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Targeting Self-Stigma in Returning Military Personnel and Veterans: A Review of Intervention Strategies

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Research suggests that mental health-related stigma significantly decreases the use of mental health services by military personnel and veterans. The goal of this article is to review what is known about mental health stigma as it relates to military personnel and veterans, as well as to offer an interpretive review of self-stigma intervention

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strategies that have been applied within the field. Target areas for future work and the concerns and challenges faced by interventionists are discussed.

The stigma of mental illness is a significant barrier to mental health care (e.g., Corrigan, 2004) and appears to be a particularly powerful deterrent in the military (e.g., Greene-Shortridge, Britt, & Castro, 2007). Consequently, stigma about mental health in the military is being addressed in the psychological trauma community (e.g., Britt, 2000; Gould, Greenberg, & Hetherton, 2007), among policy makers outside the military (e.g., American Psychiatric Association, 2008; Tanielian & Jaycox, 2008), and in the Department of Defense (Department of Defense Task Force on Mental Health, 2007). There appears to be a general consensus that mental health stigma is a daunting threat to the overall health and well-being of returning service members and veterans.

Research on stigma in the military has focused primarily on describing its phenomenology and the extent to which veterans underutilize mental health care. Although it has been acknowledged that interventions aimed at reducing stigma are needed (e.g., Britt et al., 2008; Green-Shortridge et al., 2007; Sayer, Spoont, Parker, & Rosenheck, in press), few specific intervention strategies have been explored. The goal of this article is to review what is known about mental health stigma as it relates to self-stigma in military personnel and veterans, as well as to offer an interpretive review of mental health stigma intervention strategies that have been applied within the field. We discuss target areas for future work and intervention concerns and challenges with respect to applications with military personnel and veterans.

AN OVERVIEW OF MENTAL HEALTH STIGMA

Perhaps the most widely used conceptualization of stigma is based on the work of Corrigan and Watson (2002), who have distinguished between two forms of stigmatization: public and self. Public stigma entails invalidating and unjustified beliefs (i.e., prejudices and endorsed stereotypes) about others, whereas self-stigma refers to the internalization of these negative beliefs. This conceptualization suggests that any efforts to mitigate the negative effects of self-stigma require a broad understanding of societal beliefs about mental illness. Below, we review the literature on mental health stigma, with the goal of drawing inferences about how this literature might be applied to mitigate self-stigma in service members and veterans with service-related mental disorders, particularly posttraumatic stress disorder (PTSD). This literature focuses on a number of different aspects of mental health stigma, including stereotypes about the mentally ill, disorder misattribution, label avoidance, and misconceptions about psychopathology and its treatment.

An awareness of stereotypes about the mentally ill can help elucidate specific maladaptive beliefs that diminish treatment-seeking behavior in those who inter-

nalize these distorted and unhelpful beliefs and expectations. The most commonly held stereotypes about the mentally ill are that they are dangerous and violent, incompetent and unaccountable, and personally responsible for becoming, and continuing to be, mentally ill (e.g., Angermeyer & Matschinger, 2004; Corrigan et al., 2000; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Phelan, Link, Stueve, & Pescosolido, 2000; Link, Phelan, Bresnahan, Stueve, Pescosolido, 1999).

The degree to which individuals are blamed for having a disorder varies depending on the public's perception of whether they should be able to exert control over their symptoms (e.g., Weiner, 1996; Weiner, Perry, & Magnusson, 1988). Disorders seen as having a predominantly biological cause (e.g., schizophrenia) are less likely to be attributed to "weak character" than disorders that are sometimes viewed as self-inflicted (e.g., addiction, eating disorders; Boysen & Vogel, 2008; Dijker & Koomen, 2003; Stewart, Keel, & Schiavo, 2006). Although little research has examined public attitudes toward combat-related PTSD, this disorder is event-based (i.e., only veterans who experience combat are at risk for combat-related PTSD) and therefore may be more likely to be classified in the latter category.

Given that people with mental illness are often negatively perceived and blamed for being mentally ill, it is understandable that many individuals attempt to actively avoid being categorized and labeled with a mental disorder, which is often otherwise a gateway to mental health treatment. Corrigan (2004) described label avoidance as, "perhaps the most significant way in which stigma impedes care seeking" (p. 616). Although it remains unclear whether this is true of military populations, research suggests that label avoidance plays an important role in attenuating service utilization by military members. For example, Stecker, Fortney, Hamilton, and Ajzen (2007) found that servicemembers believed that a label would be assigned to them if they sought help, and Hoge et al. (2004) found that servicemembers with severe PTSD symptoms were more likely to report stigma as a barrier to care than servicemembers with less severe symptomatology.

Though the general public's views toward treatment-seeking seem to be improving (e.g., Mojtabai, 2007), a number of misconceptions remain in the public consciousness due, in part, to pop culture's unrealistic and negative portrayal of mental illness and its treatment (e.g., Granello & Pauley, 2000; Sieff, 2003; Wahl, 2003; Wilson, Nairn, Coverdale, & Panapa, 2000). As a mirror to and shaper of the culture, television and film portrayals of mental illness entail considerable mythology and misconception (Pirkis, Blood, Francis, & McCallum, 2006). For example, pop culture depicts rare disorders (e.g., dissociative identity disorder) as relatively common, mentally ill individuals as aggressive and dangerous, and mental health treatment as melodramatic; electroconvulsive therapy and ethical indiscretions are commonly found in pop culture's depictions of mental health treatment, whereas images of psychiatrists prescribing medication are a rarity (Pirkis et al.). Research suggests that such inaccurate portrayals result in increased levels of stigmatization (Wahl, 1999) and a decreased willingness among individuals to seek mental health treatment (Vogel, Gentile, & Kaplan, 2008).

THE STIGMA OF MENTAL ILLNESS IN THE MILITARY

The primary consequence of mental health stigma is that many individuals live with, and are negatively affected by, treatable forms of psychopathology. A number of different aspects of military culture may contribute to mental health stigma. For instance, many of the attitudes and beliefs that prepare warriors for battle may thwart help-seeking (Tanielian & Jaycox, 2008). Attitudes such as toughness, mission focus, and self- and group-based sufficiency are instilled in service members to ensure combat readiness. This belief system contributes to the notion that help-seeking is a sign of weakness and that strong, self-reliant individuals can "tough out" any problem or injury. It comes as no surprise then that in one study, at least half of soldiers and Marines meeting criteria for a mental disorder felt that seeking mental health treatment would result in being perceived as weak, being blamed for the problem, being treated differently by unit leaders, and having harm done to their careers (Hoge et al., 2004). Perhaps as a consequence, between 55 and 62% of soldiers and Marines meeting screening criteria for major depression, generalized anxiety, or PTSD indicated that they were uninterested in receiving help, and only between 13 and 27% had received treatment from a mental health professional within the past year. In another study of National Guard soldiers, Stecker and colleagues found discomfort with help seeking to be the most common barrier to care (Stecker et al., 2007).

These results are echoed in a more recent conceptualization of stigma specific to the Veterans Affairs (VA) health care system offered by Vogt and Pineles (2009). According to this conceptual model, stigma-related barriers to VA health care use include concerns about the social consequences of seeking VA health care, beliefs about the VA patient population that interfere with health care use, and more general discomfort with help-seeking for health care. Taken together, these stigma-related barriers again point to the underlying concern that service use will be equated with personal weakness. Although this model was developed to address factors that impact use of VA services among veterans, many of these domains may also apply in other settings.

Interestingly, in a recent survey conducted by the American Psychiatric Association, 88% of military members agreed that mental illness can be successfully treated, and 90% of military members agreed that mental health treatment can help people gain control of their lives (American Psychiatric Association, 2008). This suggests that discomfort with help-seeking is not easily explained by lack of confidence in mental health treatment but rather by other barriers to care. The research discussed here points to the central role that stigma plays in hindering care utilization among service members.

INTERVENTION STRATEGIES

Below we review strategies that have been applied to reduce public stigma more generally, after which we describe studies that have specifically targeted self-

stigma. Our primary interest is generating evidence-informed and testable best practices that may be applied within military and VA settings.

Previously Proposed Strategies

Most stigma intervention research conducted to date has examined one of three stigma reduction strategies described by Corrigan and Penn (1999; e.g., Corrigan et al., 2001, 2002; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Penn, Kommana, Mansfield, & Link, 1999; Spagnolo, Murphy, & Librera, 2008). These strategies are called *protest*, *education*, and *contact*. Protest refers to work aimed at redressing negative attitudes about the mentally ill. An example is the work of mental health advocacy groups that openly reject inaccurate portrayals of the mentally ill in film and television. Education involves disseminating information on mental illness to correct misconceptions and challenge stereotypes. Contact with the mentally ill aims to confront individuals holding implicit or explicit negative stereotypes, challenge their beliefs, and reduce social distancing.

The first strategy, protest, has received relatively little attention of late from stigma researchers. This is largely because social psychological research suggests that protest may not be an effective strategy for combating stigma. Forced suppression is associated with rebound effects, a phenomenon that could potentially result in increased sensitivity to, and agreement with, negative stereotypes (e.g., Macrae, Bodenhausen, Milne, & Jetten, 1994). In one study, Corrigan et al. (2001) presented images to participants that depicted disrespectful media portrayals of mentally ill individuals and then followed the images with messages condemning the negative portrayals. Results from the study suggested that protest resulted in no attitude improvement among participants.

Research examining the effectiveness of education has produced mixed findings. Although it appears that educational programs are associated with improved attitudes about the mentally ill (Corrigan et al., 2001; Holmes et al., 1999; Penn et al., 1999), there is a paucity of longitudinal research investigating attitude change over time. In one study, attitude improvements resulting from an education intervention returned to baseline at a one-week follow-up (Corrigan et al., 2002). It is unclear whether this finding would generalize to other education interventions, particularly given the level of inconsistency across study designs; education interventions have ranged from the mere administration of an informational sheet (Penn et al.) to participation in a 16-week college course (Holmes et al.).

Contact strategies appear to be the most promising of Corrigan and Penn's (1999) strategies. In one study, compared with protest/advocacy and education, contact (a 10-minute presentation by one or two individuals discussing their history of mental illness) resulted in greater recall of more positive and less negative information about presenters (Corrigan et al., 2001). Corrigan et al. (2002) also found that listening to a 10-minute presentation and participating in a 5-minute

discussion resulted in significant changes in ratings concerning personal responsibility and dangerousness. These findings are supported by other studies (Alexander & Link, 2003; Penn et al., 1999) that have found an inverse relationship between contact with mentally ill individuals and perceived dangerousness and desired social distance.

Strategies Addressing Self-Stigma

Importantly, the studies reviewed thus far have focused on targeting public forms of stigmatization. In other words, the focus has been on reducing stigma toward the mentally ill within the larger community. Although public stigma is significantly associated with decreased levels of treatment utilization, self-stigma has been suggested to fully mediate this relationship (Vogel, Wade, & Hackler, 2007). This implies that treatments aimed at promoting service utilization may best succeed by targeting self-stigma among those individuals who have internalized negative beliefs regarding mental health. According to the social-cognitive model of self-stigma posited by Watson and colleagues (Corrigan & Watson, 2002; Watson, Corrigan, Larson, & Sells, 2007; Watson & River, 2005), the likelihood that an individual will internalize negative beliefs is contingent upon personal perceptions of group identification and stereotype legitimacy. Individuals who strongly identify with a stigmatized group, and who perceive a stereotype to be legitimate, respond to stigma with diminished self-esteem and self-efficacy. Those who identify with a stigmatized group but perceive a stereotype to be illegitimate instead respond with righteous anger. Thus, Corrigan and Calabrese (2005) recommended cognitive techniques and personal empowerment as useful self-stigma reduction strategies. Researchers who have examined the effects of stigma on treatment utilization in the military have also underscored the potential usefulness of cognitive techniques (Stecker et al., 2007). Reappraising the legitimacy of certain stereotypes (e.g., "receiving treatment is a sign of weakness") may increase an individual's sense of righteous anger and empowerment and reduce acceptance of negative stereotypes.

To date, there is little research examining intervention strategies aimed at challenging self-stigmatizing beliefs. At present, three empirical studies have examined the effectiveness of self-stigma interventions (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008; MacInnes & Lewis, 2008; McCay et al., 2007). All of these interventions were delivered in group settings and were comprised of either standard cognitive techniques (e.g., psychoeducation, cognitive reappraisal) or components of acceptance and commitment therapy (ACT), which includes a focus on psychological acceptance and value-driven behavior (e.g., Hayes, Strosahl, & Wilson, 1999). Two of these interventions (Luoma et al.; MacInnes & Lewis) led to significant reductions in participants' self-reported levels of stigma; however, McCay et al. failed to find improvements in participants' ratings of self-esteem,

self-efficacy, and stigma following a self-stigma intervention. The inconsistency in these findings could be due to sample differences. Participants in the MacInnes and Luoma studies were individuals receiving treatment at inpatient facilities for either enduring mental illness or substance use. In the McCay et al. study, however, participants were outpatients at first-episode psychosis clinics. These individuals may have been especially prone to self-stigmatizing beliefs (i.e., perceiving stereotypes as legitimate) given the recent onset of their symptoms and their lack of knowledge and experience with their disorders' phenomenologies.

The findings from these first two studies are encouraging and suggest the possibility that self-stigma can be diminished; however, both studies were uncontrolled and lacked follow-up assessments. Given the paucity of research in this area, further work is clearly needed. One issue that requires particular attention relates to the modes of intervention delivery that can be realistically implemented with individuals who perceive barriers to care.

Modes of Intervention Delivery

Several modes of stigma intervention delivery have been suggested in the literature, including video-based (e.g., Corrigan, Larson, Sells, Niessen, & Watson, 2007), online (e.g., Finkelstein, Lapshin, & Wasserman, 2008; Griffiths, Christensen, Jorm, Evans, & Groves, 2004; Webb, Burns, & Collin, 2008), and group-based mediums (e.g., MacInnes & Lewis, 2008). Individual and bibliotherapeutic interventions could also serve as useful mediums for combating certain aspects of stigma, particularly with respect to reducing risk of noncompliance and treatment dropout.

Among these modes of intervention, computer-based strategies may be especially promising. Internet use is associated with anonymity and empowerment (e.g., Valaitis, 2005) and may be a particularly useful medium for addressing self-stigma. Furthermore, computer-based strategies may produce longer-lasting effects compared with printed materials. Through the use of a more interactive learning paradigm, computer-based interventions may enable participants to better retain information, thereby leading to more long-term outcomes.

Consistent with this perspective, Finkelstein et al. (2008) found that although both an anti-stigma computer program and anti-stigma printed materials significantly affected participants' scores on measures related to desired social distance from the mentally ill, attitudes toward the mentally ill, and knowledge about psychopathology, attitudes and knowledge ratings did not significantly differ from baseline when participants in the printed materials condition were reassessed after 6 months. In contrast, all three measures remained significantly different from baseline scores for participants in the computer group.

In addition to being associated with more long-term treatment effects, Web-based modes of intervention may be more cost-effective and easier to disseminate

than individual or group-based interventions. Moreover, unlike these forms of intervention, Web-based intervention does not require face-to-face contact. Given that many individuals may be unable to distinguish between face-to-face contact and general psychotherapy, face-to-face designs are inherently inappropriate modes of intervention delivery when targeting barriers to care such as stigma.

Video has also been demonstrated to be an effective medium for delivering stigma interventions (Corrigan et al., 2007). However, similar to printed material, video alone lacks interactivity and therefore may be less engaging than Internet-based interventions. Fortunately, video can be incorporated into, and used in conjunction with, computer-based mediums, which appear to be both practical and effective modes of delivery for stigma interventions.

Promising Avenues and Recommendations

Based on our review of the literature, we believe that future efforts aimed at reducing stigma in the military and the VA should focus on five targets: (a) perceptions that care utilization is a sign of weakness; (b) stereotypes about mental illness and mental health diagnoses (e.g., indicative of incompetence, dangerousness, or "craziness"); (c) self-blame (e.g., feeling responsible for having a mental illness); (d) uncertainty about the signs and symptoms of mental illness; and (e) uncertainty about the nature of treatment.

Many of the public and self-stigma reduction strategies discussed could be successfully incorporated into an intervention model intended for military veterans. Educational materials providing information on psychopathology (i.e., descriptions of trauma-related sequelae, associated symptoms, and natural course), etiology (i.e., biological diatheses), and treatment (i.e., treatment types and efficacy) would address several of our proposed intervention targets (stereotype endorsement, feeling responsible for having a disorder, uncertainty about the signs and symptoms of mental illness, uncertainty about the nature of psychotherapy) and are consistent with trauma researchers' recommendations for stigma interventions (e.g., Green-Shortridge et al., 2007; Sayer et al., in press). In addition, modified forms of contact (e.g., personal accounts of veterans' experiences with stigma and treatment, supportive comments from military leaders) might be especially useful to help counter weakness-related perceptions and normalize treatment-seeking.

As stated above, trauma researchers recommend the use of cognitive reappraisal techniques for combating stigma (e.g., Stecker et al., 2007). Among veterans, this strategy could be utilized to address multiple intervention targets, including weakness-related perceptions (e.g., "If help-seeking is met with ridicule for veterans, then a decision to seek help is a sign of inner strength and courage"), stereotype endorsement (e.g., "What evidence do you have that stereotypes are true?"), and causal misattribution (e.g., "Are you aware of the biological contributions to PTSD?").

Empowerment can leverage prized military beliefs and values (Sayer et al., 2007). Leaders could inform veterans of the damaging effects of stigma, which could promote feelings of righteous anger. Furthermore, acknowledging the empowering side effects of treatment (e.g., improved sleep, relationship satisfaction, returning to normal) could help promote treatment utilization and provide alternative self-rationales for treatment. This recommendation is supported by qualitative research conducted by Snell and Tusaie (2008), which found *disruption in significant relationships* to be the reason most frequently given by Iraq and Afghanistan veterans for seeking mental health services at a VA outpatient clinic. An exploration of individual values might enable veterans to reconceptualize current impairments as threats to their personal goals. The U.S. Army's *Battlemind* program (2008), which provides information to service members and their spouses promoting discussion about combat-related stress issues, offers an example of empowerment's application to military populations.

Lastly, acceptance-based exercises drawing on ACT principles are beginning to gain empirical support in the stigma intervention literature (e.g., Luoma et al., 2008; Masuda et al., 2007). This strategy could potentially be useful for promoting psychological acceptance and for encouraging less judgmental views of the self among veterans.

Intervention Concerns and Challenges

Although we believe that these anti-stigma strategies hold promise, we remain mindful of several concerns and limitations faced by stigma interventionists. Namely, these concerns relate to iatrogenic effects, institutional barriers to care, and moral implications associated with targeting self-stigma.

Research suggests that preexisting attitudes about mental illness bias the way in which individuals process anti-stigma education materials, such that evidence consistent with preexisting attitudes is perceived as more persuasive than contradictory evidence (e.g., Boysen & Vogel, 2008). This problem can lead to what is termed *attitude polarization* (Lord, Ross, & Lepper, 1979), which refers to the tendency of one's attitudes to strengthen after being exposed to evidence both supporting and contradicting them. Theoretically, this phenomenon could potentially produce iatrogenic effects in participants completing a self-stigma intervention. Thus, interventionists would be well advised to carefully attend to their content focus to ensure that information is not presented in a manner that could inadvertently support existing biases. Future research is necessary to determine the likelihood of iatrogenic effects resulting from self-stigma interventions.

A second concern is the presence of institutional barriers to care. For many military members, it can be difficult to separate stigma from legitimate concerns regarding real potential consequences of health seeking. Confidentiality regarding mental health treatment is a major concern for many military men and women

(Johnson et al., 2007); mental health diagnoses are listed on fitness-for-duty profiles, which may then render service members ineligible for certain career tracks (Tanielian & Jaycox, 2008). Similarly, in accordance with the National Defense Authorization Act (e.g., United States Government Accountability Office, 2009), the Department of Defense and the VA are working to increase the amount of health information exchanged between the departments. These changes could affect individuals who are currently in the military and receiving services from the VA (e.g., Army reservists and National Guardsmen). Therefore, issues of stigma may be more difficult to target for current military members compared to military veterans who have separated from military service. This should be taken into consideration in evaluating the effectiveness of stigma interventions in these two populations.

Lastly, Corrigan and Calabrese (2005) cautioned that too strong a focus on self-stigma may divert attention from the public's role in creating and maintaining stigma. This perspective draws attention to the importance of complementing efforts aimed at promoting service utilization at the individual level with initiatives targeting stigma across all levels, including the societal, institutional, and governmental. Any serious attempt to redress stigma among veterans needs to happen in the culture at large, within institutions, such as the Departments of Defense and Veterans Affairs, and among decision makers (e.g., Corrigan & Penn, 1999; Gould et al., 2007; Green-Shortridge et al., 2007; Heijnders & Van Der Meij, 2006).

SUMMARY

We reviewed a variety of anti-stigma strategies that may be relevant for efforts to reduce mental health stigma in the military. Drawing on a combination of literatures, our review considered many up-to-date, theoretically and empirically supported intervention methods. By identifying what we believe to be the most promising avenues for intervention design, we hope that this article calls attention to the topic of mental health stigma in the military and the gaps in its associated literature. More research is needed to examine self-stigma reduction strategies and their relation to treatment utilization. Randomized controlled trials and longitudinal designs may be especially useful in efforts to examine the efficacy of these strategies, as both stand-alone and combined forms of stigma intervention. Despite evidence that the majority of servicemembers meeting criteria for a mental disorder are uninterested in receiving treatment (Hoge et al., 2004), there appears to be little research to date examining stigma reduction strategies in military populations. The information provided here is intended to promote innovations and research efforts.

REFERENCES

Alexander, L. A., & Link, B. G. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health, 12*, 271–289.

American Psychiatric Association. (2008). *Military Family Mental Health Survey*. New York, NY: Author.

Angermeyer, M. C., & Matschinger, H. (2004). Public attitudes to people with depression: Have there been any changes over the last decade? *Journal of Affective Disorders, 83*, 177–182.

Boysen, G. A., & Vogel, D. L. (2008). Education and mental health stigma: The effects of attribution, biased assimilation, and attitude polarization. *Journal of Social & Clinical Psychology, 27*, 447–470.

Britt, T. W. (2000). The stigma of psychological problems in a work environment: Evidence from the screening of service members returning from Bosnia. *Journal of Applied Social Psychology, 30*, 1599–1618.

Britt, T. W., Greene-Shortridge, T. M., Brink, S., Nguyen, Q. B., Rath, J., Cox, A. L., et al. (2008). Perceived stigma and barriers to care for psychological treatment: Implications for reactions to stressors in different contexts. *Journal of Social & Clinical Psychology, 27*, 317–335.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625.

Corrigan, P. W., & Calabrese, J. D. (2005). Strategies for assessing and diminishing self-stigma. In P. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 239–256). Washington, DC: American Psychological Association.

Corrigan, P. W., Larson, J., Sells, M., Niessen, N., & Watson, A. C. (2007). Will filmed presentations of education and contact diminish mental illness stigma? *Community Mental Health Journal, 43*, 171–181.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*, 765–776.

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*, 187–195.

Corrigan, P. W., River, L. P., Lundin, R. K., Uphoff Wasowski, K., Campion, J., Mathisen, J., et al. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology, 28*, 91–102.

Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., et al. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin, 28*, 293–309.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*, 35–53.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4–7.

Department of Defense Task Force on Mental Health. (2007). *An achievable vision: Report of the Department of Defense Task Force on Mental Health*. Retrieved February 16, 2009, from http://www.health.mil/dhb/mhtf/MHTF-Report-Final.pdf

Dijker, A. J., & Koomen, W. (2003). Extending Weiner's attribution-emotion model of stigmatization of ill persons. *Basic and Applied Social Psychology, 25*, 51–68.

Finkelstein, J., Lapshin, O., & Wasserman, E. (2008). Randomized study of different anti-stigma media. *Patient Education and Counseling, 71*, 204–214.

Gould, M., Greenberg, N., & Hetherton, J. (2007). Stigma and the military: Evaluation of a PTSD psychoeducational program. *Journal of Traumatic Stress, 20*, 505–515.

Granello, D. H., & Pauley, P. S. (2000). Television viewing habits and their relationship to tolerance toward people with mental illness. *Journal of Mental Health Counseling, 22*, 162–175.

Greene-Shortridge, T. M., Britt, T. W., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172*, 157–161.

Griffiths, K. M., Christensen, H., Jorm, A. F., Evans, K., & Groves, C. (2004). Effect of Web-based depression literacy and cognitive-behavioural therapy interventions on stigmatising attitudes to depression: Randomised controlled trial. *British Journal of Psychiatry, 185*(4), 342–349.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.

Heijnders, M., & Van Der Meij, S. (2006). The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health & Medicine, 11*, 353–363.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13–22.

Holmes, E. P., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin, 25*, 447–456.

Johnson, S. J., Sherman, J. S., Hoffman, L. C., James, P. L., Johnson, J. E., Lochman, T. N., et al. (2007). *The psychological needs of U.S. military service members and their families: A preliminary report*. American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members. Retrieved November 24, 2009 from http://www.ptsd.ne.gov/publications/military-deployment-task-force-report.pdf

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*, 1328–1333.

Lord, C. G., Ross, L., & Lepper, M. R. (1979). Biased assimilation and attitude-polarization: The effects of prior theories on subsequently considered evidence. *Journal of Personality and Social Psychology, 47*, 2098–2109.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research & Theory, 16*, 149–165.

MacInnes, D. L., & Lewis, M. (2008). The evaluation of a short group programme to reduce self-stigma in people with serious and enduring mental health problems. *Journal of Psychiatric and Mental Health Nursing, 15*, 59–65.

Macrae, C. N., Bodenhausen, G. V., Milne, A. B., & Jetten, J. (1994). Out of mind but back in sight: Stereotypes on the rebound. *Journal of Personality and Social Psychology, 67*, 808–817.

Masuda, A., Hayes, S. C., Fletcher, L. B., Seignourel, P. J., Bunting, K., Herbst, S. A., et al. (2007). Impact of acceptance and commitment therapy versus education on stigma toward people with psychological disorders. *Behaviour Research and Therapy, 45*, 2764–2772.

McCay, E., Beanlands, H., Zipursky, R., Roy, P., Leszcz, M., Landeen, J., et al. (2007). A randomised controlled trial of a group intervention to reduce engulfment and self-stigmatisation in first episode schizophrenia. *Australian e-Journal for the Advancement of Mental Health, 6*, 1–9.

Mojtabai, R. (2007). Americans' attitudes toward mental health treatment seeking: 1990–2003. *Psychiatric Services, 58*, 642–651.

Penn, D. L., Kommana, S., Mansfield, M., & Link, B. G. (1999). Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. *Schizophrenia Bulletin, 25*, 437–446.

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behavior, 41*, 188–207.

Pirkis, J., Blood, R. W., Francis, C., & McCallum, K. (2006). On-screen portrayals of mental illness: Extent, nature, and impacts. *Journal of Health Communication, 11*(5), 523–541.

Sayer, N. A., Spoont, M., Parker, L., & Rosenheck, R. (in press). A quantitative study of PTSD treatment initiation in veterans. *Psychiatry: Interpersonal and Biological Processes*.

Sieff, E. M. (2003). Media frames of mental illnesses: The potential impact of negative frames. *Journal of Mental Health, 12*, 259–269.

Snell, F., & Tusaie, K. R. (2008). Veterans reported reasons for seeking mental health treatment. *Archives of Psychiatric Nursing, 22*, 313–314.

Spagnolo, A. B., Murphy, A. A., & Librera, L. (2008). Reducing stigma by meeting and learning from people with mental illness. *Psychiatric Rehabilitation Journal, 31*, 186–193.

Stecker, T., Fortney, J. C., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatric Services, 58*, 1358–1361.

Stewart, M., Keel, P. K., & Schiavo, R. S. (2006). Stigmatization of anorexia nervosa. *International Journal of Eating Disorders, 39*, 320–325.

Tanielian, T., & Jaycox, L. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Retrieved February 16, 2009, from http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf

U.S. Army. (2008). *Predeployment battlemind for spouse/couples*. Retrieved February 16, 2009, from https://www.battlemind.army.mil/assets/files/spouse_battlemind_training_predeployment2.pdf

United States Government Accountability Office. (2009). *DOD's and VA's sharing of information could benefit from improved management*. Retrieved February 16, 2009, from http://www.gao.gov

Valaitis, R. K. (2005). Computers and the Internet: Tools for youth empowerment. *Journal of Medical Internet Research, 7*, e51.

Vogel, D. L., Gentile, D. A., & Kaplan, S. A. (2008). The influence of television on willingness to seek therapy. *Journal of Clinical Psychology, 64*, 276–295.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*, 40–50.

Vogt, D. S., & Pineles, S. (2009). *An integrated model of facilitators and barriers to VA health-care use: Application to OEF/OIF veterans*. Manuscript submitted for publication.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin, 25*, 467–478.

Wahl, O. F. (2003). Depictions of mental illnesses in children's media. *Journal of Mental Health, 12*, 249–258.

Watson, A. C., Corrigan, P., Larson, J. E., & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin, 33*, 1312–1318.

Watson, A. C., & River, L. P. (2005). A social-cognitive model of personal responses to stigma. In P. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 145–164). Washington, DC: American Psychological Association.

Webb, M., Burns, J., & Collin, P. (2008). Providing online support for young people with mental health difficulties: Challenges and opportunities explored. *Early Intervention in Psychiatry, 2*, 108–113.

Weiner, B. (1996). Searching for order in social motivation. *Psychological Inquiry, 7*, 199–216.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55*, 738–748.

Wilson, C., Nairn, R., Coverdale, J., & Panapa, A. (2000). How mental illness is portrayed in children's television: A prospective study. *British Journal of Psychiatry, 176*, 440–443.