Military Psychology

ISSN: 0899-5605 (Print) 1532-7876 (Online) Journal homepage: https://www.tandfonline.com/loi/hmlp20

Biological attributions for postdeployment distress relate to higher likelihood of seeking mental health treatment in Iraq/Afghanistan service members/veterans

Rebecca K. Blais, Keith Renshaw & Danielle Christensen

To cite this article: Rebecca K. Blais, Keith Renshaw & Danielle Christensen (2018) Biological attributions for postdeployment distress relate to higher likelihood of seeking mental health treatment in Iraq/Afghanistan service members/veterans, Military Psychology, 30:1, 79-86, DOI: 10.1080/08995605.2017.1420978

To link to this article: https://doi.org/10.1080/08995605.2017.1420978

Published online: 28 Feb 2018.

MILITARY PSYCHOLOGY
2018, VOL. 30, NO. 1, 79–86
https://doi.org/10.1080/08995605.2017.1420978

Routledge
Taylor & Francis Group

Biological attributions for postdeployment distress relate to higher likelihood of seeking mental health treatment in Iraq/Afghanistan service members/veterans

Rebecca K. Blais[a,b], Keith Renshaw[c], and Danielle Christensen[a]

[a]Department of Psychology, Utah State University, Logan, Utah; [b]Department of Psychology, University of Utah, Salt Lake City, Utah; [c]Department of Psychology, George Mason University, Fairfax, Virginia

ABSTRACT

Service members/veterans (SM/Vs) underuse mental health care. Attribution theory suggests that attributions for psychological distress might inform help-seeking. Given recent mental health campaigns leveraging military values aimed at facilitating help-seeking for postdeployment distress, understanding how SM/Vs explain psychological distress may contribute to a better grasp of the low help-seeking rate in this population. The authors examined the association of biological and psychological attributions for postdeployment distress with help-seeking intentions from a mental health professional and medical doctor in 162 Iraq/Afghanistan SM/Vs. At the bivariate level, biological attributions were positively associated with help-seeking intentions from a mental health professional and medical doctor with small effect sizes. Psychological attributions were unrelated to help-seeking intentions from either provider. Path analysis revealed that biological attributions were positively correlated with help-seeking intentions from a medical doctor with a small effect size above and beyond the effects of psychological attributions and correlates. Biological attributions were also positively correlated with help-seeking intentions from a mental health professional with a small effect size but the significance value only trended toward significance (p = .06). Emphasizing the role of biology in postdeployment distress may promote help-seeking in SM/Vs, particularly help-seeking from medical professionals. Interventions that test the effectiveness of promoting biological explanations in campaigns aimed at increasing help-seeking may be a necessary next step in this area of inquiry.

ARTICLE HISTORY
Received 20 April 2017
Accepted 6 December 2017

KEYWORDS
Trauma; veterans; military; help-seeking; attributions

What is the public significance of this article?—Rates of help-seeking for psychological distress following deployment among service members/veterans (SM/Vs) remain lower than the need for such services. The purpose of the current study was to explore how SM/Vs' understanding of psychological distress relates to help-seeking intentions from both a mental health professional and a medical doctor. Results demonstrated that when SM/Vs attributed their postdeployment distress to biological factors they were more likely to seek mental health treatment relative to when they attributed their postdeployment distress to psychological factors. Efforts to increase help-seeking in this population may consider framing psychological distress within a medical model.

Biological attributions for postdeployment distress relates to increased help-seeking intentions in U.S. service members

Despite elevated rates of psychological distress following deployment (e.g., Hoge et al., 2004) and the availability of efficacious treatments offered through the Department of Defense (DoD) and Department of Veterans Affairs (VA), service members/veterans (SM/V) underuse mental health treatment. Extant research on mental health care utilization in veterans demonstrates that the majority of SM/Vs tend to not follow through with treatment referrals, receive less-than-adequate care, or terminate treatment prior to adequate symptom reduction (e.g., Garcia, Kelley, Rentz, & Lee, 2011; Harpaz-Rotem & Rosenheck, 2011; Hoerster et al., 2012; Johnston & Dipp, 2009; Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2010). Correlates of underutilization of mental health care in this population are well studied and include higher self-stigma and anticipated enacted stigma (e.g., Blais & Renshaw, 2013; Blais, Tsai, Southwick, & Pietrzak, 2015), more negative beliefs about the effectiveness of mental health care (e.g., Blais et al., 2015), and demographic characteristics of older age, minority race, and lower psychiatric distress (e.g., Blais et al., 2015; Hankin, Spiro, Miller, & Kazis, 1999; Hoerster et al., 2012).

CONTACT Rebecca K. Blais rebecca.blais@usu.edu Department of Psychology, Utah State University, 2810 Old Main EDUC487, Logan, UT 84322.
Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/hmlp.

The VA and DOD recently implemented campaigns to increase help-seeking by leveraging military values and ideology, such as "It takes the strength and courage of a warrior to ask for help" (VA, 2012) or "Seeking help is a sign of strength and fortitude, not weakness" (U.S. Army, n.d.). Despite such efforts, rates of treatment-seeking in this population remain low (e.g., Hoerster et al., 2012). Given VA and DoD efforts to leverage military ideology and values, gaining a greater appreciation of how SM/Vs understand their psychological distress may be of use when trying to increase rates of help-seeking in this population. Attributions, a causal statement about why a given phenomenon occurs (Kelly, 1973), such as mental health distress, may provide a framework through which we can better understand how SM/V view psychological distress and how those views relate to help-seeking.

Attributions and help-seeking within military samples are understudied; however, civilian data show that attributions for psychological distress are associated with willingness to seek social support and stigma (Blais & Renshaw, 2009, 2012). Attributions for psychological distress can be categorized into multiple domains, including internal/external and controllable/uncontrollable (see Kelley, 1973). Within the context of psychological distress, internal attributions suggest that distress is caused by factors that are internal to the individual, such as thinking patterns or behavior. External attributions suggest that distress is caused by factors that are external to the individual, such as prejudice or discrimination. Controllable attributions suggest that the individual can control whether they experience distress, and uncontrollable attributions suggest that an individual cannot control whether they experience distress. Studies on interpersonal interactions and illness attributions in civilians show that internal and controllable attributions for undesirable behaviors are associated with higher shame, stigma, hostility, and criticism when compared to external and uncontrollable attributions (e.g., Blais & Renshaw, 2012; Durtschi, Fincham, Cui, Lorenz, & Conger, 2011; Fincham, Harold, Gano-Phillips, 2000). Social and clinical psychologists theorize that the negative responses may occur in reaction to controllable or internal attributions factors, due to beliefs that the given behavior was carried out with self-serving desires or motivations (e.g., Blais & Renshaw, 2014; Durtschi et al., 2011).

Within the mental health literature, attributions for psychological distress are further conceptualized as biological or psychological, which have some overlap with internal and controllable attributions. Biological attributions suggest that psychological distress is caused by genetic factors, hormones, or a chemical imbalance, largely factors that are internal and uncontrollable. Psychological attributions for distress suggest that distress is caused by nonbiological factors, such as how individuals think and behave, largely factors that are internal and controllable (see Blais & Renshaw, 2012). Extant studies on psychological distress attributions in civilians show that biological attributions for distress are related to lower stigma, less blame, greater intentions to seek social support or professional health care, and more positive attitudes/behaviors toward the individual with mental illness. Psychological attributions are associated with higher stigma, greater blame, and a lower likelihood of seeking social support (see review by Barrowclough & Hooley, 2003; Blais & Renshaw, 2012; Deacon & Baird, 2009; Goldstein & Rosselli, 2003). The implicit overlap of biological attributions with uncontrollable factors and psychological attributions with controllable factors might explain why biological attributions are associated with more favorable outcomes relative to psychological attributions.

Psychological distress attributions and their association with help-seeking intentions have not yet been studied in SM/Vs. Though uncontrollable (or biological) attributions for psychological distress may be associated with fewer barriers to care in civilians, the military culture may create an environment where psychological distress attributions function differently. That is, job pressures for SM/Vs to be able-bodied and stoic individuals who are able to protect themselves, their fellow service members, and their country may heighten concerns about fitness for duty or ability to protect (see Jakupcak, Blais, Grossbard, Garcia, & Okiishi, 2014). Per the Army values, a service member is charged with "fac[ing] danger" and "enduring physical duress" and "risking personal safety." (Army.mil, n.d.-a). Moreover, the "Soldier's Creed" dictates that service members are "disciplined, physically and mentally tough … ready to deploy, engage, and destroy, the enemies of the United States …" (Army.mil, n.d.-b) Along these lines, symptoms due to defective brain chemistry that require medication can deem a service member non-deployable (Woodson, 2013). Beliefs that psychological distress is caused by controllable factors, such as psychologically based causes, directly conflicts with military values of stoicism and strength. Given these factors, it is not inherently clear that attributions will have similar effects in this population as have been detected in civilian samples.

The purpose of the current study was to examine how biological and psychological attributions for distress relate to help-seeking intentions above and beyond established help-seeking covariates of age,

nonminority race, stigma, psychiatric distress severity, and negative beliefs about treatment. Though extant studies in civilians found that greater biological attributions were associated with lower stigma and higher help-seeking intentions and behaviors, given job pressures to be fit and able-bodied soldiers, it is unclear if similar associations will be observed in a military sample. As such, we viewed the current study as exploratory in nature.

Method

Participants

Iraq/Afghanistan SM/V (n = 162) participated in the current study. Their average age was 27.90 (SD = 7.13) and the sample was predominantly male (93.8%), White (85.8%), and married (58.9%). The modal number of deployments was 1 (n = 105; range = 0–3) and the length of time since returning from deployment was 9.65 months (SD = 16.2). SM/Vs were mostly Marines (60.7%) or Army (39.3%). The majority of SM/Vs received some college education (75.5%) and had an annual income of ≤$50,000/year (73.9%). Slightly more than half of the sample (51.3%) exceeded the PTSD diagnostic threshold of 30 on the PTSD Checklist (PCL; Bliese et al., 2008; Weathers, Litz, Herman, Huska, & Keane, 1993), and a minority indicated symptoms indicative of at least mild depression (17.0%) or anxiety (13.8%), based on the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995). About one in five (20.5%) reported previous engagement in mental health treatment (see Table 1 for descriptives).

Procedure

SM/Vs (n ~ 240) attending postdeployment health assessments or Yellow Ribbon events were made aware of the study through verbal announcements by the principal investigator. SM/Vs interested in participating were given a study packet that included a waiver of documentation of informed consent (WIC) and study questionnaires (a WIC was used to protect participants' identities, which were not necessary for the current study). SM/Vs received $15 compensation for participation. Of the ~240 SM/Vs present at these events, 67.5% (n = 162) returned packets with complete data. These SM/Vs comprise participants in the current study. The University of Utah Institutional Review Board and its affiliated Department of Veterans' Affairs (VA) Human Subjects Subcommittee approved this study.

Measures

Help-seeking intentions. Help-seeking intentions were assessed using two items from the General Help-Seeking Questionnaire (Wilson, Deane, Ciarrochi, & Rickwood, 2005). SM/Vs were asked to rate how likely they were to seek help from a mental health professional or a medical doctor using a Likert scale from 1 (*extremely unlikely*) to 7 (*extremely likely*).

Attributions. Biological and psychological attributions for distress were evaluated using items from The Biological and Psychological Attribution Scale (Blais & Renshaw, 2012). This scale was originally developed to assess biological and psychological attributions for depression in civilians but was modified for the current study to assess attributions for psychological distress following deployment in SM/Vs more generally. The biological subscale contains three items reflecting biological causes for distress, and the psychological subscale contains seven items reflecting psychological causes for distress (see Table 2 for scale items). SM/Vs were asked to rate how much they believed each cause was related to any psychological distress they experienced following their deployment. Possible responses were assessed using a Likert scale, ranging from 1 (*not at all*) to 5 (*a great deal*). Items on either subscale are summed for a total score, and higher scores reflect greater beliefs in a given attribution. Veterans can indicate both attribution types as causal in their distress. A principal axis factor analysis with a direct oblimin rotation confirmed the presence of two

Table 1. Bivariate associations of attributions with helping-seeking intentions variables and established covariates of help-seeking.

Variable	M (SD)	1.	2.	3.	4.	5.	6.	7.	8.
1. HS: Mental health professional	3.21 (1.87)								
2. HS: Medical doctor	2.69 (1.70)	.59***							
3. Biological attribution	5.12 (2.65)	.19*	.18*						
4. Psychological attribution	15.34 (7.69)	−.01	.08	.54***					
5. Negative beliefs about mental health treatment	4.98 (2.05)	−.36***	−.15	−.09	.23**				
6. Self-stigma	28.13 (7.70)	−.41***	−.24**	−.03	.06	.41***			
7. AES unit leader	12.77 (6.27)	−.14	−.08	.21**	.26**	.23**	.32***		
8. Psychological distress	.00 (1.00)	.02	.01	.42***	.56***	.23**	.12	.13	
9. Age	27.90 (7.13)	.14	.16*	−.04	−.11*	−.07	−.18*	−.05	−.02

Note. HS = Help-seeking; AES = Anticipated enacted stigma.
*$p \leq .05$; **$p \leq .01$; ***$p \leq .001$.

Table 2. Principal axis factor analysis with a direct oblimin rotation of biological and psychological attributions items.

Attribution	Psychological factor	Biological factor
Chemical imbalance	−.06	**.80**
Genetics	.14	**.52**
Biological changes	.01	**.80**
My own inadequacies	**.80**	−.07
My personality	**.85**	−.00
My upbringing	**.64**	.18
My social and/or family environment	**.71**	.10
Situations or events that have happened in my life (besides my deployment)	**.71**	.03
The way I think and/or the way I interpret things	**.85**	−.05
The way I behave	.80	.00

Note. Bolding indicates where item loads on either the biological or psychological attribution subscale.

factors, biological and psychological, that accounted for 66.85% of the variance. Factor weights are shown in Table 2. The biological and psychological subscales had adequate internal reliability (Cronbach's alpha = .76, .92, respectively).

Stigma. Self-stigma was evaluated using the 10-item Self-Stigma of Seeking Help (Vogel, Wade, & Haake, 2006) scale. Wording changes were made to the original scale to direct participants to respond to stigma for having a mental health problem in place of stigma for help-seeking. A sample item is: "I would feel inadequate if I had difficult negative emotions or psychological problems." SM/Vs indicated their agreement with each statement using a Likert scale of 1 (*strongly disagree*) to 5 (*strongly agree*). Five items were reverse scored, and all items were subsequently summed for a total score with higher scores reflective of greater self-stigma. Internal consistency for the Self-Stigma of Seeking Help for problem was high in the current sample (Cronbach's alpha = .84).

Anticipated enacted stigma from unit leaders was assessed using the 5-item Perceptions of Stigmatization by Others for Seeking Help (Vogel, Wade, & Ascheman, 2009). Wording changes were made to the original scale to direct participants to respond to anticipated enacted stigma for having a mental health problem in place of stigma for help-seeking. A sample item from the Perceptions of Stigmatization by Others for Seeking Help for problem includes, "If you were experiencing difficult negative emotions or psychological problems, to what degree do you believe your unit leader would think of you in a less favorable way?" SM/Vs rated their agreement with each statement using a Likert scale of 1 (*strongly disagree*) to 5 (*strongly agree*). The five items were summed for a total score and higher scores indicated higher anticipated enacted stigma. Cronbach's alpha in the current sample was also high, .94.

Covariates. Established correlates of help-seeking in this population include age, previous engagement in mental health treatment, negative beliefs about mental health care, and psychiatric distress severity (e.g., Blais et al., 2015; Hankin et al., 1999; Hoerster et al., 2012). Age, race, and previous engagement in mental health treatment were assessed using the demographic inventory designed for this study. Negative beliefs about mental health were assessed using two items from the Perceived Barriers to Care Scale (Britt, 2000; i.e., "Mental health care does not work," "I do not trust mental health professionals"). SM/Vs indicated how much they agreed with either statement using a Likert scale of 1 (*not at all*) to 5 (*extremely*), and scores were then averaged. These two items are frequently used to assess negative beliefs about mental health care in veterans (e.g., Blais et al., 2015; Britt et al., 2008).

Psychological distress was assessed using three measures. The PCL (Weathers et al., 1993) assessed severity of PTSD symptoms over the past month. SM/Vs rated how much each symptom bothered them using a Likert scale from 1 (*not at all*) to 5 (*extremely*). Items were summed for a total score. Cronbach's alpha in the current sample was .95. The Depression and Anxiety subscale of the Depression Anxiety Stress Scale–Short Form (Lovibond & Lovibond, 1995) assessed depressive and anxiety symptoms over the last week. SM/Vs indicated how much each symptom bothered them using a Likert scale of 0 (*did not apply to me at all*) to 3 (*applied to me very much, or most of the time*). Scores for either subscale were summed for a total score. A positive screen for probable depression or anxiety is reflected by a score of 10+ or 8+, respectively. Cronbach's alpha for the depression and anxiety subscales in the current sample was high, .93 and .85, respectively. To minimize mulitcollinearity between these three highly comorbid mental health conditions, an exploratory factor analysis using continuous scores on each measure was used to create a composite score of mental health distress (e.g., Pietrzak & Cook, 2013). This composite score was used in all analyses.

Analytic plan

Bivariate associations among attributions, stigma, help-seeking variables, and established covariates were assessed using Pearson correlations and analyses of variance. The association of attributions, stigmas, and established covariates were subsequently included in a path analysis with help-seeking from a mental health professional and from a medical doctor as the dependent co-varying outcomes. Goodness of fit was assessed using normed fit index (NFI), Tucker-Lewis index (TLI), comparative fit index (CFI), and the root mean

square error of approximation (RMSEA). Based on prior recommendations, cut-offs of .90 for the NFI, TLI, and CFI and .08–.10 for the RMSEA were selected (see Marsh, Hau, & Wen, 2004). Effect sizes were calculated using Cohen's (1992) recommendations.

Results

Means, standard deviations, and bivariate associations for all variables are presented in Table 1. Biological and psychological attributions were strongly, positively correlated with each other (large effect) and with psychological distress (medium-to-large), suggesting a tendency to make more attributions of either type when feeling more distress. Both types of attributions were moderately, positively correlated with anticipated enacted stigma (small-to-medium effects), but nonsignificantly correlated with self-stigma. Psychological attributions were positively correlated with negative beliefs about mental health treatment (small effect) but nonsignificantly correlated with help-seeking intentions from either medical doctors or mental health professionals. In contrast, biological attributions were nonsignificantly correlated with negative beliefs but positively correlated with help-seeking intentions from medical doctors and mental health professionals (small effects). Previous engagement (yes/no) in mental health treatment was associated with higher biological attributions, $t(35) = 4.67$, $p < .001$; psychological attributions, $t(152) = 4.26$, $p < .001$; psychological distress, $t(144) = 6.93$, $p < .001$; and greater intentions to seek mental health treatment from a mental health professional, $t(153) = 3.93$, $p < .001$.

Path analysis was used to simultaneously model help-seeking intentions from either provider with attributions, stigma variables, negative beliefs about mental health, previous engagement in mental health care, and age entered as the independent variables. A covariance between help-seeking from a mental health professional and medical doctor was added. Covariances between all independent variables except age were also added. The model was an adequate fit to the data (NFI = .99, TLI = 1.01, CFI = 1.00, RMSEA = .00). Biological attributions were positively related to help-seeking from a medical doctor with a small effect size. Biological attributions showed a trend toward a significant positive association with help-seeking intentions from a mental health professional, also with a small effect size ($p = .06$). Psychological attributions were unrelated to help-seeking from a mental health professional and medical doctor. Older age was positively associated with help-seeking intentions from a medical doctor with a small effect size but unrelated to help-seeking intentions from a mental health professional. Negative beliefs about mental health treatment were negatively associated with help-seeking intentions from a mental health professional with a medium effect size but unrelated to help-seeking intentions from a medical doctor. Previous engagement in mental health care was positively associated to help-seeking intentions from a mental health professional with a small effect size but unrelated to help-seeking intentions from a medical doctor. All other associations with help-seeking intentions were non-significant (see Figure 1).

Discussion

The purpose of the current study was to explore how SM/Vs' understanding of psychological distress relates to help-seeking intentions from both a mental health professional and a medical doctor. Understanding of psychological distress was focused specifically on the association of biological and psychological attributions with help-seeking intentions. Findings demonstrated that higher biological attributions were related to higher help-seeking intentions from a medical doctor and psychological attributions were unrelated to help-seeking intentions from either provider. Biological attributions were related to higher help-seeking intentions from mental health professional with a small effect size but this association only trended toward significance ($p < .06$). Consistent with prior research, more negative beliefs about mental health care were negatively associated with help-seeking intentions from a mental health professional whereas previous engagement in mental health treatment was associated with higher help-seeking intentions from a mental health professional (e.g., Blais et al., 2015). However, and contrary to prior research (e.g., Hankin et al., 1999), older age was associated higher help-seeking intentions from a medical doctor.

The positive association of biological attributions with help-seeking intentions from a medical doctor was consistent with prior help-seeking research in civilians (e.g., Blais & Renshaw, 2012; Han, Chen, Hwang, & Wei, 2006; Wrigley, Jackson, Judd, & Komiti, 2005). It is possible that when SM/Vs attribute distress to biological causes, they view treatment as more efficacious relative to psychological attributions. As such, efforts to increase help-seeking in SM/Vs, particularly among medical providers, might focus on framing psychological distress within the biomedical model that describes psychological distress as a result of genetic influences, chemical imbalances, and hormone imbalances. Prior studies examining the utility of framing distress in the biomedical model compared to the

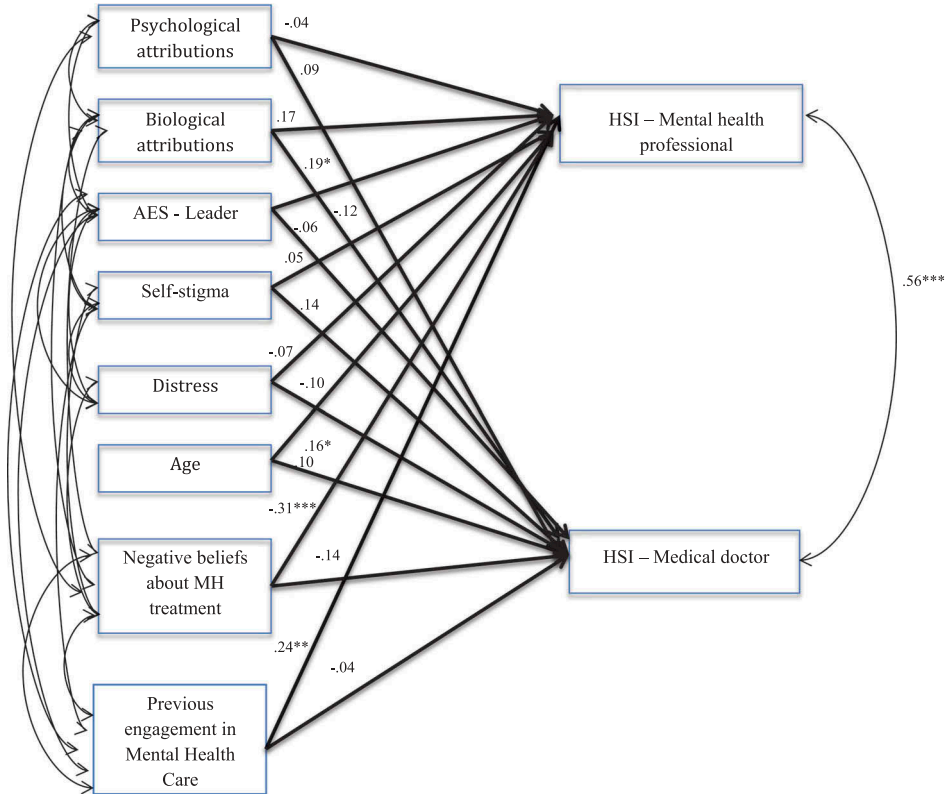

Figure 1. Help-seeking intentions, attributions, stigma, distress, and negative beliefs about mental health treatment.
Note. HSI = Help-seeking Intentions. AES = Anticipated enacted stigma. MH = Mental health. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

psychological model found that when distress was framed in biomedical model, participants reported fewer barriers to care (e.g., Blais & Renshaw, 2012; Deacon & Baird, 2009).

Beliefs that distress was caused by psychological factors were unrelated to help-seeking intentions from either provider. Previous campaigns sponsored by the VA and DoD to increase help-seeking in distressed SM/Vs have used slogans such as "It takes the strength and courage of a warrior to ask for help" (VA, 2012) or "Seeking help is a sign of strength and fortitude, not weakness" (U.S. Army, n.d.). Stating that help-seeking requires "strength" or "courage" may draw from more psychologically-based beliefs. Results from the current study suggest that psychologically-based beliefs are unrelated to help-seeking and the consistently low rate of mental health care utilization in this population may be a result of psychologically-based campaigns. The current study demonstrated that psychological beliefs were related to more negative beliefs about mental health care, suggesting that not only might psychological attributions be unrelated to help-seeking, for some, it may deter help-seeking due to perceived ineffectiveness of treatment. Indeed, when veterans perceive treatment to be ineffective, they make fewer gains during therapy (e.g., Price et al., 2015).

Although biological attributions were related to higher help-seeking intentions from a medical doctor in the current sample, biological attributions were also associated with higher anticipated enacted stigma from unit leaders, and prior research in this sample revealed that higher anticipated enacted stigma was associated with lower help-seeking intentions from a mental health professional (Blais & Renshaw, 2013). Taken together, the current findings suggest a unique and complex association of help-seeking intentions, distress, stigmas, and attributions that require additional study.

Limitations of the current study include the use of a self-report cross-sectional study design that prohibits statements of causality. These associations were also tested using a convenience sample of SM/Vs, which limits generalizability. Finally, the study was limited to help-seeking intentions and not actual help-seeking behavior. Extant literature shows that intentions to seek mental health treatment do not always result in actual help-seeking behaviors (e.g., Ajzen, Brown, & Carvajal, 2004). Future research should examine the association of attributions with actual help-seeking

behaviors using a longitudinal study design with a more representative sample of SM/Vs.

Notwithstanding these limitations, findings from the current study show that how SM/Vs explain psychological distress relates to their intentions to seek mental health treatment from either a mental health professional or a medical doctor. Beliefs that distress was due to biological factors was associated with higher help-seeking intentions, particularly from a medical doctor. Alternatively, beliefs that distress was due to psychological factors was unrelated to help-seeking. Efforts to increase help-seeking might incorporate biomedical models of distress.

Acknowledgment

The author wishes to thank the service men and women who participated in the current study. Data collection was completed while Dr. Blais was a graduate student in the Department of Psychology at the University of Utah. Data analysis and interpretation was completed when Dr. Blais was an Assistant Professor at Utah State University. The authors wish to thank Felicia Andresen for comments on the revised version of this manuscript.

Disclosure statement

There are no conflicts of interest to disclose.

Funding

Funding for this study was provided by the American Psychological Association–Division 19 (Society for Military Psychology); Division 19 - APA.

References

Ajzen, I., Brown, T. C., & Carvajal, F. (2004). Explaining the discrepancy between intentions and actions: The case of hypothetical bias in contingent valuation. *Personality and Social Psychology Bulletin*, *30*, 1108–1121.

Army. (n.d.-a). *The Army values*. Retrieved from https://www.army.mil/values/

Army. (n.d.-b). *Soldier's Creed*. Retrieved from https://www.army.mil/values/soldiers.html

Barrowclough, C., & Hooley, J. M. (2003). Attributions and expressed emotion: A review. *Clinical Psychology Review*, *23*(6), 849–880.

Blais, R. K., & Renshaw, K. D. (2009, November). Illness attributions and social support seeking intentions in romantic relationships. In R. Brock Chair (Ed.), *Moving beyond global relationship satisfaction: Targeting specific relationship processes in couples' research*. New York, NY. Association of Behavioral and Cognitive Therapies.

Blais, R. K., & Renshaw, K. D. (2012). The association of biological and psychological attributions for depression with social support seeking intentions in individuals with depressive symptoms. *Behavioural and Cognitive Psychotherapy*, *40*(5), 605–617.

Blais, R. K., & Renshaw, K. D. (2013). Perceptions of partners' attributions for depression in relation to perceptions of support and conflict in romantic relationships. *Journal of Marital And Family Therapy*. doi:10.1111/jmft.12055

Blais, R. K., & Renshaw, K. D. (2014). Perceptions of partners' attributions for depression in relation to perceptions of support and conflict in romantic relationships. *Journal of Marital and Family Therapy*, *40*, 498–508.

Blais, R. K., Tsai, J., Southwick, S. M., & Pietrzak, R. H. (2015). Barriers and facilitators related to mental health care use among older veterans in the United States. *Psychiatric Services*, *66*(5), 500–506.

Bliese, P. D., Wright, K. M., Adler, A. B., Cabrera, O., Castro, C. A., & Hoge, C. W. (2008). Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology*, *76*(2), 272–281.

Britt, T. W. (2000). The stigma of psychological problems in a work environment: Evidence from the screening of service members returning from Bosnia. *Journal of Applied Social Psychology*, *30*(8), 1599–1618.

Britt, T. W., Greene-Shortridge, T. M., Brink, S., Nguyen, Q. B., Rath, J., Cox, A. L., … Castro, C. A. (2008). Perceived stigma and barriers to care for psychological treatment: Implications for reactions to stressors in different contexts. *Journal of Social and Clinical Psychology*, *27*(4), 317–333.

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112* (1), 155–159.

Deacon, B. J., & Baird, G. L. (2009). The chemical imbalance explanation of depression: Reducing blame at what cost? *Journal of Social and Clinical Psychology*, *28*(4), 415–435.

Durtschi, J. A., Fincham, F. D., Cui, M., Lorenz, F. O., & Conger, R. D. (2011). Dyadic processes in early marriage: Attributions, behavior, and marital quality. *Family Relations*, *60*(4), 421–434.

Fincham, F. D., Harold, G. T., & Gano-Phillips, S. (2000). The longitudinal association between attributions and marital satisfaction: Direction of effects and role of efficacy expectations. *Journal of Family Psychology*, *14* (2), 267–285.

Garcia, H. A., Kelley, L. P., Rentz, T. O., & Lee, S. (2011). Pretreatment predictors of dropout from cognitive behavioral therapy for PTSD in Iraq and Afghanistan War veterans. *Psychological Services*, *8*(1), 1–11.

Goldstein, B., & Rosselli, F. (2003). Etiological paradigms of depression: The relationship between perceived causes, empowerment, treatment preferences, and stigma. *Journal of Mental Health*, *12*(6), 551–563.

Han, D., Chen, S., Hwang, K., & Wei, H. (2006). Effects of psychoeducation for depression on help-seeking willingness: Biological attribution versus destigmatization. *Psychiatry and Clinical Neurosciences*, *60*(6), 662–668.

Hankin, C. S., Spiro III, A., Miller, D. R., & Kazis, L. (1999). Mental disorders and mental health treatment among US department of veterans affairs outpatients: The Veterans health study. *American Journal of Psychiatry*, *156*(12), 1924–1930.

Harpaz-Rotem, I., & Rosenheck, R. A. (2011). Serving those who served: Retention of newly returning veterans from

Iraq and Afghanistan in mental health treatment. *Psychiatric Services*, *62*(1), 22–27.

Hoerster, K. D., Malte, C. A., Imel, Z. E., Ahmad, Z., Hunt, S. C., & Jakupcak, M. (2012). Association of perceived barriers with prospective use of VA mental health care among Iraq and Afghanistan war veterans. *Psychiatric Services*, *63* (4), 380–382.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*(1), 13–22.

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.

Johnston, S. L., & Dipp, R. D. (2009). Support of marines and sailors returning from combat: A comparison of two different mental health models. *Military Medicine*, *174*(5), 455–459.

Kelley, H. H. (1973). The processes of causal attribution. *American Psychologist*, *28*(2), 107–128.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research and Therapy*, *33* (3), 335–343.

Marsh, H. W., Hau, K. T., & Wen, Z. (2004). In search of golden rules: Comment on hypothesis-testing approaches to setting cutoff values for fit indexes and dangers in overgeneralizing Hu and Bentler's (1999) findings. *Structural Equation Modeling*, *11*(3), 320–341.

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*, *298*(18), 2141–2148.

Pietrzak, R. H., & Cook, J. M. (2013). Psychological resilience in older US veterans: Results from the national health and resilience in veterans study. *Depression and Anxiety*, *30*(5), 432–443.

Price, M., Maples, J. L., Jovanovic, T., Norrholm, S. D., Heekin, M., & Rothbaum, B. O. (2015). An investigation of outcome expectancies as a predictor of treatment response for combat veterans with ptsd: Comparison of clinician, self-report, and biological measures. *Depression and Anxiety*, *32*(6), 392–399.

Seal, K. H., Maguen, S., Cohen, B., Gima, K. S., Metzler, T. J., Ren, L., … Marmar, C. R. (2010). VA mental health care services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *Journal of Traumatic Stress*, *23*(1), 5–16.

U.S. Army. (n.d.). *Breaking the stigma*. Retrieved from http://www.soc.mil/Stigma/Index.html

U.S. Department of Veterans Affairs. (2012). *Guide to VA mental health services for Veterans and their families*. Retrieved from http://www.mentalhealth.va.gov/docs/MHG_English.pdf

Vogel, D. L., Wade, N. G., & Ascheman, P. L. (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*(2), 301–308.

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.

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993, October). *The PTSD checklist (PCL): Reliability, validity, and diagnostic utility*. Paper presented at the meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help-seeking intentions: Properties of the general help-seeking questionnaire. *Canadian Journal of Counselling*, *39*(1), 15.

Woodson, J. (2013). *Clinical practice guidance for deployment-limiting mental disorders and psychotropic medications*. Retrieved from file:///Users/Rebecca/Downloads/Signed%20HA%20Guidance%20Deployment%20Limiting%20Mental%20Disorders%20and%20Psychotropic%20Medications.pdf

Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry*, *39*(6), 514–521.