EXPLORING THE RELATIONSHIP BETWEEN MILITARY VETERANS AND THEIR ATTITUDES TOWARDS MENTAL HEALTH COUNSELING

by

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ABSTRACT

KIMBERLY SUNSHINE WILLIAMS. Exploring the Relationship Between Military Veterans and Their Attitudes Towards Mental Health Counseling. (Under the direction of DR. HENRY HARRIS)

The United States veteran population continues to grow, presenting increasing concerns about mental health needs of this unique group. Veterans are at a higher risk of military-related problems and mental health issues, particularly given that the United States has continuously engaged in war for almost two decades (Ganz et al., 2021; Hoffmire, & Denneson, 2018; U.S. Department of Veteran Affairs, 2019). Many actions have been taken to address barriers to mental health treatment for veterans including accessibility, mental health treatment training, research efforts for veteran subcultures, and increased public education (Congress.gov, n.d.; Dingfelder, 2009). Despite these efforts, the utilization of mental health services continues to be low among the veteran population and they do not present for mental health treatment in proportion to the identified mental health needs for this group (Ganz, et al., 2021; Ghahramanlou-Holloway, 2018; Seidman et al., 2018; Vogt et al., 2014; Coll, et. al., 2011). This research study utilized a non-experimental correlational survey design to explore the relationship between veterans' (N=153) attitude towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health and (e) education level. Standard multiple regressions indicated only one significant relationship between whites and beneficial attitudes toward mental health services. Gender, era of service, previous mental health experiences, and education level were insignificant in relation to beneficial attitudes. There were not statistically significant findings for pessimism toward mental health and the predictor variables.

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DEDICATION

This is dedicated to my grandmother, Egene Williams. I thank God that you are here to witness this accomplishment. I also dedicate this work to my guardian angels, my grandparents, Charles Kee Sr., Willie Kee, Roy Lee Williams, and to my dear old dad, Charles Kee Jr.

TABLE OF CONTENTS

LIST OF TABLES xi

CHAPTER ONE: INTRODUCTION 1

Veterans 1

Attitudes and Mental Health 4

Significance of Study 8

Purpose of Study 8

Research Questions 8

Assumptions 9

Delimitations 10

Limitations 10

Threats to Internal Validity 10

Threats to External Validity 11

Operational Definitions 11

Chapter Summary 13

Organization of Study 13

CHAPTER TWO: REVIEW OF THE LITERATURE 15

Theoretical Framework: Theory of Planned Behavior 15

Veterans and Mental Health 17

Veteran History and Mental Health 20

Suicide and Veterans 21

Veterans Seeking Mental Health Treatment 24

Gender 27

Mental Health Stigma Barrier 28

Veteran Mental Health Issues 30

Chapter Summary 33

CHAPTER THREE: METHODOLOGY 34

Participants 34
Data Collection Procedures 35
Instrumentation 36
Attitudes Towards Mental Health Treatment Scale 36
BA Subscale 37
PMS Subscale 38
Demographics Questionnaire 38
Open Question 38
Research Design 38
Research Questions 39
Data Analysis 40
Data Screening 40
Descriptive Statistics 40
Standard Multiple Regression 41
Chapter Summary 41
CHAPTER FOUR: RESULTS 42
Participants 42
Instrument Reliability 44
Data Screening 45
Missing Values 45
Outliers, Normality, and Multicollinearity 45
Descriptive Statistics 46
Multiple Regression 48

Research Question One 49

Research Question Two 49

Content Analysis of Individual Responses 50

Stigma 50

Military Leadership 51

Training of Counselors or Perceptions of Treatment 52

Hope 54

Chapter Summary 55

CHAPTER FIVE: DISCUSSION 57

Discussion of Results 57

Discussion of Demographic Data 57

Discussion of Multiple Analysis 58

BA Subscale 58

PMS Subscale 60

Qualitative Data and Variables 61

Contributions to the Study 62

Limitations of the Study 63

Implications of the Findings 64

Recommendations for Future Research 71

Concluding Remarks 73

REFERENCES 74

APPENDICES 89

Appendix A: INTRODUCTORY LETTER 90

Appendix B: INFORMED CONSENT FORM 91

Appendix C: ATTITUDES TOWARD MENTAL HEALTH TREATMENT SCALE 93

Appendix D: DEMOGRAPHICS QUESTIONNAIRE 95

LIST OF TABLES

TABLE 1: Demographics of Participants 44

TABLE 2: Pearson Correlation between Predictors, BA, PMS Subscales 47

TABLE 3: Descriptive Statistics for Variables 48

TABLE 4: Multiple Regression Evaluating Predictors of Beneficial Attitudes for Seeking Mental Health Services 49

TABLE 5: Multiple Regression Evaluating Predictors of Pessimism for Seeking Mental Health Services 50

CHAPTER ONE: INTRODUCTION

The veteran population continues to grow, as the size of the military decreases. As an identified subculture within the United States (U.S.), this population continues to present with unique challenges to their mental health. Statistics support increases among diagnoses within the veteran population including posttraumatic stress disorder, substance use disorder, bipolar disorders and disorders related to traumatic brain injuries (U. S. Department of Affairs, 2019). Additionally, the suicide rate among veterans has elevated to grave concern, making up a significant proportion of completed suicides within the U.S. population (Center for Disease Control and Prevention, 2021; U.S. Department of Affairs, 2019). Despite the Veteran's Health Administration being the largest healthcare provider for this group, many veterans continue to choose not to seek treatment for mental health issues. The hope for this study was to add more insight into contributing factors for poor mental health utilization rates among veterans.

Veterans

Veterans are directly impacted by a military culture that espouses unquestioned norms, values, beliefs and practices that may comprise the military ethos. As active-service members, individuals must completely embrace an attitude of self-reliance, resilience, toughness, and unwavering dedication to the dictated overall mission. This culture also promotes a sense of belonging, brotherhood and connection through a common mission (Burek, 2018; Fisher et al., 2016; Tsai et al., 2014). In doing so, individuals' civilian worldviews may be diminished to better assimilate into military culture (Moore, 2017). Consequently, as veterans depart from the military, they may still be heavily influenced by the military culture, adding further complications to their living experiences (Exum et al., 2011; Harding 2017). The "esprit de corps" may become weakened or nonexistent for veterans, resulting in no longer feeling the

sense of belonging, the brotherhood, nor the connection to a common mission (Burek, 2018). Thus, there is a high probability that veterans will often face significant challenges related to separation from the military, transition back into civilian society and consolidation of changing and dynamic identities in different worlds.

The issues of transition from the military to the civilian world are of significance, given the continued decrease of the U.S. military. Meeting the needs of veterans has been an unresolved matter that continues to be problematic with this increase. Among this group is a fastgrowing number of female veterans, currently accounting for about 9% and projected to be closer to 17% by 2040 according to the U.S. Census Bureau (Vespa, 2020). Female veterans are often underrepresented due to the much higher number of male veterans, thus contributing the insufficiency in treatment for female veterans (Cheney et al., 2018; Hoffmire & Denneso, 2018). An implication of this may be related to the increase in suicides among female veterans and the further conclusion that a higher percentage of the females who committed suicide had not presented for mental health services within a year of the suicide (U.S. Department of Affairs, 2019). Additional factors to consider for the importance of mental health treatment among veterans are the differences between veteran experiences and era of service. The largest group of veterans consists of individuals who served during the era of Vietnam, with the second largest group serving during peacetime only, 6.4 million and 4.0 million respectively (Vespa, 2020). While the number of veterans in this category appears to decline, likely due to age, the number of more recently serving veterans continues to increase. This group is largely comprised of the 9/11 and post 9/11 cohort. Research conducted with this group has indicated a higher number service-connected disabilities among this specific group, including mental health related disabilities, as well as a greater risk for mental health issues (Igielnik, 2019; Vespa, 2020).

Contributing factors to higher risks of mental health issues may be linked to the terrorist attacks on September 11, 2001, resulting in an increase in the number of military personnel engaging in or being exposed to combat, being more frequently deployed, and having a higher probability of experiencing some type of traumatic or distressing experiences (Igielnik, 2019). Additionally, unique to this particular cohort are higher levels of education, including some college. Female counterparts present with higher education levels than nonveteran females (Vespa, 2020). While there is not much literature about education level and mental health treatment seeking behaviors, this may be an area to consider in this research given the commonality between era of service and gender within this group. It should also be noted that higher education has been linked to higher socioeconomic status which may result in a different quality of life that aligns with work toward positive mental health (Belo et al., 2020; Vespa, 2020). Thus, education levels may account for some impact on addressing mental health concerns in the veteran population. As previously stated, addressing mental health may become normalized by individuals as part of a desired quality of life or overall healthy self. Thus, it is also important to assess for veterans' previous mental health experiences, both as active-duty service members and as veterans, to adequately account for other contributing factors involved in addressing mental health problems. Experiences during time in the military may continue to impact these behaviors as a veteran. Recalling the military ethos, active-duty personnel may choose against seeking treatment and try to handle mental health issues on their own, as found in a survey of 2,048 U.S. soldiers by Britt et al. (2020). Such values and behavioral responses may be informed by stigma about mental health issues for military personnel and veterans. Although stigma continues to be pervasive within the veteran population, some research supports that individual who have received previous mental health services express more willingness to seek services in the future (Blais & Renshaw, 2014; Miggantz, 2017). Receiving mental health services may weaken or negate

stigma for some individuals. This notion supports further the need to explore links between attitudes and seeking services to promote engagement in treatment.

While the previously discussed factors do not provide an exhaustive list of factors, related to seeking mental health, these factors remain significant. There is a lack of research on how these factors impact attitudes toward seeking mental health. Yet, it is apparent that there is need for this exploration due to the consistently growing mental health concerns of veterans and the documented underutilization of mental health services by veterans. The intent of this research was to examine the impact of these factors on veterans seeking mental health services and contribute to the growing literature in this area.

Attitudes and Mental Health

In the field of mental health, attitudes play an important role. Client's' beliefs and attitudes are pivotal to treatment outcomes in many ways. Many counseling approaches deem the subjective experiences and perceptions of the client as the most critical factors in the counseling relationship. Roger's (2007) believed that a positive therapeutic relationship was necessary for change within the client. While research has not supported this concept to be necessary, the therapeutic relationship has been found to be significant contributor to successful treatment outcomes, if viewed positively by the client (Johnson et al., 2018). This is particularly salient because it establishes the significance of the beliefs and attitudes of the client about the counseling experience. The attitudes of clients about their mental health services may determine the level of investment into treatment, the perception of trust for the provider and the treatment itself, and the decision to continue or discontinue treatment. Thus, belief in the process and one's own capability to change, or self-efficacy are related directly to attitudes. The concept of self-efficacy has been empirically validated as an impacting variable in mental health treatment and outcomes (Bandura, 2011; Rabani Bavojdan, et al., 2011). Assessing for attitudes of the

clients is important throughout the mental health treatment process. For many veterans, there may be several factors that impact their attitudes about treatment. Some veterans of minority culture have expressed concern about not having access to mental health providers who look like them. They express feeling judged, misunderstood, and even stereotyped (Spoont et al., 2017). Others express discomfort or dissatisfaction with having providers who are not veterans or military personnel. For example, having to retell and possibly explain about their experiences to someone who has no military experience leads to difficulty trusting the providers and confiding in the providers.

In addition to assessing attitudes of veteran clients during the therapeutic process, it is imperative to highlight attitude concerns that may exist prior to engaging in any mental health services. Stigma is one of the most recognized barriers to mental health services due to the pervasive negative impact on mental health (Acosta et al., 2014; McGuffin et al., 2021; Tanielian et al., 2016). Public stigma describes the publicly endorsed views of others about a stigmatized group, in this case, veterans. These views are often negative in that they are unproven, stereotypical, and discriminatory. For many veterans, public stigma may include such notions as: all veterans have posttraumatic stress disorder (PTSD), most veterans have schizophrenia, veterans with mental disorders are dangerous, and veterans who need help are weak or failures, inferior and inadequate (Sharp et al., 2015; Vogel et al., 2010). For veterans, public stigma may impact decisions to seek treatment and continue treatment. Public stigma may also be embraced by mental health providers which in turn, may impact the therapeutic relationship, which impacts the veteran's attitude about mental health services as well (APA Practice Organization, 2016). These perceptions can contribute to a myriad of problems including lack of empathy, poor treatment services, and even fear of losing medical or disability benefits (Acosta et al., 2014). Self-stigma occurs when one internalizes public stigma about self (Harding, 2017; Jennings et

al., 2015). This can be detrimental to veterans, again due to possibly choosing not to seek help because of such attitudes. The military culture, deemed a sub-culture itself of American civilian society, strongly influences the veteran culture (Exum et al., 2011; Harding, 2017). Veterans may view themselves as weak if they are unable to just get over mental health issues and continue to follow the same warrior's creed and military ethos that once guided their self-perceptions (Fisher et al., 2016; Harding, 2017). They may even choose not to disclose their struggles with mental health, leading to undiagnosed and untreated issues that will continue to worsen (Dabovich, et al., 2019). Self-stigma may be tied to perceived stigma, which denotes the belief that others will have negative thoughts or perceptions about people mental health issues. With 8.4% of the military force being formally diagnosed with mental health disorders but potentially not seeking mental health services, the influence of perceived stigma on attitudes can lead to significant concerns about veterans seeking mental health services (Ganz et al., 2021; GhahramanlouHolloway, 2018; Seidman et al., 2018).

It should be noted that the United States military has sought to de-stigmatize mental health problems for some time. In 2006, the online program "Military Pathways" was implemented to provide online mental health screenings, virtual doctors, and educational and promotional materials to veterans, families, and other military personnel to strengthen selfefficacy for seeking treatment. The stigma campaign, "Real Warriors" was introduced in 2009 with the goal of connecting veterans and their families with care and providing educational, and supportive resources about mental health issues such as depression, anxiety and posttraumatic stress disorder (Dingfelder, 2009; Health.mil, nd). In addition, information was solicited from mental health professionals and organizations to help address stigma. The American

Psychological Association (APA) recommended that the Department of Defense (DOD) increase confidentiality of mental health treatment whenever possible, and that a public education campaign be implemented to focus more on resiliency as opposed to mental health problems (Dingfelder, 2009). The Research and Development Corporation (RAND corporation) enlisted an expert panel of mental health stigma experts and experts on mental health in the military, to address the ongoing issue of stigma as a barrier to mental health. These experts worked together to offer priorities to the DOD for reducing stigma. The results included an agreement to focus on interventions for increasing help-seeking, as a top priority. The "Wounded Warrior" organization has focused on helping those who have served in the military on or after September 11, 2001, and incurred mental and physical injuries, illnesses and/or wounds (Wounded Warrior Project, n.d.). The Wounded Warrior Project offers free access to intensive outpatient therapy services, retreats, interactive programs, and other supportive resources. On October 17, 2020, the "Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019" was passed into law to help increase the mental health workforce, provide better access for rural veterans to mental health services, and to strengthen research on veteran's mental illness and suicide risks (Congress.gov, n.d.). Additionally, the number of mental health providers and behavioral healthcare centers has increased, with the inclusion of civilian mental health counselors to address the inefficiency in meeting mental health needs of military personnel in a timely manner (Ghahramanlou-Holloway, 2018; Institute of Medicine, 2010). Despite these efforts and the increase in availability of treatment in behavioral healthcare, veterans have remained reluctant to use these services (Ganz et al., 2021; Ghahramanlou-Holloway, 2018; Seidman et al., 2018; Vogt et al., 2014; Coll et. al., 2011).

Significance of Study

As the veteran population continues to grow, mental health needs continue to increase. While measures have been taken to address the diverse needs presented by this unique group, there continues to be a lack of response to and utilization of these services by veterans. Much research focusing on the transition from the military to civilian life is short-term and targeted toward barriers to utilization of services. However, there is a need to address issues related to long-term mental health concerns for veterans. Thus, there is need to continue investigation of veteran attitudes toward mental health services. It will be important to consider potential relationships between these attitudes and factors such as: race, gender, era of service, previous mental health experiences as an active-duty service member or veteran, and education level. This study aimed to add knowledge of veteran attitudes to the field for the purpose of increasing cultural awareness that will promote insight into effective treatment approaches with this unique population.

Purpose of Study

The purpose of this study was to explore the relationship between veterans and their attitudes toward mental health services. The following research questions were addressed in the study:

1. What is the relationship between veterans' beneficial attitudes towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level?
2. What is the relationship between veterans' pessimism towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level?

The researcher's hypotheses were as follows:

1. White veterans would have a higher positive attitude towards seeking mental health treatment than nonwhite veterans.
2. Females would have greater positive attitudes towards seeking mental health treatment than males.
3. Veterans from most current era of service would have a higher level of seeking mental health treatment than those from eras occurring longer ago.
4. Veterans with previous counseling experience as an active-duty member would have a less positive attitude towards seeking mental health treatment than veterans without counseling experience.
5. Veterans with previous counseling experience as a veteran would have a more positive attitude towards seeking mental health treatment than veterans without counseling experience.
6. Veterans with a higher educational level would have more positive attitudes towards seeking mental health treatment.

Assumptions

The following assumptions were be made:

1. Participants will comprehend and respond to each survey item.
2. Participants will complete surveys honestly.
3. Participants will be veterans as defined in this study.

Delimitations

The following delimitations were be utilized:

1. Participants were identified utilizing listservs from professional organizations, internet, social media, and students, faculty, and staff of The University of North Carolina, Charlotte.
2. Information was obtained via self-reported surveys.
3. Participants were identified via snowball method.
4. Participants were required to read and respond to surveys in English.

Limitations

1. This study was correlation. Causation could not be inferred.
2. Social desirability bias may have occurred with self-report method.
3. Potential dishonesty from participant could have occurred due to potential concerns about impacting veteran benefit status and distrust of systemic data collection.
4. There may be a lack of representation of those who do not utilize VHA services could have occurred.

Threats to Internal Validity

Internal validity refers to how much the changes in the dependent variable can be attributed to the independent variable(s), rather than extraneous variables (Mertens, 2015). Threats to the internal validity of this study included social desirability bias and instrumentation. To address social desirability and minimize this threat to validity, the researcher reminded participants of the anonymity of their responses in this study. The purpose of this was to discourage participants from answering in a manner they perceived as favorable to the researcher and to encourage honest responses to survey items. Additionally, the researcher reviewed the reliability and validity of the instrument and utilized the instruments that proved to be reliable and valid according to previous studies.

Threats to External Validity

External validity refers to the extent to which findings from a study can be applied or generalized to the population (Mertens, 2015). Although the researcher utilized convenience and snowball sampling methods, any veteran across the United States could participate in the study. Therefore, the researcher expected the study results to be generalizable to the population of veterans of the United States military.

Operational Definitions

The operational definitions of the study's significant terms and variables were as follows:

Veteran

For the purpose of this inquiry, veterans were defined as men and women that did not currently serve on active duty in the U.S. Armed Forces yet did so in the past either in the Air Force, Army, Coast Guard, Marine Corps, or Navy. In addition, veterans also included Reservist and National Guard individuals if they were mobilized to full-time military service by the federal government or have 20 years of experience regardless of if they were mobilized (Parker et al., 2019).

Gender

For the purpose of this study, gender was defined as female, male, or other (free response). Gender options were included on the demographics form.

Previous Mental Health Experiences

For the purpose of this study, previous mental health experiences included any experiences of veterans with professionals identified as mental health professionals such as psychiatrists, psychologists, psychotherapists, social workers, counselors, psychotherapists, and others. In addition, these included professionals identified by veterans as someone helping or

addressing mental health needs directly with the veterans. This could include medical professionals in the nursing field and peer helpers or whomever veterans identified as professional providers of mental health services. Veterans' responses were separated to indicate whether they had previous mental health experience as an active-duty member or whether they had previous mental health experience as a veteran. Participants were able to provide a dichotomous response to this option (yes or no).

Race

For the purpose of this study, race was defined in coherence with the categories utilized by the United States Census Bureau. The categories included: White, Black or AfricanAmerican, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and Hispanic or Latino (United States Census Bureau, 2020). Addition options of Nonresident Alien and 2 or more races, and Other was provided. A free response option was available for participants to provide information if the identified race was not listed (Other), as well as if they were of two or more races. Responses to the racial identity inquiry were included on the demographics form.

Education Level

For the purpose of this study, education level reflected the highest level of education completed by the participant. Participant options included less than high school, high school diploma or GED, some college, two-year college degree, bachelor's degree, master's degree, doctoral degree, and professional degree. Level of education was recorded on the demographics form.

Attitudes Toward Mental Health Services

For the purpose of this study, attitude toward mental health services was considered the outcome variable. Attitude was measured using the subscales of the Attitudes Towards Mental Health Treatment Scale (ATMHT). The two subscales, Beneficial Attitudes About Seeking Mental Health Treatment (BA) and Pessimistic Attitudes About Mental Health Services (PMS) focused on assessing for beneficial attitudes about seeking mental health services and pessimistic attitudes about mental health services (Conner et al., 2018).

Summary

This chapter presented a statement of the problem, overview of the problem, the significance of the study, purpose of the study and identified gaps in the literature. This chapter also presented the independent and dependent variables, the research question and corresponding hypotheses, operational definitions, assumptions, delimitations, limitations, and threats to internal and external validity.

Organization of the Study

Chapter one presented the significance of the study, the purpose of the study, the variables, the research question and hypotheses, the assumptions, delimitations, limitations, threats to internal and external validity, and operational definitions. Chapter two presents a review of the literature that is related to the variables in this study. Current evidenced-based literature related to the relationship between veteran attitudes and predictor variables in this study is examined for significant findings and existing gaps. Chapter three outlines the methodology used in the study. Descriptions of the participants, procedures, data collection, instrumentation, research design, and data analysis are addressed in the chapter. Chapter four presents the results of the study. Instrument reliability, data screening, descriptive statistics,

correlations, and multiple regression findings are included in this chapter. Chapter five presents the results of the study. Discussions of demographic information, identified variables, contributions of the study and limitations of the study were included. Additionally, this chapter detailed implications of the findings and recommendations for future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

The purpose of this study was to examine the relationship between attitudes of veterans towards mental health service and (a) gender (b) race (c) era of service (d) previous mental health services as an active-duty service member or as a veteran, and (e) education level. The first part of this chapter presented the theoretical framework along with an overview of the military and veterans. Following was a conceptual understanding of attitudes and mental health, along with related current research. The remaining sections presented empirical research related to each of the predictor variables, namely gender, race, era of service, previous mental health services either as an active-duty service member or as a veteran, and education.

Theoretical Framework Theory of Planned Behavior

In order to understand Ajzen & Fishbein's theory of planned behavior (TPB), the theory of reasoned action (TRA) must first be explained. The TRA originated in social psychology aligning with attempts to explain how and why attitude influences behavior by addressing the relationship between behaviors and one's intentions to act on the behaviors (Ajzen, 1991; Fishbein & Ajzen, 1975). The theory holds that three constructs influence behavior: attitudes, subjective norms, and intention. Attitudes represent our beliefs about the behavior. These attitudes may be positive or negative depending on two influencing variables, behavioral beliefs, and normative beliefs.

Behavioral Beliefs

The behavioral beliefs represent our beliefs about the potential consequences of completing the behaviors, as well as the evaluation of those consequences. If beliefs about consequences are positive, there is more likelihood of carrying out the behavior. For veterans, these beliefs may consist of feeling that mental health services will be helpful or feeling that

seeking mental health services does not mean one is weak. However, if the beliefs about the potential consequences are negative, such as being viewed as weak for seeking mental health services or that mental health services will not be helpful, veterans will be less likely to seek services.

Normative and Subjective Beliefs

Normative beliefs or subjective norms capture the social aspect and represent how much one feels pressured by others to do the behavior. Subjective norms are also influenced by two factors- the perception of expectations from significant others and the motivation to comply with the perceived expectations of others. Do veterans consider how their family and friends feel about their seeking mental health? How much does the perception of significant others actually motivate veterans to seek mental health services? In turn, behavioral attitudes and normative beliefs influence intention which is the determining factor in whether one will overtly do the behavior. For veterans, the behavior is seeking mental services. In 1985, Ajzen & Fishbein expanded to the theory to address the problem of intentions being a primary determinant for a single behavior and not ongoing or repeating behaviors. The TPB included an additional construct, perceived control behavior (Ajzen, 1991). Perceived behavioral control is the how much control one perceives to have of the behavior. Since all behaviors are not fully under one's control, it is labeled as perceived control.

Veterans may doubt their capability of seeking and obtaining effective mental health services. They may perceive that they are at the mercy of the VHA as far as seeking or obtaining mental health services. The addition of this perceived behavioral control helped to account more for repetitive behaviors, thus addressing veteran's decision to seek help and continue with mental health services (continuing to engage in help seeking behaviors). Initially, attitude and subjective

norms impacted behavior through intentions. Later, the perceived barrier control impacted behavior both through intention and directly (Ajzen, 1991).

Veterans and Mental Health

More recent research has supported a correlation between attitudes and health behaviors related to utilization of mental health services and mental health treatment retention rates (Conner et al., 2018). Diala et al., (2000) conducted a study that consisted of a nationally representative sample and found that participants who expressed a negative attitude toward treatment were five times less likely to seek treatment than those with more positive attitudes. The military itself has been defined as a civilian subculture group (Exum et al., 2011) that requires service members to completely embrace the norms, values, beliefs, and practices of the military while simultaneously relinquishing some of these attributes reflective of civilian society (Moore, 2017). For service members, the military ethos becomes an established worldview, and the values of this culturally diverse group must be recognized by mental health providers to provide effective treatment and to combat barriers to treatment. According to the Department of Veteran Affairs (2021), the veteran population is representative of nearly 20 million individuals and 10 percent of them are comprised of females. Of these 20 million veterans, 3 million are from the Word War II era, 1.1 million Korean Conflict, 4.3 million Peacetime only, 8.1 million Gulf War, and 6.3 million from the Vietnam era. It is important to keep in mind that veterans represent a diverse group of individuals with unique challenges impacted by the era they served. For example, a survey of Post 9/11 veterans conducted by Pew the Research Center (Parker et al., 2019) found that these veterans experienced higher deployment rates than pre-9/11 veterans, with 77% having been deployed at least once in the post-911 group and 58% in the pre-9/11 group. This is significant since deployments were during wartime, increasing exposure to combat. Many veterans attributed negative impacts on their mental health to deployments. Of

post-911 veterans, 49% experienced combat as opposed to 29% or pre-911 veterans. Many veterans verbalized experiencing trauma, perceiving that they experienced post-traumatic stress even without formal diagnoses (Parker et al., 2019). Additionally, post-911 veterans experienced varied outcomes once separated from the military. Some veterans felt well prepared to reintegrate into society while many others continued to struggle with mental health issues that negatively impacted psychosocial factors including their jobs, financial status, family and other relationships (Igielnik, 2019; Parker et al., 2019). Further, Pew researchers conducted an analysis of 1853 veterans examining the unique variables for veterans and adjustment to civilian lifestyle (Morin, 2011). Post-911 veterans and veterans serving in wartime eras had a higher probability of incurring a traumatic experience. Nearly 32% of all veterans reported having a military-related experience that they described as distressing or traumatic; 43% percent of post-911 veterans reported the same. About 10% of veterans in the study reported some type of serious injury, with post 911 veterans reporting at 16% (Morin, 2011). Additionally, these experiences have impacted veterans' lives relationally. Veterans in this study reported subsequent family problems with their transition to civilian status, with post-911 veterans being more likely to experience family issues than veterans of other areas. The research reported 77% percent of veterans being post-911 veterans who have been deployed while married reported more family problems verses 34% of other veterans serving in different eras (Morin, 2011). It should be noted that some variables, such as education level, may have a positive impact on transition. Pew research found that commissioned veterans who had graduated from college reported an easier adjustment than personnel who were enlisted and high school graduates (Morin, 2011). Thus, the military culture and experiences may heavily impact veteran identity, even beyond active-duty (Harding, 2017).

When working with culturally diverse clients, it is important to recognize their worldview as it reflects their identity, and their perceptions of and relationship to the world (Sue,

1978). Coll et al., (2011) utilize the worldview of veterans to inform understanding in working with veterans. In examining the nature of relationships for veterans (the relationship dimension), the hierarchical, collectivistic nature must be taken into consideration. Veterans may be used to authority and a chain of command for decision making. Counseling often requires a collaborative relationship that is contrary to this hierarchical nature. Thus, a high level of trust in others is a necessity for relationship building between veterans and mental health providers, which may be challenging to facilitate. Additionally, the collectivistic nature of veteran relationships may contrast with seeking individual help (Sue & Sue, 2003; Coll et al., 2011). However, the loss of the connection to a unit or military family also contrasts the practicality of addressing problems through this group approach.

Time as a worldview should also be a consideration with the veteran population (Grossman, 2009; Coll et al., 2011). Recognizing and attending to the past can be part of veteran identity, glorifying the warrior ethos and grounding them in a purpose toward a mission. Focusing on the present and future may be more problematic than helpful as it forces the client into situations of the unknown and possible grief experiences consisting of losses due to death, separation from the unit or military family, or other current psychosocial related losses. The emotional worldview is also examined as the stoic nature of veterans may continue to be present beyond active duty (Brown & Landrum-Brown, 1995; Coll et al., 2011). This emotional state must be recognized as an adaptive quality that has likely become a coping response to the military lifestyle rather than resistance to change and addressing mental health issues. Mental health professionals may need to take the time to help veterans identify or become aware of their range of emotions, encourage and support veterans to express these emotions, as well as model expression of a variety of emotions. Additionally, the cultural values of this population support a persona of strength, resourcefulness, efficiency and possibly perfection. Removing these facades

may lead to self-perceptions of weakness, fear of being ostracized and incompetence in military personnel. Thus, these individuals may be unlikely to seek services that provoke them to unveil hidden parts of self (Coll et al., 2011).

Benevolence as a worldview should also be considered in understanding the veteran population (Coll et al., 2011). Despite the different branches of military, the values of peacefulness and restraint are upheld. This includes the placing the unit first in regard for comrades, respecting leadership, concern for self within the group and under leadership, and contributing to the success of the group (Grossman, 2009). However, the division from the military for veterans complicates this worldview. In addition, this view often does not align with the civilian society, as the primary purpose of such values was to strengthen camaraderie against others for survival. Thus, this may translate into mistrust and resistance to treatment from veterans. Mental health providers will need to be mindful and empathic of this underlying worldview when interacting with veterans (Coll et al., 2011).

Acknowledging worldviews is imperative to fully comprehending the attitudes of veterans. Assessing attitudes of veterans is an integral component of seeking mental health services. Various cultural components inform worldview and attitudes, from demographics to experiences, supporting the ongoing need to study attitudes which are potentially modifiable (Conner et al., 2018; Sue & Sue, 2003).

Veteran History and Mental Health

The United States has engaged in combat for many decades. The transition of military recruitment from involuntary to voluntary status in 1973 changed the experience of the military personnel. One significant change since this time has been the decreased size of the military, which has subsequently contributed to an increasing frequency of repeated deployments and extension of deployment times for personnel (The Military to Civilian, 2018). Consequently,

there was an increase in both direct and indirect exposure to combat for personnel; either directly engaging with the enemy in warfare and/or indirect engagement in roles such as infirmary, kitchen, communications, and others. While research has supported long-term negative impact on individuals who have experienced deployment, a significant negative impact on long term mental health has been associated with indirect exposure to combat, such as hearing sounds and working in highly targeted areas such as the kitchen or infirmary (Ciarleglio et al., 2018; The Military to Civilian, 2018). Thus, any member of the military may experience mental health issues regardless of exposure to warfare and/or repeated deployments. In response to a drawdown of the U.S. military, in the 1990's, Veteran's Health Administration's (VHA) medical services were downsized. This resulted in overwhelming demands for VHA medical services and A growing inability to meet the mental health needs of military personnel and veterans, prompting the need for awareness and attention to more effective mental health services for this unique culture (The Military to Civilian, 2018).

Suicide and Veterans

As the military continues to decrease in size, the veteran population continues to expand. Mental health issues experienced by active-duty persons will influence veteran transition and subsequent living quality, especially if unresolved. A direct representation of the pervasive issues with mental health is found in the increasing number of suicides among the veteran population. Suicide has been deemed "serious health problem", being designated as the 10th leading cause of death in the United States (Centers for Disease Control and Prevention, 2021a; CDC, 2021b). In general suicide rates have increased consistently since 1999 within the U.S population with suicide rates continuing to increase more rapidly in the adult veteran population than the nonveteran adult population (CDC, 2021b.; U.S. Department of Affairs, 2020). From 2005 to 2017, there was a 43.6% increase in adult deaths by suicide across the nation. This timeframe

includes a 6.1% increase in suicide rates by veterans, accounting for 13.5% of all deaths by suicide in the adult population (U. S. Department of Affairs, 2020). Related to mental health, a higher number of suicides has been found in veterans who have received a mental health diagnosis; the highest rates were among veterans with bipolar disorder and opioid use disorders (U.S. Department of Affairs, 2020). Additionally noted mental health diagnoses for veterans included anxiety disorders, personality disorder and schizophrenia (U.S. Department of Affairs, 2020). However, even in the absence of severe mental illness, psychosocial problems have been found to contribute to struggles with daily living and even to the suicide rates among veterans (U.S. Department of Affairs, 2020). Many veterans contend with issues related to psychosocial aspects including housing and homelessness, finances and employment, involvement, and access to community service for healthcare, and relationships and support systems. In fact, there has been an increasingly disproportionate number of veterans comprising the homeless population in society (Hamilton et al., 2011). According to the Office of Public and Intergovernmental Affairs (2020), veterans are at risk of suicide within 30 days of losing housing. These additional psychosocial factors may be related to mental health issues and have been identified as contributors to suicide, even when a formal mental health diagnosis is not present (CDC, 2021b; National Institute for Mental Health, 2021). An assessment of the post 9/11 service member population, who experienced the longest war fought by the U.S. voluntary force, presented increased suicide rates, substance use issues, and divorce rates (U. S. Department of Affairs, 2020).

The U.S. government has worked to implement many policies and programs to combat mental health issues and positively impact psychosocial issues faced by veterans. The Veteran's Health Administration (VHA) is currently the largest healthcare organization in the U.S and

offers access to a variety of medical and mental health services to active military personnel and veterans (U. S. Department of Veteran Affairs, 2019.; Roberts & Warner, 2018; Tsai et al., 2014). However, much of the veteran population do not utilize VHA services (Ciarleglio et al., 2018; Tsai et al., 2014). An analysis of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) veterans yielded that 62% had utilized VHA services since 2002 (Epidemiology Program, 2017). In addition to the VHA's struggle to meet the evolving needs of veterans, is the issue of veterans choosing not to utilize VHA services. In ongoing effort to help address these concerns, the U.S. government responded by granting inclusion of private sector services to help address mental health concerns. However, there is still some question about the effectiveness of treatments provided to veterans through civilian services (Hester, 2017; Verkamp, 2021).

Consequently, some veterans show a preference for mental health services from other veterans. Familiarity with the military culture has been identified as one reason for such preference. Having to explain military experiences to civilian professionals was not viewed positively by post 9/11 veterans (National Academy of Sciences, 2018). Not only do some veterans view civilian providers and ineffective, but research also supports some lack of cultural competence among civilian providers (Botero Jr. et al., 2020; Johnson et al., 2018; Tanielian et al., 2018). Additionally, veterans often have trouble navigating systemic policies and simply assessing mental health services, which continues to remain a concern for the general public as well (Cheney et al., 2018; Hester, 2017). As veterans transition back into civilian society, some may continue to embrace the values of the military culture while others may distance themselves from the military culture (Harding, 2017). Veterans are faced with reconciling the warrior mentality of an active service member with a new civilian identity (APA Practice Organization, 2016). Navigating the transition from the military ethos of teamwork, discipline, pride, and

commitment to the mission may be further complicated by mental health issues and barriers to addressing mental health issues (APA Practice Organization, 2016).

Veterans Seeking Mental Health Treatment

Regardless of title, any professional mental health provider must establish a working alliance or rapport with those receiving services. Significant to rapport building is the client's perception of the therapeutic relationship (Leach, 2005; Rogers, 2007). If veterans' do not perceive providers as knowledgeable, interested, or helpful, they may also view mental health services incompatible with their needs (Ganz et al., 2021). Veterans may experience a loss of identity after being separated from the military, even as they return home to their families and social systems (APA Practice Organization, 2016).

In response to not seeking or dropping out of treatment, veterans often express concern about not being understood or respected by providers (APA Practice Organization, 2016). Some veterans may choose to engage in self-treatment or try to tough it out in accordance with the military mantra (Harding, 2017; Dabovich et al., 2019a). Such attitudes toward seeking treatment can be dangerous, as early treatment is one of the best predictors for PTSD, which is often comorbid (Ganz et al., 2021). Many veterans continue to express not having trust in mental health professionals (Vogt et al., 2014).

In a 2011 study conducted by Kim et al., one in four individuals expressed that they would only seek mental health treatment as a last resort due to this lack of trust. Cheney et al. (2018) utilized mixed methods cultural domain analysis with a sample of sixty-six veterans and concluded five cultural dimensions of access barriers to VHA services. Relative to attitude, the researchers found that veterans lacked trust in non-military health providers, attributing this to decreased motivation to remain in treatment (Cheney et al., 2018). Possibly related to lack of trust is unique military culture which espouses needs of the collective over the individual,

relentless devotion to the mission, stoicism, and compliance (Coll et al., 2011). Johnson et al., (2018) utilized one-way and two-way ANOVA with a comparison between two versions of vignettes to explore veteran preferences for psychotherapist. The researchers found veterans to prefer therapists who were veterans. These values mediate attitudes of veterans and help-seeking behaviors.

Veteran attitudes may additionally be impacted by Combat-Masculine Warrior (CMW) (Dunivin, 1994). This paradigm creates a divide among soldiers, defining a real soldier as someone with combat experience/exposure separate for those without. The combat experienced masculine warrior is held at higher esteem than others who do not have combat experience. Further, the ideal soldier becomes synonymous with the CMW, who is characterized by valor, heroism, and strength. This paradigm may pose complications for those combat veterans suffering from mental health issues. On the one hand, Fraser et al., (2010) found that people with combat experience received more sympathy form military personnel. Conversely for veterans, carrying this idea into life outside the military may lead to isolation, negatively impacting the veteran's mental health due to decreased help-seeking behaviors or lack of utilization of needed mental health services (Ashley & Brown, 2015; Fraser et al., 2010)

To explore the potential impact of CMW on attitudes towards seeking mental health services, Ashley & Brown (2015) conducted a study of veterans utilizing survey data and vignettes. The results indicated that all the veterans were less accepting of other non-combat veteran's help-seeking behaviors, while combat veterans were less accepting of other combat veterans' help seeking behaviors. Espoused negative views among veterans about the mental health of other veterans based on active-duty experiences may impact attitudes of veterans toward mental health services.

Previous mental health experiences can encompass many variables for veterans. Often, these variables may become barriers to utilization of mental health services. One example is the many different types of helping professionals and their approaches to mental health. Veterans may have become accustomed to the language and approach of the military, using and responding to language and approaches that reflect similar values. However, mental health professionals may incorporate different approaches from traditional military and veteran related healthcare systems. Cheney et al. (2018) utilized a cultural domain analysis to elicit barriers to VHA mental health services, more specific to veterans. The researchers were deliberate in use of language from veteran view rather than healthcare model which many veterans may encounter in VHA services. Professionals in the setting were more likely to employ biomedical and scientific research-based language to describe and address treatment with veterans. However, the need for more meaningful interactions was identified for more effective treatment approaches (Cheney et al., 2018).

There is limited research that focuses on the impact of previous mental health services with veterans' attitudes toward seeking mental health. Some researchers have studied active-duty service members and found more positive attitudes toward seeking mental health services by those who had received services after joining the military than those who had never received services after joining the military (Ganz et al., 2021). However, Tanielian et al., (2016) found similar beliefs in veterans and active-duty members and concern about veterans continuing to utilize the military ethos of toughing it out as a barrier to mental health treatment for veterans. Vogel et al., (2006) also found this difference between participants who had previously sought mental health services from those who did not, in establishing psychometric properties for a stigma measuring scale. Another study by Rosen et al., (2011) found a greater level of psychological impairment with just an initiation of psychotherapy. This could continue to factor

into future attitudes of veterans. Thus, exploration for a potential impact of previous mental health experiences on veterans' attitudes toward mental health services should be considered.

Gender

Much past research about suicide among veterans has included primarily individuals who have utilized VHA services (Monteith et al, 2021). Males comprise the most served gender group of veterans by the VHA resulting in predominantly male samples for most military-related studies (Tsai et al, 2014). However, increasing rates of suicide among the veteran population as a whole, prompted governmental action to focus on addressing the needs of veterans who were serviced by the VHA, as well as those who did not utilize VHA services (Monteith et al, 2021). Currently, women are identified as the fastest growing subgroup of veterans in the United States, with an estimation of two million living women veterans (Center for Women Veterans, 2020). The number of female veterans is predicted to account for 15% of the U.S. veteran population by 2035, increasing from 9% in a 2018 report (U.S. Department of Affairs, 2020). Consequently, rates of suicide among female veterans have continued to increase in comparison with male veterans, reflecting a 34% increase in age-adjusted suicide rates for females and a 13% increase for males (Department of Veteran Affairs, 2019). In comparison to civilian adults both female and male veterans continue to be at a higher risk for suicide. The 2019 National Veteran Suicide Prevention Annual Report listed the rate of female veteran suicides at 2.2 times the rate of civilian women, while the rate of male veterans was 1.3 times higher than civilian males (Hoffmire, & Denneson, 2018; U.S. Department of Veteran Affairs, 2019; U.S. Department of Veteran Affairs, 2017). Additionally, a survey of the use of VHA services by female veterans yielded results of 17.8% increase in suicides between 2005 and 2015. A 2017 investigation revealed that 68% females who died from suicide that year, did not utilize VHA services in the previous year (U.S. Department of Affairs, 2019).

While females are continuing to increase in the veteran population, the most common perception of a veteran continues to align more readily with males (Strong et al., 2018). This skewed, yet prevalent view has also contributed to enduring issues faced by women, including but not limited to accessibility of veteran resources, inadequate healthcare services, and unmet mental health needs. Despite the increasing concerns associated with women veteran challenges, very little research continues to be conducted with women veterans specifically, risking contribution to ineffective treatment for women or lack of treatment for women overall (Cheney et al., 2018; Hoffmire, & Denneso, 2018). The female veteran population continues to be underrepresented in research, in part due the small representation in VHA patients (Cheney et al., 2018). Thus, it will be important to assess for gender-related factors in understanding veterans' attitudes toward mental health.

Mental Health Stigma Barrier

An enduring barrier to seeking help for mental health issues is stigma (Corrigan, 2004; Vogel et al., 2006). Both public stigma and self-stigma present barriers to mental health care for veterans and civilians (Kulesza et al., 2015; Sharp et. al., 2015). Public stigma involves the negative perception of others about an individual, possibly leading to stereotyping, discrimination, or prejudice (Corrigan 2004; Sharp et. al., 2015). In reference to mental health, the person seeking mental health services is perceived as socially unacceptable. Self-stigma involves internalization of negative thoughts or beliefs about self and what others think of the individual. This may lead to self-labeling that is detrimental to self-esteem and/or self-worth (Corrigan, 2004).

While the concepts are unique, both contribute to barriers for seeking mental health for veterans. Studies have shown that stigma may carry over from active duty to veteran status. Blais and Renshaw (2014) found high rates of self-stigma among military members to be associated

with decreased help-seeking behaviors. While this study also sampled active-duty members, OIF/OEF veterans were found to have the highest treatment dropouts, suggesting a link between self-stigma in military and veteran population. Hoge et al., (2004) found that one in three veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) believed they would be stigmatized for simply seeking treatment. A study by Stecker and colleagues found that nearly three quarters of OIF veterans were fearful of receiving a diagnosis (Stecker et al., 2010).

In a study completed by Mittal et al., (2013), participants subscribed to PTSD resulting from combat rather than natural disaster volunteer missions, seeing the former as less stigmatizing. The same study yielded a more stigmatizing view of mental health disorders than PTSD because the former was more biologically based (Mittal et al., 2013). These studies bring into question the perceptions and impact of stigma for veterans. Of the U.S. military population, the OEF/OIF group have been found to experience a great deal of self-stigma (Harris et al., 2015).

For some time, fewer studies provided direct measures of self-stigma than of public stigma (Kulesza et al., 2015; Kim et al., 2010). In response to this, Vogel et al., (2006) created the first direct scale, Self-Stigma of Seeking Help Scale (SSOSH) over a course of five studies. Self-stigma was identified as a significant factor in seeking mental health services. However, the sample consisted of a general group of college students, not allowing for generalization to veterans. A study conducted by Cheney et. al., supported veteran concern about receiving stigmatizing labels, in addition to being seen as weak and a failure for seeking mental health services (2018).

Veterans may try to continue living according to the military ethos and cultural idea of trying to push through and work out their problems on their own. When this fails veterans may internalize the belief that they are weak and unable to live up to the military mentality, resulting

in psychosocial issues, more psychological problems and potentially worsening physical issues (Dabovich et al., 2019a, Ganz et al., 2021). Continued research about the impact of negative personal beliefs and self-stigma impacted attitudes needed to be conducted in relationship to mental health treatment barriers for veterans (Vogt et al., 2014). Vogt et al., conducted a study of OEF/OIF veterans to address the extent of impact on self-stigma and attitudes towards mental health services. The results yielded less negative internalized beliefs than public stigma, however the participants also did not directly reject the beliefs. Many responded with neutral responses suggesting a need to research further about perceptions of negative self-beliefs (Vogt et al., 2014). This study did find significant connections of personal beliefs to substance abuse related mental health treatment. Overall, the negative beliefs were related to being less likely to seek treatment for mental health and substance abuse issues by OEF/OIF veterans, indicating selfstigma as a barrier to treatment (Vogt et al., 2014).

There has also been some indication of intersectionality of stigma and race and the impact seeking mental health services (Snowden, 2001; Wong, 2017). Yet, some recent studies have found an increase in willingness to seek mental health services across races (Wong et al., 2017). Wong conducted a survey of adults and found that irrespective of race or ethnicity, many supported that there was a high level of public stigma in association to people with mental health issues (2017). While some research has found little to no differences between races in their attitude, based on race alone, race and stigma may impact attitudes about seeking mental health services (Snowden, 2001; Wong, 2017).

Veteran Mental Health Issues

Research has supported an increase in suicides, posttraumatic stress disorder, traumatic brain injuries (TBI) and other mental health issues (DoD, 2019; Ganz, et al., 2021). Tanielian et al. (2008) utilized survey data to examine 31% of troops returning from Iraq and Afghanistan. The researchers determined that 11.2% had a mental health diagnosis of PTSD or depression, 7.3% experienced PTSD or depression and TBI, and 12.2% were diagnosed with TBI only. Consequently, approximately 300,000 OEF and OIF veterans were found to be suffering from PTSD or major depression, while about 320, 000 experience TBI (Tanielian et al., 2008). Parker et al. (2019) surveyed post-911 veterans and found that about 53% of deployed veterans reported negative impact to their mental health. TBI has presented at prevalent rates for the military population with 20% or more experiencing head injuries during time in the military (Bomyea et al., 2016). In a study of 49,626 patients of the VHA, researchers found that veterans with a history of TBI were more likely to die by suicide (Brenner et al., 2011). A cross-section comparison study of 85 veterans examined the presence of neuropsychiatric symptoms in groups. Poorer mental health outcomes were found to have significant association with mild to moderate TBI, particularly when accompanied by headaches (Bomyea et al., 2016). Higher rates of PTSD and depression have been noted in military populations with mild TBI (Bomyea et al., 2016; Jouzdani et al., 2014).

Post-Traumatic Stress Disorder (PTSD) has been present for some time within the veteran population. It is usually prevalent in individuals who have had some exposure to traumatic experiences. Given that the U.S. has engaged in continuous conflict for almost two decades, there is a high risk of PTSD among the increasing veteran population (Tanielian et al.,

2008; Inoue et al., 2021). Although not as commonly expected within the veteran population as PTSD, depression has accounted for up to 9% of appointments in ambulatory mental health networks (Inoue et al., 2021). There has been an increase from 11.4% to 15% of military members diagnosed with depression after deployments to Iraq or Afghanistan (Inoue et al., 2021). Parker et al. (2019) reported an increase in experience of posttraumatic stress (PTS) from 38% to 55% in combat veterans prior to and following 9/11. Suicide rates continue to increase more rapidly in the adult veteran population than the non-veteran adult population (CDC, 2021b.; U.S. Department of Affairs, 2019).

Currently, veteran suicides are the highest in history at a rate of over 6,000 deaths annually. Suicide prevention in the veteran population has become priority for the DoD and the VHA. A Presidential Executive Order was signed in 2018 to improve suicide prevention services for veterans (Inoue et al., 2021). Research has also found that suicide rates tend to be higher among males who have been at war during their younger ages (Rozanov, & Carli, 2012). Veterans with PTSD have been found to be more likely to endorse suicidal ideation when examining veterans of the Iraq Afghanistan War (Jakupcak et al., 2009).

Often present with mental health issues are substance use disorders (SUDs). Inoue et al. (2021) noted a study examining military personnel that cited approximately 30% of completed suicides and 20% of deaths due to high-risk behavior could be attributed to alcohol or drug use. Post-911 veterans have been found to be at high risk for co-occurring SUDs and mental health disorder (Pedersen et al., 2020). While research has found physical access to care to be less of a problem, many veterans still do not seek treatment for SUDs (Pedersen et al, 2020). A 2019 study of veterans across eras pre/post-911 reported that one-in-five struggled with SUDs (Parker et al., 2019).

Adequate treatment of these issues is imperative for veterans. Lack of treatment and addressing mental health and TBI exacerbates psychosocial components of veterans lives such as employment and stability and relationships with significant others and society. Additionally, these factors may contribute to engagement in high-risk behaviors which can be health threatening for veterans (Parker et al., 2019; Tanielian et al., 2008). The VHA continues to address structural barriers to mental health, including increasing providers and locations for access to services by veterans. Additionally, the DoD and VHA have increased training in evidence-based practices for providers (Taneilian et al., 2008). Despite such efforts, problems with PTSD, depression, TBI, and SUDs remain, as well as low utilization rates of services by veterans (Tanielian et al., 2008)

Chapter Summary

The review of literature indicated the continued need to address veteran's attitudes toward mental health services. Despite efforts to address barriers to mental health services such as access, stigma, education and training, the response of veterans to utilization of services remains low (DoD, 2019; Coll et al., 2011). Veterans have expressed that they believe mental health services to be helpful yet follow through with obtaining and maintaining the mental health services continues to be problematic (Miggantz, 2017; Seidman et al., 2018). Thus, this research aimed to add knowledge to this area by further examining veteran attitudes toward mental health services.

CHAPTER THREE: METHODOLOGY

The purpose of this study was to examine the relationship between veterans' attitude towards mental health services and (a) race, (b) gender, (c) era of military service (d) previous experiences with mental health as active-duty members or as veterans, and (e) education level. This chapter includes descriptions of participants, procedures and data collection instruments, and research design and data analysis.

Participants

The sample of participants was composed of self-identified U.S. veterans that had been discharged or released from the U. S. Armed Forces. More specifically they consisted of individuals that served on active duty in the Air Force, Army, Marine Corps, and Navy. Veterans that served in the National Guard, or Reserve units were additionally included because of a change in 2016 federal law. This change granted official veteran status to National Guard and Reserve members that deployed for a minimum of 180 days on active-duty orders and had not received a bad conduct or dishonorable discharge. Veteran status also was given to these individuals if they had served 20 or more years regardless of if they never were on active-duty orders for more than 180 days (Veterans Claims Insider, 2021). It is also important to note that some of these units often assist in sensitive missions prior to the arrival of main force and given the dangerous conditions, they are not immune from experiencing combat regardless of their Military Occupational Specialty (MOS). To further highlight the significance, National Guard and Reserve units comprised approximately 45% of all the Armed Forces sent to Iraq and Afghanistan. In addition, according to military.com, they made up slightly over 18% of the casualties suffered.

Data Collection Procedures

The researcher received approval from the Institutional Review Board (IRB) at the University of North Carolina at Charlotte to conduct the study. Upon approval from the IRB, participants were identified using social media and convenience sampling. Sources of recruitment included social media outlets and listservs (CESNET and diversegrad). Additionally, the researcher received approval to amend the IRB request to include permission to recruit from the university faculty, staff, and students, as well as research panels. Recruitment posts and emails were employed to inform prospective participants that the online survey was open for completion. The researcher sent recruitment emails and posts requesting participation on different dates. In addition to the sampling strategies previously mentioned, the researcher incorporated snowball sampling by asking willing veteran participants to forward the online survey to other veterans that met the inclusion criteria and were interested in participating. The inclusion criteria included classification as a U.S. veteran as defined by the U.S. Department of Veteran Affairs which consists of Veterans of Air Force, Army, Coast Guard, Marine Corps, Navy, National Guard, and Reserve.

Once participants reviewed the recruitment email and decided to participate in the study, they were able to proceed to the informed consent in SurveyShare. The informed consent stated the purpose of the study, participation criteria, benefits and risks of participating, participation was voluntary, and participant responses were confidential. Skip logic was applied to discontinue the survey if participants did not meet inclusion criteria. If the participant met the inclusion criteria and agreed to the informed consent, they were able to move forward to the survey components. The survey components included the Attitudes Towards Mental Health Treatment Scale (ATMHT) scale for the purpose of assessing their attitudes toward mental health services (Conner et al., 2010) and a demographics questionnaire created by the researcher.

SurveyShare was the Internet-based survey and questionnaire tool used to disseminate the survey and collect all data. While this Internet-based survey was an effective modality to collect data, it also resulted in limited responses (Dillman et al., 2009). To help increase the response rate, the researcher implemented the procedures previously mentioned and supported by Dillman and colleagues (2009). Participants were initially directed to the informed consent page of the survey. If the participants agreed to the informed consent, they were prompted to answer the qualifying question of whether or not they were veterans. Those responding yes were allowed to complete the survey. Those responding no were not permitted to complete the survey. Once the surveys were completed, the data was downloaded into a Microsoft Excel spreadsheet to be placed into Statistical Package for the Social Sciences (SPSS). Since there was no personal identifiable information collected, the data was stored in a secure Google drive folder of the primary researcher that aligned with university level two data storage guidelines. All collected data was retained securely on a password-protected drive.

Instrumentation

Data was collected via self-reported instruments. The data collection instruments included the Attitudes Towards Mental Health Treatment Scale (ATMHT) developed by Conner et al., (2010) along with a demographic questionnaire developed by the researcher. There was also an open-ended question option for participants to provide an additional written response of their choice at the end of the questionnaire.

Attitudes Towards Mental Health Treatment Scale (ATMHT).

The purpose of the ATMHT scale was to reflect a participant's attitude toward professional mental health services. This instrument is made up of two subscales which are

Beneficial Attitudes about Seeking Mental Health Treatment (BA) and Pessimism About Mental Health Services (PMS). This is a 20-item scale with a four-point Likert scale. For the purpose of this study, an "undecided" option was added, incorporating a 5-point Likert scale, ranging from "Strongly Disagree" (1) to "Strongly Agree" (5). The 5-point Likert scale included the addition of an "undecided" response to increase participant completion due to having a middle option (Revilla et al., 2013). The ATMHT scale is a modified version of the 29-item Fisher and Turner's Attitudes Toward Seeking Professional Psychological Help Scale (Conner et al., 2010). The modified version was created to update language, broaden inclusion of various types of mental health service providers and make items more culturally sensitive (Conner et al., 2018). The original scale identified only psychologists and psychiatrists as mental health professionals, while the ATMHT utilizes wording to incorporate a variety of mental health professionals for consideration by participants. Additionally, language modifications were made to the original scale to reflect sensitivity to gender identification and cultural awareness of unique attitudes of racial/ethnic minorities attitudes toward mental health (Conner et al., 2010; 2018).

The psychometric properties of the ATMHT scale were found adequate in a study with a sample size of 548 adult participants from a community-based setting (Conner et al., 2018). The researchers reported a coefficient alpha of 0.76 for internal reliability.

Beneficial Attitudes about Seeking Mental Health Treatment Subscale (BA)

The Beneficial Attitudes about Seeking Mental Health Treatment subscale (BA) measures level of beneficial attitudes about seeking mental health treatment. This is a 10-item subscale. The internal reliability for the BA subscale was reported to have a coefficient alpha of 0.84 (Conner et al., 2018). The higher the scores indicated a higher level of beneficial attitudes toward seeking mental health. The lower the score indicated lower beneficial attitudes toward seeking mental health treatment.

Pessimism About Mental Health Services (PMS)

The Pessimism Toward Mental Health Services Subscale (PMS) measures pessimism about seeking mental health treatment. This is a 10-item subscale. The internal reliability for the PMS subscale was reported to have a coefficient alpha of 0.79 (Conner et al., 2018). The higher the score the more pessimism there is for seeking mental health treatment services. The lower the score the lower the pessimism for seeking mental health treatment services.

Demographics Questionnaire

The researcher developed a 16-item self-report demographics questionnaire to obtain descriptive information about participants' gender, age, racial identity, level of education, military branch of service, era of service, and previous experience with mental health services. This questionnaire was presented to participants at the end of the survey. The format of the questionnaire consisted of a list of choices as well as the option to respond freely to questions.

Open-ended Question Option

The researcher provided an open-ended question to allow for participants to add further information. The question, "What other comments would you like to add?" was an effort to elicit further input on factors that participants perceived as impactful on attitudes toward mental health services.

Research Design

This study utilized a non-experimental correlational survey design to explore the relationship between veterans' attitude towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health and (e) education level. The non-experimental survey design was also useful because the researcher did not manipulate any variables, which limited the causal inferences that could be made from this research (Tabachnick & Fidell, 2007).

Research Questions

The following research questions were addressed in the study:

1. What is the relationship between veterans' beneficial attitudes towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level?
2. What is the relationship between veterans' pessimism towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level?

The researcher's *a priori* hypotheses were as follows:

1. White veterans would have a higher positive attitude towards seeking mental health treatment than nonwhite veterans.
2. Females would have greater positive attitudes towards seeking mental health treatment than males.
3. Veterans from most current era of service would have a higher level of seeking mental health treatment than those from eras occurring longer ago.
4. Veterans with previous counseling experience as an active-duty member would have a less positive attitude towards seeking mental health treatment than veterans without counseling experience.
5. Veterans with previous counseling experience as a veteran would have a more positive attitude towards seeking mental health treatment than veterans without counseling experience.
6. Veterans with higher educational level would have more positive attitudes towards seeking mental health treatment.

Data Analysis

Two multiple regressions were conducted to address the following research questions:

1. Does (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level impact veterans' beneficial attitudes toward mental health treatment services?
2. Does (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level impact veterans' pessimism toward mental health treatment services?

Multiple regression was selected for each analysis because it was the most appropriate for examining relationships between several predictor variables and an outcome variable (Tabachnick & Fidell, 2007). The data collected using SurveyShare was downloaded into the Statistical Package for the Social Sciences (SPSS) (Tabachnick & Fidell, 2007) for further screening.

Data Screening

The data was screened for missingness and outliers. Additionally, the assumptions of multiple regression were examined. Normality, multicollinearity, homoscedastic, and linearity were investigated. After screening the data and determining that all assumptions were tenable or that adjustments were needed, the researcher conducted standard multiple regressions to further analyze the data and determine the strength of the relationship between the predictor variables and the outcome variable.

Descriptive Statistics

Descriptive statistics were used to describe the characteristics of the participants. Frequencies and percentages were used to describe nominal level data. Means and standard deviations were used to describe continuous variables.

Standard Multiple Regression

Multiple regression is a popular technique used across disciplines to assess the relationship between one outcome variable and multiple predictor variables (Tabachnick & Fidell, 2007). Attitude towards mental health treatment services, both beneficial and pessimism, were the outcome variables for this study, and the predictor variables were gender, race, era of service in the military, previous experience with mental health, and education level. Each of the predictor variables were entered into the regressions to predict the relationship to veterans' attitudes toward mental health services.

Chapter Summary

This chapter outlined the research methodology for this study. The descriptions of participants, data collection procedures, and instrumentation were described. The research design, research questions, and hypotheses were also presented. Finally, the data analysis was addressed, to include screening, descriptive statistics, and the standard multiple regressions.

CHAPTER FOUR: RESULTS

The purpose of this study was to examine the relationship between veterans' attitude towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level. Two research questions guided this study. The first question was, what is the relationship between veterans' beneficial attitudes towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an activeduty service member or as a veteran, and (e) education level? The second research question was, what is the relationship between veterans' pessimism towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level? This chapter includes the results of this research study. First, the participant demographic results are presented. Next, reliability of the subscales utilized in the study is described. The following section describes the process of data screening. Next, the descriptive statistics for each variable are presented. In the final section, the results from multiple regressions are presented and the themes from the openended question were presented. A summary of the results is provided at the conclusion of the chapter.

Participants

Overall, 153 U.S. veterans participated in the study. Individuals that self-identified as Whites made up 56% (n = 86) of the sample, followed by 28% (n = 42) of African-Americans, two or more races was 9% (n = 14), other race was 3% (n = 4), and 1% (n = 1) identified as Hispanic/Latinx. Male veterans represented 77% (n = 118) of participants and the remaining 23% (n = 35) were female. Thirty percent (n = 46) of the veterans were between the ages of 2534, 26% (n = 55) were 55 and older, and 20% (n = 30) were between ages of 35 to 44. With

regards to the branch of service represented by veterans, 45% (n = 69) were Army, followed by Air Force with 18% (n = 27), Navy with 17% (n = 26), Marine with 16% (n = 24), Coast Guard with 4% (n = 6), and Other with 0.7% (n = 1) (See Table 1).

Eighty-eight percent (n = 134) of veterans identified as enlisted with ranks ranging from E-2 to E-9. The remaining 12% (n = 19) were officers with ranks ranging from 0-1 to O-7. The veteran participants also held a variety of Military Occupational Specialties (MOS) that included Logistics, Aircraft Mechanic, Combat Medic, Communications, Dental Assistant, Electronics, Healthcare Specialist, Infantry, Intelligence, Military Police, Recon Specialist, Transportation, and Vehicle Operations. The years of service indicated that 33% (n = 50) of veterans served 3-4 years, 31% (n = 47) served 1-2 years, 13% (n = 20) served 11-15 years, 11% (n = 17) served 1620 years, 9% (n = 14) served 5-8 years, and 3% (n = 5) served 9-10 years. Serving in combat or war zone is a challenge that many veterans have encountered over the past 20 years and within this sample 55% (n = 84) that had served in this capacity. In addition, 63% (n = 97) of veterans indicated they had seen a counselor or therapist for mental health services. However, while serving on active duty, 68% (n = 105) reported they never received mental health treatment. It is important to further note that 49% (n = 75) indicated they felt the need to see a counselor or therapist, 46% (n = 71) reported this service was not needed, and 5% (n = 7) responded they were unsure. In reference to the additional predictor variables, participants who served during the era of September 2001 and later comprised 51% (n = 78) of the sample while those who served prior to this era comprised 49% (n = 75) of the sample. The education level for participants consisted of primarily of 2- or 4-year college degrees (42%, n = 64), graduate or professional degrees (31%, n = 47), and high graduates or some college (28%, n = 43).

Table 1 *Demographics of Participants*

Variable		Number of Responses (*N*=153)	Percentage
		n	%
Race or Ethnicity			
	American Indian/Alaskan Native	1	7
	Asian	5	3
	Black/African American Hispanic/Latinx	42	28
	Native Hawaiian/Pacific Islander	1	1
	Nonresident Alien	0	0
	White	0	0
	2 or more races Other	86	56
Gender		14	9
	Female	4	3
	Male		
Age			
	18-24	35	23
	25-34	118	77
	35-44		
	45-54	8	5
	55 and older	46	30
Era of Service		30	20
	September 2001 or later	29	19
	August 1990 to August 2001	40	26
	May 1975 to July 1990		
	August 1964 to April 1975		
	February 1955 to July 1964	78	51
	July 1947 to June 1950	10 3	13
	More than one era	10	7
Previous Mental Health Experience		3	7
	As Active-Duty Service Members As a Veteran	1	2
		30	1
Education Level			20
	High School and Some College	48	
	2-Year or 4-Year Degree	97	31
	Graduate or Professional Degree		63
		42	
		64	28
		47	42
			31

Instrument Reliability

This section provides the reliability of the subscales used in the study. Cronbach's alpha (α) of internal consistency was used to assess the reliability of each subscale, Beneficial Attitudes About Seeking Mental Health Treatment and Pessimism Towards Mental Health Services. The reliability of each subscale ranged from .545 to .784.

Data Screening

The Statistical Package for Social Sciences (SPSS) software 27 was used to screen the data. Data were screened for missing values, outliers, normality, and multicollinearity. Additional assumptions for multiple regression were considered and examined before conducting the data analysis. These assumptions included linearity and homoscedasticity of residuals, both of which were analyzed through scatterplots.

Missing Values

Based on the report of incomplete responses generated through SurveyShare, a total of 163 participants began the survey but not all completed the questions or were not eligible for inclusion in the study. This study included a rule-out question which provided the option for participants to select yes or no for veteran status. If the participant selected yes, they could continue to the survey. If they responded no, the participants did not meet criteria and were not allowed to continue the survey. Nine participants did not meet the criteria and were removed from the data set. Deletion of the nine participants left a total of one incomplete response to the survey. This participant did not respond to the demographics questionnaire and was deleted as the demographics questionnaire was utilized to provide data on the independent variables. The total participants included in the final set of data was 153.

Outliers, Normality, and Multicollinearity

The distribution of the data was examined through SPSS and screened for univariate outliers. The no outliers were detected within the data set. Skewness and kurtosis of the data were evaluated to determine whether or not the assumption of normality was violated. As the values for skewness and kurtosis coefficients were not above 1 nor below -1, no presenting issues regarding the normality of the data were found. An additional conduction of the ShapiroWilk test yielded nonsignificant results for both the BA and PMS subscales, indicating a

normal distribution. Multicollinearity determines whether or not variables are highly correlated or an ideal combination of one another (Tabachnick & Fidell, 2007). Assumption testing was conducted to identify whether issues regarding multicollinearity existed among the variables. The variation inflation factor (VIF) for each variable was less than 10 indicating no presenting issues related to multicollinearity (Hahs-Vaughn, 2017).

Descriptive Statistics

The following section presents the correlation coefficients and other descriptive statistics. The correlation coefficients among the variables are shown in Table 2. All categorical variables were dummy coded. Race was coded white (1) and nonwhite (0) in order to create more equal sample sizes from the overall sample. Gender was coded to female (1) and nonfemale (0) to quantify the nominal data for analysis. To create more equal sample sizes, era of service was dummy coded to SeptandPost (1) which represented individuals who served during and after September 2001, and BeforeSept (0) which represented individuals who served in eras prior to September 2001. Previous mental health experience was coded as two binary variables, veterans with mental health service as active-duty service members (ADmhserv) and veterans with previous mental health experience as veterans (VAmhserv). These binary variables were coded as ADmhserv (1) representing veteran who had previous mental health experiences as activeduty service members and NoADmh (2) representing veterans who had no previous mental health experiences; VAmhserv (1) representing veterans with previous mental health experience as veterans and NoVAmh (0) representing veterans with no previous mental health experience as veterans. Education level was coded to into three groups to create more equal samples sizes. These groups were HSsc (1) representing individuals with high school degrees and some college, 2Year4Year (2) representing individuals who held either a 2-year or 4-year college degree, and

Graduate (3) representing individuals who held graduate and professional degrees.

Most of the correlation coefficients between the outcome variables and predictor variables were nonsignificant and below .20.

Table 2 *Pearson Correlation between Predictors, BA Subscale and PMS Subscale*

Variable	BA	PMS	White	Female	SeptandPost	ADmhserv	VAmhserv	EdLevel
BA	1	.640**	.207*	.018	.069	-.023	.158	.142
PMS		1	.048	.010	.006	-.022	.023	.120
White			1	.010	-.049	.086	.177*	.120
Female				1	.067	.135	.026	.160*
SeptandPost					1	.212**	.232**	-.049
ADmhserv						1	.426**	.135
VAmhserv							1	.026
EdLevel								1

Note: *p < .05, **p < 0.01

Table 3 reports the means, standard deviations and ranges for BA and PMS by race, gender, era of service, previous mental health experience, and education level. To assess beneficial attitudes toward mental health treatment, participants (N = 153) completed the BA Subscale. The BA Subscale was comprised of 10 questions on a five-point Likert scale. The Likert scale ranged from Strongly disagree (1), Disagree (2), Undecided (3), Agree (4), and Strongly Agree (5). Higher scores on the BA Subscale indicated more positive attitudes towards seeking mental health services. There was little difference between participants' average scores and most expressed neutral attitudes towards mental seeking mental health services (M = 36.77, SD = 4.32). To assess pessimism toward mental health treatment, participants (N = 153) completed the PMS Subscale. The PMS Subscale was comprised of 10 questions on a five-point Likert scale. The Likert scale ranged from Strongly disagree (1), Disagree (2), Undecided (3), Agree (4), and Strongly Agree (5). Higher scores on the PMS Subscale indicated more pessimism towards seeking mental health services. There was little difference between

participants' average scores and most expressed neutral attitudes towards mental seeking mental health services (M = 35.35, SD = 5.67).

Table 3 *Descriptive Statistics for Variables*

	Variable	*M*	*SD*	N	Minimum	Maximum
BA	White	36.77 37.56	4.32 4.34	153	24	48
	Female	36.91 37.06	3.72 4.40	86	27	48
	SeptandPost	37.29 36.63	4.42 4.63	35	31	45
	VAmhserv	36.77 35.35	4.32 5.67	78	24	45
	ADmhserv	37.56 35.46	5.93 5.73	97	24	48
	EdLevel	35.38 35.45	5.76 6.24	48	24	48
		35.17	6.26	153	24	48
PMS	White	35.35	5.67	153	19	48
	Female			86	20	46
	SeptandPost			35	23	45
	VAmhserv			78	22	48
	ADmhserv			97	19	48
	EdLevel			56	20	48
				48	19	46

Note: BA = Beneficial Attitudes Towards Seeking Mental Health Services; PMS = Pessimism Towards Seeking Mental Health Services; White = Race and whites verses nonwhites; Female = Gender and females verses nonfemales; SeptandPost = era of military service and service time from September 2001 and following; ADmhserv = previous mental health services as an activeduty member; VAmhserv = previous mental health services as a veteran; EdLevel = education level

Multiple Regression

Two standard multiple regressions were conducted to examine the following research questions: (1) What is the relationship between veterans' beneficial attitudes towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level?; (2) What is the relationship between veterans' pessimism towards mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level?

Research Question 1

The first research question examined the outcome variable of beneficial attitudes towards mental health service. The results of the multiple regression are below. The unstandardized regression coefficients (*B*) and intercept, standardized regression coefficients (β), and semipartial correlations (sr_i), *t*-values, and *p*-values are reported in Table 4. The variance accounted for (R^2) equaled .085 (adjusted $R^2 = .047$), which was different from zero ($F_{(6, 146)} = 2.260$, $p = .041$). For this model, only one of the six predictor variables, White, was statistically significant and directly related to beneficial attitudes toward mental health treatment. These findings suggest that after controlling for all other predictor variables, White individuals are more likely to have more beneficial attitudes toward seeking mental health treatment than nonwhite individuals.

Table 4 *Multiple Regression Evaluating Predictors of Beneficial Attitudes for Seeking Mental Health Services*

IV's	*B*	*β*	sr_i	*t-value*	*p-value*
White	1.55	.18	.17	2.20	.03
Female	.061	.01	.01	.074	.94
SeptandPost	.672	.08	.078	.94	.35
VAmhserv	1.34	.15	.14	1.65	.10
ADmhserv	-1.16	-.12	-.12	-1.40	.16
EdLevel	.630	.11	.11	1.37	.17

Note: White = Race and whites verses nonwhites; Female = Gender and females verses nonfemales; SeptandPost = era of military service and service time from September 2001 and following verses those serving prior to September 2001; ADmhserv = previous mental health services as an active-duty member; VAmhserv = previous mental health services as a veteran; EdLevel = education level.

Research Question 2

The second research question examined the outcome variable of veterans' pessimism towards mental health services. The unstandardized regression coefficients (*B*) and intercept,

standardized regression coefficients (β), and semi-partial correlations (sr_i), *t*-values, and *p*-values for model two are reported in Table 5. The variance accounted for (R^2) equaled .019 (adjusted R^2 = .029), which was different from zero ($F_{(7, 145)}$ =.395, *p*=.90). For this model, none of the predictor variables was statistically significant and directly related to pessimism towards mental health treatment.

Table 5 *Multiple Regression Evaluating Predictors of Pessimism for Seeking Mental Health Services*

IV's	*B*	*β*	sr_i	*t-value*	*p-value*
White	.374	.03	.03	.289	.70
Female	.-.074	-.01	-.01	-.065	.95
SeptandPost	.244	.02	.02	.251	.80
VAmhserv	.216	.18	.02	.197	.84
ADmhserv	-.513	-.04	-.04	-.456	.65
EdLevel	.876	.12	.12	.118	.17

Note. White = Race and whites verses nonwhites; Female = Gender and females verses nonfemales; SeptandPost = era of military service and service time from September 2001 and following verses those serving prior to September 2001; ADmhserv = previous mental health services as an active-duty member; VAmhserv = previous mental health services as a veteran; EdLevel = education level.

Content Analysis of Open-ended Question

The final question was open ended and gave participants the opportunity to voluntarily share additional comments. A total of 33% (*N* = 54) responded and four themes appeared to emerge from the responses that reflect stigma, military leadership, training of mental health counselors, and hope.

Stigma

Elements of stigma was a powerful theme that was revealed by numerous veterans. According to Miggantz (2017) there are a number of factors that impact stigma for veterans that

include previous experience seeking mental health services, possible negative consequences of acknowledging mental health issues, and attitudes of higher-ranking officers. For example, one response stated, “Sometimes units will look at you in a different light if you mention seeing a mental health professional”. Another veteran stated “While I am a strong proponent for the mental health profession, I know several active-duty Navy members who are not open to the mental health profession for fear of retribution, associated stigma, etc.” A third veteran highlighted the impact of stigma by responding:

> There is a stigma in the military that seeking mental health assistance will have a detrimental impact on one's career and promotional opportunities. Though there have been tremendous strides in addressing this perception since I retired in the early 2000s there still is this lingering apprehension among military members that seeking mental health assistance equates to the end of one's career.

Military Leadership

The role of military leadership was also an emerging theme among participants. Tsai, et al. (2014) reported on the importance of support from leadership within the military to seek support as a potential way to increase positive mental health seeking behaviors from veterans. Negative perceptions and experiences related to leadership and mental health can pose ongoing challenges and inevitable negative consequences for veterans who do not seek mental health services. One participant shared:

> While serving, I never considered seeking mental health treatment. I witnessed a mass casualty event (over 20 killed in a plane crash), a shooting (one friend killed), and multiple fatalities during training events. At no point did I ever consider seeking mental

health treatment. Doing so would have been considered weakness and would have jeopardized my ability to get a top-secret clearance.

Despite the implementation of command consults to promote help seeking behaviors for mental health issues, veterans still believed they would be penalized regardless of the outcome (Ghahramanlou-Holloway et al., 2018; Vogt et al., 2014). Additional comments expressed support for this belief. They included "I would say most reasons veterans don't get help is because there always seems to be a negative effect afterwards. For me I thought seeking help would make me a better soldier, however it just ended my career." Additionally, some comments directly address the role of leadership specifically in addressing mental health issues.

> Mental health options for veterans are directly affected by Leadership attitudes and the specific environment. Some duty locations, organizations, or even career fields still have negative connotations and attitudes towards mental health professionals and treatment. Some even to a point of punishing (unofficially) those who seek mental health support.

Another veteran added:

> I believe mental health with veterans is seen as a hard subject due to the way higher command treats it while you're in, multiple people I served with committed suicide and I remember higher ups saying "we should throw them a party because they got what they wanted and we got rid of a weaker link" the problem begins while veterans are serving, not after.

These views align with study findings by Britt et al., that officers were more likely to endorse barriers to getting treatment for mental health symptoms, endorsed the beliefs of symptoms going away on their own, and endorsed the preference for managing problems on one's own (Britt et al., 2020). With little perceived support from direct leadership, junior ranking personnel

are less likely to seek help for mental health issues and may even internalize these beliefs as guiding values that accompany them as veterans.

Training of Mental Health Counselors or Perceptions of Treatment Received

When working with the veteran population, it is important to the get to know the unique needs of this culture. For this reason, many service members and veterans may prefer a counselor or therapist who has acquired some military experience (Johnson et al., 2018). The following comment attests to this sentiment, "The issue I had with a therapist was the girl was younger than me and had never actually served in the military so I had a hard time believing that she can understand the things that I went through as a female in the military. I did find it helpful to talk to her somewhat but for me it was the time and distance I had to travel to get to her." Veterans in study expressed concern about the ability for therapists to effectively counsel veterans and military personnel, stating, "counselor or therapist would need a top-secret clearance to effectively counsel military personnel" Another shared:

> Veterans may not feel comfortable seeking mental health services due to sharing harrowing experiences with someone that has no previous experience (farther than the possible child of military or dependent) -Therapies only last for a handful of sessions whereas some issues that people suffer from may require longer.

Others expressed concern about the effectiveness of the services they had received or would receive in therapy. One stated, "Most mental health counselors do not spend enough time to make the patient comfortable. That way the patient would open up. Most people will not open up if they're not comfortable." Others wrote, "All they wanted me to do was track my sleep cycle for a few weeks and then talk about it…complete waste of time!" and "Veterans don't trust the mental health community because it is wildly inconsistent, and frequently unhelpful." These concerns about treatment should be considered and implemented into training for mental health

professionals, specifically civilian professionals. It is important to utilize evidence-based practice as they have been shown to improve recovery rates in certain mental health and substance-use conditions.

Hope

An additional emerging theme centered around hope. Some veterans expressed openness to mental health efforts and acknowledged the positive changes that have occurred. One person commented, "I am glad that mental health issues are taken serious these days. Many years ago people were thought of as soft for seeking mental health which is far from the truth". Another individual shared:

I've lost more vet friends to suicide than combat. I lost ten years of my life, a marriage, and $500k+ because of ptsd, depression, anxiety, and self-medicating with drugs. I firmly believe in therapy, MAT, etc. I wish the VA had helped me sixteen years ago. They have gotten a lot better. Lots of work still needs to be done as not all service providers (clinicians, psychologist, psychiatrists, etc) are created/trained/functioning. Similarly, another veteran committed, "One of the greatest assets I have had in my life was mental health care."

Despite the many enduring issues related to seeking treatment, some veterans remain open to the thought of seeing someone for help. This notion is supported by the following statement, "I think seeing a therapist needs to be considered more in our community." Although veterans seem to underutilize services, these comments imply that some are insightful about the uniqueness of their challenges and open to mental health services for help with such challenges. This feedback is encouraging, given the importance of attitudes and beliefs on intention to seek and maintain mental health services (Conner et al., 2018).

Chapter Summary

The purpose of this study was to explore the relationship between veterans' attitudes toward mental health services and (a) race (b) gender (c) era of service in the military, (d) previous experiences with mental health as an active-duty service member or as a veteran, and (e) education level. This chapter describes the results of the study. First, the reliability of each subscale was presented. Second, the descriptive statistics of the data were described. Lastly, the results from each multiple regression and open-ended question were provided.

The BA Subscale was statistically significant but only at approximately 8.5%. There was statistical difference between white and non-white supporting a direct relationship between white individuals and beneficial attitudes toward mental health treatment. On average, whites scored 1.5 units higher than nonwhites on the BA subscale, indicating that white individuals are more likely to have more positive attitudes toward seeking mental health services. As a whole, the six variables account for only 8.5%, leaving 92% of the variance unaccounted for with the BA Subscale. Gender, era of service, previous mental health experiences, and education level were insignificant in relation to beneficial attitudes. There were not statistically significant findings for the PMS subscale and predictor variables.

Written responses to the open-ended question provided further elaboration from participants in reference to attitudes toward mental health. Four themes emerged from the responses: the continued existence of stigma, the impact of military leadership, training of mental health counselors, and a sense of hope. Participants shared that stigma continues to be relevant in relation to mental health. Stigma often begins during active-duty. The reinforcement of stigma through military leadership impacted attitudes toward seeking mental health. However, there was indication of knowledge and sense that mental health services can be helpful with more training for providers and addressing stigma within the military among those in leadership.

This indicated hopeful attitudes of veterans toward mental health services.

CHAPTER FIVE: DISCUSSION

This research study examined the relationship between veterans' attitudes towards mental health services and (a) race, (b) gender, (c) era of military service (d) previous experiences with mental health as active-duty members or as veterans, and (e) education level. The results of this research study are addressed in this chapter. This chapter presents the results of the study, the limitations of the study, and the implications of the findings. Lastly, recommendations for future research and concluding remarks are discussed.

Discussion of Results

Discussion of the Demographic Data

Although there is diversity within the U. S. veteran population, there was underrepresentation in the sample for this research. Most of the participants were white (56%) and male (77%). These demographics, however, align with the most recent national demographics of the U.S. (U.S. Department of Veteran Affairs, 2021). In addition, most of the sample served in the September 2001 or later era. Twenty percent of the participants served during more than one era. While the largest living groups of veterans in the U.S. today are from the Vietnam Era, the September 2001 and Post Era hold the youngest veterans which may be more highly represented in this survey research (Vespa, 2020). A total of 98% of veterans reported some previous experience with mental health services, with 63% receiving services when they were veterans and 31% receiving services when they were active-duty service members. The highest number in level of education was individuals with 2- and 4-year degrees (42%), second was individuals with professional degrees (31%), and last was individuals with high school diplomas or some college (28%). This does align with the census data reporting that the most recent veterans have the highest levels of education among all veteran groups, thus

being representative of education level among veterans (U.S. Census Bureau, 2020). Thus, the sample is mostly representative of the veteran population in the United States.

Discussion of Multiple Analysis

Multiple regression analysis was used to assess the relationship between beneficial attitudes toward mental health treatment and (a) race, (b) gender, (c) era of military service (d) previous experiences with mental health as active-duty members or as veterans, and (e) education level. Multiple regression analysis was also used to assess the relationship between pessimistic attitudes toward mental health treatment and (a) race, (b) gender, (c) era of military service (d) previous experiences with mental health as active-duty members or as veterans, and (e) education level.

Beneficial Attitudes Toward Mental Health Services and Race

The results of this study concluded a significant relationship between whites and beneficial attitudes toward mental health services. This was the only significant finding in the study. Whites comprised over 56% of the participants for this study. Previously established data has supported that whites have typically utilize and maintain mental health services more in general than other races (American Psychiatric Association, 2017; Spoont et al., 2017; Terlizzi, & Zablotsky, 2020). For this study, whites were compared to one group comprised of several races considered to be minorities. Several factors should be considered with these findings. Initially, collapsing the groups together increases the probability of missing findings unique to specific groups. For example, Koo et al., surveyed OEF/OIF veterans only, and concluded that minorities utilized mental health services at a slightly higher rate than whites. However, further examination within specific racial groups supported that the frequency of use of services was not as significantly different as the type of services utilized by ethnic groups in the study (Koo et al., 2015). Additionally, the American Psychiatric Association (2017) reported differences among

the most frequently utilized types of services by racial groups. American Indian/Alaska Natives and people who identified as two or more races were likely to utilize outpatient type services. Blacks and people of two or more races utilized inpatient services more frequently while Asians utilized mental health services less frequently than any other group. Thus, consideration of types of services should be examined in conjunction with this finding. Further, it is imperative to access minority populations for research, given that the percentage of non-Hispanic white veterans is projected to decrease from 74% to 61% over the next twenty years. Black veterans are projected to increase from 12% to 15 % while Hispanic veterans will increase from 8% to 12%. In addition, there are projections of growth within additional minority races with the largest projection of 1.8 in those veterans of multiple races (U.S. Department of Affairs, 2020). Additionally, studies have not been conclusive about the impact of stigma and race, however public stigma about mental health has been identified as significant across races and still prominent within the minority veteran groups (APA, 2017; Wong, 2017; Vogt et al., 2014). Additionally, minority veterans have a higher probability of developing PTSD than whites. This can be attributed to a number of factors, however the likelihood of exposure to military related trauma has been higher for minorities (Department of Affairs, 2017). PTSD has been cited as one of the ten most prevalent formally identified disabilities for minorities by the Minority Veterans' Report (Department of Affairs, 2017). Also, psychosocial difficulties such as homelessness, awareness of available benefits, and comorbid issues such as chronic disease have been found to be more predominantly present in the minority veteran population. Despite the availability of vast services for minorities through the VHA, racial disparities persist in these areas (Department of Affairs, 2017). While the number of minority veterans utilizing VHA benefits or services continues to grow, it has been noted that minority veterans continue to utilize

health care benefits at a lower rate than non-minority veterans, this includes mental healthcare services (APA, 2017; U.S. Department of Affairs, 2020; Department of Veterans Affairs, 2017).

Pessimistic Attitudes Towards Mental Health Services and Variables.

There were no significant findings on this scale. There were some slight differences in scores among the sample. More white individuals expressed pessimistic attitudes. This may suggest need for further exploration within groups as found by Muralidharan et al. (2016). They discovered no significant difference in how attitudes of veterans were impacted between whites and minority groups but did find informative in-group differences. Females were slightly higher on the pessimistic scale as well which may be reflective of the continued concerns about addressing needs that are unique to women veterans such as reproductive health issues (Cheney et al., 2018; Hoffmire & Denneso, 2018). While women may present for treatment for various reasons including insurance coverage and low healthcare cost, pessimism about the effectiveness of treatment may still be present. Although, women continue to follow through with treatment more than their male counterparts, this indicates still some negative perception of services. The era of service was almost identical in terms of pessimistic attitudes. While the majority were from September 2001 or later, the next highest specific groups represented the Gulf War era and Vietnam era. This may be an indication of some impact of experiences with combat and trauma on veteran perceptions of mental services (Vespa, 2020). Veterans with no previous mental health services scored slightly higher on average than those who had experienced previous mental health services, highlighting the importance of utilization of services to further promote more involvement with mental health services (Miggantz, 2017; National Academy of Sciences, 2018; Terlizzi & Zablotsky, 2020). Active-duty members may have less choice in interaction with mental health services than veterans, supporting the higher percentage of receipt of mental health services. However, veteran perceptions of services could be impacted by previous

experiences with mental health services while serving active duty. Individuals with 2- and 4Year degrees also expressed more pessimistic attitudes on average in comparison to their counterparts on this scale. This may be related to the high number of more recent veterans in this category. This group is the September 2001 and post group who have high probability of exposure to trauma and are also younger in age (Belo et al., 2020; Raghupathi, & Raghupathi, 2020). It is important to further explore the relationship of education to attitudes toward mental health services.

Additionally, the qualitative data suggests that attitudes toward mental health may need to be considered on a continuum and within context. Statements represented some hopefulness and willingness to seek treatment services, while others suggested concerns about the quality and effectiveness of services. Receipt of mental health services as active-duty service members was heavily related to perceived systemic barriers and discouragement. However, post-service related comments implied that focus on enhancing and informing mental health service providers is desired by veterans, which in turn supports openness to mental health services.

Qualitative Data and Variables.

Although enough significance was not present for application to the population overall some potential differences among variables were also noted. While women did not fair statistically greater than males, they scored slightly higher than males which is similar to Britt et al.'s findings (2020). Females and males did not have strong differences, yet females tended to endorse the negative items on surveys about attitudes less than male counterparts. While literature still supports less utilization of mental health services by men than women, intention to seek mental health services or more open attitudes toward mental health services may be present in both groups (Terlizzi & Zablotsky, 2020; Sagar-Ouriaghli et al., 2019). Although the majority of the sample served from September 2001 forward, there was again, very little difference in the

average scores for the subscale. Given the increased risk of mental health issues due to higher exposure to combat and trauma, this may indicate that attitudes are not as increasingly negatively impacted. A 2017 survey by the Committee to Evaluate VA Mental Health Services documented that veterans from September 2001 and following represented the highest era enrolled in VHA services (National Academy of Sciences, 2018). This suggests some intent to seek mental health services at some point after transition, among the most current cohort of veterans. In relation to previously experienced mental health services, those who had received prior services as veterans and active service members averaged slightly higher in more positive perception of mental health services than those who had never received mental health services. This may indicate that barriers to seeking treatment, such as stigma, become less impactful the more that treatment is experienced by veterans (Miggantz 2017; Terlizzi & Zablotsky, 2020). Additionally, individuals with higher levels of education espoused more positive attitudes towards mental health services which is also suggested by research. Higher education in general often positively impacts psychosocial factors such as occupation, socioeconomic status, relationships with others, and additional areas (Belo et al., 2020; Raghupathi, & Raghupathi, 2020). In turn, self-care and seeking out of health services may be indirectly associated with higher education due to the impact on psychosocial factors. Much of this research's findings parallel that of civilian society, which may offer some indication of more successful transitioning of veterans, although still with concerns to address.

Contributions of the Study

This research study is one of the first to examine the veteran population utilizing the Beneficial Attitudes Toward Mental Health Treatment Subscale and the Pessimistic Attitudes

Toward Mental Health Treatment Subscale from the Attitudes Toward Mental Health Treatment Scale (Conner et al., 2018). As this population is considered a culture within itself, it is important to conduct research specific to this group and mental health. The results from this study provide insight and implications about working with veterans and mental health to important stakeholders such as mental health practitioners, medical professionals, community organizational providers, and families.

Additionally, the results from this research expand the current literature about mental health attitudes, veterans and areas related to mental health (CDC, 2021; Igielnik, 2019; The Military to Civilian, 2018). This study reinforces empirical findings of whites seeking mental health services more than minorities. This is important given that it highlights the need to intentionally target more diversified samples from the population to gain more generalizable information. This study also promotes new avenues to explore veteran responses qualitatively for a broader picture and assessment of needs related to this group. The qualitative data suggests that more positive attitudes may be held by veterans, there is openness to mental health but concern about competence of providers and effectiveness of services. This indicates the need to further explore the treatment that is provided to veterans and how outcomes are measured. Attitudes may play as lesser role than the type of service delivery (outpatient, inpatient, community) and treatment selection. Addressing these areas may be just as significant for increasing veteran behavior of seeking and maintaining treatment services.

Limitations of the Study

The limitations of this study are presented here. One limitation includes the likelihood of social desirability with the use of the survey format to gather self-reported responses. Although participants were informed of anonymity and confidentiality, participants may have responded in a manner that they perceive as favorable to the researcher due to the content of the survey items.

Secondly, while there was some minority representation, there was not enough participants within each individual racial group for unique comparisons. Minority groups were collapsed into "non-whites" group and compared with "whites". This is a limitation due to the loss of specific information unique to each group and lack of conclusions about races other than whites. The same application was necessary for era of service and education level, prohibiting the gathering of information about specific groups other than the majority. Third, there may be potential bias in the survey responses as individuals who participated may be more motivated overall to complete the surveys on this topic. They may have an interest in the topic or be drawn to the topic for specific reasons which could in turn, possibly impact the data. Fourth, there was a lack of diversity among the participants with white males vastly outnumbering other participants, including females only. A more diverse sample size may have generated different results. Lastly, there was a low reliability score for the Beneficial Attitudes Toward Mental Health Subscale for this research. While Conner, et al. (2018) reported a coefficient alpha of .84 in the study with the subscale, this study yielded a coefficient alpha of .54. The general recommendation for an instrument is a coefficient alpha .7 or higher (Hahs-Vaghn, 2017). This presents a question to the trustworthiness of the significance of race. The addition of the "undecided" option to the survey also needs to be revisited. The addition of more categories invites more personal interpretation (Revilla et al., 2013). This study may need to be completed again with a four-point Likert scale to hopefully limit variation of interpretation among participants.

Implications of the Findings

This research study expands the existing literature about relationship between veteran's attitudes toward mental health services and (a) race, (b) gender, (c) era of military service (d) previous experiences with mental health as active-duty members or as veterans, and (e)

education level. The results of this study present implications for counselors, mental health professional organizations, veteran-affiliated healthcare organizations and the community.

An interesting finding from this research is the correlation between the two subscales. While one would expect there to be a negative correlation, the data from the survey results indicated a positive relationship between beneficial attitudes toward seeking mental health and pessimism about mental health. It is important to take into consideration that the scales are not specifically defined as optimistic verses pessimistic attitudes (Conner et al., 2018). The results indicate that one can have the desire or openness to receiving counseling and still remain pessimistic about aspects of mental health services, such as the effectiveness of the treatment. The lack of significance between the outcome variables and predictor variables, except for whites in the race variable, may be directly linked to the positive correlation between the scales. Most responses to the open-ended question indicated knowledge about mental health services and some implication that veterans felt mental health services could be helpful for them. Veterans shared that they wish they had been encouraged to openly seek mental health services and counseling for any issue, not just severe issues such as those related to lethality. Some expressed direct openness to seeking mental health treatment and regret for not having pursued mental health treatment as active-duty member and veterans. Only one response labeled mental health services as a "complete waste of time". However, there were several behavioral beliefs and subjective beliefs presented that impacted behavioral follow through to receiving services.

Behavioral and subjected beliefs presented by participants varied but primarily supported the expectation of negative outcomes for seeking and/or receiving mental health services (Ajzen, 1991). A primary perceived consequence was the risk of being viewed as weak by leadership and peers for seeking help. Many confirmed the ongoing existence of this stigma as a barrier to voluntarily seeking help even when they felt the need or desire. Additionally, veterans feared the

loss of security clearance and jobs as a result of seeking mental health services. One veteran responded thinking that seeking help would result in being a better soldier but only ended his/her career. Two others shared about being informed that their mental health issues would result in imminent separation from their jobs, leading them to seek different diagnoses. Several veterans stated that the stigma continues to be strong among the veteran population, fearing retribution, loss of benefits and other negative consequences for mental health services (Vogt et al., 2014). Negative beliefs about personal outcomes from completing the behavior of obtaining mental health services, as well as the strong influence of the negative perception held by peers and those in leadership may impact the help seeking behaviors (Ajzen, 1991). If those beliefs about consequences are positive, there will be more likelihood to carry out the behaviors. The subjective norms representative of the military culture, as shared by this sample's responses, indicated less social pressure from military leadership to seek help. More than three participants disclosed being discouraged to take time for appointments, as well as scrutinized for the type of appointments. Thus, there seemed to be high motivation to comply with not seeking mental health services which was perceived as the norm of the military culture (Ajzen, 1991; Kulesza et al., 2015; Sharp et al., 2015, Vogel et al., 2006). Perceived control over behaviors can be considered as well. This component in the theory of planned behavior directly impacts the likelihood of repetitive behaviors. Participants' comments related to this component included the difficulty in initially navigating veteran services. However, some veterans stated that the services are plentiful and helpful, after this time and if the services remain available. Veterans may endure uncertainty about finances, healthcare and other issues during this time. As such, they may utilize active-duty perceptions or knowledge to help them with transitioning, invoking the warrior mentality to cope with situations and provide a sense of familiarity (Cheney et al., 2018; Hester, 2017, Moore, 2017). Unfortunately, this can be detrimental as one veteran shared about

not seeking mental health services in order to avoid being the "broken" veteran who could not transition back into civilian society. Again, veterans express feeling that mental health services would be beneficial but still do not initiate or continue to engage in mental health services as a result of pessimism about outcomes. Despite the negative behavioral and normative beliefs and perceived control, the notion or belief that mental health services would be beneficial to one's wellbeing exists. In fact, hindsight and reflection by veterans about these barriers as active-duty members support the presence of both beneficial attitudes and pessimism at the same time. This is important to consider in assessing the relationship between attitudes and the independent variables in this study. Given that there were no significant relationships found yet there was some correlation between the scales, the focus of research on attitude toward seeking mental health may need to be reconsidered or expanded to address the perceptions of outcomes of treatment.

For example, previous research has indicated that different races utilize different types of services at varying rates to address mental health issues (APA, 2017; Koo et al., 2015). Types of services may range from traditional outpatient to inpatient treatment, as well as psychotherapy only to the inclusion of psychotropic therapy. Additionally, the important aspects of therapy may differ to different ethnicities. For example, some research found that the perception of how much a therapist cared for the client was most important within the Hispanic group (Koo et al., 2015). Gender may also be related to chosen of mental health service types. One female participant in this study verbalized feeling that civilian counselors took more time to listen which was viewed as having a better understanding of the female veteran culture. She expressed more openness to civilian outpatient services, as the approach aligned more with her unique needs as female and a veteran. Another veteran shared that therapists either place veterans "on a pedestal or treat them like they are damaged" while therapists from different generations tend to "mirror reflect the

veteran's experiences". This may suggest further need to explore generational differences such as eras served and ages and the relationship to mental health services. Such statements imply the need for more culturally informed mental health awareness and training for professionals who work with the veteran population (Botero Jr. et al., 2020; Johnson et al., 2018; Tanielian et al., 2018). The veteran's perception of mental healthcare providers plays a significant role in treatment outcomes as it directly impacts the veteran buy-in to the process, commitment to treatment, as well as efficacy in the veteran (Bandura, 2011; Johnson et al., 2018; Spoont et al., 2017). Counselors must take note of these concerns given that it is the client's perception of the counseling process that relates primarily to the outcomes. Counselors have the ethical responsibility to provide effective and informed services. It is also imperative that counselors are able to demystify the process for veteran clients to strengthen the therapeutic relationship, encourage voluntary veteran participation in therapy and maintain veteran commitment to therapeutic services for an adequate length of time to experience change. Thus, it is imperative that counselors seek ongoing training to help with this unique culture (American Counseling Association, 2014). Some of this study's participants shared the belief that civilian counselors could not be equipped to serve veterans due to their lack of knowledge of active-duty experiences. They also indicated that such experiences are often not shared with civilian counselors due to security reasons, group inclusion, reliving of trauma and other reasons. However, some veterans find sharing these experiences with counselors to be helpful as it allows for reconnection to the past and the glory of military culture. Veterans' espoused beliefs of what is helpful for them may be contradictory to the training of civilian clinicians, leading to veterans' persistent concerns about the quality of care they receive, the effectiveness of the care they receive and the appropriateness of the care they receive they receive from mental health service providers (Grossman, 2009; Coll et al., 2011). Additionally, civilian counselors have expressed

concerns about their own competence and confidence with working veterans (Botero Jr. et al., 2020; Tanielian et al., 2018). Training for counselors is provided for those who are paneled by military and veteran insurances (Military OneSource, n.d.). However, there is an indication the more training is needed beyond what is provided to meet insurance paneling requirements. Counselors must stay abreast of the ongoing challenges faced by veterans and remain consciously intentional in their approach to work with veterans from a culturally informed perspective (Johnson et al., 2018). As veterans have indicated a preference toward counselors who are veterans, civilian counselors may need to consider a partnership with veterans in the mental health field (Cheney et al., 2018). This type of consultative relationship can happen through forging supervision relationships, inclusion of required veteran-related education at workshops, presentations, and interactive trainings for counselors who are serving veterans, and increasing counselors' knowledge and participation in local community resources for veterans. It is imperative for counselors to embrace the case management, consultation, and counseling sides to better address veteran issues holistically. Engaging in such a collaboration may be helpful for tailoring established counseling approaches more uniquely to the veterans they serve. Veteran mental health professionals will also be able to educate potential veteran clients about counseling approaches and the benefits of such approaches for veterans as members of the civilian society. This partnership may help bridge the gap between openness to seek help and actively seeking help.

The counselor is only part of the larger picture for veteran mental health care. Just as establishing a relationship with other veteran mental health professions is important, it is also important to establish relationships with veteran-affiliated healthcare organizations to ensure knowledge about veteran needs and promote integrated healthcare among professionals working with veterans. The VHA has access to the veteran population more consistently and more

frequently. Thus, the organization is able to obtain more knowledge and insight about veteran health issues, psychosocial concerns, supports, and other challenging life areas in addition to mental health issues than civilian care providers (Reisman, 2016). The government has passed legislation to address the growing severity of mental illness to include civilian service providers due to the VHA not being able to do so as an individual entity. The VHA has privileges to medical records, previous history, research, and specialized treatment options for veterans. However, given the need for additional mental health providers, there must be advocacy from governmental agencies to assist with inclusion of all providers to such privileges. Losing access to more veteran tailored treatments by choosing a civilian provider may contribute to lack of seeking or maintaining mental health treatment services. Examples of unique services or more frequently employed services for veterans include virtual reality therapy, eye movement desensitization and reprocessing, prolonged exposure therapy, and other targeted treatment for veteran related issues. For civilians, obtaining expertise in these areas can often be too expensive and too time-consuming without assistance. While special programs have been established for consultation and free training resources for civilians, these programs are limited to certain states. Additionally, treatment options such as prolonged exposure therapy require more availability and access to additional supportive services which may be more readily available at the VHA than most community mental health settings (Reisman, 2016). These constraints and limitations do not excuse counselors from implementing evidence-based practices, also veterans may not consider these barriers as acceptable for lack of similar treatment approaches. All of the previously mentioned components are significant to treatment planning for veteran services, as well as addressing evolving veteran needs to work toward overall health. This is not only beneficial to veterans but to various stakeholders who are impacted by individual veteran care. High veteran suicide rates, homelessness, unemployment, and other challenges significant to this

group pose negative impact on families and communities, as well as economic costs to society overall (Reisman, 2016). Given this widespread impact of the lack of mental health services and the need for advocacy to expand training for civilian counselors to provide effective services to veterans, action must occur at various levels, from civilian to governmental. This also involves intentionality from professional counseling organizations to gain access to resources that are helpful for civilians. As individual counselors may be limited in access to such veteran organizations, it is the duty of may counseling organizations to advocate for the counseling profession. National mental health organizations such as the National Board of Certified Counselors (NBCC) and the American Counseling Association (ACA) (National Board of Certified Counselors, n.d.; ACA, n.d.) espouse missions to advocate for counseling fiend, represent the legislative needs of the mental health field and increase employment of counselors by the Department of Affairs. NBCC continues to advocate for credentialing standards from the D.O.D to permit mental health counselors to service all branches of the military (NBCC, n.d.). Additionally, subgroups of these larger organizations and grassroot organizations should be involved in this effort. Ensuring communication across these entities will fortify the efforts to address mental health counseling needs for veterans. Bridging government and VHA organizations, civilian and veteran professional providers and community resources will help strengthen counselor competencies for working with veterans, promote integrated healthcare services for veterans, and increase seeking and maintenance of mental health treatment by veterans.

Recommendations for Future Research

This research study sought to extend the knowledge and understanding in relation to veteran attitudes toward mental health services. The following recommendations for future research are offered. First, given that this is the first use of the BA Subscale and PMS Subscale

as measurements of attitudes with veterans, it will be important to replicate this study with different samples. Obtaining a larger sample size may offer more information into beneficial and pessimistic attitudes toward mental health and veterans. In addition, the correlation between the scales may indicate a need to explore types of mental health services and the relationship with attitudes and the demographic variables utilized.

Second, the addition of more qualitative data on whites and non-whites is recommended. As the number of white participants was significantly more than non-whites, the more efficient method of gathering data and discovering differences will be through qualitative rather than primarily quantitative. The same method should be considered for females and non-females in order to capture the specific information about females, as well as the additional demographic variables.

Third, considering the qualitative information and the closeness of attitudes between the two subscales, it is recommended to repeat this study with individuals who have served in leadership and were directly involved in mental health services with veterans. This may provide insight into the origin or sources of reinforcement of potential negativity related to seeking help. Participants shared that leadership in the military does not support seeking help, thus an examination of leadership would be informative and provide some implications for the military. This is important as the veteran identity is often still very closely tied to the military culture.

Lastly, with the potential issue of sampling bias, future research could be conducted to explore ways to investigate veterans who are not as open to seeking mental health services. There was little significant difference between the scales, there was an equally pessimistic part of the sample in comparison to those with more positive views. Conducting research with this group could provide more specific information for what is needed to promote more openness toward seeking mental health services.

Concluding Remarks

Attitudes are integral to counseling outcomes. Positive attitudes toward counseling increase intention to seek help and motivation to maintain commitment to care. Veterans are a unique culture with beliefs, values, and attitudes that may potentially encompass conflicting worlds, the military and civilian society. Consequently, their life experiences can be complicated as they try to integrate from one culture to the other. Thus, it is imperative to assess veterans' attitudes toward mental health services when working to help veterans with related issues. This research study contributes to literature about veterans and mental health. The significant findings highlight the correlation between more beneficial attitudes about mental health counseling in whites. Overall, the results from the study inform counselors, mental health professional organizations, veteran-affiliated healthcare organizations. This study also presents areas of future research to ensure representation in data by all veterans and exploration of systemic contributions to attitudes toward mental health services.

References

Acosta, J. D., Becker, A., Cerully, J. L., Fisher, M. P., Martin, L. T., Vardavas, R., Slaughter, M. E., & Schell, T. L. (2014). *Mental health stigma in the military*. RAND Corporation. http://www.jstor.org/stable/10.7249/j.ctt14bs47s

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2) 179-211. https://doi.org/10.1016/0749-5978(91)90020-T

American Counseling Association. (2014) *2014 ACA code of ethics*. https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychiatric Association. (2017). *Mental health disparities: Diverse populations*. https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf

American Psychological Association (APA) Practice Organization. (2016). *Understanding military culture. Good practice.* https://www.apaservices.org/practice/goodpractice/2016-winter.pdf

Ashley, W., & Brown, J.D. (2015). The impact of combat status on veterans' attitudes toward help seeking: the hierarchy of combat elitism. *Journal of Evidence-Informed Social Work, 12*(5), 534-542. http://doi/10.1080/15433714.2014.992695

Bandura, A. (2012). On the functional properties of perceived self-efficacy revisited. *Journal of Management*, *38*(1), 9–44. https://doi.org/10.1177/0149206311410606

Belo, P., Navarro-Pardo, E., Pocinho, R., Carrana, P., & Margarido, C. (2020). Relationship between mental health and the education level in elderly people: mediation of leisure attitude. *Frontiers in Psychology*, *11*, 573–573. https://doi.org/10.3389/fpsyg.2020.00573

Blais, R.,& 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. https://doi.org/10.1037/mil0000036

Bomyea, J., Lang, A. J., Delano-Wood, L., Jak, A., Hanson, K. L., Sorg, S., Clark, A. L., & Schiehser, D. M. (2016). Neuropsychiatric predictors of post-injury headache after mildmoderate traumatic brain injury in veterans. *Headache*, t*he Journal of Head and Face*

Pain 56(4), 699–710. https://doi.org/10.1111/head.12799

Botero Jr., G., Rivera, N. I., Calloway, S. C., Ortiz, P. L., Edwards, E., Chae, J., & Geraci, J. C. (2020). A lifeline in the dark: Breaking through the stigma of veteran mental health and treating America's combat veterans. *Journal of Clinical Psychology*, *76*(5), 831–840. https://doi.org/10.1002/jclp.22918

Brenner, L., Betthauser, L. M., Homaifar, B. Y., Villarreal, E., Harwood, J. E., Staves, P. J., & Huggins, J. A. (2011). Posttraumatic stress disorder, traumatic brain injury, and suicide attempt history among veterans receiving mental health services. *Suicide & Life-Threatening Behavior*, *41*(4), 416–423. https://doi.org/10.1111/j.1943-278X.2011.00041.x

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Britt, T., Sipos, M., Klinefelter, Z., & Adler, A. (2020). Determinants of mental and physical health treatment-seeking among military personnel. *The British Journal of Psychiatry, 217*(2), 420-426. doi:10.1192/bjp.2019.155

Brown, M. T., & Landrum-Brown, J. (1995). Counselor supervision: Cross-cultural perspectives. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 263–286). Sage Publications, Inc.

Burek, G. (2018). Military culture: working with veterans. *The American Journal of Psychiatry Resident's Journal, 13*(9), 3–5. https://doi.org/10.1176/appi.ajp-rj.2018.130902

Center for Women Veterans. (2020, February). *I am not invisible.* U.S. Department of Veteran Affairs. https://www.va.gov/womenvet/iani/index.asp

Centers for Disease Control and Prevention. (2021, December 2). *Suicide is a large and growing health problem.* https://www.cdc.gov/suicide/facts/

Centers for Disease Control and Prevention. (2021, December 2). *Suicide rates are higher among veterans.* https://www.cdc.gov/suicide/facts/disparities-in-suicide.html

Cheney, A. M., Koenig, C. J., Miller, C. J., Zamora, K., Wright, P., Stanley, R., Fortney, J., Burgess, J. F., & Pyne, J. M. (2018). Veteran-centered barriers to VA mental healthcare services use. *BMC Health Services Research*, *18*(1), 591–591. https://doi.org/10.1186/s12913-018-3346-9

Ciarleglio, Aslan, M., Proctor, S. P., Concato, J., Ko, J., Kaiser, A. P., & Vasterling, J. J. (2018). Associations of stress exposures and social support with long-term mental health outcomes among U.S. Iraq War Veterans. *Behavior Therapy*, *49*(5), 653–667. https://doi.org/10.1016/j.beth.2018.01.002

Coll, J., Weiss, E., & Metal, M. (2011). The influence of military culture and veteran worldviews on mental health treatment: practice implications for combat veteran help-seeking and wellness. *International Journal of Health, Wellness & Society*, *1*(2), 75–86. https://doi.org/10.18848/2156-8960/CGP/v01i02/41168

Congress.gov. *Improving Mental Health Care for Veterans Act of 2020.* Retrieved December 1, 2021, from https://www.congress.gov/bill/116th-congress/senate-bill/3210/all-info

Conner, K., Rigg, K., Yu, L., Hongdao, M., Pilkonis, P., Brown, C. (2018). Psychometric properties of the attitudes toward seeking mental health treatment scale. *American Journal of Geriatric Psychiatry. 18*(6).

Conner, K., Carr, V., Grote, N., Rosen, D., Reynolds, C., Brown, C. (2010). Mental health treatment seeking among older adults with depression: the impact of stigma and race. *Journal of Cultural Diversity 25*(1). doi: 10.1097/JGP.0b013e3181cc0366

Corrigan, P. (2004). How stigma interferes with mental health care. *The American Psychologist*, *59*(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Dabovich, P.A., Eliott, J.A., & McFarlane, A.C. (2019a). The meanings soldiers attach to health and their impacts on primary health-care utilization and avoidance in an Australian highrisk combat unit. *Armed Forces & Society, 47*(2) https://doi. org/10.1177/0095327X19852652.

Dabovich, P.A., Eliott, J.A., & McFarlane, A.C. (2019b). Individuate and separate: values and identity re-development during rehabilitation and transition in the Australian army. *Social Science & Medicine,* 222, 265–273. https://doi.org/10.1016/j. socscimed.2019.01.012

Department of Veterans Affairs. (2017). *National suicide data appendix; 2019.* https://www.mentalhealth.va.gov/docs/data-sheets/2017/2005-2017_National_Data_Appendix.xlsx

Department of Veterans Affairs. (2018). *National strategy for preventing veteran suicide 2018–2028*. www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

Department of Veterans Affairs. (2019). *National veteran suicide prevention annual report; 2019*. www.mentalhealth.va.gov/docs/datasheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

Diala, C, Muntaner, C., Walrath, C., Nickerson, K. J., LaVeist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry*, *70*(4), 455–464. https://doi.org/10.1037/h0087736Department of Veterans Affairs. (2017). *National suicide data appendix; 2019.* https://www.mentalhealth.va.gov/docs/datasheets/2017/2005-2017_National_Data_Appendix.xlsx

Dillman, D.A., Smyth, J. D., Christian, L. M., & Dillman, D. A. (2009). *Internet, mail, and mixed-mode surveys: the tailored design method.* (3rd ed). Wiley & Sons.

Dingfelder, S. F. (2009). The military's war on stigma. *Monitor on Psychology*, *40*(6). http://www.apa.org/monitor/2009/06/stigma-war

Dunivin, K. (1994). Military culture: change and continuity. *Armed Forces and Society*, *20*(4), 531–547. https://doi.org/10.1177/0095327X9402000403

Epidemiology Program. (2017). *Analysis of VA health care utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND).* https://www.publichealth.va.gov/docs/epidemiology/healthcare-utilizationreport-fy2015-qtr3.pdf#

Exum, H., Coll, J.E. & Weiss, E.L. (2011). *A civilian counselor's primer for counseling veterans* (2nd edition). Linus Publications.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research.* Addison-Wesley.

Fischer, E. P., McSweeney, J. C., Wright, P., Cheney, A., Curran, G. M., Henderson, K., & Fortney, J. C. (2016). Overcoming barriers to sustained engagement in mental health

care: perspectives of rural veterans and providers: overcoming barriers to mental health care. *The Journal of Rural Health*, *32*(4), 429–438. https://doi.org/10.1111/jrh.12203

Fraser, I. H., Fish, T. A., Brodie, D. A., Fournier, W. I., Houlihan, M., & Nussey, B. A. (2010). Reported experience with PTSD and attitudes toward peers with PTSD at a large Canadian army base. *Journal of the American Association of Behavioral and Social Sciences*. http://aabss.org/Perspectives2010/PTSDmilitaryAtti tudes.pdf

Ganz, A., Chikako, Y., Parekh, B., Koritzky, G., Berger, S. (2021). Military culture and its impact on mental health and stigma. *Journal of Community Engagement and Scholarship 13*(4). https://digitalcommons.northgeorgia.edu/jces/vol13/iss4/10

Ghahramanlou-Holloway, M., LaCroix, J. M., Koss, K., Perera, K. U., Anderson, R., VanSickle, M. R., Novack, L. A., & Trieu, T. H. (2018). Outpatient mental health treatment utilization and military career impact in the United States marine corps. *International Journal of Environmental Research and Public Health, 15*(4), 828. doi:http://dx.doi.org/10.3390/ijerph15040828

Grossman, D. (2009). *On killing: The psychological costs of learning to kill in war and society*. Back Bay Books.

Hamilton, A., Poza, I., & Washington, D. L. (2011). "Homelessness and trauma go hand-inhand": pathways to homelessness among women veterans. *Women's Health Issues*, *21*(4), S203–S209. https://doi.org/10.1016/j.whi.2011.04.005

Harding, S. (2017). Self-stigma and veteran culture. *Journal of Transcultural Nursing*, *28(5),* 438–444. https://doi.org/10.1177/1043659616676319

Health.mil. (n.d.). *Real warriors campaign.* https://www.health.mil/Military-HealthTopics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Real-

Warriors-Campaign

Harris,J., Farchmin, L., Stull, L., Boyd, J., Schumacher, M., & Drapalski, A. L. (2015). Prediction of changes in self-stigma among veterans participating in partial psychiatric hospitalization: the role of disability status and military cohort. *Psychiatric Rehabilitation Journal*, *38*(2), 179–185. https://doi.org/10.1037/prj0000118

Hahs-Vaughn, D. L. (2017). *Applied multivariate statistical concepts*.Taylor & Francis.

Hester, R. (2017). Lack of access to mental health services contributing to the high suicide rates among veterans. *International Journal of Mental Health Systems*, *11(1),* 47–47. https://doi.org/10.1186/s13033-017-0154-2

Hoffmire, C. A., & Denneson, L. M. (2018). *Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions*. Health Services Research & Development. U.S. Department of Veteran Affairs. https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5

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*(1), 13–22. https://doi.org/10.1056/NEJMoa040603

Igielnik, R. (2019). *Key findings about America's military veterans.* Pew Research Center. https://www.pewresearch.org/fact-tank/2019/11/07/key-findings-about-americasmilitary-veterans/

Inoue, C., Shawler, E., Jordan, C. H., Jackson C. A. (2021). *Veteran and Military Mental Health Issues*. StatPearls Publishing.

Institute of Medicine. (2010). *Provision of Mental Health Counseling Services Under TRICARE*. Washington, DC: The National Academies Press. https://doi.org/10.17226/12813

Jakupcak, M., Cook, J., Imel, Z., Fontana, A., Rosenheck, R., & McFall, M. (2009). Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan War veterans. *Journal of Traumatic Stress*, *22*(4), 303–306. https://doi.org/10.1002/jts.20423

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 treatmentseeking? A three path model. *Psychiatric Rehabilitation Journal, 38,* 109-116. doi:10.1037/prj0000138

Johnson, T., Ganz, A., Berger, S., Ganguly, A., & Koritzky, G. (2018). Service members prefer a psychotherapist who is a veteran. *Frontiers in Psychology*, *9*, 1068–1068. https://doi.org/10.3389/fpsyg.2018.01068

Jouzdani, S. R., Ebrahimi, A., Rezaee, M., Shishegar, M., Tavallaii, A., & Kaka, G. (2014). Characteristics of posttraumatic headache following mild traumatic brain injury in military personnel in Iran. *Environmental Health and Preventive Medicine*, *19*(6), 422–428. https://doi.org/10.1007/s12199-014-0409-3

Kim, P. Y., Britt, T. W., Klocko, R. P., Riviere, L. A., & Adler, A. B. (2011). Stigma, negative attitudes about treatment, and utilization of mental health care among soldiers. *Military Psychology*, *23*(1), 65–81. https://doi.org/10.1080/08995605.2011.534415

Koo, K. H., Madden, E., & Maguen, S. (2015). Race-ethnicity and gender differences in VA health care service utilization among U.S. veterans of recent Conflicts. *Psychiatric Services, 66*(5), 507–513. https://doi.org/10.1176/appi.ps.20130049

Kulesza, M., Pedersen, E., Corrigan, P., & Marshall, G. (2015). Help-seeking stigma and mental health treatment seeking among young adult veterans. *Military behavioral health*, *3*(4), 230–239. https://doi.org/10.1080/21635781.2015.1055866

Leach, M. (2005). Rapport: a key to treatment success. *Complementary Therapies in Clinical Practice*, *11*(4), 262–265. https://doi.org/10.1016/j.ctcp.2005.05.005

Military OneSource (n.d.). Retrieved April 10, 2022, from https://www.beaconhealthoptions.com/providers/beacon/network/military-onesource/

McGuffin J. J., Riggs, S. A., Raiche, E. M., & Romero, D. H. (2021). Military and veteran helpseeking behaviors: role of mental health stigma and leadership. *Military Psychology*, *33*(5), 332–340. https://doi.org/10.1080/08995605.2021.1962181

McGurk, D., Sinclair, R. R., Thomas, J. L., Merrill, J. C., Bliese, P. D., & Castro, C. A. (2014). Destructive and supportive leadership in extremis: Relationships with posttraumatic stress during combat deployments. *Military Behavioral Health*, *2(3),* 240–256. doi:https://doi.org/10.1080/21635781.2014.963765

Mertens, D. M. (2015). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods.* (4th ed.). Washington, DC: Sage.

Michalopoulou, L.E., Welsh, J. A., Perkins, D. F., & Ormsby, L. (2017). Stigma and mental health service utilization in military personnel: a review of the literature. *Military Behavioral Health*, *5(1),* 12–25. https://doi.org/10.1080/21635781.2016.1200504

Miggantz, E. L. (n.d.). *Stigma of mental health care in the military*. http://www.med.navy.mil/sites/nmcsd/nccosc/healthProfessionalsV2/reports/Documents/Stigma%20White%20Paper.pdf

Military.com (2021). *National Guard: service in the War on Terror.* https://www.military.com/national-guard-birthday/national-guard-service-in-the-war-onterror.html

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. https://doi.org/10.1037/h0094976

Monteith, L. L., Holliday, R., Hoffmire, C. A., & Bahraini, N. H. (2021). Female veterans' willingness to seek veterans' health administration and non-veterans' health administration services for suicidal thoughts and mental health concerns. *Medical Care*, *59*, S23–S30. https://doi.org/10.1097/MLR.0000000000001480

Morin, R. (2011). *The difficult transition from military to civilian life*. Pew Research Center. https://www.pewresearch.org/social-trends/2011/12/08/the-difficult-transition-frommilitary-to-civilian-life/#fn-10341-1

Moore, E. (2017). *Grateful nation: Student veterans and the rise of the military-friendly campus.* Duke University Press.

Muralidharan, A., Austern, D., Hack, S., & Vogt, D. (2016). Deployment experiences, social support, and mental health: comparison of black, white, and Hispanic U.S. veterans deployed to Afghanistan and Iraq: Ethnoracial minority veterans and deployment. *Journal of Traumatic Stress*, *29*(3), 273–278. https://doi.org/10.1002/jts.22104

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division;

Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services. (2018). *Evaluation of the Department of Veterans Affairs mental health services: Need, usage, and access and barriers to care.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK499497/

National Board for Certified Counselors (n.d.) *The NBCC creed. Military health system*. https://www.nbcc.org/govtaffairs/militaryhealth

National Institute of Mental Health (2021). *Suicide*. Retrieved April 4, 2022, from https://www.nimh.nih.gov/health/statistics/suicide

Office of Public and Intergovernmental Affairs (2020, December 1). *Department of veterans affairs biennial outreach report to congress.* https://www.va.gov/opa/docs/report-VA-Biennial-National-Outreach-20201201.PDF

Parker, K., Igielnik, R., Barrosos, A., & Cilluffo, A. (2019). *The American veteran experience and the post-911 generation.* Pew https://www.pewresearch.org/socialtrends/2019/09/10/the-american-veteran-experience-and-the-post-9-11-generation/

Pedersen E. A., Bouskill, K. E., Holliday, S. B., Cantor, J., Smucker, S., Mizel, M. L., Skrabala, L., Kofner, A., & Tanielian, T. (2020). *Improving substance use care: addressing barriers to expanding integrated treatment options for post-9/11 veterans*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR4354.html

Rabani Bavojdan, M., Towhidi, A., & Rahmati, A. (2011). The relationship between mental health and general self-efficacy beliefs, coping strategies and locus of control in male drug abusers. *Addiction and Health*, *3*(3-4), 111–118.

Reisman, M. (2016). PTSD treatment for veterans: What's working, what's new, and what's next. *Pharmacy and Therapeutics, 41*(10), 623–634.

Revilla, M. A., Saris, W. E., & Krosnick, J. A. (2014). Choosing the number of categories in agree–disagree scales. *Sociological Methods & Research*, *43*(1), 73–97. https://doi.org/10.1177/0049124113509605

Roberts, L. W., & Warner, C. H. (Eds.). (2018). *Military and veteran mental health: A comprehensive guide.* Springer Publishing Company. https://doi.org/10.1007/978-1-4939-7438-2

Rogers, C. (2007). The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy: Theory, Research, Practice, Training*, *44*(3), 240–248.

Rozanov, V., & Carli, V. (2012). Suicide among War Veterans. *International Journal of Environmental Research and Public Health*, *9*(7), 2504–2519. https://doi.org/10.3390/ijerph9072504https://doi.org/10.1037/0033-3204.44.3.240

Rosen, C. Greenbaum, M., Fitt, J., Laffaye, C., Norris., V., & Kimerling, R. (2011). Stigma, help-seeking attitudes, and use of psychotherapy in veterans with diagnoses of posttraumatic stress disorder. *Journal of Nervous and Mental Disease 199*(11), 879-885. doi: 10.1097/NMD.0b013e3182349ea5

Raghupathi, V., & Raghupathi, W. (2020). The influence of education on health: an empirical assessment of OECD countries for the period 1995-2015. *Archives of Public Health = Archives Belges de Santé Publique*, *78*(1), 20–20. https://doi.org/10.1186/s13690-020-00402-5

Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., & Brown, J. S. L. (2019). Improving mental health service utilization among men: A systematic review and synthesis of behavior change techniques within interventions targeting help-seeking. *American Journal of Men's Health*, *13*(3), 1557988319857009–1557988319857009.

https://doi.org/10.1177/1557988319857009

Seidman, A. J., Wade, N. G., Lannin, D. G., Heath, P. J., Brenner, R. E., & Vogel, D. L. (2018). Self-affirming values to increase student veterans' intentions to seek counseling. *Journal of Counseling Psychology, 65*(5), 653-660. https://doi.org/10.1037/cou0000289

Sharp, M.L., Fear, N. T., Rona, R.J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L., (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews 37*(1), 144-162. https://doi.org/10.1093/epirev/mxu012

Snowden, L. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research 3*(4), 181-187. doi: 10.1023/a:1013172913880

Spoont, M., Nelson, D., van Ryn, M., & Alegria, M. (2017). Racial and ethnic variation in perceptions of VA mental health providers are associated with treatment retention among veterans with PTSD. *Medical Care*, 55(9), S33–S42. https://doi.org/10.1097/MLR.0000000000000755

Stecker, T., Fortney, J., Hamilton, F., Sherbourne, C., & Ajzen, I. (2010). Engagement in mental health treatment among veterans returning from Iraq. *Patient Preference and Adherence, 4,* 45-49. doi: 10.2147/PPA.S7368

Strong J. D., Crowe, B. M., & Lawson, S. (2018). Female veterans: navigating two identities. *Clinical Social Work Journal*, *46*(2), 92–99. https://doi.org/10.1007/s10615-017-0636-3

Soucy, J. (2016). Guard and Reserve members receive "Veteran" status. *National Guard*. https://www.nationalguard.mil/News/Article/1038989/guard-and-reserve-members-receiveveteran-status/

Sue, D.W. (1978). Worldviews and counseling. *Personnel and Guidance Journal, 56*, 458-462. https://doi.org/10.1002/j.2164-4918.1978.tb05287.x

Sue, D. W. & Sue, D. (2003). *Counseling the culturally different: theory and practice*. John Wiley & Sons.

Tabachnick, B. G., & Fidell, L. S. (2007). *Using Multivariate Statistics* (5th ed.). Allyn and Bacon.

Tanielian, T., & Jaycox, L. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery.* Rand Corporation. https://www.rand.org/pubs/monographs/MG720.html

Tanielian, T., Woldetsadik, M. A., Jaycox, L. H., Batka, C., Moen, S., Farmer, C., & Engel, C. C. (2016). Barriers to engaging service members in mental health care within the US military health system. *Psychiatric Services*, *67(7),* 718–727. doi:https://doi.org/10.1176/appi.ps.201500237

Terlizzi, E. P., Zablotsky, B. (2020). *Mental health treatment among adults: United States, 2019*. *NCHS Data Brief, 380, 1–8.*

Tsai, J., Rosenheck, R. A., & Kane, V. (2014). Homeless female U.S. veterans in a national supported housing program: Comparison of individual characteristics and outcomes with male veterans. *Psychological Services, 11*(3), 309–316. https://doi.org/10.1037/a0036323

Tsai, J., Whealin, J. M., & Pietrzak, R. H. (2014). Asian American and Pacific Islander military veterans in the United States: Health service use and perceived barriers to mental health services. *American Journal of Public Health, 104*(S4), S538–S547. https://doi.org/10.2105/AJPH.2014.302124

United States Census Bureau. (2020). *Improved race and ethnicity measures reveal U.S. population is much more multiracial.*

https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measuresreveal-united-states-population-much-more-multiracial.html

United States Department of Veteran Affairs. (2018). *The military to civilian transition 2018.* https://benefits.va.gov/TRANSITION/docs/mct-report-2018.pdf

United States Department of Veteran Affairs. (2017). *Minority veteran report. Military service history and VA benefit utilization statistics.* https://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_Report.pdf

United States Department of Veteran Affairs. (2020). *The national veteran suicide prevention annual report.* https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf

United States Department of Veteran Affairs. (2017). *Racial and ethnic minority veterans.* https://www.va.gov/HEALTHEQUITY/Race_Ethnicity.asp

United States Department of Veteran Affairs. (2019). *Verification assistance brief. determining veteran status.* https://www.va.gov/OSDBU/docs/Determining-Veteran-Status.pdf

United States Department of Veteran Affairs. (2019). *National veteran suicide prevention annual report.* https://www.mentalhealth.va.gov/docs/datasheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdM

Verkamp, K. (2021). From warrior ethos to obscurity: Veteran reintegration literature review. *Journal for Nurse Practitioners*, 17(5), 564–569. https://doi.org/10.1016/j.nurpra.2020.12.01

Vespa, J. (2020). *Those who served: America's veterans from World War II to the war on terror.* U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2020/demo/acs-43.pdf

Veterans Claims Insider. (2021, June 25). *Are national guard veterans? YES! Here's the 8 Best VA benefits for National Guard and Reservists (The Ultimate Guide)*

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325

Vogel, D. L., Shechtman, Z., & Wade, N. G. (2010). The role of public and self-stigma in predicting attitudes toward group counseling. *The Counseling Psychologist*, *38*(7), 904–922. https://doi.org/10.1177/0011000010368297

Vogt D, Fox A., Di Leone B. (2014). Mental health beliefs and their relationship with treatment seeking among U.S. OEF/OIF veterans. J*ournal of Traumatic Stress, 27(3), 307–313. https://doi.org/10.1002/jts.21919*

Wong, E. C., Collins, R. L., Cerully, J., Seelam, R., & Roth, B. (2017). Racial and ethnic differences in mental illness stigma and discrimination among Californians experiencing mental health challenges. *Rand health quarterly*, *6*(2), 6.

Wounded Warrior Project. (n.d.). *Who we are.* Retrieved December 1, 2021, from https://www.woundedwarriorproject.org/mission

Appendix A INTRODUCTORY LETTER

Greetings,

You are invited to participate in an online survey examining veterans' attitudes about mental health services. This study will be conducted by Kimberly Williams, a doctoral candidate at The University of North Carolina at Charlotte. It is anticipated that the results from this study will inform mental health services to better meet the needs of veterans.

If you have already completed the survey, your time is greatly appreciated, and you can disregard this email. The survey will take approximately 10-15 minutes to complete. Participation is voluntary and you can choose to discontinue participation at any time. To participate in this study, you must be at least 18 years of age, be identified as a veteran in accordance to the Department of Veteran Affairs and able to read and understand the English language.

There are no foreseeable risks associated with this study. Your participation and responses are, and will remain, confidential.

Your participation in this survey is important and appreciated. As a veteran, you understand the importance of understanding the unique mental health needs of the veteran population. Insight gained from this study will provide implications for mental health providers, mental health training programs and administrative services related to mental health needs for veterans.

Should you have any questions or concerns about the study, please contact Kimberly Williams or her faculty advisor, Dr. Henry Harris:

Kimberly Williams, Doctoral Candidate
Department of Counseling
(704) 477-2685
kwill246@uncc.edu

Dr. Henry Harris, Full Professor
Department of Counseling
(704) 687-8971
hharris2@uncc.edu

If you are interested in participating in this study, please proceed via the link below:
http://uncc.surveyshare.com/s/AYA432C

Appendix B

Informed Consent

Department of Counseling
9201 University City Boulevard, Charlotte, NC
28223-0001 t/ 704-687-8960 f/ 704-
687-1636 www.counseling.uncc.edu/

Informed Consent

Research Title: EXPLORING ATTITUDES TOWARDS MENTAL HEALTH AMONG MILITARY VETERANS

Introduction:

You are invited to participate in a research study to explore the attitudes of veterans toward mental health. Please read the information carefully. At the bottom of this screen, you will have the option to decide whether or not you would like to participate in the survey.

Investigator(s):

Kimberly Williams, a doctoral candidate in the Department of Counseling at UNC Charlotte, is the principal research investigator for this study. The research will be overseen by Dr. Henry Harris, a Full Professor in the Department of Counseling at UNC Charlotte.

Description and Length of Participation:

You have been selected to participate in this survey because you are a U.S. veteran as defined by the U.S. Department of Veteran Affairs. Participation in this study is voluntary. The survey will take approximately 1015 minutes to complete. You must be at least 18 years old to take this survey.

Risks and Benefits of Participation:

Risks: This study involves no foreseeable risks. You are asked to try to answer all survey questions to the best of your ability; however, if there are any items that make you uncomfortable or that you would prefer to skip, please leave your response unanswered. Your responses are, and will remain, confidential.

Benefits: Your participation in this survey is important and appreciated. As a veteran, you understand the importance of understanding the unique mental health needs of the veteran population. While there are no direct benefits to participating in this study, it is anticipated that the data collection will provide further insight to inform mental health services for veterans,

mental health training programs and administrative services related to mental health needs for veterans.

Inclusion Criteria:
You are eligible to participate in this study if you meet the following inclusion criteria: a) You recognized by the U.S. Department of Veteran Affairs as a U.S. veteran.

Confidentiality:
The researcher will make every effort to ensure your privacy is maintained for the duration of the study. No identifiable information will be connected to your responses, and your participation in this study will remain confidential. All survey data will be kept, securely, in the researcher's password-protected account associated with her UNC Charlotte e-mail account. After this study is complete, the data could be used for future research studies or shared with other researchers for use in other studies without asking for your consent again. The data we share will NOT include information that could identify you.

Withdrawal Privilege:
Your participation in this study is voluntary; therefore, if you decide to participate in the study, but choose to discontinue your participation, you may do so at any time. It is anticipated that this survey will take 10-15 minutes to complete.

Fair Treatment and Respect:
UNC Charlotte wants to ensure that you are treated in a fair and respectful manner. Should you have any questions about how you are treated as a participant in this study, you may contact the Office of Research Protections and Integrity via phone, (704) 687-1871, or email, unccirb@uncc.edu.

Should you have any questions or concerns about the study, please contact Kimberly Williams or her faculty advisor, Dr. Henry Harris:

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Participant Consent
By providing your consent, you are agreeing to the following: a) you have read this form or have had it read to you; b) you understand the information presented in this form, the research study, risks and benefits, and inclusion criteria; c) you consent to participate in this research study.

YES- If you consent to participate in the survey, please proceed by entering your email address below. NO- If you do not wish to participate in the survey, you may exit this page.

APPENDIX C

Attitude Towards Seeking Mental Health Treatment Seeking Scale (ATMHT)

Please indicate how much you agree/disagree with the following statements.

1 = Strongly Disagree 2 = Disagree 3= Undecided 4 = Agree 5 = Strongly Agree

1. Professional mental health services can effectively reduce mental health problems.
2. If I sought mental health services, it is likely I would find a therapist that I would feel comfortable opening up to.
3. In my community, people take care of their emotional problems on their own; they don't seek professional mental health services.
4. Mental health professionals are well trained.
5. If I were experiencing a mental health breakdown, I am confident that taking medications would provide me with relief.
6. I do not fully trust mental health professionals.
7. I feel confident that I could find a therapist that is understanding and respectful of my ethnicity/culture.
8. Mental health professionals don't really care about you, they are just there for a pay check.
9. Due to time and financial constraints, seeking mental health services is not a feasible option for me.
10. Professional mental health treatment would not be helpful for me.
11. My family would support me seeking professional mental health services.
12. Mental health services are only effective if your therapist matches your race and/or ethnicity.
13. Most therapists have a lot of book smarts, but no street smarts.
14. I would be comfortable seeing a therapist that is a lot younger than me.
15. I believe that therapy is the most effective way to deal with mental health problems.
16. Most mental health professionals have negative beliefs about the mentally ill.
17. Seeking professional mental health services is a last resort.
18. I would be comfortable seeing a therapist that is of a different race than I am.

19. I know people who have had negative experiences when they sought professional mental health services.

20. I would seek help from my family and friends, before seeking help from a mental health professional.

Subscales:
Beneficial Attitudes about Seeking Mental Health Treatment (BA= 1, 2, 4, 5, 7, 11, 14, 15, 18, 19,

Pessimism about Mental Health Services (PMS = 3, 6, 8, 9, 10, 12, 13, 16, 17, 20)

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

1. Age _____

2. Race or Ethnicity: (Please select all that apply)
   a. American Indian/Alaskan Native
   b. Asian
   c. Black/African American
   d. Hispanic/ Latinx
   e. Native Hawaiian/ Pacific Islander
   f. Nonresident Alien
   g. White
   h. 2 or more races
   i. Other

3. Gender
   a. Female
   b. Male
   c. Other _____ (fill in the blank)

4. Branch of Service
   a. Air Force
   b. Army
   c. Coast Guard
   d. Marine Corps
   e. Navy
   f. Other

5. Military rank: _____

6. Education level
   a. less than high school
   b. High school diploma/GED
   c. Some college
   d. Two Year college degree
   e. Bachelor's college degree
   f. Master's Degree
   g. Doctoral Degree
   h. Professional Degree (MD, DDS, JD, Other)

7. Marital status
   a. Married
   b. Single
   c. Divorced
   d. Other

8. State Location: _____ <State Initials>

9. When did you serve on active duty in military?
   a. September 2001 or later
   b. August 1990 to August 2001 (includes Persian Gulf War)
   c. May 1975 to July 1990
   d. Vietnam era (August 1964 to April 1975)
   e. February 1955 to July 1964
   f. Korean War (July 1950 to January 1955)
   g. January 1947 to June 1950
   h. World War II (December 1941 to December 1946)
   i. November 1941 or earlier

10. Years of Service
   a. Less than 1 year
   b. 1-4 years
   c. 5-8 years
   d. 9-12 years
   e. 13-16 f . 17-20
   g. 21 or more

11. Did you ever serve in a combat or war zone?
   a. yes b. no

12. Primary military job: _____(admin, security police, logistics, etc)

13. As a veteran, have you ever seen a counselor for mental health treatment?
   a. yes b. no

14. Would you worry about what other people would think about you if you were in counseling?
   a. yes b. no c. unsure

15. How do you think most veterans perceive counseling?
   a. sign of strength b. weakness c. unsure

16. While serving on **active duty**, did you ever feel the need to see a counselor or therapist?
   a. yes b. no c. unsure

17. While serving active duty, did you believe seeking counseling would negatively affect your military career?
   a. yes b. no c. unsure

18. What other comments would you like to add?