Self-stigma and Veteran Culture

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Self-stigma and Veteran Culture – Final Version

Self-stigma is the internalization of negative beliefs which are then applied to one's self-concept (Watson, Corrigan, Larson, & Sells, 2007). Self-stigma has negative consequences which are relevant to nursing including increased depression, decreased self-esteem (Boyd, Adler, Otilingam, & Peters, 2014), decreased quality of life (Corrigan, Sokol, & Rusch, 2013), and decreased treatment-seeking (Bathje & Pryor, 2011; Jennings et al., 2015; Tucker et al., 2013). Cultural factors may impact self-stigma and its consequences. The United States military veteran population, including the Operating Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veteran population, is one cultural group that experiences self-stigma and its health-related implications (Harris et al., 2015). The Giger and Davidhizar transcultural assessment model is a helpful framework for organizing the assessment of a cultural group. This paper will provide an overview of the Giger and Davidhizar model, veteran culture, and self-stigma, as well as discuss these concepts with regard to evidence-based nursing practice and research.

Giger and Davidhizar's Model of Transcultural Nursing

Giger and Davidhizar's cultural model provides a framework for providing care to clients from diverse backgrounds. The model's broad philosophical assumption is that each person is a unique individual, influenced by many cultural variables (American Association of Colleges of Nursing [AACN], 2008). The metaparadigm of this model consists of five interrelated concepts: transcultural nursing, culturally competent care, culturally unique individuals, culturally sensitive environments, and health and health status (Giger & Davidhizar, 2002). Giger and Davidhizar (2002) defined transcultural nursing as a "culturally competent practice field that is client centered and research focused" (p. 187). Therefore, the overall purpose of transcultural nursing

is to learn and apply information specific to culture in order to provide competent care (Dowd, Giger, & Davidhizar, 1998).

Culturally competent care occurs when cultural information is used in a meaningful way; the process of providing culturally competent care is “dynamic, fluid, and continuous” (Giger, & Davidhizar, 2002, p.187). The process of becoming a culturally competent practitioner, therefore, is not a linear process. This model also views the nurse-client relationship as nonhierarchical, the nurse and client are partners in assessing cultural needs (AACN, 2008). Culturally unique individuals refers to the idea that each client is a cultural being, influenced by their beliefs and experiences, and that the nurse should avoid stereotyping or making assumptions (Dowd et al., 1998). Culturally sensitive environments facilitate the provision of culturally competent care irrespective of the type of clinical setting (Giger & Davidhizar, 2002). Lastly, health and health status refers to the idea that the meaning of health varies across cultures and the client’s personal definition of health should be understood in order to provide culturally competent care (Giger & Davidhizar, 2002). These concepts, as a whole, refer to the idea that nursing care should be tailored to meet the individual cultural needs of each client.

Giger and Davidhizar’s model provides a framework for cultural assessment. The cultural assessment process is guided by six broad areas which are thought to be areas of variability existing across all cultures (AACN, 2008). The six assessment areas are: communication, space, social organization, time, environmental control, and biological variations (Giger & Davidhizar, 2002). Communication encompasses all verbal and nonverbal communication (AACN, 2008). Space includes consideration of proxemics and how culture influences personal space and comfort with various degrees of physical space (AACN, 2008). Social organization includes family roles, relationships, hierarchy, and issues of authority and

influence (Giger & Davidhizar, 2002). Time as a cultural variable refers to past, present, or future-orientation (Giger & Davidhizar, 2002). Environmental control includes whether a person's sense of control is internal versus external, including the degree to which the person believes he/she can influence or alter the environment (Giger & Davidhizar, 2002). The final area of assessment, biological variations, refers to physical differences including genetics, metabolism, and body structure (AACN, 2008). This framework provides a prescriptive approach to the cultural assessment process, which can also be applied to help organize information about cultural groups.

Veteran Culture

Veterans of the United States military are a distinct cultural group (Coll, Weiss, & Yarvis, 2011). This group is comprised of all individuals who served in any branch of the military, including the Army, Air Force, Navy, Coast Guard, and Marine Corps (United States Department of Veterans Affairs, n.d.-c). According to the United States Census Bureau (2015), there are 21.8 million veterans. Within this larger cultural group, there are further subdivisions based on service era. Veterans of the recent conflicts in Iraq and Afghanistan are collectively referred to as Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans or are sometimes referred to as post-9/11 veterans (National Center for Veterans Analysis and Statistics [NCVAS], 2015). As of 2013, there were 2.4 million OIF/OEF veterans (NCVAS, 2015).

While there are many differences between the OIF/OEF veterans and the larger veteran population, there are three specific differences that are of particular importance to nursing practice. The first distinction is that 30.5% of the OIF/OEF veteran population has a service-connected disability, which is nearly twice the rate of any previous veteran population (NCVAS, 2015). Notably, post-traumatic stress disorder (PTSD) was not recognized as a service-

connected disability until 1980 (Hobbs, 2008), which could be a factor in the higher disability rate in the OIF/OEF population. The second distinction is that the OIF/OEF veterans utilize Veterans Affairs health care at lower rates than other veterans, with only 17.8% receiving VA care (NCVAS, 2015). The OIF/OEF veteran population is also the fastest growing veteran population and is expected to grow by 51% between 2013 and 2018 (NCVAS, 2015). The implications of this cultural group's rapid growth, disability status, and utilization of non-VA healthcare are that nurses are highly likely to encounter OIF/OEF veterans regardless of clinical setting. Therefore, it is important to understand this cultural group in order to provide culturally competent care.

Veteran culture is heavily influenced by military culture as the single defining feature of a veteran is his/her past service in the military. According to the United States Department of Veterans Affairs (n.d.-b), "even though the veteran has left the service, the service may not have left the veteran" (para. 5). However, Coll et al. (2011) explained that there can be a range of reactions to military service amongst veterans, some retaining military culture and others becoming more removed or even distrustful of the government. Therefore, while understanding military culture can help inform an understanding of veteran culture, Giger and Davidhizar's (2002) caution against stereotyping is especially relevant.

Service members learn military culture during basic training, a process Redmond et al. (2015) described as "degrading" (p. 14), intended to break the civilian identity in order to form the military identity. In addition, service members are ruled by a separate set of laws than civilians, the Uniformed Code of Military Justice (UCMJ) (Redmond et al., 2015). The UCMJ includes character requirements and infractions can include offenses such as cheating on a test or being unfaithful to one's spouse (Kuehner, 2012). Violations of the UCMJ can be grounds for

removal from the military; therefore its influence on military norms and culture, and by extension, veteran culture, is significant (Kuehner, 2012). Essentially, veterans are assimilated into military culture during basic training, and then these ways of thinking and behaving are reinforced as necessary requirements in order to remain a part of the military.

Communication:

According to Coll et al. (2011), military culture directs how service members communicate with each other and with non-service members (civilians). Communication includes the use of many acronyms and slang terms, some of which originated for use over radio communication (United States Department of Veterans Affairs, n.d.-a). Communication style tends to be direct and authoritative, likely a reflection of the hierarchical relationships between service members (Hall, 2011). Service members are expected to follow the chain of command, communicating first with their direct supervisor (Coll et al., 2011). Generally, military members are expected to be obedient (Coll et al., 2011) and questioning authority is not valued (Hall, 2011). Hall (2011) added that "secrecy" is valued over "openness" in communication (p. 10), therefore nurses should be mindful of this when interviewing veteran clients.

Space:

Regarding space, service members in training or on deployment live in close quarters and have minimal privacy (Hall, 2011). Service members often experience frequent relocations, separations, and reunions, leading to "isolation and alienation" (Hall, 2011, p. 9). It is unclear in the literature how the individual's prior cultural background might affect the variable of space both during and after military service.

Social Organization:

Social organization in the military is marked by hierarchical relationships which are determined by rank. Hall (2011) explained that there is a divide between officers and enlisted members, such that socializing between the two groups is not permitted. On the other hand, the military is like a "second family" as well (Hall, 2011, p. 12), and "unit cohesion" (Coll et al., 2011, p. 488) is highly valued. While each branch of the military has its own mottos and core values (United States Department of Veterans Affairs, n.d.-c), commonalities across all branches include courage, loyalty, sacrifice, high standards, and stoicism (Hall, 2011; Redmond et al., 2015; Westphal & Convoy, 2015) and "mission focus" exemplified by prioritizing the mission over individual needs and never accepting defeat (United States Department of Veterans Affairs, n.d.-b). There is also a distinction between veterans and civilians, where veterans often reported feeling most understood by others veterans (Mittal et al., 2013). Veterans are likely to view health care providers as "civilian/officer-equivalent/authority figures" (Hall, 2011, p. 11). The implication of this is that non-veteran nurses will be seen as both authority figures and outsiders who may not understand the veteran.

Time:

According to Redmond et al. (2015), service members are future-oriented as evidenced by their focus on the mission, signing contracts to commit to years of service, planning for a military career or planning for future veteran benefits. Hall (2011) also explained that service members are always prepared for future disasters, which also evidences future-orientation. However, veterans also have disproportionately higher rates of post-traumatic stress disorder (PTSD) than civilians (Hobbs, 2008), and this disorder involves re-experiencing of the past (American Psychiatric Association [APA], 2013) which could alter orientation from the future to the past. Giger and Davidhizar (2002) explained that engaging in preventive healthcare is

"motivated by a future reward" (p.185). The quality of future-orientation may therefore be helpful for veterans with respect to engagement in the healthcare system, where past-orientation might be a disadvantage.

Environmental Control:

Military values such as toughness and mission focus (Coll et al., 2011; Hall, 2011) lend themselves to a more external locus of control. In contrast to this, OIF/OEF service members do face specific environmental challenges including longer and more frequent deployments to combat zones than previous veteran populations and exposure to Improvised Explosive Devices (Coll et al., 2011). Due to this, OIF/OEF veterans have experienced combat-related injuries such as traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) (Coll et al., 2011).

Biological Variations:

Although the veteran population is comprised of individuals from various ethnic and cultural backgrounds, the OIF/OEF population is primarily young, male, and white (Redmond et al., 2015). According to the National Center for Veterans Analysis and Statistics (2015), 75% of OIF/OEF veterans are under forty four years of age and 68.5% are white, though they are also the most racially diverse veteran population. Nine percent of veterans are female (NCVAS, 2016). As a cultural group, they have disproportionately higher rates of PTSD, depression, and substance abuse (Hobbs, 2008). According to Bruce (2010), OIF/OEF veterans have a lower risk of all-cause mortality but the same or possibly an increased rate of suicide when compared to the general population. Given that individuals who serve in the military tend to be in better health overall (the "Healthy Soldier Effect"), the suicide rate is particularly concerning (Bruce, 2010).

Self-stigma

According to Goffman's (1963) seminal work, the term stigma was first used by the ancient Greeks and originally referred to a physical mark made on a person (often a cut or a burn) to signal that the person was disgraced in some way. Currently, stigma is used to refer to the disgrace or discrediting of the person more generally and no longer refers to a physical mark (Goffman, 1963). Self-stigma is a related concept and refers to the internalization of stigma that occurs when a person applies negative beliefs to his/her self-concept (Watson et al., 2007). It has been studied in populations including depression, severe mental illness, substance abuse, inflammatory bowel disease, and smoking (Boyd et al., 2014). Self-stigma is particularly salient in mental health because it is associated with increased depressive symptoms, decreased self-esteem (Boyd et al., 2014), decreased quality of life (Corrigan et al., 2013). The self-stigma of seeking mental health treatment is associated with decreased intentions to seek treatment (Bathje & Pryor, 2011; Jennings et al., 2015; Tucker et al., 2013).

Self-stigma is thought to be a progressive process that begins with awareness of negative beliefs about a devalued group, then agreement with these stereotypes, and finally the application of those negative beliefs to the self (Corrigan, Rafacz, & Rusch, 2011). Therefore, an antecedent to self-stigma is public stigma (Watson et al., 2007). In fact, in countries with less public stigma of mental illness, there is also less self-stigma (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012). Many instruments have been developed to measure the concept of self-stigma and these are based on varying theories, which makes it difficult to compare studies of self-stigma (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012; Wei, McGrath, Hayden, & Kutcher, 2015). Two of the most frequently used instruments are the Internalized Stigma of Mental Illness (ISMI) scale and the Self-Stigma of Mental Illness scale (SSMIS, long and short forms), both of which have been shown to have reliability and validity (Boyd et al., 2014; Corrigan et al., 2012). The ISMI

contains five subscales (alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance) (Boyd et al., 2014). The SSMIS contains statements to assess the awareness, agreement, application, and harm of negative stereotypes (Corrigan et al., 2012).

In addition to the self-stigma of mental illness, there is evidence that help-seeking itself has its own stigma (Bathje & Pryor, 2011; Jennings et al., 2015; Tucker et al., 2013). This concept is measured by the Self-Stigma of Seeking Help (SSOSH) scale where increased self-stigma of help-seeking is correlated with decreased intentions to seek mental health treatment (Lannin, Vogel, Brenner, & Tucker, 2015). The self-stigma of mental illness itself was not shown to reduce intentions to seek treatment (Lannin et al., 2015), thereby supporting the distinction between these two related self-stigmas. This is consistent with Corrigan et al.'s (2011) progressive self-stigma theory in that people who are aware of public stigma might choose to avoid mental health treatment as a way of avoiding association with and thus membership in the stigmatized group.

Veterans and Self-stigma

The self-stigma of mental illness and the self-stigma of seeking help are both relevant to the OIF/OEF veteran population. Veterans experience health disparities with respect to mental illness; the veteran population has a higher prevalence of substance abuse, depression, and PTSD (Hobbs, 2008). As a result, the concept of self-stigma is an important part of understanding this cultural group. In a qualitative study of PTSD-related stigma in OIF/OEF veterans, Mittal et al. (2013) found that veterans were aware of negative stereotypes (e.g. "crazy", "violent", "unstable", p. 89), but were unlikely to agree with the stereotypes which may be a protective factor against self-stigma development. However, participants described engaging in treatment avoidance as a way of avoiding stigma (avoiding the "label"); participants also believed that

PTSD from combat was more stigmatizing than PTSD from natural disasters due to the volunteer nature of their military service (Mittal et al., 2013). Furthermore, participants felt that other mental disorders were more stigmatizing than PTSD because they were more biologically-based (Mittal et al., 2013).

Boyd, Juanamarga, and Hashemi (2015) found that younger veterans (OIF/OEF/Desert Storm) receiving mental health treatment felt more judged and experienced more shame than other veterans. About 25% of veterans experienced self-stigma, and self-stigma was associated with the belief that psychiatric medications were less helpful (Boyd et al., 2015). Gilliam, Norberg, Ryan, and Tolin (2013) found that OIF/OEF veterans preferred psychotherapeutic treatments for PTSD rather than psychiatric medication due to the perception that medication was more socially stigmatizing.

Blais and Renshaw (2014) stated that there was a higher rate of help-seeking self-stigma among military service members than civilians, and that this stigma was associated with decreased help-seeking, regardless of combat exposure or mental health symptoms. This implies that military culture itself may influence rates of help-seeking self-stigma and actual help-seeking behavior. Increased help-seeking stigma was also associated with increased likelihood of treatment dropout and OIF/OEF veterans had the highest treatment dropout rates (Britt, Jennings, Cheung, Pury, & Zinzow, 2015). Brown and Bruce (2015) found that while self-stigma is a factor for seeking treatment in OIF/OEF veterans, concerns about the impact of help-seeking on one's career was a greater factor. Career concerns related to stigma, combined with higher rates of help-seeking self-stigma, further lower veteran engagement in mental health treatment.

Harris et al. (2015) studied a psychoeducational intervention to reduce self-stigma in veterans in a partial hospitalization program. At baseline, 37% of the veteran population experienced at least moderate self-stigma; a diagnosis of PTSD was associated with higher self-stigma than other diagnoses (Harris et al., 2015), which is interesting in contrast to the qualitative work of Mittal et al. (2013) where participants felt PTSD was less stigmatizing. After five weekly sessions of psychoeducation, self-stigma was reduced, but OIF/OEF veterans and veterans receiving disability experienced less reduction in self-stigma than other veterans (Harris et al., 2015). Of note, 30.5% of OIF/OEF veterans receive service-connected disability (NCVAS, 2015) and 10-18% have PTSD (United States Department of Veterans Affairs, 2015), suggesting that this population experiences a compounding of risk factors for increased self-stigma.

Lucksted et al.'s (2011) pilot study of the Ending Self-Stigma (ESS) program studied the effects of an outpatient, group-based, psychoeducational intervention for veterans with serious mental illness (SMI, e.g. schizophrenia, schizoaffective, or major mood disorders). Veterans who received the intervention did experience a statistically significant reduction in self-stigma (Lucksted et al., 2011), though this study was not specific to the OIF/OEF veteran population or to non-SMI diagnoses.

In addition to studies of self-stigma in the veteran population, other studies of self-stigma in civilians can provide some additional insight into cultural factors that might impact self-stigma in veterans. For example, Jennings et al. (2015) found that increased self-reliance was associated with less treatment-seeking. Self-reliance is valued in military culture, where needing help is a sign of weakness (Coll, 2011; Hall, 2011), therefore veteran help-seeking behavior may suppressed by self-reliance. In Bathje and Pryor's (2011) study, females had lower levels of self-stigma and also a higher rate of intention to seek help. The veteran population is primarily male

(NCVAS, 2016; Redmond et al., 2015), which may be associated with more self-stigma and less help-seeking.

Ben-Zeev, Corrigan, Britt, and Langford (2012) explained that military culture has a history of encouraging label avoidance such as the former “don’t ask, don’t tell” policy for gay and lesbian service members. This cultural value of “secrecy” (Hall, 2011) can facilitate avoidance of mental health treatment as a way of avoiding a label and the stigma associated with that label. This is consistent with Mittal et al.’s (2013) findings where veterans discussed avoiding mental health treatment.

Perez-Garin, Molero, and Bos (2015) found that the “alienation” subscale of the Internalized Stigma of Mental Illness scale was most strongly correlated with psychological well-being, meaning that those who felt more alienated were less psychologically well. This may be a relevant factor in veteran culture as veterans tend to feel most understood by their peers (Mittal et al., 2013) and less understood by civilians (Hall, 2011).

Application to Evidence-based Nursing Clinical Practice

Awareness of the OIF/OEF veteran culture and self-stigma has many implications for evidence-based nursing clinical practice. OIF/OEF veterans are frequently seeking healthcare in non-VA settings (NCVAS, 2015). Consequently, nurses in all practice settings are likely to encounter OIF/OEF veterans. Screening all clients for past military service can help identify veterans and improve understanding of the effect of service on clients’ lives (United States Department of Veterans Affairs, n.d.-d) and can also help to identify potential risk factors for mental illnesses, self-stigma, and treatment avoidance.

Understanding veteran culture can help nurses to better understand veteran treatment preferences and to intervene more effectively when making referrals to mental health treatment.

For example, Held and Owens (2012) stated that “reframing” seeking help as a “form of strength and sign of courage” (p. 140-141) could help increase service members’ engagement in mental health treatment. This is consistent with Westphal and Convoy’s (2015) discussion of using the term “stress injury” versus “stress disorder” as an example of how terminology can be adapted for military and veteran culture. For mental health nurse clinicians, the cultural preference for therapy versus medications is also important to note (Gilliam et al., 2013). When psychiatric medications are used, it is worth noting that increased self-stigma is associated with viewing medications as less helpful (Boyd et al., 2015).

Nurses are well placed to help veterans experiencing self-stigma. Currently, the research on interventions to reduce self-stigma is limited. Yanos, Lucksted, Drapalski, Roe, and Lysaker (2015) reviewed several interventions for self-stigma. All were group-based and most were based on psychoeducation; some were professionally led, while others were peer-led, though all showed a significant reduction in self-stigma (Yanos et al., 2015). Veteran culture may be especially responsive to peer interventions given the cultural beliefs of being most understood by other veterans (Mittal et al., 2013) and the military cultural value of unit cohesion and teamwork (Coll et al., 2011). One option for veterans that is currently available is the Veteran Centers where veterans can receive counseling and peer support (United States Department of Veterans Affairs, 2016). Understanding of veteran culture can enhance the assessment of veteran clients as well as guide the nurse in culturally competent interventions.

Application to Evidence-based Nursing Research

There are many gaps in the literature with regard to self-stigma as well as self-stigma in the OIF/OEF veteran population. One significant difficulty in evaluating research on self-stigma is the number of different instruments used to measure this concept, which makes it hard to

compare studies (Mittal et al., 2012; Wei et al., 2015). In addition, there is a lack of research in the area of protective factors, or variables that might help to prevent self-stigma. It has been suggested that lack of agreement with negative stereotypes could disrupt the process of developing self-stigma (Corrigan et al., 2011). In a small qualitative study of OIF/OEF veterans, participants were unlikely to agree with negative stereotypes (Mittal et al., 2013), but this is an area that requires further exploration.

While several studies focused on reducing self-stigma in people with mental illness, no studies focused specifically on a diagnosis of PTSD. PTSD is a common diagnosis in returning OIF/OEF veterans, occurring in an estimated 10 to 18% of this population (United States Department of Veterans Affairs, 2015). The prevalence rate of self-stigma in OIF/OEF veterans with a diagnosis of PTSD is unclear, but is an area that warrants further attention. With regard to the veteran population, which is largely male (NCVAS, 2016), more research is needed for female veterans who may have different mental health needs or treatment preferences.

There are relatively few studies on interventions to reduce self-stigma and, to this author's knowledge, no known interventions that have been tested in a one-to-one format. While group-based treatment might be culturally appropriate for veterans due to military values of teamwork and unit cohesion (Coll et al., 2011), veteran engagement in treatment and the high dropout rates of the OIF/OEF veterans (Britt et al., 2015) suggest that one-to-one interventions might be worth further exploration. Furthermore, the veteran cultural tendency of decreased help-seeking might make interventions provided in less stigmatizing settings (e.g. primary care) more acceptable to this group and would be worth further investigation.

This author is particularly interested in designing and studying the effects of a psychoeducational intervention that could be delivered in a one-on-one format between

psychiatric providers and clients. The literature supports psychoeducation as an intervention to reduce self-stigma (Yanos et al., 2015), therefore this would be a reasonable framework for the intervention. The one-on-one format has not yet been studied, but deserves investigation as it might be more culturally acceptable to the OIF/OEF veteran population due to this group's preference to avoid "labels" (Mittal et al., 2013). Given the varying degrees of self-stigma across different mental health diagnosis (Harris et al., 2015) and the cultural differences in the veteran population (Coll et al., 2011; Hall, 2011; Westphal & Convoy, 2015), focusing specifically on the population of veterans with a primary diagnosis of PTSD could be a way to tailor the intervention in a way that might be more culturally competent.

Conclusion

In conclusion, veterans and OIF/OEF veterans are a unique cultural group with distinct treatment needs and preferences. Nurses in all clinical settings may encounter OIF/OEF veterans and therefore should be aware of this culture. The use of Giger and Davidhizar's model can help guide the nurse in assessing OIF/OEF veterans and developing culturally competent interventions. The concept of self-stigma is particularly salient in this population due to mental health disparities (Hobbs, 2008) and cultural values which may decrease engagement with mental health treatment. Self-stigma research, including interventions to target self-stigma, is limited and there are many gaps in the literature. However, knowledge of self-stigma and its implications, combined with knowledge of the OIF/OEF culture, can help the nurse to deliver culturally competent interventions.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Assocation.

American Association of Colleges of Nursing (AACN). (2008). Tool kit of resources for cultural competent education for baccalaureate nurses. Retrieved from http://www.aacn.nche.edu/education-resources/toolkit.pdf

Bathje, G.J. & Pryor, J.B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling, 33*(2), 161-176. Retrieved from http://eds.a.ebscohost.com.regiscollege.idm.oclc.org/

Ben-Zeev, D., Corrigan, P.W., Britt, T.W., & Langford, L. (2012). Stigma of mental illness and service use in the military. *Journal of Mental Health, 21*(3), 264-273. doi: 10.3109/09638237.2011.621468

Blais, R.K. & Renshaw, K.D. (2014). Self-stigma fully mediates the association of anticipated enacted stigma and help-seeking intentions in National Guard service members. *Military Psychology, 26*(2), 114-119. doi: 10.1037/mil0000036

Boyd, J.E., Adler, E.P., Otilingam, P.G., & Peters, T. (2014). Internalized stigma of mental illness (ISMI) scale: A multinational review. *Comprehensive Psychiatry, 55*(1), 221-231. doi: 10.1016/j.comppsych.2013.06.005

Boyd, J.E., Juanamarga, J., & Hashemi, P. (2015). Stigma of taking psychiatric medications among psychiatric outpatient veterans. *Psychiatric Rehabilitation Journal, 38*(2), 132-134. doi: 10.1037/prj0000122

Britt, T.W., Jennings, K.S., Cheung, J.H., Pury, C.L., & Zinzow, H.M. (2015). The role of different stigma perceptions in treatment seeking and dropout among active duty military personnel. *Psychiatric Rehabilitation Journal, 38*(2), 142-149. doi: 10.1037/prj0000120

Brown, N.B. & Bruce, S.E. (2015). Stigma, career worry, and mental illness symptomatology: Factors influencing treatment-seeking for Operation Enduring Freedom and Operation Iraqi Freedom soldiers and veterans. *Psychological Trauma: Theory, Research, Practice, and Policy.* [Advance online publication]. doi: 10.1037/tra0000082

Bruce, M.L. (2010). Suicide risk and prevention in veteran populations. *Annals of the New York Academy of Sciences, 1208*(1), 98-103. doi: 10.1111/j.1749-6632.2010.05697.x

Coll, J.E., Weiss, E.L., & Yarvis, J.S. (2011). No one leaves unchanged: Insights for civilian mental health care professionals into the military experience and culture. *Social Work in Health Care, 50*(7), 487-500. doi: 10.1080/00981389.2010.528727

Corrigan, P.W., Michaels, P.J., Vega, E., Gause, M., Watson, A.C., & Rusch, N. (2012). Self-stigma of mental illness scale – short form: Reliability and validity. P*sychiatry Research, 199(*1), 65-69. doi: 10.1016/j.psychres.2012.04.009

Corrigan, P.W., Rafacz, J., & Rusch, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. *Psychiatry Research, 189*(3), 339-342. doi: 10.1016/j.psychres.2011.05.024

Corrigan, P.W., Sokol, K.A., & Rusch, N. (2013). The impact of self-stigma and mutual help programs on the quality of life of people with serious mental illness. *Community Mental Health Journal, 49*(1), 1-6. doi:10.1007/s10597-011-9445-2

Dowd, S.B., Giger, J.N., & Davidhizar, R. (1998). Use of Giger and Davidhizar's transcultural assessment model by health professions. *International Nursing Review, 45*(4), 119-128. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9728301

Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012). Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *Psychological Medicine, 42*(8), 1741-1752. doi: 10.1017/S0033291711002558

Giger, J.N. & Davidhizar, R. (2002). The Giger and Davidhizar transcultural assessment model. *Journal of Transcultural Nursing, 13*(3), 185-188. doi: 10.1177/10459602013003004

Gilliam, C.M., Norberg, M.M., Ryan, C.E., & Tolin, D.F. (2013). Understanding Afghanistan and Iraq veterans' treatment preferences and perceptions of stigma. *The Behavior Therapist, 36*(7), 172-179. Retrieved from http://hdl.handle.net/1959.14/282639

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity* [Kindle edition]. Retrieved from Amazon.com

Hall, L.K. (2011). The importance of understanding military culture. *Social Work in Health Care, 50*(1), 4-18. doi: 10.1080/00981389.2010.513914

Harris, J.I., Farchmin, L., Stull, L., Boyd, J., Schumacher, M., & Drapalski, A.L. (2015). *Psychiatric Rehabilitation Journal, 38*(2), 179-185. doi: 10.1037/prj0000118

Held, P. & Owens, G.P. (2012). Stigmas and attitudes toward seeking mental health treatment in a sample of veterans and active duty service members. *Traumatology, 19*(2), 136-143. doi: 10.1177/1534765612455227

Hobbs, K. (2008). Reflections on the culture of veterans. *American Association of Occupational Health Nurses Journal, 56*(8), 337-341. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18717299

Jennings, K.S., Cheung, J.H., Britt, T.W., Goguen, K.N., Jeffirs, S.M., Peasley, A.L., & Lee, A.C. (2015). How are perceived stigma, self-stigma, and self-reliance related to treatment-seeking? A three path model. *Psychiatric Rehabilitation Journal, 38*(2), 109-116. doi: 10.1037/prj0000138

Kuehner, C.A. (2012). My military: A navy nurse practitioner's perspective on military culture and joining forces for veteran health. *Journal of the American Association of Nurse Practitioners, 25*(2), 77-83. doi: 10.1111/j.1745-7599.2012.00810.x

Lucksted, A., Drapalski, A., Calmes, C., Forbes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: Pilot evaluation of a new intervention to reduce internalized stigma among people with mental illness. *Psychiatric Rehabilitation Journal, 35*(1), 51-54. doi: 10.2975/35.1.2011.51.54

Mittal, D., Drummond, K.L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma associated with PTSD: Perceptions of treatment seeking combat veterans. *Psychiatric Rehabilitation Journal, 36*(2), 86-92. doi: 10.1037/h0094976

Mittal, D., Sullivan, G., Chekuri, L., Allee, E. & Corrigan, P.W. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. *Psychiatric Services, 63*(10), 974-981. Retrieved from http://eds.a.ebscohost.com.regiscollege.idm.oclc.org/

National Center for Veterans Analysis and Statistics. (2015). *Profile of post-9/11 veterans: 2013* [PowerPoint slides]. Retrieved from http://www.va.gov/vetdata/docs/Special Reports/Post_911_Veterans_Profile_2013.pdf

National Center for Veterans Analysis and Statistics. (2016). *Profile of women veterans: 2014* [PowerPoint slides]. Retrieved from http://www1.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2014.pdf

Perez-Garin, D., Molero, F., & Bos, A.E. (2015). Internalized mental illness stigma and subjective well-being: The mediating role of psychological well-being. *Psychiatry Research, 228*(3), 325-331. doi: 10.1016/j.psychres.2015.06.029

Redmond, S.A., Wilcox, S.L., Campbell, S., Kim, A., Finney, K., Barr, K., & Hassan, A.M. (2015). A brief introduction to the military workplace culture. *Work, 50*(1), 9-20. doi: 10.3233/WOR-141987

Tucker, J.R., Hammer, J.H., Vogel, D.L., Bitman, R.L., Wade, N.G., & Maier, E.J. (2013). Disentangling self-stigma: Are mental illness and help-seeking stigmas different? *Journal of Counseling Psychology, 60*(4), 520-531. doi: 10.1037/a0033555

United States Census Bureau. (2015). *How do we know? A snapshot of our nation's veterans.* Retrieved from http://www.census.gov/library/infographics/veterans.html

United States Department of Veterans Affairs. (2015). *Mental health effects of serving in Aghanistan and Iraq.* Retrieved from http://www.ptsd.va.gov/public/PTSD-overview/reintegration/overview-mental-health-effects.asp

United States Department of Veterans Affairs. (2016). *Vet center program.* Retrieved from http://www.vetcenter.va.gov/

United States Department of Veterans Affairs. (n.d.-a). *Mental health services: Understanding military culture: Common terms & lingo*. Retrieved from http://www.mentalhealth.va.gov/communityproviders/docs/terms_lingo.pdf

United States Department of Veterans Affairs. (n.d.-b). *Mental health services: Understanding military culture: In service of the mission: Teamwork and shared goals*. Retrieved from http://www.mentalhealth.va.gov/communityproviders/docs/mission_oriented.pdf

United States Department of Veterans Affairs. (n.d.-c). *Mental health services: Understanding military culture: Expression of values and ideals by service branch.* Retrieved from http://www.mentalhealth.va.gov/communityproviders/docs/values.pdf

United States Department of Veterans Affairs. (n.d.-d). *How to screen for military service.* Retrieved from http://www.mentalhealth.va.gov/communityproviders/screening_howto.asp

Watson, A.C., Corrigan, P., Larson, J.E., & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin, 33*(6), 1312-1318. doi: 10.1093/schbul/sbl1076

Wei, Y., McGrath, P.J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help-seeking: A scoping review. *BMC Psychiatry, 15*, 291. doi: 10.1186/s12888-015-0681-9

Westphal, R.J. & Convoy, S.P. (2015). Military culture implications for mental health and nursing care. *The Online Journal of Issues in Nursing, 20*(1), manuscript 4. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/26824262

Yanos, P.T., Lucksted, A., Drapalski, A.L., Roe, D., & Lysaker, P. (2015). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal, 38*(2), 171-178. doi: 10.1037/prj0000100