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Perceptions of the Veterans Administration and Mental Health Treatment Seeking Intentions Among Veterans

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Perceptions of the Veterans Administration and Mental Health Treatment Seeking Intentions Among Veterans

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Abstract

Among the veteran population there is a trend of underutilizing mental health services despite the higher number of veterans with mental health diagnoses. Though previous research has examined barriers to mental health care such as stigma and a warrior mentality, there may be additional barriers that emanate from the system to which veterans are entitled and encouraged to use, the Veterans Administration (VA). This study examined the mediational relationships among perceptions of the VA, attitudes about seeking mental health treatment at the VA, and intentions to seek mental health treatment at the VA among veterans. Data from 96 veterans were collected via social media platforms (i.e., Facebook, Twitter, and Instagram). The results of the study showed there was a significant positive relationship between perceptions of the VA and intentions to seek mental health treatment at the VA. As positive perceptions of the VA increased, so did veterans' reports of intentions to seek mental health treatment at the VA. There was also a relationship between attitudes about seeking mental health treatment at the VA and intentions to seek mental health treatment at the VA, indicating that as attitudes became more positive, ratings of reported intentions to seek mental health treatment at the VA increased. Finally, attitudes mediated the relationship between perceptions and intentions in the predicted direction, thus supporting the hypothesis. The current study provides evidence that perceptions and attitudes of the VA may facilitate seeking VA mental health treatment when perceptions are more positive. Conversely, negative perceptions of the VA may present a barrier to seeking such services. The results further define what influences veteran mental health utilization and have the potential to inform

policy changes to improve the VA's image and services to increase the use of mental health services among the veteran population.

Perceptions of the Veterans Administration and Mental Health Treatment Seeking Intentions Among Veterans

Introduction

Over the years, there have been a number of negative stories in the media about the Veterans Administration (VA) and its treatment of veterans. Though the general public may not be directly affected by these negative stories of the VA, veterans are, as the VA may be their only source of mental health and medical care. Veterans may seek treatment at the VA for many reasons, including mental health issues, and negative stories about the VA may influence their view of the entity they are encouraged and entitled to use. Though there may be other barriers to general VA use and VA mental health care use such as financial, personal, and physical obstacles, as well as difficulties navigating the VA health care system, a negative perception of the VA may also influence whether a veteran uses the health care benefits that are afforded to them.

Veterans Administration

The VA was originally proposed by President Hoover in 1929 as a way to consolidate all the individual entities that were providing services to veterans (U.S. Department of Veterans Affairs, 2018). In 1930, Congress created the VA, by combining three bureaus that were previously overseeing veteran affairs—the Veterans' Bureau, the Bureau of Pensions, and the National Homes for Disabled Volunteer Soldiers (U.S. Department of Veterans Affairs, 2018). Once established, the agency was responsible for a number of services, including medical services, disability compensation and allowances, life insurance, bonus certificates, retirement payments, and pensions (U.S. Department of Veterans Affairs, 2018). The ultimate goal of the services provided to

veterans was to help with the transition from military life to civilian life, as well as to improve veterans' quality of life after service (National Center for Veterans Analysis and Statistics [NCVAS], 2020). The first administrator of the VA, General Frank Hines, was himself a veteran and had been the director of the Veterans' Bureau since 1923 (U.S. Department of Veterans Affairs, 2018). The next decade saw a significant increase in the number of VA hospitals across the country from 64 to 91 hospitals and an increase in the number of beds from approximately 34,000 to 62,000 (U.S. Department of Veterans Affairs, 2018). Though psychological services were not a major focus of the VA early on, there was a significant increase in interest in this area in the 1930s when it was reported that neuropsychiatric conditions accounted for more than half of the patients at the VA (U.S. Department of Veterans Affairs, 2018). The early inclusion of treatment for psychological conditions indicates that, early on, the VA was trying to treat mental health issues that affected the veteran population (U.S. Department of Veterans Affairs, 2018). Over the years, more benefits and bills were passed to provide more for veterans—as well as their families—after serving in the military (U.S. Department of Veterans Affairs, 2018). Today, the benefits and services still include medical and mental health care, disability/service connected benefits, educational and vocational training, and financial benefits, among many other resources (Stoddard et al., 2017).

VA Mental Health Services

Aside from the health care and additional benefits, the VA also provides a number of mental health services to veterans, including individual counseling, group counseling, substance abuse treatment, psychiatric treatment, and trauma-focused treatment (U.S. Department of Veterans Affairs, 2023). The easiest way to initiate mental health services

with the VA, according to its website, is for a veteran to speak to their primary care provider at the VA if they are currently receiving medical care there (U.S. Department of Veterans Affairs, 2023). The other option for initiating mental health services is to contact a local VA medical center or Vet Center to talk about what kind of treatment might be appropriate (U.S. Department of Veterans Affairs, 2023). Vet Centers are smaller offices and buildings, compared to the medical center campuses, that provide mental health services to combat veterans and their families (U.S. Department of Veterans Affairs, 2010). Vet Centers minimize the clinical environment often seen in the medical centers and instead are more informal and inviting with smaller offices and artwork and photographs from veterans (U.S. Department of Veterans Affairs, 2010). Additionally, Vet Centers hire psychologists and social workers who have specialized training in working with the difficulties and challenges faced by combat veterans, such as posttraumatic stress disorder (PTSD; U.S. Department of Veterans Affairs, 2010). Vet Centers offer free individual and group counseling to veterans and their families (U.S. Department of Veterans Affairs, 2023). The services provided at these centers include military sexual trauma counseling, readjustment counseling, bereavement counseling, employment counseling, and substance abuse assessment and referrals (U.S. Department of Veterans Affairs, 2023).

VA Service Utilization

According to a study conducted by U.S. Veterans Eligibility Trends and Statistics, approximately 9,828,570 veterans used VA benefits in fiscal year 2017 whereas 10,170,229 veterans did not use VA benefits (NCVAS, 2020). The demographics for veterans who used and did not use VA benefits were also examined. With regard to male

veterans, those who tended to use benefits were older, with the highest number of users falling in the 65 to 74 year age range (NCVAS, 2020). Female veterans were found to have similar rates of use and non-use across age groups (NCVAS, 2020). The researchers also examined the distribution of usage with regard to gender and time period/operation of war. They determined almost half of the female veterans who used VA benefits were post 9/11 era veterans whereas the majority of male users were either Vietnam era or post 9/11 era veterans (NCVAS, 2020).

VA Mental Health Service Utilization

In 2013, Congress mandated the National Academies of Sciences, Engineering, and Medicine to conduct a study to examine the Veterans Health Administration's mental health care services and make recommendations for improvements (National Academies of Sciences, Engineering, and Medicine [NAESM], 2018). The key findings of the study indicated there was a "substantial" unmet need for mental health services in the recent veteran population (i.e., veterans of Operation Enduring Freedom [OEF], Operation Iraqi Freedom [OIF], and Operation New Dawn [OND]; NAESM, 2018). Results of the study showed approximately half of the veterans surveyed who had a need for mental health services, as identified by mental health screeners, were not using VA or non-VA mental health services (NAESM, 2018). Results also showed over half of the veterans surveyed did not perceive a need to use mental health services despite being deemed in need of treatment by the screeners (NAESM, 2018).

The study showed that though many veterans receive high-quality mental health care from the VA, the VA's ability to consistently provide high-quality care in all facilities to all populations is an ongoing challenge (NAESM, 2018). The researchers

stated that though all mental health treatment within the VA is evidence-based, there are significant gaps in treatment delivery (NAESM, 2018). Difficulties with staffing, infrastructure, and providing timely care all contribute to the variability in the delivery of mental health services within the VA (NAESM, 2018). With regard to staffing, the researchers identified higher rates of burnout among providers as accounting for a high turnover rate, which results in inadequate staffing for the evidence-based mental health treatment (NAESM, 2018).

Research also indicates the use of VA mental health services by veterans is not always a long-term endeavor. One study that examined the long-term usage at a VA PTSD clinic showed approximately 68% of OEF/OIF era veterans dropped out of the program before completion (Garcia et al., 2011). In fact, additional research has found differences among the different eras of veterans with OEF/OIF veterans missing more appointments and ceasing treatment at higher rates than Vietnam era veterans (Erbes et al., 2009).

Access to Outside Service Providers

Though the report on the mental health care services of the VA provided evidence about the problem areas, veterans do not always have a choice when it comes to seeking treatment outside of the VA (NAESM, 2018). The reason so many veterans end up relying on the VA is because of cost and difficulty accessing outside providers. Prior to June of 2019, veterans had to live 40 or more miles away from a VA facility or wait longer than 30 days to see a service provider before the VA would pay for them to see an outside provider (U.S. Department of Veterans Affairs, 2019b). This limits the accessibility of services to veterans who cannot afford to seek services closer or earlier

outside of the VA. In June of 2019, a law was passed that changed the stipulations of the VA paying for outside service providers such that the 40 miles turned into 30 minutes and the 30 days turned into 20 days (U.S. Department of Veterans Affairs, 2019b). This decision was made with particular regions in mind as in some areas, travelling 40 miles could take significantly longer than 30 minutes (U.S. Department of Veterans Affairs, 2019b). There were also changes with regard to specialty care and the time frame for those services to be covered by the VA. These stipulations include that if the veteran has to wait longer than 28 days and if they have to drive an hour or more to get to a VA facility, the VA will cover the cost of an outside provider for specialty care (U.S. Department of Veterans Affairs, 2019b). These changes allow some veterans to receive outside services without having to worry about the cost, but many veterans are still having to wait for the new thresholds for number of days and travel distance to be met before they can seek affordable treatment outside the VA.

Mental Health Among the Veteran Population

Research has shown the military population has a unique prevalence of mental health issues. In fact, there are higher rates of mental illness within the veteran population as compared to individuals in the general public (De Luca et al., 2016). The U.S. Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program (Kemp & Boassarte, 2013) reported approximately 36% of military personnel returning from deployment have a mental health diagnosis and approximately 22 veterans complete suicide a day. Research has also shown the prevalence of mental health diagnoses among veterans has greatly increased as the number of military personnel being deployed has increased since 2001 (Schell & Marshall, 2008). Approximately 29% of OEF/OIF

veterans seeking care at the VA have a PTSD diagnosis (Fox et al., 2015). Research also indicates a heightened risk of a mental health diagnosis among female veterans due to the prevalence of increased combat exposure and a higher risk of experiencing military sexual trauma and intimate partner violence (Gerber et al., 2014; Street et al., 2007; Vogt et al., 2011). This discrepancy in mental health care usage also applies to the VA specifically, with low numbers of veterans with mental health diagnoses using and continuing mental health treatment (Garcia et al., 2014). Despite the higher prevalence of PTSD and other mental health diagnoses among the veteran population, the treatment seeking rate for this population is low (Hoge et al., 2014). There appear to be a number of veteran-specific barriers that affect whether this population will seek treatment in general as well as from the VA.

Barriers to Mental Health Treatment

Barriers to veterans seeking treatment include a warrior/military mentality, stigma, and a negative view of mental health providers (Coll et al., 2011; De Luca et al., 2016; Wakefield et al., 2007; Wray et al., 2016). The idea of a warrior mentality, meaning being able to help oneself and not admitting weaknesses, is a barrier closely linked to stigma surrounding mental health within the military (Coll et al., 2011; De Luca et al., 2016). The results of a study looking at warrior mentality demonstrated many veterans had a military cultural view that they could take care of their own problems and "just suck it up" (Wray et al., 2016). These veterans also expressed that their problems were their own and they did not need to be discussed with other individuals (Wray et al., 2016). Other veterans in the study reported that having problems after deployment was a normal occurrence so they did not see a reason for seeking treatment (Wray et al., 2016).

In connection with the warrior mentality, there is also the influence of a masculine ideology due to the traditionally male-dominated demographics of the military (Garcia et al., 2014). Research has shown this masculine ideology has a negative impact on treatment seeking behaviors, specifically among younger veterans, due to the perceptions of being seen as weak and feeling as though they should be able to handle their own difficulties (Berger et al., 2005; Coll et al., 2011; De Luca et al., 2016; Wakefield et al., 2007; Wray et al., 2016). This masculine ideology has also been studied with regard to its impact on female veterans and that fact that the military culture values masculinity and devalues femininity, which has impacts on female veterans' mental health treatment usage (Ashley et al., 2017). This masculine ideology also influences the self-view of both male and female veterans and emphasizes the need for a high level of self-reliance to deal with problems and an overall stoicism in response to stressors (Finley, 2011; Jakupcak et al., 2006; Lorber & Garcia, 2010).

Stigma and negative attitudes related to mental health have also been researched as barriers to treatment seeking among the veteran population. In fact, one study showed that when veterans had negative beliefs about mental health, they were unlikely to seek treatment for their problems whether at the VA or from an outside provider (Pietrzak et al., 2009). More specifically, negative beliefs about therapy not being effective for most people or that therapy was a sign of weakness decreased the likelihood that the participants in the study would seek mental health treatment (Pietrzak et al., 2009). Other studies have looked at gender differences and barriers to mental health treatment and overall utilization of VA care options (Kelly et al., 2008; Stoddard et al., 2017). These studies revealed gender differences related to the influence of stigma for the veteran

population (Stoddard et al., 2017). Specifically, male veterans are less likely to seek treatment as compared to female veterans because of mental health stigma (Kelly et al., 2008; Stoddard et al., 2017). Negative treatment attitudes have been researched with regard to different veteran eras with results indicating OEF/OIF veterans who were already enrolled in VA care were more likely to report having negative attitudes about treatment as compared to other eras of veterans (i.e., Persian Gulf and Vietnam; Garcia et al., 2014). Research also shows the stigma specifically related to seeking treatment can be a barrier to mental health treatment utilization (Williston et al., 2020). A specific study examined whether or not mental health literacy (i.e., education about mental health diagnoses and treatment) influenced the amount of stigma surrounding mental health treatment seeking (Williston et al., 2020). The results indicated those who reported higher mental health literacy also reported fewer negative beliefs related to seeking mental health treatment (Williston et al., 2020). Negative beliefs about treatment and mental health in general may also affect whether veterans see a need for care. Research demonstrates having a lower perceived need for mental health treatment is associated with lower usage of mental health services (Fikretoglu et al., 2008). A study examining the mechanisms that influenced mental health treatment utilization among female veterans demonstrated perceived need for care was a mediator between treatment seeking stigma and mental health treatment utilization (Williston et al., 2020). The results of the study showed the women who reported negative beliefs about seeking mental health treatment also had lower ratings for perceived need for mental health treatment (Williston et al., 2020). This research demonstrated how much barriers and stigma can affect other

factors, such as perceived need for care, that ultimately influence treatment utilization among the veteran population.

Research has also demonstrated a common barrier to mental health treatment for veterans is the view of the mental health provider (Wakefield et al., 2007). Though not all VA mental health staff are civilians, some veterans have expressed concerns that civilian therapists would not understand them or be able to treat their problems because they would not understand their experiences or the military culture (Wakefield et al., 2007; Wray et al., 2016). Other research indicated a lack of trust in a civilian therapist affects a veteran's motivation and willingness to remain in treatment for mental health problems (Cheney et al., 2018). In addition, veterans have reported some fear associated with mental health providers, and particularly psychiatrists (Wray et al., 2016). Veterans in the Wray et al. (2016) study stated simply hearing the word "psychiatrist" can elicit fear in some veterans and there are concerns about the medications psychiatrists may prescribe and the associated side effects.

A qualitative study of veteran-specific barriers to using VA mental health treatment identified five different domains of barriers, two of which were not specific to the VA, but pertained to the veteran (Cheney et al., 2018). The first domain was worry and concern about what others think. The veterans interviewed identified stigma, vulnerability, and trust as barriers to using VA mental health services (Cheney et al., 2018). They attributed some of these concerns to not wanting to be seen as "crazy" or as going against the military attitude and admitting a potential weakness or failure (Cheney et al., 2018). These findings align with other research that indicated the military culture

and mentality influences the view of mental health and mental health treatment among the veteran population (Coll et al., 2011; De Luca et al., 2016).

Another domain was financial, personal, and physical obstacles, which included personal life struggles such as homelessness or legal troubles as well as transportation concerns related to the distance required to travel or the cost of traveling (Cheney et al., 2018). Additional research on personal factors of veterans revealed transportation and distance travelled to get to VA facilities as barriers to mental health treatment (NAESM, 2018). Additionally, results of the study conducted by the NAESM showed that if veterans have a non-supportive significant other, they are less likely to seek mental health treatment. Research also indicates there are barriers specific to OEF/OIF veterans due to their age (Garcia et al., 2014). For example, younger veterans tend to be a part of the workforce more so than Vietnam veterans who are closer to retirement age. Research indicates this poses a logistical barrier to mental health treatment due to time commitments and work interference (Garcia et al., 2014). Other barriers cited by the researchers in the National Academies of Sciences, Engineering, and Medicine study included consequences for seeking treatment, such as employment concerns related to missing work for appointments, fears that seeking mental health treatment will affect their ability to own guns, concerns that seeking treatment would affect their contact with or custody of their children, and concerns about losing medical or disability benefits because of seeking mental health treatment (NAESM, 2018). Though there are personal reasons why a veteran may choose to not seek care at the VA, there are also other eligibility standards that may influence whether a veteran can use services at the VA. If a

veteran was dishonorably discharged or has a discharge status of "other than honorable," they may not be eligible for VA benefits (U.S. Department of Veterans Affairs, 2022).

VA-Specific Barriers to Mental Health Treatment

Research has shown some veterans do not feel they are receiving adequate care when they seek treatment at the VA (Franco et al., 2016). This can cause problems for veterans because some may not be able to seek treatment outside of the VA for monetary reasons, transportation, or regulations put in place by the VA about outside providers (Wakefield et al., 2007). Some of the reasons given for not seeking care at the VA include negative perceptions about the VA itself, accessibility, and the quality of both medical and mental health services (Franco et al., 2016). Veterans surveyed in one study reported the fact that they were treated as a number instead of as a person affected their overall satisfaction with treatment at the VA (Stoddard et al., 2017). Another study examined the reasons female veterans used or did not use the VA system and one of the findings showed women were concerned with the quality of care (Washington et al., 2006). The female veterans who used the VA system reported that they believed the quality of care at the VA was poor (Kelly et al., 2008).

The other domains within the qualitative study that examined barriers to using VA mental health treatment focused specifically on the VA itself (Cheney et al., 2018). The third domain was confidence in the overall VA health care system. The veterans interviewed cited staffing and appointment problems as well as a lack of follow-up care as reasons they were not confident in the VA's mental health services (Cheney et al., 2018). An overall lack of providers, long wait times, and seemingly being passed from one clinic to another were cited as reasons why veterans withdrew from seeking mental

health treatment altogether (Cheney et al., 2018). The fourth domain pertained to navigating VA health care benefits and services. Veterans cited a lack of understanding and an overall misunderstanding of VA benefits as reasons they were not using mental health services at the VA (Cheney et al., 2018). Many of the veterans interviewed mentioned that even when they determined they were eligible for services and obtained their benefits, they had no knowledge of how to enroll in certain health care services (Cheney et al., 2018). Another study also illustrated that a lack of awareness on the part of veterans about how connect with the VA in order to start receiving mental health services was a major barrier to seeking mental health treatment at the VA (NAESM, 2018). Additionally, those surveyed reported the process of applying for and accessing mental health services was "burdensome" and "unsatisfying" (NAESM, 2018). The researchers explained that veterans wished for improvements in the ease of making appointments as well as better customer service in order to make accessing mental health services more appealing (NAESM, 2018). The researchers also cited policy-related issues such as workforce problems and navigating eligibility requirements as barriers to veterans using mental health services at the VA (NAESM, 2018).

The final domain of the Cheney et al. (2018) study was centered around concerns about privacy, security, and the abuse of services. More specifically, veterans identified a fear of their personal information being disclosed to outsiders, resulting in negative consequences (Cheney et al., 2018). The researchers stated that across ages, there was an overall distrust of the VA health care system because it is a government institution (Cheney et al., 2018). The participants also cited that veterans misusing the VA health

care system for disability payments and pain medications negatively affected the VA health care experiences of other veterans (Cheney et al., 2018).

Perceptions of the VA

A handful of studies have examined how veterans view the VA and whether these views or other factors affect their use of VA services. One study in particular examined whether or not community-based veterans were using VA care and what factors affected whether they were using of not using the VA for services (Franco et al., 2016). Though a large proportion of veterans studied (73.5%) stated they had other health insurance and thus sought services outside of the VA, those who did not have other health insurance reported they did not use the VA because of uncertainty about their qualification, negative personal experiences, and hearsay about negative experiences (Franco et al., 2016). In another study looking specifically at women veterans and their use of VA services, 69% of nonusers said they made their decision based on negative perceptions they developed when going to the VA with a family member or friend (Washington et al., 2007). Another more recent study of veterans illustrated perceptions based on personal experiences or rumors heard from other veterans influenced whether a veteran sought care at the VA (Stoddard et al., 2017). More specifically, six out of 10 veterans reported they had negative or bad experiences at the VA with regard to the health care system (Stoddard et al., 2017). This study had a small sample size and was qualitative in nature, but results provided an in-depth look into the decision-making process veterans use when choosing not to seek treatment where they have benefits.

Only one study was found that exclusively looked at mental health treatment and attitudes about the VA (Fox et al., 2015). Researchers polled both male and female

veterans with regard to their mental health symptoms, their positive perceptions of VA care, perceived fit in the VA setting, beliefs about mental health and treatment, and their use of VA mental health care (Fox et al., 2015). Their results indicated that for women, positive perceptions of the VA as well as an entitlement to VA care were associated with greater use of VA mental health services (Fox et al., 2015). Also for women, a negative belief about mental health treatment seeking was associated with decreased use of the VA for mental health care (Fox et al., 2015). These negative beliefs were specific to treatment seeking as opposed to the other domains included in the measure used (i.e., Endorsed and Anticipated Stigma Inventory), which were negative beliefs about mental illness, negative beliefs about mental health treatment, concerns about stigma from loved ones, and concerns about stigma in the workplace (Fox et al., 2015; Vogt et al., 2014). Meanwhile for men, entitlement to services, similarity to other VA users with regard to health concerns and common demographic characteristics, and beliefs about mental health were associated with use of VA mental health services (Fox et al., 2015). For men, negative beliefs about mental health and treatment seeking were associated with less use of the VA for mental health care (Fox et al., 2015). Though this study examined how perceptions of the VA are associated with mental health service use, the researchers did not examine whether perceptions affected treatment seeking intentions.

The Theory of Planned Behavior

There is a difference between stigma and attitudes about mental health treatment seeking and the actual behavior that leads to an individual seeking mental health treatment. The theory of planned behavior, as outlined by Ajzen (1991), describes how attitudes influence an individual's intention to perform a particular behavior and how

those factors (i.e., attitudes and intentions) help predict whether an individual will follow through with a behavior. The structure of the theory of planned behavior starts with attitudes toward the behavior, subjective norms, and perceived behavioral control of being able to perform the behavior (Ajzen, 1991). These three factors then influence the intention of performing the behavior. Attitude toward the behavior refers to the individual's favorable or unfavorable evaluation of the behavior to be performed (Ajzen, 1991). The concept of subjective norms refers to the social pressure the individual perceives to be placed on them to perform or not perform the intended behavior (Ajzen, 1991). The third concept of perceived behavioral control refers to the perceived ease and accessibility of the individual's ability to follow through with the intended behavior (Ajzen, 1991). These three factors together or one factor on their own can influence the second step in the theory, which is intention. Intention within this theory is defined as the indication of how hard people are willing to try or how much effort an individual is willing to exert in order to perform a particular behavior (Ajzen, 1991). According to the theory, the stronger the intention an individual has to engage in a behavior, the more likely they will be to perform that behavior (Ajzen, 1991). In the context of mental health treatment seeking intentions at the VA, the stronger an individual's intention to seek mental health treatment at the VA, the more likely they will be to follow through and seek that treatment. Research conducted on the theory of planned behavior has demonstrated that the application of this theory, with regard to intentions, often varies across different behaviors and situations (Ajzen, 1991). Some applications of this theory demonstrate that attitudes about the behavior are more closely associated with intentions than are the other factors of subjective norms and perceived control of the behavior

(Ajzen, 1991). Studies in which researchers have examined intentional behaviors such as getting drunk (Schlegel et al., 1992), attending classes (Ajzen & Madden, 1986), and losing weight (Schifter & Ajzen, 1985) have all shown personal considerations/attitudes about the behavior to be more influential than social pressure and perceived control of the behavior. Perceptions of the VA may influence whether or not a veteran intends to seek mental health treatment at the VA. According to this theory, their intention may also be influenced by their attitude about seeking mental health treatment at the VA. Research has demonstrated veterans often have stigma and negative beliefs about mental health and mental health treatment and according to the theory of planned behavior, those attitudes may affect their intention to follow through with certain behaviors, namely seeking mental health treatment (Ajzen, 1991; Coll et al., 2011; De Luca et al., 2016; Fikretoglu et al., 2008; Kelly et al., 2008; Pietrzak et al., 2009; Stoddard et al., 2017; Wakefield et al., 2007; Williston et al., 2020; Wray et al., 2016).

Rationale

The higher prevalence of mental illness among the veteran population and their low treatment utilization despite these higher numbers leads to questions about what has impeded their treatment seeking intentions. A large number of studies have examined mental health stigma and the impact of being socialized in the military culture on the view of mental health and subsequent treatment (Berger et al., 2005; Coll et al., 2011; De Luca et al., 2016; Wakefield et al., 2007; Wray et al., 2016). Another area that has been researched is the view of mental health providers, specifically when they are civilians treating military/veteran personnel (Cheney et al., 2018; Wakefield et al., 2007; Wray et al., 2016). Research has primarily focused on views of mental health diagnoses as well as

mental health treatment and service providers, but there may be other barriers such as perceptions of entities like the VA that provide these services. Little research has been done on whether or not perceptions can influence a veteran's willingness to seek mental health treatment from either outside providers or the VA. Some research has indicated there are barriers to veterans seeking medical treatment at the VA, especially women who feel they are not understood at male-dominated VA medical centers (Washington et al., 2007). Other research has highlighted that there are VA-specific reasons why veterans may be hesitant to seek mental health treatment at the VA and that there are shortcomings when it comes to mental health treatment at the VA as determined by government evaluation research (NAESM, 2018). Evidence that the VA itself may be a barrier to the use of services when a veteran may not be able to seek services outside of the VA leads to the question of whether or not perceptions of the VA can also be a barrier to mental health treatment. More specifically, does having positive or negative experiences at the VA, hearing stories about the VA from friends or family, and seeing positive and negative stories in the media about the VA shape one's perception of the VA and serve as an additional barrier to seeking mental health treatment there? Perceptions of the VA may also lead a veteran to develop attitudes about seeking mental health treatment that align with their perceptions. According to the theory of planned behavior, attitudes about a behavior are closely linked to intentions about engaging in that particular behavior, which can then influence whether the behavior is completed (Ajzen, 1991). Due to the higher prevalence of mental illness among the veteran population along with the increased risk of suicide, determining barriers to mental health treatment is particularly important. Understanding whether or not perceptions of the VA itself affect treatment seeking

attitudes and intentions would be clinically relevant in terms of addressing the sources of such barriers to improve treatment seeking intentions at the VA. Knowing whether perceptions of the VA serve as a barrier could inform clinicians as well as government entities about how to and remediate the impacts of negative experiences and perceptions of the VA on veterana' mental health.

Aims

The specific aim of the current study was to examine the association between perceptions of the VA system with a veteran's intention to seek mental health treatment at the VA. Specifically, the study was designed to assess whether veterans' perceptions based on personal experience, secondhand knowledge of experiences, and media representation skewed their perception of the VA to be more positive or negative. The study was also designed to assess veterans' attitudes about seeking mental health treatment at the VA and the interplay with intention to seek mental health treatment at the VA. More specifically, how was a veteran's perception of the VA and its mental health services associated with their attitude about seeking mental health treatment at the VA and subsequently how was that associated with their intention to follow through and seek mental health treatment at the VA? In order to add to the literature, the current study took into consideration the impact of a mediational relationship between perceptions of the VA, attitudes about seeking mental health treatment at the VA, and intentions about seeking mental health treatment at the VA. The researcher in this study aimed to further narrow down whether perceptions of the VA served as a barrier to veterans using mental health treatment specifically at the VA.

Hypotheses

It was hypothesized that veterans' higher levels of positive perceptions of the VA based on media reports, personal experience, or secondhand knowledge would be associated with higher self-reported intentions to seek mental health treatment at the VA. Additionally, it was hypothesized that the relationship between perceptions and intentions to seek mental health treatment at the VA would be mediated by the veterans' self-reported attitudes about seeking mental health treatment at the VA.

Methods

Design

This study involved the use of a correlational research design to examine the relationship between perceptions of the VA and intention to seek mental health treatment at the VA and whether attitudes about seeking mental health treatment at the VA mediated this relationship.

Participants

Participants were U.S. veterans. The population included any individual who was considered a veteran based on the definition provided by Title 38 of the Code of Federal Regulations: "A person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable" (U.S. Department of Veterans Affairs, 2019a, p. 1). Active duty members of the military were excluded as the researcher was looking to examine veterans specifically. The sample did not exclude veterans based on theatre of war or combat experience. Veterans who were active duty and were stationed in the United States or on foreign military bases without direct combat exposure were included in the participant sample. Exclusion criteria consisted of veterans with psychotic disorders to ensure participants were competent enough to voluntarily participate and serve as accurate historians.

Participants were recruited through snowball sampling by using social media and other online platforms (i.e., Facebook [a social networking website intended to make it easy to connect and share with friends and family], Instagram [a free video and photo sharing social networking application accessed from phones and computers], and Twitter [a "microblogging" social networking website that allows users to interact, comment, and

repost entries]. In addition to recruitment on Facebook in general, specific veteran Facebook groups were used after obtaining permission from group leaders to post a recruitment flyer (see Appendix A). The researcher ensured the posting of research recruitment flyers did not violate the current terms of service of any of the sites. According to a power analysis, the targeted sample size was 84 participants (alpha ≤ .05, medium effect size, power = .80; Cohen, 1992) with the final sample consisting of 134 survey responses, 96 of which were completed and included in the current analyses.

Measures

Demographics Questionnaire

All participants completed a demographic characteristics questionnaire created for the purpose of the study that included open-ended response options (see Appendix B). Participants were asked to provide general demographic information, such as age, gender, race/ethnicity, current town and state in which they reside, highest level of education, and marital status. They were also asked to provide information specific to the current study such as their eligibility to use VA services; their mental health diagnoses; if they had sought mental health treatment before, where they had sought mental health treatment before; if they were currently seeking mental health treatment, where and for what reasons; if they were exposed to combat, where, and for how long; if they served a tour of duty, where, and how long; if they were stationed overseas, where, and for how long; and how long they have been considered a veteran (i.e., been non-active duty military).

VA Perception Questionnaire

A perception questionnaire was used to determine participants' perceptions of the VA hospital and the services offered (see Appendix B). A modified version of the

Perceptions of VA-Specific Institutional Barriers to Care measure used by Vogt et al. (2006) to examine ratings of Veterans Health Administration medical care was used to examine perceptions of the VA with regard to mental health treatment. The original study and assessment measured barriers to medical treatment use at the VA with only women participants. These barriers included availability of services, physicians' skill and sensitivity, logistics of care, and facility/physical environment characteristics (Vogt et al., 2006). In the original study, each domain was analyzed in terms of internal consistency, resulting in the following scores: .84 (availability of services), .89 (physician sensitivity and skill), .90 (logistics of care), and .73 (facility/physical environment characteristics; Vogt et al., 2006). Fox et al. (2015) modified the measure to include both men and women and changed the questionnaire prompt of the entire measure to include the participants' own experiences and what they had heard from others to determine their overall rating of VA health care. Instead of using the original four barriers, the modified measure only included three domains: perceived availability of services at the VA, ease of use, and perceived staff skill and sensitivity (Fox et al., 2015). All domains were rated using a 5-point Likert scale ranging from 1 (*extremely negative*) to 5 (*extremely positive*; Fox et al., 2015). The internal consistency coefficient of the sum scale for the modified version used by Fox et al. was .88. There is no known reliability for the individual domains used in the measure.

The researcher in the current study used the modified version of the Perceptions of VA-Specific Institutional Barriers to Care measure that focused on mental health used by Fox et al., which included a modified instruction prompt as well as three of the four original domains. The modified version of the perception measure was used with both

male and female veterans and was in line with the aim of the current study to include all genders. The current internal consistency scores for the measure and the three domains are as follows: total perception measure, $\alpha = .96$; availability of services, $\alpha = .89$; ease of use, $\alpha = .91$; and staff skill and sensitivity, $\alpha = .91$.

Mental Help Seeking Intention Scale

Treatment seeking intentions were measured using a modified questionnaire that aligns with the theory of planned behavior, the Mental Help Seeking Intentions Scale (MHSIS; see Appendix B; Ajzen, 2006; Hammer et al., 2018; Hammer & Spiker, 2018). The MHSIS consists of three items related to an individual's intention to seek mental health treatment if they are dealing with a mental health concern (Hammer & Spiker, 2018). Respondents rate their answers to the three questions on a 7-point Likert scale ranging from 1 (*extremely unlikely*) to 7 (*extremely likely*), 1 (*definitely false*) to 7 (*definitely true*), and 1 (*strongly disagree*) to 7 (*strongly agree*; Hammer & Spiker, 2018). A higher score indicates a greater intention to seek mental health treatment whereas a lower score indicates a lesser intention to seek mental health treatment (Hammer & Spiker, 2018). In the current study, the MHSIS was used twice. One version was the original form, which referred to mental health treatment in general. A modified version of the MHSIS was also used that was specific to seeking mental health treatment at the VA. With regard to reliability and validity, the MHSIS was also compared to other measures of intention to seek mental health treatment, namely the Intentions to Seek Counseling Inventory (ISCI) and the General Help-Seeking Questionnaire (GHSQ; Hammer & Spiker, 2018). In comparison to the other measures, the MHSIS was found to demonstrate the strongest evidence of predictive validity through logistical regressions

(ISCI = $p < .05$, GHSQ = $p < .02$, MHSIS = $p < .01$). The results of the study also indicated the MHSIS had an internal consistency score as measured by a Cronbach's alpha of .94 (Hammer & Spiker, 2018; Hammer & Vogel, 2013; Hess & Tracey, 2013; Mo & Mak, 2009). Additionally, the study examined whether or not the MHSIS was reliable with regard to replications, and the factor determinacy (FD = .97) and construct reliability/replicability (H index = .94) were above the cutoff scores (FD > .90; H index > .80), indicating construct replicability (Hammer & Spiker, 2018). The study also determined there was predictive evidence of validity with regard to the MHSIS as the results demonstrated a 70% accuracy rate among the community sample used in the study (Hammer & Spiker, 2018). The internal consistency for the non-modified version of the MHSIS for the current sample was $\alpha = .97$ and the VA-specific version of the MHSIS had an internal consistency score of $\alpha = .98$.

Mental Help Seeking Attitudes Scale

The mediation variable of attitudes about seeking mental health treatment was measured using a modified version of a questionnaire based on the theory of planned behavior (see Appendix B; Ajzen, 2006; Hammer et al., 2018). The Mental Help Seeking Attitudes Scale (MHSAS) is a 9-item scale that examines an individual's attitude toward seeking help from a mental health professional (Hammer et al., 2018). The higher the score on this measure, the more positive the respondent's attitude toward seeking mental health treatment and the lower the score the more negative their view of seeking mental health treatment (Hammer et al., 2018). Respondents were asked to rate different domains on a 7-point scale with the prompt, "If I had a mental health concern, seeking help from a mental health professional would be…" The researcher in the current study

modified the prompt for the MHSAS to be specific to the VA setting. The modified prompt was, “If I had a mental health concern, seeking help from a mental health professional at the VA would be…” (Hammer et al., 2018). Each domain has two anchor points that the respondent must use to rate their response. For example, participants rank their opinion of seeking help from a mental health professional on a scale from useless to useful. The item has seven options with the middle/neutral option being a 0 and the useless and useful sides of the item having options from 1 to 3 (useless 3 2 1 0 1 2 3 useful; Hammer et al., 2018). The other domains include unimportant versus important, unhealthy versus healthy, ineffective versus effective, good versus bad, healing versus hurting, disempowering versus empowering, satisfying versus unsatisfying, and desirable versus undesirable (Hammer et al., 2018). Scores are recoded and compiled to create a mean score that determines one’s overall attitude toward seeking mental health treatment (Hammer et al., 2018). The original Likert scale in the measure was recoded to be a normal 7-point Likert scale ranging from 1–7, as per measure scoring instructions, in order to fully score and calculate mean scores for each participant (Hammer et al., 2018). The MHSAS is a relatively new measure that has been examined in two studies in comparison to other measures designed to measure treatment seeking attitudes (Hammer et al., 2018). The results of that study indicated the MHSAS is more in line with the theory of planned behavior as compared to the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPH) and the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Ajzen, 2006; Hammer et al., 2018). The results indicated the MHSAS accounted for 9% more unique variance on the theory of planned behavior variables (i.e., subjective norms, perceived behavioral control, intention, public

stigma, self-stigma, and anticipated risks and benefits) as compared to the ATSPPH and IASMHS (Hammer et al., 2018). The researchers also examined whether the MHSAS had test–retest reliability and reported there was high reliability of scores with the MHSAS over a 3-week period (r = .76) and no significant mean differences between the two trials (Hammer et al., 2018). Additional analyses indicated the factor determinacy (FD = 97) and construct reliability/replicability (H index = .94) were above the cut off scores, meaning there is construct replicability in the measure. The internal consistency score of the MHSAS was reported using a Cronbach's alpha of .93 (Hammer et al., 2018). With regard to validity, the study reported there was convergent validity with the other measures (i.e., ATSPPH and IASMHS) that were also examining treatment seeking behaviors at a $p < .05$ level (Hammer et al., 2018). This study indicated the MHSAS measured more variables in the sample that were not accounted for by the ATSPPH or IASMHS with regard to the theory of planned behavior and treatment seeking intentions (Hammer et al., 2018). The internal consistency score for the MHSAS with the current sample was $\alpha = .96$.

Procedures

Participants were recruited via the social media platforms Facebook, Instagram, and Twitter. A recruitment flyer was posted on the respective social media platforms with clear indications of the inclusion criteria. The flyer outlined the purpose of the study and the types of variables the researcher was looking to examine, namely that the study was about veterans' perceptions of the VA and mental health treatment seeking intentions. After permissions were granted by veteran specific Facebook group leaders, the researcher posted the recruitment flyer in these more exclusive groups. A link was

provided within the flyer and accompanying description when posting on the social media platforms. There was a clear disclosure of the researcher's affiliation with schools as well as the researcher's status as a doctoral student. Information about the approval of the study by the Institutional Review Board at National Louis University was included in the flyer as was the researcher's contact information in case the participants had any questions. Individuals who saw the research recruitment flyer were encouraged to share the flyer with others who may have qualified for participation in the study. Once participants determined they were eligible to participate in the study, they clicked on the link, which took them to a series of surveys as well as an informed consent form (see Appendix C). The first screen that participants encountered was the consent form about their participation in the research study. The informed consent form included additional information about the study, what would be asked of participants, how much time their participation was anticipated to take, and resources and contact information if they had any questions. Measures to protect the confidentiality and anonymity of participants were outlined in the informed consent form, which indicated that no identifying information would be obtained and that raw questionnaire data would be password protected and only available to the researcher and the research supervisor. After the informed consent form, participants filled out the demographics questionnaire. Following the demographics questionnaire, participants filled out the unmodified MHSIS questionnaire, then the perceptions of the VA questionnaire, and the two modified treatment seeking behavior questionnaires (i.e., MHSAS and MHSIS) in that order. The online survey ended with a debriefing form thanking participants for their time and participation and providing links

to resources (see Appendix D). Specifically, for the veteran population, mental health resources within the VA as well as outside of the VA were provided.

Statistical Analyses

First, normality of distributions were examined for all main study variables and descriptive analyses were conducted. In addition, preliminary analyses were conducted to determine the relationships between demographic variables and the main study variables using correlations and ANOVAs. Additionally, zero-order correlations were conducted on continuous study variables to examine preliminary relationships between the independent and dependent variables.

A mediation analysis was used to determine whether the hypothesis that the relationship between perceptions of the VA held by veterans and intention to seek mental health treatment at the VA was mediated by attitudes about VA mental health treatment. The macro analysis outlined by Preacher and Hayes (2004) allowed for the four analyses that Baron and Kenny (1986) originally outlined related to mediation to be run but provided additional analyses that increased the statistical power of the results. The macro analysis for this study identified whether there was a significant positive relationship between perceptions of the VA and intention to seek mental health treatment at the VA. Based on the hypotheses, this would mean that the lower the participants' perceptions of the VA, the lower their intention to seek mental health treatment. Next, the macro was used to analyze the relationship between the independent variable and the potential mediation variable to determine whether there was a significant relationship. With regard to this study, the analysis examined the relationship between perceptions of the VA and attitudes about seeking mental health treatment at the VA. The hypothesis for the current

study predicted a positive relationship between these two variables. More specifically, as perceptions of the VA decreased, so would attitudes about seeking mental health treatment at the VA. The third analysis included in the macro examined the relationship of the potential mediator variable with the dependent variable while controlling for the independent variable. The variables from the current study were attitudes about seeking mental health treatment at the VA and intention to seek mental health treatment at the VA. The third analysis was also predicted to reveal a positive relationship with intentions and attitudes decreasing together. The fourth and final analysis in the macro that was outlined by Baron and Kenny (1986) was the analysis of the independent variable and the dependent variable while controlling for the potential mediation variable. In the current study, this was an analysis of perceptions of the VA compared to intentions to seek mental health treatment at the VA while controlling for attitudes about seeking mental health treatment at the VA. The hypothesis of this study predicted that there would not be a significant relationship in the analysis due to the mediation variable being controlled.

According to the Preacher and Hayes (2004) model, the use of a bootstrapping method can increase the statistical power of the analyses. The bootstrapping method allows for the mediation model to be applied to smaller samples with more confidence while also making no assumptions about the shape of the distribution (Preacher & Hayes, 2004). This method accomplishes this by taking a large number of samples from the original sample size of the data, sampling with replacement, and computing indirect effects for each of the samples (Preacher & Hayes, 2004). This analysis is interpreted via confidence intervals, which are reported in the output at both the 95% and 99% levels (Preacher & Hayes, 2004). For the current study, the alpha value used was less than .05

so 95% confidence intervals were examined in the bootstrapping output. In line with the direction of the hypotheses, the 95% confidence interval would not include 0, which would indicate significance at or below the .05 level (Preacher & Hayes, 2004). This analysis, when included with all the others in the macro, would indicate a simple mediation between perceptions of the VA and intentions to seek treatment at the VA by attitudes about seeking mental health treatment at the VA.

Results

Sample Demographics

General

The final sample consisted of 96 self-identified U.S. veterans. The overall number of participants obtained through online recruitment totaled 134 but due to missing data that would not allow for hypothesis testing, 38 individuals were excluded from the final sample. The age of participants in the final sample ranged from 26–79 years with a mean of 54.22 years (*SD* = 11.06). Participants reported living in a total of 31 different states within the United States with Illinois having the most participants at 18 (18.8%). In addition, three (3.1%) participants reported living outside of the continental United States or in a different country at the time of participation. Table 1 outlines the remaining demographic characteristics for the current sample.

Table 1

Demographic Variables

Variable	*n*	%
Gender		
Male	73	76
Female	22	22.9
Transgender	1	1
Race/Ethnicity		
Caucasian/White	90	93.8
Latinx	4	4.2
Native American/Alaskan Native	1	1
American	1	1
Education		
High school diploma/Equivalent	26	27.1
Technical/Trade school certificate	15	15.6

Variable	*n*	%
Some college	1	1
Associate's degree	8	8.3
Bachelor's degree	22	22.9
Master's degree	22	2.1
Doctoral degree	2	2.1
Marital status		
Married	61	63.5
Divorced	19	19.8
Separated	3	3.1
Single	6	6.3
Civil union	1	1
Widowed	4	4.2
Other[a]	2	2.1

[a] Other responses included fill-in responses of "being in a relationship" for a specified amount of time.

Military and Veteran Status Information

The sample's (*n* = 85) military service in the armed forces ranged from 3–43 years with the mean number of years being 14.34 years (*SD* = 8.89). Participants (*n* = 76) were asked to specify how long they had held the status of being a veteran (i.e., being non-active duty military), which ranged from 0–50 years with the mean length of time being 20.98 years (*SD* = 11.50). All participants within the final sample reported they were eligible for services through the VA. With regard to the duration of overseas deployment, a total of 76 participants responded with the total time ranging from 1–204 months over one or multiple deployments (*SD* = 28.05). The mean length of total deployment overseas was 22.90 months. Those who reported being exposed to combat also reported the duration of their exposure (*n* = 71), which ranged from 1–144 months over one or multiple deployments with the mean length of exposure to combat being 13.12 months (*SD* = 18.53). In terms of duration (*n* = 61), the range spanned 4–204

months for total time stationed overseas over one or more stationed assignments with the mean stationed time being 36.92 months (*SD* = 36.65). Table 2 includes all additional military demographics for the sample.

Table 2

Military Demographic Variables

Variable	*n*	%
Branch		
Army	55	55.3
Marines	10	10.4
Navy	11	11.5
Air Force	18	18.8
National Guard	2	2.1
Overseas deployment status		
Yes	85	88.5
No	11	11.5
Combat exposure status[a]		
Yes	71	74
No	22	22.9
Stationed overseas status		
Yes	64	66.7
No	32	33.3
Overseas deployment location		
Middle East	73	76
Asia	23	23.9
Africa	6	6.2
Caribbean	3	3.1
Mediterranean	2	2
U.S. territories/States	1	1
Central and South America	12	12.5
Europe	3	3.1
Australia/New Zealand	1	1
Combat exposure location		

Variable	*n*	%
Middle East	65	67.7
Asia	9	9.4
Africa	5	5.2
Central and South America	3	3.1
Europe	3	3.1
Caribbean	1	1
Stationed overseas location		
Middle East	9	9.4
U.S./U.S. territory	1	1
Asia	15	15.6
Central and South America	2	2.1
Europe	31	32.3

Note. Location categories include the following: Middle East- Saudi Arabia, Kuwait, Iraq, Iran, Afghanistan, Desert Storm, Persian Gulf, Qatar, Kyrgyzstan, Jordan, Bahrain, Turkey, and the Red Sea; Asia- Japan, Korea, Southeast Asia, Far East, Vietnam, China, Southwest Asia, Philippines, and the Pacific; Africa- Somalia, Djibouti, East Africa, and Egypt; Central and South America- Honduras, Panama, and Venezuela; Caribbean- Jamaica, Barbados, Haiti, and Cuba; U.S. Territory/States- Hawaii and Guam; Europe- Bosnia, Macedonia, Kosovo, Portugal, Yugoslavia, Germany, England, and Scotland.

[a] Three participants did not respond to this question.

Mental Health

The next series of background questions pertained to mental health diagnoses and mental health treatment. The majority (70.8%) of the participants reported having received a formal health diagnosis in their lifetime, with the most prevalent diagnosis being PTSD (54.2%). The majority (72.6%) had previously sought mental health treatment and did so at a VA (63.5%). Table 3 contains the participant numbers and percentages for the current sample on these variables.

Table 3

Mental Health Demographic Variables

Variable	*n*	%
Formal mental health diagnosis		
Yes	68	70.8
No	28	29.2
Diagnosis		
PTSD/Trauma	52	54.2
Depression/Mood disorder	37	38.6
Anxiety/Panic attacks	27	28.1
Anger	2	2.1
ADHD	2	2.1
Sleep disorders	2	2.1
Instability	1	1
Agoraphobia	1	1
OCD	1	1
Personality disorders	1	1
Gender dysphoria	1	1
Eating disorders	1	1
Previous mental health treatment seeking status		
Sought treatment	70	72.6
Not sought treatment	26	27.1
Previous mental health treatment location		
VA	60	62.5
Private/Outside VA providers	19	19.8
Unknown/Not disclosed	3	3.1
Current mental health treatment status		
Currently in treatment	45	46.9
Not in treatment	51	53.1
Current mental health treatment location		
VA	38	39.6
Private/Outside VA provider	8	8.3
Current reason for seeking mental health treatment		

Variable	*n*	%
PTSD/Trauma	24	24.9
Maintenance/Daily functioning	8	8.4
Medication	3	3.1
Depression/Mood disorders	22	22.9
Anxiety/Panic attacks	19	19.8
ADHD	2	2.1
Sleep disorders	2	2.1
Substance/Relapse/Addiction	2	2.1
Gender dysphoria	1	1
Agoraphobia	1	1
OCD	1	1

Note. VA = Veterans Administration.

Main Study Measures

A series of reliability analyses were run on all measures to determine the internal consistency of the measures with this sample ($N = 96$). The non-VA specific MHSIS consisted of three questions. Cronbach's alpha showed the questionnaire to reach a high level of internal consistency ($\alpha = .97$). The perceptions measure that examined overall perception of the VA ($\alpha = .96$) as well as availability of services consisting of seven items ($\alpha = .89$), ease of use consisting of 11 items ($\alpha = .91$), and staff skill and sensitivity consisting of eight items ($\alpha = .91$) also had high levels of internal consistency. The original measure for perceptions of the VA consisted of 28 items but due to experimenter error, two of the original items were left off. Despite the two items being left off, the overall internal consistency of the perception measure for this sample was high and the subscale of ease of use, which originally included the missing items, also had a high level of internal consistency. The MHSAS consists of nine items ($\alpha = .96$) indicating a high level of internal consistency for this measure within the sample. The MHSIS that was

altered to be specific to the VA consisted of three items ($\alpha = .98$) indicating a high level of internal consistency. Table 4 includes the descriptive statistics associated with the main study measures.

Table 4

Main Study Measure Descriptive Statistics

Measure	Min	Max	*M*	*SD*
MHSIS	1	7	5.2	1.82
Perceptions of the VA	26	130	77.54	22.21
MHSAS	1	7	4.33	1.79
MHSIS (VA version)	1	7	4.15	2.12

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

Distributions of Study Variables

A series of normality distribution analyses were computed for the main variables in the study. The MHSIS non-VA version was abnormally distributed ($p < .001$). The skewness of the MHSIS non-VA version was -.77, indicating the distribution was left-skewed. The kurtosis of the MHSIS non-VA version was -.359, indicating the distribution was light-tailed as compared to a normal distribution. The perceptions measure was normally distributed ($p < .14$). The skewness of the perceptions measure was .021, indicating the distribution was right-skewed. The kurtosis of the perceptions measure was -.012, indicating the distribution was light-tailed compared to a normal distribution. The MHSAS was normally distributed ($p < .08$). The skewness of the MHSAS was -.16, indicating the distribution was left-skewed. The kurtosis of the MHSAS was -.76, indicating the distribution was light-tailed. The MHSIS VA version was not normally distributed ($p < .002$) and its skewness was -.08, indicating the

distribution was left-skewed. The kurtosis of the MHSIS VA version was -1.34, indicating it was light-tailed compared to a normal distribution.

Associations Between Demographic and Main Study Variables

A series of zero-order correlations were run between the continuous variables and the independent and dependent variables. With regard to age, there was a significant positive correlation between the age of the participant and their score on the MHSIS non-VA version ($p < .03$). This means that within the sample, as age increased so did their report of having the intention to seek help from a mental health professional. Age was not significantly correlated with any other measure score or subscale, including the VA-specific MHSIS. The variable of years as a veteran was positively correlated with the non-VA scores on the MHSIS ($p < .02$), meaning that as the number of years of being a veteran increased, so did the MHSIS score, which means those who had been a veteran longer tended to report having higher intentions to seek help from a mental health professional. There were no additional significant correlations between continuous variables and measure and subscale scores within the sample. Tables 5–7 illustrate the correlations among the above-mentioned variables.

Table 5

Age and Main Study Variable Correlations

Variable	1	2	3	4	5
1. Age	—				
2. MHSIS	.19*	—			
3. Perceptions of the VA measure	.06	.29**	_		
4. MHSAS	.03	.74**	.61**	—	
5. MHSIS (VA Version)	.01	.47**	.60**	.82**	—

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

* $p \leq 0.01$. ** $p \leq 0.05$.

Table 6

Years of Service and Main Study Variable Correlations

Variable	1	2	3	4	5
1. Years of service	—				
2. MHSIS	.08	—			
3. Perceptions of the VA measure	.09	.29**	_		
4. MHSAS	.12	.52**	.74**	—	
5. MHSIS (VA Version)	.11	.47**	.60**	.82**	—

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

* $p \leq 0.01$. ** $p \leq 0.05$.

Table 7

Years as Veteran and Main Study Variable Correlations

Variable	1	2	3	4	5
1. Years as veteran	—				
2. MHSIS	.20*	—			
3. Perceptions of the VA measure	-.08	.29**	_		
4. MHSAS	-.09	.53**	.61**	—	
5. MHSIS (VA Version)	-.08	.47**	.60**	.82**	—

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

* $p \leq 0.01$. ** $p \leq 0.05$.

Continuous background variables were also correlated with each other, including years of service, years being a veteran, duration of deployment, duration of combat exposure, and duration of time stationed overseas. Age and years of service were positively correlated ($p < .001$), indicating that the older one reported being the more years of military service they had. This trend was also true for age and years holding veteran status ($p < .001$), meaning that as age increased within the sample, so did the number of years qualifying as a veteran. Age and deployment length and combat exposure duration were not correlated, but there was a positive correlation between age and how long the participants in the sample were stationed overseas ($p < .007$). This correlation indicates that as the age within the sample increased, the number of years stationed overseas also increased. Years of service was positively correlated with years of being a veteran within the sample ($p < .004$), indicating that the number of years served increased while years holding the status of a veteran also increased. In addition to veteran status, the number of years served in the military was also positively correlated with the number of months spent stationed overseas ($p < .003$). With regard to years being a

veteran, the only correlation was between years as a veteran and length of time in a combat zone ($p < .03$). Deployment time was positively correlated with length of time in a combat zone ($p < .006$) and length of time stationed overseas ($p < .001$). Table 8 contains the correlations between continuous variables.

Table 8

Age and Continuous Variable Correlations

Variable	1	2	3	4	5	6
1. Age	—					
2. Years of service	.36**	—				
3. Years as a veteran	.65**	-.28**	_			
4. Duration of deployment	.15	.21*	-.10	—		
5. Duration of combat exposure	-.14	.10	-.22*	.31**	—	
6. Duration stationed overseas	.31**	.38**	-.12	.67	-.07	—

* $p \leq 0.01$. ** $p \leq 0.05$.

A series of analysis of variances (ANOVAs) were performed to determine whether there were any statistical differences between groups of discrete background variables and the independent and dependent variables. Results of the analyses showed there were no statistically significant differences between categories of the independent variables for race/ethnicity, education, marital status, VA eligibility, state of residence, military branch, deployment status, deployment location, exposure to combat, stationed overseas status, mental health diagnosis status, mental health diagnosis, previous treatment location, and current reason for seeking treatment on any of the independent or dependent study variables.

In examining combat exposure region (i.e., where participants were physically exposed to combat) and the independent, dependent, and mediating variables, there was a statistical difference between means for the perception of the VA measure, $F(2, 71) =$

5.49, $p < .006$, and MHSAS score, $F(2, 71) = 3.47$, $p < .03$. A Tukey post hoc test was computed to determine which groups had differing means. The overall perceptions measure differed at a significant level between one and three or more regions of combat ($p < .006$) and two regions and three or more regions of combat exposure ($p < .008$). Those who had been exposed to combat in one or two regions had overall more positive perceptions of the VA as compared to those who were exposed to combat in three or more regions. Additionally, there were statistical differences between means for the MHSAS between one region and three or more regions ($p < .04$) and between two regions and three or more regions of combat exposure ($p < .04$). This means those who were exposed to combat in one or two regions had more positive attitudes about seeking mental health treatment at the VA than those who were exposed to combat in three or more regions. There was a difference between means for region stationed overseas and the perceptions of the VA measure, $F(2, 47) = 3.66$, $p < .03$. Statistical significance was found between whether participants were stationed overseas at one region versus two overseas regions and the overall perceptions measure ($p < .03$). This indicates those who were stationed overseas in one region, regardless of duration, had more positive overall perceptions of the VA.

A statistical difference was found between VA and outside VA current treatment on the MHSIS VA version, $F(2, 49) = 4.57$, $p < .01$. Those who reported seeking treatment at the VA had higher ratings, indicating they reported higher intentions of seeking mental health treatment from the VA as compared to those who were currently seeking treatment outside of the VA. The last statistical difference found was between mental health treatment seeking statuses (i.e., those who were still currently seeking

mental health treatment, those who never sought mental health treatment, and those who were no longer seeking mental health treatment). First, there was a statistical difference between those who were still seeking mental health treatment and those who were no longer seeking mental health treatment after having sought treatment in the past on the MHSIS non-VA version, $F(2, 93) = 6.44$, $p < .002$. Those who were still seeking mental health treatment reported higher intentions to seek mental health treatment than those who were no longer seeking mental health treatment. There was also a statistical difference between those who were currently seeking treatment and those who were no longer seeking treatment on the MHSIS VA version, $F(2, 93) = 6.17$, $p < .003$. Those who were still seeking mental health treatment reported higher intentions to seek mental health treatment at the VA compared to those who were no longer seeking mental health treatment. There was a statistical difference between those who had sought mental health treatment in the past and those who were no longer seeking mental health treatment at the time of completing the survey on the perceptions of the VA measure, $F(2,93) = 4.23$, $p < .02$. Those who reported they were still currently seeking mental health treatment had more positive perceptions of the VA as compared to those who had sought mental health treatment in the past but were no longer currently seeking mental health treatment ($p < .02$). There was also a statistical difference found between mental health treatment seeking status on the MHSAS, $F(2, 93) = 1.03$, $p < .02$. There was a significant difference between those who had never sought treatment and those who had sought treatment in the past but were currently not seeking mental health treatment ($p < .04$). Those who had never sought mental health treatment had more positive attitudes about mental health treatment at the VA than did those who were no longer seeking mental

health treatment. Additionally, there was a significant difference between those who were still currently seeking treatment and those who had sought mental health treatment in the past but were no longer seeking treatment ($p < .03$). Those who were still seeking mental health treatment at the time of the survey had more positive attitudes about VA mental health treatment than did those who were no longer seeking mental health treatment. Tables 9–12 demonstrate the significant ANOVA results for the main variables.

Table 9

Combat Region and Main Study Measures ANOVA

Measure	One region		Two regions		Three or more regions		*F(2,71)*	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*		
MHSIS	5.18	1.77	5.40	1.53	5.42	2.24	.22	.006
Perceptions measure	81.14	21.33	87.00	18.53	41.33	17.62	5.49*	.13
MHSAS	4.39	1.66	4.96	2.04	1.96	0.71	3.47*	.09
MHSIS (VA Version)	4.29	2.29	5.28	0.94	2.00	0.24	2.58	.07

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

*$p < .05$.

Table 10

Overseas Location and Main Study Measures ANOVA

Measure	One region		Two regions		Three or more regions		*F(2,47)*	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*		
MHSIS	5.05	1.82	6.39	1.34	3.00	-[a]	2.27	.09
Perceptions measure	74.35	20.33	95.67	16.33	100.00	-[a]	3.66*	.13
MHSAS	4.06	1.66	5.67	0.96	3.78	-[a]	2.67	.10
MHSIS (VA Version)	4.14	2.05	5.33	2.26	5.00	-[a]	0.93	.04

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

[a] Only one participant was stationed overseas in three or more locations.

*$p < .05$.

Table 11

Current Treatment Location and Main Study Measures ANOVA

Measure	VA/VAMC military provider		Private practice/Outside VA provider		Both VA & outside VA providers		*F(2,47)*	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*		
MHSIS	5.68	1.54	6.52	0.74	6.00	-[a]	1.01	.05
Perceptions measure	83.30	24.32	67.57	6.54	78.00	-[a]	1.33	.06
MHSAS	4.88	1.70	3.48	1.10	4.00	-[a]	2.25	.10
MHSIS (VA Version)	5.18	1.85	3.00	2.90	4.33	-[a]	3.98*	.16

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

[a] Only one participant was seeking treatment at both a VA site and with an outside VA provider.

*$p < .05$.

Table 12

Mental Health Treatment Seeking Status and Main Study Measures ANOVA

Measure	Never sought treatment		Still seeking treatment		No longer seeking treatment		*F(2,47)*	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*		
MHSIS	5.06	2.07	5.79	1.46	4.25	1.76	6.44*	.12
Perceptions measure	80.27	17.42	81.74	24.57	66.54	18.87	4.23*	.08
MHSAS	4.65	1.72	4.60	1.66	3.46	1.88	4.03*	.08
MHSIS (VA Version)	4.24	2.08	4.72	2.03	2.94	1.94	6.17*	.12

Note. MHSIS = Mental Help Seeking Intention Scale, MHSAS = Mental Help Seeking Attitudes Scale.

*$p < .05$.

Hypothesis Testing

A series of bootstrapped multiple regressions was performed to determine whether there were associations between the independent, dependent, and mediator variables. A bootstrapping method was used to reduce error. The bootstrapping method does not assume normality and is best applied to smaller samples with more confidence (Preacher & Hayes, 2004). The bootstrapping samples were set at 1,000 sampling for each of the regression analyses performed for hypothesis testing. As outlined by Preacher and Hayes (2004), the first regression analysis was performed between the independent and dependent variables to determine the effect of perceptions of the VA on the sample's reports of intentions to seek mental health treatment specifically at the VA. The relationship between high positive perceptions of the VA and high positive intentions to seek mental health treatment at the VA was positive and significant ($R = .61$, $\beta = .609$, $p < .001$). The R^2 value indicates the independent variable of perceptions of the VA

accounted for 37% of the variance in the dependent variable of intentions to seek mental health treatment at the VA ($R^2 = .370$) with a confidence interval not containing 0, which indicates there was an indirect effect between the two variables (95% CI [.045, .071]).

The next regression performed was between the independent variable and the mediator variable (i.e., between perceptions of the VA and attitudes about mental health treatment at the VA). The relationship between the independent and mediator variables was significant ($R = .74$, $\beta = .059$, $p < .001$), indicating that the more positive the perceptions of the VA, the more positive the attitude about mental health treatment. Perceptions of the VA accounted for 55% of the variance in attitudes about mental health treatment at the VA ($R^2 = .545$, 95% CI [.050, .069]).

The next analysis as outlined by Preacher and Hayes (2004) was a hierarchical multiple regression between the mediator and the dependent variable while controlling for the independent variable. In other words, attitudes about mental health treatment at the VA was regressed on reported intentions to seek mental health treatment at the VA while controlling for perceptions of the VA. According to the results, perceptions accounted for 37% of the variability in intentions whereas both attitudes and perceptions accounted for 67% of the variability in intentions. The change in R^2 was statistically significant, indicating that when the perception variable was controlled for, attitudes accounted for 30% of the variance in intentions. These results indicate attitudes about mental health treatment at the VA made a statistically significant contribution to predicting the outcome of reported intentions to seek mental health treatment at the VA after controlling for perceptions. In examining the beta values and significance levels, only the mediator variable of attitudes was statistically significant ($\beta = .813$, $p < .001$).

The bootstrapping method also indicated that when including perceptions and attitudes, only the variable of attitudes was statistically significant ($p < .001$, 95% CI [.802, 1.106]).

The final analysis was between the independent variable and the dependent variable while controlling for the mediator. For this analysis, the relationship between perceptions of the VA and reported intentions of seeking mental health treatment at the VA was examined while controlling for attitudes about mental health treatment at the VA. Results indicated attitudes accounted for 67% of the variance in the intentions variable whereas perceptions and attitudes accounted for 67% of the variance in intentions. The change in R^2 indicates that when including attitudes, the result was statistically significant ($p < .001$), meaning the variable of attitudes on its own was a significant contributor to the outcome of reported intentions to seek mental health treatment at the VA. Beta indicated only the variable of attitudes was significant both when calculated alone ($\beta = .82$, $p < .001$) and when calculated including perceptions ($\beta = .81$, $p < .001$). The bootstrapping method also supported the significance of attitudes both on its own ($p < .001$, 95% CI [.871, 1.070]) and including perceptions ($p < .001$, 95% CI [.820, 1.107]), indicating there was not an effect between perceptions and intentions when attitudes were controlled for. This indicates there was a mediational relationship between the independent and dependent variables, meaning that within this sample, perceptions of the VA and its influence on reported intentions of seeking mental health treatment at the VA were mediated by attitudes about mental health treatment at the VA. Tables 13–15 illustrate the regression analyses and the bootstrapping analyses ($N = 1,000$) run with the main study variables.

Table 13

Regression Analyses of Perceptions, Intentions, and Attitudes

Predictor	R^2	*B*	*SE*	*t*	*p*
Perceptions of the VA as predictor					
Intentions to seek MH treatment at VA	.370	.058	.008	7.438	.001
Attitudes about MH treatment at VA	.545	.059	.006	10.603	.001

Note. MH = Mental health, VA = Veterans Administration.

Table 14

Regression Analyses of Main Study Variables While Controlling for Perceptions and Attitudes

Predictor	R^2	*B*	*SE*	*t*	*p*
Attitudes to seek MH treatment at VA as predictor					
Intentions (Controlling for perceptions of the VA)	.672	.001	.008	.097	.923
Perceptions of the VA as predictor					
Intentions (Controlling for attitudes)	.672	.966	.105	9.236	.001

Note. MH = Mental health, VA = Veterans Administration.

Table 15

Bootstrapping Analysis of Indirect Effects of Main Study Variables

Independent variable	Mediator variable	Dependent variable	*β*	*SE*	*p*	95% CI [lower, upper]
Perceptions →	----	Intentions	.058	.006	.001	[.045, .071]
Perceptions →	Attitudes	----	.059	.005	.001	[.050, .069]
Perceptions → (Controlled)	Attitudes →	Intentions	.966	.075	.001	[.802, 1.106]
Perceptions →	Attitudes → (Controlled)	Intentions	.001	.006	.906	[-.012, .013]

Note. Perceptions = Perceptions of the VA, Intentions = Intentions to seek mental health treatment at the VA, Attitudes = Attitudes about mental health treatment at the VA.

Discussion

The aim of this study was to examine whether veterans' perceptions of the VA influenced their intention to seek mental health treatment at the VA, as well as whether the relationship between perceptions and intentions was mediated by attitudes about seeking mental health treatment at the VA. The veteran population, despite having a higher prevalence of mental health problems as compared to the general population, does not use mental health treatment at the same rates as civilians (De Luca et al., 2016). The VA is often the only source of treatment for veterans as there are rules and laws in place for seeking treatment outside of the VA (U.S. Department of Veterans Affairs, 2019b). These factors make views of the VA a potentially important barrier to veterans seeking mental health treatment at the VA. Results with this sample indicated a positive correlational relationship between positive perceptions of the VA and higher positive intentions to seek mental health treatment at the VA. This correlation means the more positive a veteran's perception of the VA, the more likely they were to have higher intentions to seek mental health treatment at the VA. Along with perceptions of the VA, research also indicates attitudes and beliefs about mental health and mental health treatment can both facilitate and hinder treatment follow through (Fox et al., 2015). The results of the current study supported a significant and positive relationship between perceptions of the VA and the study's mediational variable, indicating that as perceptions of the VA became more positive, participants also reported more positive attitudes about seeking mental health treatment at the VA. The theory of planned behavior indicates there is a relationship between attitudes about a behavior and intentions to perform said behavior (Ajzen, 1991). Results of the current study indicated there was a significant

positive relationship between the mediator variable and the dependent variable even after controlling for the independent variable. This means there was a positive correlational relationship between attitudes about seeking mental health treatment at the VA and intentions to seek mental health treatment at the VA. Within the current sample, the more positive a veteran's attitude about seeking mental health treatment at the VA, the higher their intention to seek mental health treatment at the VA irrespective of their overall perception of the VA. Last, the mediational hypothesis was supported, suggesting positive perceptions of the VA predicted higher intentions to seek mental health treatment at the VA mediated by positive attitudes toward seeking mental health treatment at the VA. In other words, as the perception of the VA became more positive among the veterans in this sample, the more positive their attitudes were about seeking mental health treatment at the VA, and the higher their intentions were to seek mental health treatment at the VA.

These findings support previous research conducted specifically with veterans and their beliefs about seeking mental health treatment and their perceptions of the VA. Fox et al. (2015) found that among women veterans, more positive perceptions of the VA led to more willingness to use VA services specifically for mental health care. The results also indicated that for women veterans, a negative belief about mental health, specifically about seeking treatment, was associated with a decrease in the use of mental health services at the VA (Fox et al., 2015). The Fox et al. study results also indicated that for men, more negative beliefs about mental health and specifically mental health treatment seeking were associated with decreased use of mental health services at the VA. Though the current study examined attitudes, Fox et al. used beliefs about different aspects of

mental health at the VA with seeking treatment being a significant negative predictor of VA care utilization. This type of relationship is supported by the current study's results as attitudes about seeking mental health treatment at the VA were related to reported intentions to seek mental health treatment at the VA. Unfortunately, whether participants in the current sample followed through on intentions to seek mental health treatment at the VA was not directly examined so the researcher cannot discuss the utilization of services, simply the intention to use said services. An additional study showed women specifically did not use VA services because of negative perceptions of the VA based on experiences of going to the VA with a family member or friend (Washington et al., 2007). Though this study is older than the current research and the more recent study done by Fox et al. (2015), these results are supported, namely that perception of the VA, whether positive or negative, can influence mental health treatment utilization in the future. The current study adds to the previous literature by implicating a mediational component that interplays with the view of the VA to increase or decrease intentions to seek mental health treatment at the VA. These results stress the importance of the reputation of the VA and the experiences veterans have there and how that can influence their attitudes and intentions about seeking mental health treatment at the VA.

The current study also provides some support for the theory of planned behavior. Within this theory, Ajzen (1991) posited that attitudes have an impact on an individual's intention to engage in a future behavior. Ajzen outlined and researched three different factors that can influence the intention to perform a behavior: attitudes toward the behavior, subjective norms, and perceived behavioral control of the performance of the behavior (Ajzen, 1991). Two of the measures used in the current study, the MHSAS and

the MHSIS, were informed and based heavily on the theory of planned behavior, namely attitudes about the behavior influencing intentions to perform a behavior. Previous research examining attitudes and their influence on intentions to perform a behavior is supported by the current results as there was a significant relationship between attitudes about seeking mental health treatment at the VA and intentions to seek mental health treatment at the VA. Though the current study did not include the other two factors of subjective norms and perceived control of performing the behavior, results support previous research that showed attitudes are more influential on intentions than are other factors (Ajzen & Madden, 1986; Schifter & Ajzen, 1985; Schlegel et al., 1992). These results emphasize the importance of counteracting negative beliefs, attitudes, and stigma against mental health treatment among the veteran population. The clear connection between attitudes and intentions lays a foundation for future research examining other influences on attitudes aside from perceptions of the VA.

The NAESM (2018) reported approximately half of the veterans at the time of their survey were not using mental health services at the VA or outside of the VA. This report detailed how certain aspects of the VA, such as consistency of care, ease of use, and timely care, were reported by veterans as reasons for not using VA mental health services (NAESM, 2018). Availability of services, ease of use, and staff skill and sensitivity were subcategories of the perceptional measure of the VA used in the current study and encompass many of the above-mentioned barriers reported by veterans (i.e., "Waiting time to get an appointment for a regular check-up," "Healthcare provider skill and expertise," "Availability of mental health services," and "The amount of paperwork that needs to be completed to receive care"). Based on the results, it may follow that these

barriers outlined by veterans may influence their overall perception of the VA and in turn influence a veteran's attitudes about seeking mental health treatment at the VA and consequently their intention to seek mental health treatment at the VA. The current sample had an overall higher use rate of VA mental health services as compared to the NAESM research, which may have affected the overall positive perceptions the veterans within the sample reported. More experience with the availability of services, ease of use of services, and staff skill and sensitivity may have influenced the veterans' perceptions within the current sample. Further research would need to be conducted to determine what experiences or views shape a veteran's perception of the VA, but it appears that in some ways the current study supports that having positive views of the availability of services, ease of use of the system, and perceived staff skill and sensitivity can positively influence attitudes and intentions to seek mental health treatment at the VA. Understanding how these views of the VA affect mental health treatment can inform what aspects of the VA system may need to be addressed to improve treatment for the veteran population.

Additional research has identified a military mentality or culture, stigma, and negative views of mental health as barriers to treatment seeking among the veteran population (Coll et al., 2011; De Luca et al., 2016; Wakefield et al., 2007; Wray et al., 2016). These barriers to mental health treatment may also influence attitudes about seeking mental health treatment, which, based on the current study, may affect intentions to seek mental health treatment at the VA. Results of the current study demonstrated a relationship between attitudes about seeking mental health treatment at the VA and intentions to seek mental health treatment at the VA, but did not specifically account for

what influenced attitudes about seeking mental health treatment at the VA. Future research related to this study could be conducted to examine what influences attitudes about mental health treatment at the VA specifically to better combat those barriers before they affect treatment seeking intentions. For example, it would be interesting to explore whether attitudes are based on first-hand experience with mental health treatment at the VA or hearsay from others. The researcher in the current study posits that VA perceptions influence attitudes about seeking mental health treatment but could not design the study to encompass all aspects of what may affect attitudes about seeking mental health treatment at the VA.

Though the current study results are both positive and significant, there are alternative explanations for why there may be relationships among perceptions of the VA, attitudes about seeking mental health treatment at the VA, and intentions to seek mental health treatment at the VA. Positive attitudes about mental health in general as opposed to specific treatment at the VA could explain the current study results. If a participant had positive attitudes about mental health treatment in general irrespective of whether they sought treatment at the VA before, they may have still reported more positive attitudes about seeking mental health treatment at the VA and would then have more positive intentions to seek mental health treatment at the VA. Another alternative explanation could be the inconsistency in the quality of care among different VA run mental health treatment locations as outlined by the NAESM (2018) report. The majority of the participants could have experienced above average or average treatment at the VAs they were using and those experiences may have influenced their overall perceptions of the VA and their mental health treatment. Those who had more negative perceptions of

the VA may have had experiences at below average locations due to staffing, training, or burnout (NAESM, 2018). There is no way to tell whether these alternative explanations are true but replication of the current study and other related studies with different samples may help reduce confounding factors that may explain the current study results.

Additional findings regarding several background variables in the current study are of note. First, the current sample reflected decreased current use of mental health treatment as compared to their history of mental health treatment use. The veteran population has higher rates of mental health diagnoses and difficulties yet lower rates of treatment utilization as compared to the general population (De Luca et al., 2016). In the current sample, 72.9% of the veterans reported having sought treatment in the past, and approximately 26% of those who had previously sought treatment reported no longer seeking mental health treatment at the time of survey completion. The reasons for no longer seeking treatment were not included in the current study, but there were significant differences between those who were still seeking mental health treatment and those who were no longer seeking treatment on all of the measures. The results indicated those who had never sought mental health treatment had more positive attitudes about seeking mental health treatment at the VA as compared to those who had sought treatment at the VA in the past but were no longer seeking mental health treatment at the VA. The experience of mental health treatment at the VA and attitudes about seeking that treatment may potentially be a factor in whether or not veterans continue therapy at the VA. Though those who were no longer seeking mental health treatment at the VA had more negative attitudes about seeking VA mental health treatment, those who were still using mental health treatment at the VA had positive attitudes about seeking treatment.

The significant differences between these three groups may indicate quality of care differences at different facilities, treatment of different mental health problems, and different service providers may be barriers to continued care as previous research has indicated (NAESM, 2018). One limitation of the above-mentioned results is that a baseline of attitudes about seeking mental health treatment was not gathered and may have influenced the results of the attitudes measure as there was no additional attitudinal measure to compare VA versus general mental health treatment seeking attitudes.

The trend of significant differences also applies to perceptions of the VA as a whole. Those who were still seeking treatment at the VA had more positive perceptions of the VA compared to those who were no longer seeking mental health treatment. This may indicate overall perceptions of the VA may be a barrier to continuing care or that differing experiences within the VA can promote or hinder continued mental health treatment among the veteran population. The scope of the current study did not allow for further examination of why these veterans were no longer seeking treatment, but this is a line of research that may be beneficial for this population in the future. The barriers discussed in the literature may play a part in shaping overall perceptions of the VA and further research to parse out what experiences and barriers may influence these perceptions may provide further insight into how to better support this population in continued mental health treatment.

The majority of the veterans (84.4%) who were currently seeking treatment at the time of participation were seeking mental health treatment from the VA as opposed to an outside provider. Though the measures used in the current study did ask about current reasons for seeking mental health treatment, they did not examine the reason a treatment

provider was chosen. Why veterans choose one provider over another and their overall satisfaction with their mental health treatment is another direction for future study. Veterans often do not have choices or flexibility in terms of their providers due to laws and policies. Understanding how this lack of choice in provider may influence views of the VA system and mental health treatment could inform potential policy changes to improve treatment (U.S. Department of Veterans Affairs, 2019b).

Another notable result was the significant positive relationship between age and intentions to seek mental health treatment in general but not with intentions to seek mental health treatment at the VA. Age was unrelated to the other main variables of the study, indicating there may be an overall willingness to seek mental health treatment as members of the veteran population age, but this willingness to seek mental health treatment may not extend specifically to the VA. Research supports this notion as the NCVAS (2020) report indicated older veterans had the highest rates of mental health treatment utilization. Though the current study results apply to mental health treatment in general, the NAESM results pertained to the VA, indicating there may be some predictors of VA mental health treatment utilization such as age of the veteran. An additional explanation for this positive relationship between age and intentions to seek mental health treatment could be related to the time of service. For example, older veterans who may have served in Vietnam may have more mental health consequences as a result of the hardships soldiers faced related to the unpopularity of the war and the more negative reception they received when coming home. Further research with different and more representative samples may be able to determine how good of a predictor age is for VA

mental health treatment utilization and whether there are additional factors that predict usage, such as time of service.

Several limitations of the current study should be noted. First, the recruitment method used may have limited the outreach to the veteran population and therefore limited the sample obtained. The use of online recruitment may have unintentionally excluded veterans who did not have access to technology or those who did not have a social media account. According to the online survey program used in the study, all of the responses were obtained through Facebook, thereby limiting the sample to only those who had access to a Facebook account or were a member of the groups where the recruitment flyer was posted. In addition to the outreach method, the use of veteran groups on Facebook may have limited the current sample to those who had more positive views of the VA. The researcher in the current study had no way of determining whether there were differences in the platform that veterans were on and their perceptions of the VA as the current sample came purely from Facebook. Another limitation related to the correlational design of the study. This methodology limits conclusions about causality and the direction of effects among variables. For example, the results illustrate there was a relationship between perceptions of the VA and attitudes about seeking mental health treatment at the VA, but the results did not allow for the specification of direction. Though the hypothesis was that perceptions of the VA would influence attitudes about seeking mental health treatment at the VA, the actual results may be the inverse, with attitudes about seeking mental health treatment at the VA influencing overall perceptions of the VA. An additional limitation was the use of self-report measures for the study's main variables. Self-report measures are subject to personal biases, social desirability,

exaggeration, and unwillingness/hesitation to be truthful. The researcher in the current study emphasized the anonymity of the survey in order to minimize the possibility of biased responding, but there was no way to determine whether this attempt was successful. The use of self-report measures also limited the results of the study due to the research about the lack of high correlations between self-reported intentions and actual behaviors (Ong & Weiss, 2000). The literature on the theory of planned behavior, which was used in this study, indicates attitudes and intentions together are good predictors of future behaviors, but other elements such as subjective norms and perceived behavioral control were outside of the scope of this study. Future research about how perceptions and attitudes about the VA and their mental health treatment influence intentions to seek treatment and potential follow through would benefit from including the full triad of the planned behavior theory (Ajzen, 1991).

The overall generalizability of results is another limitation of the current study. The current sample from the veteran population was not representative as the majority of the sample was White and in the Army, and a high number of participants were from Illinois. The gender demographics for the sample were not representative of the veteran population with an overrepresentation of female participants as compared to data provided by the U.S. Department of Labor in 2019 (Glowacki, 2019).

In conclusion, the overall results of the study indicated a positive, statistically significant relationship among perceptions of the VA, attitudes toward seeking VA mental health treatment, and intentions to seek mental health treatment at the VA within this sample. The veteran population has many different barriers to seeking mental health treatment. The current study provides evidence that perceptions and attitudes toward the

VA may facilitate seeking VA mental health treatment when perceptions are more positive. Conversely, negative perceptions of the VA may present a barrier to seeking such services. Future research should be conducted to examine how perceptions of VA care and attitudes toward seeking VA mental health treatment can be improved. For example, better understanding which aspects of care at the VA and mental health treatment affect the continuance of care the most would be a line of study that could inform policy changes and employee training. An additional area of research that may help provide further insight into policy change would be an examination of traits and other factors that might be present in veterans who do and do not continue therapy and whether those are internal traits or the result of external factors that are influenced by mental health treatment and the VA system.

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Appendix A: Recruitment Flyer

GRADUATE STUDENT RESEARCH

Veterans Needed

My name is Hilary Hines and I am a doctoral student at the Illinois School of Professional Psychology at National Louis University.
I am conducting a study with Veterans in order to better understand veterans' perceptions of the VA (Veteran's Administration) as well as attitudes and behaviors related to seeking mental health treatment at the VA.

You are eligible to participate if you:

- **Are a Veteran**
- **Are eligible to receive services at the VA**
- **Have internet to access the survey**

You can access the survey by clicking the link provided or copying and pasting the URL into your browser
"Link"

This study has been approved by National Louis University's Institutional Review Board. If there are any questions or concerns regarding the current research, please contact Hilary Hines at hhines2@my.nl.edu

If you know of anyone that meets the criteria to participate and would be interested in completing the survey, please feel free to share this flyer and the information included.

Thank you for your time and consideration,

Hilary Hines, M.A.

Appendix B: Participant Battery

Demographics Questionnaire

General Questions

1. Age:_____
2. Gender:
    - Male
    - Female
    - Nonbinary
    - Other _____
3. Race/Ethnicity:
    - African American/Black
    - Caucasian
    - Latinx
    - East Asian
    - South Asian
    - Native American/Alaskan Native
    - Other _____
4. Current Town and State of Residence: _____
5. Highest Level of Education Completed:
    - Less than a High School Diploma
    - High School Diploma
    - Trade School Degree
    - Bachelor's Degree

- Master's Degree
- Doctorate or higher
- Other _____

6. Marital Status:
    - Single
    - Married
    - Divorced
    - Separated
    - Civil Union
    - Other _____

Military Questions

7. Branch of the Military Served in:
    - Army
    - Marine Corps
    - Navy
    - Air Force
    - Coast Guard
    - National Guard
    - Space Force
8. How many years did you serve?: _____
9. How long have you been a veteran (been non active duty military)?: _____
10. Are you currently eligible to receive VA services (i.e. have the appropriate number of active duty days and a discharge other than dishonorable)?:

- Yes
- No

11. Were you ever deployed?:
    - Yes
    - No
12. Where were you deployed?: _____
13. How long were you deployed?_____
14. While deployed were you exposed to combat?:
    - Yes
    - No
15. How long were you in a combat zone?: _____
16. Where was the combat zone you were in?: _____
17. Were you ever stationed overseas (not in the United States)?:
    - Yes
    - No
18. Where and for how long were you stationed overseas?:_____

Mental Health Questions

19. Do you have any formal mental health diagnoses?:
    - Yes
    - No
20. If you do have mental health diagnoses, list them here:

    _____

21. Have you sought mental health treatment before?:

- Yes
- No

22. Where have you sought mental health treatment (company name not specific location is sufficient)?:_____

23. Are you currently seeking mental health treatment?:
    - Yes
    - No

24. If you are currently seeking mental health treatment, where are you receiving that treatment (company/organization name not specific location is sufficient)?:

    _____

25. If you are currently seeking mental health treatment, what is the current reason why?:

    _____

Mental Health Seeking Intention Scale (Unmodified)

For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression). Please mark the box that best represents your opinion.

1. If I had a mental health concern, I would intend to seek help from a mental health professional.

   (Extremely Unlikely) 1 2 3 4 5 6 7 (Extremely Likely)

2. If I had a mental health concern, I would try to seek help from a mental health professional.

(Definitely False) 1 2 3 4 5 6 7 (Definitely True)

3. If I had a mental health concern, I would plan to seek help from a mental health professional.

(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)

Perceptions of VA-Specific Barriers to Care

Prompt: Based on your own experiences or what you have heard from others, rate your opinion of the following aspects of VA health care

1. Availability of emergency medical services

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

2. Availability of primary care services

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

3. Availability of family planning and birth control services

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

4. Availability of gynecological care

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

5. Availability of mental health services

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

6. Ability to get a female or male doctor, depending on your preference

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

7. Amount of privacy (e.g., presence of privacy curtains, screens, etc.)

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

8. Waiting time to get an appointment for a regular check-up

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

9. Waiting time to get an appointment when you're sick

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

10. Waiting time at the pharmacy

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

11. The among of paperwork that needs to be completed to receive care

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

12. Ability to get in touch with the medical staff my phone

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

13. Coordination of care across services

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

14. Availability of parking

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

15. Convenience of location

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

16. Accessibility by public transportation

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

17. Hours when VA facilities are open

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

18. The cleanliness of VA facilities

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

19. Staff knowledge of women's healthcare needs

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

20. Staff knowledge of healthcare needs of veterans from your cohort (for example OEF/OIF veterans)

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

21. Staff courtesy and respect toward patients

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

22. Healthcare provider skill and expertise

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

23. Staff ability to speak your native language

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

24. Staff familiarity with veterans' unique healthcare needs

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

25. Healthcare provider attentiveness during appointments

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

26. Healthcare provider interest in patients' thought and opinion about their healthcare

(Extremely Negative) 1 2 3 4 5 (Extremely Positive)

Mental Help Seeking Attitudes Scale (Modified)

For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression).

Please mark which best represents your opinion. For example, if you feel that your seeking help would be extremely useless, you would mark closest to "useless." If you are undecided, you choose "0". If you feel that your seeking help would be slightly useful, you would choose "1" closer to "useful."

If I had a mental health concern, seeking help from a mental health professional at the VA would be...

(Useless)	3	2	1	0	1	2	3	(Useful)
(Important)	3	2	1	0	1	2	3	(Unimportant)
(Unhealthy)	3	2	1	0	1	2	3	(Healthy)
(Ineffective)	3	2	1	0	1	2	3	(Effective)
(Good)	3	2	1	0	1	2	3	(Bad)
(Healing)	3	2	1	0	1	2	3	(Hurting)
(Disempowering)	3	2	1	0	1	2	3	(Empowering)
(Satisfying)	3	2	1	0	1	2	3	(Unsatisfying)
(Desirable)	3	2	1	0	1	2	3	(Undesirable)

Mental Health Seeking Intention Scale (Modified)

For the purposes of this survey, “mental health professionals” include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, “mental health concerns” include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression). Please mark the box that best represents your opinion.

1. If I had a mental health concern, I would intend to seek help from a mental health professional at the VA (Veterans Administration).

   (Extremely Unlikely) 1 2 3 4 5 6 7 (Extremely Likely)

2. If I had a mental health concern, I would try to seek help from a mental health professional at the VA (Veterans Administration).

   (Definitely False) 1 2 3 4 5 6 7 (Definitely True)

3. If I had a mental health concern, I would plan to seek help from a mental health professional at the VA (Veterans Administration).

   (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)

Appendix C: Consent Form

National Louis University
Informed Consent for Online Participation in Research
"Perceptions of the VA and Mental Health Treatment Seeking Intentions Among Veterans"

You are being asked to participate in an online survey for a research project being carried out by Hilary Hines a doctoral student at the Illinois School of Professional Psychology, at National Louis University. The study is called "Perceptions of the VA and Mental Health Treatment Seeking Intentions Among Veterans", and is occurring from 04-2021 to 04-2022. The purpose of this study is to better understand veterans' perceptions of the VA and their attitudes and behaviors related to seeking mental health treatment at the VA. This form outlines the purpose of the study and provides a description of your involvement and rights as a participant.

Participation in this study will include:

Completion of an online survey, expected to take approximately 25-30 minutes to complete. The survey consists of questionnaires asking demographic questions and questions about attitudes, perceptions, and behavioral intentions to seeking mental health care.

The risks of participating in this study are minimal and no more than you would experience on a daily basis. Due to the study focusing on mental health information there may be some distress experienced due to this topic. Your participation is voluntary and you are free to discontinue your participation at any time without penalty or bias. While there are no direct benefits for you as the participant it is hoped that this research will provide information to benefit veteran mental health services. The results of this study may be published or otherwise reported at conferences, and used to inform the literature on barriers to mental health treatment among the veteran population, but participants' identities will in no way be revealed (participation will be anonymous and data reported will bear no identifiers that could connect data to individual participants). To ensure confidentiality the researcher will keep compiled results on a password protected hard drive. Only Hilary Hines and her research supervisor, Dr. Zakowski, will have access to the data. The information being collected will not be used for any purposes other than the proposed research. All data will be destroyed three years after the completion of this study.

There are no anticipated risks or benefits, no greater than that encountered in daily life. While there may be no direct benefit to you, the information gained from this study may be useful in better understanding how the VA can change policy in order to better serve the veteran population.

Upon request you may receive summary results from this study and copies of any publications of this study. Please email the researcher, Hilary Hines at [redacted] to request results from this study.

In the event that you have questions or require additional information, please contact the researcher, Hilary Hines, [redacted]

If you have any concerns or questions before or during participation that has not been addressed by the researcher, you may contact Dr. Sandra Zakowski; email: szakowski@nl.edu], the co- chairs of NLU's Institutional Research Board: Dr. Shaunti Knauth; email: Shaunti.Knauth@nl.edu; phone: (312) 261-3526; or Dr. Christopher Rector; email: CRector@nl.edu; phone: (312) 621-9650. Co-chairs are located at National Louis University, 122 South Michigan Avenue, Chicago, IL.

Thank you for your consideration.

Consent: I understand that by checking 'Yes" below, I am agreeing to participate in the study *(Perceptions of the VA and Mental Health Treatment Seeking Behaviors*). My participation will consist of the completion of the online survey taking approximately 30 minutes to complete.

ELECTRONIC CONSENT: Please select your choice below. You may print a copy of this consent form for your records. Clicking on the "Agree" button indicates that

- You have read the above information
- You voluntarily agree to participate
- You are 18 years of age or older

¨ Agree
¨ Disagree

Appendix D: Debrief Statement

Thank you for taking the time to participate in my study!

Below are some resources for mental health services both through the VA as well as outside providers that help veterans in the community.

VA Resources:
Veterans Crisis Line
Phone: 800-273-8255 then dial 1

Search for Mental Health Services Through the VA via symptom/disorder or type of treatment:
VA Mental Health Services Website

Non VA Resources:
Midwest Shelter for Homeless Veterans
Community Resource
Phone: (630) 871-8387
https://www.helpaveteran.org

Military One Source
Non-VA Military Resource through Department of Defense
Website

The Soldiers Project
Free Confidential Therapy for Veterans
Phone: 877-576-5343
Flyer

Homecoming for Veterans
Find a Clinician for Free 20 Minute Session
Find a Clinician

Thank you again for your participation and helping me try and better understand veteran mental health and treatment seeking intentions. If there are any questions or concerns feel free to reach out: [redacted].

Thank you for your time and thank you for your service.

Sincerely,

Hilary Hines
PsyD Student
ISPP at NLU