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**THE MILITARY UNIFORM'S IMPACT ON PATIENT TRUST AND DISCLOSURE IN PATIENT-PROVIDER  
INTERACTIONS**

By

Jessica Correale

B.A. University of Maine, 2018

M.A. University of Maine, 2021

A THESIS

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

(in Psychology)

The Graduate School

The University of Maine

May 2021

Advisory Committee:

Mollie Ruben, Assistant Professor of Psychology, Advisor

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# **THE MILITARY UNIFORM'S IMPACT ON PATIENT TRUST AND DISCLOSURE IN PATIENT-PROVIDER INTERACTIONS**

By Jessica Correale

Thesis Advisor: Dr. Mollie A. Ruben

An Abstract of the Thesis Presented  
in Partial Fulfillment of the Requirements for the  
Degree of Master of Arts  
(in Psychology)  
May 2021

Beyond a provider's interpersonal skills, static cues such as a provider's attire can greatly impact patient impressions. Attire has been found to be an important early determinant of patient confidence, trust, and satisfaction (Petrilli et al., 2015). While previous literature has investigated the impact of providers in white coats, limited studies have looked at the impact of military uniforms. This is an important research question as providers in military treatment facilities always wear their military uniforms. Additionally, service members suffer from high rates of PTSD and depression (Novotney, 2020). Beyond overcoming the initial stigma to make an appointment, disclosure is likely the most important step toward healing trauma-related distress. However, many individuals with trauma-related distress fail to disclose this to their providers (Defever, 2014). Consequently, the suicide rate for military members is at an all-time high, likely due to undiagnosed mental health disorders (Novotney, 2020).

Therefore, the present research aimed to examine how provider attire (military uniform vs. medical white coat) impacts ratings of provider trustworthiness and ultimately military members' anticipated willingness to disclose mental health related information. I hypothesized: 1) Patients viewing providers who were wearing white coats, as opposed to military uniforms, would report greater anticipated disclosure of mental health information; 2) Greater perceptions of provider's

trustworthiness would elicit greater anticipated disclosure of mental health information; and 3) The relationship between provider attire and anticipated willingness to disclose mental health related information would be partially explained by perceptions of provider's trustworthiness such that a higher rating of trustworthiness would elicit greater anticipated disclosure.

Veteran participants recruited through social media and online platforms ( $N = 95$ ) were randomly assigned to view 1 of 2 provider photograph sets in an online rating study. Each set contained 30 photographs split evenly between provider gender (male vs. female) and attire (military uniform vs. white coat). Participants only saw one photograph per provider (i.e., their white coat or military uniform photograph) so that attire varied within-subjects. The stimuli photos were taken from the Chicago Face Database and each individual was photoshopped to be wearing a white coat and a military uniform. Participants were shown each provider photograph one at a time and asked to make ratings of the provider's trustworthiness as well as indicate their anticipated mental health related disclosure. Results indicated a significant effect of attire such that there was more disclosure to white coat providers ( $M = 4.38, SD = .22$ ) compared to military uniform providers ( $M = 4.27, SD = .24$ ) [ $F(1, 28) = 8.00, p = .009, \eta_p^2 = .22$ ] and an effect of provider gender such that there was more disclosure to female ( $M = 4.42, SD = .22$ ) compared to male providers ( $M = 4.24, SD = .21$ ) [ $F(1, 28) = 7.46, p = .011, \eta_p^2 = .21$ ].

These results have a multitude of clinical implications. First, providers in military treatment facilities always wear their uniforms with patients. The results of this study suggest that by mandating a white coat policy instead of a military uniform policy, veterans may be more likely to disclose health relevant information. Second, it is likely that provider photographs influence patient decisions to make or keep appointments and also set expectations as to how the provider will act during their first appointment. Therefore, these findings can inform marketing campaigns around mental health within military medicine and the VA healthcare system.

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## CHAPTER 1

### INTRODUCTION

An important yet often overlooked factor in the field of health services is the patient provider relationship. This relationship is the foundation of patient care and understanding its function has long been the goal of many social psychologists. Healthcare providers with good communication skills build rapport with their patients and see better health outcomes overall (Lang, 2012). Perhaps most importantly, it is the aspect of trust in rapport building that has the greatest impact (Dang et al., 2017). This holds especially true when dealing with mental health related issues as these topics are sensitive and often leave patients feeling vulnerable. Specifically, a patient's choice to disclose their symptoms, thoughts, and feelings requires that a foundation of trust and rapport between the patient and provider be built (Hillen et al., 2018). Therefore, a lack of trust with one's provider is likely a barrier to mental health related disclosure.

It is especially important in military healthcare settings for providers to build trust with their patients as this group is more likely than the civilian population to experience many of the risk factors for suicide (APA, 2020). Similarly to the rates in the general population, approximately 21% of service members were diagnosed with a mental health disorder between fiscal years 2005-2016 (Deployment health clinical center, 2017). However, in 2019, there were 498 service members who died by suicide, a rate that has been consistently rising since 2014 (DOD, 2020). This is approximately 27.7 veterans per 100,000, in stark comparison to the 14 per 100,000 deaths by suicide in the general population (Friedl, 2020). This suicide rate for military members is an all-time high, likely partially due to undiagnosed and untreated mental health disorders (APA, 2020). Beyond overcoming the initial stigma to make an appointment, disclosure is one of the most important steps toward healing trauma-related distress. However, many military patients with trauma-related distress fail to disclose this to their providers.

Therefore, from a prevention standpoint, it is crucial to identify factors that impact rates of service member disclosure.

Research thus far has shown that a provider's behavior during a medical appointment can greatly impact patient outcomes. For example, it has been demonstrated that patient-centered behavior can encourage patients to disclose more psychosocial and lifestyle information and engage more in the medical dialogue (Roter et al., 2014; Duggan & Parrott, 2000). Provider behavior has even been found to impact pain tolerance levels such that participants interacting with nonverbally supportive physicians show increased pain tolerance and a reduction in the amount of pain expressed compared to patients interacting with low nonverbally supportive physicians (Ruben et al., 2016).

Although we know a provider's nonverbal behavior impacts patient outcomes, more static cues such as a provider's appearance (i.e., attire) are often overlooked. Because appearance in the military is such a salient attribute of one's power (e.g., rank is directly visible) it is likely that provider appearance also has a strong impact on patients' perceptions of their providers, and consequently the patient-provider relationship. However, limited studies have addressed how this salient factor impacts help-seeking behavior, such as willingness to disclose mental health symptoms, within the military setting. Therefore, the present experiment aimed to examine how provider attire (military uniform vs. medical white coat) impacts ratings of provider trustworthiness and ultimately military members' willingness to disclose mental health related information to them.

### **Trust**

Trust in the patient-provider relationship is crucial because trust increases patient comfort levels which has been linked to higher levels of patient disclosure (Lee & Lin, 2008). The more a patient discloses, the better equipped a provider is to diagnose and offer treatment. Furthermore, a meta-analysis of over 47 studies found that patients report more beneficial health behaviors, higher satisfaction and health-related quality of life, as well as better symptom-oriented subjective outcomes

when they had higher trust in their health care professional (Birkhäuer et al., 2017). A provider must work to attain a patient's trust in order to effectively collect information and deliver the proper treatment regimen. Many factors, such as open communication and keeping promises, are associated with gaining and maintaining trust and it is a process that requires interaction between the patient and the provider (Trowbridge & Pearson, 2013). However, judgments regarding someone's trustworthiness can be made even in the absence of social interaction, simply by observing the person or by learning about them indirectly (Toma, 2010). This is further supported by literature on first impressions which shows that impressions of many characteristics, including trustworthiness, are often formed rapidly and spontaneously from minimal information (Todorov & Uleman, 2003; Uleman et al., 2005). For example, in online dyads it is very common for interactants to form impressions of someone's trustworthiness based on static profile information before any interaction with that person (Toma, 2010). Additionally, studies investigating first impressions of providers have found that impressions are formed by just viewing photographs (Hall et al., 2020) and that these impressions likely bias subsequent behavior through expectancy effects and confirmation biases. Because impressions of trust can be formed even in the absence of viewing someone's dynamic behavior, it is likely that there are cues within an individual's appearance (e.g., clothing, gender) that are associated with their trustworthiness.

### **Attire**

Provider attire is an important early determinant of patient confidence, trust, and satisfaction (Petrilli et al., 2015). Many studies have shown that provider attire has an impact on patient impressions (Gherardi et al., 2009; Gallagher et al., 2008; Palazzo et al., 2010; Brase & Richmond, 2004). This idea is not novel and dates as far back to ancient Greece as Hippocrates stated that providers should "be clean in person, well-dressed, and anointed with sweet-smelling unguents" (Jones, 1923, p. 311). The overall pattern in the literature suggests that patients prefer providers to dress formally and that formal attire increases confidence in the provider's competence (Gledhill et al., 1997). While formal attire might elicit

impressions of competence, it has also been found that formal dress might lead patients to view their provider as less friendly or understanding which could impact disclosure (Gledhill et al., 1997). A potential solution for this tradeoff, as suggested by Brase & Richmond (2004), is having providers wear a white coat. Though the white coat effect is well-established [patients exhibit blood pressure above the normal range with providers in a white coat than in other settings (Pickering et al., 1988)], research has found that wearing a white coat gives the impression of competence without being overly formal and detracting from impressions of friendliness and approachability (Brase & Richmond, 2004). While researchers have investigated the impact of providers wearing white coats, limited studies have looked at the impact of military uniforms. This is important because providers in military treatment facilities always wear their military uniforms. Despite little research, it is posited that because military uniforms are formal by nature, visibly display rank, and carry a contrasting cultural message of aggression, they may influence impressions and alter trust (Trowbridge & Pearson, 2013; Spears & Smith, 2001). Additionally, service members face a cultural stigma around mental health related ailments and their associated treatments (Acosta et al., 2014). Therefore, it is crucial to understand the impact of provider attire on patient impressions especially among a military sample.

### **Gender**

Outside of the medical context, differences in the interpersonal style of women compared with men are well documented. For instance, women tend to disclose more information about themselves in conversation (Dindia & Allen, 1992), are rated to have a warmer and more engaged style of nonverbal communication (Hall, 1990), and they encourage others to talk to them more freely and in a warmer way than men do (Hall, 1990). There are also well-documented gender differences in the communication styles of providers. For instance, female providers facilitate more open and equal conversation than their male counterparts (Shin et al., 2015). They ask more questions, share more information, engage in more psychosocial discussions and rapport building behavior, and are more

encouraging of patient participation in their interactions (Shin et al., 2015). Female primary care providers have also been found to engage in more communication that can be considered patient centered (Roter et al., 2002) and are perceived to be more interpersonally competent than male providers (Shin et al., 2015). Because of female providers' generally warmer and more engaging style, it is reasonable to predict that provider gender could impact military members' ratings of trustworthiness such that attire might have less of an impact for female in comparison to male providers. The potential impact of gender could also be explained by the stereotype that both the fields of medicine (Hall et al., 2020) and the military (Carreiras, 2004) are traditionally associated with men. Based on these stereotypes, male providers might be rated as more trustworthy regardless of their attire. It is possible, then, that attire will have a greater impact on the trustworthiness of the female providers than it will for the male providers. Therefore, in this design, gender was included and explored as a potentially confounding variable. And, while we know that gender is non-binary, for the purposes of this study, I only examined perceptions of male presenting and female presenting providers.

### **Present Study**

To date, no research has looked specifically at the impact that a military provider's attire has on a patient's impressions of trustworthiness and thus willingness to disclose information, particularly mental health related information. While attire has not been studied extensively in a military medical setting, one group of researchers did look at aspects of disclosure in relation to provider attire while including a military uniform in comparison to scrubs with and without a white coat. This study was conducted within an OBGYN clinic (Niederhauser et al., 2009). Participants were shown 4 sets of attire with one male provider and one female provider for each: scrubs with white coat, scrubs without a white coat, military uniform with a white coat, and military uniform without a white coat. Participants were asked their preference in provider attire and then to rate the photographs in terms of their confidence, comfort level, desire to return, and desire to follow advice. Only 7% of active-duty

participants reported that they preferred their provider wear a military uniform while the majority (63%) reported that they preferred their provider wear scrubs. Participant comfort level, desire to return, and desire to follow advice was significantly lower when the provider wore only a military uniform (without a white coat) compared to when in a white coat (Niederhauser et al., 2009). There were no gender differences among the ratings for the male or female provider.

While this study helped to pave a pathway towards better understanding the impact of military uniforms in healthcare settings, there are many questions still left unanswered. First, this study was conducted in a specialized medical setting (an OBGYN clinic), and thus only recruited female participants. The specialized setting, as well as the solely female population, limits the generalizability of these results. Second, the participants attention was specifically drawn to the attire of the providers they were viewing which may have led to demand characteristics. For instance, they were asked “Do you prefer your provider to wear a white coat?” and “if your provider was dressed in this outfit, would that make you more or less comfortable talking to them? If your provider is dressed in this outfit, would it make you feel more or less confident in his/her abilities?” Due to the nature of these questions, the impressions that were given might not have been true “first” impressions. Participants may not have viewed the providers holistically and might have altered their answers based on other factors, like the fact that they were in a military OBGYN clinic. Furthermore, previous literature has found some discrepancies between what people say and think about providers’ attire and their actual choices or behaviors. For example, Menahem and Shvartzman (1998) found that 75% of their participants stated that the attire of the provider had no influence on their decision in choosing a family provider, yet 52% of them later reported that they preferred their provider to be dressed in a white coat.

Similar to Niederhauser et al.’s study, I investigated perceptions of provider attire (including a military uniform), but for the first time examined how attire relates to participants’ perceived comfort with disclosure of mental health related information. My experimental design attempted to address the

shortcomings of Niederhauser et al.'s design. For example, I recruited participants of any gender and any veteran status. Additionally, participants in my study were not explicitly made aware of the main hypothesis under investigation, namely the impressions of attire. In order to accomplish this, participants were not asked anything about the provider's appearance or attire. Rather, participants were asked about their perceptions of the provider's trustworthiness and their anticipated willingness to disclose mental health related information to that provider. While participants saw a mix of uniform and white coat providers, it is assumed that they did not suspect anything in particular about the attire and gave their true impressions of trustworthiness, as attire was subtle (see Figure 1). In summary, this study aimed to examine how attire impacted ratings of provider trustworthiness and ultimately military members' anticipated willingness to disclose mental health related information. I tested the following three hypotheses:

H1: Patients viewing providers who were wearing white coats, as opposed to providers in military uniforms, would report greater anticipated disclosure of mental health related information.

H2: Greater perceptions of provider's trustworthiness would elicit greater anticipated disclosure of mental health related information.

H3: The relationship between provider attire and willingness to disclose mental health related information would be partially explained by perceptions of provider's trustworthiness such that a higher rating of trustworthiness would elicit greater anticipated disclosure.

## CHAPTER 2

### METHODS

#### Participants

Veterans ( $N= 135$ ) were recruited via the University of Maine Sona student pool, by word of mouth on the Maine Air National Guard base (through the PI's network), and through University of Maine veteran email recruitment. However, 25 participants were removed from analysis due to completing less than 99% of the survey, 13 participants were removed for failing 1 or more attention checks, and 1 participant was removed for reporting photo quality below 50%. The final sample for analysis was 95. Participants ranged in age from 18-77 ( $M = 30.54$ ,  $SD = 9.71$ ), were predominantly male (58 male, 35 female, 1 intersex), white, and served an average of 7.09 years ( $SD = 5.79$ ). Additionally, participants came from a variety of branches including Air Force, Army, Marines, and the Navy, as well as a variety of statuses (active duty, guard, reserves, and retired) (see Table 2.1 for more sample demographics).

Table 2.1. Sample Demographics.

Characteristic	Mean, Standard Deviation, or Frequency
Age	$M = 30.54$ $SD = 9.71$ Range: 18-77
Sex	58 Male 35 Female 1 Intersex
Ethnicity	77 White 10 Black 8 Asian 2 American Indian/ Alaskan Native 1 Native Hawaiian or Pacific Islander 2 Other
Veteran Status	35 Active Duty 11 Reserve 33 Guard 15 Retired

Table 2.1 Continued.

Branch	45 Air Force 25 Army 13 Marines 11 Navy
Years Served	$M = 7.09$ $SD = 5.79$

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### **Materials**

This study was conducted online using Qualtrics. The stimuli were created using Adobe Photoshop 2020. I pulled the first 15 white male photos and the first 15 white female photos from the Chicago Face Database (Ma et al., 2015). This database provides high-resolution photographs of male and female faces of varying ethnicity between the ages of 17-65. All of the individuals had a neutral facial expression. I then created two photographs for each male and female which acted as the attire independent variable: one with them photoshopped wearing a military uniform and one with them photoshopped wearing a white coat (see Figure 2.1 below). There was a total of 60 photos. While statistics on the number of white providers in the military do not publicly exist, statistics released by the Association of American Medical Colleges (2018) suggests that the majority of practicing providers are white (56.2%). Within the military, these numbers are likely higher as the percentage of white active-duty officers (which physicians have to be in the military) is just under 80% (Council on Foreign Relations, 2020). Therefore, this study was limited to impressions of white providers only.

Figure 2.1 Provider example, wearing both a military uniform and a white coat.



### **Measures**

*Provider Perceived Trustworthiness:* Participants rated each provider on their perceived trustworthiness utilizing 3 of the 11 items from Anderson & Dedrick’s (1990) Trust in Provider Scale (see Appendix A). These questions were slightly modified to fit with the study design. For example, participants rated on a 1-7 scale from *very strongly disagree* to *very strongly agree*, how much they agreed with the following statement: “I trust this provider and would follow their advice”.

*Participant Anticipated Disclosure:* Participants rated on a 1-7 scale from *very strongly disagree* to *very strongly agree*, how much they agreed with the following 2 statements: “I would feel comfortable talking to this provider about my mental health” and “I would disclose any mental health related symptoms to this provider”.

*Participant Demographics:* Participants completed demographic information including their age, gender, military affiliation, and rank (if applicable) (see Appendix B).

### **Procedure**

The study was advertised to prospective participants as research on “First Impressions of Providers from Photographs”. Interested participants were sent a link via email to the study. The email included a general explanation of the study and its purpose. It read: “The purpose of this study is to better understand first impressions of providers. You will be asked to imagine that you visit a hospital or

clinic for a medical consultation for yourself and you see a new provider. You will see a series of photographs of different providers you might see. For each photo, you will rate your first feeling about the provider on a few questions. We know that first impressions are often revised after one knows a person better, but in this case, we are interested only in your very first feeling about the provider.” Each participant was randomly assigned to view 1 of 2 photo sets. Each set contained 30 photos split evenly between provider gender (male vs. female) and attire (military uniform vs. white coat). Participants only saw one photo per provider (i.e., their white coat photo or their military uniform photo) but attire varied within-subjects.

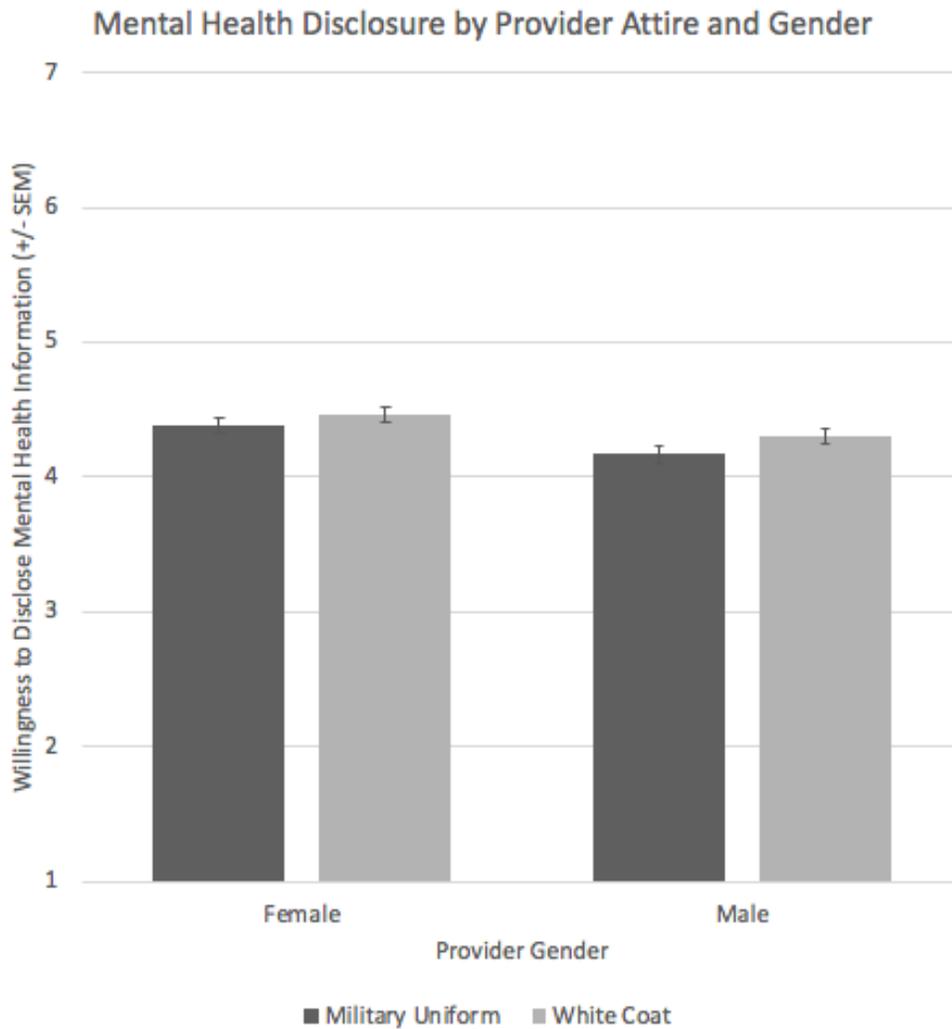
Participants began by reading and signing the informed consent (see Appendix C for consent form). Once this was completed and they were ready to begin, they were shown each provider photograph one at a time. They had to complete the trustworthiness scale as well as indicate their anticipated mental health related disclosure for each provider before they could move to the next photograph. Once done completing the ratings of the 30 photographs, participants were prompted to fill out information in order to receive compensation (for Sona participants one credit, for community members an emailed \$10 Amazon.com gift card).

## CHAPTER 3

### RESULTS

Results were analyzed in SPSS. A repeated measures analysis of variance (ANOVA) tested the effects of target gender (male vs. female) and attire (white coat vs. military uniform) on anticipated mental health disclosure (See Figure 3.1). In support of Hypothesis 1, results indicated a significant main effect of attire such that participants reported significantly higher anticipated mental health disclosure with white coat providers ( $M = 4.38, SD = .22$ ) compared to military uniform providers ( $M = 4.27, SD = .24$ ) [ $F(1, 28) = 8.00, p = .009, \eta_p^2 = .22$ ]. In addition, there was a significant main effect of provider gender such that there was more disclosure to female ( $M = 4.42, SD = .22$ ) compared to male providers ( $M = 4.24, SD = .21$ ) [ $F(1, 28) = 7.56, p = .011, \eta_p^2 = .21$ ] (See Figure 2). There was no significant interaction of attire and gender [ $F(1, 28) = .48, p = .50, \eta_p^2 = .02$ ].

Figure 3.1. Mental health disclosure by provider attire and gender.

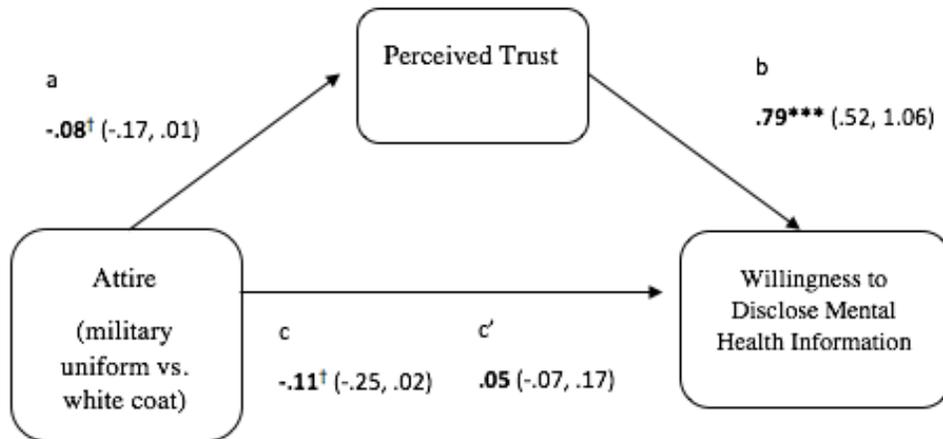


In support of Hypothesis 2, the correlation between participants' ratings of trust and anticipated mental health disclosure revealed a significant positive relationship such that the more participants perceived a provider to be trustworthy, the greater anticipated level of mental health disclosure [ $r(93) = .235, p = .022$ ].

For Hypothesis 3, a mediation analysis testing the impact of attire on mental health disclosure mediated through trust using Montoya & Haye's (2017) Memore, which accounts for repeated measures designs, was conducted (See Figure 3.2). In congruence with the results aforementioned, on average,

participants reported being marginally more willing to disclose mental health related information to providers in white coats vs. military uniforms ( $p = .09$ ). Similarly, providers in white coats were perceived as marginally more trustworthy than were providers in military uniforms ( $p = .08$ ). Additionally, more perceived trust resulted in a significant effect on willingness to disclose mental health related information ( $p < .001$ ). However, the indirect effect of attire on disclosure through perceived trust was not significant ( $p = .39$ ). Therefore, both attire and trust impact mental health disclosure, however, the impact of attire is not mediated by trust, as hypothesized.

Figure 3.2 Memore Mediation Model



Note. The standardized regression coefficient between attire and mental health disclosure, controlling for trust is in brackets. 95% CI's are reported in parentheses. Military uniform coded as 1, white coat coded as 0.  $^{***} p < .001$ ,  $^\dagger p < .10$ .

## CHAPTER 4

### DISCUSSION

This experiment aimed to examine how provider attire (military uniform vs. medical white coat) impacts ratings of provider trustworthiness and ultimately military members' willingness to disclose mental health related information to them. From this, I proposed the following three hypotheses: 1) Patients viewing providers who are wearing white coats, as opposed to provider's in military uniforms, would report greater anticipated disclosure of mental health related information; 2) Greater perceptions of provider's trustworthiness would elicit greater anticipated disclosure of mental health related information; and 3) The relationship between provider attire and willingness to disclose mental health related information would be partially explained by perceptions of provider's trustworthiness such that a higher rating of trustworthiness would elicit greater anticipated disclosure.

The results indicated a significant effect of attire such that there was more anticipated mental health related disclosure to white coat providers compared to military uniform providers. Additionally, results indicated a significant effect of provider gender such that there was more anticipated disclosure to female compared to male providers. Lastly, in line with previous literature, the results indicated that more trust in a provider was correlated with higher levels of anticipated disclosure (Birkhäuer et al., 2017; Hillen et al., 2018; Lee & Lin, 2008).

In summary, from this experiment we saw that participants rated some providers as more trustworthy than others based solely on their photographs. More specifically, they rated providers in white coats as more trustworthy compared to the same providers in military uniforms. While previous literature has not extensively investigated military uniforms, these results further support literature on the importance of provider attire and the impact on patient impressions. Incorporating military uniforms in this design provided a novel and critical finding. Lastly, participants reported greater anticipated disclosure and more trust in female compared to male providers. This is line with previous literature

which suggests that female providers are more patient-centered (Roter et al., 2002) as more patient-centered providers tend to have greater overall patient outcomes (Birkhäuer et al., 2017).

These results have several clinical implications. Because photographs of providers are often posted publicly online for prospective patients to see, understanding how these photographs impact viewers' impressions is crucial. It is likely that a photograph of a provider influences patient decisions to make or keep appointments and also sets expectations as to how the provider will act during their first appointment. Therefore, these findings can inform marketing campaigns around mental health within military medicine and the VA healthcare system.

Perhaps most critical is the fact that providers in military treatment facilities always wear their military uniforms when seeing patients. Based on the results of this study, it is crucial for future work to further investigate the impact that military uniforms have on patient-provider interactions. In this study, participants rated the uniformed providers as less trustworthy in comparison to providers in white coats. Previous literature has shown trust to be critical in the patient-provider relationship (Lee & Lin, 2008; Birkhäuer et al., 2017). Additionally, participants reported less anticipated mental health disclosure to uniformed providers in comparison to those in white coats. Considering that disclosure is critical for mental health diagnosis and treatment, and that service members suffer from high rates of PTSD and depression, this finding has potentially very important clinical implications.

It is important to consider that these findings could be due to the nature of the experimental design. Participants were viewing static photographs of various providers and the results relied entirely on self-report measures. Therefore, it is hard to know exactly *why* participants rated each provider in the way that they did. It is reasonable to question whether the ratings were due to other confounding provider characteristics such as age or attractiveness. Additionally, it is likely that a participant's level of anticipated disclosure is different than what their disclosure would actually be when face to face with any of the providers they saw. While isolating attire was a good first start, future research should take

other provider characteristics and behaviors into consideration. For example, future experiments should investigate if factors such as the age of a provider or their attractiveness impacts perceived trust and anticipated disclosure. Future experiments could also control for verbal and behavioral factors such as provider warmth, smiling intensity, and tone of voice. Of course, behavioral cues would require live interactions.

Overall, the current research showed the power of first impressions in patient-provider interactions. More specifically, it showed the power of attire in that white coat providers were perceived as more trustworthy and patient's anticipated disclosing more mental health related information to them. However, while this design found important significant results, more work is still needed in order to fully understand the impact that military uniforms have in patient-provider dynamics.

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## APPENDIX A: TRUST IN PROVIDER SCALE

Imagine you are meeting with this provider for care. Indicate how much you agree with the following statements on a 1-7 scale with 1 meaning you strongly disagree with the statement and 7 meaning you strongly agree with the statement.

	Very Strongly Disagree	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Very Strongly Agree
I trust this provider and would follow their advice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I worry that this provider wouldn't keep the information we discuss totally private.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I distrust this providers opinion and would want to get a second one.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel comfortable talking to this provider about my mental health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would disclose any mental health related symptoms to this provider.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**APPENDIX B: PARTICIPANT DEMOGRAPHICS**

The following questions ask about demographic information.

**What sex were you assigned at birth? (check one)**

Male

Female

Intersex

**What is your current gender identity? (Check all that apply)**

Male

Female

Female-to-Male (FTM)/Transgender Male/Trans Man

Male-to-Female (MTF)/Transgender Female/Trans Woman

Genderqueer or gender nonconforming, neither exclusively male nor female

Additional Gender Category/(or Other), please specify \_\_\_\_\_

**What is your age in years? \_\_\_\_\_**

**I consider myself a member of the following racial group (check all that apply):**

White

Black or African American

American Indian or Alaska Native

Asian Native

Hawaiian or Other Pacific Islander

Other

**I consider myself a member of the following ethnic group (check one):**

Hispanic or Latino

Not Hispanic or Latino

**What is the highest degree or level of school you have completed?**

Less than high school High school/GED

Some college

2-year college (Associates)

4-year college (BA, BS)

Master's degree

Provideral degree

Professional degree (JD, MD)

Other \_\_\_\_\_

**Which of the following choices best describes your current work status (check all that apply)?**

Work full time

Work part-time

Student

Unemployed or looking for work

Disabled and unable to work

Retired

Other (please specify) \_\_\_\_\_

**What state do you currently reside? \_\_\_\_\_**

**What best describes your relationship status?**

Married/living with partner

Have a primary partner but we don't live together

No primary partner

Dating one or more people

Separated or divorced

Widowed

**Military Status:** The following questions ask about your military history.

**What is your current Veteran status? (check one)**

Active Duty

Guard

Reserve

Retired

**What branch of the military did you/do you serve?**

Air Force

Army

Coast Guard

Marines

Navy

**If applicable, what was your rank at discharge?**

E1	E2	E3	E4	E5	E6	E7	E8	E9
O1	O2	O3	O4	O5	O6	O7	O8	O9

**If applicable, what type of discharge did you receive on your original DD 214?**

Honorable

General

Medical

Other than honorable conditions

Bad Conduct Discharge

Officer Discharge

Dishonorable

## APPENDIX C: INFORMED CONSENT

### CONSENT FORM

You are invited to participate in a research project being conducted by Jessica Correale, a master's student in the Psychology Department at the University of Maine with faculty sponsor, Mollie Ruben, PhD, Assistant Professor of Psychology. The purpose of the research is to examine veterans' impressions of medical providers. You must be (1) at least 18 years of age, (2) fluent in English, and (3) a person holding veteran status to participate.

#### **What Will You Be Asked to Do?**

If you decide to participate, you will view a series of 30 photographs and make first impression judgments about each photograph. After viewing these photographs, you will be also be asked to complete a demographic questionnaire including questions about your gender, race, military history, etc. The entire study should take approximately 30 minutes.

#### **Risks:**

Except for your time and inconvenience, there are no risks to you from participating in this study.

#### **Benefits:**

While this study will have no direct benefit to you, this research may help us to implement better medical procedures for military members. Furthermore, the results can inform future trainings for VA, DoD, and/or civilian providers.

#### **Compensation:**

-Sona participants will receive 1 credit

-Community members will receive a \$10 Amazon.com gift card

You may stop at any time but you will not receive compensation if you leave early. If you skip questions that you don't feel comfortable answering, you will still receive full compensation.

#### **Confidentiality**

Your name will not be on any of the data. An identification number will be used to protect your identity. A logbook linking your name to the data will be kept separate from the data *on a password-protected computer using software that provides additional security and will be destroyed by March,*

2022. Data will be kept on a password protected computer indefinitely. Your name or other identifying information will not be reported in any publications.

**Voluntary**

Participation is voluntary. If you choose to take part in this study, you may stop at any time. You may skip any questions you do not wish to answer without impacting your compensation but you must get to the end of the survey to receive compensation.

**Contact Information**

If you have any questions about this study, please contact one of the Principal Investigators (**University of Maine:** Jessica Correale; 207-745-2383; [jessica.correale@maine.edu](mailto:jessica.correale@maine.edu) or Mollie Ruben; 207-581-2049; [mollie.ruben@maine.edu](mailto:mollie.ruben@maine.edu)). If you have any questions about your rights as a research participant, please contact the Office of Research Compliance, University of Maine email: [umric@maine.edu](mailto:umric@maine.edu).

Your electronic signature below indicates that you have read the above information and agree to participate.

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Signature

Date

## **BIOGRAPHY OF THE AUTHOR**

Jessica Correale was born in Presque Isle, Maine on January 23, 1996. She was raised in Bangor, Maine and graduated from Bangor High School in 2014. She attended the University of Maine and graduated in 2018 with a bachelor's degree in Psychology. During her undergraduate career, Jessica took a gap year to join the Maine Air National Guard where she currently serves part time. After graduating, she entered the Psychological Sciences graduate program at The University of Maine in the fall of 2019. Jessica is a candidate for the Master of Arts degree in Psychology from the University of Maine in May 2021.