Soldiering On:

Psychosocial Barriers to Mental Health Treatment Among Military Personnel

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December 5, 2016

The majority of military personnel who are diagnosed with mental health problems do not seek treatment. This project will research psychosocial explanations for why this occurs, and further research will be explored about potential ways to reduce these barriers to care.

Developing a mental disorder in response to trauma or other stressors can occur in a wide range of people, from many different backgrounds, and is not confined to any particular demographic. However, certain careers are marked by higher risk. In the armed forces, the stressors and potential traumas that come with being a soldier put military personnel in increased danger of mental health issues such as major depressive disorder, generalized anxiety disorder (GAD), and post-traumatic stress disorder (PTSD). Instances of psychological afflictions in soldiers have been recorded throughout history, from "soldier's heart" during the Civil War to "shell shock" during World War I (Nash, Silva, & Litz, 2009). In more recent years, rates of both PTSD and major depressive disorder were found to be higher among the United States military when compared to the civilian population, and a significant portion of soldiers returning from Iraq and Afghanistan (19-44%) struggled with some kind of mental health issue (Zinzow, Britt, McFaddeb, Burnette, & Gillispie, 2012). Treatment for such mental disorders has been developed and is continuing to be researched. Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) have been shown to help assuage symptoms of PTSD (Zinzow, Britt, McFaddeb, Burnette, & Gillispie, 2012). Evidence-based treatments exist for GAD and major depressive disorder, as well as other issues that may be diagnosed in military personnel. The trend in the data, however, shows that the majority of military personnel who are diagnosed with a mental health problem do not seek treatment and that concern about barriers to care is greatest among those whose symptoms are most severe (Hoge et al., 2004; Hoge et al., 2014).

Many psychosocial factors may be involved in why military personnel do not seek mental health treatment. Some of these may be specifically related to the military; military training, for instance, requires toughness and emotional detachment, and military culture promotes self and unit-reliance as well as "soldiering-on"—pushing through your own problems rather than showing weakness or asking for help from someone else (Dickstein, Vogt, Handa, & Litz, 2010). Other factors may pertain to public stigma: fear that other people will view a soldier differently if he or she reveals a mental illness, e.g. civilians labeling them "a crazy vet" or unit members no longer trusting them (Hoge et al., 2004; Stecker, Shiner, Watts, Jones, Conner, 2013). Soldiers may also find it difficult to admit needing medical help for a mental illness as opposed to a physical injury, possibly due to the view that mental disorders brought on by trauma and stress are "avoidable" or "self-inflicted," and thus show a sign of weakness. This barrier may be especially potent as the military is comprised mostly of young men, a demographic that appears to be particularly susceptible to help-seeking stigma (Greene-Shortridge, Britt, & Castro, 2007). Studies have gathered research on these and other factors that influence treatment-seeking among soldiers, in order to learn what interventions may most effectively reach military personnel who are in need of help.

An oft-cited study in later research on this topic is a 2004 study done by Hoge, Castro, Messer, McGurk, Cotting, and Koffman (Hoge et al., 2004). In order to evaluate mental health issues and potential "barriers to care," this study examined US Army and Marine Corps soldiers, who would serve or had served in Iraq and Afghanistan. The institutional review board of the Walter Reed Army Institute of Research gave its approval to this study. The researchers' samples included 2530 Army soldiers before deployment; 1962 Army soldiers after deployment; 894 Army soldiers after deployment; and 815 Marines after deployment. Participants were collected through recruitment by the researchers. The soldiers were briefed about the details of the study and guaranteed anonymity, and the researchers obtained written consent from each soldier who agreed to participate. The researchers also compared their participants to all of the Army and Marine soldiers involved in the same deployments, in order to ensure that their sample represented the population they wished to study.

The method used to gather data was an anonymous survey. A participant was deemed to have "responded" to the survey if they finished any part of it. Ninety-eight percent of the entire group of participants met the criteria for a response. In order to measure mental health among the participants, the researchers used screening questionnaires and an official symptom checklist in the survey to diagnose PTSD, GAD, major depressive disorder, and substance abuse. The survey also asked questions about the soldiers' combat experiences, if they were experiencing any life-affecting problems, whether they wished to receive help for those problems, if they had used mental health care in the past, and what their thoughts were on perceived barriers to care and stigma.

The gathered data was scanned and analyzed using logistic regression to control for demographic differences. The subsequent results showed that a significant portion of the participants had been in serious combat, and a positive correlation emerged between rates of mental disorders and the amount of combat experience. Among the participants who met the criteria for a mental disorder, only 38-40% reported that they would be interested in getting treatment and only 23-40% reported receiving treatment in the past. Also, these participants were twice as likely as those who did not meet criteria for a mental disorder to report concerns about stigma and other barriers to care. The three barriers that were most highly rated by respondents to the survey were (1) their unit losing trust in them, (2) their leaders viewing them differently, and (3) being perceived as weak, with this last barrier receiving the highest endorsement.

There were several limitations to this study. The researchers used a cross-sectional design involving several groups of Marines and Army personnel, which may not yield as accurate results as a longitudinal design. The participants were also selected from an active-duty work site, so the study was not able to examine responses among wounded or discharged personnel. Also, because the study used a survey, there was an inherent risk of misreport among the participants, although this may have been lessened by the survey's anonymity. The researchers took care to make their sample as representative as possible and adhered to proper

guidelines for conducting an experimental study. "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care" (Hoge et al., 2004) provided a significant contribution to literature on this topic and showed the prevalence of mental health disorders as well as perceived barriers to care among active-duty military personnel.

In 2007, Stecker, Fortney, Hamilton, and Ajzen conducted a study based on the theory of planned behavior (Stecker, Fortney, Hamilton, & Ajzen, 2004). According to this theory, the researchers hypothesized that seeking mental health treatment was related to the beliefs that individuals have about such an action. They planned to assess beliefs about mental health treatment in veterans of Iraq, and they defined "seeking treatment" as occurring within one year after return from Iraq. In order to obtain participants, the researchers gave information on the study to Army National Guard soldiers at drill weekends and instructed interested candidates to undergo an informed consent brief and a mental health screening. Eligibility for the study was determined by whether or not the soldier met diagnostics for at least one of the following mental disorders: depression, panic disorder, GAD, PTSD, and alcohol abuse disorder. The study received approval from an institutional review board.

Twenty soldiers were selected to participate in the study. All participants were interviewed by phone, using elicitation methods. Three types of beliefs, as structured by the planned behavior theory, were investigated—behavioral beliefs (about possible consequences of an action), normative beliefs (about views others might have), and control beliefs (about things that might impede or aid the action). Participants were asked about perceived pros and cons of receiving mental health care, to determine behavioral beliefs; about those who do and do not approve of mental health care, to determine normative beliefs; and about anything that would cause them to be more or less likely to utilize mental health care, to determine control beliefs.

The gathered data was reviewed and coded by several individuals, who organized it according to the three belief categories of the planned behavior theory. Positive behavioral beliefs included that receiving mental health care would result in feeling better (80%), that having someone to talk to would be beneficial (50%), and that treatment would be a way to regain their normal life (30%). Negative behavioral beliefs included fear of being stereotyped (70%) and the fear that seeking treatment would damage their careers (55%)—higher-ranking individuals expressed fear that their subordinates would not follow them as well, and other individuals expressed worries of no longer being deployed or promoted. In the normative belief category, 75% of participants agreed that everyone would be supportive of them receiving mental health care. However, the other 25% reported that loved-ones wanted them to "toughen-up" rather than seek treatment. Most of the participants, though not all, agreed that the military would support treatment seeking. In response to what would make them more likely to use mental health care, participants identified confidentiality and a secure environment as factors. The largest barrier to care identified by the participants was their personal beliefs about mental health treatment (65%). Soldiers reported that refusing to admit a problem, as well as thinking they could take care of it on their own, had affected their decision of whether or not to seek

treatment. In addition to gathering data on beliefs about mental health care, this study also revealed that only 25% of the soldiers who met criteria for a mental disorder had received treatment.

Limitations of this study include the narrow population (one National Guard unit), the reliance of the researchers on the planned behavior theory, and the fact that the interviews were done by phone, which may have obstructed the researchers' ability to interpret the soldiers' reactions and responses. However, the soldiers may have felt more at ease to give honest answers over the phone rather than in a face-to-face interview. This study—"An Assessment of Beliefs About Mental Health Care Among Veterans Who Served in Iraq" (2007)—showed strength in communicating directly with the participants, and thus was able to uncover factors that may limit soldiers' use of mental health care. The researchers also suggested that further investigation be done into the fact that their participants had reported fears of stigma while also reporting that they had support for seeking treatment.

C.H. Warner, Appenzeller, Mullen, C.M. Warner, and Griger conducted a study in 2008 to evaluate soldiers' opinions on mental health screening and seeking treatment post-deployment (C.H. Warner, Appenzeller, Mullen, C.M. Warner, & Griger, 2008). The goal of their study was to determine the best methods of providing mental health screening to returning soldiers and to assess barriers to seeking treatment. The researchers received approval from an institutional review board and from involved military commanders to conduct the study.

In pre-deployment briefings, a survey was distributed to all soldiers in a single bridge combat team. The survey was declared to be anonymous, and the soldiers were made aware that they would receive no negative consequences if they chose not to participate. Sections within the survey dealt with different issues, including screening preferences and attitudes toward care-seeking, as well as barriers to and facilitators of treatment. In the care-seeking attitudes section, participants were asked to rate their response to a statement and to answer whether they would seek treatment at any of a list of facilities. In the barriers and facilitators section, participants were asked to rate their response to eight barriers to care—six of which had been included in the 2004 study by Hoge et al.—as well as their response to seven potential facilitators of care. Within another section, participants filled out specific demographic information, including whether or not they had completed military "Battlemind" training.

Eighty-one point three percent of the soldiers who were offered the survey participated in the study. The data was analyzed using logistic regression, and two questions were specifically targeted: (1) whether soldiers would seek treatment based on screening results and/or their own belief that they needed help and (2) what soldiers' opinions would be on barriers to and facilitators of care. According to the results, 84.8% of the soldiers had previously received Battlemind training and 65.7% agreed that they would seek treatment if they thought they had a problem or were diagnosed with one. Soldiers who had received Battlemind training were 1.56 times more likely to seek treatment. When asked about screening preferences, participants

indicated the highest amount of trust in military physicians and mental health personnel from within their unit, with the least amount of trust in military physicians not within their unit and civilian providers. In the section on barriers to care, 45% of the participants generally disagreed with the listed barriers, while 26% agreed with them. The three largest barriers identified in the 2004 study by Hoge et al.—being seen as weak, being treated differently by leadership, and having their unit lose trust in them—were all reduced, with "being seen as weak" showing the greatest reduction in agreement responses. However, although the other two barriers were reduced, they remained two of the largest barriers identified by participants. In response to the questions on facilitators of care, the one most endorsed was encouragement from loved ones.

This study was limited by its cross-sectional design, confined to a single unit and based on a self-conducted survey. However, the sample was shown to be representative of the population of deploying soldiers, and the anonymity of the survey was purposed to promote honesty. The survey was given before deployment and therefore may not reflect the opinions of soldiers post-deployment. "Soldier Attitudes toward Mental Health Screening and Seeking Care upon Return from Combat" (2004) provided a valuable look at soldiers' preferences for mental health screening and their views on seeking care. The study showed reductions in barriers endorsed in previous studies, but it also demonstrated that barriers still remain. Results obtained by this study pointed towards the benefit of Battlemind training, involving family and friends in the treatment-seeking process, and integrating mental health care into a military context.

In 2009, Wright, Cabrera, Adler, Bliese, Hoge, and Castro conducted a study to determine if there was a relationship between military leadership and unit cohesion and stigma and perceived barriers to care in soldiers (Wright, Cabrera, Adler, Bliese, Hoge, & Castro, 2009). The researchers hypothesized that units with more cohesion and better leadership would experience less stigma and perceived barriers to mental health care. Their study was approved by the Institutional Review Board of the Walter Reed Army Institute of Research.

The study was conducted with an anonymous survey which was distributed to 680 soldiers from units in a single division, 3 months after returning from deployment. Before taking the survey, all participants provided written informed consent. The survey contained sections on mental health symptoms, unit leadership and cohesion, and stigma and perceived barriers to care. The mental health assessment used evidence-based clinical scales to evaluate symptoms for depression, anxiety, and PTSD. The section on unit leadership and cohesion used two scales. The first scale assessed leadership by giving the participants four leader behaviors and asking them to report how frequently the behaviors occurred in their own leaders; the second scale assessed unit cohesion, using three statements which soldiers were asked to rate based on the similarity to their own units. Both scales had been previously used in military research. Stigma and barriers to care were evaluated with 16 statements representing factors that might dissuade soldiers from seeking care.

After the data was analyzed, the three items which the soldiers ranked highest as impediments to seeking treatment were (1) losing the trust of their unit, (2) being treated differently by their leaders, and (3) being seen as weak. A relationship emerged which showed that soldiers who rated both their leadership and unit cohesion higher also ranked lowest on the stigma and barriers to care scales. The researchers had already controlled for the demonstrated effect of mental health symptoms on experiencing stigma.

This study was limited in that it relied on a survey, which, despite the fact that it was anonymous, could not ensure honest answers from the participants. The study was also conducted only within combat support units, and therefore results may not generalize to other units. Likewise, the participants had all recently returned from deployment, so the data did not include reports about leadership and unit cohesion from units which had not been deployed. "Stigma and Barriers to Care in Soldiers Postcombat" (2009) showed three main stigma-related issues which may affect soldiers' decision to seek care. This study also provided insight into a possible avenue for reducing these issues, by demonstrating that good leadership and unit cohesion may decrease stigma and barriers to care among soldiers.

Another study, conducted a few years later in 2013, looked at treatment-seeking barriers among military personnel who had served in Iraq and Afghanistan and who met the criteria for PTSD (Stecker, Shiner, Watts, Jones, & Conner, 2013). Their study was approved by the Committee for Human Subjects Protection at Dartmouth's Medical School.

The researchers collected participants through in-person recruiting and advertisements. Interested candidates were required to take a PTSD screening test to determine eligibility. In order to participate, candidates had to screen positive for PTSD; be a veteran of Iraq, Afghanistan, or both; and not have sought mental health treatment. One hundred forty-three military personnel were included in the study. To obtain the desired data, the researchers conducted telephone sessions with each participant. During these sessions, participants were told how thoughts and beliefs may influence actions, and the participants were asked to identify beliefs that affected the action of treatment-seeking for them personally.

The gathered answers were recorded and then coded. One hundred eighty-nine beliefs about treatment-seeking were recorded, and they were categorized into four main areas: (1) concern about treatment, (2) emotional readiness, (3) stigma, and (4) logistical issues. In the area of concern about treatment, 13% identified a belief that treatment providers would not understand them, some stating that only another veteran would understand. In the area of emotional readiness, more than half (52%) did not believe they needed treatment, and 35% did not feel emotionally prepared to undergo treatment. Twenty-two percent indicated that it would be too hard to share details about their PTSD with someone else, giving fears of "going crazy" or being "triggered" by recounting their trauma. Only 16% stated beliefs regarding stigma. Thirty-nine percent of these beliefs dealt with issues such as pride, being seen as weak, and feeling that they should push through their problems. Another 39% involved fears about the consequences

of seeking treatment, such as damaging their careers, losing security clearance, and no longer being deployed. Twenty-three percent of stigma-related beliefs concerned being labeled. By contrast, only 8% of all beliefs fell into the area of logistical issues.

The results of this study may not generalize to veterans without PTSD symptoms, such as those suffering from other mental health issues. The study was cross-sectional and depended upon self-reported data, and the four categories proposed may have been too broad to encompass all stated beliefs. The study may also be limited by the sample size and range, which was small enough that individual experiences, as well as gender and race, may have biased results. However, the researchers were able to obtain a substantial sample of veterans who had PTSD symptoms and had not received treatment and were able to speak with them about reasons for why this was. This study—"Treatment-Seeking Barriers for Veterans of the Iraq and Afghanistan Conflicts Who Screen Positive for PTSD" (2013)—also showed that, among the sample, stigma was not the highest-rated barrier, with concern about treatment and emotional readiness ranking at the top, although a number of veterans still endorsed stigma as an influential factor in them not seeking care.

In 2014, Hoge, Grossman, Auchterlonie, Riviere, Milliken, and Wilk performed a study on PTSD treatment which explored low treatment-seeking in veterans, as well as reasons for dropping out of treatment (Hoge, Grossman, Auchterlonie, Riviere, Milliken, & Wilk, 2014). Their study was approved by the institutional review board of the Walter Reed Army Institute of Research.

Data was obtained from two separate sources: (1) a population-based cohort of 45, 462 soldiers who had taken the Post-Deployment Health Assessment after returning from Afghanistan, and (2) a cross-sectional survey of 2, 420 infantry soldiers, also after returning from Afghanistan. The cohort was analyzed to determine how many of those diagnosed with PTSD received adequate treatment. The survey was administered to determine how many of the participants needed care, how many had received it and how much, what their beliefs were towards mental health treatment, and (if applicable) their reasons for dropping out of care. Reasons for drop-out were obtained by a number of yes-no questions which had been developed based on previous research and experience. The cohort analysis was approved by the Walter Reed Army Institute of Research, and all participants in the survey gave informed consent.

Results from analyzing the data showed that 5% (2,230) of the soldiers in the cohort had received a PTSD diagnosis, and 22% of those soldiers had only had one treatment visit. Of the soldiers who were surveyed and met the criteria for PTSD (229), 48% said they had received mental health care; of those soldiers, 22% had only had one visit, and 24% had dropped out of treatment. The most common reason for drop-out (66% of all soldiers) was feeling like they could take care of their problems on their own. Thirty-eight percent endorsed stigma as a barrier to care, and 40% indicated that they did not feel comfortable with the mental health professional. Other reasons included worries about confidentiality (34%), not believing that the treatment was

effective (38%), and various issues concerning the relationship with the mental health professional (2/3 of all soldiers).

The study was limited by its dependence on self-reported data and data obtained from an administration, and the survey did not screen for other mental disorders besides PTSD. However, the sample sizes for both the cohort and the survey were large, and results and demographics were fairly consistent between both groups, which reinforce the reliability of the data. "PTSD Treatment for Soldiers After Combat Deployment: Low Utilization of Mental Health Care and Reasons for Dropout" (2014) provided a valuable look at PTSD prevalence, low treatment-seeking, and drop-out rates among the military population. This study also gathered data on soldiers' opinions and experiences concerning mental health care, which may be used in developing interventions to improve treatment-seeking rates and the effectiveness of care.

A study conducted in 2015—by Kulesza, Pedersen, Corrigan, and Marshall—examined public and perceived public treatment-seeking stigma in young adult veterans and its relationship to mental health care utilization (Kulesza, Pedersen, Corrigan, & Marshall, 2015). The researchers differentiated between public stigma (viewing others in a negative way) and perceived public stigma (applying those negative views to yourself). They hypothesized that veterans who reported higher levels of either kind of stigma would be less likely to seek treatment. The researchers controlled for other factors that might influence treatment seeking—such as age, gender, race, and symptom severity—and the study was approved by an institutional review board.

Participants were obtained through social-media recruitment, and their eligibility was determined by a series of questions and analysis. Candidates were required to be between 18 and 34 years of age and to not be in active or reserve duty. Eight hundred twelve veterans were included in the study. All participants took an online survey, which assessed mental health, stigma concerns, and treatment receipt. The section on mental health used validated measures to screen for PTSD, depression, anxiety, alcohol use disorder, and cannabis use disorder. In the section on stigma, participants were asked to rate 6 statements representing perceived public stigma (how would this affect your decision to seek treatment) and 6 statements representing public stigma (how would you view another person considering seeking treatment).

The data was analyzed using regression models, in order to control for other factors that might influence treatment-seeking and to evaluate both public and perceived public stigma. Of the 812 veterans who participated in the survey, 72% met diagnostics for at least one of the included mental disorders. Among this group, those who reported higher levels of perceived public stigma were less likely to seek treatment (public stigma had no significant association with treatment utilization). More participants agreed with the perceived public stigma items than the public stigma items. For example, 44% said that they would be seen as weak for seeking treatment, while only 12% said that they would view another veteran as weak; over 35% said they would be treated differently, while only 10% said they would treat another veteran

differently. The majority of veterans did not anticipate negative responses from others if they were to seek treatment (e.g., 56% did not think they would be seen as weak), but a large portion of them did endorse this belief (44%).

This study was limited in that it was a cross-sectional design, and that it utilized an online survey, which prevented the researchers from being able to conclusively determine identity and eligibility, and the participants may not have answered honestly. The definition of perceived public stigma may have been too broad to accurately assess different kinds of beliefs, such as perceptions from loved ones versus the general public. "Help-Seeking Stigma and Mental Health Treatment Seeking Among Young Adult Veterans" (2015), however, gave a valuable addition to literature on this topic by evaluating both public and perceived public stigma and determining a relationship between perceived public stigma and treatment utilization.

Although all of these studies relied on surveys or similar interviews, the researchers strove for the highest level of accuracy possible in their studies; and, in order to examine personal beliefs, using a survey was one of their few and best options. All of the studies were approved by an institutional review board, and all participants in each study gave their consent. Spanning from 2004 to 2015, these studies show that a substantial portion of military personnel are continuing to suffer from mental health issues and are not receiving effective treatment. Many different factors may facilitate or hinder mental health treatment-seeking, and these factors vary from individual to individual. However, research has been able to determine items that are common barriers among those who need treatment. Also, in the military population, specific barriers have been noted that are different from those of civilians. After reviewing the results of these seven studies, main barriers endorsed by a majority of the focus population include: (1) being seen as weak/being labeled, (2) being treated differently by their leaders and/or unit, (3) damaging their careers, (4) not admitting a problem/feeling they could take care of it on their own, (5) lacking support/not feeling emotionally ready, (6) not thinking treatment would help, and (7) not trusting the medical professional/not thinking the medical professional would understand them. To reduce these barriers, specialized action is required.

Numerous strategies have been developed in the hope of encouraging treatment-seeking, making treatment more effective, and preventing mental disorders among military personnel. Several early intervention programs have been introduced to the military, including "Battlemind"—a training program designed to inform and instruct soldiers about psychosocial reactions to combat, mental health, and reintegration into civilian life (Zinzow, Britt, McFadden, Burnette, Gillispie, 2012). "Battlemind" promotes "mental strength," and the program has been shown to reduce symptoms and stigma. Strong leadership involvement and support is suggested (Greene-Shortridge, Britt, Castro, 2007). If leaders take an active role in identifying those in need and encouraging them to seek help, fear and stigma about admitting a mental health problem may be significantly reduced. Identifying seeking help as a sign of strength may also enable soldiers to seek care (Dickstein, Vogt, Handa, Litz, 2010). To make mental health issues and their treatment less aversive, other informative interventions—which provide awareness for

mental health disorders, evidence-based treatment, and the consequences of not getting aid—may be helpful (Zinzow, Britt, McFadden, Burnette, Gillispie, 2012).

Because of the uniqueness of military culture, soldiers may not feel comfortable entering a civilian clinic to receive mental health treatment, especially for a therapy treatment which will require them to share their experiences. A soldier may find it difficult to accept treatment from a civilian medical professional who has not been in combat and will likely not understand the culture that the soldier comes from. Interventions that may combat this barrier include training medical professionals about various aspects of military culture (such as the chain of command and military jargon), bringing clinical treatment into a military setting, and implementing uniformed health care providers (Zinzow, Britt, McFadden, Burnette, Gillispie, 2012). Also, it may be beneficial to adjust some treatment methods to include items specific to military issues—such as survivor's guilt, emotional detachment, and readjustment to civilian life ((Zinzow, Britt, McFadden, Burnette, Gillispie, 2012).

Another proposed intervention may reduce cultural differences as a barrier to seeking treatment by bringing other veterans alongside returning military personnel to support them and encourage them to seek treatment if needed (Greden, Valenstein, Spinner, Blow, Gorman, Dalack, Marcus, & Kees, 2010). The "Buddy-to-Buddy" program promotes help-seeking as an act of resilience and strength and encourages strong ties with family and other veterans, in keeping with military values of unit cohesion and fighting alongside your buddies to overcome problems. This use of "culture to change culture"(p. 93) may be a strongly viable method to reduce psychosocial barriers to treatment-seeking.

With a significant portion of military personnel affected by mental disorders, and the military context presenting potentially unique barriers to care, action is required to determine barriers and ways to counteract them. Further research is recommended to determine what interventions are effective in reaching the military population with needed mental health treatment, as well as ways to possibly prevent mental disorders in soldiers and to adapt treatment itself to be more advantageous.

References

1. Dickstein, B.D., Vogt, D.S., Handa, S., Litz, B.T. (2010). Targeting Self-Stigma in Returning Military Personnel and Veterans: A Review of Intervention Strategies. *Military Psychology, 22,* 224-236. doi: 10.1080/08995600903417399

2. Greden, J.F, Valenstein, M., Spinner, J., Blow, A., Gorman, L.A., Dalack, G.W….Kees, M. (2010). Buddy-to-Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide. *Annals of the New York Academy of Sciences, 1208,* 90-97. doi: 10.1111/j.1749-6632.2010.05719.x

3. Greene-Shortridge, T.M., Britt, T.W, Castro, LTC C.A. (2007). The Stigma of Mental Health Problems in the Military. *Military Medicine, 172,* 157-161. Retrieved from http://www.publications.amsus.org/

4. 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. *The New England Journal of Medicine, 351,* 13-22. Retrieved from http://www.nejm.org/

5. Hoge, C.W., Grossman, S.H., Auchterlonie, J.L., Riviere, L.A., Milliken, C.S., Wilk, J.E. (2014). PTSD Treatment for Soldiers After Combat Deployment: Low Utilization of Mental Health Care and Reasons for Dropout. *Psychiatric Services, 65,* 997-1004. doi: 10.1176/appi.ps.201300307

6. Kulesza, M., Pedersen, Eric., Corrigan, P., Marshall, G. (2015). Help-Seeking Stigma and Mental Health Treatment Seeking Among Young Adult Veterans. *Military Behavioral Health, 3(4),* 230-239. doi: 10.1080/21635781.2015.1055866

7. Nash, W.P., Silva, C., Litz, B. (2009). The Historic Origins of Military and Veteran Mental Health Stigma and the Stress Injury Model as a Means to Reduce It. *Psychiatric Annals, 39,* 789-794. doi: 10.3928/00485713-20090728-05

8. 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. Retrieved from http://ps.psychiatryonline.org/

9. Stecker, T., Shiner, B., Watts, B.V., Jones, M., Conner, K.R. (2013). Treatment-Seeking Barriers for Veterans of the Iraq and Afghanistan Conflicts Who Screen Positive for PTSD. *Psychiatric Services, 64,* 280-283. doi: 10.1176/appi.ps.001372012

10. Warner, C.H., Appenzeller, G.N., Mullen, K., Warner, C.M., Grieger, T. (2008). Soldier Attitudes toward Mental Health Screening and Seeking Care upon Return from Combat. *Military Medicine, 173,* 563-569. Retrieved from http://griegermd.com

11. Wright, K.M., Cabrera, O.A., Adler, A.B., Bliese, P.D., Hoge, C.W., Castro, C.A. (2009). Stigma and Barriers to Care in Soldiers Postcombat. *Psychological Services, 6,* 108-116. doi: 10.1037/a0012620

12. Zinzow, H.M., Britt, T.W., McFadden, A.C., Burnette, C.M., Gillispie, S. (2012). Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care. *Clinical Psychology Review, 32,* 741-753. doi: 10.1016/j/cpr.2012.09.002