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EDUCATIONAL PSYCHOLOGY, COUNSELING, AND SPECIAL EDUCATION

INVESTIGATING THE STIGMA OF POST-TRAUMATIC STRESS DISORDER WITHIN  
THE COLLEGE COMMUNITY

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## ABSTRACT

Stigmatization has been identified as a barrier to care for veterans with mental illness, specifically post-traumatic stress disorder (PTSD). This study examined the degree of stigmatization ascribed to the diagnosis of PTSD, as well as help-seeking behavior and flourishing levels of veterans who are students compared to civilians who are students. A sample of 48 students, including 22 veterans and 26 civilians, enrolled at The Pennsylvania State University participated in this study by completing a short survey that included a series of scales. Despite my research predictions, the findings showed that both groups reported similar help-seeking behavior and social stigma attitudes towards PTSD. In addition, the findings showed no statistically significant relationship between higher flourishing levels and lower rates of stigma, which was unexpected. The findings also showed a statistically significant relationship between civilians who are students and self-stigma of mental illness, but this did not support my prediction that veterans who are students would have more self-stigma of mental illness. These findings are important as they could help mental health professionals develop more efficient anti-stigma programs and promote the treatment of mental illness, especially PTSD, in the active duty, veteran, and civilian populations.

Keywords: *stigma, post-traumatic stress disorder, veterans, civilians, students*

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## Chapter 1

### Introduction

Over the span of several wars, America's combat veterans have exhibited physical, mental, and emotional reactions to what they have experienced during the course of their enlistment. These reactions have culminated into a diagnosis that has been known by several names, including shell shock, traumatic (war) neurosis, soldier's heart, gross stress reaction, and battle/combat fatigue. In 1980, the American Psychiatric Association added post-traumatic stress disorder (PTSD) to the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2010). The addition of this diagnosis to the DSM-III supported the concept that the etiological agent was outside the individual rather than an inherent individual weakness.

One important finding, which was not apparent when PTSD was first proposed as a diagnosis in 1980, is that it is relatively common. The National Comorbidity Survey determined a lifetime prevalence of PTSD at 7.8 %, while individuals who have been raped or are combat veterans have an incidence rate between 10 % and 30 % (van der Kolk & Courtois, 2005). Thus PTSD has become a social problem and a mental health problem. Researchers are interested in this topic because the prevalence has escalated in recent years with a rise in the number of active duty and veteran suicides, which are commonly associated with the symptoms of PTSD. Also, as a result of GI Bill Benefits, there has been an influx in the number of student veterans who are returning home from combat and transitioning back into society by joining the college/university community (Rudd, Goulding, & Bryan, 2011).

More research is needed for veterans and civilians to be better prepared to address the symptoms of PTSD and to de-stigmatize the general diagnosis of PTSD in the military community, the college community, and the general public. In addition, college campuses and counseling professionals must be trained to adequately address the issues that are relevant to student veterans. This research was designed to investigate perceptions of PTSD and mental health treatment in the college community. The main goals of this research were to find out if civilians who are students would be more willing to seek professional help, if veterans who are students would have higher self-stigma scores, if civilians who are students would have more social stigma towards the diagnosis of PTSD, and if people with higher flourishing rates would have lower rates of stigma.

In regards to this study, flourishing can be defined as the ability to live within an optimal range of human functioning, that connotes goodness, well-being, growth, and resilience (Diener et al., 2009). Also, this study specifically investigated the student population because there are an increasing number of veterans entering the college community after combat and after military discharge from active service due to GI Bill Benefits and as a general attempt at reintegration.

## Chapter 2

### Literature Review

In the last decade, reports have shown an increase in symptoms that are often associated with the diagnosis of post-traumatic stress disorder in the military community (van der Kolk & Courtois, 2005). Diagnostic criterion for PTSD includes a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. The fifth criterion concerns duration of the symptoms, while the sixth criterion specifies that the individual must experience functional impairment as a result of the symptoms (APA, 2000). The categorization of traumatic stress contrasts from other stressors as most individuals have the ability to cope with ordinary stress, while their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor. Thus individual differences exist when regarding the capacity to cope with traumatic stress or different trauma thresholds, resulting in some individuals developing the symptoms of PTSD, while others do not develop any symptoms after exposure to extremely stressful situations (van der Kolk & Courtois, 2005).

It is important to investigate the factors associated with PTSD, such as depression and suicide. In recent years, an increasing number of veterans and active duty military personnel who have the symptoms of PTSD have committed suicide, which can have a detrimental effect on the family structure and can impact other people who have interacted with the individual (Erspamer, 2008). In a study conducted by Macgruder et al. (2004), primary care patients ( $N = 513$ ) at two Veterans Administration (VA) Medical Centers were randomly selected and recruited to

investigate demographic characteristics and functional status among veterans treated at clinics. According to Magruder et al. (2004), PTSD symptom levels were significantly related to age (younger people had more severe symptoms), employment status (people with disabilities had higher symptom levels), war zone experience, and access to care. Also, PTSD symptomatology was inversely related to mental and physical functioning, even after controlling for potential confounding variables. It has also been observed that combat-related guilt was the most significant predictor of suicide attempts, as combat veterans may feel guilty about surviving when others have died, acts of omission and commission, and other general thoughts or feelings related to the combat experience. An act of omission refers to the failure to perform an act expected to be done by another person whereas an act of commission is doing an act that causes harm (Sher, Braquehais, & Casas, 2012).

### *Suicide and Veterans*

In an internal Veterans Administration study, Espramer (2008) found that veterans under VA care were attempting suicide at a rate of about 1,000 per month and succeeding an average of eighteen times every day. This statistic supports the stark reality that the total number of veteran suicides in a single year has eclipsed the number of combat deaths in the Iraq and Afghanistan wars combined. In addition, the fear to seek professional help for mental illness can also increase the incidence of suicidal ideation for service members. According to Sher et al. (2012), the suicidal process is related to feelings that one does not belong with other people, feelings that one is a burden on others or society, and a habituation to painful experiences. This habituation to painful experiences may be the result of military training and combat exposure, which may help the veteran in a combat scenario, yet ultimately harm the veteran when he or she attempts to re-enter the general population (Sher et al., 2012).

Suicidal ideation is a critical problem within the military community that is not restricted to a single country or generation. Observations have suggested a relatively high prevalence of suicide ideation and suicide attempts in different generations of war veterans and in different countries. In a survey of U.S. veterans, those who screened positive for PTSD were more than four times as likely to endorse having suicidal ideation compared with veterans who screened negative for PTSD. There are several factors that may increase a service member's risk of suicidal ideation. These factors include comorbid disorders, impulsive behavior, feelings of guilt or shame, re-experiencing symptoms, and prewar traumatic experiences. Also, when a service member has two or more co-existing psychiatric disorders, the risk of suicidal ideation is 5.7 times higher than a service member with PTSD alone (Sher et al., 2012).

According to Rudd et al. (2011), the average student veteran reported experiencing moderate anxiety, moderately severe depression, significant symptoms of PTSD, and evidencing at least some noticeable suicide risk. In a national sample of student veterans, almost 35 % experienced "severe anxiety," 24 % experienced "severe depression," 46 % experienced significant symptoms of PTSD, 46 % experienced suicidal thoughts at one point, with 20 % previously having a suicidal plan, 10 % thought of suicide often/very often, and 8 % had previous suicide attempts. These rates are significantly higher than those reported by civilian college students in general. The data also indicated that the student veterans' suicide related problems were comparable to or more severe than those of veterans seeking mental health services from Veterans Affairs medical centers (Rudd et al., 2011).

#### *Stigma and PTSD*

The study of the social stigmatization of PTSD is necessary considering the large number of service members returning to the United States who are being diagnosed with PTSD, the

likelihood of self-stigmatization as a barrier to care, and the extensive costs that may result from not seeking care. The traditional definition of stigma was first proposed by Goffman (1963) as “an attribute that is deeply discrediting” (p.12). The recognition of this attribute leads the stigmatized individual to be “reduced... from a whole and usual person to a tainted and discounted one” (Goffman, 1963, p.12). This presents stigma as a relationship between attribute and stereotype. According to Goffman (1963), these attributes can be divided into three main groups: “abominations of the body,” “blemishes of individual character,” or “tribal stigmas” (p.13). Other studies describe stigma as a form of deviance that leads others to judge an individual as illegitimate for participation in a social interaction (Elliot, Ziegler, Altman, & Scott, 1982). This judgment occurs because of a perception that the stigmatized individual lacks the skills or abilities to carry out such an interaction, and is also influenced by judgments about the dangerousness and unpredictability of the person (Elliot et al., 1982). Stigma about mental illness may determine how and even whether people seek help for mental health problems, their level of engagement with treatment, and the outcome of their problems.

Corrigan and Watson (2002) proposed a framework in which stigma is categorized as either self-stigma or social stigma. In general, stigmatized attitudes and beliefs towards individuals with mental health and drug use disorders are often in the form of social stigma, which is structural within the general public. Many individuals with mental illness have reported social discrimination in the community, giving accounts of being physically and verbally attacked by strangers and neighbors, their property being vandalized, or being physically barred from shops and pubs. These reports also included examples of individuals being spoken to as if they were stupid or like children, being patronizing, and, in some instances, having questions addressed to those accompanying them rather than themselves (Lyons, Hopley, & Horrocks,

2009). As described by Lyons et al. (2009), individuals with mental illness felt a range of emotions surrounding their experiences of discrimination from social stigma, including, anger, depression, fear, anxiety, isolation, guilt, embarrassment, and above all, hurt. This social stigma, or even the perception that a social stigma exists, can become internalized by a person resulting in self-stigma (Ahmedani, 2011).

According to Ahmedani (2011), social stigma is structural and can create barriers for individuals with a mental or behavioral disorder. Structural means that the stigma is a belief held by a large faction of society in which persons with the stigmatized condition are less equal or are part of an inferior group. Thus the stigma is embedded in the social framework to create a belief of inferiority. This disparity between the larger faction of society and the persons with the stigmatized condition may result in unequal access to treatment services and basic needs (Ahmedani, 2011).

Stigma is not only held among others in society, but can also be internalized by the person with the condition. Thus, the continued impact of social/public stigma can influence an individual to develop negative feelings of self-worth. As Ahmedani (2011) noted, with self-stigma the knowledge that stigma is present within society can have an impact on an individual even if that person has not been directly stigmatized. This impact can have a deleterious effect on a person's self-esteem and self-efficacy, which may lead to an altered behavioral presentation.

It has also been reported that service members repeatedly state that they would never seek military care for PTSD due to stigma, whether real or perceived, stating that they feel they would be ostracized and punished, accused of trying to get out of duty, and that their jobs or a chance at promotion would be in jeopardy (Fairweather, 2008). Stigma remains one of the largest barriers to care for people who are in need of treatment for the symptoms of PTSD. Mental illness stigma

has been associated with problems obtaining housing, health care, employment, and problems in relationships with friends and family, as well as reducing the chances of seeking help for symptoms because of self-blame (Corrigan & Kleinlein, 2005). This historical perception of mental illness may cause self-stigmatization if the veteran is aware of it, which can negatively impact self-esteem and subsequent health care seeking behavior. It is a standpoint that seeking help, particularly mental health care, is anathema to military culture. In addition to the general fear of stigma that may be received in the military community, many veterans fear the possibility of health care or disability information appearing on their military records.

Hoge (2010) studied members of four U.S. combat infantry units (three Army units and one Marine Corps unit) using an anonymous survey that was administered to the subjects either before their deployment to Iraq ( $N = 2530$ ) or three to four months after their return from combat duty in Iraq or Afghanistan ( $N = 3671$ ). When service members diagnosed with PTSD or depression were surveyed about stigma and other barriers to receiving care, they reported the following: nearly 40 % expressed distrust in mental health professionals, 50 % believed it would harm their career, 59 % believed that members of their unit might have less confidence in them, 63 % believed that their unit leaders would treat them differently, 51 % believed their leaders would blame them for the problems, and 65 % believed that they would be seen as weak. In a comparison group, service members who did not have a diagnosis of PTSD or depression in the same units reported the following: 24 % believed it would harm their career, 31 % believed that members of their unit might have less confidence in them, 33 % believed that their unit leaders would treat them differently, 20 % believed their leaders would blame them for the problems, and 31 % believed that they would be seen as weak (Hoge, 2010).

### *Treatment Options for PTSD*

If mental illness is treated early enough, it can reduce further ill health, and ultimately the risk of suicide, but individuals often will not seek professional help until their symptoms have become serious (Lyons et al., 2009). Despite the availability of treatment options, the inadequacy of the Veterans Administration (VA) to handle the sizable number of veterans returning home with PTSD and traumatic brain injuries (TBI), among other disabilities and injuries, puts these service members in a difficult position upon re-entry into the post-war environment. The negative attitudes within the military culture associated with having and treating a mental disorder are another major barrier to care that must be addressed system wide.

Tanielian et al. (2008) found that 300,000 U.S. service members who experienced combat in Iraq or Afghanistan experience PTSD symptoms or major depression, and nearly 320,000 service members report experiencing a TBI. Despite these numbers, roughly half of the service members who need treatment for these conditions seek it, and only slightly more than half who receive treatment obtain only minimally adequate care (Tanielian et al., 2008). This can be attributed to the fact that despite the exponential increase in veterans diagnosed with PTSD, a March 2008 report by the VA confirmed that the average number of visits per veteran in PTSD mental health programs has rapidly decreased (Erspamer, 2008).

The experience of trauma is a unique occurrence, so the treatment should vary for each individual who seeks help. The progress in finding a universal and effective treatment for individuals with PTSD is still in its infancy. As noted by Hoge (2010), the difference in improvement between people who receive treatment and people in comparison groups is small. Despite this finding, there are several treatment options available to individuals with PTSD, although the effectiveness of these options may remain in question. These options include

medications (e.g., SSRIs) and psychotherapy, which includes cognitive behavioral therapy, eye movement desensitization and reprocessing, group therapy, and stress inoculation training.

According to Hoge (2010), most of these therapies require at least ten to twelve sessions to be effective (and often many more). The form of mental health therapy with the strongest scientific evidence of effectiveness is exposure therapy, which includes talking about the traumatic experience(s) with a psychotherapist in a structured manner, or writing about the experience(s) and reviewing the writing while in session. Exposure therapy can also include various exercises to reduce the tendency to avoid situations that trigger strong reactions (Hoge, 2010).

The public and professionals within the rehabilitation and human services field and the medical field need to be adequately prepared when working with clients who experience symptoms of PTSD. Individuals who do not seek care for mental illness may experience considerable long-term consequences. For example, the health condition may get worse over time, impact physical health, and effect personal relationships. Promoting the treatment of these individuals and the pursuit of mental health care is vital for combat veterans because experience has indicated that the ramifications of trauma can extend throughout the family and can have multigenerational effects (Forman & Havas, 1990).

### *Study Hypotheses*

Based on the preceding review of literature, the current study will examine support for the following four hypotheses: (a) civilians who are students will be more willing to seek professional help for a mental health issue than veterans who are students, (b) veterans who are students will have higher self-stigma scores than civilians who are students, (c) civilians who are

students will have more social stigma towards the diagnosis of PTSD than veterans who are students, and (d) individuals with higher flourishing levels will have lower rates of stigma.

### *Theoretical Framework*

The possible relationship between stigma and mental illness can be explained by modified labeling theory. In this theory, the expectations of becoming stigmatized, in addition, to actually becoming stigmatized, are factors that influence psychosocial well-being (Ahmedani, 2011). According to Link, Struening, Cullen, Shrout, and Dohrenwend (1989), the rationale behind this hypothesis is that the degree to which individuals believe they will be devalued and discriminated against directly corresponds to the degree of them feeling threatened or stigmatized in their interactions with others. In other words, even if labeling does not directly produce mental disorder, the act of labeling can still lead to negative outcomes. In this context, it is primarily the fear of being labeled that causes the individual to feel stigmatized, which reduces the individual's likelihood of seeking help for symptoms and consequently reduces the individual's opportunity to flourish.

## Chapter 3

### Methods

In this section a description of the study will be presented that includes a summation of the individuals who participated in the study, a brief overview of each of the scales that were included in the survey distributed to each of the participants, a synopsis of how the data was collected, and the calculated response rate for this study. This study was approved by The Pennsylvania State University IRB Board.

#### *Participants*

Although 50 individuals participated in this study, two cases were removed from the veteran responses because they reported having a diagnosis of post-traumatic stress disorder. The sample for this study thus included a total of 48 participants. This total was comprised of 22 veterans and 26 civilians. All of these participants were enrolled as undergraduate or graduate students at The Pennsylvania State University. Students ranged in age from 19 years to 52 years, with the mean age of 24.4 years (standard deviation of 6.7). There were several races identified in the sample (88 % White/Caucasian, 2 % Black/African American, 6 % Asian/Pacific Islander and 4 % were classified as Other/Mixed). Also, the sample was 64 % male and 36% female. Participants included freshmen (6 %), sophomores (22 %), juniors (30 %), seniors (30 %), and graduate students (12 %).

In regards to the veteran population, military branches represented included Marines (38%), Army (21 %), Air Force (8 %), and Navy (33 %). Of those veterans, 63 % had experienced combat at least once during their enlistment, with length of enlistment being a mean

of 7.4 years. Overall, 71 % of veteran participants had been a victim of and/or witnessed a traumatic event.

The participants were recruited during the fall of 2013, either in person or by e-mail, from various locations on The Pennsylvania State University (University Park) campus. A majority of the veteran population was recruited from the Penn State Veterans Organization and the Office of Veterans Programs, while the civilian population was recruited through a convenience sample at various locations at The Pennsylvania State University campus. The only exclusionary data that was involved in this study was age, since all participants had to be at least 18 years old, and the designation that all individuals had to be current Pennsylvania State University students. In addition, no deception was used as the students were informed about the purpose of the research and the procedures to be followed. All of the students provided implied informed consent to participate. The participants were not compensated for their participation.

### *Measures*

The data for this study were collected from the students' responses on a seven-page survey (refer to the Appendix for the complete survey). The survey had five parts; each part was designed to collect data for each of the four hypotheses posited in the beginning of this study. The first section of the survey asked students to provide demographic information such as gender, age, class standing, and race/ethnicity. It also investigated the students' status as a civilian or veteran and gauged their knowledge of post-traumatic stress disorder. These questions were included primarily to describe the sample as well as to measure each participant's diagnostic history and awareness of PTSD.

The second part of the survey included a post-traumatic stress disorder vignette (APA, 2000; Friedman, 2006) that provided a brief story about an individual who exhibited the

symptoms of PTSD, according to the DSM-IV TR diagnostic criterion and consistent with previous research studies. Participants were then asked a series of 7 items that assessed the participants' willingness to interact with the person described in the vignette in various social situations. Each item was rated on a Likert scale with 1 representing "always willing" and 6 representing "always unwilling." The scores were summed with a possible minimum score of 7 and a maximum score of 42, with a higher score indicating greater desired social distance (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Since social distance can often be the result of perceived dangerousness, item 8 asked participants to evaluate the dangerousness of the depicted combat veteran using a 6 point Likert scale with 1 representing "extremely unlikely" and 6 representing "extremely likely." Thus the perceived dangerousness measure consisted of one question, with a minimum score of 1 and a maximum score of 6, with a higher score indicating greater perceived dangerousness (Link et al., 1999). In the present study, the internal reliability of this measure was .82.

The third part of the survey included the Self-Stigma of Seeking Help Scale (SSSHS; Vogel, Wade, & Haake, 2006), which consists of 10 items that gauge the participants' willingness to seek help if they need it. Each item was scored on a 5 point Likert scale with 1 representing "strongly agree" and 5 representing "strongly disagree." In regards to this measure, a larger score is indicative of the participant having more self-stigma towards seeking help from a mental health professional (Vogel, Wade, & Haake, 2006). For this study, the internal reliability of this measure was .94. The fourth part included a modified version of the Self-Stigma of Mental Illness Scale (SSMIS; Corrigan, Watson, & Barr, 2006), which consisted of two sections that measured social and self-stigma. The first section included 10 items that investigated what each participant perceived the public to believe about persons with PTSD. This

measure, for the purposes of this study, was found to have an internal reliability of .88. The second section included 10 items that assessed how each participant personally perceived persons with PTSD. In the present study, the internal reliability for this measure was .87. Once again, each item was scored on a 9 point Likert scale with 1 representing “strongly disagree” and 9 representing “strongly agree.” In regards to this measure, a higher score is indicative of the participant having more self-stigma towards the diagnosis of PTSD (Corrigan, Watson, & Barr, 2006).

Finally, the fifth part of this survey included a Flourishing (FLG; Diener et al., 2009) scale, which used 8 items to measure the participants’ self-perceived success in important areas of life such as relationships, self-esteem, purpose, and optimism. This measure also included a 7 point Likert scale with 1 representing “strongly disagree” and 7 representing “strongly agree.” In regards to this measure, a higher score is indicative of a more positive psychological well-being (Diener et al., 2009). For the purposes of this study, the internal reliability of this measure was .89.

### *Procedures*

Civilian students enrolled at The Pennsylvania State University were asked to participate in person during a weekly club meeting with a diverse amount of students represented. Students were informed about the study with an explanation of the purpose of the study, the instructions for completing the survey, and an explanation of who was eligible for the survey. All students were told that the survey would take about 15 minutes of their time and that all of the data would remain confidential. Participation was entirely voluntary and approximately 26 civilian students opted to complete the survey in a paper-and-pencil format. Students were first read a verbal informed consent form, which explained to the participants that by completing the survey they

are consenting to their own participation in the study. To keep survey responses confidential, students were asked not to put their name or any other identifying marks on the survey.

Thereafter, the participants were instructed to complete the survey at their own pace and then the survey was distributed to each student. Upon completion, the surveys were given directly to the principal investigator.

A total of 80 surveys were distributed to prospective participants throughout the course of this study. Of those 80 individuals, 50 completed surveys were received representing an overall response rate of 63 %. Data from the civilian group was collected at a weekly Pennsylvania State University club meeting. During the beginning of this meeting, a brief description of the survey and the benefits of participating in the survey were described. Of the 50 surveys distributed to this group, 26 individuals completed the survey for a response rate of 52 %.

The veteran student population was asked to participate both in person and through e-mail. Similar to the civilian population, the veterans were informed about the research study prior to their participation. Overall, 24 veterans completed the survey in a paper-and-pencil format at a weekly club meeting and in an electronic survey format through a Penn State veterans listserv, but only data from 22 veterans was analyzed because two individuals reported having a diagnosis of post-traumatic stress disorder. To contact the veteran participants for the study, the Office of Veterans Programs forwarded an email to the individuals listed on The Pennsylvania State University veteran listserv. The email consisted of a brief description of the survey and the benefits of participating in the survey included with the contact information of the principal investigator. All interested individuals then contacted the principal investigator and were provided with a link to the survey itself. Of the 15 surveys that were sent to this group, 13 individuals completed the survey for a response rate of 87 %.

Data from the veteran group was also collected at a Penn State Veterans Organization weekly meeting. During the beginning of this meeting, a brief description of the survey and the benefits of participating in the survey were described. Of the 15 surveys distributed to this group, 11 individuals completed the survey for a response rate of 73 %. Overall, a total of 30 surveys were distributed to the veteran group with 24 veterans completing the survey at a response rate of 80 %.

A cursory examination of the demographics of the respondents revealed that a diverse range of individuals and majors were represented. During the survey administration to both groups/individuals, the procedure involved was the same as aforementioned in regards to informed consent, survey distribution/collection, and confidentiality of the responses. The data was then analyzed using Microsoft Excel and SSPS Version 22.

## Chapter 4

### Findings

In this section, the results of the study will be presented. The following sections will describe the data analysis and whether each hypothesis was statistically supported or not statistically supported. Tables that depict the overall findings of each hypothesis are also included in this section.

#### *Data Analysis*

In order to investigate the first three hypotheses (A, B, & C), independent *t*-tests were conducted to determine if there were significant differences between the veterans and civilians on measures of help-seeking tendencies and stigma. To investigate the fourth hypothesis (D), a two-tailed Pearson correlation analysis was conducted to determine the relationship among flourishing levels and stigma measures for the entire sample. As noted prior, two cases were removed prior to analysis, since both cases had reportedly been diagnosed with post-traumatic stress disorder. Thus they were not included in this analysis.

#### *Results*

In regards to the first hypothesis, the results of the independent *t*-tests revealed no significant difference between civilians and veterans on help-seeking tendencies. Table 1 shows the relationship between veterans and civilians in terms of help-seeking tendencies. There was a non-significant difference between the veteran and civilian participant groups on help-seeking scores. Of those participants, veterans scored similarly on help-seeking tendencies ( $M = 2.91$ ,  $SD = .22$ ), compared to civilians who scored a mean of 2.78 ( $SD = .27$ ). This relationship was

statistically non-significant. This data did not support my hypothesis that civilians who were students would be more willing to seek professional help for a mental health issue than veterans who were students ( $t(48) = 1.708, p = .094$ ).

**Table 1: Relationship between veteran and civilian help-seeking tendencies.**

		N	Mean	Standard Deviation	Standard Error Mean	Sig. (2-tailed)
Help-seeking Behavior	Veterans	22	2.9091	.22234	.04740	.094
	Civilians	26	2.7846	.27378	.05369	

Regarding the second hypothesis, the relationship between veterans and civilians in regards to the presence of self-stigma of mental illness is presented in Table 2. Veterans who were students scored significantly lower on a measure of self-stigma ( $M = 1.9, SD = .83$ ) compared to the civilians who were students ( $M = 2.8, SD = 1.0$ ). This relationship is statistically significant at the .01 level. This data did not support my hypothesis that veterans who were students would have more self-stigma of mental illness than civilians who were students ( $t(48) = -3.220, p = .002$ ). However, the opposite was found: Civilians who were students reported significantly higher rates of self-stigma than the veterans who were students.

**Table 2: Relationship between veteran and civilian self-stigma of mental illness.**

		N	Mean	Standard Deviation	Standard Error Mean	Sig. (2-tailed)
Self-Stigma	Veterans	26	1.9636	.83412	.17784	.002
	Civilians	22	2.8462	1.03082	.20216	

\* $p < .01$

Regarding the third hypothesis, the difference was statistically non-significant. Table 3 shows the relationship between veterans and civilians in regards to social stigma towards the diagnosis of post-traumatic stress disorder in the college community. Veterans who were students scored similarly on the measure of social stigma ( $M = 4.1$ ,  $SD = 1.48$ ) compared to civilians who were students ( $M = 4.14$ ,  $SD = 1.22$ ). This data did not support my hypothesis that civilians who were students would have more social stigma towards the diagnosis of PTSD than veterans who were students ( $t(48) = .102$ ,  $p = .920$ ).

**Table 3: Relationship between veteran and civilian social stigma towards PTSD.**

		N	Mean	Standard Deviation	Standard Error Mean	Sig. (2-tailed)
Social Stigma	Veterans	22	4.1818	1.47572	.31462	.920
	Civilians	26	4.1423	1.21956	.23918	

Table 4 shows the results of the correlation analysis that revealed the possible relationship between flourishing rates and various forms of stigma. The results of the two-tailed Pearson correlation analysis revealed no significant relationships among flourishing levels and stigma levels. A positive relationship was detected between the variables of flourishing levels and social stigma ( $r = .178$ ,  $n = 48$ ,  $p = .226$ ). There were also negative relationships detected between flourishing levels and the stigma vignette ( $r = -.008$ ,  $n = 48$ ,  $p = .958$ ), as well as the flourishing levels and self-stigma ( $r = -.191$ ,  $n = 48$ ,  $p = .192$ ), but none of these relationships were statistically significant. Thus this data did not support my hypothesis that individuals with higher flourishing levels would have significantly lower rates of stigma.

**Table 4: Pearson correlation analysis of flourishing levels compared to stigma.**

Flourishing Levels	N	Stigma Vignette		Social Stigma		Self Stigma	
		Pearson Correlation (r)	Sig. (2-tailed)	Pearson Correlation (r)	Sig. (2-tailed)	Pearson Correlation (r)	Sig. (2-tailed)
	48	-.008	.958	.178	.226	-.191	.192

## **Chapter 5**

### **Discussion**

Considering the large number of veterans returning to the United States from war, and the potential costs of untreated mental health conditions, the aim of this study was to better understand how veterans are perceived in the general population. Findings of the present study expand understanding of the relationship between post-traumatic stress disorder, stigma, help-seeking behavior, and flourishing in the military and civilian population of students at The Pennsylvania State University. In this section, each of the four relationships and major findings will be discussed and suggestions for future research will be offered.

The results of the study did not support the first hypothesis that civilians who are students will be more willing to seek professional help for a mental health issue than veterans who are students. No statistically significant relationship was found between help-seeking tendencies and the civilian population, which was surprising. These findings may have come about because a sizable number of the participants had previously received help for mental health symptoms. Overall, 36 % of the participants had sought help from a mental health professional, which was not expected. Also, the availability of the Office of Veterans Programs and the Penn State Veterans Organization (among other clubs) allow veterans to come together under a common experience, which may reduce the stressors that are often associated with reintegration into the college community and promote help-seeking behavior. This may explain why the findings of this study were not consistent with previous studies, especially the study conducted by Tanielian et al. (2008) who found that a substantial amount of veterans have been returning to the United

States with adverse mental health symptoms, yet only roughly half of those who need treatment for mental health symptoms actually seek it.

The results of the study did not support the second hypothesis that veterans who are students will have more self-stigma of mental illness than civilians who are students. The reverse was found in the current study. Civilians who were students reported a statistically higher rate of self-stigma compared to the veterans who were students. This result was surprising to find, but may have come about because all of the participants were enrolled at The Pennsylvania State University, which actively promotes Counseling and Psychological Services (CAPS) on campus to all students who are in need. As aforementioned, the availability of veteran organizations at The Pennsylvania State University allows veterans to come together with a common experience, which may reduce the occurrence of self-stigmatization. Another reason for the higher self-stigma among civilians who were students could be due to the majority of participants in the veteran group (95 %) receiving military training/education on PTSD. This may have been the reason why the findings of this study did not align with the study conducted by Fairweather (2008), who found that service members repeatedly stated that they felt they would be ostracized and punished, accused of trying to get out of duty, and believed their jobs or a chance at promotion would be in jeopardy if they were to seek help for PTSD symptoms.

The results of the study did not support the third hypothesis that civilians who are students will have more social stigma towards the diagnosis of PTSD than veterans who are students. The mean difference between the groups' social stigma scores were non-significant. These findings may be attributed to the sizable portion of the participants who reported being a witness to a traumatic event (48 %). This personal experience may explain why both the civilians and veterans had similar rates of social stigma. Also, there may not have been a significant

relationship between social stigma and the civilian or veteran population because all of the participants in this study were in college. Approximately 96% of the total sample had some knowledge of PTSD, reporting that they had received this knowledge from college or military courses. These findings were surprising because they did not support the previous literature, such as the study by Lyons et al. (2009), who found that many individuals with mental illness reported experiencing social discrimination in the community, giving accounts of being physically and verbally attacked by strangers and neighbors, their property being vandalized, or being physically barred from shops and pubs.

Finally, the results of the study did not support the fourth hypothesis that individuals with higher flourishing levels would have lower rates of stigma. No statistically significant relationship was found among flourishing levels and rates of help-seeking, self-stigma, or social stigma. This was surprising because it indicates that well-being may not be a protective factor for negative perceptions in regard to post-traumatic stress disorder. Thus increasing an individual's well-being may not decrease either social stigma or self-stigma, nor may it increase trust/overall stigma regarding PTSD. These findings support the idea that any individual, despite his/her well-being, is susceptible to stigmatizing attitudes and perceptions. These findings may have come about because of the small number of participants in this study. Also, the small sample size may have been the reason why the findings were not supported by the study conducted by Rudd et al. (2011), who found that the average student veteran reported experiencing moderate anxiety, moderately severe depression, significant symptoms of PTSD, and evidencing at least some noticeable suicide risk. In this study, feelings of well-being were diminished by mental illness and the stigma was more prominent in the student community, which reduced help-seeking behavior (Rudd et al., 2011).

### *Limitations*

The findings of this study must be considered in the context of its limitations. One limitation concerns the small sample size. Due to this small sample size and the population consisting only of undergraduate and graduate students enrolled at The Pennsylvania State University, the generalizability of the results is limited. Also, the small sample size may have made it difficult to detect significant differences between both sample groups. It is possible that a larger sample size that incorporates a national sample of civilians who are students and veterans who are students would result in different findings. A random sample rather than a convenience sample of students at The Pennsylvania State University would also improve the generalizability of results.

Another limitation may be that the data consisted of a majority of White/Caucasian participants (88 %), which means that the results of this study cannot be generalized to the greater population. However, one of the important strengths to the research is that the balance between civilian and veteran participants is relatively even (45.8 % veterans and 54.2 % civilians), which helps when attempting to support the hypotheses.

### *Suggestions for Future Research*

The findings from this research are important in terms of social implications. Research and further education about the stigmatization of veterans in the school environment and military culture can lead to better policies and prevention efforts that may assist with the de-stigmatization of the diagnosis of post-traumatic stress disorder and other mental illnesses. This may help protect students, both civilians and veterans, who are wary about seeking professional help for any mental health symptoms.

Conducting the same study using a larger sample size may prove beneficial to future researchers. Also, it may be of interest to survey both groups at the national level, so the results can be generalized. In addition, a similar survey may be administered at a number of universities, so it can be observed whether a more prominent stigma exists depending on the university location.

Researchers need to continue conducting empirical research to ascertain the factors that contribute to stigma in the community about post-traumatic stress disorder. First, researchers should identify the types of stigma that are most frequent among civilians in the student community and veterans in the student community. Second, researchers should determine what types of factors influence students to engage in stigmatization. Finally, experimental research should be conducted to test various strategies for preventing further stigmatization of the post-traumatic stress disorder diagnosis to determine which strategies are most effective in the civilian and military communities.

If I were to start this study all over again, I would try to find additional sources that may be more relevant to the presented hypotheses. Continuing with the same topic of post-traumatic stress disorder stigmatization, the next step I would take would be to examine what some of the most common risk factors and protective factors are associated with the development of post-traumatic stress disorder when a service member is exposed to a traumatic event. I would investigate these factors so prevention efforts may be taken to protect the mental health of service members and to promote help-seeking behavior of future veterans.

### *Conclusion*

This paper focused on the factors associated with college student perceptions of post-traumatic stress disorder, including help-seeking behavior, reports of self-stigma, reports of

social stigma, and whether or not higher flourishing levels will have lower rates of stigma. Very few research studies in the area of stigma and post-traumatic stress disorder exist, and even fewer studies have looked at help-seeking behavior, social distance, and perceived dangerousness as measures of stigmatization in the college student population. Although the findings in this study did not coincide with previous studies, the findings still contribute to the body of knowledge that is continuing to develop around the diagnosis of post-traumatic stress disorder.

The study of the help-seeking behavior, social stigmatization, and self stigmatization of PTSD is necessary considering the large number of combat veterans returning to the United States who are being diagnosed with PTSD. It is imperative to consider the likelihood of self-stigmatization as a barrier to care, as well as the costs for not seeking mental health care, such as an increased risk of suicidal ideation or ramifications that extend throughout the family and have multi-generational effects. In addition, mental illness stigma has been associated with problems obtaining housing, health care, employment, and problems in relationships with friends and family.

These findings are important as they could help mental health professionals develop more efficient anti-stigma programs and promote the treatment of mental illness, especially for PTSD, in the active duty, veteran, and civilian population. This would create more community awareness, which may lead to an overall decrease in the number of PTSD-related suicides each year. More research is needed for veterans and civilians to be better prepared to address the symptoms of PTSD and to de-stigmatize the general diagnosis of PTSD in the military community, the college community, and the general public.

## REFERENCES

- Ahmedani, B. K. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values and Ethics*, 8, 1-14.
- Corrigan, P. W., & Kleinlein, P. (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, D. C.: American Psychological Association.
- Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9, 35-53.
- Corrigan, P. W., Watson, A. C., Barr, L. (2006). The self-stigma of mental illness: implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25 (2), 875–884.
- Diagnostic and statistical manual of mental disorders* (4th ed.). (2000). Washington, DC: American Psychiatric Association.
- Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D., Oishi, S., & Biswas-Diener, R. (2009). New measures of well-being: Flourishing and positive and negative feelings. *Social Indicators Research*, 39, 247-266.
- Elliott, G. C., Ziegler H. L., Altman, B. M., & Scott D. R. (1982). Understanding stigma: Dimensions of deviance and coping. *Deviant Behaviour*, 3, 275-300.
- Erspamer, G. P. (2008). The new suspect class: Tragically, our veterans. *Human Rights*, 35, 17-20.
- Fairweather, A. N. (2008). Compromised care: The limited availability and questionable quality of health care for recent veterans. *Human Rights*, 35, 2-24.

- Friedman, M. J. (2006). Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *American Journal of Psychiatry, 163* (4), 586-593.
- Forman, S. I., & Havas, S. (1990). Massachusetts' posttraumatic stress disorder program: A public health treatment model for Vietnam veterans. *Public Health Reports, 105*, 172-179.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Harmondsworth, Middlesex: Penguin Books.
- Hoge, C. W. (2010). *Once a warrior always a warrior: Navigating the transition from combat to home*. Guilford, Connecticut: Globe Pequot Press.
- Link, B., Struening, E., Cullen, F., Shrout, P., & Dohrenwend, B. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 52*, 400-423.
- Link, B., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, and social distance. *American Journal of Public Health, 89*, 1328-1333.
- Lyons, C., Hopley, P., & Horrocks, J. (2009). A decade of stigma and discrimination in mental health: The more things change, the more they stay the same. *Journal of Psychiatric and Mental Health Nursing, 16*, 501-507.
- Magruder, K. M., Frueh, B. C., Knapp, R. G., Johnson, M. R., Vaughan, J. A., Carson, T. C., Powell, D. A., & Hebert, R. (2004). PTSD symptoms, demographic characteristics, and functional status among veterans treated in VA primary care clinics. *Journal of Traumatic Stress, 17*, 293-301.

- Rudd, M. D., Goulding, J., & Bryan, C.J. (2011). Student veterans: A national survey exploring psychological symptoms and suicide risk. *Professional Psychology: Research and Practice, 42*, 354-360.
- Sher, L., Braquehais, M. D., & Casas, M. (2012). Posttraumatic stress disorder, depression, and suicide in veterans. *Cleveland Clinic Journal of Medicine, 79*, 92-97.
- Tanielian, T., Jaycox, L. H., Adamson, D. M., Burnam, A. M., Burns, R. M., Caldarone, L. B., & ... Yochelson, M. R. (2008). Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. *RAND Corporation*. Retrieved from <http://www.rand.org/pubs/monographs/MG720>
- van der Kolk, B., & Courtois, C. (2005). Complex trauma. *Journal of Traumatic Stress Special, 18*, 385-388.
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337.

## Appendix A

### STUDY SURVEY

#### Demographic Questionnaire

**Please fill out as completely as you can. All responses will be kept confidential.**

1. Gender (check one):  Male  Female
2. Age: \_\_\_\_\_ (in years)
3. Major(s): \_\_\_\_\_
4. Semester Classification(check one):  Freshman  Sophomore  Junior  Senior  
 Graduate
5. Race/ Ethnicity (check one or all that apply):  
 White, Non-Hispanic  
 Hispanic/Latino  
 African American/Black  
 Native American  
 Asian American/Pacific Islander  
 Other \_\_\_\_\_ (specify)
6. Have you ever sought help from a mental health professional?  Yes  No
7. Have you ever been diagnosed with a mental health problem?  Yes  No
8. Have you ever been enlisted in the military?  Yes  No  
 (If YES, answer parts a, b, & c below. If NO, skip to #9).
  - a. **If yes**, which branch?: \_\_\_\_\_
  - b. **If yes**, for how long have you been enlisted?: \_\_\_\_\_
  - c. **If yes**, have you experienced combat?:  Yes  No
9. Do you have a disability or chronic illness or are you taking medications for anything?  
 Yes  No
  - a. **If yes**, please specify: \_\_\_\_\_
10. Have you ever been a victim of and/or witnessed a traumatic event?  
 Yes  No
  - a. **If yes**, have you experienced any of the following (check all that apply):  
 Reliving the traumatic event through flashbacks/nightmares

\_\_\_\_\_ Avoiding people/places/thoughts that remind you of the trauma

\_\_\_\_\_ Hyper-arousal, which includes difficulty sleeping, outbursts of anger,  
difficulty concentrating, easily startled

b. **If yes**, have you ever sought help for any of the above? \_\_\_\_\_Yes \_\_\_\_\_No

11. Do you know what post-traumatic stress disorder is? \_\_\_\_\_Yes \_\_\_\_\_No

a. **If yes**, how did you learn about it? (Examples: media, class, personal experience, etc.)

\_\_\_\_\_

12. Has anyone in your family or someone close to you been diagnosed with post-traumatic stress disorder (PTSD)? \_\_\_\_\_Yes \_\_\_\_\_No

Please read the brief story about John, then answer the following questions.

**Vignette: John with Post- Traumatic Stress Disorder**

*John is a private in the Army and returned home from Iraq 2 months ago. During his tour of duty he experienced a considerable amount of combat exposure and also witnessed his best friend being killed. One month after arriving home he began having flashbacks from combat as if he never left. He began feeling nervous and agitated, and fears about his family's safety consumed him. He walks around his house at night checking the locks on the windows and doors to ensure the safety of his family. John also has had trouble sleeping at night, waking with nightmares about his best friend's death. He felt like it was his fault he died, that he should have been able to prevent it. John stopped meeting with his friends from the Army because they remind him of his traumatic experiences in Iraq. John is suffering from feelings of emptiness and detachment and his family and friends are growing concerned about him. But John doesn't feel like talking. John has been diagnosed with post-traumatic stress disorder (PTSD).*

Using the six-point scale below, mark the appropriate number corresponding to your beliefs about John. Please do not leave any statements blank. Select just one number for each statement.

(1)	(2)	(3)	(4)	(5)	(6)
Always Willing	Usually Willing	Sometimes Willing	Sometimes <u>Unwilling</u>	Usually <u>Unwilling</u>	Always <u>Unwilling</u>

1. How willing would you be to work with a person like John? \_\_\_\_\_
2. How willing would you be to move next door to a person like John? \_\_\_\_\_
3. How willing would you be to make friends with a person like John? \_\_\_\_\_
4. How willing would you be to recommend a person like John for a job? \_\_\_\_\_
5. How willing would you be to accept your child to marry a person like John? \_\_\_\_\_
6. How willing would you be to rent a room to a person like John? \_\_\_\_\_
7. How willing would you be to trust a person like John to take care of your child? \_\_\_\_\_
8. How likely is it that John would do something violent toward other people? (circle one)  

<b>Extremely Likely</b>	<b>Very Likely</b>	<b>Somewhat Likely</b>	<b>Somewhat <u>Unlikely</u></b>	<b>Very <u>Unlikely</u></b>	<b>Extremely <u>Unlikely</u></b>
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Were there circumstances with respect to this experiment, the experimenter, or events in your life that influenced your responses? **If yes**, please explain:

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### SSSHS Scale

Please read the following statements. For each item please rate how you might react if you were considering seeking help.

**1. I would feel inadequate if I went to a therapist for psychological help.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**2. My self-confidence would NOT be threatened if I sought professional help.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**3. Seeking psychological help would make me feel less intelligent.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**4. My self-esteem would increase if I talked to a therapist.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**5. My view of myself would not change just because I made the choice to see a therapist.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**6. It would make me feel inferior to ask a therapist for help.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**7. I would feel okay about myself if I made the choice to seek professional help.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**8. If I went to a therapist, I would be less satisfied with myself.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

**10. I would feel worse about myself if I could not solve my own problems.**

1	2	3	4	5
Strongly Disagree		Agree / Disagree Equally		Strongly Agree

### SSMIS

There are many attitudes about people who receive treatment for Post-traumatic Stress Disorder (PTSD). Post-traumatic Stress Disorder is a mental health disorder that results for some people exposed to a life-threatening event. Symptoms of this disorder can include a) re-experiencing the event, b) avoiding stimulus associated with the traumatic event, and/or c) having extreme behavioral reactions. We would like to know what you think most of the public as a whole (or most people) believe about these attitudes. Please answer the following items using the 9-point scale below.

Strongly Disagree	Neither agree Nor disagree	Strongly Agree
1	2      3	4      5      6
7	8	9

Section 1:

### **I think the public believes....**

1. \_\_\_\_ most persons with PTSD cannot be trusted.
2. \_\_\_\_ most persons with PTSD are disgusting.
3. \_\_\_\_ most persons with PTSD are unable to get or keep a regular job.
4. \_\_\_\_ most persons with PTSD are dirty and unkempt.
5. \_\_\_\_ most persons with PTSD are to blame for their problems.
6. \_\_\_\_ most persons with PTSD are below average in intelligence.
7. \_\_\_\_ most persons with PTSD are unpredictable.
8. \_\_\_\_ most persons with PTSD will not recover or get better.
9. \_\_\_\_ most persons with PTSD are dangerous.
10. \_\_\_\_ most persons with PTSD are unable to take care of themselves.

## Section 2:

Now answer the next 10 items using the agreement scale.

Strongly	Neither agree	Strongly
Disagree	Nor disagree	Agree
1	2	3
4	5	6
7	8	9

## I think...

1. \_\_\_ most persons with PTSD are to blame for their problems.
2. \_\_\_ most persons with PTSD are unpredictable.
3. \_\_\_ most persons with PTSD will not recover or get better.
4. \_\_\_ most persons with PTSD are unable to get or keep a regular job.
5. \_\_\_ most persons with PTSD are dirty and unkempt.
6. \_\_\_ most persons with PTSD are dangerous.
7. \_\_\_ most persons with PTSD cannot be trusted.
8. \_\_\_ most persons with PTSD are below average in intelligence.
9. \_\_\_ most persons with PTSD are unable to take care of themselves.
10. \_\_\_ most persons with PTSD are disgusting.

### FLG Scale

**Below are 8 statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by indicating that number response for each statement.**

- 7 Strongly Agree
- 6 Agree
- 5 Slightly Agree
- 4 Mixed or Neither Agree Nor Disagree
- 3 Slightly Disagree
- 2 Disagree
- 1 Strongly Disagree

\_\_\_ I lead a purposeful and meaningful life.

\_\_\_ My social relationships are supportive and rewarding.

\_\_\_ I am engaged and interested in my daily activities.

\_\_\_ I actively contribute to the happiness and well-being of others.

\_\_\_ I am competent and capable in the activities that are important to me.

\_\_\_ I am a good person and live a good life.

\_\_\_ I am optimistic about my future.

\_\_\_ People respect me.

## Appendix B

### DSM-IV TR (APA, 2000, p.467) DIAGNOSTIC CRITERIA FOR POST- TRAUMATIC STRESS DISORDER:

#### *Criterion A: Stressor*

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror.

#### *Criterion B: Intrusive Symptoms*

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated).
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

#### *Criterion C: Avoidant/Numbing Symptoms*

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

*Criterion D: Autonomic Hyper-arousal*

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hyper-vigilance.
5. Exaggerated startle response.

In addition, the DSM- IV requires that the PTSD symptoms be present for more than one month (similar symptoms that occur for less than a month is diagnosed as acute stress disorder). PTSD is considered to be chronic if the symptoms are present for more than three months. The DSM- IV describes the occurrence of delayed onset, in which symptoms emerge more than six months after the event

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### Education

- Bachelor of Science Degree in Crime, Law, and Justice; Schreyer Honors College at The Pennsylvania State University, Spring 2014
- Bachelor of Science Degree in Rehabilitation and Human Services; Schreyer Honors College at The Pennsylvania State University, Spring 2014
  - Minor in Psychology; The Pennsylvania State University, Spring 2014
  - Minor in Political Science; The Pennsylvania State University, Spring 2014
  - Minor in Sociology; The Pennsylvania State University, Spring 2014

### Awards and Honors

- Criminology Student Marshal, The Pennsylvania State University, Spring 2014
- Rehabilitation & Human Services Student Marshal, The Pennsylvania State University, Spring 2014
- Excellence in Communication Certificate, College of Liberal Arts, The Pennsylvania State University, Spring 2014
- President's Sparks Award, The Pennsylvania State University, Spring 2012
- Dean's List (Fall 2010, Spring 2011, Summer 2011, Fall 2011, Spring 2012, Summer 2012, Fall 2012, Spring 2013, Summer 2013, Fall 2013, Spring 2014), The Pennsylvania State University

### Activities

- Member of the Paterno Liberal Arts Undergraduate Fellows Program
- Member of the Phi Alpha Theta Honor Society
- Member of the Pi Sigma Alpha Honor Society
- Member of the Alpha Kappa Delta Honor Society
- Member of the Psi Chi Honor Society
- Member of the Phi Kappa Phi Honor Society
- Member of the Omicron Delta Kappa Honor Society
- Member of the National Society of Collegiate Scholars
- Member of the Golden Key International Honour Society

### Professional Presentation

“Race, Class, and Gender: Critical Analysis of the U.S. Juvenile Justice System.” Presented at the Eastern Sociological Society Conference, Spring 2012