THE RELATIONSHIP OF ADULT ATTACHMENT TO THE WILLINGNESS OF SOLDIERS TO SEEK HELP FOR BEHAVIORAL HEALTH CONCERNS

Richard A. Barton

University of Pennsylvania, bartonric@icloud.com

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Abstract

Statement of Problem: This study sought to determine the influence of attachment styles and stigma on the willingness of soldiers to seek help for mental health concerns and the degree to which stigma mediates the relationship between attachment style and help-seeking. Methods: This study utilized data gathered from an anonymous survey of U.S. Army soldiers (N=538) used in a mixed-methods Epidemiological Consultation (EPICON). Participants responded to validated items measuring depression, anxiety, post-traumatic stress, and alcohol use. Measures also included stigma, attachment types, and help-seeking. Analysis assessed the mediating effect of stigma on the willingness of insecure attachment styles to seek help across formal and informal helping categories. Results: Attachment avoidant soldiers were found more resistant to the idea of help-seeking than attachment anxious soldiers. Comparisons of insecure attachment styles (anxious and avoidant) found attachment avoidance predicted increases in stigma, corresponding with declines in help-seeking willingness, with the most significant decrease linked to unit peers and leaders. However, while stigma negatively influenced attachment anxious soldiers’ willingness to seek help from both military and civilian sources, it only mediated a decline in attachment avoidant soldiers’ willingness to seek help from military sources, not civilian. Conclusion: Findings align with prior research indicating anxious attachment adult hesitation can delay help-seeking, and under certain conditions, attachment avoidant adults can be open to help-seeking. Results also suggest when promoting help-seeking with service members and veterans, understanding the intersections between adult attachment types, stigma, and help-seeking is essential to effective clinical and community outreach practice.

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THE RELATIONSHIP OF ADULT ATTACHMENT TO THE WILLINGNESS OF
SOLDIERS TO SEEK HELP FOR BEHAVIORAL HEALTH CONCERNS

Richard A. Barton.
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in
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Supervisor of Dissertation
Dr. Phyllis Solomon
Professor, School of Social Policy and Practice

Dissertation Committee
Phyllis Solomon Ph.D, School of Social Policy and Practice
Michelle Evans-Chase Ph.D., School of Social Policy and Practice
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Phyllis Solomon

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Chapter 1: Background and Significance

Statement of Problem:

Veterans represent 8.5% of the general population; since 9/11, the number of former and current service members who have died by suicide exceeds the number of those killed in combat, with the active-duty population averaging one death per day (Stanley & Larsen, 2019; Waitzkin et al., 2018). In 2019, the veteran population averaged 17.2 suicides a day, accounting for 13.7% of adult suicides in the United States (National Veteran Suicide Prevention Annual Report, 2021). At the 2013 National Conference on Mental Health, President Barrack Obama noted that veterans affected by “invisible wounds of war” often view help-seeking as a sign of weakness. Despite the variety of resources offered by the Armed Forces, Department of Veteran Affairs (V.A.), and Veteran Service Organizations, many service members and veterans remain reluctant to seek help for mental health concerns (Hoge et al., 2004).

The decision to seek help typically involves a series of cognitive assessments that include an appraisal of expectations, social supports, and resources (Larose et al., 1999). In times of stress, those with good insight into their psychological wellbeing are more likely to seek help from friends, family, or professionals (Oliver et al., 2005). Conversely, those with poor insight and reluctant to seek help only do so after personal stress levels have reached a high point (Clement et al., 2015; Vogel et al., 2006). For the latter, decisions to seek help often include a mix of factors consisting of actual or suspected barriers, stigma concerns, resource awareness, and skepticism of mental health services (Skopp et al., 2012).
Past experiences typically inform the cognitive process of assessing help-seeking expectations, social support, and personal resources (Larose et al., 1999). Theorists contend adult help-seeking is linked to childhood caregiver experiences of “separation, distress, and reunion” that create an internalized structure that informs adult interactions (Cheng et al., 2015, p. 465). Research indicates that individuals who were exposed to consistent, responsive, and open childhood caregiver relationships, as adults often maintain a positive view of self and others. While adults who experienced non-responsive, inconsistent, or unreliable caregivers typically see themselves as unlovable and tend to see others as undependable or untrustworthy (Cheng et al., 2015, p. 465).

These concepts underpin the Internal Working Models concepts of Attachment Theory, an inner mechanism thought to shape individual relationship styles (Cheng et al., 2015). Internal Working Models are typified by secure, avoidant, or anxious characteristics linking personal comfort levels with intimacy, levels of self-reliance, and abandonment concerns (Cheng et al., 2015). Attachment traits are thought to shape inner views of self and others and influence the willingness to seek help (Shaffer et al., 2006). For example, adults with avoidant tendencies, resulting from exposure to a “cold and rejecting” primary caregiver, tend to view interaction with mental health providers as risky (Shaffer et al., 2006, p. 442). Alternatively, those who experienced warm and caring caregiver relationships are typically open to the idea of help-seeking for interpersonal or mental health concerns (Owens et al., 2014).

Like the general population, in times of stress, service members who can “mobilize positive mental representations and interpersonal resources” are at lower risk for long-term behavioral health issues (Currier et al., 2012, p. 633). At the same time,
those who find it difficult to draw on “supportive relationships within their military unit or community” are at greater risk for prolonged mental health issues (Currier et al., 2012, p. 633). Military culture also presents unique factors that can influence the evaluation of social support structures, help-seeking resources, and expectations. For example, wartime experiences can modify “pre-existing meaning structures,” altering perceptions of self and others, refashioning relationships and personal needs, changing psychological wellbeing, and help-seeking behaviors (Currier et al., 2012, p. 633).

Other factors can also affect service members’ perspectives on social support, help-seeking resources, and expectations, such as a shared warrior ethos emphasizing individual “discipline, mental toughness, and self-sufficiency” (Skopp et al., 2012, p. 1037). A byproduct of the warrior ethos is an “embrace the suck” mentality that supports the management of physical and mental challenges often associated with the military lifestyle, yet paradoxically, can contribute to delays in help-seeking for behavioral health concerns (Castro et al., 2015; Nicholson, 2016; Skopp et al., 2012). Additional factors include a legacy of past policies employed as force-multiplying strategies to infer an inherent weakness or “lack of moral fiber” in those who experienced common emotional, physical, and psychological reactions to combat, effectively suppressing generations of service members help-seeking for mental health concerns (Edgar Jones, 2006, p. 439; Jones & Wessely, 2014). These factors contributed to the stigmatization of help-seeking for mental health concerns, resulting in common help-seeking problems shared by many service members that include the anticipation of adverse reactions by others, concerns for appearing weak to peers or leaders, or worries about their career or job status (Britt et al., 2008). For military populations, untreated mental health issues are associated with
increased family problems, declines in personal readiness, and lower reenlistment rates (Skopp et al., 2012).

Post 9/11, a greater understanding, and appreciation for the effect of combat and high operational tempo on the psychological health and wellness of service members and families have helped erode long-held stereotypes linked to help-seeking for behavioral health concerns (Hoge et al., 2016). This shift has led to meaningful changes in how military behavioral health services are delivered, as exemplified by the wholesale restructuring of the U.S. Army’s Behavioral Health Care System (Hoge et al., 2016). However, despite the efforts to remove obstacles, many remain (Jones, 2013), illustrated by the comparatively unchanged suicide rates for service members and veterans (Hoge et al., 2016).

To contribute to the existing research on service members’ help-seeking behaviors and its intersection with theories of attachment and stigma, this researcher utilized secondary data sources to examine the following questions:

To what extent do Anxious and Avoidant attachment styles relate to the willingness of soldiers to seek help for mental health concerns?

To what extent does stigma mediate the willingness of Anxious or Avoidant attachment style soldiers to seek help for mental health issues?

**Historical Context:**

In the summer of 2010, the war in Afghanistan became the nation’s longest war (Williams, 2010). During the winter of 2011, 73% of the U.S. Army’s active component had served in Iraq and Afghanistan, with many on their second or third combat tours
(Baiocchi, 2013). The battlefield strategies applied to manage and treat those serving in Iraq and Afghanistan psychologically and emotionally affected by exposure to combat or wartime experiences can be linked to the proactive “forward psychiatry” concepts first employed during World War I (1914-1918) (Greene-Shortridge et al., 2007, p. 791; Jones & Wessely, 2014, p. 216). Similarly, the “deeply engrained” cultural stigma that many service members associate with psychological and emotional difficulties can also be traced back to the First World War (Jones & Wessely, 2014, p. 1710).

**Before 1914:**

Before the outbreak of the “Great War” (World War I), the treatment of psychological illness was associated with maltreatment and warehousing resulting in negative perceptions of mental health treatment (Jones & Wessely, 2014, p. 1712). At the time, physical and psychological stresses that resulted from exposure to combat were generally considered an organic product of individual predisposition and personal makeup (Jones, 2001, p. 246). Martin Charcot, who treated soldiers serving in the Franco-Prussian War (1870-1871), hypothesized that certain individuals were characteristically more susceptible to trauma (Jones et al., 2007, p. p. 165). Sigmund Freud and Joseph Breuer also reinforced concepts of individual predisposition to traumatic neurosis and the idea that soldiers, to avoid frontline duty or to qualify for war pensions, intentionally exaggerated or manufactured their combat-related psychological distress (Bogacz, 1989, p. 232; Jones & Wessely, 2007, p. 216).

In contrast, as a field surgeon in the British Army during the Second Boar War (1899-1902), Sir Anthony Bowlby, father of John Bowlby and who during World War I served as the Consulting Surgeon to the Allied Forces, viewed “prolonged mental strain
and bodily fatigue” the result of cumulative exposure to the combat environment (Jones, 2001, p. 242). Nonetheless, adhering to the consensus of the times, British Army physicians did not officially report any cases of war-related neuroses (Jones, 2001, p. 165). A retrospective review of 6,200 Second Boar War medical discharges found that 11 Soldiers were released from active service for psychological reasons (Jones, 2001, p. 242), with one discharge resulting in a war pension for “nervous shock” as a result of direct exposure to shell blasts (Jones, 2001, p. 242).

*World War I:*

Before the outbreak of World War I, warfighting strategies were informed by advancing technologies and “short war” theories that predicted wars would end rapidly using decisive, aggressive, and mobile tactics (House, 1976, p. 164). Along with other factors, this miscalculation resulted in a static and entrenched frontline, with tactics being dominated by intense artillery fire and massed waves of infantry that resulted in a scale of physical and psychological trauma far more substantial than had ever been imagined (Camp, 2014, p. 145; Jones & Wessely, 2007, p. 216).

In the early days of the war, soldiers were generally not stigmatized for psychological distress; those with symptoms resulting from combat engagements were classified as battle casualties, authorized to wear distinctive wound stripes on their uniform sleeves, and eligible for war pensions (Jones & Wessely, 2014, p. 1711; Loughran, 2012, p. 106). As each army struggled with the new combat environment, the static and entrenched frontline expanded, artillery was used to clear enemy mines and emplacements just prior to massed attacks of infantry (Shively & Perl, 2012, p. 235). As the rate of artillery fire and the use of high-energy munitions increased, the blasts became
more concentrated and frequent, as did the psychological, emotional, and physical reactions to combat (Newcombe & Lerner, 1982, p. 5; Shively & Perl, 2012).

This constellation of physical, psychological, and emotional symptoms was a new phenomenon. Early in 1915, a Lancet article used the term “shell shock” to describe some of these symptoms, becoming the term used to link the adverse effects of war on psychological wellbeing (Loughran, 2012, p. 105). Early on, treatment strategies took a physical approach, gradually shifting to neurological methods, resulting in various theories and opinions on the causes of shell shock, leading to uneven policies, management protocols, and treatment practices (Jones, 2001, p. 246).

As the war wore on, the treatment and evacuation of the ill, wounded, and injured improved, resulting in higher rates of those returned to frontline duty (E. Jones, 2006, p. 537). This resulted in mounting pressures to improve the rate of return for those suffering from shell shock (E. Jones, 2006). Applying lessons learned by the Russians during their war with Japan (1904-1905), the French Army placed specialized treatment units closer to the frontlines to provide more immediate treatment and to establish expectations for recovery and a return to the frontlines (Jones et al., 2007, p. 215). Over time the strategy of Proximity, Immediacy, and Expectation (PIE) was adopted by both the British and American militaries and continue to inform the strategies used by the U.K., U.S., and Israeli Armed Forces to manage and treat combat-related post-traumatic stress in the field (Jones et al., 2007, p. 215).

Despite those efforts, controversies over the nature of and treatment for shell shock resulted in limited improvements to the rates of return (E. Jones, 2006, p. 537). The view that shell shock symptoms were being faked or exaggerated to escape frontline duty
led to draconian treatment and “re-education” strategies (Jones & Wessely, 2014, p. 1711). For many warfighting and medical leaders, the lack of clarity further linked shell shock to ideas of cowardice and malingering, leading to several summary court-martials, with some resulting in executions (Bogacz, 1989, p. 227; E. Jones, 2006, p. 537). Nonetheless, at the end of the war, in the British Army alone, there had been over 200,000 service members diagnosed with a combat-related psychological or psychosomatic disorders (Jones & Wessely, 2014, p. 1711).

Between the Wars:

The stigmatization of shell shock had not been exclusive to the allied forces; in 1916, the German Association of Psychiatry War Congress determined war “distress or functional impairment” stemmed from pre-existing weaknesses or predisposition to “hysteria” (Greene-Shortridge et al., 2007, p. 791). The Imperial German Army discontinued shell shock as a medical term and replaced it with “hysteria” to feminize its symptoms (Greene-Shortridge et al., 2007, p. 791). By 1922, the United Kingdom had over 75,000 veterans in treatment for shell shock (Bogacz, 1989, p. 227). The escalating costs of treatment led the British War Office to commission the Southborough Committee to, among its many tasks, identify strategies for dealing with the shell-shocked veterans and mitigate shell shock in future wars (Bogacz, 1989; Shively & Perl, 2012, p. 236). Like the German Army, the Southborough Committee also concluded that shell shock was the result of a deficiency in “willpower” and had been used as an excuse to evade duty (Shively & Perl, 2012, p. 236). It was decided that shell shock was no longer a “valid diagnostic entity,” and its use was banned (Shively & Perl, 2012, p. 236). Policy recommendations were developed to prevent the classification of those presenting with
the symptoms of shell shock as battlefield casualties (Shively & Perl, 2012). The committee also recommended policies to institute rigorous training to develop individual “élan vital” intended as preventative measures (Bogacz, 1989, p. 227; Joy, 2008, p. 240).

Although many viewed the Southborough Committee’s findings as controversial, resulting in significant debates and public discourse, many of the recommendations resulted in morale and leadership procedures and training programs used to test and screen out potential “psychiatric casualties” (Jones & Wessely, 2014, p. 1711). Over time some of the programs did demonstrate value in promoting certain protective factors (Jones & Wessely, 2014). Nonetheless, the declarations and policies linking cowardice to shell shock served to further stigmatize and suppress the development of new strategies for addressing wartime psychological injuries (Bogacz, 1989, p. 248; Jones & Wessely, 2014).

World War II:

As World War II dawned, with policies intended to stigmatize shell shock in place, prevention strategies emphasizing rigorous training and screening procedures were instituted as primary tools to address psychological reactions to the combat environment (Jones et al., 2003; Jones & Wessely, 2014, p. 1711). As the war wore on, proven and battle-weary combat veterans, including those who served with distinction, began arriving in far greater numbers at front-line medical aid stations with symptoms of “shell shock” (Jones & Wessely, 2014). These outcomes revealed the limitations to the protective and deterrence strategies, resulting in acceptance that sustained periods of combat can lead to a “breaking point” (Jones & Wessely, 2014, p. 1711). To disentangle concepts of illness from shell shock, the term “battle fatigue” was introduced (Jones &
Wessely, 2014, p. 1711) and eventually adopted by both the U.S. and U.K. Armed Forces for the balance of World War II and throughout the Korean War (Jones & Wessely, 2014, p. 1711).

*Post-World War II:*

The impact of both the Korean and Vietnam Wars on veterans helped to influence societal views and policies, highlighted by shell shock symptoms being re-conceptualized and included within the Post-Traumatic Stress Disorder (PTSD) framework and in 1980, its introduction into the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Jones et al., 2007, p. 165). To aid in the de-stigmatization and normalizing of war trauma, all references to hysteria in the DSM were removed, with combat added to the list of events recognized to evoke “significant symptoms of distress in almost everyone” (Greene-Shortridge et al., 2007, p. 791).

As shell shock evolved into battle fatigue and, subsequently, post-traumatic and combat stress concepts, generations of military mental health providers were deployed closer to the frontlines, including Iraqi and Afghanistan (Jones & Wessely, 2014, p. 1713). In 2001, building on the lessons of the past, the U.S. Army began adding positional slots for uniformed Social Workers, Psychologists, and specially trained enlisted members to the formal organizational structures of its Brigade Combat Teams and later shifted many of its garrison behavioral health clinics closer to its warfighting units (Hoge et al., 2016, p. 2). During that time the rate of “invisible wounds” remained appreciably unchanged (Hoge et al., 2016, p. 1), and despite the efforts to increase access, reduce barriers and decrease stigma, an estimated two-thirds of U.S. veterans and service members affected by combat and post-traumatic stress never sought professional help
(Shaffer et al., 2006, p. 442). With veteran suicides averaging 17.2 per day (National Veteran Suicide Prevention Annual Report, 2021) and sixty percent of today’s service members and veterans with mental health concerns unlikely to seek help (Sharp et al., 2015), the identification of factors that both deter and promote service member’s help-seeking behaviors remains essential.

**Factors Shaping Military Help-Seeking:**

Research indicates help-seeking attitudes can be shaped by desires to conform and adhere to group norms (Adler et al., 2015; Sharp et al., 2015). Within the civilian population, groups that share norms similar to the military, concerns about being judged or shunned can make help-seeking outside the group appear risky (Nam et al., 2013, p. 213). Paradoxically, in the military, the norms and values that promote duty, honor, selfless service, and respect of mental toughness, calmness, and forgoing personal safety under adverse conditions, can also deter help-seeking behaviors (Bryan et al., 2012). Concerns over being stigmatized not only prevent help-seeking (Clement et al., 2015), they can result in treatment avoidance and delays to care (Vogel & Wei, 2005), heighten the risk for increased symptoms, and can result in adverse outcomes (Cheng et al., 2015; Clement et al., 2015).

Past caregiver experiences can also influence help-seeking attitudes, perceptions, and decisions to seek, delay or forgo help-seeking (Cheng et al., 2015; Vogel & Wei, 2005). Insecure attachment representations (Avoidant and Anxious) can suppress help-seeking and influence the significance placed on stigma concerns (Fonseca et al., 2018). Attachment representations can also directly or indirectly influence help-seeking behaviors by shaping internal perceptions and stigma beliefs (Fonseca et al., 2018).
Literature reviews revealed that studies linking attachment, stigma, and help-seeking mainly were focused on college students with a smaller proportion focused on military populations. The research devoted to military populations primarily concentrated on the alignment of help-seeking with attachment types, stigma, or perceived mental health. Studies linking the intersection of attachment representations, stigma, and service members’ willingness to seek help were not in evidence.

**Help-seeking Theories and Concepts:**

Help-seeking encompasses the need to solve a problem, searching for help, and a request for assistance (Grinstein-Weiss et al., 2005); specific to mental health, help-seeking can be viewed as an “adaptive coping process” (Rickwood & Thomas, 2012, p. 180). Four primary theories underpin help-seeking concepts: Expectancy-Value Models, which work to identify help-seeking outcomes based on the presumption and chance that the anticipated results will occur; Dual-Process ideas, which seek to measure the deliberative and systematic components of help-seeking, while accounting for the spontaneous actions that emerge along with a series of probing encounters; Stage Theories, which explore outcomes along with a series of “discrete phases” where help-seeking is contemplated as stress levels increase and a plan to seek assistance is acted on; and finally the Series Framework, which works to identify the “personal conditions” met as help-seeking intentions are informed by an “interconnected, cumulative, and logical order” (White et al., 2018, pp. 65-66). Central to each theory is a problem needing a solution, the decision to seek help, and the search for a helping resource (Cornally & McCarthy, 2011).

**Types and Sources of Help:**
Researchers typically align helping resources into two categories, formal and informal, with the former representing the help provided by trained professionals (Rickwood & Thomas, 2012) and the latter assistance found through family members, peers, co-workers, or mentors (White et al., 2018, p. 59). Researchers emphasize categorical alignments to make a clear distinction between professionals who require formal training and those who have received specific, ad hoc, or little to no training (Rickwood & Thomas, 2012).

*Help-Seeking Research and Forecasting:*

Among the many factors, problem recognition is generally viewed as the primary starting point in the help-seeking process (Cornally & McCarthy, 2011). Other help-seeking factors can include levels of stress and the willingness or intention to seek help (White et al., 2018). Causation, duration, interpretation, and problem appraisal are also research considerations, along with internal beliefs and help-seeking attitudes, motivation, and preferred sources of help (Cornally & McCarthy, 2011).

For example, a web-based survey developed by the U.S. Department of Defense Suicide Prevention Office (DSPO) included questions to determine the types of helping sources service members seek (Walsh, 2017). Among the items, participants (N= 6,000) were asked if contemplating suicide which helping resources they would seek out. The majority selected informal sources, with 73% choosing intimate partners 64% indicating a preference for friends, parents, or parental figures (Walsh, 2017). Of those selecting formal resources, 55% preferred mental health providers, with 20% choosing self-management (Walsh, 2017). Regardless of the source, openness to the idea of help is
considered vital to the help-seeking process, as it represents a willingness to disclose personal problems to another (Cornally & McCarthy, 2011).

Willingness and intention are typically the two primary concepts used to predict help-seeking behaviors (Hammer & Vogel, 2013). Social scientists view intention as a decision-making process informed by weighing benefits and disadvantages to help-seeking, further shaped by socio-cultural beliefs, norms, and how others may view the decision to seek help (Cornally & McCarthy, 2011). Researchers generally consider intention established once a plan for help-seeking is determined (White et al., 2018). For research, intention is typically used to determine the odds someone will act on their decision (White et al., 2018, p. 65).

The concept of willingness (considered by many researchers to be a more effective way of forecasting help-seeking behaviors) represents the personal acknowledgment of an existing problem but not necessarily having a plan to resolve it (Wilson, 2005, p. 17). While intention has been found effective at predicting low-risk help-seeking outcomes, it tends to be less effective when conditions are seen as socially unacceptable and stigmatizing (Gerrard et al., 2008). On the other hand, willingness has demonstrated a capacity to predict help-seeking even when individuals are faced with new, stigmatizing, or emotionally charged problems (Gibbons et al., 1995; Hammer & Vogel, 2013). Willingness typically reflects a spontaneous and positive response to unexpected help; while correlating with intention, it is viewed as a distinct and separate concept (Hammer & Vogel, 2013; Wilson, 2005). Spontaneity is believed to negate pre-existing concerns, making willingness less vulnerable to stigma (Hammer & Vogel, 2013, p. 85).
Within cohesive populations like the military, help-seeking can be perceived by some to be stigmatizing and therefore risky; under these circumstances, contact with a helping source is typically the result of an unplanned, hasty, or random encounter (Coleman et al., 2017). In these situations, willingness is viewed as best suited for predicting and providing insights into the help-seeking process. (Coleman et al., 2017; Hammer & Vogel, 2013, p. 84).

**The Influence of Stigma and Military Culture on Help-seeking:**

Informed by social psychology, *stigma* can be defined as separating individuals from the larger group by “marking them with traits viewed as less desirable” (Corrigan, 2004, p. 615). Compared to civilian populations, stigma disproportionately lowers veterans’ and service members’ help-seeking for mental health (Clement et al., 2015, p. 24). A Department of Veterans Affairs (V.A.) study of combat veterans (N=100) illustrates just how pervasive mental health stigma can be: among those reporting a positive experience during treatment, their views on the value of treatment increased, as did their perceptions of stigma (DeViva et al., 2016, p. 314). Other studies indicate that service members who identify with multiple mental health issues tend to report higher degrees of self-management and stigma apprehension (Kim et al., 2011). The association of stigma with mental health treatment often results in delays to care, higher levels of stress, and a greater chance of forgoing care (Adler et al., 2015; Clement et al., 2015, p. 21; Kim et al., 2011, p. 66).

*Stigma and Shifting Trends in Military Help-Seeking Behaviors:*

Stigma is recognized to negatively influence service members’ help-seeking behaviors by contributing to apprehensions for being singled out, appearing weak, or
losing the confidence of peers or leaders (Sharp et al., 2015, p. 156). However, a meta-
analysis on stigma and help-seeking found the influence of anticipated stigma on service
members’ help-seeking behaviors to be lower than expected (Sharp et al., 2015, p. 158).
Certain aspects of the military lifestyle were identified as possible protective factors such
as greater familiarity with available resources, regular exposure to health care
practitioners, and daily peer and leader interactions, making the intentional concealment
of interpersonal or mental health issues challenging (Sharp et al., 2015). The study also
found that in military units with a culture or individual leaders that fostered and promoted
helping resources, the rates of help-seeking were higher, and stigma lower (Sharp et al.,
2015, p. 158).

A systematic review of military mental health help-seeking and service utilization
(2003 to 2011) found that higher use of helping services corresponded with lower levels
of stigma (Hom et al., 2017). Factors identified to support help-seeking included gender
(female service members tend to seek help more often), marital status, supportive family
and friends, strong unit cohesion, compassionate leadership, and favorable views of
mental health treatment (Hom et al., 2017). Conversely, one-third of the participants who
reported mental health concerns did not seek services, corresponding with service
member rates of underutilization (Hom et al., 2017).

A study using DoD Health-Related Behavior Studies (N=12,853) survey data
(N=22,627) found positive attitudes and beliefs about behavioral health services were
associated with declines in stigma and higher rates of use (Quartana et al., 2014). It was
also found that those who served in the later phases of the Afghanistan or Iraq wars and
met the criteria for a mental health disorder were two times more likely to seek behavioral health services than those who served in the earlier stages of those campaigns. Although the study identified an overall decline in rates of stigma, it also found that a substantial portion of the U.S. Army’s population still reported concerns over stigmatization (Quartana et al., 2014).

**Attachment Concepts:**

Attachment theorists view childhood caregiver experiences as central to how personal bonds and mental representations are translated and adapted into internalized maps used to navigate adult relationships (Woodhouse et al., 2015, p. 3). The resulting prototypes or representations, known as internal working models, provide personalized systems for organizing and reconciling “behaviors, expectations, and emotions” while circumnavigating personal relationships (Waters et al., 2002, p. 3). Some researchers believe the internal working models established during childhood remain relatively stable throughout adulthood. In contrast, others view them as open to modification through relationships that take a corrective role. Nonetheless, it is generally agreed that the “reality of an adult’s childhood experiences, be it positive or negative, cannot be altered” (Roisman et al., 2005, p. 106).

Researchers focused on romantic attachments generally view the internal working model as a framework that organizes and shapes the cognitive characteristics of the adult social experience (Shaffer et al., 2006). The process of interactional patterns resulting in internal representations that are molded and adopted into mental prototypes is referred to as the prototype hypotheses (Shaffer et al., 2006). These “automatic images” or
representations are believed to be encoded onto a framework used to interpret and select social encounters and guide adult interactions and relationships (Madigan et al., 2015).

*Attachment Representations:*

Attachment representations are typically aligned and categorized by types, styles, or along a dimensional axis (Shaffer et al., 2006). Within the dimensional approach, the axis endpoints generally represent avoidant or anxious characteristics, defined as those with low trust in others or who view themselves as unlovable. At the same time, those who are usually secure with self and others fall in and around the center points of the axis (Shaffer et al., 2006). These representations are used in a taxonomy that aligns the individual types or styles into three primary attachment categories: avoidant, anxious, and secure.

Attachment theorists have employed internal working model representations to predict levels of personal bonding, intimacy, emotional stability, and perceptions of reliability in others (Belsky, 2002, p. 167). Adult attachment researchers have also used internal working models and prototype taxonomies to identify and describe how childhood caregiver interactions influence adult relationships and the level of proximity to others during times of stress (Shaffer et al., 2006).

Attachment theory has proven helpful in help-seeking research for civilian (Cheng et al., 2015; Rickwood & Thomas, 2012) and military populations (Currier et al., 2012). Attachment theory has been utilized in the U.S., U.K., Netherlands, Israel, and other countries to study military and veteran populations. In general, attachment theory has
been applied to gain insights into the influences of past and current social bonds on cognitive processes and how military experiences influence them.

*Attachment Representations and Help-seeking:*

Theorists view help-seeking intentions as derived from a process of cognitive reasoning that supports or delays the creation of help-seeking strategies (White et al., 2018). In general, those who delay or avoid help-seeking tend to lack attunement or insight into the source of their problems or overlook declines in their mental health, commonly resulting in increased levels of stress which can lead to reactionary or impulsive help-seeking decisions (Coleman et al., 2017, p. 1887).

Many variables shape the decision to seek help or not; internal working models have demonstrated the capacity to offer insights into how help-seeking intentions and willingness are developed (Vogel & Wei, 2005). Specifically, internal working models work to reveal how “discreet and interrelated” cognitive representations are linked in shaping internalized views of self and that of others by aligning perceptions of self-worth and the anticipation of certain behaviors by others (Lopez et al., 1998, p. 79).

For help-seeking researchers, internal working models have proven effective for predicting how internalized “automatic images” influence intentions and forecast levels of spontaneity (Vogel & Heath, 2016, p. 696). Typical applications include isolating the point at which favored behaviors in others are identified, emulated, and internalized and how those mental representations (prototypes) influence help-seeking behaviors (Gibbons et al., 1995). Internal working models have also shown an ability to show how internalized representations are operationalized, can mediate adult help-seeking behaviors
(Waters et al., 2002, p. 3), and determine levels of avoidance, bonding, or proximity to others in times of stress (Vogel & Heath, 2016, p. 696; Vogel & Wei, 2005, p. 348).

**Contributing and Influencing Factors:**

Researchers examine a myriad of factors that intersect with individual attachment styles, mental health, and the help-seeking behaviors of service members. Self-medicating with alcohol to manage past trauma and other behavioral health difficulties is one such factor (Servies et al., 2012, p. 2). A study on how attachment characteristics influence mental health symptoms found that insecure attachment types correlated with increased post-traumatic stress symptoms, mental health concerns, alcohol consumption, and excessive drinking (Currier et al., 2012). For combat veterans with insecure attachments, lower levels of help-seeking and delays in care can be linked to alcohol and the misuse of substances to mitigate anxiety and related post-traumatic symptoms (Owens et al., 2014).

Anxiety, typified by excessive worry, uneasiness, hypervigilance, and somatic complaints, is another factor often associated with traumatic experiences (Neria et al., 2010) and linked to insecure attachment styles (Muris et al., 2001). A study (N=248) looking at the role of emotional dysregulation in attachment security, generalized anxiety, and depression found secure attachments were linked to lower levels of emotional dysregulation, anxiety, and depression and insecure attachments primarily associated with higher levels (Marganska et al., 2013).

Depression is another factor linked to service members’ mental health concerns and attachment insecurities (Elklit & Karstoft, 2016). A systematic review of past and
current frontline mental health treatment data found that higher rates of depression were associated with combat-related experiences (Russell & Figley, 2017). When looking at the help-seeking behaviors of U.S. service members (N=233) one study found that 72% of those who sought care outside of the military health system met the criteria for major depression (Waitzkin et al., 2018). An additional study estimated depression among veterans as high as 31%, and among those seeking services, the rate of comorbid post-traumatic stress and depression to be as great as 36% (Owens et al., 2014).

A final additional factor, “persistent and pervasive trauma,” particularly “manmade trauma,” is considered capable of altering how individuals view themselves and others (Horesh et al., 2014, p. 376). Service members that encounter combat situations are 2 to 3 times more likely to experience some level of post-traumatic stress than those with little to no exposure to combat (Britt et al., 2017). The combination of exposure to trauma and attachment insecurities increases the risk for post-traumatic outcomes (Currier et al., 2012). Attachment insecurities and the desire for autonomy elevate the risk for greater social isolation, lower help-seeking behaviors, and increase the odds for acute and chronic behavioral health difficulties (Currier et al., 2012).

*Attachment Theory Research and Military Populations:*  
Researchers have used attachment theory to provide insight into civilian and military populations (Cheng et al., 2015; Currier et al., 2012; Rickwood & Thomas, 2012). Researchers focused on the military have used attachment theory to study specific groups such as former prisoners of war, combat veterans, and military families (Woodhouse et al., 2015). Attachment theory has also been applied to specific research topics that include post-traumatic stress (Campbell et al., 2016; Escolas, 2012; Franz et
al., 2014), leadership behaviors (Davidovitz et al., 2007), and stressful life events (Horesh et al., 2014; Mikulincer & Florian, 1995). Attachment theory has further been employed to understand better the effects of deployment on caregiver separation and military dependents (Barker & Berry, 2009), relationships between leaders and followers (Mayseless, 2010), and to predict the attrition rates of new service members (Cabrera, 2006).

**Rationale for the Current Study:**

While many factors work to influence the help-seeking decisions of service members, the intent of this study is to offer additional insight into the aspects that contribute to those decisions. Through the lens of attachment theory, this study examines factors commonly recognized to reduce the willingness of service members and veterans to seek help. Based on a review of historical and scientific literature centered on military populations and culture, which focused on help-seeking, attachment, and stigma theories, this study examined the following hypotheses:

Those who are identified as having an *Anxious* or *Avoidant* attachment style will report less willingness to seek help than those identified as neither *Anxious* nor *Avoidant*.

Those who are identified as having an *Anxious* or *Avoidant* attachment style will be more likely to report stigma as a barrier to seeking help than those identified as neither *Anxious* nor *Avoidant*.

The relationship between *Anxious* or *Avoidant* attachment styles and the willingness to seek help for mental health concerns will be partially mediated by stigma.
Chapter 2: Methods

Study Overview and Sample:

Utilizing the outcomes from an anonymous survey developed by the U.S. Army Public Health Center (APHC) employed for a mixed-methods Epidemiological Consultation (EPICON), this study sought to determine the influence of attachment styles on the willingness of soldiers to seek help for mental health concerns and the degree stigma affected their willingness to seeking help.

The 2013 EPICON was designed to assess the impact of daily stressors on a unit’s morale (N=733). The survey focused on several areas of interest, including identifying attachment types, help-seeking behaviors, stigma perceptions, behavioral health symptoms, barriers to care, and job satisfaction. The survey portion of the EPICON consisted of open source validated scales to determine the prevalence of depression, anxiety, post-traumatic stress, excessive alcohol use, and attachment types.

Additional scales used to determine the impact of stigma and barriers to care were developed by behavioral health scientists and social epidemiologists at the Walter Reed Army Institute of Research (WRAIR) Center for Military Psychiatry and Neuroscience. WRAIR also developed items to measure help-seeking behaviors that were used by U.S. Army Mental Health Advisory Teams deployed to Iraq and Afghanistan (2004-2011). These items were selected to fill survey gaps or replace items determined a poor fit for measuring the influence of combat on the help-seeking behaviors of those deployed during Operation Iraqi Freedom and Operation Enduring Freedom. The demographic items were developed by a multidisciplinary team consisting of behavioral and public...
health scientists from APHC’s Behavioral & Social Health Outcome Practice (BSHOP) Division.

The survey portion of the EPICON was administered by laptop on two separate occasions at several locations. The survey was made available to participants on various three-day periods over a two-month timeframe. Of the unit’s 733 personnel, 601 individuals opted to complete the survey; of those surveyed, 538 were uniformed members of the United States Army. For this study, the U.S. Army civilian data was excluded; only the service member’s data (N=538) was used.

Measures:

Dependent Variable:

Willingness to seek help: Using the survey questions developed by WRAIR to measure help-seeking, the dependent variable was calculated by summing the number of ‘yes’ responses to the binary (yes or no) question “If you had a behavioral health concern in the future, would you go to the following?” Responses to this question were selected from a list of common formal and informal military and civilian helping sources. The list of formal helping sources includes professional, medical, and mental health caregivers. The informal sources include chaplains, friends, and the chain of command. The response list consists of a box providing space to identify “other” formal or informal sources. The formal and informal sources were used as separate dependent variables for this study.

Independent Variable:

Attachment Styles: The Revised Adult Attachment Scale (RAAS) was used to determine attachment types; it is a self-report instrument containing 18-items on a 5-point
Likert scale. The RAAS works to identify attachment dimensions that are derived from statements asking participants about the “function and feel of relationships with partners, significant others, and people in general” (O'Connor & Elklit, 2008, p. 62). This study used the two-dimension scoring method, aligning attachment types along dimensions of anxiety (model of self) and avoidance (model of other); (O'Connor & Elklit, 2008). Scores were calculated by averaging items 3, 4, 9, 10, 11, 15 and, 1, 2, 5, 6, 7, 8, 12, 13, 14, 16, 17, 18 respectively. The RAAS contains three subscales, *comfort with emotional closeness*; *comfort with depending on trust in others*; and *anxious concerns about being abandoned or unloved* (Steele et al., 2018, p. 405). Questions included, *I find it relatively easy to get close to people, I am somewhat uncomfortable being close to others, and I often wonder whether other people really care about me.*

The first two subscales correlated well with the avoidance dimension ($r = 0.86$ and $r = 0.79$) demonstrating adequate test-retest reliability ($\alpha = 0.73$) and internal consistency ($\alpha = 0.59$) (Steele et al., 2018). The latter dimension correlated well with the dimension *of other* found in other self-reporting attachment scales ($r = 0.74$) and demonstrated adequate test-retest reliability ($\alpha = 0.73$). Subscale scores were found to correlate with measures of self-esteem, social behavior, openness, satisfaction in relationships and are linked to depressive and anxiety symptoms, negative affect, and susceptibility to distress (Ravitz et al., 2010, p. 425). The RAAS is commonly used in psychosomatic research (Ravitz et al., 2010) and by military researchers (Steele et al., 2018). The Cronbach’s alpha for the current sample for anxious attachment was 0.89 and 0.87 for avoidant attachment.
Mediator:

Stigma: Tested as a mediator for the relationship between Attachment Style (IV) and the Willingness to Seek Help (DV). This was measured by the EPICON questions asking respondents to *rate each of the possible concerns that might affect your decision to seek behavioral health services*. Participants were provided a set of Likert scale selections consisting of strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree. Questions included: *My leaders discourage the use of behavioral health services*, *My unit leadership might treat me differently*, and *I would be seen as weak*. The items were aligned with three concepts, fear of discrimination, structural barriers, and organizational barriers. The fear of discrimination items 7, 10, 11, 12, 13, and 14 were averaged to create a stigma sub-score. The Cronbach’s alpha for the current sample was 0.94

Control Variables:

Post-Traumatic Stress: The influence of post-traumatic stress on help-seeking behaviors was measured using the PTSD Check List-Civilian Version (PCL-C). The civilian version of the PTSD Check List has demonstrated the capacity to denote PTSD symptoms that result from combat-related experiences while accounting for other events seen as traumatic (e.g., bereavement, motor vehicle accident, rape, physical assault, and abuse) (Currier et al., 2012). Questions included, *Avoiding activities or reminded you of the stressful experience*, *Feeling jumpy or easily startled*, and *Feeling emotionally numb or feelings for those close to you*. The PCL-C is a self-report 17-item scale using a 5-point Likert format (1 = not at all to 5 = extremely). It was designed to identify degrees of post-trauma symptoms occurring over 30 days. The VA has used this tool (Wilkins et al.,
2011, p. 596) in various clinical and research settings (Weathers, 1993, p. 1). Although it was found to be psychometrically sound, it may overestimate levels of prevalence (Wilkins et al., 2011, p. 603). The instrument correlates well with the Mississippi Scale, MMPI-2 PK scale, and the Impact Event Scale (Weathers, 1993, p. 2). Fourteen studies examining various psychometrics, including military samples, found the internal consistency of the tool to be good, with total score values above ($\alpha = 0.75$) (Wilkins et al., 2011, p. 603). Strong correlations reflect instrument validity with the Mississippi Scale, a 35 item self-report instrument frequently used to screen veterans for symptoms of combat-related PTSD ($r = 0.79$) (Wilkins et al., 2011, p. 603), and those receiving treatment ($r = 0.85$) (Weathers, 1993, p. 2). The interrater reliability of the PCL-C was $\alpha = 0.74$ (Andrykowski et al., 1998, p. 588) while the Cronbach’s alpha was found to be 0.90 (Gelaye, 2017, p. 1) indicating its suitability as a tool for diagnosing PTSD symptoms, as was its ability to identify prolonged symptoms ($\alpha = 0.58$) (Andrykowski et al., 1998, p. 588). Cronbach’s alpha for this sample was 0.95.

**Alcohol Use:** To measure the effect of alcohol misuse and abuse on help-seeking, the Alcohol Use Disorders Identification Test (AUDIT-C) was used. The AUDIT-C, a brief screening tool, is commonly used to assess current use, year-long hazardous drinking, and signs of dependency (Bradley et al., 2003, p. 821). Frequency is assessed by three questions, “How often do you have a drink containing alcohol?” and measured on a 5-point scale (1 = never, 5 = 4 or more times per week), “How many drinks containing alcohol do you have on a typical day when you are drinking?” measured by five choices ranging from (1 or 2) to (10 or more), and finally, “How often do you have six or more drinks on one occasion?”. This is gaged by five choices, starting with never
and concluding with *daily*. The AUDIT-C has been shown effective at screening for alcohol abuse and dependence; among veteran populations, it has been proven as effective as the CAGE questionnaire (Bradley et al., 2003, p. 829). Compared to similar screening tests, the AUDIT-C performed as well or better than the 10 question AUDIT (Allen et al., 1997, p. 618) and was significantly better than the augmented CAGE or self-reporting (Bradley et al., 2003, p. 1208). The AUDIT-C is a validated screening test for heavy drinking, active alcohol abuse, and dependence (Bush, 1998, p. 1789). It is also a better detector of heavy drinkers in veteran populations when compared to the 10 item AUDIT (Bush, 1998, p. 1791). It has also been validated as effective for identifying alcohol abuse or dependence among Iraq and Afghanistan veterans, yielding an adequate internal consistency ($\alpha = 0.75$) (Crawford et al., 2013, p. 104). In a review of screening instruments for problem drinking, the AUDIT-C measure of internal consistency (Cronbach’s alpha) was 0.80 (Rumpf et al., 2013). The Cronbach’s alpha for this sample was 0.69.

**Generalized Anxiety Disorder:** The impact of generalized anxiety on help-seeking was determined by the 7-item Generalized Anxiety Disorder-7 (GAD 7). This instrument is considered to have good operating characteristics for identifying generalized and social anxiety and PTSD (Kroenke et al., 2010, p. 345). A seven-item 4-point Likert-type scale is used to measure symptoms ranging from 0 (not at all) to 3 (almost every day) with a total maximum score of 21. A German national study found the GAD 7’s internal consistency to be very good ($\alpha = 0.89$) (Löwe, 2008, p. 268), while other studies found internal consistency to be excellent ($\alpha = 0.92$), and good test-retest reliability (intraclass correlation = 0.83) (Kroenke et al., 2010, p. 346). The German study also found it
appropriate for screening all genders and age groups (Löwe, 2008, p. 271). The GAD-7 produces scores that strongly correlate ($r = 0.72$) with the Beck Anxiety Inventory (BAI), has demonstrated excellent internal and test-retest reliability with the BAI ($\alpha = 0.92$) ($\alpha = 0.83$) and Symptom Checklist Anxiety Scale ($r = 0.74$) respectively (Spitzer et al., 2006, p. 1094). When compared against other screening tools the GAD-7 Cronbach’s alpha was found to be 0.79–0.91, indicating a good internal consistency (Williams, 2014, p. 1). Cronbach’s alpha for the current sample was 0.90.

**Depression:** To measure the influence of depression on help-seeking, the results from the Patient Health Questionnaire (PHQ-9) were used. The PHQ-9 is a brief depression screening tool derived from the Patient Health Questionnaire subscales (Kroenke et al., 2001, p. 606). The PHQ-9 assesses for depressive symptom frequency (e.g., sleeping problems, poor appetite/overeating, or trouble concentrating) using nine questions on a self-reported rating scale of frequency, with the responses ranging from *not all to nearly every day*. The PHQ-9 has reliability calculations suggesting high internal consistency ($\alpha = 0.92$) (Kroenke et al., 2001, p. 611), it is validated for use in the primary care setting (sensitivity of 78% / specificity of 85%) (Martin et al., 2006, p. 72). It also has provided positive predictive values to exceed other depression screening instruments (Martin et al., 2006, p. 72). Depression severity scores were found to be strongly associated with the short version of the Beck Depression Inventory ($r = 0.73$; $P < 0.0001$) and General Health Questionnaire-12 ($r=0.59$) (Martin et al., 2006, p. 75). A meta-analysis determined the cut-off scores between 8 and 11 and revealed satisfactory diagnostic properties (Manea et al., 2012, p. 191). In a study of U.S. Army soldiers who
served in direct combat, the Cronbach’s alpha for the PHQ-9 was found to be .79 (Maguen et al., 2010, p. 87). The Cronbach’s alpha for the current sample was 0.89.

**Past Help-Seeking:** The influence of past help-seeking on current help-seeking was derived from a scale developed by WRAIR (*Accessing of Helping Sources*). Scores were gathered by summing the number of responses to ‘yes’ on the binary (yes or no) question: *Have you ever gone to the following with a behavioral health concern?* Like the *Willingness to Seek Help* items, participants selected items from a list of common civilian and military formal and informal helping sources. The formal help list comprised professional medical and mental health caregivers, with informal selections represented by chaplains, friends, and the chain of command. Those responses and alternative sources identified under the “other” category were analyzed to determine the frequency of use.

**Combat-related deployments:** Responses for the number of times deployed into a combat theater were collected to assess its influence on help-seeking.

**Demographics:** Demographic information was collected using questions developed by the APHC team for the 2013 EPICON survey. Questions included age, gender, levels of education, amount of time in service, and rank.

**Data Preparation:**

Nine new variables were created in preparation for data analysis, and a series of diagnostic and model specification tests were conducted. The tests included collinearity and skew diagnostics of all variables. A series of correlation matrices and multiple regression models were conducted to specify variables more parsimoniously to be included in final mediation analyses.
New Variables:

Four continuous *Willingness to Seek Help* variables were created from Q72 “If you had a behavioral health concern in the future, would you go to the following…”. The first, *Willingness Formal Military*, was created by summing items 1-4 where 1=Yes and 0=No. The second, *Willingness Formal Civilian*, was created by adding items 5-8 where 1=Yes and 0=No. The third, *Willingness Informal Military*, was created by summing items 9 and 12 where 1=Yes and 0=No. The fourth, *Willingness Informal Civilian*, was created by adding items 10 and 11 where 1=Yes and 0=No.

Four continuous *Past Help-Seeking* variables were also created from Q71 “Have you ever gone to the following with a behavioral health concern?” The first, *Past Help Formal Military*, was created by summing items 1-4 where 1=Yes and 0=No. The second, *Past Help Formal Civilian*, was created by adding items 5-8 where 1=Yes and 0=No. The third, *Past Help Informal Military*, was created by summing items 9 and 12 where 1=Yes and 0=No. The fourth, *Past Help Informal Civilian*, was created by adding items 10 and 11 where 1=Yes and 0=No.

Finally, one categorical variable, *Served in Combat Theater* (Q51/52), was collapsed into a binary variable for inclusion in multiple regression models. Combat Service Binary was created by collapsing *Iraq* and *Afghanistan* = 1, *Kuwait/Qatar* and *Other* = 0.

Skew:

Skew diagnostics were conducted to test the assumption that the independent variables were normally distributed. Eight variables were found to be highly skewed
(more than ±1), including \textit{PTS Score} (skewness = 1.75), \textit{Depression Score} (skewness = 1.45), \textit{Anxiety Score} (skewness = 1.55), \textit{Alcohol Use} (skewness = 1.37), \textit{Past Help – Military Formal} (skewness = 1.63), \textit{Past Help – Civilian Formal} (skewness = 2.90), Past Help – \textit{Military Informal} (skewness = 1.95), \textit{Past Help – Civilian Informal} (skewness = 1.71). Histograms were used to identify the source of the skew, with seven of the variables (\textit{PTS}, \textit{Depression}, \textit{Anxiety}, and the four \textit{Past Help} variables) showing floor effects, with skew due to the percentage of cases, ranging from 32% to 82%, reporting the lowest score. Because the four \textit{Past Help} variables were simple counts ranging from 1 to 4 sources of help within each category, each was transformed into a binary variable (1= help from at least one source in that category, 0 = no help from any source within that category) to address skewness and allow for inclusion in model specification analysis.

The histogram for \textit{Alcohol Use} suggested the skew was due to outliers. To normalize the distribution and include it in analysis, the four outliers (11, 12, 13, 15) were Winsorized to the value at the 95 percentile (10). This process reduced the skew for \textit{Alcohol Use} to an acceptable level (skewness = 0.71).

\textbf{Multicollinearity:}

A regression model was tested to identify multicollinearity among measured variables. The model included \textit{Willingness – Military Formal}, the independent variable \textit{Anxious Attachment}, and the nine covariates. The VIF statistic for three of the nine covariates suggested multicollinearity, including \textit{Anxiety} (VIF = 2.60), \textit{PTS} (VIF = 3.38), and \textit{Depression} (VIF = 3.58). Correlation coefficients were then evaluated, and the three covariates with high VIF scores were found to be highly correlated (see Table 2.1), supporting multicollinearity among the three variables: \textit{Anxiety} and \textit{PTS} (r = 0.73,
p<0.01), Anxiety and Depression (r=0.75, p<0.01), and PTS and Depression (r=0.81, p<0.01). Therefore, these three collinear covariates were not included in hypothesis testing to avoid biased estimates of the primary variables of interest.

**FIGURE 2.1 CORRELATIONS AMONG ATTACHMENT STYLES, WILLINGNESS TO SEEK HELP, AND STIGMA**

<table>
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<tr>
<th></th>
<th>WM Id Formal</th>
<th>Anxious Attach</th>
<th>Stigma</th>
<th>PTS</th>
<th>Depression</th>
<th>Anxiety</th>
<th>PH Id Formal</th>
<th>PH Ctr Formal</th>
<th>PH Id Inform</th>
<th>PH Ctr Inform</th>
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<td>Alcohol Use</td>
<td>0.05</td>
<td>0.18**</td>
<td>0.00</td>
<td>0.29**</td>
<td>0.29**</td>
<td>0.39</td>
<td>0.00</td>
<td>0.04</td>
<td>0.06</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

*p<0.05    **p<0.01

**Model Specification:**

The goal of hypothesis testing for this study was to test Stigma as a mediator of the relationship between Attachment Style and Willingness to Seek Help. Before conducting mediation analysis, a correlation matrix was created with the DV, the mediator, and all covariates to narrow measures that were not significantly related to the DV or the mediator. Additionally, a regression model was tested to identify the remaining covariates that significantly predicted increases in Willingness to Seek Help and Stigma. The mediation analyses included only the variables primarily related to the DV and the mediator. Reducing the number of tests by first assessing the covariates and separating those that were not significant helped to protect against the likelihood of a Type I error by specifying the most parsimonious model for analyses.

As seen in Table 2.2, all independent variables, the dependent variables, and stigma were significantly related. All measures thus were included in hypothesis testing.
As seen in Table 2.3, neither combat nor any of the measures of past help seeking significantly predicted changes in both Willingness to Seek Help and Stigma and were therefore not included in hypothesis testing. Final hypothesis testing included mediation analyses of the relationship between each of the attachment styles (Avoidant and Anxious) with the four measures of willingness to seek help defined by source of help (Military Informal, Military Formal, Civilian Formal, and Civilian Informal), with no additional covariates.

**TABLE 2.1 MULTIPLE REGRESSION ANALYSIS OF HYPOTHESIZED COVARIATES OF DV AND MEDIATOR**

<table>
<thead>
<tr>
<th>Willing to Seek Help Source</th>
<th>Willing Military Formal</th>
<th>Willing Civilian Formal</th>
<th>Willing Military Informal</th>
<th>Willing Civilian Informal</th>
<th>Avoidant Attachment</th>
<th>Anxious Attachment</th>
<th>Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>SE</td>
<td>B</td>
<td>SE</td>
<td>B</td>
<td>SE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>2.34</td>
<td>0.39</td>
<td>1.26</td>
<td>0.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxious Attachment Score</td>
<td>-0.27*</td>
<td>0.08</td>
<td>-0.21</td>
<td>0.41*</td>
<td>0.05</td>
<td>0.37</td>
<td></td>
</tr>
<tr>
<td>Alcohol Use Winsorized</td>
<td>-0.023</td>
<td>0.05</td>
<td>-0.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PastHelp Military binary</td>
<td>-0.66*</td>
<td>0.22</td>
<td>-0.24</td>
<td>0.03</td>
<td>0.11</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>PastHelp CivilFormal binary</td>
<td>-0.041</td>
<td>0.26</td>
<td>-0.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PastHelp Military binary</td>
<td>0.89*</td>
<td>0.24</td>
<td>0.31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PastHelp CivilFormal binary</td>
<td>-0.17</td>
<td>0.22</td>
<td>-0.06</td>
<td>-0.06</td>
<td>0.12</td>
<td>-0.02</td>
<td></td>
</tr>
<tr>
<td>Combat binary</td>
<td>0.02</td>
<td>0.28</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*AdjR² = 0.09, F(7, 225) = 5.89*  *AdjR² = 0.13, F(3, 534) = 21.76*  
*p<0.001
Analysis Plan:

Data analysis was done using the Statistical Package for the Social Science (SPSS), the standard statistical software package utilized by the Army Public Health Center (APHC). Descriptive statistics were summarized to describe the sample. Categorical variables (gender, age, education, marital status, grade/rank, time in the service and combat theater) were summarized using frequencies. Continuous variables (willingness to seek help, anxious attachment score, avoidant attachment score, past help-seeking, combat theater, post-traumatic stress, anxiety, depression, alcohol use, and stigma) were summarized using means, standard deviations, minimum and maximum values. Relationships between continuous variables were summarized using a correlation matrix.

Hypothesis Testing:

Hypothesis testing was conducted using multiple regression analysis. Sixteen models were used to test Stigma as a partial mediator of the relationship between attachment styles and the willingness to seek help (Baron & Kenny, 1986; James & Brett, 1984; Judd & Kenny, 1981). The first model for each attachment style estimated path c: the relationship between X (either Anxious Attachment Style or Avoidant Attachment Style) and one measure of Y (Willingness to Seek Help from Informal Military Sources, Willingness to Seek Help from Informal Civilian Sources, Willingness to Seek Help from Formal Military Sources, or Willingness to Seek Help from Formal Civilian Sources). The second model for each attachment style estimated path a: the relationship between X (Anxious or Avoidant Attachment) and the mediator (Stigma). The third model for each attachment style estimated path b: the relationship between M (Stigma) and one measure
of Y (Willingness to Seek Help from Informal Military Sources, Informal Civilian Sources, Formal Military Sources, or Formal Civilian Sources, while controlling for X (either Anxious Attachment or Avoidant Attachment).

Parameter estimates for each set of models were examined to see if 1) the beta value ($b$) of X (Attachment) predicting Y (Willingness) in Model 1 (path c) was significant; 2) the beta value ($b$) of X (Attachment) predicting M (Stigma) in Model 2 (path a) was significant, and 3) the beta value ($b$) of M (Stigma) predicting Y (Willingness) while controlling for X (Attachment) in Model 3 (path b) was significant. When these three conditions were met, the beta values ($b$) of X in Model 1 (path c) and Model 3 (path $c'$) were compared to establish whether Stigma entirely or partially mediated the relationship between Attachment and Willingness to Seek Help, when path $c'$ was more minor than path c, that provided evidence for partial mediation. When path $c'$ was equal to zero, that provided evidence for complete mediation. The amount of mediation, or the indirect effect, was calculated by multiplying path $a*b$. The significance of the indirect effect was estimated by calculating standard errors using Selig.
and Preacher’s online Monte Carlo simulation (http://quantpsy.org/medmc/medmc.htm)\(^1\) using \(a\) and \(b\) to create a distribution of \(a \times b\) values with which confidence intervals and associated \(p\)-values were estimated (MacKinnon et al., 2004). Because of the large number of tests conducted across measures of the Dependent Variable *Willingness to Seek Help* and Independent Variable *Attachment Style*, which can increase the likelihood of a Type 1 error, a Bonferroni correction was applied to the cutoff value at which the null hypothesis would be rejected. The \(p\)-value cutoff was identified by dividing the conventional cutoff (\(p<0.05\)) by the number of planned tests (\(n=16\)): \(p<0.05 / 16 = 0.003\). Therefore, relationships will be identified as significant at \(p<0.003\).

---

Chapter 3: Results

Data from 538 uniformed Army personnel were utilized for this study. As shown in Table 3.1, the sample consisted of 441 men (82%) and 97 women (18%) who fell primarily in the 20-24 ($n=116$, 22%) and 25-29 ($n=184$, 34%) age groups, and more than half of the respondents were married ($n=313$, 58%). Just about all had at least a high school diploma and 90% had some college or more education.

3.1 Demographic Characteristics of the Study Sample

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>441</td>
<td>82</td>
</tr>
<tr>
<td>Female</td>
<td>97</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 20</td>
<td>13</td>
<td>2.4</td>
</tr>
<tr>
<td>20-24</td>
<td>116</td>
<td>21.6</td>
</tr>
<tr>
<td>25-29</td>
<td>184</td>
<td>34.2</td>
</tr>
<tr>
<td>30-34</td>
<td>113</td>
<td>21</td>
</tr>
<tr>
<td>35-39</td>
<td>72</td>
<td>13.4</td>
</tr>
<tr>
<td>40+</td>
<td>46</td>
<td>7.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, never married</td>
<td>163</td>
<td>30.3</td>
</tr>
<tr>
<td>Married</td>
<td>313</td>
<td>58.2</td>
</tr>
<tr>
<td>Separated</td>
<td>17</td>
<td>3.2</td>
</tr>
<tr>
<td>Divorced</td>
<td>45</td>
<td>8.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some high school</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>GED</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>High school diploma</td>
<td>52</td>
<td>9.7</td>
</tr>
<tr>
<td>Some college/Associate's</td>
<td>322</td>
<td>59.9</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>125</td>
<td>23.2</td>
</tr>
<tr>
<td>Master's/Doctoral degree</td>
<td>37</td>
<td>6.9</td>
</tr>
</tbody>
</table>

As summarized in Table 3.2, the characteristics of the cohort data, collected using Defense Manpower Data Center administrative data, generally reflects the time in service
and rank of U.S. Army personnel during this time period and over the last two decades (Quartana et al., 2014; Ryan et al., 2007; US Army Demographics 2020, 2020).

### 3.2 Military Characteristics of the Study Sample

<table>
<thead>
<tr>
<th>Time in the Army</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>14</td>
<td>2.6</td>
</tr>
<tr>
<td>1-2 years</td>
<td>129</td>
<td>24</td>
</tr>
<tr>
<td>3-4 years</td>
<td>67</td>
<td>12.5</td>
</tr>
<tr>
<td>5+ years</td>
<td>328</td>
<td>61</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1-E4</td>
<td>190</td>
<td>35.3</td>
</tr>
<tr>
<td>E5-E6</td>
<td>212</td>
<td>39.4</td>
</tr>
<tr>
<td>E7-E9</td>
<td>49</td>
<td>9.1</td>
</tr>
<tr>
<td>W01-W05</td>
<td>87</td>
<td>16.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Served in Combat Theater</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>23</td>
<td>4.3</td>
</tr>
<tr>
<td>Yes</td>
<td>246</td>
<td>45.7</td>
</tr>
</tbody>
</table>

Table 3.3 summarizes the descriptive statistics for the continuous independent, dependent, and control variables used in the study. The average scores for both anxiety ($M=10.39$, $SD=4.27$) and depression ($M=13.15$, $SD=4.91$) are higher than the clinical cutoff identified by the Army Public Health Center, which is a score equal to or greater than 10 for both the GAD (anxiety) and the PHQ-9 (depression). This is not the case for PTS, which averaged $M=26$ ($SD=12$), well below the identified cutoff of 42 determined by the Army Public Health Center for this population. Also noted is the pattern of differences in the mean scores of Willingness variables compared to the mean scores of Past Help variables for the same categories. For instance, the average score for the
willingness to seek help from formal military sources is $M=1.51$ ($SD=1.22$), the average score for past help-seeking from formal military sources is $M=0.46$ ($SD=0.80$).

### 3.3 Mean, Standard Deviations, Minimum, and Maximum Scores for Continuous Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>6.16</td>
<td>2.06</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Avoidant Attachment</td>
<td>2.66</td>
<td>0.82</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Anxious Attachment</td>
<td>2.01</td>
<td>0.99</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Post Traumatic Stress</td>
<td>25.99</td>
<td>12.01</td>
<td>17</td>
<td>81</td>
</tr>
<tr>
<td>Anxiety</td>
<td>10.39</td>
<td>4.27</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Depression</td>
<td>13.15</td>
<td>4.91</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>Past Help - Formal Military</td>
<td>0.46</td>
<td>0.80</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Past Help - Formal Civilian</td>
<td>0.19</td>
<td>0.52</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Past Help - Informal Military</td>
<td>0.44</td>
<td>0.87</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Past Help - Informal Civilian</td>
<td>0.39</td>
<td>0.65</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Stigma</td>
<td>2.07</td>
<td>1.08</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Willingness - Formal Military</td>
<td>1.51</td>
<td>1.22</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Willingness - Formal Civilian</td>
<td>1.48</td>
<td>1.27</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Willingness - Informal Military</td>
<td>1.65</td>
<td>1.25</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Willingness - Informal Civilian</td>
<td>1.69</td>
<td>1.25</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Correlations among continuous variables indicate that all categories of *Willingness to Seek Help* were strongly and positively correlated with each other, ranging from $r=0.54$, $p<0.01$ (*Civilian Informal* and *Military Formal*) to $r=0.78$, $p<0.01$ (*Civilian Formal* and *Military Formal*), suggesting that the willingness to seek help from one category strongly predicts the willingness to seek help from all other types. All categories of *Past Help* were similarly correlated, ranging from $r=0.45$, $p<0.01$ (*Civilian Informal* and *Military Formal*) to $r=0.63$, $p<0.01$ (*Civilian Informal* and *Military Informal*), suggesting that past help-seeking from one category strongly predicts past help-seeking
from all other categories. These relationships were not as strong as those among the Willingness to Seek Help categories.

*Willingness* categories were weakly positively correlated with past help-seeking of the same type but not significantly associated with any other past help categories. All *Willingness* categories were moderately and negatively associated with *Attachment styles*, *Stigma*, *PTS*, *Depression*, and *Anxiety*. Alcohol use was not significantly correlated with willingness to seek help from *Military Formal* or *Military Informal* sources but was weakly negatively correlated with willingness to seek help from *Civilian Formal* ($r=-0.13$, $p<0.001$) and *Civilian Informal* ($r=-0.12$, $p<0.001$) sources. Unlike the negative relationships with *Willingness* categories, *Attachment styles*, *Stigma*, *PTS*, *Depression*, and *Anxiety* were moderately positively correlated with all categories of *Past Help*. Alcohol use was not significantly related to any past help-seeking. *Avoidant* and *Anxious* attachment styles were strongly positively correlated with each other ($r=0.51$, $p<0.001$).

*Stigma* was moderately positively correlated with both *Avoidant* ($r=0.37$, $p<0.001$) and *Anxious* ($r=0.42$, $p<0.001$) attachment styles and negatively correlated with all *Willingness* categories. Stigma was also moderately positively correlated with *PTS* ($r=0.40$, $p<0.001$), *Depression* ($r=0.38$, $p<0.001$), and *Anxiety* ($r=0.39$, $p<0.001$) but not alcohol use. *Stigma* was not significantly associated with any *Past Help* categories except *Civilian Informal*, with which it was weakly positively correlated ($r=0.12$, $p<0.05$). See Table 3.4 for further detail.
3.4 CORRELATIONS AMONG CONTINUOUS VARIABLES

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 W.Mil Forma</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 W.Civ Forma</td>
<td>0.78**</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>3 W. Mil Inform</td>
<td>0.60**</td>
<td>0.54**</td>
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<td></td>
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</tr>
<tr>
<td>4 W. Civ Inform</td>
<td>0.71**</td>
<td>0.72**</td>
<td>0.67**</td>
<td>1</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Anxious Att</td>
<td>-0.19**</td>
<td>-0.17**</td>
<td>-0.20**</td>
<td>-0.22**</td>
<td>1</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Avoidant Att</td>
<td>-0.26**</td>
<td>-0.25**</td>
<td>-0.39**</td>
<td>-0.31**</td>
<td>0.51**</td>
<td>1</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Stigma</td>
<td>-0.25**</td>
<td>-0.18**</td>
<td>-0.32**</td>
<td>-0.21**</td>
<td>0.37**</td>
<td>0.42**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 PTS</td>
<td>0.24**</td>
<td>-0.22**</td>
<td>-0.36**</td>
<td>-0.31**</td>
<td>0.49**</td>
<td>0.47**</td>
<td>0.40**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Depression</td>
<td>0.20**</td>
<td>0.20**</td>
<td>0.30**</td>
<td>0.29**</td>
<td>0.48**</td>
<td>0.42**</td>
<td>0.38**</td>
<td>0.81**</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10 Anxiety</td>
<td>0.21**</td>
<td>0.18**</td>
<td>0.30**</td>
<td>0.25**</td>
<td>0.44**</td>
<td>0.42**</td>
<td>0.39**</td>
<td>0.73**</td>
<td>0.75**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 PH Mil Forma</td>
<td>0.10*</td>
<td>-0.06</td>
<td>0.11*</td>
<td>0.05</td>
<td>0.22**</td>
<td>0.22**</td>
<td>0.67</td>
<td>0.39**</td>
<td>0.39**</td>
<td>0.34**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 PH CIV Forma</td>
<td>0.07</td>
<td>0.13**</td>
<td>-0.006</td>
<td>0.04</td>
<td>0.13**</td>
<td>0.13**</td>
<td>0.08</td>
<td>0.28**</td>
<td>0.27**</td>
<td>0.24**</td>
<td>0.56**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 PH Mil Inform</td>
<td>0.04</td>
<td>0.03</td>
<td>0.16**</td>
<td>0.04</td>
<td>0.21**</td>
<td>0.08</td>
<td>0.05</td>
<td>0.25**</td>
<td>0.24**</td>
<td>0.24**</td>
<td>0.56**</td>
<td>0.45**</td>
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<td>0.03</td>
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<td>0.16**</td>
<td>0.13**</td>
<td>0.20**</td>
<td>0.28**</td>
<td>0.27**</td>
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<td>0.53**</td>
<td>0.63**</td>
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<td>-0.13**</td>
<td>-0.07</td>
<td>-0.12**</td>
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<td>0.13**</td>
<td>0.03</td>
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<td>0.00</td>
<td>0.04</td>
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* p<0.05 ** p<0.01

Hypothesis Testing – Anxious Attachment Style

Table 3.5 summarizes the three models that tested stigma as a mediator of the effect of Anxious Attachment style on willingness to seek help from Formal Military sources. Model 1, which included anxious attachment alone, accounted for 4% of the variance in willingness to seek help \( R^2=0.04, F(1, 536)=19.82, p<0.001 \). Anxious attachment style significantly predicted decreased willingness, with a 1-point decrease in willingness associated with each additional ~4-point increase in the anxious attachment \( B=-0.23, p<0.001 \). Model 2, which tested the effect of anxious attachment style on stigma, accounted for 14% of the variance in stigma \( R^2=0.14, F(1, 536)=, p<0.001 \). Anxious attachment style significantly predicted increased stigma, with a 1-point increase in stigma associated with each additional ~2.5-point increase in the anxious attachment \( B=0.40, p<0.001 \). Model 3, which tested the effect of anxious attachment style on
willingness while controlling for stigma, accounted for 7% of the variance in willingness \([R^2=0.07, F(2, 535)=20.71, p<0.001]\). Anxious attachment style was no longer a significant predictor of willingness to seek help. Stigma significantly predicted willingness to seek help, with a 1-point decrease in willingness associated with each additional ~4-point increase in stigma \((B=-0.23, p<0.001)\).

### 3.5 ANXIOUS ATTACHMENT, WILLINGNESS TO SEEK HELP FROM FORMAL MILITARY SOURCES, AND STIGMA

<table>
<thead>
<tr>
<th></th>
<th>Model 1 Military Formal (c)</th>
<th>Model 2 Stigma (a)</th>
<th>Model 3 Military Formal (b)</th>
</tr>
</thead>
<tbody>
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<td>-0.19</td>
</tr>
<tr>
<td>Stigma</td>
<td>-0.23**</td>
<td>0.05</td>
<td>-0.20</td>
</tr>
<tr>
<td>(R^2)</td>
<td>0.04</td>
<td>0.14</td>
<td>0.07</td>
</tr>
<tr>
<td>(F(1, 536)=19.82^{**})</td>
<td>(F(1, 536)=83.32^{**})</td>
<td>(F(2, 535)=20.71^{**})</td>
<td></td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.001

As shown in Figure 3.1, \(Path \ c = -0.23\) from Model 1 is more significant than \(Path \ c' = -0.14\) from Model 2, suggesting that the effect of anxious attachment on willingness to seek help from formal military sources is reduced when stigma is added to the model. Additionally, the change in willingness to seek help predicted by anxious attachment is no longer significant at the Bonferroni adjusted level of \(p<0.003\) when stigma is added to the model (Model 3). Finally, the indirect effect \((a*b = 0.09)\) of anxious attachment on willingness via its impact on stigma was significant at \(p<0.01\) (99% CI: -0.15, -0.04). Together, these findings support the hypothesis that the relationship between anxious attachment and willingness to seek help from formal military sources is at least partially mediated by stigma.
Figure 3.1 *Effect of Anxious Attachment on Willingness – Formal Military as Mediated by Stigma*

![Diagram showing the relationship between Anxious Attachment, Stigma, and Willingness towards Formal Military sources.](image)

\[
\text{Indirect effect: } a \times b = -0.09, p < 0.01
\]

*Table 3.6* summarizes the three models that tested stigma as a mediator of the effect of Anxious Attachment style on willingness to seek help from Formal Civilian sources. Model 1, which included anxious attachment alone, accounted for 3% of the variance in willingness to seek help \([R^2=0.03, F(1, 536)=16.74, p<0.001]\). Anxious attachment style significantly predicted decreased willingness, with a 1-point decrease in willingness associated with each additional ~5-point increase in anxious attachment \((B=-0.22, p<0.001)\). Model 2, which tested the effect of anxious attachment style on stigma, accounted for 14% of the variance in stigma \([R^2=0.14, F(1, 536)=, p<0.001]\). Anxious attachment style significantly predicted increased stigma, with a 1-point increase in stigma associated with each additional ~2.5-point increase in anxious attachment \((B=0.40, p<0.001)\). Model 3, which tested the effect of anxious attachment style on willingness while controlling for stigma, accounted for 5% of the variance in willingness \([R^2=0.05, F(2, 535)=20.11, p<0.001]\). Anxious attachment style was no longer a significant predictor of willingness to seek help. Stigma significantly predicted...
willingness to seek help, with a 1-point decrease in willingness associated with each additional ~5-point increase in stigma ($B=-0.16$, $p<0.001$).

### 3.6 Anxious Attachment, Willingness to Seek Help from Formal Civilian Sources, and Stigma

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
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<tbody>
<tr>
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<td>Civilian Formal (c)</td>
<td>Stigma (a)</td>
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<tr>
<td>Stigma</td>
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<td>0.05</td>
</tr>
<tr>
<td>$R^2$</td>
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<tr>
<td>$F(1, 536)$</td>
<td>16.74**</td>
<td></td>
</tr>
<tr>
<td>$F(2, 535)$</td>
<td>20.11**</td>
<td></td>
</tr>
</tbody>
</table>

**$p<0.001$**

As shown in Figure 3.2, Path $c = -0.22$ from Model 1 is more significant than Path $c' = -0.16$ from Model 2, suggesting that the effect of anxious attachment on willingness to seek help from formal civilian sources is reduced when stigma is added to the model. Additionally, the change in willingness to seek help predicted by anxious attachment is no longer significant at the Bonferroni adjusted level of $p<0.003$) when stigma is added to the model (Model 3). Finally, the indirect effect ($a*b = 0.06$) of anxious attachment on willingness via its effect on stigma was significant at $p<0.01$ (99% CI: -0.12, -0.01). Together, these findings support the hypothesis that the relationship between anxious attachment and willingness to seek help from formal civilian sources is at least partially mediated by stigma.
Table 3.7 summarizes the three models that tested stigma as a mediator of the effect of Anxious Attachment style on willingness to seek help from Informal Military sources. Model 1, which included anxious attachment alone, accounted for 4% of the variance in willingness to seek help \(R^2=0.04, F(1, 535)=23.24, p<0.001\). Anxious attachment style significantly predicted decreased willingness, with a 1-point decrease in willingness associated with each additional ~4-point increase in anxious attachment \((B=-0.26, p<0.001)\). Model 2, which tested the effect of anxious attachment style on stigma, accounted for 14% of the variance in stigma \(R^2=0.14, F(1, 536)=, p<0.001\). Anxious attachment style significantly predicted increased stigma, with a 1-point increase in stigma associated with each additional ~2.5-point increase in anxious attachment \((B=0.40, p<0.001)\). Model 3, which tested the effect of anxious attachment style on willingness while controlling for stigma, accounted for 11% of the variance in willingness \(R^2=0.11, F(2, 534)=32.58, p<0.001\). Anxious attachment style was no longer a significant predictor of willingness to seek help. Stigma significantly predicted
willingness to seek help, with a 1-point decrease in willingness associated with each additional ~3-point increase in stigma ($B = -0.32, p < 0.001$).

### 3.7 Anxious Attachment, Willingness to Seek Help from Informal Military Sources, and Stigma

As shown in Figure 3.3, Path $c = -0.26$ from Model 1 is more significant than Path $c' = -0.13$ from Model 2, suggesting that the effect of anxious attachment on willingness to seek help from informal military sources is reduced when stigma is added to the model. Additionally, the change in willingness to seek help predicted by anxious attachment is no longer significant at the Bonferroni adjusted level of $p < 0.003$) when stigma is added to the model (Model 3). Finally, the indirect effect ($a*b = -0.13$) of anxious attachment on willingness via its effect on stigma was significant at $p < 0.01$ (99% CI: -0.19, -0.07). Together, these findings support the hypothesis that the relationship between anxious attachment and willingness to seek help from informal military sources is at least partially mediated by stigma.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Military Informal (c)</td>
<td>Stigma (a)</td>
<td>Military Informal (b)</td>
</tr>
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<td>SE</td>
<td>B</td>
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<tr>
<td>(Constant)</td>
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<td>0.12</td>
<td>0.60</td>
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<tr>
<td>Anxious Attachment</td>
<td>-0.26**</td>
<td>0.05</td>
<td>-0.20</td>
</tr>
<tr>
<td>Stigma</td>
<td></td>
<td></td>
<td>-0.32**</td>
</tr>
<tr>
<td>$R^2 = 0.04$</td>
<td>$R^2 = 0.18$</td>
<td>$R^2 = 0.11$</td>
<td>$F(1, 535) = 23.24**$</td>
</tr>
</tbody>
</table>

**$p < 0.001$**
Table 3.8 summarizes the three models that tested stigma as a mediator of the effect of Anxious Attachment style on willingness to seek help from Informal Civilian sources. Model 1, which included anxious attachment alone, accounted for 5% of the variance in willingness to seek help \[ R^2=0.05, F(1, 536)=28.38, p<0.001 \]. Anxious attachment style significantly predicted decreased willingness, with a 1-point decrease in willingness associated with each additional ~3.5-point increase in anxious attachment \( (B=-0.28, p<0.001) \). Model 2, which tested the effect of anxious attachment style on stigma, accounted for 14% of the variance in stigma \[ R^2=0.14, F(1, 536)=, p<0.001 \]. Anxious attachment style significantly predicted increased stigma, with a 1-point increase in stigma associated with each additional ~2.5-point increase in anxious attachment \( (B=0.40, p<0.001) \). Model 3, which tested the effect of anxious attachment style on willingness while controlling for stigma, accounted for 18% of the variance in willingness \[ R^2=0.18, F(2, 535)=19.64, p<0.001 \]. Anxious attachment style significantly predicted willingness to seek help, with an additional 1-point decrease in willingness associated with each additional ~5-point increase in anxious attachment \( (B=0.22, p<0.001) \). Stigma also significantly predicted willingness to seek help, with a 1-point
decrease in willingness associated with each additional ~7-point increase in stigma ($B=-0.17, p<0.001$).

### 3.8 Anxious Attachment, Willingness to Seek Help from Informal Civilian Sources, and Stigma

As shown in Figure 3.4, Path $c = -0.28$ from Model 1 is larger than Path $c' = -0.22$ from Model 2, suggesting that the effect of anxious attachment on willingness to seek help from informal civilian sources is reduced when stigma is added to the model. Additionally, the indirect effect ($a*b = -0.07$) of anxious attachment on willingness via its effect on stigma, was significant at $p<0.01$ (99% CI: -0.10, -0.05). Together, these findings support the hypothesis that the relationship between anxious attachment and willingness to seek help from informal civilian sources is at least partially mediated by stigma.
Hypothesis Testing – Avoidant Attachment Style

Table 3.9 summarizes the three models that tested stigma as a mediator of the effect of Avoidant Attachment style on willingness to seek help from Formal Military sources. Model 1, which included avoidant attachment alone, accounted for 7% of the variance in willingness to seek help [$R^2=0.07$, $F(1, 536)=39.88$, $p<0.001$]. Avoidant attachment style significantly predicted decreases in willingness, with a 1-point reduction in willingness associated with each additional ~2.5-point increase in the avoidant attachment ($B=-0.39$, $p<0.001$). Model 2, which tested the effect of avoidant attachment style on stigma, accounted for 18% of the variance in stigma [$R^2=0.18$, $F(1, 536)=115.04$, $p<0.001$]. Avoidant attachment style significantly predicted increases in stigma, with a 1-point rise in stigma associated with each additional ~2-point increase in avoidant attachment ($B=0.455$, $p<0.001$). Model 3, which tested the effect of avoidant attachment style on willingness while controlling for stigma, accounted for 10% of the variance in willingness [$R^2=0.10$, $F(2, 535)=26.97$, $p<0.001$]. Avoidant attachment style significantly predicted willingness to seek help, with an additional 1-point decrease in willingness.
associated with each additional ~3.5-point increase in avoidant attachment ($B=0.29$, $p<0.001$). Stigma also significantly predicted willingness to seek help, with a 1-point decrease in willingness associated with each additional ~5-point increase in stigma ($B=-0.19$, $p<0.001$).

### 3.9 Avoidant Attachment, Willingness to Seek Help from Formal Military Sources, and Stigma

As shown in Figure 3.5, Path $c = -0.39$ from Model 1 is larger than Path $c' = -0.29$ from Model 2, suggesting that the effect of avoidant attachment on willingness to seek help from formal military sources is reduced when stigma is added to the model.

Additionally, the indirect effect ($a*b = -0.11$) of avoidant attachment on willingness via its effect on stigma, was significant at $p<0.01$ (99% CI: -0.19, -0.03). Together, these findings support the hypothesis that the relationship between avoidant attachment and willingness to seek help from formal military sources is at least partially mediated by stigma.
Table 3.10 summarizes the three models that tested stigma as a mediator of the effect of *Avoidant Attachment* style on willingness to seek help from *Formal Civilian* sources. Model 1, which included avoidant attachment alone, accounted for 6% of the variance in willingness to seek help \([R^2=0.06, F(1, 536)=34.86, p<0.001]\). Avoidant attachment style significantly predicted willingness to seek help, with a 1-point decrease in willingness associated with each additional ~2.5-point increase in avoidant attachment \((B=-0.38, p<0.001)\). Model 2, which tested the effect of avoidant attachment style on stigma, accounted for 18% of the variance in stigma \([R^2=0.18, F(1, 536)=115.04, p<0.001]\). Avoidant attachment style significantly predicted increases in stigma, with a 1-point increase in stigma associated with each additional ~2-point increase in avoidant attachment \((B=0.455, p<0.001)\). Model 3, which tested the effect of avoidant attachment style on willingness while controlling for stigma, accounted for 7% of the variance in willingness \([R^2=0.07, F(2, 535)=19.62, p<0.001]\). Avoidant attachment style significantly predicted willingness to seek help, with an additional 1-point decrease in willingness associated with each additional ~3-point increase in avoidant attachment \((B=0.32, p<0.001)\).
However, stigma was not a significant predictor of willingness to seek help in Model 3. Therefore, the hypothesis that stigma mediates the relationship between avoidant attachment and help-seeking from formal civilian sources is not supported.

### 3.10 Avoidant Attachment, Willingness to Seek Help from Formal Civilian Sources, and Stigma

<table>
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<tr>
<th>Model 1</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Civilian Formal (c)</td>
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<td>Civilian Formal (b)</td>
</tr>
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<td><strong>B</strong></td>
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</tr>
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<td>Avoidant Attachment</td>
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</tr>
<tr>
<td>Stigma</td>
<td>-0.11</td>
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$\text{R}^2 = 0.06$  
$\text{R}^2 = 0.18$  
$\text{R}^2 = 0.07$

$F(1,536) = 34.86**$  
$F(1,536) = 115.04**$  
$F(2,535) = 19.62**$

**p<0.001

Table 3.11 summarizes the three models that tested stigma as a mediator of the effect of Avoidant Attachment style on willingness to seek help from Informal Military sources. Model 1, which included avoidant attachment alone, accounted for 15% of the variance in willingness to seek help [$R^2=0.15$, $F(1, 535)=97.40$, $p<0.001$]. Avoidant attachment style significantly predicted decreases in willingness, with a 1-point reduction in willingness associated with each additional ~2-point increase in avoidant attachment ($B=-0.59$, $p<0.001$). Model 2, which tested the effect of avoidant attachment style on stigma, accounted for 18% of the variance in stigma [$R^2=0.18$, $F(1, 536)=115.04$, $p<0.001$]. Avoidant attachment style significantly predicted increases in stigma, with a 1-point increase in stigma associated with each additional ~2-point increase in avoidant attachment ($B=0.455$, $p<0.001$). Model 3, which tested the effect of avoidant attachment style on willingness while controlling for stigma, accounted for 18% of the variance in willingness [$R^2=0.18$, $F(2, 534)=59.27$, $p<0.001$]. Avoidant attachment style significantly
predicted willingness to seek help, with an additional 1-point decrease in willingness associated with each additional ~2-point increase in avoidant attachment ($B=0.48$, $p<0.001$). Stigma also significantly predicted willingness to seek help, with a 1-point decrease in willingness associated with each additional ~5-point increase in stigma ($B=-0.21$, $p<0.001$).

### 3.11 Avoidant Attachment, Willingness to Seek Help from Informal Military Sources, and Stigma

As shown in Figure 3.6, $Path\ c = -0.59$ from Model 1 is larger than $Path\ c' = -0.48$ from Model 2, suggesting that the effect of avoidant attachment on willingness to seek help from informal military sources is reduced when stigma is added to the model. Additionally, the indirect effect ($a* b = -0.12$) of avoidant attachment on willingness via its effect on stigma, was significant at $p<0.01$ (99% CI: -0.20, -0.04). Together, these findings support the hypothesis that the relationship between avoidant attachment and willingness to seek help from informal military sources is at least partially mediated by stigma.

<table>
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<tr>
<th></th>
<th>Model 1 Military Informal (c)</th>
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<th>Model 3 Military Informal (b)</th>
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<td>Avoidant Attachment</td>
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<td>-0.39</td>
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<tr>
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<tr>
<td>$F(1, 535)$</td>
<td>97.40**</td>
<td></td>
<td>$F(1, 536)$ = 115.04**</td>
</tr>
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</table>

**p<0.001
Table 3.12 summarizes the three models that tested stigma as a mediator of the effect of Avoidant Attachment style on willingness to seek help from Informal Civilian sources. Model 1, which included avoidant attachment alone, accounted for 9% of the variance in willingness to seek help \( R^2=0.09, F(1, 536)=55.67, p<0.001 \). Avoidant attachment style significantly predicted willingness to seek help, with a 1-point decrease in willingness associated with each additional ~2-point increase in avoidant attachment \( B=-0.47, p<0.001 \). Model 2, which tested the effect of avoidant attachment style on stigma, accounted for 18% of the variance in stigma \( R^2=0.18, F(1, 536)=115.04, p<0.001 \). Avoidant attachment style significantly predicted increases in stigma, with a 1-point increase in stigma associated with each additional ~2-point increase in avoidant attachment \( B=0.455, p<0.001 \). Model 3, which tested the effect of avoidant attachment style on willingness while controlling for stigma, accounted for 10% of the variance in willingness \( R^2=0.10, F(2, 535)=30.24, p<0.001 \). Avoidant attachment style significantly predicted willingness to seek help, with an additional 1-point decrease in willingness associated with each additional ~2.5-point increase in avoidant attachment \( B=0.41, p<0.001 \). However, stigma was not a significant predictor of willingness to seek help in
Model 3. Therefore, the hypothesis that stigma mediates the relationship between avoidant attachment and help-seeking from informal civilian sources is not supported.

### 3.12 Avoidant Attachment, Willingness to Seek Help from Informal Civilian Sources, and Stigma

Table 3.13 provides an overview of effect sizes across all measures of the DV (Willingness to Seek Help) and the two measures of the IV (Attachment Style).

Comparisons across the different measures of the IV and DV suggest that, compared to Anxious Attachment Style, Avoidant Attachment Style predicted a larger increase in stigma and larger decreases in the willingness to seek help each of the four sources, with the largest decline associated with the willingness to seek help from informal military sources. However, stigma mediated the relationship between Anxious Attachment Style and all four of the sources of help. In contrast, it only mediated the relationship between Avoidant Attachment Style and willingness to seek help from military sources, both formal and informal.
Chapter 4: Discussion and Conclusions

This study sought to determine the influence of attachment styles and stigma on the willingness of soldiers to seek help for mental health concerns and the degree to which stigma mediates the relationship between attachment style and willingness to seek help. Overall, and similar to the research literature (Cacciola & Psouni, 2020; Mikulincer et al., 1999; Vogel & Wei, 2005), attachment avoidant soldiers were found more resistant to the idea of help-seeking than attachment anxious soldiers. When comparing the two insecure attachment styles (anxious and avoidant), results indicated avoidance styles predicted a significant increase in stigma that corresponded with a decline in the willingness to seek help from sources categorized by formal (e.g., professional) and informal (e.g., laypeople), military and civilian. The largest decrease was associated with informal military sources (e.g., unit peers and leaders). Interestingly, for avoidant
soldiers, stigma only had a negative effect on the willingness to seek help from the two military sources, but not the civilian sources.

In testing the mediating effect of stigma on the relationship between attachment styles and help-seeking, findings supported the first hypothesis that soldiers with insecure attachment styles would be less willing to seek help for behavioral health issues from informal and formal resources, both military and civilian. The findings align with prior research that found adults with insecure attachments tend to link stigma with help-seeking more often than individuals with secure attachments (Nam & Lee, 2015; Shaffer et al., 2006). Additional research also found that insecurely attached adults are more often associated with the negative effects of stigma on stress and help-seeking attitudes than securely attached adults (Bradstreet et al., 2018; Nam & Lee, 2015; Vogel et al., 2007).

The second hypothesis, which predicted that soldiers with insecure attachment styles were more likely to report stigma as a barrier to help-seeking was supported and is consistent with earlier literature. Previous research focused on internal working models found when compared with securely attached adults, attachment-insecure adults tended to acknowledge higher levels of mental health stigma and greater resistance to help-seeking for personal concerns and mental health issues (Nam & Lee, 2015; Shaffer et al., 2006). Studies have also found that individuals with higher degrees of adult attachment insecurity can be associated with greater feelings of negativity toward the idea of help-seeking from professional sources (Fonseca et al., 2018; Nam & Lee, 2015; Shaffer et al., 2006) and heightened stigma perceptions linked to reductions in the willingness to seek help (Nam & Lee, 2015; Vogel et al., 2007).
The third hypothesis, predicting stigma would mediate the relationship between anxious and avoidant attachment styles and the willingness to seek help for mental health concerns, was only partially supported. While the mediating effect of stigma reduced the willingness of attachment anxious soldiers to seek help from all four categories, stigma only decreased the willingness of attachment avoidant soldiers to seek help from formal and informal military resources, not civilian.

Although attachment anxious adults are generally open to the idea of help-seeking, both anxious and avoidant attachment types can be linked to mental health stigma and its negative influence on help-seeking attitudes (Bradstreet et al., 2018; Nam & Lee, 2015). Stigma’s effect on help-seeking behaviors is partially shaped by factors that differentiate the two attachment types from one another. Attachment anxious adults primarily operate from a negative-self/positive-other internal working model highlighted by consistent approval-seeking and an overemphasis of internal stressors to garner support from others. In contrast, attachment avoidant adults tend to work from an internal working model that emphasizes a positive-self/negative-other prototype that generally leads to the self-management of stressful events (Vogel & Wei, 2005).

Anxiously attached adults typically acknowledge internal distress and are open to the idea of help-seeking from both formal and informal resources (Fonseca et al., 2018; Vogel & Wei, 2005). Nonetheless, help-seeking barriers, principally stigma, can negatively influence the help-seeking attitudes of attachment anxious adults. Concerns over interpersonal and mental health difficulties can result in feelings of shame and apprehension for rejection by others that can lead to an internalized friction between the need to seek assistance while simultaneously underrating the ability of others to provide
adequate support, typically resulting in feelings of ambivalence towards help-seeking (Britt et al., 2008; Fonseca et al., 2018; Shaffer et al., 2006).

Other factors that work to increase help-seeking indecision on the part of attachment anxious adults include vulnerability to elevated levels of stress and susceptibility to the internalizing of stigma commonly resulting from concerns for how others may view them, fear of being rejected, and a tendency to ruminate (Bradstreet et al., 2018). The tension that results from help-seeking hesitation and the desire for help may assist in explaining stigma’s role in lowering the willingness of anxious attachment soldiers to seek help from informal and formal helping resources, military and civilian.

In contrast, avoidant attachment adults tend to be less willing to seek help for interpersonal or mental health issues (Vogel & Wei, 2005). Attachment avoidant adults typically view help-seeking as a high-risk/low-reward process, often preferring to handle interpersonal problems on their own (Currier et al., 2012). For adults with higher levels of avoidant attachment, stress tends to elevate their urge to self-manage personal or mental health issues (Nam & Lee, 2015). However, research has also found that attachment avoidant adults are not always negatively associated with help-seeking. Studies have shown that attachment avoidant adults can recognize the difficulties created by poor social support and identify its negative impact on personal stress levels, often resulting in increased willingness to seek help (Cheng et al., 2015; Vogel & Wei, 2005).

Interestingly, while studies indicate insecure attachment styles are generally associated with stigma, attachment avoidance is not always associated with self-stigma (Bradstreet et al., 2018). Attachment avoidant adults’ preference for self-reliance, a general distrust of others, and the tendency to not ruminate on adverse life experiences
are factors thought to lower their risk for self-stigmatization (Bradstreet et al., 2018). This suggests that while both avoidant and anxious attachment soldiers may share concerns for the cultural stigma associated with help-seeking in the military, attachment avoidant soldiers may be better equipped at disregarding, not internalizing, that stigma. These factors imply that as stress levels rise, attachment avoidant soldiers may begin to reassess the risks associated with help-seeking from civilian versus military resources and determine civilian sources offer less risk. This provides a plausible explanation for stigma’s paradoxical effect on the help-seeking attitudes of the attachment avoidant soldiers who were unwilling to seek help from military sources, notably those they serve with, but acknowledge a willingness to seek help from sources outside the military domain.

Alternatively, while attachment avoidant adults tend to be uncomfortable with admitting to interpersonal difficulties and are typically less willing to seek help, as indicated above, they can be willing to share personal problems (Britt et al., 2008; Vogel & Wei, 2005). Within military organizations, a primary source of social support is derived from unit peers and leaders. The trust and bonds that connect soldiers to unit peers and leaders help foster unit cohesion (Siebold, 2007). Unit cohesion helps unite unit members, enhance performance, and increase operational effectiveness (Du Preez et al., 2012). Good cohesion encourages a supportive unit climate, which has been identified to reduce stigma and help-seeking barriers associated with mental health concerns (Britt et al., 2020; Grady et al., 2017). The bonds that connect unit members help build and sustain the unit’s culture of trust and climate of support, each serving to promote help-seeking (Britt et al., 2020).
For attachment avoidant soldiers serving in units with poor cohesion, their working model of positive-self/negative-other may heighten concerns for appearing competent and composed, further reinforcing the desire to remain self-reliant. A unit culture that supports stigma associated with help-seeking for interpersonal or mental health issues may work to erode the willingness of attachment avoidant soldiers to share their struggles with unit peers or leaders. Significant distress over a perceived lack of support may lead these soldiers to view informal and formal military resources with more risk than those independent of the military community and may explain why attachment avoidant soldiers were much less willing to seek help from their peers or leaders and yet be open to the idea of civilian helping resources.

**Implications for Practice**

Adults operating from a secure positive-self/positive-other attachment working model are typically at lower risk for mental health and interpersonal difficulties (Clark & Owens, 2012; Fonseca et al., 2018; Mikulincer & Shaver, 2015). They are more apt to seek help than those less securely attached when faced with problems. Nonetheless, regardless of the attachment style, stigma can still negatively influence help-seeking. For mental health professionals working with military and veteran populations, understanding the intersections between adult attachment types, stigma, and help-seeking is essential to effective clinical and community outreach practice.

**Outreach to Service Members and Veterans:**

For social workers and other mental health professionals working in outreach programs aimed at supporting service members and veterans (e.g., Veteran Service Organizations, Army Community Services) successfully transitioning into a new duty
station or from the military, adjusting to college or vocational settings, or recovering from addiction or trauma, insights gained through the lens of attachment theory can be used to inform outreach strategies and program development. In the same vein, building and maintaining a proficient level of military and cultural competency is vital to understanding the influence of stigma on the help-seeking behaviors of service members and veterans.

Understanding that attachment-insecure service members may want to avoid conventional mental health settings by choosing to seek help indirectly offers outreach and community programs an opportunity to support the needs of service members before a crisis occurs. Service member and veteran outreach programs may want to consider utilizing secure base concepts highlighted by availability, encouragement, and exploration (Feeney & Thrush, 2010). First conceived by John Bowlby, and further developed with Mary Ainsworth, secure base concepts help underpin Attachment Theory. The underlying idea of the safe base concept suggests that children seek comfort from their caregiver, helping to build confidence, competence, and resilience as they explore the world around them, with the knowledge that their caregiver provides a safe base or haven to return to. Those children who experience caregivers that are indifferent or inconsistent tend to feel less secure, which has been found to contribute to insecure attachment styles (Waters et al., 2002). Caregiver relationships are viewed to translate into internal representations that evolve into an internal working model that fosters personalized rules of engagement used to navigate adult relationships (Woodhouse et al., 2015). For attachment insecure adults, although not typically easy, internal working models can be altered through positive relational experiences and improved personal
insight (Roisman et al., 2005). Alternatively, some also theorize that internal working models can be negatively influenced through exposure to negative life events such as trauma (Roisman et al., 2005). However, in general, individual attachment styles and internal working models are reflected through relationships of trust, making imperative the establishment of a secure base for transitioning service members and veterans to operate from. Applying secure base concepts can provide service members and veterans a safe base of support for navigating life transitions reinforcing feelings of confidence, competence, and resilience. Providing a secure base can also offer service members and veterans a sense of cohesion and positive experiences, while working through the “strangeness of their new situation” (Fleming, 2008), potentially offering encounters that reflect secure relationships.

Workshops and educational programs that encourage good help-seeking behaviors may want to consider creating secure spaces to conduct interactive activities that promote personal introspection and insight development. Holding discussions to explore the benefits of good mental health and help-seeking while providing information on symptoms, signs, and treatment options may help normalize common concerns, reduce the adverse effects of stigma on help-seeking attitudes, and lower stress levels. For attachment anxious adults, exploratory discussions may reduce feelings of help-seeking ambivalence encourage tendencies to seek help while lowering self-stigmatizing concerns. Likewise, understanding the propensity of attachment avoidant adults to prefer self-reliance and view others as less reliable may require outreach programs to consider holding discussions and offer information on the benefits of help-seeking versus the risks, along with providing exploratory self-paced or web-based materials. Finally, outreach
programs may also want to consider increasing staff awareness and knowledge on attachment theory and stigma’s influence on the help-seeking behaviors of attachment insecure service members and veterans.

**Social Media Outreach:** As an outreach tool, social media has proven effective at promoting healthy behaviors (Laranjo et al., 2015; Maher et al., 2014) to increase personal well-being, reduce social isolation, and foster a sense of belonging (Choi & Noh, 2019). Outreach programs that utilize social media should develop insights into how service members use social media to improve their messaging effectiveness. For instance, knowing that female service members and veterans, opposed to their male colleagues, are more likely to use social media to seek community connections and discuss or seek health care information can help to shape targeted messaging (Kelly, 2020).

In the same way, understanding how insecurely attached adults interact with social media can also help to inform and tailor messaging strategies. While attachment-insecure adults generally mirror their offline behaviors, each attachment type is apt to engage with social media at different rates and not for the same reasons (Young et al., 2020). For example, attachment avoidant adults typically do not use social media to create meaningful connections but use social media platforms to address loneliness and internal distress (Young et al., 2020). Attachment anxious adults tend to use social media more frequently but protect against rejection by maintaining a level of social distance (Young et al., 2020). If attachment anxious adults develop a following, they usually benefit from increases in self-esteem (Young et al., 2020). Social media messaging informed by attachment theory may help reduce the stigma associated with help-seeking for interpersonal or mental health difficulties through messaging that normalizes help-
seeking, encourages connecting with others, promotes healthy behaviors (e.g., help-seeking), and highlights the benefits of early intervention.

**Outreach in Military Organizations:** Uniformed social workers, psychologists, and enlisted behavioral health staff assigned to warfighting units or onboard ships can also apply safe base concepts by leveraging their proximity to service members and utilizing principles associated with unit cohesion. Units with higher cohesion rates and positive leadership typically report lower stigma and barriers to care (Hom et al., 2017). Greater cohesion typically reduces the number of adverse outcomes and increases help-seeking rates (Du Preez et al., 2012; Grady et al., 2017).

Unit-level behavioral health providers may want to create opportunities to directly connect with service members and leaders to reinforce unit cohesion and readiness by promoting supportive networks, positive leadership traits, stigma reduction, and the benefits of early intervention. Seeking duty day locations where soldiers are gathered in groups or large numbers, such as a motor pool or at a firing range during weapons qualification, can increase availability and establish connections, helping to disarm the stigma associated with mental health and potentially nudging the ambivalent or less willing towards help-seeking. Creating opportunities to discuss ambivalence or reluctance towards help-seeking, perceived expectations, and anticipated risks may also reduce stigma and stress levels. Hosting interactive discussions to explore the benefits of connectedness, self-awareness, and help-seeking beliefs while providing information to debunk myths around mental health and help-seeking may also aid in increasing stigma indifference and foster enhanced help-seeking.
Clinical Work with Service Members and Veterans: Attachment theory and related research can provide a therapeutic structure for clinical work with adults, couples, adolescents, and children. For social workers and other mental health providers working in the clinical setting, attachment theory’s fundamental concepts serve to underpin the “therapist’s role as a secure base for patient self-exploration” (Eagle, 2017). A therapist can provide a safe space that encourages personal exploration by offering continuity of care marked by consistent and dependable support while maintaining availability.

Clinicians may want to consider screening for adult attachment styles to identify individual factors contributing to a client’s expectations, level of willingness, and degree of perceived crises. Identification of a client’s attachment type can allow for discussion on stigma-informed beliefs, perceptions of the clinical process, and identification of barriers they may have overcome to seek help. The present study suggests anxiously attached service members may be reluctant to seek help due to internalized stigma; providers who assess for self-stigma while addressing feelings of ambivalence may help lower feelings of distress. Like prior research (Britt et al., 2008; Vogel & Wei, 2005), the findings also suggest avoidant service members, may be potentially uncomfortable and more resistant to help-seeking, yet be willing to seek help under certain circumstances. Collectively, the results underscore the importance for mental health providers to understand how insecure attachments can contribute to the help-seeking decisions of service members and the influence stigma can have on their decision-making process.

Strengths and Limitations of Study:

The findings from this study help extend the research on service member help-seeking. The findings also suggest that factors shaped by military culture (e.g., stigma)
may mediate the help-seeking intentions of service members. A strength of this study is that the demographic make-up of population surveyed (N=538) generally reflects the population of the U.S. Army over the last two decades (Quartana et al., 2014; Ryan et al., 2007; *US Army Demographics 2020*, 2020). The current findings should be interpreted in recognition of several limitations. First, the data used to inform the study was collected by the U.S. Army Public Health Center to inform an Epidemiological Consultation designed to assess the impact of daily stressors on a unit’s morale, limiting this researcher’s ability to include other variables (e.g., level of combat exposure) or select alternative data collection instruments. In addition, the survey data was collected while Operation Iraqi Freedom and Operation Enduring Freedom were both ongoing and may not completely reflect current military populations and may limit comparisons. Nonetheless, the data represents a cross-section of a U.S. Army population that generally reflects units of similar size and mission set. Similarly, the sample of U.S. Army soldiers serving in a combat support unit potentially limits generalization to service members and veterans serving in different circumstances. However, unlike past wars, the nature of combat in both combat theaters did not limit combat-related experiences to those serving primarily in warfighting units, increasing the likelihood that members of this unit were exposed to the same range of conditions experienced by the military population that served during these conflicts. Of the studies sample population (N=538), the percentage of those who served in a combat theater reflects the number of those deployed from 2003 through 2013 (Elbogen et al., 2013; *Mental Health Advisory Team 9 (MHAT 9)* Operation Enduring Freedom (OEF), 10 October 2013; Ryan et al., 2007).
Future Research:

Considering the limitations, future research should examine additional variables such as combat exposure to better understand the relationship between attachment styles, war-related trauma, stigma, and the willingness to seek help. While secure attachments are considered more protective against PTSD than insecure attachments (Escolas, 2012; Mikulincer, 2015) and potentially support a better rate of recovery (Forbes et al., 2010), stigma is a factor that can generally alter help-seeking for secure and insecure service members (Quartana et al., 2014; Vogel et al., 2007). Researchers may also want to contemplate help-seeking studies to evaluate the influence of variables associated with unit cohesion to help identify the intersection of attachment types, stigma, and the factors that promote unit trust and support, and help-seeking. Future research should also consider examining models that include relationships that link additional factors, such as connectedness and attachment style. The results also imply that relationships between attachment styles and the willingness of soldiers to seek help for mental health concerns may be affected by the source of support from military or civilian, indicating the willingness of attachment-insecure soldiers to seek help may be moderated depending on the source and should be considered for further research.

Conclusion:

The present study adds to the current knowledge of factors that contribute to the willingness of service members to seek help for mental health or interpersonal concerns. This study set out to determine the effect of insecure attachment styles on the willingness of soldiers to seek help for mental health concerns and to what degree stigma affected their help-seeking intentions. Overall, and similar to previous research (Cacciola &
Psouni, 2020; Mikulincer et al., 2009; Vogel & Wei, 2005), attachment avoidant soldiers were found more resistant to the idea of help-seeking than their attachment anxious counterparts. In line with research (Shaffer et al., 2006), the findings also suggest that outreach programs, clinicians, and researchers should be aware of attachment styles and associated factors (e.g., stigma) that may negatively influence the willingness of service members to seek help.

To effectively reach those in need, outreach efforts should consider how attachment anxiety and avoidance contribute to individual help-seeking decisions and recognize the greater likelihood that service members and veterans with insecure attachments will seek help through indirect pathways. The results also reinforce the importance for outreach and clinical staff to recognize that while avoidant individuals tend to resist acknowledgment of internal distress and are less likely to seek help, they are generally willing to disclose their lack of support and its impact on personal stress levels, which can lead to an increased willingness to seek help (Britt et al., 2008; Vogel & Wei, 2005).

This highlights the importance for mental health care providers to screen for attachment types to increase awareness for the factors that may be motivating individuals to seek help and better understand their willingness to accept services. Supporting the ability of attachment avoidant adults to assess current relationships and the level of support available may help increase personal insight. In the same way, similar strategies may help attachment anxious individuals better weigh the benefits of seeking help against their perceptions of how others view them, potentially reducing their risk for help-seeking hesitancy. These strategies, along with linking past caregiver experiences with
current relationships and their influence, may help attachment insecure individuals move towards a more secure attachment style.

Service members and veterans who experienced deployments into combat areas or were subject to high operational tempo often face additional stressors that can lower the willingness to seek help and potentially amplify insecure attachment characteristics. Outcomes from a study of combat veterans (N=157) found that 12% reported frequent alcohol misuse and more than a third reported clinical levels of Post-traumatic Stress Symptoms (PTSS), of that population attachment insecure veterans reported higher levels of PTSS, alcohol use, and hazardous drinking than attachment secure veterans from the same cohort (Currier et al., 2012) further reinforcing the need to identify attachment types during the screening process.

Research (Vogel & Wei, 2005) has found that self-stigma can have a significant influence on help-seeking attitudes and intentions, suggesting that attachment anxious service members may be at an even greater risk for help-seeking hesitancy and the importance of applying interventions that help reduce self-stigma linked to help-seeking. Strategies could include interventions to help boost self-esteem personal resiliency and reduce negative thinking.

For mental health providers who work in proximity or are assigned to warfighting units, efforts to promote the overall climate of support across large formations and within smaller units can lead to supportive supervisors and unit peers, which have been found to lower mental health stigma (Sharp et al., 2015). The findings from this study highlight the importance of promoting a strong unit support climate to increase the potential that attachment insecure service members will ask for help with interpersonal problems or
seek treatment for mental health difficulties; for attachment insecure service members, these actions may help buffer the effect of stigma on help-seeking by reducing help-seeking ambivalence and increasing stigma indifference.
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