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SOCIOCULTURAL PREDICTORS OF WHITE VETERANS' ATTITUDES TOWARDS VA MENTAL HEALTH CARE

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SOCIOCULTURAL PREDICTORS OF WHITE VETERANS' ATTITUDES TOWARDS VA MENTAL HEALTH CARE

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By
Elyssa Christine Berney

Lexington, Kentucky

Director: Dr. Joseph Hammer, Associate Professor of
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Lexington, Kentucky

2023

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ABSTRACT OF DISSERTATION

SOCIOCULTURAL PREDICTORS OF WHITE VETERANS' ATTITUDES TOWARDS VA MENTAL HEALTH CARE

U.S. Veterans are less likely to seek help than their civilian counterparts despite having higher levels of self-reported distress, in part due to comparatively poorer attitudes towards seeking mental health treatment. While some aspects of cultural socialization (e.g., gender role expectations, certain types of stigma) have been established to influence Veterans' attitudes towards mental health treatment, other aspects of health care access (e.g., trust in health care institutions or individual providers) may benefit from increased focus. Additionally, one aspect of cultural socialization that is understudied in white Veterans is that of racial-cultural socialization (i.e., whiteness). Much of the research into veterans' help seeking does not account for white veterans' unique racial-cultural socialization, making whiteness invisible and furthering the assumption that racial socialization does not apply to white people, despite the U.S. military's general milieu as a white space.

The present study, grounded in the Integrated Behavioral Model (IBM), addresses these research and treatment gaps by using an alternative SEM model testing framework in 377 white Veterans to examine the direct and indirect links between ten sociocultural variables and attitudes towards seeking help from Veterans Health Administration (VHA) mental health services in white veterans. Sociocultural variables include self-stigma of seeking help, individual provider trust, perceived stigma from other veterans, perceived stigma of loved ones, beliefs about VA health care system competence, emotional control, perfectionism, either-or thinking, and military identity commitment.

Key findings include: individuals high in either-or thinking, perceived stigma of loved ones, and with low perceived trust in VA system competence had poorer attitudes towards VHA mental health care both directly and indirectly via self-stigma of seeking help and trust in a hypothetical VA mental health provider. In particular, the relationships between multiple aspects of stigma and the relationship between trust in the VA institution and individual VA providers are discussed. Results indicate addressing these stigma and trust constructs, as well as addressing aspects of white racial-cultural socialization (i.e., either-or thinking and perfectionism) in research and clinical work with white Veterans, may improve attitudes towards VA mental health care in this population.

KEYWORDS: Veteran help-seeking, whiteness, white racial culture, VA mental health care, integrated behavioral model

Elyssa Christine Berney

April 28, 2023

SOCIOCULTURAL PREDICTORS OF WHITE VETERANS' ATTITUDES TOWARDS VA MENTAL HEALTH CARE

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Date

DEDICATION

To Patricia Miller Stevens, ABD.
You should have been first.

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No one finishes a dissertation alone, and I cannot possibly acknowledge all the people who have helped me climb this particular mountain.

(But I will try).

First, my Dissertation Chair, Dr. Joseph Hammer – who has helped me understand the type of researcher, clinician, and person I want to be. You have seen me grow from a post-bac student to a doctoral candidate, and I hope I've made you proud.

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For my villages: the HAMMER Lab, the Beerbuds, and the University of Kentucky Newman Center Choir.

For my parents, Tim and Becky, and my siblings, Jesse, Ryan and Liam. You taught me what it was to be curious, care about people, and stand up for the things that matter (even if it meant arguing until 3am).

For Greg Timmons, who has dealt with my terrible jokes and has never, ever stopped believing in me.

For my participants, who gave their time, trust, and experiences to (hopefully) make VA care a little bit easier to access.

This one's for all of you.

Author Note. I must begin this manuscript with acknowledgement of one small, but significant, deviation from APA style—my choice to decapitalize *white*. I make this choice as an act of linguistic resistance, in the style of April Baker-Bell (2020), "choosing to disassemble white supremacy in my language by lowercasing the "w" in white and white supremacy as well as the "e" in eurocentric" (Johnson, 2018, p. 121). This has a rich precedent in higher education and intersectionality research (Harris & Patton, 2019) and in Latinx Critical Theory (Pérez Huber, 2010), as well as Native and Indigenous linguistic scholarship (Leonard, 2020). I recognize, however, that choosing not to capitalize white can imply that whiteness is not a culture in itself – or worse, obfuscate the role of a unified white cultural role in creating and perpetuating inequality (Ewing, 2020). To that end, I seek in this manuscript to do the opposite – to present a unified and comprehensive understanding of the role of hegemonic whiteness in white Veterans' mental health care attitudes.

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CHAPTER ONE: INTRODUCTION

U.S. military personnel and Veterans of conflicts after World War II are significantly more likely to experience mental health distress over their lifetime than civilian counterparts (Graziano & Elbogen, 2017). Veterans not accessing mental health care leads to disproportionate consequences at individual, community, and systemic levels. Elevated distress can cause increased negative cognitive, psychosocial individual outcomes (Efird & Lightfoot, 2020) including suicide rates 19-30% higher than civilian counterparts (Lyon, 2017; Wood et al., 2020). These concerns, if left untreated, can also cause stress in families (Wilson et al., 2015), caregivers (Griffin et al., 2017), dependents (Diehle et al., 2017), and romantic partnerships (Johnstone & Cogan, 2021; Schnittker, 2019), which can create a cyclical effect with respect to mental health symptomology both on the part of the Veteran and the community system. Finally, inadequately treated mental health concerns results in significant economic burden on the part of both Veterans themselves and their families as well as the VHA (Szukis et al., 2021) and the larger national and global economic system (Trautmann et al., 2016).

Simultaneously, Veterans of the U.S. Armed Forces who do not receive a dishonorable discharge are generally eligible for free or low-cost mental health care via the Veteran's Health Administration (VHA; U.S. Department of Veterans Affairs, 2020). Despite comparatively easy access to mental health care via the VHA, Veterans underutilize VHA health care (Graziano & Elbogen, 2017) or wait multiple years post-discharge to access mental health services for distress incurred while in the military (Maguen et al., 2012). In specific, it appears that only approximately half of recent Veterans in need of mental health care seek help from the VHA (Baker, 2014) despite

comparatively inexpensive mental health care access (U.S. Department of Veterans Affairs, 2020a), suggesting a large gap between the number of Veterans who may benefit from mental health treatment and Veterans who access it. Potential reasons for this treatment gap have included distrust of health providers (van den Berk-Clark & McGuire, 2014), perceived and internalized stigma of seeking help for mental health concerns(Blais & Renshaw, 2013; Botero Jr. et al., 2020; Roscoe, 2020), and sociocultural norms and expectations related to gender (Crowley & Sandhoff, 2017; McDermott et al., 2017) and military or Veteran identity (Meyer et al., 2016). However, many of these potential avenues for intervention have not been compared with respect to their relationship with attitudes towards VA mental health care, or have been named as qualitative themes in certain study populations without determining how they influence Veterans as a broader population. Finally, while many studies of Veterans' mental health care attitudes are comprised of predominantly white participants, very few studies have specifically attended to the role of white racial identity and cultural expectations in white Veterans' attitudes towards mental health care. Therefore, the aim of this study will be to examine the links between key sociocultural variables (e.g., stigma, Veteran identity) and white veterans' attitudes towards seeking mental health care from the Veteran's Health Administration (VHA).

This study focuses on white Veterans because while the United States military is a predominantly white institution in both its numerical demographics of enlisted and officer personnel (U.S. Department of Defense et al., 2019) and its cultural milieu (Darda, 2018), research studying military personnel historically uses predominantly white samples without accounting for the racial-cultural context of whiteness. This entrenches

the presence of white values without proper attention to the processes by which aspects of whiteness impact white veterans' health care decisions (Efird & Lightfoot, 2020). This renders our understanding of white veterans' help seeking incomplete, such that white Veterans are used as baseline of understanding without in-depth study as to the cultural factors that impact their health behaviors (Malat et al., 2018). Research concerning white veterans' health care must reveal and challenge privilege and priority, rather than covering it over (Bowleg & Bauer, 2016; Henry, 2017). This is in line with recent scholarship calling for whiteness to be broadly understood as an encompassing racial identity with distinct cultural norms (Miller, 2017; Schooley et al., 2019). Moreover, as a white researcher doing work with primarily white providers, clients, and participants, it is essential to do the work of whiteness engaging whiteness (Liebert, 2021), without allowing the work of whiteness to become valuable for its intellectual stimulation and social clout rather than a moral imperative (Leonardo & Porter, 2010).

Theoretical Framework

The current study is grounded in the Integrated Behavioral Model (IBM; Montaño & Kasprzyk, 2008), an empirically supported model used to understand the major factors that predict intention to perform a behavior – based on the understanding that intention to perform a behavior (henceforth "intention") accounts for significant variance in actual engagement in behavior (Ajzen, 1991). Based on the Theory of Planned Behavior (TPB; Ajzen, 1991), the IBM argues that intention to perform a behavior—in this case, seek help for mental health concerns—is shaped by three major constructs: Attitudes towards the behavior, perceived social norms surrounding the behavior, and personal agency with respect to completing the behavior. Each of these three major constructs can in turn be

predicted by more distal sociocultural variables, including differential treatment due to sociodemographic status or internal traits or states (Montaño & Kasprzyk, 2008). The IBM provides help seeking researchers a strong theory-grounded framework for identifying key distal sociocultural variables that collectively shape the help seeking attitudes of a given population, thereby providing empirically supported targets for future intervention testing.

Attitudes as the Dependent Variable

Attitudes are considered to be the combination of affective evaluation of a behavior ("experiential" attitudes; considering the behavior unpleasant or pleasant) and cognitive judgments of a behavior as good or bad ("instrumental" attitudes; considering the behavior helpful, useful, or worth doing; Montaño & Kasprzyk, 2008). For multiple reasons, the chosen dependent variable for this study is attitudes towards seeking help, rather than intention to seek help or help-seeking behavior. First, attitudes are consistently the strongest predictor of intention to seek help (Li et al., 2014), which in turn is the strongest predictor of actual help seeking behavior (Ajzen, 1991; Hammer & Spiker, 2018). Hence, attitudes are the most common outcome variable studied in the professional mental health help seeking literature (Hammer et al., 2018). Second, using attitudes as the sole dependent variable facilitates structural model parsimony, allowing researchers to examine the relationship among distal sociocultural variables (e.g., stigma, military identity commitment) and attitudes toward seeking help in greater detail than is possible when attempting to model all IBM constructs (e.g., perceived norms, personal agency, intention, behavior) simultaneously. More specifically, the focus of this study will be attitudes of Veterans towards seeking mental health services from the VHA.

Military Veterans choose to seek mental health support from the VHA rather than non-VHA providers for multiple reasons, including reduced cost (Veteran's Health Administration Office of Health Equity, 2020) and preference for providers who have a degree of cultural competence with respect to Veterans (Reger et al., 2008). Moreover, the VHA's integrated health system may make it easier for Veterans seeking medical services from VHA providers to be connected to mental health providers within the same system (Davis et al., 2016). For these reasons, the goal of this study will be to assess sociocultural variables' relationships with attitudes towards help-seeking from the VHA specifically, which is likely similar but not synonymous with general mental health help-seeking attitudes.

Identifying Key Sociocultural Independent Variables

A significant body of work has identified many sociocultural variables associated with reduced mental health help-seeking in veterans, including multiple types of stigma (Brown & Bruce, 2016; Currier et al., 2018; Hamblen et al., 2019; Roscoe, 2020), endorsement of cultural values which prohibit help-seeking (e.g., self-reliance; Jakupcak et al., 2014b) and distrust of the VA or mental health service providers (Fischer et al., 2021; Ouimette et al., 2011), However, these variables are often examined individually, using self-report measures with untested psychometric properties and methods that do not control for measurement error nor key control variables (e.g., past help seeking, gender, current distress). Moreover, studies of veterans' access to mental health care tend to recruit study populations that are overwhelmingly white men (e.g., Neilson et al., 2020) who identify as heterosexual if queried (e.g., Richard & Molloy, 2020) and who predominantly served as enlisted Army personnel (e.g., Adams et al., 2017). This

research, while partially representative of the U.S. military as a whole (Meadows et al., 2018; U.S. Department of Defense et al., 2019), also often fails to account for role of hegemonic cultural expectations at work in veterans. Thus, the present study will aim to address these limitations by (a) examining a robust set of sociocultural variables, (b) in the context of an empirically supported behavior prediction model (i.e., the IBM), (c) using psychometrically sound measures, (d) using structural equation modeling to reduce the biasing impact of measurement error on results, (e) control for a wide array of demographic and background variables that may influence help seeking attitudes, and (f) use a critical lens that seeks to account for the role of some aspects of whiteness and military sociocultural values in both modeling and interpretation.

Self-Stigma of Seeking Help

One of the variables we expect to be most proximally associated with attitudes towards seeking help is that of self-stigma of seeking help, or the anticipated "reduction in a person's self-esteem or sense of self-worth due to the perception held by the individual that [they would be] socially unacceptable for seeking psychological help" (Currier et al., 2018; Vogel et al., 2019, p. 303), which Veterans are more likely to endorse than their civilian counterparts (Currier et al., 2018). Self-stigma has been found to fully mediate the relationship between other forms of stigma and help-seeking intention in a sample of predominantly white Veterans (Blais & Renshaw, 2013). Moreover, self-stigma is powerfully associated with attitudes in its own right; in an overwhelmingly white sample of Veterans and active duty military personnel, self-stigma of seeking help was both directly related to attitudes and partially mediated the relationship between perceived public stigma and attitudes (Held & Owens, 2013). It is

expected that self-stigma of seeking help will mediate the relationship between attitudes and many sociocultural variables (see Figure 1).

Provider Trust

Another variable consistently cited in qualitative literature surrounding veterans' attitudes towards help seeking is that of trust of individual mental health providers (as distinct from distrust of the health care system in general; (Haro et al., 2019; Nichter et al., 2020; Rafferty et al., 2019). This may manifest in multiple ways, from seeing mental health providers as unable to develop a caring relationship (Haro et al., 2019), focused on medication or hospitalization (Ganzini et al., 2013), or unable to understand veterans' unique experiences and concerns (Botero Jr. et al., 2020). This last piece may also tap into mental health providers being seen as outsiders in a military context, and speaking to a mental health provider may be at best unhelpful and at worst, jeopardize group safety (Bryan & Morrow, 2011). This points to mistrust of mental health providers being possibly an enculturated value of military life that may be socially, if not personally, adaptive (i.e., promotes group cohesion by avoiding being separated, contributes to group goals by avoiding individual weakness) while in service but disallows Veterans from seeking care when they need it after discharge (Bryan & Morrow, 2011). Previous studies of the relationship between trust in provider and trust in the health care system suggests that the two constructs are related but distinct (Gupta et al., 2014). Moreover, Veterans seeking care from the VHA are likely to have formed an impression of VHA services long before they interact with an individual VHA mental health provider (Cheney et al., 2018), suggesting that perceived VHA competence is more likely to predict trust in VHA provider than vice versa. Similarly, other enculturated military values (identity

commitment, emotional control, self-reliance) are commonly cited as related to trust in mental health providers (e.g., Fischer et al., 2016). Therefore, we posit that emotional control, self-reliance, military identity commitment, and perceived lack of VHA competence will be negatively associated with attitudes via negative relationships with individual provider trust (see below for rationale).

Perceived Stigma of Seeking Help

The second type of stigma with documented links to help-seeking attitudes is that of perceived stigma of seeking help, or beliefs that the public at large, or a specific reference group, holds negative stereotypes towards individuals who seek mental health treatment (Kulesza et al., 2015). This type of stigma is typically considered to predict but be theoretically distinct from self-stigma of seeking help (Goode & Swift, 2019). Veterans appear to be particularly sensitive to stigma from fellow Veterans or leadership, such that perceived stigma from unit leaders negatively predicted help-seeking intentions in a sample of white men OEF/OIF National Guard members who were predominantly members of the Church of Jesus Christ of Latter-Day Saints (Blais & Renshaw, 2014). Similarly, a sample of predominantly white men Veterans indicated that the simple documentation of a mental health problem on a medical record was a significant barrier to help seeking (Porcari et al., 2017) The U.S. military's emphasis on unit cohesion emphasizes teamwork and camaraderie between service personnel, with an anticipated result of more successful missions and ideally better-supported personnel (Weiss & Coll, 2011). However, that same emphasis on unit cohesion may increase the importance of perceived stigma with respect to fellow Veterans, such that the fear of losing support

from other Veterans is aversive in itself – especially when linked with perceived weakness and lack of control associated with mental illness (Meyer et al., 2016).

However, veterans' relationship with other military personnel are not their only salient relationships. Mental illness in Veterans often affects their families and close others (Hamblen et al., 2019), and Veterans often cite their families, partners, and friends as who they would most prefer to seek psychological help from rather than mental health providers (Porcari et al., 2017). In turn, then, perceived stigmatization from loved ones and close civilian others for seeking help may likely predict self-stigma of seeking help in Veterans (Skopp et al., 2012), much as public stigma does (Vogel et al., 2013). It is therefore expected that perceived stigma both from other veterans, and from important civilian loved ones, will indirectly predict less favorable attitudes via greater self-stigma of seeking help in the given population, as has been shown in Blais & Renshaw (2014); however, it is also possible that perceived stigma will directly predict less favorable attitudes as well, beyond its relationship with attitudes via the mediation effect via self-stigma (Pattyn et al., 2014).

Hegemonic Masculine Norms

While the construct of conformity to masculine norms is expansive and beholden to other sociocultural expectations (e.g., regional or racial differences in interpretation of masculine constructs; Brassel et al., 2020), conformity to certain hegemonic U.S. masculine norms (e.g., those enforced by white culture and that is characterized by relation to subordinated masculinities as well as subordinated femininity; Messerschmidt, 2019) does predict decreased help-seeking behavior in Veterans (Heath et al., 2017). Specifically, the masculine norms of emotional control/restrictive emotionality (i.e.,

affective restriction of emotional experience and expression) and self-reliance (i.e., avoiding the need for support from others) appear to have specific bearing on both mental health symptomatology and willingness to seek help (Heath et al., 2017; Jennings et al., 2015). These norms are specifically emphasized in military training (Abraham et al., 2017) and appear to reverberate in veterans' treatment decisions well after discharge (e.g., Desai et al., 2016).

Emotional Control. Emotional control, or the belief that one should hide or conceal their emotions from others (Parent & Moradi, 2011), is a common predictor of help-seeking attitudes and behavior across multiple forms of therapy seeking (Hammer & Spiker, 2018; Spiker et al., 2020). Moreover, emotional control has been found to be associated with increased PTSD symptomatology, increased alexithymia (i.e., difficulty identifying and expressing emotions), and lower levels of social support, as is emotional toughness (a construct intending to combine the roles of emotional control and self-reliance) in a sample of predominantly white Army men Veterans in treatment at a VHA facility (Jakupcak et al., 2014). Emotional control has also been shown to be associated with self-stigma in predominantly white war zone-deployed student Army and Navy Veterans (McDermott et al., 2017), as well as mediate the relationship between self-conscious emotions and self-stigma. In addition, emotional control may be associated with decreased trust in mental health providers due to its twofold association both with white masculinities and military subcultural values, both of which are associated with decreased trust in mental health professionals (Arbisi et al., 2013; Fischer et al., 2021; Seidler et al., 2017). Veterans who endorse high levels of control may be distinctly less likely to share psychological distress with mental health providers due to fear of losing

affective control (Burns & Mahalik, 2011). It is expected that emotional control will indirectly negatively related to attitudes via both decreased trust in VA mental health providers and increased self-stigma of seeking help. Additionally, emotional control may directly negatively affect attitudes towards help seeking; emotional control and other masculine norms items have been consistently associated with more negative attitudes towards help seeking (Wong et al., 2016), and emotional stoicism, a similar construct, has been shown to be associated with underuse of VHA mental health care in predominantly white rural Veterans (Fischer et al., 2021).

Self-Reliance. Similarly, the construct of self-reliance, or a preference for relying on one's own capability in problem solving and avoid assistance (e.g., Choo & Marszalek, 2019) has also been shown to consistently predict lower treatment utilization in Veterans (Elbogen et al., 2013; Fischer et al., 2016), often citing that needing mental health care is seen as a sign of weakness (Fischer et al., 2016). This phenomenon additionally seems to appear across service eras, with Vietnam-era Veterans seeking first-time mental health care noting that self-reliance often serves as defense against perceived uncaring social or governmental institutions (Desai et al., 2016). Self-reliance also has been shown to have specific direct relationships with help seeking attitudes (Jennings et al., 2015; Stotzer et al., 2012) as well as indirect relationships with attitudes via self-stigma (Jennings et al., 2015; McDermott et al., 2017). Additionally, qualitative evidence suggests that self-reliance and trust in mental health providers are closely linked with attitudes in predominantly white rural Veterans (Fischer et al., 2016). In this population of white veterans, we expect that self-reliance will have an indirect negative effect on attitudes via a positive relationship with self-stigma of seeking help and negative

relationship with provider trust. In addition, self-reliance may be directly negatively associated with attitudes as well, such that self-stigma and provider trust will only partially mediate the self-reliance → attitudes relationship, similar to the findings of Jennings et al. (2015).

The Role of Whiteness

While the body of research conducted on white Veterans is substantial, much of this focus embodies the implication of whiteness as racelessness (Darda, 2018) and implies that samples of predominantly or overwhelmingly white men Veterans are predictive of overall veterans' beliefs and behavior. However, the literature stands to benefit from a systematic interrogation of this implication (Zuberi & Bonilla-Silva, 2008), instead rendering whiteness visible and understanding how white cultural expectations operate within white Veterans (Darda, 2018). Additionally, while many measures seek to assess white peoples' relationships with various aspects of racial identity, including white racial consciousness (Claney & Parker, 1989), white social customs or culture (P. K. Miller, 2017), or even white fragility (Langrehr et al., 2021), these measures do not encompass sociocultural norms of whiteness that may influence help-seeking. Rather, the concept of *white supremacy culture* (Okun, 2021; Okun & Jones, 2001) may be more useful in describing characteristics shared and espoused by white people as a way of maintaining power. To be clear, this is not a way of being that is unique to white supremacists, but rather the characteristics white people share in order to consciously or unconsciously maintain white supremacy in institutions and culture. These characteristics are not unique to white people; however, they do make up part of the "water in which we're swimming" (Okun, 2021). By selecting some components of white

supremacy culture and contextualizing them in white veterans' broader experience, we may be able to understand the role aspects of white racial culture play in white veterans' decision-making about their health care. Incorporating facets of white supremacy culture (Okun, 2021) into our understanding of white veterans' help-seeking behavior may allow for the combination of two points: that racial identity components likely do influence white veterans' decision-making around health care, and that the incorporation of whiteness as a racial identity in need of assessment is a vital step in its deconstruction within a research sphere (Godwin, 2020). Using these constructs within a lens of critical whiteness allows for the integration of white culture within a quantitative model, thereby allowing them to be interrogated both theoretically and conceptually and continue the 'thick' work of deconstructing whiteness in our institutions (Liebert, 2021; Madriaga, 2005).

Perfectionism. The construct of perfectionism is defined by Okun (2021) as "the conditioned belief and attitude that we can be perfect based on a standard we did not create and that we are led to believe will prove our value" (p. 8). More specifically, perfectionism is characterized by Okun as a facet of white supremacy culture due to its role in both establishing untenable societal and social standards that disproportionately punish people of color. Within this lens, there is an emphasis on what individuals do incorrectly rather than what they have done well, and an emphasis on the conflation between an individual and their performance or negative qualities (i.e., a person *is* their mistakes, rather than *makes* mistakes; Okun, 2021). A critical whiteness lens extends this thought process into the purpose of perfectionism – that is, to keep individuals within the power structure under pressure to conform and therefore sap their energy and ability to

question said power structure (Okun, 2021). It is not surprising, then, that perfectionism is associated with increased psychological distress (Macedo et al., 2014). Moreover, perfectionism, while not an enculturated value of military service, may be associated with its high degree of structure and high-stakes work environment (Jennings & Hannah, 2011; Rice & Liu, 2016), and has been identified as a barrier to resilience in military populations (Rice & Liu, 2016).

Perfectionist traits have been established to be negatively associated with help seeking attitudes, posited to be due to lower stigma tolerance and lower levels of interpersonal openness (Dang et al., 2020). Therefore, we expect that perfectionism will negatively predict attitudes via higher self-stigma of seeking help (Zeifman et al., 2015). However, perfectionism may also have a negative direct relationship with attitudes (Dang et al., 2020), resulting in a partially mediated model.

Either-Or Thinking. Similarly, the value of either-or thinking, or the expectation that issues can and should be considered in a binary way (Okun, 2021), is posited by Okun to uphold white cultural values due to its emphasis on conflict and a binary way of looking at the world (2021). Specifically, binary thinking operates using *or* rather than *and*, which specifically can create psychological distress when applied to a well/unwell or good/bad dichotomy (Giusti et al., 2020). This presents in veteran's health care as well, where Veterans cite fear of being burdensome and belief that other Veterans need care more than they do as a barrier to accessing VA health care services (Elnitsky et al., 2013). This may interact with other forms of stigma as well, such as impressions of mental illness etiology as wholly psychological or wholly biological (P. Byrne, 2000) being associated with multiple types of stigma of seeking help (Larkings & Brown, 2018;

Mannarini & Rossi, 2019). Either-or thinking may also be associated with reduced problem recognition, and therefore reduced perceived need, which is commonly associated with attitudes (Bonabi et al., 2016). A study of alcohol use concerns in predominantly white adults suggested that binary conceptions of alcohol use (i.e., problem/not a problem) is associated with lower problem recognition (Morris et al., 2020). Therefore, we expect that either-or thinking will negatively predict attitudes via a negative relationship with self-stigma. Additionally, either-or thinking may be directly negatively associated with attitudes, resulting in a partially mediated model.

Military Personnel and the VHA

Identity Commitment

White US masculinity in general promotes self-reliance, emotional control, and stigma of mental health help seeking (Cole & Ingram, 2020; Mahalik & Di Bianca, 2021; Vogel et al., 2011). This is exacerbated by military training, hierarchy, and enculturation (Shields et al., 2017) and persists after discharge (H. Atuel & Castro, 2018). These cultural expectations serve important functions in a military setting, such that they make for soldiers who are willing to engage in self-sacrifice for the larger benefit of the military, but they are not without consequences after the period of military service, such that patterns of thinking and behavior that are adaptive in a military context may is detrimental in context of mental health needs (Bulmer & Eichler, 2017). Moreover, Veteran identity is often conceived of as a homogenous monolith, rather than a cultural identity that can vary on basis of personal characteristics and individual service experiences (Hack et al., 2017). Therefore, *identity commitment,* or the degree to which Veterans define themselves by their history of military service, may predict self-stigma

(Dickstein et al., 2010). While self-stigma is not in itself an espoused value of the U.S. military, it is commonly cited as an implicitly understood tenet of military and Veteran personnel's relationship with mental health (Dickstein et al., 2010; McDermott et al., 2017), perhaps as an extension of the values of self-reliance and stoicism (Heath et al., 2017; Stotzer et al., 2012).

It is therefore expected that military identity commitment will be negatively associated with attitudes towards help-seeking via higher self-stigma of seeking help. Similarly, military identity commitment may predict attitudes via enculturated mistrust of mental health providers, as is commonly cited by Veterans as a barrier to treatment (King & Snowden, 2020; Weiss & Coll, 2011). Military identity commitment may also be negatively associated with attitudes directly, as themes related to military identity fusion have been qualitatively explored as being related to mental health attitudes (McCaslin et al., 2021).

Perceived Lack of VHA Competence

Negative perceptions of VHA health care are consistently named as a barrier to Veteran mental health help-seeking (Cheney et al., 2018). These concerns can take the form of issues with bureaucracy, frustration with scheduling or with follow up, or confusion discerning how to instigate mental health care as separate from physical health care (Bovin et al., 2019; Cheney et al., 2018). More frustratingly, a global evaluation of VHA mental health services suggested that Veterans may be either receiving incorrect information with respect to their eligibility for VHA mental health care or misinterpreting a complex access network (National Academies of Science, Engineering, and Medicine et al., 2018), and qualitative interviews support that Veterans with mental health concerns

may not perceive the VHA as a generally caring organization (Fischer et al., 2021). More than half of current VHA users indicate having had at least one negative experience with VHA care or not having seen improvement during treatment, and 20% of a sample of over 50,000 Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND) VHA health care users (a group of majority white men over 30) with need for mental health services indicated that poor treatment quality was a reason for avoiding treatment in future (National Academies of Science, Engineering, and Medicine et al., 2018). If a Veteran perceives that the VHA as an institution is inefficiently run or cannot provide competent care, it is likely to affect their perceptions of individual providers who operate within said institution (McCormick et al., 2019). However, trust in provider and trust in health care systems broadly have been repeatedly shown to have some relationship, but be distinct experiences, in medical settings (Cunningham et al., 2007; Gupta et al., 2014). Alternatively, perceived lack of VHA competence may affect attitudes directly, given the strong relationship between these constructs as espoused in qualitative analysis of veterans' needs (McCormick et al., 2019; van den Berk-Clark & McGuire, 2014).

Current Study

The current study sought to investigate the direct and indirect links between ten sociocultural constructs relevant to Veterans and their attitudes towards seeking help from a VHA mental health provider, set within a critical whiteness framework. In addition to hypothesized effects previously outlined (see Figure 1 for visual depiction of all hypotheses), we expected additional effects related to sociodemographic variables (i.e., subjective social status, service branch, age, service era, length of service, gender,

level of current psychological distress, and previous past mental health help-seeking from both the VHA and civilian providers) that are important to statistically control for in order to get a clearer picture of the true relationship between the sociocultural variables and attitudes. Past help-seeking and level of distress are expected to have a positive association with attitudes based on prior research (Pearson et al., 2009; Porcari et al., 2017). Conversely, subjective social status (Bharat et al., 2020; Zell et al., 2018), being a man (Fox et al., 2014; Williston et al., 2019), and age (Gonzalez et al., 2011) have previously been shown to have negative associations with help seeking attitudes or intention. Nature of discharge is hypothesized to have an association with intention due to the fact that military personnel who are discharged for a medical reason are provided with resources for placing initial appointments with their local VA (U.S. Department of Veterans Affairs, 2020b), possibly lowering the access barrier and therefore increasing their impression of perceived VHA competence and therefore individual provider trust. The current study brings multiple sociocultural constructs known to be associated with Veterans' mental health attitudes into one model, and comprehensively explores how multiple key sociocultural factors are linked with white veterans' attitudes toward seeking VHA mental health care. For convenience, specific hypotheses are detailed below.

1a) Attitudes will be directly negatively predicted by self-stigma.

1b) Attitudes will be directly positively predicted by individual provider trust.

2a) Perceived stigma from other Veterans will positively directly predict self-stigma.

2b) Perceived stigma from loved ones will positively directly predict self-stigma.

2c) Emotional control will positively directly predict self-stigma.

2d) Self-reliance will positively directly predict self-stigma.

2e) Perfectionism will positively directly predict self-stigma.

2f) Either-or thinking will positively directly predict self-stigma.

2g) Military identity commitment will positively directly predict self-stigma.

3a) Emotional control will negatively directly predict individual provider trust.

3b) Self-reliance will negatively directly predict individual provider trust.

3c) Military identity commitment will negatively directly predict individual provider trust.

3d) Perceived lack of VHA competence will negatively directly predict individual provider trust.

4a) Perceived stigma from other Veterans will negatively indirectly predict attitudes via a positive relationship with self-stigma.

4b) Perceived stigma from loved ones will negatively indirectly predict attitudes via a positive relationship with self-stigma.

4c) Emotional control will negatively indirectly predict attitudes via a positive relationship with self-stigma.

4d) Perfectionism will negatively indirectly predict attitudes via a positive relationship with self-stigma.

4e) Either-or thinking will negatively indirectly predict attitudes via a positive relationship with self-stigma.

4f) Military identity commitment will negatively indirectly predict attitudes via a positive relationship with self-stigma.

5a) Military identity commitment will negatively indirectly predict attitudes via a negative relationship with individual provider trust.

5b) Perceived lack of VHA competence will negatively indirectly predict attitudes via a negative relationship with individual provider trust.

5c) Emotional control will negatively indirectly predict attitudes via a negative relationship with individual provider trust.

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CHAPTER TWO: METHOD

Participants and Procedures

Review and approval for this study and all procedures were obtained by both the University of Kentucky and Lexington Veterans Affairs Medical Center IRBs. The study was advertised as a study of veterans' opinions about VA mental health care. Interested participants were directed to an online survey that begins with an informed consent page, continues with the survey items, and ends with a debriefing page. Participants were recruited via ResearchMatch, a national health volunteer registry of individuals interested in being contacted for research purposes supported by the U.S. National Institutes of Health as part of the Clinical Translational Science Award program, as well as social media sites geared towards Veteran identity, such as r/Veterans and VeteransConnect. Finally, participants were recruited via snowball sampling from same as well as via Veterans known to the first author. Additionally, one arm of the study recruited participants through the primary care offices of the Lexington VAMC. However, no participants were finally recruited via this approach. Interested participants were able to enroll in a raffle for one of five $25 gift cards (1 per approximately 150 participants) in a separate survey.

The final data set contained 377 individuals who identified as white Veterans. Cisgender men made up 74.5% (n = 275) of the retained sample, while 22.2% (n = 82) identified as cisgender women and 0.5% (n = 2) identified as nonbinary. Ten individuals (2.7%) did not indicate their gender. Veterans' ages ranged from 20 to 89, with their median age being 47 years old (M = 49.72, SD = 19.233). 35.6% identified as 35 or younger, 37% identified as between 36 and 65, and 28.4% identified as being 66 and 89.

With respect to subjective social status, respondents generally self-identified as somewhere in the middle, with both median and modal responses being 6 on a 1 to 10 point scale (*M* = 5.65, *SD* = 2.12). The bulk of respondents (58.2%) self-identified as being between a 4 and a 7 on the Subjective Social Status ladder graphic, with 7% identifying as the bottom two rungs of the ladder and 9.9% identifying as the top two rungs of the ladder. Participants' service length ranged from .40 years to 40 years, with the participant reporting 40 years of service clarifying that they served in the National Guard. Median service length was 6 years (*M* = 9.104, *SD* = 8.57). The most common length of service was 3 years. With respect to service branch, 30.1% (n = 111) of the sample reported having been in the Army, 22.0% (n = 81) Navy, 16.0% (n = 59) Air Force, 11.1% (n = 41) Marines, 8.7% (n = 32) Coast Guard, and 4.3% (n = 16) reported having been part of multiple branches. 4.3% (n = 16) of participants reported only having been a member of the National Guard or Reserves, and 3.5% (n = 13) did not report which branch they served with. In total, 7.3% of respondents indicated having ever served in the National Guard, and 6.1% of respondents indicated having ever served in the Reserves. Upon suggestion of participants, an item concerning combat Veteran status was included approximately halfway through data collection. Of those individuals responding to this item, 51.3% (n = 77) reported having experienced hostile direct or indirect fire or having served in a combat zone, while 48.7% (n = 73) did not. With reference to having left the military, 63.4% (n = 234) participants reported having left via retirement, Expiration of Term of Service (ETS), or having completed their contract. Medical reasons (e.g., "med-board") or medical retirement) was the second most common reason for leaving, with 17.3% (n = 64) reporting having been separated for

medical reasons, 6.5% reported having experienced a non-disciplinary or chapter separation (n = 24), and 5.7% (n = 21) reported having experienced a chapter or disciplinary separation. The remainder of participants (6%) either did not provide a reason for separation or indicated a different reason for separation, including disagreeing with their chapter separation (e.g., "I should've been med-boarded.") With respect to previous history of adulthood mental health service use, 35% of respondents indicated having never met with a mental health professional affiliated with the VA (n = 129). Of those Veterans who reported having met with a VA-affiliated mental health professional, 24.4% (n = 57) reported having met with one only once, 20.9% (n = 49) reported having met with one two times, 14.9% reported having met with one three times (n = 35), and 39.7% (n = 93) reported having met with a VA-affiliated mental health professional four or more times. In a similar vein, 30.1% (n = 111) of respondents reported having never met with a mental health professional not affiliated with the VA (henceforth "civilian provider"). Of those reporting previous civilian mental health service use, 23% (n = 58) reported having met with a civilian provider one time, 24.6% (n = 62) reported having met with a civilian provider two times, 8.3% (n = 21) reported having met with a civilian provider three times, and 44.05% reported having met with a civilian provider four or more times. Veterans reported an average score on a distress measure of 6.80 out of 24 (*SD* = 5.06), above the general cutoff for moderate mental distress on the Kessler Screening Scale for Psychological Distress (Prochaska et al., 2012).

Measures

Attitudes Towards Help Seeking

The Mental Help Seeking Attitudes Scale (MHSAS; Hammer et al., 2018) is a nine-item instrument that assesses respondents' evaluative relationship with mental health care help-seeking. It is rated on a seven-point semantic differential scale anchored by bipolar adjectives (e.g., *helpful* vs. *unhelpful*), with higher scores indicating more positive attitudes ($\alpha = .92$). Items were modified such that the item stem read "If I had a mental health concern, my seeking help from a VHA mental health provider in the next three months would be…[good/bad]". The MHSAS has demonstrated evidence of reliability (e.g., $\alpha = .90$; Spiker et al., 2020) and validity (e.g., significant positive association with intention to seek help; Hammer et al., 2018), as well as evidence of measurement invariance across men and women, help-seeking experience, and degree of psychological distress (Hammer et al., 2018) in samples of predominantly white women. Cronbach's alpha in the current sample was .92.

Self-Stigma of Seeking Help

The Self-Stigma of Seeking Help – Three item version (SSOSH-3; Brenner et al., 2021) is a three-item measure of an individual's self-labeling of themselves as socially unacceptable due to seeking help for a mental health problem (Vogel et al., 2006). It was developed by Brenner et al. (2021) using item response theory to shorten the SSOSH-10 while maximizing information and variability. Items are rated on a five-point partially anchored Likert-type scale ranging from 1 (*strongly disagree*) to 3 (*agree and disagree equally*) to 5 (*strongly agree*). No items are reverse keyed, and higher scores indicate greater endorsement of self-stigma of seeking help. The SSOSH-3 has demonstrated

evidence of criterion validity (i.e., similar associations with attitudes towards seeking help, public stigma, and intention to seek as the original SSOSH-10 (Vogel et al., 2006). Differential item functioning suggests that the SSOSH-3 behaves similarly between men and women, as well as predominantly white community-dwelling and college adults (Brenner et al., 2021). In the study sample, Cronbach's alpha for the SSOSH-3 was .90.

Provider Trust

The Health Care Relationship Trust Scale - Revised (Bova et al., 2012) is a thirteen-item measure of an individual's trust in their health care provider, developed in order to address shortcomings of earlier physician trust scales. Items are rated on a five-point partially anchored Likert-type scale (0 = *none of the time,* 2 = *occasionally or a moderate amount of the time,* 5 = *all of the time*). One item is reverse keyed. Higher scores indicate higher trust in the provider relationship. Items were modified to use "My VHA therapist would… [be an excellent listener]" in order to accommodate the prospective nature of the study and the nature of the provider (Mondek & Silverman, 2020). The HCRTS-R was developed in a sample of predominantly white adult primary care patients with a large range of ages. The HCRTS-R has been rated "good" using a COSMIN checklist on structural validity. Cronbach's alpha in the current sample was .95.

Perceived Stigma by Other Veterans for Seeking Help

The Perceptions of Stigmatization by Others for Seeking Help Scale (PSOSH; Vogel et al., 2009) is a five-item scale used to assess a respondents' endorsement of their seeking help being stigmatized by their social group (Vogel et al., 2009). Items are rated on a five-point Likert-type scale (1 = *Not at all* to 5 = *A great deal*), with higher scores

indicating greater endorsement of perceived stigmatization of seeking help from the respondent's social group. No items are reverse scored. To measure perceived stigma by other Veterans for seeking help, the instructions were modified to read "to what degree do you believe other Veterans would…" with items like "…see you in a less favorable way." This scale has demonstrated reliability evidence of between .78 and .93 in US samples (Vogel et al., 2019) and demonstrated partial metric and scalar invariance across eleven different countries and regions with varying predominant racial and cultural communities and languages (Vogel et al., 2019). Additionally, the PSOSH demonstrated evidence of consistency in a sample of college Veterans and active duty personnel who were predominantly white men ($\alpha = .92$; Goode & Swift, 2019) as well as discriminant (i.e., construct distinctiveness with other types of stigma) and concurrent (i.e., moderate positive association with other measures of help-seeking stigma) validity (Vogel et al., 2009). In the current sample, Cronbach's alpha for the PSOSH with reference to other Veterans was .90.

Perceived Stigma by Civilian Loved Ones for Seeking Help

In addition to the PSOSH being used to assessed perceived stigma from prior veterans, the PSOSH were modified a second time to measure perceived stigma by loved ones for seeking help (e.g., "to what degree do you believe [your loved ones] would…[think you posed a risk to others?]"). Reliability and validity information for the PSOSH are listed above. In this sample, the Cronbach's alpha for the PSOSH with reference to the participants' loved ones was .91.

Emotional Control

The Emotional Control subscale of the CMNI-30 (α = .83 in the current sample) is a three-item instrument that assesses a respondent's preference to avoid experiencing and expressing emotional content (Levant et al., 2020). It is rated on a six-point Likert-type scale (0 = *strongly disagree* to 5 = *strongly agree*), with higher scores indicating more endorsement of the emotional control construct. The emotional control subscale of the CMNI-30 has demonstrated evidence of reliability (α = .90 in the initial validation sample) and validity (e.g., significant and negative association with scores on the Generalized Anxiety Disorder – 7 and the PHQ – 2).

Self-Reliance

The Self-Reliance subscale of the Conformity to Masculine Norms Inventory-30 item version (CMNI-30; Levant et al., 2020) is a three-item instrument that assesses a respondent's reluctance to ask for assistance and preference for relying on oneself (Levant et al., 2020). It is rated on a six-point Likert-type scale (0 = *strongly disagree* to 5 = *strongly agree*), with higher scores indicating more endorsement of the self-reliance construct. All three items are reverse scored. The self-reliance subscale of the CMNI-30 has demonstrated evidence of reliability (α = .78 in both white men and men of color in the initial validation sample) and validity (e.g., greater endorsement of self-reliance is associated with higher scores on the Patient Health Questionnaire – 2 in the validation sample). In the current sample, Cronbach's alpha was .576. Please refer to the results section for commentary on this low alpha coefficient.

Perfectionism

The rigid perfectionism subscale of the Big Three Perfectionism Scale – Short Form (BTPS-SF; Feher et al., 2020) is a four-item measure of an individual's endorsement of rigid perfectionism, or "demanding flawless performance from the self" (Feher et al., 2020, p. 38). Items are rated on a six-point scale ranging from 1 (*disagree strongly*) to 5 (*agree strongly*) and no items are reverse keyed. The BTPS-SF has demonstrated high degrees of correlation with the original BTPS in two samples of predominantly women Canadian college students (Feher et al., 2020), as well as evidence of stability of said constructs over time and association with salient affective constructs in white American college students (Feher et al., 2020; Lowe, 2021). In the current sample, Cronbach's alpha for the BTPS-SF rigid perfectionism scale was .88.

Either-Or Thinking

The dichotomous belief subscale of Dichotomous Thinking Inventory (DTI; Oshio, 2009) is a five-item measure of an individual's propensity to believe that "anything in the world can be divided into two categories such as "black or white", "good or bad", or "winner or loser" (p.735). Items are rated on a six-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). The dichotomous belief subscale of the DTI has have demonstrated a reliability estimate of .84 in the initial validation sample of 352 men and women Japanese undergraduates, and similar internal consistency in samples of Dutch and Australian adults (Bonfá-Araujo et al., 2021). Moreover, the dichotomous belief subscale of the DTI has been shown to be associated with other measures of ambiguity intolerance (Oshio, 2009). In the current sample, Cronbach's alpha for the dichotomous belief subscale of the DTI was .89.

Military Identity Commitment

The military identity commitment subscale of the revised Warrior Identity Scale (WIS; Lancaster et al., 2018) is a three-item measure of a respondent's identification with a military identity. Items are rated on a four-point Likert-type scale (1 – *strongly disagree* to 4 – *strongly agree*) with higher scores indicating stronger endorsement of military identity commitment. This subscale has demonstrated internal consistency in multiple samples of U.S. active duty and Veteran personnel, as well as association with increased symptoms of post-traumatic stress disorder (Hart & Lancaster, 2019; Meca et al., 2021). In the current sample, Cronbach's alpha for the military identity commitment subscale of the WIS was .79.

Health Care System Distrust Scale

The Competence subscale of the Revised Health Care System Distrust Scale (HCDS-R; (Shea et al., 2008) is a four-item measure of a respondent's distrust of a given health care institution. It is rated on a five-point Likert-type scale (1 = *strongly disagree* to 5 = *strongly agree*), with higher scores indicating greater perceived lack of competence of the a given health care institution. Items were modified such that they will reference the Veterans' Health Administration, such as "The [VHA] makes too many mistakes." This subscale has demonstrated evidence of reliability ($\alpha = .77$) in the validation sample of 255 community dwelling individuals who were 36.1% white and predominantly women with at least a high school degree ($\alpha = .79$ in the subsample of 92 white individuals). In the current sample, Cronbach's alpha for the competence subscale of the HCDS-R was .85.

Control Variables

Age. Age was assessed with one free-entry item: "What is your age?"

Service Length. Service length was assessed with one free-entry item: "How long did you serve?"

Service Branch. Service branch were determined via one self-report item: "With what branch of the United States military did you predominantly serve?" Categorical responses were coded as Army, Marine Corps, Navy, Air Force, Space Force, Coast Guard, National Guard, and Reserves. Respondents were permitted to select more than one option (e.g. if a respondent served in the Air National Guard and the Army, they could select "Air Force," "National Guard," and "Army"). Participants were then dummy coded as "yes" or "no" for each option.

Nature of Separation from the Military. Nature of military separation were assessed with one self-report item: "What was the nature of your separation from the military?" Categorical responses were coded as Expiration Term of Service (ETS) or completed contract, medical separation or medical retirement, chapter or disciplinary separation, and non-disciplinary or chapter separation and retirement. Participants were then dummy coded as "yes" or "no" for each option.

Gender Identity. Participant gender were assessed with one self-report item: "what is your gender?" Respondents were given an array of responses consistent with most recent recommendations (Maroney et al., 2017) as well as the option to self-identify.

Previous VHA Mental Health Care Experience. Previous experience with the VHA mental health care system were assessed with the following item: "How many

times have you met with a mental health professional affiliated with the VHA?" Said item were rated on a five-point Likert-type response scale (0 = *Never,* 1 = *1 time,* 2 = *2 times,* 3 = *3 times*, 4 = *4 or more times*).

Previous Non-VHA Mental Health Care Experience. Previous experience with non-VHA mental health care systems were assessed with the following item: "How many times have you met with a mental health professional *not* affiliated with the VHA?" Said item were rated on a five-point Likert-type response scale (0 = *Never,* 1 = *1 time,* 2 = *2 times,* 3 = *3 times*, 4 = *4 or more times*).

Psychological Distress. The Kessler Screening Scale for Psychological Distress (K6; Kessler et al., 2002) were used to measure self-reported psychological distress within participants. The K6 is a 6-item scale measuring general psychological distress (item stem: "During the past month, about how often did you feel…" with sample items such as *restless.* Participants rate each item from 1 (*none of the time*) to 5 (*all of the time*) with higher scores being interpreted as higher distress. Suggested cutoffs for the K6 propose 5 as the cutoff for moderate mental distress and 13 for severe mental distress (Prochaska et al., 2012). The K6 has demonstrated evidence of internal consistency (α = .89; Kessler et al., 2002) as well as construct validity via Rasch analysis in a large sample of adults (Khan et al., 2014). In this sample, Cronbach's alpha for the K6 was .87.

Subjective Social Status. The MacArthur Scale of Subjective Social Status Scale (SSS) is an indicator designed to determine an individual's self-assessment their personal, social, and cultural capital in relation to others in their society and in their community. Respondents indicate where they stand on a visual "ladder" of status (1 = *low* to 10 = *high*). The SSS has demonstrated the ability to predict adult psychological health (Helms,

2017) and can mediate fully or partially the relationships between other indicators of social class and clinical health outcomes (Demakakos et al., 2008).

Analytic Plan

Prior to fitting the initial measurement model, exploratory ANOVAS, independent sample t-tests, and bivariate correlations were conducted to determine which of the sociodemographic control variables were significantly associated with any endogenous variable (i.e., attitudes, trust in provider, and self-stigma of seeking help) and thus should be controlled for during structural equation model (SEM) testing. Qualifying categorical nominal control variables with more than two levels were dummy coded (e.g., "respondent was medically separated" was dummy coded as 0 if they were not medically separated or retired or coded 1 if they were) and the dummy codes were used during model testing. Control variables meeting criteria for inclusion as control variables included age, distress as measured on the K6, binary gender identity (i.e., identifying as a cisgender man or a cisgender woman), length of service, subjective social status, experience with civilian mental health providers, identifying as a Marine, identifying as having been medically retired or separated, and identified as having experienced a non-disciplinary chapter separation from the military. Of note, previous experience with VA mental health providers was not significantly associated with any endogenous variable. All control variables excepting the K6 were modeled as observed variables.

Upon pilot testing of the confirmatory factor analysis model, multiple control variables (in specific, having experienced a non-disciplinary chapter separation and having been medically retired) were determined by M*plus* to be statistically indistinguishable and were removed from the model. Additionally, the self-reliance

construct was removed from the model due to poor reliability statistics ($\alpha = .57$, with no single item loading above .70). To disattenuate error due to subscale differences, latent variables were created for most constructs. We modeled all latent constructs using the corresponding (sub)scale items as manifest indicators. Past non-VA help-seeking, being a Marine, subjective social status, and binary gender were operationalized as observed variables.

In line with best practices in model development (Weston & Gore, 2006), a fully mediated theorized model (Figure 1) was tested first which specified that all distal factors would be fully mediated by the proximal mediators of self-stigma of seeking help and trust in provider (the "full mediation" or "core model"). Due to multiple distal factors having possible direct associations with attitudes, after the fully mediated model we secondly tested the fit of an alternative partial mediation model in which all distal variables were allowed to have direct effects on attitudes and nine specific indirect effects on attitudes were examined via the two mediators of self-stigma of seeking help and provider trust (see Table 2).

The chi-square statistic ($\chi 2$) was used to test exact fit of all measurement and structural models, whereas the Root Mean Square Error of Approximation (RMSEA), Comparative Fit Index (CFI), and Tucker-Lewis Index (TLI) were used to assess the approximate fit for all models. The WLSMV estimator does not provide the Standardized Root Mean Square Residual (SRMR). If the $\chi 2$ was non-significant ($p > .05$), then the model demonstrated exact fit and therefore also approximate fit (Asparouhov & Muthén, 2018). In the case of a significant $\chi 2$ the following approximate fit criteria were used: RMSEA $\leq .06$, CFI $\geq .95$, TLI $\geq .95$, and SRMR $\leq .08$ for good fit and RMSEA $\leq .10$,

CFI ≥ .90, TLI ≥ .90, and SRMR ≤ .10 for acceptable fit (Hu and Bentler, 1999; Weston & Gore, 2006). To compare the fit of the core structural and alternative structural model, the DIFFTEST function in M*plus* version 6.11 was used. A significant chi-square difference test ($\chi 2 < .05$) would indicate that the additional constraints imposed by the core structural model created significantly worse fit and the less constrained alternative structural model should be retained for indirect effects testing. To test the indirect effects, we used the bootstrapping procedure outlined by Shrout and Bolger (2002). We instructed Mplus to make 1,000 bootstrap draws of the data and output bias-corrected bootstrap confidence intervals for the indirect effects. The indirect path was considered significant if it did not include zero in the 95% CI.

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CHAPTER THREE: RESULTS

Data Preparation

The initial sample of participants were 666 individuals who identified as white Veterans who were eligible for VA mental health care. Of note, a large proportion of late-stage data collection was in danger of fraudulent or malicious responding due to potential participants (in particular, participants recruited from Reddit) responding negatively to the nature of the study (i.e., studying white identity). In particular, some potential respondents via this recruitment method explicitly expressed interest in entering fraudulent data through comments and replies. Due to this concern, steps were taken to identify and remove malicious, fraudulent, or manufactured responses. Participants were deleted who declined to consent to the survey or had no data on the consent item (n = 17), failed either of two attention checks (n = 195), had reCAPTCHA scores of less than 0.5 (n = 58; Griffin et al., 2021), or whose survey completion time indicated they spent less than 3 seconds to read and complete each item on average (n = 16; Huang, 2012). Additionally, participants were deleted if they entered string data that indicated they may not be taking the survey seriously or may be entering false data (e.g., "lizard" for gender, n = 1). Multivariate outliers were identified using the Mahalanobis distance test (n = 8) and were removed. Data did not violate any multicollinearity (VIFs < 1.6) or reasonably normal distribution guidelines (Byrne,2016). Data was analyzed using M*plus* version 6.11 (Muthén & Muthén, 1998-2021). Given the ordered-categorical nature of the data, data was analyzed using a polychoric correlation matrix based on the mean and variance adjusted weighted least square (WLSMV) estimator in M*plus* 6.11. Covariance coverage

for the data ranged from .910 to 1.00, justifying WLSMV's use of pairwise deletion to handle missing data.

Findings

Confirmatory factor analysis (CFA) was conducted to first determine whether the data fit the hypothesized measurement models. The measurement model demonstrated approximate fit, $\chi2$ (1655, N = 378) = 3188.67, $p < .001$; RMSEA = .050 [90% CI of .047, .053]; CFI = .957; TLI = .954. The manifest indicator loadings on the latent variables were all significant at $p < .05$. The initial hypothesized full mediation structural model exhibited acceptable fit, $\chi2$ (2025, N = 378) = 5222.90, $p < .001$; RMSEA = .065 [90% CI of .063, .068]; CFI = .913; TLI = .908. The alternative partial mediation structural model (Figure 2) also exhibited acceptable fit, $\chi2$ (2018, N = 378) = 5200.95, $p < .001$; RMSEA = .065 [90% CI of .063, .068]; CFI = .913; TLI = .908. Difference testing results $\chi2$ [7, N = 378] = 49.048, $p < .001$ suggested that increased restrictions on the model (i.e., the more constrained full mediation model) resulted in worse model fit, thus this alternative partial mediation structural model was retained for indirect effect testing. All hypothesized direct effects were supported with the exception of perceived stigma from other Veterans → self-stigma, perfectionism → self-stigma, military identity commitment → self-stigma, and military identity commitment → individual provider trust. Nine indirect effects were tested (See Table 1) and three were found to be significant (i.e., did not include zero in the 95% confidence interval). The final structural model accounted for 86.0% of the variance in attitudes towards VA mental health care, 62.3% of the variance in self-stigma of seeking help, and 81.2% of the variance in trust in

provider. All significant indirect effects aligned with hypotheses with the exception of the positive military identity commitment → trust in VA provider → attitudes path.

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Table 1

Bootstrap Analysis of Magnitude and Statistical Significance of Indirect Effects for the Structural Model

			Standardized indirect effect		Bootstrap estimate		95% CI (unstandardized)	
Predictor	Mediator	Outcome	β	*SE*	*B*	*SE*	Lower bound	Upper bound
Perceived Stigma- Other Veterans	Self-Stigma	Attitudes	-.002	.119	-.002	.114	-.135	.158
Perceived Stigma – Loved Ones	**Self-Stigma**	**Attitudes**	**-.093**	**.149**	**-.086**	**.137**	**-.546**	**-.014**
Emotional Control	**Self-Stigma**	**Attitudes**	**-.048**	**.042**	**-.049**	**.042**	**-.175**	**-.010**
Perfectionism	Self-Stigma	Attitudes	.025	.051	.024	.049	-.002	.179
Either-Or Thinking	**Self-Stigma**	**Attitudes**	**-.049**	**.054**	**-.047**	**.052**	**-.233**	**-.007**
Military Identity Commitment	Self-Stigma	Attitudes	.121	.098	.016	.056	-.014	.151
Military Identity Commitment	**Individual Provider Trust**	**Attitudes**	**.105**	**.073**	**.101**	**.072**	**.012**	**.312**
Perceived Lack of VHA Competence	Individual Provider Trust	Attitudes	-.251	.162	-.232	.152	-.407	.125
Emotional Control	Individual Provider Trust	Attitudes	-.044	.067	-.046	.069	-.209	.060

Note. Indirect path is significant if the 95% confidence interval (CI) does not include 0. Bolded paths are significant.

Table 2
Means, Standard Deviations, and Intercorrelations among measures

Variables	*Range*	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Attitudes	0-54	35.38	11.87	-															
2. Self-Stigma of Seeking Help	3-15	6.69	3.12	-.381*	-														
3. Trust in Provider	1-52	34.64	11.39	.747*	-.353*	-													
4. Perceived Stigma – Veterans	6-30	11.90	5.31	-.325*	.477*	-.350*	-												
5. Perceived Stigma – Loved Ones	6-27	10.83	5.29	-.337*	.528*	-.362*	.726*	-											
6. Emotional Control	0-15	7.40	3.47	-.164*	.116T	-.195*	.062	.061	-										
7. Perfectionism	4-20	12.05	3.79	.164*	.091	.091	.177*	.194*	-.064	-									
8. Either-Or Thinking	5-30	13.16	5.93	-.037	.342*	-.110*	.377*	.439*	-.113*	.397*	-								
9. Military Identity Commitment	3-12	9.37	2.00	.314*	-.144*	.261*	-.200*	-.232*	-.055	.179*	.007	-							
10. Lack of Perceived VHA Competence	4-20	10.26	3.62	-.659*	.189*	-.679*	.199*	.218*	.152*	-.126T	.042	-.184*	-						
11. Subjective Social Status	1-10	5.65	2.12	-.061	.252*	-.139*	-.197*	.258*	-.123*	.106T	.190*	-.159*	.031	-					

Table 2 (Continued)

Variables	*Range*	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
12. Marine	NA	NA	NA	-.054	.173*	-.059	.120*	.123*	-.070	.096	.116*	-.041	-.004	.125*	-				
13. Age ^	20-89	49.72	19.22	.158*	-.353*	.227*	-.336*	-.413*	.220*	-.203*	-.465*	.265*	-.177*	-.374*	-.185*	-			
14. Service Length ^	.4 - 40	9.10	8.57	.068	-.220*	.057	-.200*	-.247*	.178*	-.028	-.209*	.373*	.000	-.246*	-.137*	.390*	-		
15. Binary Gender±	NA	NA	NA	.017	-.193*	-.033	-.135*	-.080	-.122*	.055	-.019	.081	.087	-.007	-.086	-.040	-.004	-	
16. Distress	0-24	6.80	5.06	-.285*	.278*	-.304*	.405*	.450*	-.027	.280*	.320*	-.146*	.284*	.231*	.154*	-.523*	-.163*	.045	-
17. Non-VA MH Experience	NA	NA	NA	-.033	-.312*	-.035	-.051	-.077	-.131*	-.025	-.147*	.048	.140*	-.093	-.086	.087	.192*	.183*	.180*

Note: * $p < .01$. ^ = continuous variable entered into the model as categorical. ± = 1(cisgender man), 2 (cisgender woman).

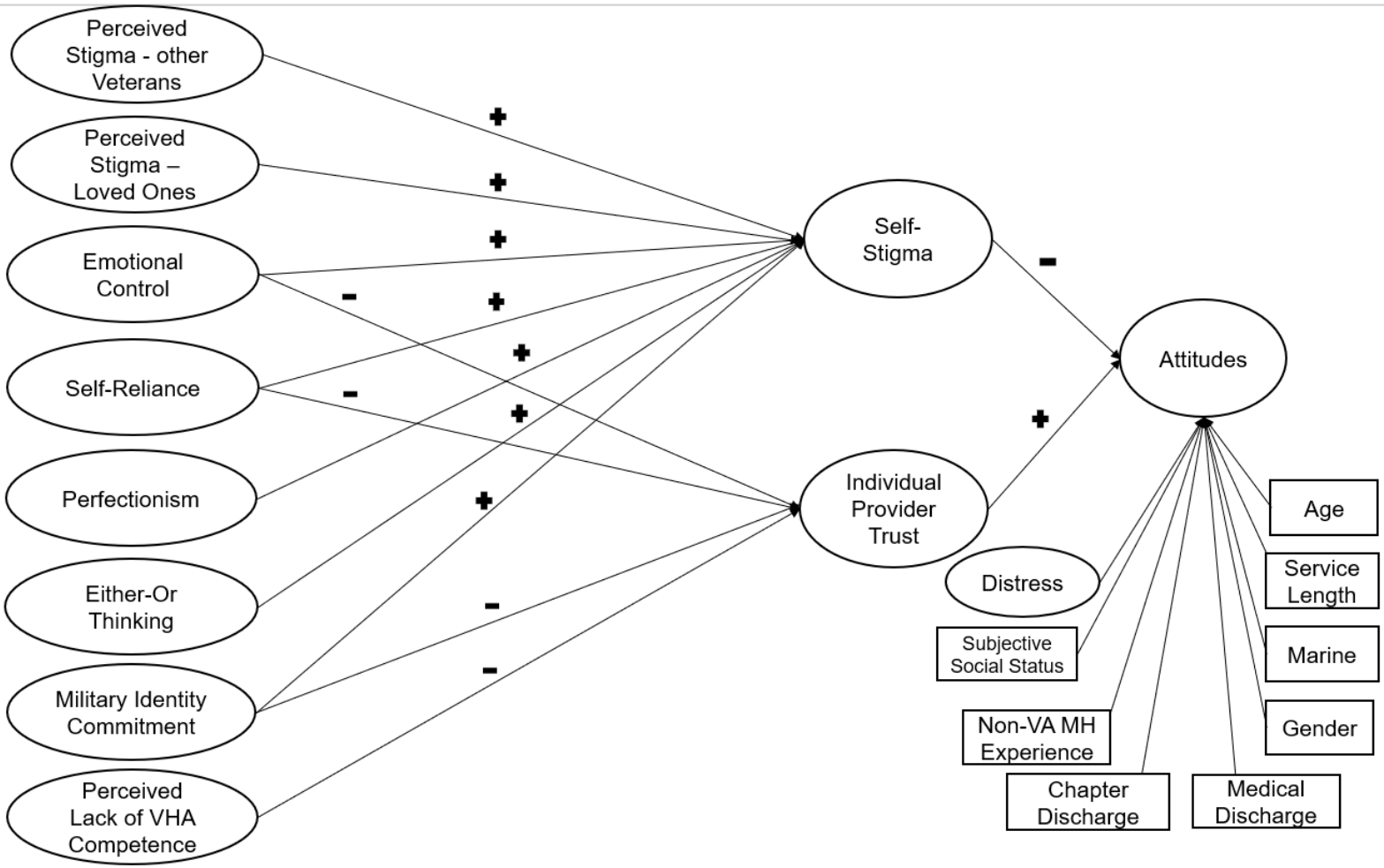

Figure 1. The fully mediated hypothesized model

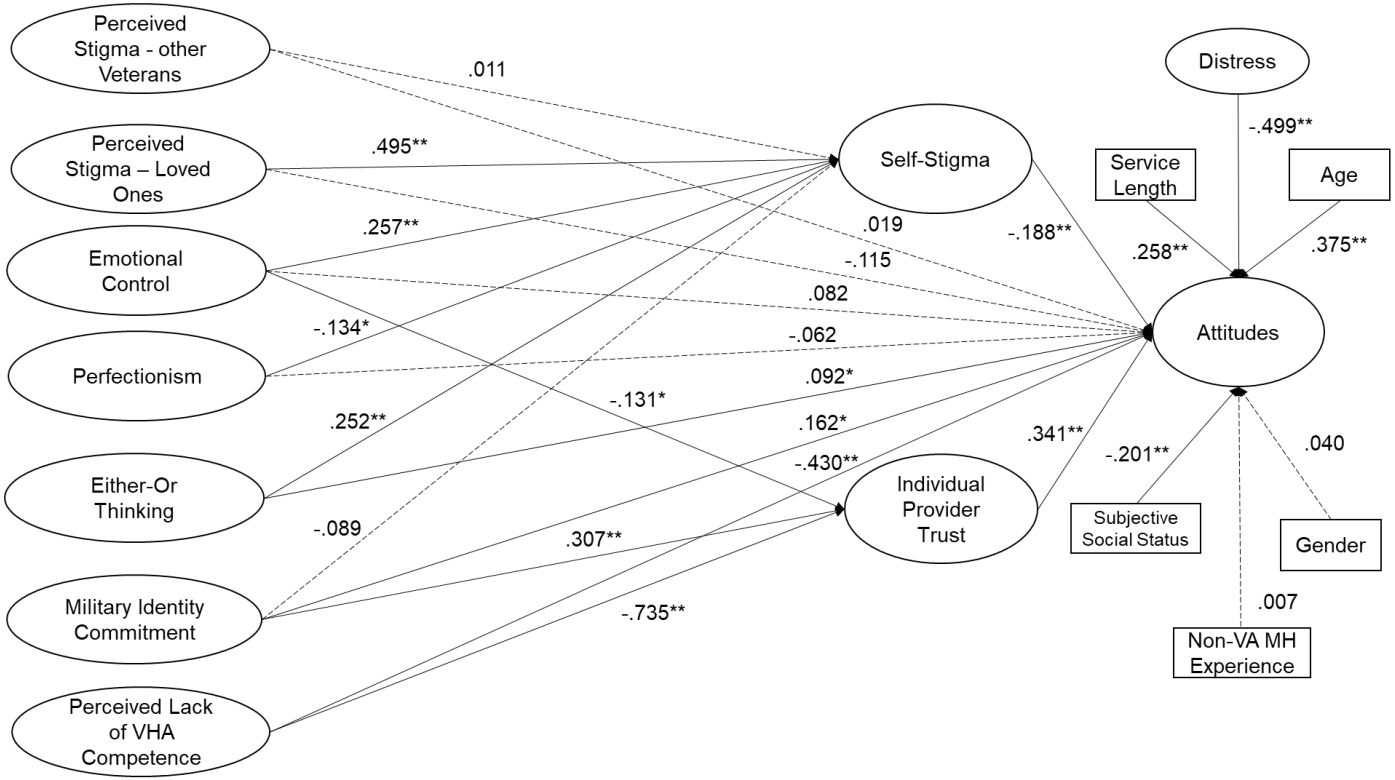

Figure 2. The final structural model.

Parameter estimates represent standardized regression coefficients. * = $p < .05$, ** = $p < .001$. Dashed lines indicate non-significant results. Error terms, correlations, and indicator factor loadings are omitted for visual clarity.

CHAPTER FOUR: DISCUSSION

The current study was designed to evaluate the direct and indirect relationships between multiple sociocultural constructs and white Veterans' attitudes towards VA mental health care. Additionally, a goal of the study was to specifically examine aspects of white supremacy culture and different dimensions of health care trust as it applies to Veterans' attitudes towards VA mental health care.

Consistent with hypotheses, self-stigma was significantly negatively associated with attitudes towards VA mental health care and individual provider trust was significantly positively associated with attitudes towards VA mental health care. The relationship between Veteran self-stigma and attitudes towards mental health care is well-established (Dickstein et al., 2010; Elnitsky et al., 2013; McDermott et al., 2017), but the relationship between trust in individual providers and mental health attitudes is in the process of being established, especially in Veterans without specific medical concerns (Bova et al., 2012). This highlights the importance of the Veteran-provider relationship, both in reference to long-term mental health services and referral sources for VA mental health services (i.e., primary care-mental health integration and primary care providers).

With reference to perceived stigma from other Veterans and civilian loved ones, a surprising picture emerges. While perceived stigma from loved ones was significantly directly associated with attitudes via self-stigma and exerted a moderate effect size on self-stigma, perceived stigma from other Veterans was not significantly directly or indirectly associated with attitudes via self-stigma. This is inconsistent with some previous research suggesting that perceived stigma from unit leaders may influence self-stigma in National Guard personnel (Blais & Renshaw, 2014).

Perhaps the most parsimonious explanation for this finding is that of statistical artifact, given the strong correlation between perceived stigma from loved ones and perceived stigma from other Veterans (r = .726). When modeling constructs that may lay claim to similar variance in predicted variables (in this case, self-stigma of seeking help), that variance is awarded to the predictor variable with the strongest predictive value. In this case, the variance accounted for by perceived stigma from other Veterans may be outcompeted by the variance accounted for by perceived stigma from loved ones. Lending weight to this argument is the moderate to strong bivariate correlation between self-stigma of seeking help and perceived stigma of other Veterans (r = .477) and perceived stigma from loved ones (r = .528). This pattern of data suggests that while a relationship between perceived stigma from other Veterans and self-stigma of seeking help may exist, that relationship is statistically redundant when the relationship between perceived stigma from loved ones and self-stigma of seeking help is accounted for.

However, conceptually, other research has also suggested that while Veterans may be concerned about stigma coming from other Veterans, they are significantly less likely to endorse judging a fellow Veteran in a similar position (Kulesza et al., 2015). It may be useful to explore how community expectations may manifest in active duty versus Veteran circles, or whether Veterans may feel disconnected from active duty community members after separation (Franco et al., 2020; Graham, 2022). Exploring how perceived stigma from other Veterans may vary across life span and levels of distress may help elucidate how this relationship changes over time and how it interrelates with other constructs – including perceived stigma from loved ones. Regardless, this finding outlines an important avenue for intervention related to self-

stigma in Veterans, such that families, workplaces, and other civilian communities may be instrumental in reducing self-stigma of seeking help in Veterans. This question has been addressed to some degree in recently separated Veterans (Albright et al., 2011; Sherman & Larsen, 2018) as well as older Veterans (Brewster et al., 2021) and women Veterans (Kelly et al., 2020), including seeking support from wider networks on social media.

However, both quantitative and qualitative studies consistently highlight the importance of family and community attitudes – both overt and covert – in Veterans' decision to seek support and care (e.g., Silvestrini & Chen, 2022). This may be especially important in white Veterans' families and communities. While not directly measured in this model, denial and defensiveness has been named as a core tenet of white supremacy culture (Okun, 2021). This may come into play when considering family distress, intergenerational trauma, and mental illness. –Additionally, it has been theorized that white individuals' high rate of suicide in comparison to the global majority may also be associated both with relational silencing, hopelessness, lower emotional flexibility and "lack of redemption narratives across generations" – i.e., families (Malat et al., 2018, p. 152). It may be that this framework can be extended and interconnected with understanding of military and Veteran culture to provide understanding as to how white Veterans and their families may pass on implicit or explicit beliefs about strength in the face of adversity, disenchanted beliefs in meritocracy, or other aspects of stigma that contribute to lower rates of help-seeking. Additionally, this intersects strongly with expectations of strength, power maintenance rugged individualism, and avoidance of weakness – expectations certainly not unique to white men, but named consistently as

components of white masculinities (Brassel et al., 2020). Given the large proportion of men in the current sample as well as the importance of masculine ideal in U.S. military irrespective of gender (Crowley & Sandhoff, 2017), it seems especially crucial to consider how aspects of whiteness and masculinities interrelate in white Veterans.

Emotional control was significantly indirectly related with attitudes via self-stigma of seeking help, consistent with previous literature (Heath et al., 2017). However, despite being significantly associated with trust in provider, emotional control did not have a significant indirect effect on attitudes via individual provider trust. Additionally, with the addition of self-stigma as a mediator, emotional control was not significantly directly related with attitudes in this sample. This may suggest that self-stigma may almost completely mediate the relationship between emotional control and attitudes towards VA mental health care in this sample, while still allowing for the salience of emotional control as a potential barrier to trusting individual VA providers. While interventions have been developed related to masculinities and mental health attitudes, a Veteran-specific intervention related to emotional control may provide an opportunity to both improve perceptions of VA mental health providers and reduce self-stigma in Veterans (McDermott et al., 2017).

In contrast to the initial hypothesis, perfectionism was significantly negatively associated with self-stigma, not significantly directly associated with attitudes, and was not significantly indirectly related to attitudes via self-stigma. This is likely due to the high association between either-or thinking and perfectionism in the model as well as the nature of structural equation modeling, such that correlated constructs (in this case, r = .40) compete for variance in dependent variables (Fishbein & Ajzen, 2009). In this case,

it may be that perfectionism and either-or thinking exert both positive and negative influences on self-stigma of seeking help, but due to the nature of the structural equation modeling setup, the variance that may typically be assigned to a positive relationship between perfectionism and SSOSH is instead assigned to the stronger relationship between either-or thinking and SSOSH. Therefore, the model instead exposes a smaller but still significant negative relationship between perfectionism and self-stigma of seeking help. This explanation becomes more likely when considering that this finding is in contrast to previous research in predominantly students that perfectionism likely increases self-stigma of seeking help and self-stigma of mental illness (Shannon et al., 2018; Zeifman et al., 2015). Additionally, this is surprising given research in Veterans suggesting that some types of perfectionism are associated with increased distress and mental illness symptoms (Kaplan et al., 2015; Raines et al., 2019).

This may also be attributable to the particular subscale used to measure perfectionism in this sample, such that it did not accurately capture how Veterans may connect perfectionism to self-stigma. The rigid perfectionism subscale of the Big Three Perfectionism scale is designed to measure self-directed perfectionism (i.e., flawless performance from the self; Feher et al., 2020); sample item "It is important to me to be perfect in everything I attempt." However, the BTPS-SF also contains two other perfectionism subscales, including *self-critical perfectionism,* which includes items such as "the idea of making a mistake frightens me." Rigid perfectionism was chosen for this study due to its emphasis on self-orientation and self-worth related to being good or perfect, which appeared to better capture Okun's (2021) definition within the white supremacy culture framework, as well as one low-loading item on self-critical

perfectionism in the original validation study. However, it may be that self-critical perfectionism, which focuses more on concern over mistakes and socially prescribed perfectionism, may have better captured aspects of perfectionism that associate with mental health attitudes (Zeifman et al., 2015). Additionally, some studies suggest that perfectionism overall may decrease as individuals age, which is also supported by a significant negative correlation between age and perfectionism in this sample (Robinson et al., 2021).

By contrast, either-or thinking did align with our initial hypothesis (i.e., was positively associated with self-stigma, had a small but significant direct effect on attitudes, and was significantly indirectly associated with attitudes via self-stigma of seeking help). This would suggest that Veterans higher in binary thinking strategies are more likely to have higher self-stigma of seeking help and, by association, more negative attitudes towards seeking VA mental health care. Through a critical whiteness lens, these Veterans may experience specific barriers to seeking mental health care due to culturally-coded dichotomies of success/failure and strength/weakness, entrenched in early development. These dichotomies may then further be supported by military cultural values and intertwine with other community-cultural expectations (i.e., masculinities, social class expectations; Abraham et al., 2017; Caddick et al., 2018; Hsu & Ketchen, 2013), where admitting any hint of emotional need is interpreted as weakness. This dichotomy may also lend itself to an “us versus them” belief system where VA providers may be classed as an apathetic, misunderstanding malevolent ‘other’, especially if they are expected to be civilians rather than fellow Veterans (Atuel & Castro, 2018).

While the effect size of the relationship between perceived lack of VHA competence and trust in individual provider was moderate to strong (> 0.5; Ferguson, 2016), perceived lack of VHA competence did not significantly indirectly predict attitudes via provider trust. However, perceived lack of VHA competence and individual provider trust were significantly negatively correlated with each other (r = -.679). Additionally, perceived lack of VHA competence was significantly positively associated with self-stigma of seeking help (r = .189), but trust in provider was significantly negatively associated with self-stigma of seeking help (r = -.353), suggesting another instance of related constructs competing for the same variance in attitudes. Qualitative and anecdotal evidence would suggest that these constructs may compete and create conflict within individual Veterans (i.e., "I hate the VA, but I can deal with Dr. [Name]"). The simultaneous relationship and distinctiveness between individual provider trust and institutional trust has been documented in community-based research, especially in communities with experience of medical racism and oppression (Mencin Čeplak & Hlebec, 2012; Webb Hooper et al., 2019). However, the important differences between these constructs underscore the importance of Veterans' perception both of the VA as an institution *and* their relationships with individual VA mental health providers. Indeed, given the strong relationships between the constructs, it is likely that negative interactions with either the VA institution or a VA provider may create a "halo effect" for the other. The weight of these constructs being both interrelated and importantly distinct is also supported by perceived lack of VHA competence's direct negative relationship with attitudes, suggesting that Veterans who distrust the VHA have poorer attitudes towards VA mental health care both via their perceptions of individual providers and

independently. This may be especially salient in a mental health context, where Veterans may access mental health care via their primary care provider or via rapid access models – both of which may present crucial avenues for intervention or alienation for Veterans in distress.

Irrespective of the quality of VA providers, perceptions of the VHA institution as uncaring or overly bureaucratic clearly do severely impact Veterans' comfort with and attitudes towards the VA and its providers (MacGregor et al., 2011; McCormick et al., 2019). Also of note, VA institutional reputation can vary widely across health care systems or regions of the United States, quickly summarized by the aphorism "if you've seen one VA, you've seen one VA" (e.g., Lamberty et al., 2003), as well as publicly available facility quality data (Veteran's Health Administration, 2022). This variation may be best addressed by comparing perceived lack of VHA competence and individual provider trust endorsed by Veterans in multiple catchment areas or Veteran Integrated Services Networks (VISNs). In short, a Veteran who has had negative interactions with VA bureaucracy may never have the opportunity to have a positive or caring interaction with a VA mental health provider; conversely, one negative interaction with a VA provider may "poison the well" for the institution at large. Understanding how these constructs may causally predict each other, rather than just determining their cross-sectional relationship, may be crucial to understanding how to improve Veterans' experience both with individual mental health provider and the VHA institution at large.

By contrast, military identity commitment was found to be significantly positively associated with individual provider trust – in contrast to the initial hypotheses. Additionally, military identity commitment exerted significant direct effects on attitudes

and indirect effect on attitudes via trust in provider. This suggests that participants high in military identity commitment both are more likely to trust a hypothetical VA mental health provider and have more positive attitudes towards VA mental health care in general, in direct conflict with the initial hypothesis. It may be that individuals high in military identity commitment may see the VA system or individual VA providers as extensions of a positive experience with the DoD (Strom et al., 2012). It may also be that individuals who report high military identity commitment are more likely to have positive experiences and memories of military service, which may make encountering VA health care less intimidating. Military identity commitment was not significantly indirectly associated with attitudes via self-stigma of seeking help, also in contrast to the initial hypothesis. However, this may be yet another instance of competing for variance, as military identity commitment is significantly positively correlated with attitudes (r = .314) and significantly negatively correlated self-stigma of seeking help (r = -.144). This suggests that the true relationship between these variables may be obscured by other constructs competing for similar variance and may instead be consistent with previous research (e.g., Clary et al., 2021; Weiss & Coll, 2011). This may also be related to the comparative age of our sample in contrast to length of service (median age = 47 years, median length of service = 6 years), such that Veterans who are further removed from military service or who served prior to OEF/OIF may retain identity commitment (supported by a significant positive correlation between age and military identity commitment, r = .265) without retaining less helpful aspects of military community culture (Harris et al., 2015), or that older Veterans in general may a) have more positive relationship with Veteran identity and b) be more likely to use VA health care (R. E.

Adams et al., 2017; Brewster et al., 2021; Di Leone et al., 2016). Alternatively, other studies of Veterans with mental health concerns have suggested some protective aspects of Veteran identity, including active treatment attitudes (Firmin et al., 2016).

Limitations and Future Directions

This study must considered in light of its limitations. First, while this study is focused on white Veterans, this focus does limit its generalizability to Veterans with minoritized racial identities. While certain aspects of this study, especially trust in VA institutions and VA providers as well as military cultural values, may also demonstrate similar or more emphasized patterns in Veterans of color, further research would benefit from establishing qualitative similarities and differences in how white Veterans internalize and describe their trust or distrust of VA providers relative to Veterans of color, given important differences in historical mistreatment by medical personnel (Feagin & Bennefield, 2014) and current medical racism (Feyman et al., 2022; Gollust et al., 2018). Moreover, while either-or thinking and perfectionism are conceptualized as components of white racial culture in this study, endorsement of these constructs is not limited to white people and it may be expected that respondents of color may also exhibit similar relationships between these constructs and attitudes towards VA care. Similarly, while the U.S. military is majority cisgender men, cisgender men are still overrepresented in this sample relative to their proportion in the U.S. military and in terms of prospective and current VA mental health service users (National Academies of Science, Engineering, and Medicine et al., 2018). Additionally, it may behoove future researchers to narrow focus to Veterans who are currently experiencing mental health distress; while the average K6 score in our respondents did correspond with moderate mental health

distress, it may be that level of distress may moderate other variable relationships. This is further supported by distress's significant relationship with attitudes in the final model. These important differences should be explored in future studies with populations that more closely match prospective VA mental health service users in context of age, ethnicity, ability, social class, sexual orientation, and other relevant demographic factors. In particular, understanding the role of gender and social class as they interact with white racial culture may especially elucidate how white racial culture operates across other axes of oppression salient to the military and VA health care access (Bonds, 2019; Hsu & Ketchen, 2013; Madriaga, 2005).

Additionally, the current study's cross-sectional nature, as well as the chosen dependent variable of attitudes, limits our ability to make claims about help-seeking intention or behavior. Longitudinal studies suggest that while attitudes are one of the best predictors of intention, and intention is a strong predictor of behavior (Adams et al., 2022), it remains that seeking help for a mental health concern is a dynamic process, possibly made more complex by perceived difficulties in accessing VA mental health care (Castro et al., 2015; Evans et al., 2019). Future research may benefit from longitudinal studies (i.e., growth curve analysis) tracking Veterans over time to determine which factors are most predictive of the move from improved attitudes to intention to help-seeking behavior. With respect to attention specifically, it is also well-established that other constructs are significant predictors of intention to seek help (Ajzen, 1991), namely perceived norms (i.e., how an individual believes their behavior will be received by close others) and personal agency (i.e., if a respondent believes they are capable of seeking help). While our use of perceived stigma in the current model does partially

overlap with the construct of perceived norms, future studies may consider incorporating the full integrated behavioral model in order to ascertain the full relationship between attitudes and intention.

Additionally, the remarkable strength of the relationship between trust in provider and distrust in VHA system competence must be discussed. While trust in a hypothetical VA provider and distrust in VHA system competence were hypothesized to be associated, it is likely that the this relationship is also due in part to these constructs possibly being sibling constructs (Lawson & Robins, 2021), or constructs that are "conceptually or empirically overlapping, but distinct" (p. 345). In particular, these constructs share related nomological networks, are conceptually related, and likely share related underlying causes, three major indicators for being sibling constructs. Future research may benefit from specific differentiation between these two constructs in Veterans, likely using a mixed-methods approach to parse out how Veterans experience trust in the institution of the VA versus trust in individual providers (Carlson et al., 2022; Haro et al., 2019). Alternatively, using cross-lag or experimental manipulation studies may provide insight as to which construct is the cause or predictor of the other, in individual Veterans. The same recommendations may be made with reference to types of perceived stigma in the same study, such that the correlation between perceived stigma from loved ones and other Veterans was quite large (> 0.8), despite exerting differential effects on attitudes towards VA mental health care.

Moreover, how Veterans initially make contact with VA health care – in particular, via medical retirement or after chapter separation – may have specific implications for their relationships with and attitudes towards VA care. Due to data and

software limitations, we were not able to include type of discharge in the final model. Future work in this vein may wish to oversample for Veterans who, after having been medically retired, have specific bureaucratic assistance in accessing VA mental health care. Similarly, Veterans who did not complete their tour of duty but were instead separated via chapter or disciplinary separation may have materially different feelings towards the Department of Defense and, by extension, the VHA. This is supported by post hoc correlation analyses suggesting that being medically separated and experiencing a disciplinary chapter separation is significantly positively correlated with perceived lack of VHA competence, and that experiencing a disciplinary chapter separation is significantly negatively correlated with attitudes towards VA care. Understanding if and how nature of separation may impact initial attitudes towards VA care may identify specific groups of Veterans who might benefit from specialized outreach or intervention.

Extending the theme of bureaucracy, one aspect of VA health care that was not addressed directly in this study is perceived accessibility of mental health care. Though most VA mental health systems operate on an 'access' model (Levine et al., 2017), accessing VA health care is still perceived to be arduous and unnecessarily bureaucratic by many Veterans (McCormick et al., 2019; Miller et al., 2021). While beliefs related to ease of access may have been partially been caught by our measure of perceived VA competence, it may behoove future researchers to intentionally differentiate between perceived VA system competence and ease of VA mental health care access in order to best address Veteran concerns.

Clinical, Policy, and Advocacy Implications

At its heart, this study outlines multiple major takeaways: First, that the role of military, community, and masculine culture exerts conflicting influences on Veterans' attitudes towards VA mental health care; second, that white Veterans have a complicated relationship with the VHA, especially with reference to trusting the institution versus individual mental health providers; and third, and that the role of white racial culture is a still as-yet largely unexplored potential influence on white Veterans' mental health attitudes. The first of these takeaways is strongly evocative of a consistent body of research focused on how Veterans experience stigma, shame, and masculinities (in particular, regardless of gender). This study provides support for some well-established avenues for intervention, including addressing emotional control and multiple forms of stigma in interventions aimed at mental health treatment-naïve Veterans. These interventions can take the form of concerted PR campaigns or in a primary care provider's office, but addressing these constructs that have well-established relationships with more negative mental health attitudes is a crucial part of increasing mental treatment uptake in Veterans that need it. More broadly, however, action steps must be taken culturally to reduce implicit and explicit stigma of seeking help for mental health concerns, both within the military and within U.S. culture generally. This may also take the form of providing more support for primary care-mental health integration staff, as this is an increasingly common format for VA primary care centers.

Secondarily, despite qualitative and anecdotal evidence suggesting an important distinction and interrelatedness of trust in the VA institution versus trust in individual VA providers, more research is needed to elucidate the relationship and potential causality

between these two constructs. While the VHA is one of the largest and most comprehensive integrated health systems in the world, its nature as a large, bureaucratic institution, the variability in patient satisfaction across health care systems, and some negative press have contributed to Veterans having varied opinions of the VA in general. Relatedly, for Veterans who may be uncertain or nervous about accessing VA care at all, a negative first experience with primary care or mental health care may indelibly reduce Veterans' trust in VA providers as a whole. However, the opposite is also true. Streamlined access to VA care, as well as feeling camaraderie, connection, or understanding with even one VA provider, has the potential to change the course of a Veterans' mental health treatment permanently – or keep them connected to treatment even in the face of other negative experiences. In white Veterans, who are significantly less likely to be mistreated by health providers solely due to their race, relationships with the VA institution and VA providers may be most easily established or changed, if needed. Changing Veterans' beliefs about VA institutional barriers is an ongoing process that requires the work of individual VA staff, concerted systems intervention to reduce barriers to care, and policy work in the form of financial support for effective and adequate staffing, outreach initiatives, and training that allows staff to meet the needs of all of the nation's Veterans.

To this point, this study represents a small step in a research agenda that allows researchers and clinicians working with Veterans to conceptualize whiteness in our studies and our treatment plans. This study approaches white racial culture as endorsed by individual participants, and does provide some evidence that certain aspects of white racial culture – in particular, perfectionism and either-or thinking—do influence white

Veterans' attitudes towards VA mental health care. While white Veterans are certainly not the only people to endorse these expectations, understanding how whiteness can negatively impact even individuals who benefit from white supremacy allows us to approach white racial culture as just that – a collection of community expectations that are not in themselves helpful or harmful, but when weaponized can cause harm to self and others. It is possible that specifically addressing perfectionism or the idea that seeking help for mental health concerns besmirches a 'perfect' persona may be helpful in increasing positive attitudes towards VA mental health care. Similarly, framing both distress and mental health care access as a value-neutral spectrum, rather than a good/bad or healthy/unhealthy dichotomy, may allow for reduced distress and increased positive attitudes around mental health care access for Veterans. Further work is needed to elucidate first, how these aspects of culture are espoused in white Veterans' families of origin, schools, and non-military or Veteran community culture. However, just as, if not more, important is addressing these expectations within military culture itself. Given that the U.S. military is by definition a colonialist and imperialist project, it cannot surprise us that whiteness and white racial culture is embedded into military culture and value norms. Irrespective of the U.S. military's political legitimacy or current value norms, however, it remains true that Veterans re-enter civilian society in need of mental health support.

Finally, this study is an attempt to normalize exploring white racial culture within VA settings – not just within the Veterans we serve, but in understanding that the VA as a whole operates as a white institution. Our community-cultural values – informed by white racial culture and white supremacy – *will* present themselves in our research and clinical work. At this juncture, we as white researchers and providers have the

opportunity to either ignore this reality or face it head-on. By confronting white racial culture both in its internal workings in ourselves and our clients, as well as its systemic harm through white supremacy, we have the opportunity to provide better and more nuanced care to white Veterans, critically evaluate, and deconstruct harmful or invisible norms in research and mental health care, *and* make a safer and more accessible mental health care environment for all Veterans.

Conclusion

The current study both lends weight to previously acknowledged predictors of Veterans' attitudes towards VA health care, but also highlights several important aspects of Veteran community culture and interaction with VA care that may be crucial avenues for future study and intervention. The findings point to the complex role of trust in Veterans' attitudes towards care as well as a further need to differentiate between the role of institutions (both VA health care systems and, more broadly, white racial-cultural systems) and individuals in Veterans' attitudes towards and access to health care. Researchers and providers aiming to increase treatment uptake for white Veterans may consider the role of multiple aspects of racial, gender, and other cultural socialization as well as the effects of overlapping systems of privilege and oppression in treatment attitudes.

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References

Abraham, T., Cheney, A. M., & Curran, G. M. (2017). A Bourdieusian analysis of U.S. military culture fround in the mental help-seeking literature. *American Journal of Men's Health*, *11*(5), 1358–1365. https://doi.org/10.1177/1557988315596037

Adams, C., Gringart, E., & Strobel, N. (2022). Explaining adults' mental health help-seeking through the lens of the theory of planned behavior: A scoping review. *Systematic Reviews*, *11*(1), 160. https://doi.org/10.1186/s13643-022-02034-y

Adams, R. E., Urosevich, T. G., Hoffman, S. N., Kirchner, H. L., Hyacinthe, J. C., Figley, C. R., Boscarino, J. J., & Boscarino, J. A. (2017). Social support, help-Seeking, and mental health outcomes among Veterans in Non-VA facilities: Results from the Veterans' Health Study. *Military Behavioral Health*, *5*(4), 393–405. https://doi.org/10.1080/21635781.2017.1333067

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

Albright, G., Goldman, R., Shockley, K. M., McDevitt, F., & Akabas, S. (2011). Using an avatar-based simulation to train families to motivate Veterans with post-deployment stress to seek help at the VA. *Games for Health Journal*, *1*(1), 21–28. https://doi.org/10.1089/g4h.2011.0003

Arbisi, P. A., Rusch, L., Polusny, M. A., Thuras, P., & Erbes, C. R. (2013). Does cynicism play a role in failure to obtain needed care? Mental health service utilization among returning U.S. National Guard soldiers. *Psychological Assessment*, *25*(3), 991–996. https://doi.org/10.1037/a0032225

Atuel, H., & Castro, C. (2018). Military cultural competence. *Clinical Social Work Journal*, *46*(2), 74–82. https://doi.org/10.1007/s10615-018-0651-z

Atuel, H. R., & Castro, C. A. (2018). Military Cultural Competence. *Clinical Social Work Journal*, *46*(2), 74–82. https://doi.org/10.1007/s10615-018-0651-z

Baker, M. S. (2014). Casualties of the Global War on Terror and their future impact on health care and society: A looming public health crisis. *Military Medicine*, *179*(4), 348–355. https://doi.org/10.7205/MILMED-D-13-00471

Bharat, V., Habarth, J., Keledjian, N., & Leykin, Y. (2020). Association between subjective social status and facets of depression self-stigma. *Journal of Community Psychology*, *48*(3), 1059–1065. https://doi.org/10.1002/jcop.22314

Blais, R. K., & Renshaw, K. D. (2013). Stigma and demographic correlates of help-seeking intentions in returning service members. *Journal of Traumatic Stress*, *26*(1), 77–85. https://doi.org/10.1002/jts.21772

Blais, R. K., & Renshaw, K. D. (2014). Self-Stigma Fully Mediates the Association of Anticipated Enacted Stigma and Help-Seeking Intentions in National Guard Service Members. *Military Psychology*, *26*(2), 114–119. https://doi.org/10.1037/mil0000036

Bonabi, H., Müller, M., Ajdacic-Gross, V., Eisele, J., Rodgers, S., Seifritz, E., Rössler, W., & Rüsch, N. (2016). Mental health literacy, attitudes to help seeking, and perceived need as predictors of mental health service use: A logitudinal study. *The Journal of Nervous and Mental Disease*, *204*(4), 321–324. https://doi.org/10.1097/NMD.0000000000000488

Bonds, A. (2019). Race and ethnicity II: White women and the possessive geographies of white supremacy. *Progress in Human Geography*, *44*, 030913251986347. https://doi.org/10.1177/0309132519863479

Bonfá-Araujo, B., Oshio, A., & Hauck-Filho, N. (2021). Seeing Things in black-and-white: A scoping review on dichotomous thinking style. *Japanese Psychological Research*, *n/a*(n/a). https://doi.org/10.1111/jpr.12328

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

Bova, C., Route, P. S., Fennie, K., Ettinger, W., Manchester, G. W., & Weinstein, B. (2012). Measuring patient–provider trust in a primary care population: Refinement of the health care relationship trust scale. *Research in Nursing & Health*, *35*(4), 397–408. https://doi.org/10.1002/nur.21484

Bovin, M. J., Koenig, C. J., Zamora, K. A., Pyne, J. M., Miller, C. J., Lipschitz, J. M., Wright, P. B., & Burgess, J. F. (2019). Veterans' experiences initiating VA-based mental health care. *Psychological Services*, *16*(4), 612–620. https://doi.org/10.1037/ser0000233

Bowleg, L., & Bauer, G. (2016). Invited reflection: Quantifying intersectionality. *Psychology of Women Quarterly*, *40*(3), 337–341. https://doi.org/10.1177/0361684316654282

Brassel, S. T., Settles, I. H., Jellison, W. A., & Dodson, C. (2020). Power and race in Black and White men's perceptions and experiences of manhood. *Translational Issues in Psychological Science*, *6*(4), 325–343. https://doi.org/10.1037/tps0000257

Brenner, R. E., Colvin, K. F., Hammer, J. H., & Vogel, D. L. (2021). Using Item Response Theory to develop revised (SSOSH-7) and ultra-brief (SSOSH-3) self-stigma of seeking help scales. *Assessment*, *28*(5), 1488–1499. https://doi.org/10.1177/1073191120958496

Brewster, L., McWade, B., & Clark, S. J. A. (2021). A point of connection? Wellbeing, the veteran identity and older adults. *Ageing & Society*, *41*(9), 1984–2005. https://doi.org/10.1017/S0144686X20000161

Brown, N. B., & Bruce, S. E. (2016). Stigma, career worry, and mental illness symptomatology: Factors influencing treatment-seeking for Operation Enduring Freedom and Operation Iraqi Freedom soldiers and veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(3), 276–283. https://doi.org/10.1037/tra0000082

Bryan, C. J., & Morrow, C. E. (2011). Circumventing mental health stigma by embracing the warrior culture: Lessons learned from the Defender's Edge program. *Professional Psychology: Research and Practice*, *42*(1), 16–23. https://doi.org/10.1037/a0022290

Bulmer, S., & Eichler, M. (2017). Unmaking militarized masculinity: Veterans and the project of military-to-civilian transition. *Critical Military Studies*, *3*(2), 161–181. https://doi.org/10.1080/23337486.2017.1320055

Burns, S., & Mahalik, J. (2011). Suicide and dominant masculinity norms among current and former United States military servicemen. *Professional Psychology: Research and Practice*, *42*, 347–353. https://doi.org/10.1037/a0025163

Byrne, B. M. (2016). *Structural Equation Modeling With AMOS: Basic Concepts, Applications, and Programming, Third Edition* (3rd ed.). Routledge. https://doi.org/10.4324/9781315757421

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, *6*(1), 65–72. https://doi.org/10.1192/apt.6.1.65

Caddick, N., McGill, G., Greaves, J., & Kiernan, M. D. (2018). Resisting decline? Narratives of independence among aging limbless veterans. *Journal of Aging Studies*, *46*, 24–31. https://doi.org/10.1016/j.jaging.2018.06.002

Carlson, G., Than, C., Rose, D., Brunner, J., Chanfreau-Coffinier, C., Canelo, I., Klap, R., Bean-Mayberry, B., Agrawal, A., Hamilton, A., Gerber, M., & Yano, E. (2022). What drives women Veterans' trust in VA healthcare providers? *Women's Health Issues*, *32*. https://doi.org/10.1016/j.whi.2022.02.004

Castro, C. A., Kintzle, S., & Hassan, A. M. (2015). The combat veteran paradox: Paradoxes and dilemmas encountered with reintegrating combat veterans and the agencies that support them. *Traumatology*, *21*, 299–310. https://doi.org/10.1037/trm0000049

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

Choo, P. Y., & Marszalek, J. M. (2019). Self-compassion: A potential shield against extreme self-reliance? *Journal of Happiness Studies*, *20*(3), 971–994. https://doi.org/10.1007/s10902-018-9978-y

Claney, D., & Parker, W. M. (1989). Assessing White racial consciousness and perceived comfort with Black individuals: A preliminary study. *Journal of Counseling & Development*, *67*(8), 449–451. https://doi.org/10.1002/j.1556-6676.1989.tb02114.x

Clary, K. L., Pena, S., & Smith, D. C. (2021). Masculinity and stigma among emerging adult military members and veterans: Implications for encouraging help-seeking. *Current Psychology*, 1–17. https://doi.org/10.1007/s12144-021-01768-7

Cole, B. P., & Ingram, P. B. (2020). Where do I turn for help? Gender role conflict, self-stigma, and college men's help-seeking for depression. *Psychology of Men & Masculinities*, *21*(3), 441–452. https://doi.org/10.1037/men0000245

Crowley, K., & Sandhoff, M. (2017). Just a girl in the Army: U.S. Iraq War Veterans negotiating femininity in a culture of masculinity. *Armed Forces & Society*, *43*(2), 221–237. https://doi.org/10.1177/0095327X16682045

Cunningham, C., Sohler, N., Korin, L., Gao, W., & Anastos, K. (2007). HIV status, trust in health care providers, and distrust in the health care system among Bronx women. *AIDS Care*, *19*, 226–234. https://doi.org/10.1080/09540120600774263

Currier, J., Mcdermott, R., & Sims, B. (2018). Do student service members/veterans experience worse mental health stigma than their peers? A comparative study in a national sample. *Journal of American College Health*, *66*, 1–13. https://doi.org/10.1080/07448481.2018.1440569

Dang, S. S., Quesnel, D. A., Hewitt, P. L., Flett, G. L., & Deng, X. (2020). Perfectionistic traits and self-presentation are associated with negative attitudes and concerns about seeking professional psychological help. *Clinical Psychology & Psychotherapy*, *27*(5), 621–629. https://doi.org/10.1002/cpp.2450

Darda, J. (2018). Military whiteness. *Critical Inquiry*, *45*(1), 76–96. https://doi.org/10.1086/699574

Davis, M. J., Moore, K. M., Meyers, K., Mathews, J., & Zerth, E. O. (2016). Engagement in mental health treatment following primary care mental health integration contact. *Psychological Services*, *13*(4), 333–340. https://doi.org/10.1037/ser0000089

Demakakos, P., Nazroo, J., Breeze, E., & Marmot, M. (2008). Socioeconomic status and health: The role of subjective social status. *Social Science & Medicine*, *67*(2), 330–340. https://doi.org/10.1016/j.socscimed.2008.03.038

Desai, M., Pavlo, A., Davidson, L., Harpaz-Rotem, I., & Rosenheck, R. (2016). "I want to come home": Vietnam-era Veterans' presenting for mental health care, roughly 40 years after Vietnam. *Psychiatric Quarterly*, *87*(2), 229–239. https://doi.org/10.1007/s11126-015-9382-2

Di Leone, B. A. L., Wang, J. M., Kressin, N., & Vogt, D. (2016). Women's veteran identity and utilization of VA health services. *Psychological Services*, *13*(1), 60–68. https://doi.org/10.1037/ser0000021

Dickstein, B. D., Vogt, D. S., Handa, S., & Litz, B. T. (2010). Targeting self-stigma in returning military personnel and Veterans: A review of intervention strategies. *Military Psychology*, *22*(2), 224–236. https://doi.org/10.1080/08995600903417399

Diehle, J., Brooks, S. K., & Greenberg, N. (2017). Veterans are not the only ones suffering from posttraumatic stress symptoms: What do we know about dependents' secondary traumatic stress? *Social Psychiatry and Psychiatric Epidemiology*, *52*(1), 35–44. https://doi.org/10.1007/s00127-016-1292-6

Efird, C. R., & Lightfoot, A. F. (2020). Missing Mayberry: How whiteness shapes perceptions of health among white Americans in a rural Southern community. *Social Science & Medicine*, *253*, 112967. https://doi.org/10.1016/j.socscimed.2020.112967

Elbogen, E. B., Wagner, H. R., Johnson, S. C., Kinneer, P., Kang, H., Vasterling, J. J., Timko, C., & Beckham, J. C. (2013). Are Iraq and Afghanistan Veterans using mental health Services? New data From a national random-sample survey. *Psychiatric Services*, *64*(2), 134–141. https://doi.org/10.1176/appi.ps.004792011

Elnitsky, C. A., Andresen, E. M., Clark, M. E., McGarity, S., Hall, C. G., & Kerns, R. D. (2013). Access to the US Department of Veterans Affairs health system: Self-reported barriers to care among returnees of Operations Enduring Freedom and Iraqi Freedom. *BMC Health Services Research*, *13*(1), Article 1. https://doi.org/10.1186/1472-6963-13-498

Evans, E. A., Tennenbaum, D. L., Washington, D. L., & Hamilton, A. B. (2019). Why women Veterans do not use VA-provided health and social services: Implications for health care design and delivery. *Journal of Humanistic Psychology*, 0022167819847328. https://doi.org/10.1177/0022167819847328

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science & Medicine*, *103*, 7–14. https://doi.org/10.1016/j.socscimed.2013.09.006

Feher, A., Smith, M. M., Saklofske, D. H., Plouffe, R. A., Wilson, C. A., & Sherry, S. B. (2020). The Big Three Perfectionism Scale–Short Form (BTPS-SF): Development of a brief self-report measure of multidimensional perfectionism. *Journal of Psychoeducational Assessment*, *38*(1), 37–52. https://doi.org/10.1177/0734282919878553

Ferguson, C. J. (2016). *An effect size primer: A guide for clinicians and researchers* (p. 310). American Psychological Association. https://doi.org/10.1037/14805-020

Feyman, Y., Avila, C. J., Auty, S., Mulugeta, M., Strombotne, K., Legler, A., & Griffith, K. (2022). Racial and ethnic disparities in excess mortality among U.S. veterans during the COVID-19 pandemic. *Health Services Research*, *n/a*(n/a). https://doi.org/10.1111/1475-6773.14112

Firmin, R. L., Luther, L., Lysaker, P. H., & Salyers, M. P. (2016). Veteran identity as a protective factor: A grounded theory comparison of perceptions of self, illness, and treatment among veterans and non-veterans with schizophrenia. *American Journal of Psychiatric Rehabilitation*, *19*(4), 294–314. https://doi.org/10.1080/15487768.2016.1231642

Fischer, E. P., Curran, G. M., Fortney, J. C., McSweeney, J. C., Williams, D. K., & Williams, J. S. (2021). Impact of attitudes and rurality on Veterans' use of Veterans Health Administration mental health services. *Psychiatric Services*, appi.ps.201900275. https://doi.org/10.1176/appi.ps.201900275

Fischer, E. P., McSweeney, J. C., Wright, P., Cheney, A., Curran, G. M., Henderson, K., & Fortney, J. C. (2016). Overcoming Barriers to Sustained Engagement in Mental Health Care: Perspectives of Rural Veterans and Providers. *The Journal of Rural Health*, *32*(4), 429–438. https://doi.org/10.1111/jrh.12203

Fishbein, M., & Ajzen, I. (2009). *Predicting and changing behavior: The reasoned action approach*. Psychology Press. https://doi.org/10.4324/9780203838020

Fox, A., Meyer, E., & Vogt, D. (2014). Attitudes about the VA health-care setting, mental illness, and mental health treatment and their relationship with use among female and male OEF/OIF Veterans. *Psychological Services*, *12*. https://doi.org/10.1037/a0038269

Franco, Z., Hooyer, K., Ruffalo, L., & Fung, R. (2020). Foreword to special issue on Veterans health and well-being—collaborative research approaches: Toward Veteran community engagement. *Journal of Humanistic Psychology*, *61*, 002216782091926. https://doi.org/10.1177/0022167820919268

Ganzini, L., Denneson, L. M., Press, N., Bair, M. J., Helmer, D. A., Poat, J., & Dobscha, S. K. (2013). Trust is the basis for effective suicide risk screening and assessment in Veterans. *Journal of General Internal Medicine*, *28*(9), 1215–1221. https://doi.org/10.1007/s11606-013-2412-6

Giusti, L., Salza, A., Mammarella, S., Bianco, D., Ussorio, D., Casacchia, M., & Roncone, R. (2020). #Everything will be fine. Duration of home confinement and "all-or-nothing" cognitive thinking style as predictors of traumatic distress in young university students on a digital platform during the COVID-19 Italian lockdown. *Frontiers in Psychiatry*, *11*, 1398. https://doi.org/10.3389/fpsyt.2020.574812

Godwin, A. (2020). Sitting in the tensions: Challenging Whiteness in quantitative research. *Studies in Engineering Education*, *1*(1), Article 1. https://doi.org/10.21061/see.64

Gollust, S. E., Cunningham, B. A., Bokhour, B. G., Gordon, H. S., Pope, C., Saha, S. S., Jones, D. M., Do, T., & Burgess, D. J. (2018). What causes racial health care disparities? A mixed-methods study reveals variability in how health care providers perceive causal attributions. *Inquiry: A Journal of Medical Care Organization, Provision and Financing*, *55*, 0046958018762840. https://doi.org/10.1177/0046958018762840

Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race and education. *Social Psychiatry and Psychiatric Epidemiology*, *46*(1), 45–57. https://doi.org/10.1007/s00127-009-0168-4

Goode, J., & Swift, J. K. (2019). An empirical examination of stigma toward mental health problems and psychotherapy use in Veterans and active duty service members. *Military Psychology*, *31*(4), 335–345. https://doi.org/10.1080/08995605.2019.1630231

Graham, E. (2022). *Combating social isolation and loneliness among Veterans after separation from military service* (Issue Brief No. 59; Population Health Research Brief Series). Lerner Center for Public Health Promotion & Population Health. https://www.maxwell.syr.edu/research/lerner-center/population-health-research-brief-series/article/combating-social-isolation-and-loneliness-among-veterans-after-separation-from-military-service

Graziano, R., & Elbogen, E. B. (2017). Improving mental health treatment utilization in military Veterans: Examining the effects of perceived need for care and social support. *Military Psychology : The Official Journal of the Division of Military Psychology, American Psychological Association*, *29*(5), 359–369. https://doi.org/10.1037/mil0000169

Griffin, J., Lee, M., Bangerter, L., Van Houtven, C., Friedemann-Sánchez, G., Phelan, S., Carlson, K., & Meis, L. (2017). Burden and mental health among caregivers of veterans with traumatic brain injury/polytrauma. *American Journal of Orthopsychiatry*, *87*, 139–148. https://doi.org/10.1037/ort0000207

Gupta, C., Bell, S. P., Schildcrout, J. S., Fletcher, S., Goggins, K. M., & Kripalani, S. (2014). Predictors of healthcare system and physician distrust In hospitalized cardiac patients. *Journal of Health Communication*, *19*(0 2), 44–60. https://doi.org/10.1080/10810730.2014.934936

Hack, S. M., DeForge, B. R., & Lucksted, A. (2017). Variation in Veteran identity as a factor in Veteran-targeted interventions. *Psychiatric Services*, *68*(7), 727–729. https://doi.org/10.1176/appi.ps.201600237

Hamblen, J. L., Grubaugh, A. L., Davidson, T. M., Borkman, A. L., Bunnell, B. E., & Ruggiero, K. J. (2019). An Online peer educational campaign to reduce stigma and improve help seeking in Veterans with posttraumatic stress disorder. *Telemedicine and E-Health*, *25*(1), 41–47. https://doi.org/10.1089/tmj.2017.0305

Hammer, J. H., Parent, M. C., & Spiker, D. A. (2018). Mental Help Seeking Attitudes Scale (MHSAS): Development, reliability, validity, and comparison with the ATSPPH-SF and IASMHS-PO. *Journal of Counseling Psychology*, *65*(1), 74–85. https://doi.org/10.1037/cou0000248

Hammer, J. H., & Spiker, D. A. (2018). Dimensionality, reliability, and predictive evidence of validity for three help-seeking intention instruments: ISCI, GHSQ, and MHSIS. *Journal of Counseling Psychology*, *65*(3), 394–401. https://doi.org/10.1037/cou0000256

Haro, E., Mader, M., Noël, P. H., Garcia, H., Vogt, D., Bernardy, N., Bollinger, M., Pugh, M. J. V., & Finley, E. P. (2019). The impact of trust, satisfaciton, and perceived quality on preference for setting of future care among Veterans with PTSD. *Military Medicine*, *184*(11–12), e708–e714. https://doi.org/10.1093/milmed/usz078

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

Hart, R., & Lancaster, S. L. (2019). Identity fusion in U.S. military members. *Armed Forces & Society*, *45*(1), 45–58. https://doi.org/10.1177/0095327X17737021

Heath, P., Seidman, A., Vogel, D., Cornish, M., & Wade, N. (2017). Help-seeking stigma among men in the military: The interaction of restrictive emotionality and distress. *Psychology of Men & Masculinity*, *18*. https://doi.org/10.1037/men0000111

Held, P., & Owens, G. P. (2013). Stigmas and attitudes toward seeking mental health treatment in a sample of Veterans and active duty service members. *Traumatology*, *19*(2), 136–143. https://doi.org/10.1177/1534765612455227

Helms, J. E. (2017). The challenge of making Whiteness visible: Reactions to four Whiteness articles. *The Counseling Psychologist*, *45*(5), 717–726. https://doi.org/10.1177/0011000017718943

Henry, M. (2017). Problematizing military masculinity, intersectionality and male vulnerability in feminist critical military studies. *Critical Military Studies*, *3*(2), 182–199. https://doi.org/10.1080/23337486.2017.1325140

Hsu, J., & Ketchen, B. R. (2013). Working with veterans, social class, and counseling: Understanding the veteran population and implications for treatment. In W. M. Liu (Ed.), *The Oxford Handbook of Social Class in Counseling*. OUP USA.

Jakupcak, M., Blais, R. K., Grossbard, J., Garcia, H., & Okiishi, J. (2014). "Toughness" in association with mental health symptoms among Iraq and Afghanistan war veterans seeking Veterans Affairs health care. *Psychology of Men & Masculinity*, *15*(1), 100–104. https://doi.org/10.1037/a0031508

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

Jennings, P. L., & Hannah, S. T. (2011). The moralities of obligation and aspiration: Towards a concept of exemplary military ethics and leadership. *Military Psychology*, *23*(5), 550–571. https://doi.org/10.1080/08995605.2011.600158

Johnstone, H., & Cogan, N. (2021). 'He messaged me the other night and said you are my saviour'—An interpretative phenomenological analysis of intimate partners' role in supporting Veterans with mental health difficulties. *Journal of Military, Veteran and Family Health*, e20190055. https://doi.org/10.3138/jmvfh-2019-0055

Kaplan, E., Gordon, W., Krellman, J., & Spielman, L. (2015). Associations between self-discrepancy, perfectionism, depression and anxiety in Individuals with TBI. *Archives of Physical Medicine and Rehabilitation*, *96*(10), e76–e77. https://doi.org/10.1016/j.apmr.2015.08.258

Kelly, K., Fine, A., & Coppersmith, G. (2020). Social media data as a lens onto care-seeking behavior among women veterans of the US armed forces. *Proceedings of the Fourth Workshop on Natural Language Processing and Computational Social Science*, 184–192. https://doi.org/10.18653/v1/2020.nlpcss-1.20

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S.-L. T., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, *32*(6), 959–976. https://doi.org/10.1017/S0033291702006074

Khan, A., Chien, C., & Burton, N. W. (2014). A new look at the construct validity of the K6 using Rasch analysis. *International Journal of Methods in Psychiatric Research*, *23*(1), 1–8. https://doi.org/10.1002/mpr.1431

King, E. L., & Snowden, D. L. (2020). Serving on multiple fronts: A grounded theory model of complex decision-making in military mental health care. *Social Science & Medicine*, *250*, 112865. https://doi.org/10.1016/j.socscimed.2020.112865

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

Lamberty, G. J., Courtney, J. C., & Heilbronner, R. L. (2003). *The practice of clinical neuropsychology*. Taylor & Francis.

Lancaster, S. L., Kintzle, S., & Castro, C. A. (2018). Validation of the Warrior Identity Scale in the Chicagoland Veterans Study. *Identity*, *18*(1), 34–43. https://doi.org/10.1080/15283488.2017.1410157

Langrehr, K. J., Watson, L. B., Keramidas, A., & Middleton, S. (2021). The development and initial validation of the White Fragility Scale. *Journal of Counseling Psychology*, *68*(4), 404–417. https://doi.org/10.1037/cou0000483

Larkings, J. S., & Brown, P. M. (2018). Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *International Journal of Mental Health Nursing*, *27*(3), 928–941. https://doi.org/10.1111/inm.12390

Lawson, K. M., & Robins, R. W. (2021). Sibling constructs: What are they, why do they matter, and how should you handle them? *Personality and Social Psychology Review*, *25*(4), 344–366. https://doi.org/10.1177/10888683211047101

Leonardo, Z., & Porter, R. K. (2010). Pedagogy of fear: Toward a Fanonian theory of 'safety' in race dialogue. *Race Ethnicity and Education*, *13*(2), 139–157. https://doi.org/10.1080/13613324.2010.482898

Levant, R. F., McDermott, R., Parent, M. C., Alshabani, N., Mahalik, J. R., & Hammer, J. H. (2020). Development and evaluation of a new short form of the Conformity to Masculine Norms Inventory (CMNI-30). *Journal of Counseling Psychology*, *67*(5), 622–636. https://doi.org/10.1037/cou0000414

Levine, D. S., McCarthy, J. F., Cornwell, B., Brockmann, L., & Pfeiffer, P. N. (2017). Primary care–mental health integration in the VA health system: Associations between provider staffing and quality of depression care. *Psychiatric Services*, *68*(5), 476–481. https://doi.org/10.1176/appi.ps.201600186

Li, W., Dorstyn, D. S., & Denson, L. A. (2014). Psychosocial correlates of college students' help-seeking intention: A meta-analysis. *Professional Psychology: Research and Practice*, *45*(3), 163–170. https://doi.org/10.1037/a0037118

Liebert, R. (2021). What Could the White Body Do For Decolonising Psychology? 31 Questions. *Awry: Journal of Critical Psychology*, *2*(1), Article 1.

Lowe, P. A. (2021). Cross-national comparisons between Canadian and US higher edcuation students on a new, brief, multidimensional measure of test anxiety. *Journal of Psychoeducational Assessment*, *39*(6), 665–679. https://doi.org/10.1177/07342829211016933

Lyon, J. (2017). New data on suicide risk among military Veterans. *JAMA*, *318*(16), 1531–1531. https://doi.org/10.1001/jama.2017.15982

Macedo, A., Marques, M., & Pereira, A. (2014). Perfectionism and psychological distress: A review of the cognitive factors REVIEW. *IJCNMH*, *1*. https://doi.org/10.21035/ijcnmh.2014.1.6

MacGregor, C., Hamilton, A. B., Oishi, S. M., & Yano, E. M. (2011). Description, development, and philosophies of mental health service delivery for female Veterans in the VA: A qualitative study. *Women's Health Issues*, *21*(4, Supplement), S138–S144. https://doi.org/10.1016/j.whi.2011.04.006

Madriaga, M. (2005). *The star-spangled banner, US military veterans and the category of whiteness*. Flying the flag: critical perspectives on symbolism and identity, Cultural Complexity in the New Norway, University of Oslo. http://www.culcom.uio.no/english/events/conferences/2005/flags/index.html

Maguen, S., Madden, E., Cohen, B. E., Bertenthal, D., & Seal, K. H. (2012). Time to treatment among Veterans of conflicts in Iraq and Afghanistan with psychiatric diagnoses. *Psychiatric Services*, *63*(12), 1206–1212. https://doi.org/10.1176/appi.ps.201200051

Mahalik, J. R., & Di Bianca, M. (2021). Help-seeking for depression as a stigmatized threat to masculinity. *Professional Psychology: Research and Practice*, No Pagination Specified-No Pagination Specified. https://doi.org/10.1037/pro0000365

Malat, J., Mayorga-Gallo, S., & Williams, D. R. (2018). The effects of whiteness on the health of whites in the USA. *Social Science & Medicine*, *199*, 148–156. https://doi.org/10.1016/j.socscimed.2017.06.034

Mannarini, S., & Rossi, A. (2019). Assessing mental illness stigma: A complex issue. *Frontiers in Psychology*, *9*, 2722. https://doi.org/10.3389/fpsyg.2018.02722

McCaslin, S. E., Becket-Davenport, C., Dinh, J. V., Lasher, B., Kim, M., Choucroun, G., & Herbst, E. (2021). Military acculturation and readjustment to the civilian context. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(6), 611–620. https://doi.org/10.1037/tra0000999

McCormick, W., Currier, J., Isaak, S., Sims, B., Slagel, B., Carroll, T., Hamner, K., & Albright, D. (2019). Military culture and post-military transitioning among Veterans: A qualitative analysis. *Journal of Veterans Studies*, *4*(2), Article 2. https://doi.org/10.21061/jvs.v4i2.121

McDermott, R. C., Currier, J. M., Naylor, P. D., & Kuhlman, S. T. W. (2017). Student veterans' self-stigma of seeking help: Contributions of painful self-conscious emotions, traditional masculine norms, and war-zone service. *Psychology of Men & Masculinity*, *18*(3), 226–237. https://doi.org/10.1037/men0000117

Meadows, S. O., Engel, C. C., Collins, R. L., Beckman, R. L., Cefalu, M., Hawes-Dawson, J., Waymouth, M., Kress, A. M., Sontag-Padilla, L., Ramchand, R., & Williams, K. M. (2018). *2015 health related behaviors survey: Sexual orientation, transgender identity, and health among U.S. active-duty service members*. RAND Corporation. https://www.rand.org/pubs/research_briefs/RB9955z6.html

Meca, A., Allison, K., Ayers, K., Carr, K., Cox, S., Bravo, A., Davies, R., & Kelley, M. (2021). Understanding the Unique Effects of Identity in Adjustment Among Veterans. *Military Behavioral Health*. https://doi.org/10.1080/21635781.2021.1927918

Mencin Čeplak, M., & Hlebec, V. (2012). Trust in an individual physician and its contradictions. *Slovenian Journal of Public Health*, *51*. https://doi.org/10.2478/v10152-012-0007-y

Messerschmidt, J. W. (2019). The Salience of "Hegemonic Masculinity." *Men and Masculinities*, *22*(1), 85–91. https://doi.org/10.1177/1097184X18805555

Meyer, E. G., Writer, B. W., & Brim, W. (2016). The importance of military cultural competence. *Current Psychiatry Reports*, *18*(3), 26. https://doi.org/10.1007/s11920-016-0662-9

Miller, C., Gurewich, D., Garvin, L., Pugatch, M., Koppelman, E., Pendergast, J., Harrington, K., & Clark, J. A. (2021). Veterans Affairs and rural community providers' perspectives on interorganizational care coordination: A qualitative analysis. *The Journal of Rural Health*, *37*(2), 417–425. https://doi.org/10.1111/jrh.12453

Miller, P. K. (2017). How white college students enact whiteness: An investigation of the attitudinal, behavioural and cultural components that comprise white racial identity at a historically white college. *Whiteness and Education*, *2*(2), 92–111. https://doi.org/10.1080/23793406.2017.1327327

Mondek, M., & Silverman, M. J. (2020). Effects of therapist positioning within patient-preferred live music on positive and negative affect, pain, and trust in the therapist with adults on a cardiovascular unit: A three-group randomized pilot effectiveness study. *Voices: A World Forum for Music Therapy*, *20*(1). https://doi.org/10.15845/voices.v20i1.2710

Montaño, D., & Kasprzyk, D. (2008). *Health behavior and health education: Theory, research and practice*. 67–92.

Morris, J., Albery, I. P., Heather, N., & Moss, A. C. (2020). Continuum beliefs are associated with higher problem recognition than binary beliefs among harmful drinkers without addiction experience. *Addictive Behaviors*, *105*, 106292. https://doi.org/10.1016/j.addbeh.2020.106292

National Academies of Science, Engineering, and Medicine, Division, H. and M., Services, B. on H. C., & Services, C. to E. the D. of V. A. M. H. (2018). Department of Veterans Affairs mental health services: Need, usage, access and barriers to care. In *Evaluation of the Department of VeteransAffairs Mental Health Services.* National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK499497/

Neilson, E., Singh, S., Harper, K., & Teng, E. (2020). Traditional masculinity ideology, posttraumatic stress disorder (PTSD) symptom severity, and treatment in service members and veterans: A systematic review. *Psychology of Men & Masculinities*, *21*. https://doi.org/10.1037/men0000257

Nichter, B., Hill, M., Norman, S., Haller, M., & Pietrzak, R. (2020). Mental health treatment utilization among U.S. military veterans with suicidal ideation: Results from the National Health and Resilience in Veterans Study. *Journal of Psychiatric Research*, *130*, 61–67.

Okun, T. (2021, May). *White supremacy culture – Still here*. White Supremacy Culture. http://www.whitesupremacyculture.info/

Okun, T., & Jones, K. (2001). *White supremacy culture: A workbook for social change*.

Oshio, A. (2009). Development and validation of the Dichotomous Thinking Inventory. *Social Behavior and Personality*, *37*. https://doi.org/10.2224/sbp.2009.37.6.729

Ouimette, P., Vogt, D., Wade, M., Tirone, V., Greenbaum, M. A., Kimerling, R., Laffaye, C., Fitt, J. E., & Rosen, C. S. (2011). Perceived barriers to care among Veterans Health Administration patients with posttraumatic stress disorder. *Psychological Services*, *8*(3), 212–223. https://doi.org/10.1037/a0024360

Parent, M., & Moradi, B. (2011). An abbreviated tool for assessing conformity to masculine norms: Psychometric properties of the Conformity to Masculine Norms Inventory-46. *Psychology of Men & Masculinity*, *12*, 339–353. https://doi.org/10.1037/a0021904

Pattyn, E., Verhaeghe, M., Sercu, C., & Bracke, P. (2014). Public stigma and self-stigma: Differential association with attitudes toward formal and informal help seeking. *Psychiatric Services*, *65*(2), 232–238. https://doi.org/10.1176/appi.ps.201200561

Pearson, W. S., Dhingra, S. S., Strine, T. W., Liang, Y. W., Berry, J. T., & Mokdad, A. H. (2009). Relationships between serious psychological distress and the use of health services in the United States: Findings from the Behavioral Risk Factor Surveillance System. *International Journal of Public Health*, *54*(1), 23–29. https://doi.org/10.1007/s00038-009-0003-4

Porcari, C., Koch, E. I., Rauch, S. A. M., Hoodin, F., Ellison, G., & McSweeney, L. (2017). Predictors of Help-Seeking Intentions in Operation Enduring Freedom and Operation Iraqi Freedom Veterans and Service Members. *Military Medicine*, *182*(5–6), e1640–e1647. https://doi.org/10.7205/MILMED-D-16-00105

Prochaska, J. J., Sung, H., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. *International Journal of Methods in Psychiatric Research*, *21*(2), 88–97. https://doi.org/10.1002/mpr.1349

Rafferty, L. A., Wessely, S., Stevelink, S. A. M., & Greenberg, N. (2019). The journey to professional mental health support: A qualitative exploration of the barriers and facilitators impacting military veterans' engagement with mental health treatment. *European Journal of Psychotraumatology*, *10*(1), 1700613. https://doi.org/10.1080/20008198.2019.1700613

Raines, A. M., Carroll, M. N., Mathes, B. M., Franklin, C. L., Allan, N. P., & Constans, J. I. (2019). Examining the relationships between perfectionism and obsessive-compulsive symptom dimensions among rural Veterans. *Journal of Cognitive Psychotherapy*, *33*(1), 58–70. https://doi.org/10.1891/0889-8391.33.1.58

Reger, M. A., Etherage, J. R., Reger, G. M., & Ph.D, G. A. G. (2008). Civilian psychologists in an Army culture: The ethical challenge of cultural comeptence. *Military Psychology*, *20*(1), 21–35. https://doi.org/10.1080/08995600701753144

Rice, V., & Liu, B. (2016). Personal resilience and coping Part II: Identifying resilience and coping among U.S. military service members and veterans with implications for work. *Work*, *54*(2), 335–350. https://doi.org/10.3233/WOR-162301

Richard, K., & Molloy, S. (2020). An examination of emerging adult military men: Masculinity and U.S. military climate. *Psychology of Men & Masculinities*, *21*(4), 686–698. https://doi.org/10.1037/men0000303

Robinson, A., Divers, R., Moscardini, E., & Calamia, M. (2021). Perfectionism, conscientiousness, and neuroticism: Does age matter? *Personality and Individual Differences*, *172*, 110563. https://doi.org/10.1016/j.paid.2020.110563

Roscoe, R. A. (2020). The battle against mental health stigma: Examining how Veterans with PTSD communicatively manage stigma. *Health Communication*, *0*(0), 1–10. https://doi.org/10.1080/10410236.2020.1754587

Schnittker, J. (2019). Health spillovers among military spouses: Evidence from active duty, veteran, and surviving spouses. *Journal of Veterans Studies*, *4*(2), Article 2. https://doi.org/10.21061/jvs.v4i2.83

Schooley, R. C., Lee, D. L., & Spanierman, L. B. (2019). Measuring whiteness: A systematic review of instruments and call to action. *The Counseling Psychologist*, *47*(4), 530–565. https://doi.org/10.1177/0011000019883261

Seidler, Z., Rice, S., River, J., Oliffe, J., & Dhillon, H. (2017). Men's mental health: The case for a masculinities model. *The Journal of Men s Studies*, *26*, 1–13. https://doi.org/10.1177/1060826517729406

Shannon, A., Goldberg, J. O., Flett, G. L., & Hewitt, P. L. (2018). The relationship between perfectionism and mental illness stigma. *Personality and Individual Differences*, *126*, 66–70. https://doi.org/10.1016/j.paid.2018.01.022

Shea, J. A., Micco, E., Dean, L. T., McMurphy, S., Schwartz, J. S., & Armstrong, K. (2008). Development of a Revised Health Care System Distrust Scale. *Journal of General Internal Medicine*, *23*(6), 727–732. https://doi.org/10.1007/s11606-008-0575-3

Sherman, M. D., & Larsen, J. L. (2018). Family-focused interventions and resources for veterans and their families. *Psychological Services*, *15*(2), 146–153. https://doi.org/10.1037/ser0000174

Silvestrini, M., & Chen, J. A. (2022). "It's a sign of weakness": Masculinity and help-seeking behaviors among male veterans accessing posttraumatic stress disorder care. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0001382

Skopp, N. A., Bush, N. E., Vogel, D. L., Wade, N. G., Sirotin, A. P., McCann, R. A., & Metzger-Abamukong, M. J. (2012). Development and initial testing of a measure of public and self-stigma in the military: Military stigma. *Journal of Clinical Psychology*, *68*(9), 1036–1047. https://doi.org/10.1002/jclp.21889

Spiker, D. A., Berney, E. C., Hammer, J. H., & Jensen, K. C. (2020). Maintaining the Relationship: Relational Schemas and Women's Intent to Seek Couple Therapy. *The Counseling Psychologist*, *48*(6), 801–825. https://doi.org/10.1177/0011000020918400

Stotzer, R. L., Whealin, J. M., & Darden, D. (2012). Social work with Veterans in rural communities: Perceptions of stigma as a barrier to accessing mental health care. *Advances in Social Work*, *13*(1), Article 1. https://doi.org/10.18060/1891

Strom, T. Q., Gavian, M. E., Possis, E., Loughlin, J., Bui, T., Linardatos, E., Leskela, J., & Siegel, W. (2012). Cultural and ethical considerations when working with military personnel and veterans: A primer for VA training programs. *Training and Education in Professional Psychology*, *6*(2), 67–75. https://doi.org/10.1037/a0028275

Szukis, H., Joshi, K., Huang, A., Amos, T. B., Wang, L., & Benson, C. J. (2021). Economic burden of treatment-resistant depression among veterans in the United States. *Current Medical Research and Opinion*, *37*(8), 1393–1401. https://doi.org/10.1080/03007995.2021.1918073

Trautmann, S., Rehm, J., & Wittchen, H.-U. (2016). The economic costs of mental disorders. *EMBO Reports*, *17*(9), 1245–1249. https://doi.org/10.15252/embr.201642951

U.S. Department of Defense, Office of the Deputy Assistant Secretary of, Defense for Military Community and Family Policy, Office of the Deputy Assistant Secretary of, & Defense for Military Community and Family Policy. (2019). *Demographics profile of the military community*. Military OneSource. https://download.militaryonesource.mil/12038/MOS/Reports/2019-demographics-report.pdf

U.S. Department of Veterans Affairs. (2020a, September 17). *Eligibility for VA health care*. Veterans Affairs. https://www.va.gov/health-care/eligibility/

U.S. Department of Veterans Affairs. (2020b, December 30). *Active-duty service members and VA health care*. Veterans Affairs. https://www.va.gov/health-care/eligibility/active-duty/

van den Berk-Clark, C., & McGuire, J. (2014). Trust in health care providers: Factors predicting Trust among Homeless Veterans over Time. *Journal of Health Care for the Poor and Underserved*, *25*(3), 1278–1290. https://doi.org/10.1353/hpu.2014.0115

Veteran's Health Administration. (2022). *Facility Quality Data*. Access and Quality in VA Health Care. https://www.accesstocare.va.gov/Healthcare/FacilityQualityData

Veteran's Health Administration Office of Health Equity. (2020, April 30). *Your health care costs*. Veterans Affairs. https://www.va.gov/health-care/about-va-health-benefits/cost-of-care/

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology*, *60*(2), 311–316. https://doi.org/10.1037/a0031889

Vogel, D. L., Heath, P. J., Engel, K. E., Brenner, R. E., Strass, H. A., Al-Darmaki, F. R., Armstrong, P. I., Galbraith, N., Galbraith, V., Baptista, M. N., Gonçalves, M., Liao, H.-Y., Mackenzie, C., Mak, W. W. S., Rubin, M., Topkaya, N., Wang, Y.-F., & Zlati, A. (2019). Cross-cultural validation of the Perceptions of Stigmatization by Others for Seeking Help (PSOSH) Scale. *Stigma and Health*, *4*(1), 82–85. https://doi.org/10.1037/sah0000119

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, *58*(3), 368–382. https://doi.org/10.1037/a0023688

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

Vogel, D., Wade, N., & Ascheman, P. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology*, *56*, 301–308. https://doi.org/10.1037/a0014903

Webb Hooper, M., Mitchell, C., Marshall, V. J., Cheatham, C., Austin, K., Sanders, K., Krishnamurthi, S., & Grafton, L. L. (2019). Understanding multilevel factors related to urban community trust in healthcare and research. *International Journal of Environmental Research and Public Health*, *16*(18), Article 18. https://doi.org/10.3390/ijerph16183280

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

Weston, R., & Gore, P. A. (2006). A brief guide to structural equation modeling. *The Counseling Psychologist*, *34*(5), 719–751. https://doi.org/10.1177/0011000006286345

Williston, S. K., Roemer, L., & Vogt, D. S. (2019). Cultural and service factors related to mental health beliefs among post-9/11 veterans. *International Journal of Social Psychiatry*, *65*(4), 313–321. https://doi.org/10.1177/0020764019842327

Wilson, S. R., Gettings, P. E., Hall, E. D., & Pastor, R. G. (2015). Dilemmas families face in talking with returning U.S. military service members about seeking professional help for mental health issues. *Health Communication*, *30*(8), 772–783. https://doi.org/10.1080/10410236.2014.899659

Wong, Y. J., Ho, M.-H., Wang, S.-Y., & Miller, I. s. (2016). Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes. *Journal of Counseling Psychology*, *64*. https://doi.org/10.1037/cou0000176

Wood, D. S., Wood, B. M., Watson, A., Sheffield, D., & Hauter, H. (2020). Veteran suicide risk factors: A national sample of non-Veteran and Veteran men who died by suicide. *Health & Social Work*, *45*(1), 23–30. https://doi.org/10.1093/hsw/hlz037

Zeifman, R. J., Atkey, S. K., Young, R. E., Flett, G. L., Hewitt, P. L., & Goldberg, J. O. (2015). When ideals get in the way of self-care: Perfectionism and self-stigma for seeking psychological help among high school students. *Canadian Journal of School Psychology*, *30*(4), 273–287. https://doi.org/10.1177/0829573515594372

Zell, E., Strickhouser, J., & Krizan, Z. (2018). Subjective social status and health: A meta-analysis of community and society ladders. *Health Psychology*, *37*, 979–987. https://doi.org/10.1037/hea0000667

Zuberi, T., & Bonilla-Silva, E. (2008). *White logic, white methods: Racism and methodology*. Rowman & Littlefield Publishers. http://ebookcentral.proquest.com/lib/kentucky-ebooks/detail.action?docID=1343788

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Dschaak, Z. A., Spiker, D. A., **Berney, E. C.**, Miller, M. E., & Hammer, J. H. (2019). Collegian help seeking: The role of self-compassion and self-coldness. *Journal of Mental Health*. https://dx.doi.org/10.1080/09638237.2019.1677873.

Maroney, M., Matsuno, E., LaMartine, S., Nissenbaum, A., Rose, S., Stewart, J., Guerrant, M., Caso, T., **Berney, E. C**., & Pantoja-Patiño, J. (2020). *A guide for supporting trans and gender diverse graduate students.* Washington, DC: American Psychological Association of Graduate Students Committee on Sexual Orientation and Gender Diversity. Available at https://www.apa.org/apags/governance/subcommittees/supporting-diverse-students.pdf.