and previous enrollment in VHA care. Potential participants were found using VA Corporate Data Warehouse (CDW). 782,452 women were identified after removing individuals that were non-veteran or deceased, when information was discrepant or inconsistent, when identifiers were incomplete or inconsistent, or when addresses were not usable. A random sample of 3,000 women veterans who had never, previously, and were currently enrolled in VHA healthcare services were drawn from this sample and stratified by age and geographic location; these individuals were invited to participate in the current study via mailing. For the initial study, stand-alone pharmacy services and fee-based services through the Veterans Choice Program were not considered VHA care. The final analytic sample included 412 women veterans.

Procedures

Mailings with invitations to participate in the current study were sent to the sample of 3,000 women veterans. The initial mailing included a postcard consent form, instructions

[1] For the remainder of the current paper, I will reference participants as "women" for simplicity given the inclusion criteria.

for participation, survey, stamped self-addressed return envelope, and a debriefing form debriefing form. Participation was anonymous and offered via mailed paper survey or online; no compensation was provided. The study was approved by the local institutional review board.

For this secondary analysis, the Internalized Stigma of Mental Illness Scale (ISMI-10)and the Barriers to Access to Care Evaluation, Treatment Stigma Scale (BACE TSS) were examined to explore the research questions. The ISMI-10 is based on the Internalized Stigma of Mental Illness is a 29-item self-report instrument, with items rated from 1 (strongly disagree) to 4 (strongly agree) and measures self-stigma among individuals with psychiatric disorders. Boyd, Otilingam, and Deforge (2014) developed and tested the ISMI-10 short-form in Veteran samples. Although the 10-item version of the ISMI contains the five original subscales, the authors recommend using the ISMI-10 total score, with higher scores meaning higher levels of internalized mental illness stigma. This measure has demonstrated strong psychometric advantages (Boyd et al., 2014). Internal consistency was good in the current sample (Cronbach's $\alpha = .78$).

The BACE broadly measures key barriers to mental health care. The BACE TSS scale assesses stigma-related barriers to accessing mental health services, and has evidenced good reliability and validity (Clement, Brohan, Jeffrey, et al., 2014). The measure is scored from 0 (not at all) to 3 (a lot), with higher scores indicating a greater perceived barrier. Internal consistency was excellent in the current sample (Cronbach's $\alpha = .95$).

Analytic Plan

To investigate the research question, White/non-Hispanic and REM identities (African American/Black, Asian/Asian American, Pacific Islander, Native American/Alaskan Native, Multi-Racial and/or Hispanic) were compared using a multivariate analysis of variance (MANOVA) and multivariate analysis of covariance (MANCOVA) to examine if there were group differences between the two dependent variables: the Internalized Stigma of Mental Illness and Barriers to Access to Care Evaluation Treatment Stigma Subscale controlling for age. We planned to follow up with analysis of covariance (ANCOVA) tests for each separate scale controlling for age if the overall MANCOVA was significant with both dependent variables in the model. Descriptive statistics (means, standard deviations, subsample sizes) were also obtained for each racial (African American/Black, Asian American, White, Native American/Alaskan Native, Pacific Islander, Multi-Racial) and ethnic (Hispanic versus non-Hispanic) group to allow for exploratory, descriptive interpretation within the sample. Kurtosis and skewness were within normal range. Data for the ISMI-10 and BACE TSS were moderately skewed.

CHAPTER THREE: RESULTS

Demographics

The White/non-Hispanic group (*m* = 56.88 years) was statistically significantly older than the REM group (*m* = 51.91 years) (*t* (449) = 7.41, *p* < .001).

Group Difference Analyses

The multivariate analysis of covariance controlling for age did not indicate statistically significant differences in White/non-Hispanic individuals and REM individuals in internalized mental illness stigma and barriers to access to care due to mental health stigma (*F* (2, 408) = .293, Wilks' Lambda = .999, *p* = .746, partial eta squared = .001).[2] That said, within the sample, the REM group reported slightly higher levels of both internalized mental illness stigma and barriers to access care due to mental health stigma compared to the White/non-Hispanic group (*m* (internalized stigma on mental illness)= 1.85 versus 1.79, *m* (barriers to care access to care due to stigma)= .89 versus .81). See Table 1.

Exploratory descriptive data showed that Native American/Alaskan Native, Asian American, and Pacific Islander individuals reported higher mean scores on internalized mental illness stigma than other racial/ethnic groupings in the sample. Additionally, Native American/Alaskan Native, Asian American, and Multiracial individuals reported

[2] Of note, our total sample for the MANCOVA included 412 individuals who provided all data necessary for the model.

higher mean scores on barriers to access to care due to mental health stigma. Furthermore, the racial grouping that showed the highest discrepancy in scores for internalized mental illness stigma and barriers to access to care due to mental health stigma were Pacific Islander individuals, followed by African American/Black individuals and Asian American individuals. Furthermore, within the sample, the Hispanic group reported slightly higher levels of both internalized mental illness stigma and barriers to access to care due to mental health stigma compared to the non-Hispanic group (*m* (internalized stigma on mental illness)= 1.85 versus 1.80, *m* (barriers to care access to care due to mental health stigma)= 1.04 versus .81). See Tables 2 and 3 for descriptive data.

Table 1. Group Comparisons Using MANOVA and MANCOVA.

	White/non-Hispanic (*m*, *sd*)	**REM (*m*, *sd*)**	**Significance**
Mental Health Stigma			Co-varying age: *F* (2, 408) = .293, Wilks' Lambda = .999, *p* = .746, partial eta squared = .001 Without co-varying age: *F* (2, 409) = .550, Wilks' Lambda = .997, *p* = .577, partial eta squared = .003
ISMI-10	1.79 (.46)	1.85 (.54)	*ISMI-10*
BACE TSS	.81 (.83)	.88 (.94)	

Note. REM = racial/ethnic minoritized identities (African American/Black, Asian American, Pacific Islander, Native American/Alaskan Native, Multi-Racial and/or Hispanic/Latinx). ISMI-10 = Internalized Stigma on Mental Illness - 10. BACE TSS = Barriers to Access to Care Treatment Stigma Subscale.

Table 2. Exploratory Descriptives for Race

Racial Group	***ISMI-10 (m, sd)***	***BACE TSS (m, sd)***	***N***
African American/Black	1.80, .51	.77, .90	64
Asian American	1.86, .41	.84, .97	10
White	1.79, .47	.82, .84	296
Native American/Alaskan Native	1.98, .69	1.02, 1.01	6
Pacific Islander	2.30, 1.11	.14, .24	3
Multiracial	1.79, .50	.96, .86	18

Note. ISMI-10 = Internalized Stigma on Mental Illness - 10. BACE TSS = Barriers to Access to Care Treatment Stigma Subscale.

Table 3. Exploratory Descriptives for Ethnicity

Ethnic Group	***ISMI-10 (m, sd)***	***BACE TSS (m, sd)***	***N***
Non-Hispanic	1.80, .49	.81, .86	379
Hispanic	1.85, .55	1.04, .94	33

Note. ISMI-10 = Internalized Stigma on Mental Illness - 10. BACE TSS = Barriers to Access to Care Treatment Stigma Subscale.

CHAPTER FOUR: DISCUSSION

The purpose of this study was to explore racial and ethnic differences in internalized mental illness stigma and barriers to access to care due to mental health stigma in women veterans. Results did not indicate statistically significant differences between White/non-Hispanic individuals and REM individuals in measures of internalized mental illness stigma and perceived barriers to care due to mental health stigma. However, in this sample, when examining means for each group, there was a pattern of the REM group generally reporting higher scores on the ISMI-10 and BACE TSS in comparison to White/non-Hispanic individuals.

Women veterans' intersecting identities can be salient to their perceptions of the world around them (Shamaskin-Garroway et al., 2018). This dual minority experience in both gender and race/ethnicity can have an impact on mental health outcomes, and these intersecting identities may have had an impact within our sample on self-reported mental health stigma related variables.

This study emphasizes the need to better understand the experiences of specific REM (African American/Black, Asian American, Pacific Islander, Native American/Alaskan Native, Multi-Racial and/or Hispanic/Latinx) women veterans groups. Prior studies have looked at REM veterans and their mental health experiences, but few have looked at the intersection between race, ethnicity, and gender. Culture can be associated with how an individual identifies in terms of race and ethnicity and has the

ability to shape beliefs and behaviors related to mental health (Ungar, 2013). Mental health is complex, and similar to the notion of psychotherapy being tailored to a client's specific needs, research should be conducted the same way towards the population of focus (Marsella & Yamada, 2000).

Strengths and Limitations

Methods of data collection include several strengths. Participants were invited to partake in the initial study by completing self-report measures through mailings or electronically. This gave participants the option if computer literacy or access was limited.

The data that was used for the current aims had its limitations. Because this was a secondary analysis, study design and data collection were not done with the current research questions in mind. The majority of the sample identified as White, non-Hispanic, and middle-aged, which is not representative of the current or projected women veteran population within the United States. Stratifying a study sample by race and ethnicity would make results more generalizable to the population. The data that was used for this secondary analysis also had smaller sample sizes for REM groups. The analyzed sample was roughly 68% White/Non-Hispanic.. The data used for this study were also collected through a cross-sectional, self-report survey. While self-report measures are useful for many domains, it is also dependent on the participant's memory and ability to comprehend questions. Additionally, looking at each category of race and ethnicity was not feasible given the sample sizes within each racial and ethnic group. Limitations to this include missing or incomplete self-report measures, response rates from the sample, and how race and ethnicity was assessed. Because the data was

collected through the VA, a government standard demographic survey was used to obtain information regarding race and ethnicity. It is possible that participants may not have identified with one or more of the response options.

Measures used for this secondary analysis have strong psychometric properties. However, the development of these measures was not created to cater specifically to racially and ethnically diverse populations. Participants for the ISMI-10 initial psychometric validation study were 85% women and identified as 86% White, 3% Latinx, 3% African American/Black, 3% multiracial, 2% other race/ethnicity, 2% Asian American or Pacific Islander, 1% American Indian/Native American, and 1% preferred not to answer (Hammer & Toland, 2017). The sample for BACE TSS initial psychometric validation study was 80% women, 91.5% White British and White Irish identifying, leaving other minoritized racial and ethnic groups drastically under-represented (Clement et al., 2012). While these widely used measures used a sample that consisted mostly of women, the development of these widely used measures was not done on racially and ethnically diverse samples. The use of said measures on studies focusing on race and ethnicity create a unique impact on validity. It is as of yet unknown the extent to which these measures effectively measure the constructs under consideration among REM individuals.

Future Directions

In the current study, there were noticeable differences in levels of internalized mental illness stigma and levels of barriers to access to care due to mental health stigma in some of the REM groups. It would be beneficial for future research to examine how and for whom stigma is associated with perceived barriers. The population of women

veterans that hold REM identities is projected to be the fastest growing population within the military, hence the need to further understand how to better serve them. Future studies should focus on collecting data on minoritized veteran groups and their mental health experiences. Given that race and ethnicity can have an impact on mental health outcomes, it is crucial to be able to conceptualize and measure their effects.

Racial and ethnic disparities exist in treatment for PTSD among both civilians and veterans (Onoye et al., 2017). Although the Department of Veterans Affairs provides specialty treatment for mental health care, there is still a discrepancy between access and utilization (Ouimette et al., 2011). Additionally, research has shown that women veterans who identify as a racial/ethnic minority were susceptible to adverse mental health outcomes (Lehavot et al., 2019). Further research needs to be conducted on how to best serve diverse populations. The quantitative measures that were used for this secondary analyses were not created with race and ethnicity in mind and how that can impact perceived stigma. A way to accurately assess and incorporate race and ethnicity would be paramount in improving and understanding how to provide mental health care.

With the aim of this study being to explicate racial and ethnic differences for a concept as complex as mental health stigma, having more information about the lived experiences of the participants would have provided further insight. Racial/ethnic and gender differences have different presentations in how an individual perceives barriers. Qualitative research would allow for investigators to further explore attitudes and behaviors in an in-depth way and would also inform development of measures regarding internalized mental health stigma and barriers to care due to mental health stigma that are sensitive to the specific experiences of REM women veterans.

Additional research on other potential barriers to accessing care and their relation to mental health stigma would better our understanding of how to serve REM women veterans. Other barriers to receiving mental health treatment may exist for REM women veterans and women veterans broadly. Military culture is complex and can serve as an additional barrier to seeking services (Williston et al., 2020). The military can be regarded as having a male-dominated workplace culture, which can emphasize the minoritized identity of being a woman service member and veteran. Such cultural norms within the military can promote masculinity and devalues femininity (Williston et al., 2020). In addition to this, research suggests that a history of military sexual trauma (MST) can impact health seeking behaviors. Military sexual trauma is defined as sexual assault or harassment that occurs during military service (Department of Veterans Affairs, 2010). The perceived failure of an institution to protect individuals from, or respond to, traumatic events is referred to as institutional betrayal (Smith & Freyd, 2013). Institutional betrayal has been discussed in relation to MST, and how an institution responds to the traumatic event may impact perceived stigma and the likelihood of seeking VHA services (Kimerling et al., 2007).

CHAPTER FIVE: CONCLUSION

Despite limitations, this study emphasized the need to better understand how to serve racial and ethnic minoritized veteran groups with respect to mental health treatment barriers. Study results suggest that there are not differences between racial and ethnic groups in perceived mental health barriers within this sample. The stigma associated with mental illness serves as a barrier for receiving treatment through attitudinal beliefs and structural barriers. Identifying how to diminish perceived barriers for specific racial and ethnic groups will inform future treatment and hopefully improve mental health care accessibility.

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