Veterans Treating Veterans: Positive Perceptions of Potential Therapeutic Alliances

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Author Note

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Table of Contents

List of Tables and Figures

Abstract

Veteran suicide is the leading cause of veteran deaths in the United States, as reported by the Department of Veteran Affairs in 2017 and 2019. The continued increase of veteran suicides is most often attributed to the stigmatization for seeking mental health care and the subsequent perceived barriers to care. The creation of Vet Centers was a direct result of the stigma Vietnam Era veterans experienced, and the centers emphasize the concept of veteran-to-veteran care. Vet Centers continue to thrive in the post-Vietnam era, and recently are becoming more well known to active service members and veterans, but the model has not been able to stem the veteran suicide epidemic. As hypothesized in this study, the increase of the perception of a strong therapeutic alliance led to increased credibility and expectancy for treatment and decreased barriers to care and perceived stigma. This study did not support the hypothesis that a veteran therapist would directly lead to an increased therapeutic alliance and thus improve treatment. One hundred sixty-one veterans (51% female, 49% male) from the Persian Gulf & War on Terror service eras were surveyed regarding an assigned vignette of a therapist, their perceptions of a potential alliance with the therapist, and if they perceived an increase in the credibility of the therapist, and a decrease in perceived stigma and barriers. There were no distinguishable differences between the therapist profiles and how veterans perceived them as measured by this study. Future research should focus on in-session and post-session measures of therapeutic alliance with a variety of therapist models to better refine the necessary treatment considerations to successfully reduce veteran suicide.

Keywords: military, veterans, stigma, suicide, therapeutic alliance, treatment outcomes, barriers to care, treatment participation

Chapter 1

Problem Statement

There are a variety of negative outcomes that are areas of concern when military service members or veterans do not receive or engage in therapy (Kim et al., 2010; Kim et al., 2011). The stigma derived from seeking or obtaining therapy is one significant barrier to care service members and veterans experience, resulting in a lack of care seeking they need (Blais et al., 2014; Blais et al., 2015). Service members and veterans may feel less stigmatized when they seek help from therapists who are veterans themselves (Botero et al., 2020; Catherall & Lane, 1992; Johnson et al., 2018). Suicides among military service members and veterans persist at high rates, despite efforts to develop and implement effective interventions by the Department of Defense (DoD) and Veterans Affairs (VA) to reduce this epidemic. As of 2017, the VA reported 13.5% of all suicides in the United States were by veterans, and the rate of veteran suicide has remained consistent since 2005 (U.S. Department of Veterans Affairs, 2019). Data currently do not represent the total suicides per year in the military community, as active duty service members are not accounted for in the definition of a veteran for the 2019 report; active duty had been considered in the 2014 report, however (U.S. Department of Veterans Affairs, 2019).

As suicide rates increase and programmatic interventions fail to reduce the rate of suicides in the veteran community, the country is confronted with the reality that there is a significant cultural misunderstanding toward veteran mental health care (Hall, 2011; Kim et al., 2011; Reger et al., 2008). Cultural difficulties such as these are reinforced by continued misuse of federal monies regarding programs designed to reduce stigma

around mental health care and suicidal thoughts (U.S. Department of Veterans Affairs, 2019).

In 2018, the VA was budgeted $6.2 million to spend toward veteran suicide prevention efforts; however, they only spent $57,000 of the allotted funds. The lack of spending these monies shows one of the primary issues regarding the veteran connection to health care and especially toward mental health from the VA (Fischer & Farina, 1995; Kim et al., 2011; Pietrzak et al., 2009; Stecker et al., 2007). There have been a growing number of suicides for both combat and noncombat veterans, increasing to five suicides per 100,000 (27.7 to 32.2) for National Guard members who had never been federally activated (U.S. Department of Veterans Affairs, 2019). Compared to the national averages, female veterans are 2.2 times more likely to complete suicide than nonveteran females, and male veterans are 1.3 times more likely to complete suicide than nonveteran males (U.S. Department of Veteran Affairs, 2019).

Although the Veterans Health Administration has proposed a significant number of initiatives, there has been little success in stemming the rate of veteran suicides per day (U.S. Department of Veteran Affairs, 2019). This issue is compounded for veterans due to the prevalence of posttraumatic stress disorder as a result of trauma, moral injury, substance use, and a lack of social support (Ahern et al., 2015; Battles et al., 2018; Bryan et al., 2018). The lack of research surrounding veterans serving in the therapist role for other veterans demonstrates the limited avenues that are currently available and directly illuminates the possibility of a missing critical component to the treatment paradigm regarding veterans (Cabral & Smith, 2011; Catherall & Lane, 1992; Coll et al., 2011; Johnson et al., 2018).

There is an abundance of treatment options throughout the United States for military and veteran community members, but the lack of engagement and retention in care demonstrates the system is missing a crucial component (Botero et al., 2020; Catherall & Lane, 1992; Coll et al., 2011; U.S. Department of Veteran Affairs, 2019). Specifically, the use of peers when relating to military service, veteran experiences, and aiding in the reduction of stigma and other barriers to care (Blais et al., 2014; Kim et al., 2011). The veteran therapist is key to interventions that may exhibit the needed characteristics to remove perceptions of stigma, self-stigmatization, barriers to care, and present a solution to confronting the lack of mental health engagement in the military and veteran communities (Catherall & Lane, 1992; Coll et al., 2011; Kim et al., 2011).

Veterans may tend to feel more at ease within a community of peers, in this case, other veterans (Hinojosa & Hinojosa, 2011; Pfeiffer et al., 2012; Russell & Russell, 2018). The therapeutic alliance, specifically in which a therapist connects to a client, can impact therapy and lead to positive treatment outcomes (Bordin, 1979). This alliance applies to cross-cultural competence, as the military is itself a unique culture composed of nearly every demographic in the United States and other countries as well (Bordin, 1979; Catherall & Lane, 1992; Hall, 2011). In their research, Reger et al. (2008) used a vignette of a civilian therapist during their first session with a service member to exemplify the difficulty of achieving cultural competence of the military community as an outsider. This vignette demonstrated the difficulty in communication when the therapist may not understand the terminology, experiences, or significance of certain events (Botero et al., 2020; Reger et al., 2008; Taber et al., 2011). When a therapist does not fully understand what a service member or veteran is stating, it may impact the

alliance negatively due to interruptions for clarification and create a misalliance in the therapy because of repeated needs for clarification (Hall, 2011; Keller et al., 2010; Reger et al., 2008).

Significant research has recently been focused on peer-to-peer interventions within the military community and the VA (Caddick et al., 2015). Studies have shown an increase in positive treatment outcomes and a reduction in reported symptoms of posttraumatic stress when removing certain variables such as a therapist who is not competent regarding military culture (Caddick et al., 2015; Hall, 2011; Hinojosa & Hinojosa, 2011). Although it can be argued that cross-cultural competence is only applicable to American individuals, it is still necessary due to the very nature of the Armed Forces mission in the United States and abroad (Dean, 2001; Koo et al., 2016). The traditional American values clinicians may have could appear to be incongruent with the cultural representation of the military community as the community includes immigrants, cultural nonconformist, as well as different and unique sets of values that expand upon the American values most attributed in their own culture (Dean, 2001). Although an individual may have served in the military as a therapist, they could be identified by other veterans as part of the military system due to previous experiences with active duty therapist (Moore & Reger, 2006). Specifically, the experience of a therapist in the military having to report mental health information to a commanding officer, by law, can induce anxiety, feelings of stigma, and further avoidance of obtaining mental health care (Moore & Reger, 2006).

A recent study found service members typically prefer a therapist who has served in the military due to the therapeutic discussions being easier to initiate (Johnson et al.,

2018). An additional qualitative study reported veterans prefer another veteran as their therapist, citing the Vet Center model as being preferred over the general VA mental health model (Botero et al., 2020). It is no mystery then that veterans may find it challenging to explain to a therapist, who does not share their experiences, the impact of significant events, how it made them feel, or how they hoped to express these experiences to others (Johnson et al., 2018; Reger et al., 2008). Therapists have the freedom to disclose they have served, and this may help in increasing the initial alliance due to perceived congruency between the therapist-client cultures, perceptions, and shared experiences (Lavik et al., 2017; Levitt et al., 2016). Leibert and Dunne-Bryant (2014) found two specific factors impacted treatment outcomes: client expectancy and the therapeutic alliance. These findings coincide with various research studies on the therapeutic alliance and how both the therapist and client can strengthen it (Bachelor, 2013; Joseph et al., 2014). What has yet to be discovered through this area of research is a better understanding of veteran-to-veteran alliances and how they can positively impact treatment outcomes, potentially reducing suicide rates, symptoms of posttraumatic stress, substance use, and difficulties surrounding mental health stigmatization in military and veteran communities (Johnson et al., 2018; Kim et al., 2011; Kim et al., 2010; Pietrzak et al., 2009).

Operational Definitions

Therapeutic Alliance

The therapeutic alliance has been altered in its definition by various therapeutic communities and modalities. The definition, as described by Bordin (1979) and Bachelor (2013), states the overall alliance is reliant upon five factors that promote a positive

therapeutic alliance: *Confident Collaboration*, *Goal* and *Task*, *Idealized Relationship*, *Dedicated Patient*, and *Help Received*. Confident collaboration enables the therapist to reflect clients' feelings of commitment and confidence with the current therapy and therapist, building the alliance through mutual decisions (Bachelor, 2013). Goal and task are specific to the orientation of the therapists but define the relationship's working structure (Bachelor, 2013; Bordin, 1979). The idealized relationship centers around therapists and clients both having a similar perspective of the goals, tasks, and intents of therapy, and mostly agreeing on an intervention path (Bachelor, 2013; Bordin, 1979). The dedicated patient is merely ensuring the patient can understand their aspects of participation in the therapy, reinforcing their active and positive participation (Bachelor, 2013; Bordin, 1979). Lastly, the factor of help received is used in the Helping Alliance questionnaire (HAq and HAq-II) to understand the feelings of a client who has received positive and successful therapy (Bachelor, 2013; Bordin, 1979).

Stigma and Barriers to Care

Stigma and *barriers to care* are described as the negative perceptions or attitudes regarding treatment seeking, mental health treatment, and beliefs regarding mental health diagnoses (Andersen & Blais, 2019; Blais et al., 2014). Barriers to care is based upon the perception of stigma, self-imposed stigma, and the negative attitudes and beliefs that prevent one from seeking needed mental health care (Andersen & Blais, 2019; Blais et al., 2014). It is hypothesized that the presence of a positive therapeutic alliance through culture and experience matching (veteran-to-veteran) will reduce the perception of various stigma factors and subsequently reduce the perception of barriers to care (Andersen & Blais, 2019).

Credibility and Expectancy

Credibility and *expectancy* is described as the impact of a treatment rationale on therapy and is contingent on the client's expectations for psychotherapy, the process of therapy, and the therapeutic outcomes (Ahmed & Westra, 2009; Greenberg et al., 2006). The importance of this concept is the function of treatment expectancy increasing the potential of more information being presented in a therapeutic session and how the client rationalizes this presentation (Horvath, 1990). It is hypothesized that the perception of a positive therapeutic alliance will increase the perceptions of credibility and expectancy for therapy (Ahmed & Westra, 2009).

Defining a Veteran Therapist

A veteran therapist is an individual who has served in the United States Armed Forces, has been discharged, and is currently practicing as a psychologist (Houghton, 2018). The congruency of experiences between the client and psychologist can improve early therapeutic alliance creation, goals and task creation, and successful interventions with lasting symptom reduction (Bachelor, 2013; Cabral & Smith, 2011; Joseph et al., 2014; Lavik et al., 2017; Reger et al., 2008). A veteran therapist's previous military experience may be disclosed to the client in a variety of ways, including public affiliation, apparent signs of military service, or increasing and promoting programs that emphasize the hiring of therapists who have served.

Literature Review

Alliance Framework

Because psychoanalysis originally formulated the concept of the therapeutic alliance, emphasis on the importance of this concept has transcended any one theoretical

orientation and has established itself across most modern interventions (Bordin, 1979). Clinicians have continually theorized how the therapeutic alliance could positively or negatively impact treatment outcomes with a diverse range of clients (Catherall & Lane, 1992; Joseph et al., 2014; Taber et al., 2011). The significance of congruent identities, cultural beliefs, and similar experiences has been shown to have a positive impact on alliances, which subsequently leads to positive treatment outcomes (Cabral & Smith, 2011; Taber et al., 2011). The two primary components of any therapeutic alliance that are necessary to be strong and positive are bond and task (Hoffart et al., 2013). Bond in conjunction with the therapeutic alliance is conceptualized as the trust, attachment, and the client and therapist liking each other (Bordin, 1979). Task is the collaboration a therapist and client have regarding goals, therapeutic contracts, and agreement to achieve the therapeutic goals (Bordin, 1979).

Although the terms working alliance and therapeutic alliance are interchangeable within the literature, there is another term that is, at times, construed as identical to the therapeutic alliance, and that is rapport (Molnos, 1998). Although rapport can be established with a client, it is not oriented toward the same therapeutic goals as the traditional therapeutic alliance (Molnos, 1998). Rapport is associated with relating to one another but is similarly an unconscious process (Molnos, 1998). The importance of being able to work on therapeutic tasks is directly related to the treatment outcome of an individual, and, although the dynamics of rapport is essential, it does not solely account for positive treatment outcomes (Molnos, 1998). It is entirely possible to have a rapport with an individual but have little to no engagement on therapeutic goals or tasks, and thus negatively impact the overall treatment (Molnos, 1998).

Research has shown racial or ethnic minority status can weaken alliance bonds and compound the difficulty of seeking care (Koo et al., 2016; Russell & Russell, 2018). However, the therapeutic alliance typically follows a positive trend despite therapist-client differences, but the initial creation of the alliance in the first sessions is paramount to increasing positive treatment outcomes (Lavik et al., 2017; Michel et al., 2011). Posttraumatic stress is one of the prominent difficulties the military and veteran communities face, and the implementation of any intervention empowered by a robust therapeutic alliance should be emphasized (Keller et al., 2010). Increasing cultural understanding and decreasing the need to explain technical information to a therapist with prior military service can be facilitated through the therapist self-disclosing, creating a powerful connection between veteran therapists and veteran clients (Caddick et al., 2015; Levitt et al., 2016; Reger et al., 2008). The therapeutic alliance exists as a transtheoretical application for any therapeutic style and improves the potential of positive treatment outcomes for clients (Bachelor, 2013; Bordin, 1979; Catherall & Lane, 1992).

Camaraderie

Through a sense of family or "band of brothers," camaraderie forms through the service members' shared experiences, humor, and a mutual understanding of suffering (Caddick et al., 2015). These strong interpersonal bonds formed through service with a comrade can reduce symptoms of both anxiety and depression (Caddick et al., 2015). Johnson et al. (2018) found camaraderie is believed to emphasize the innate bond a veteran therapist would experience with a veteran client due to the factors discussed.

Barriers to Care

The difficulty with accessing mental health resources as an active military member or veteran can be compounded by self-stigmatization, perceptions of stigmatization for seeking help by others, and other factors related to cognitive distortions (Britt et al., 2008; Hoge et al., 2004; Kim et al., 2010). One of the primary barriers to care is self-stigmatization, and, within the military, whether your unit will view you as weak, mentally ill, or hamper your career from there on for seeking care (Hoge et al., 2004; Kim et al., 2010). Overall, the stigmatization of mental health care in the military and veteran communities is pervasive and tends to create a toxic environment that can exacerbate a person's symptoms (Blais & Renshaw, 2013; Hoge et al., 2004). Specifically, suicidality, substance use, and anxiety can all be increased through perceptions of stigmatization for seeking mental health care (Britt et al., 2008; Pietrzak et al., 2009). This creates a lower likelihood of the individual to seek support and further deteriorates mental health services being obtained, symptom reduction, and inhibits the therapeutic alliance from being created and nurtured through the completion of therapy sessions (Blais et al., 2014; Kim et al., 2011; Stecker et al., 2007).

Overview of Therapeutic Alliances

Alliances are believed to form from the initial bond, therapist-client tasks, and similarity between personalities of the therapist and client (Bordin, 1979; Taber et al., 2011). Self-disclosure can improve alliances with therapists and clients; for veterans, it can be powerful when the therapist is a former service member (Johnson et al., 2018; Lavik et al., 2017). Veteran clients seek the ability to be understood as a whole person instead of fractured components; this enables the veteran not needing to expand on their

cultural terminology and aids in the therapist and veteran joining in a shared identity, fortifying the therapeutic alliance (Botero et al., 2020; Johnson et al., 2018; Levitt et al., 2016; Reger et al., 2008).

Alliances can be strengthened through positive self-disclosure that exhibit similarities between a therapist and client, and cultural understanding (Catherall & Lane, 1992; Lavik et al., 2017). Although every component of the therapeutic alliance has an impact on the strength of the relationship, it has been postulated that goal and task, help received, and confident collaboration, as defined by Bachelor (2013), are of the utmost importance. Confident collaboration is defined as "reflecting clients' sense of confidence in and commitment to therapy" (Bachelor, 2013, p. 119), whereas help received is defined as "a more global appreciation of the benefits of therapy" (p. 130). Goal and task are interrelated with the general alliance definition but is further defined as "non-disagreement about the work of therapy" (Bachelor, 2013, p. 119). Clients are more likely to identify the alliance as being strong through in-session and post-session feedback measures when these specific variables of the alliance are prominent in therapy sessions (Bachelor, 2013; Janse et al., 2017).

Alliances between a therapist and client may become weakened or negatively impacted through inappropriate endorsements of similarities, such as endorsing cognitive distortions from the client (Levitt et al., 2016). This can be further examined through the example of a veteran stating a feeling of guilt for coming back from a deployment when others did not. An endorsement by a therapist toward this distortion would negatively impact the progression of the therapeutic alliance, especially when done by an identified outsider (nonveteran; Levitt et al., 2016). The therapist must understand that matching a

client upon a negative perception or distortion is likely to directly affect and weaken the alliance (Levitt et al., 2016). However, this should not discourage a therapist from normalizing or legitimizing the emotional or physical suffering that the client has experienced (Caddick et al., 2015).

Potential Veteran Therapeutic Alliances

Research has shown therapists who have a military background are more likely to be preferred by military populations such as active duty, National Guard, and veterans (Botero et al., 2020; Johnson et al., 2018). Due to the ingrained culture of the military from basic training onward, it is imperative for the therapist to not only understand the military culture but also have an affiliation with the military (Coll et al., 2011). The specifics of military and veteran culture and the increasing diversity among those clients cannot be overstated, and this creates difficulty regarding cultural competency by an outsider (Hall, 2011; Johnson et al., 2018; Reger et al., 2008). Competency in military and veteran culture can be evaluated through the dimensional cultural model that requires a therapist to tailor each therapy session to the individual due to the vast array of aspects that are encompassed by clients (Schim & Doorenbos, 2010; Reger et al., 2008). As presented by Reger et al. in 2008, a cultural vignette shows the need to tailor the session to account for factors such as familiarity with military unit dynamics, possible impacts of combat deployments, and stressors of a specific military occupational specialty.

The nature of the trauma service members may experience, and the stigma associated with seeking care, has illuminated many of the barriers identified in clinical research (Battles et al., 2018; Evans et al., 2018; Fischer & Farina, 1995; Kim et al., 2011). Moral injury has also led to problematic traumas many do not seek care for;

whether this is due to stigma, misunderstanding what is defined as traumatic, or irrational beliefs, these beliefs complicate positive alliance building for therapists and clients (Farnsworth, 2019; Kim et al., 2010; Pietrzak et al., 2009). The common belief that being injured or directly engaging the enemy is the only valid military trauma has led to additional difficulties such as cognitive distortions, but also creates an increase of self-stigmatizing behavior toward seeking care (Pitts et al., 2013). Individuals who have experienced varying forms of trauma not related to combat may feel their trauma is not warranted purely because they did not deploy to a combat zone (Pitts et al., 2013). Symptoms resulting from moral injury, combat, or noncombat can be mitigated through a therapist who can be genuinely understanding and empathic toward the client, increasing the impact on potential treatment outcomes being positive (Farnsworth, 2019; Taber et al., 2011). Through successful and culturally competent treatment in the military and veteran communities, the reduction of the rate of suicide is possible (Bryan et al., 2012).

Military and Veteran Cultural Competency

Military and veteran culture is immersed in unique experiences, beliefs, and emphasizes a collectivist culture over the typical culture of individuality in the United States (Hall, 2011). The need to explain to multiple providers over time what a common jargon, military locations, or impactful incident means can cause disconnect between any therapist and veteran client (Botero et al., 2020; Johnson et al., 2018; Kim et al., 2010; Koenig et al., 2014; Taber et al., 2011). The military uses a large amount of jargon to include acronyms, shorthand, technical verbiage, and self-professed dark humor to communicate inside their community (Caddick et al., 2015; Reger et al., 2008). Identified cultural barriers can be potentially mitigated by using camaraderie, shared experiences,

stories, and enabling the veteran client to feel comfortable enough to speak normally instead of using concealed language due to typical military behavior around civilians (Caddick et al., 2015; Coll et al., 2011; Hall, 2011; Pfeiffer et al., 2012; Reger et al., 2008).

Although many veterans and active duty military communities do not feel comfortable disclosing mental health concerns to leadership in their unit, they generally are comfortable with accessing peer-to-peer support networks (Ahern et al., 2015; Pfeiffer et al., 2012). Behaviors and cognitions such as peer-to-peer support are a molded behavior due to the conditioning that occurs during initial military training (Ahern et al., 2015). During the transition from deployment to garrison or military to civilian lifestyles, there is a disconnect from the perception of the military unit as a family, especially toward unit leadership (Ahern et al., 2015).

The concept of peer-to-peer interventions has been used to facilitate discussions and therapy for service members and veterans alike (Ahern et al., 2015; Hinojosa & Hinojosa, 2011). Some members of the military have described that the uniqueness of their experiences can only be understood by others who have experienced something similar, establishing the theoretical need and potential for a veteran therapist (Ahern et al., 2015; Botero et al., 2020; Johnson et al., 2018). The need for a veteran therapist is based on the social climate theory and therapeutic alliance. Social climate theory, as stated by Ahern et al. (2015), defines three concepts as key components: “support, goal/task orientation, and structure/organization” (p. 8) and further defines how the theory applies specifically to military cultures. It also analyzes the caretaking and purpose set forth by the perceptions of the military as a family, thus creating the specific

climate that fosters both positive and negative cognitions for service members (Ahern et al., 2015). Through the lens of this theory both military and veteran communities can successfully obtain and participate with a therapist who connects with them at a foundational level (Ahern et al., 2015; Johnson et al., 2018; Joseph et al., 2014).

Camaraderie Through Shared Military Experiences

Hinojosa and Hinojosa (2011) highlighted a quote that has encompassed many military stories and media: "We few, we happy few, we band of brothers. For he today that sheds his blood with me, shall be my brother" (p. 1146). William Shakespeare wrote this in his play, *Henry V*, which had set the table for other stories of camaraderie, family, and how those experiencing battle together become a family support system (Caddick et al., 2015; Hinojosa & Hinojosa, 2011). *Band of Brothers*, a nonfiction story about Echo Company of the 101st Infantry in World War II, is a form of dialogical storytelling, similar to peer-to-peer interventions, that have been used to mitigate feelings of stigma, abnormal experiences, and further promote the idea of military as a family support system for coping with trauma experiences (Ahern et al., 2015; Caddick et al., 2015; Hinojosa & Hinojosa, 2011).

Peer-based programs that take advantage of the concept of the military as family, camaraderie, and reconnecting through dialogical storytelling have shown to improve treatment seeking behaviors for military service members and veterans (Hinojosa & Hinojosa, 2011; Pfeiffer et al., 2012). The concept of military as family, when coupled with the presence of veteran service organizations (VSOs), increases the possibility of voicing mental health concerns by veterans due to the social identity theory and common affiliation bonds (Caddick et al., 2015; Pfeiffer et al., 2012; Russell & Russell, 2018).

The general social identity most service members assume is one of strength and resilience, and, as others legitimize asking for help, those actions remove the perception of stigma associated with the military identity (Caddick et al., 2015). These peer-to-peer bonds are essential due to the stigma reported by service members in previous studies stating participants would endorse receiving mental health services as "being too embarrassing" or "being seen as weak" (Kim et al., 2011; Kim et al., 2010). Both instances pose significant issues for seeking and receiving mental health services in these communities. Due to perceptions of stigma, disconnect, and a lack of symptom normalization, there is potential to drastically increase suicidal ideation and suicide attempts in the military and veteran communities (Ahern et al., 2015; Kim et al., 2010; U.S. Department of Veterans Affairs, 2019).

The most significant factor in care seeking for veterans can be drawn between camaraderie and therapeutic bonding (Caddick et al., 2015). These two factors have been shown to reliably lead to positive treatment outcomes when the therapeutic bond is emphasized (Caddick et al., 2015; Taber et al., 2011). Therapeutic bonding is interchangeable with therapeutic rapport, described as overseeing the level of identification and understanding between the therapist and client (Caddick et al., 2015; Molnos, 1998). An effective therapeutic alliance contains the components of bond or rapport to increase the overall therapeutic work and can be strengthened through feelings of camaraderie (Caddick et al., 2015; Molnos, 1998).

Camaraderie refers to the possibility of confident collaborations and leads to an idealized relationship defined as "helpful collaboration as well as non-disagreement" (Bachelor, 2013, p. 119) between the therapist and client (Bachelor, 2013; Bordin, 1979).

Allowing for a true goodness of fit regarding therapist-client identity and personalities, as well as how a therapist meets the demands of the therapy, are imperative to the success of therapeutic joining through camaraderie (Bachelor, 2013; Bordin, 1979; Lavik et al., 2017; Taber et al., 2011). Although an alliance tends to trend upward in a positive direction, earlier therapeutic connection is crucial when considering ways to improve prevention efforts with veteran suicide, treatment participation, treatment compliance, and a willingness to engage in difficult exposure interventions (Hoffart et al., 2013; Joseph et al., 2014; Keller et al., 2010; McLaughlin et al., 2014; Michel et al., 2011).

Therapeutic bonds and camaraderie can be developed through self-disclosure, which is a powerful technique to promote an early-stage connection through similar identities. This allows the client to know their therapist is also a veteran, creating a feeling of understanding clients' experiences and increasing feelings of comfort in therapy (Cabral & Smith, 2011; Hinojosa & Hinojosa, 2011; Johnson et al., 2018). The camaraderie in therapy is directly related to increasing the bond alliance factor and allows for increasing the opportunities of therapeutic discussions in session (Bachelor, 2013; Catherall & Lane, 1992).

Normalization

Feelings of isolation are one of the many causes of anxiety, depression, and thoughts of suicide in military and veteran communities (Caddick et al., 2015; U.S. Department of Veterans Affairs, 2019). Caddick et al. (2015) stipulated one of the keys to altering the cognitive distortion resulting from prior military service is by normalizing cultural standards and the veteran's personal experiences of suffering. The suffering experienced by service members and veterans, deployed or not, needs to be legitimized

and normalized (Caddick et al., 2015; Coll et al., 2011). The notion that a service member or veteran seeking help might earn the perception as weak demonstrates the stigma associated with mental health care, and this further necessitates discussion by a therapist, unit leadership, and peers regarding this negative stance (Caddick et al., 2015; Coll et al., 2011; Pietrzak et al., 2009). Facilitating the discussion regarding suffering and normalizing these experiences can be difficult for a therapist who is not viewed as understanding of the unique military and veteran culture and has not personally experienced many of the same events (Coll et al., 2011; Hall, 2011; Johnson et al., 2018).

Disclosure

Disclosing a therapist's personal military experiences can normalize discussions around stigma and can be powerful in reducing therapeutic anxiety by showing similarities between the therapist and client (Botero et al., 2020; Caddick et al., 2015; Coll et al., 2011; Johnson et al., 2018). Research has shown therapists who connect successfully with clients through disclosure do so by emphasizing who they are as a person more than who they are as a professional (Lavik et al., 2017). The perception of similarity between therapist and client can be heightened by using targeted self-disclosures around previous military experience (Lavik et al., 2017; Levitt et al., 2016).

For a client to be willing to engage in exposure-based therapies, they must feel safe and understood by the therapist (Hoffart et al., 2013; Joseph et al., 2014; McLaughlin et al., 2014). Feelings of safety and understanding can be accomplished quickly through self-disclosure that signifies congruity of life experiences (military experiences), which subsequently increases therapy participation, task orientation, task completion, and an overall increase in therapeutic bonding (Joseph et al., 2014; Lavik et

al., 2017; Levitt et al., 2016). The feelings associated with safety and understanding are extraordinarily important when working to reduce posttraumatic stress symptom severity, lowering suicidal ideation and attempts, and ensuring a positive therapeutic image for future alliance building (Hoffart et al., 2013; Wiseman & Tishby, 2014).

Veteran-to-Veteran Alliance

Catherall and Lane (1992) conceptualized the veteran-to-veteran alliance, noting the therapist role as a *Warrior Therapist*. The warrior therapist combines the identity of a warrior (veteran) with the clinical expertise of a therapist, enabling for optimal treatment and alliance formation between the warrior therapist and the warrior client (Catherall & Lane, 1992). The idea of the warrior therapist has been explored in recent research (Botero et al., 2020; Johnson et al., 2018), which investigated how active duty service members and veterans generally preferred a veteran therapist over a nonveteran therapist when given a choice. Exploring similarities between the client and therapist may go beyond gender or ethnicity but instead extends to include life experiences, which have been shown to directly and positively impact an alliance and the subsequent treatment outcomes (Bachelor, 2013; Botero et al., 2020; Cabral & Smith, 2011; Johnson et al., 2018; Koo et al., 2016).

The basis of a veteran-to-veteran alliance can be further explored through peer-to-peer based interventions used during military deployment and civilian reintegration models (Caddick et al., 2015; Hinojosa & Hinojosa, 2011; Pfeiffer et al., 2012). The reintegration models are typical when service members return from deployment or transition to civilian life after their service (Caddick et al., 2015; Pfeiffer et al., 2012). As alluded to in *Band of Brothers*, the military as a family support system has a specific

power through camaraderie or what we, as therapists and mental health professionals, refer to as therapeutic bonding (Caddick et al., 2015). When working with service members or veterans in therapy, it is imperative they feel understood and can avoid reexplaining jargon or unique military circumstances. The shared vocabulary and sense of connection may alleviate some fractures in rapport and prevent and reductions of a therapeutic alliance (Caddick et al., 2015; Coll et al., 2011; Lavik et al., 2017).

Although many of the studies discuss peer-to-peer models, the models can better be examined through the conceptualization of a peer veteran therapists and peer veteran clients, decisively providing congruency of experiences and identifiable characteristics (Caddick et al., 2015; Coll et al., 2011; Hall, 2011). Creating the most influential alliance, specifically within the military and veteran community, can be done through sharing the unique experiences; Ahern et al. (2015) provided context for this through thematic analysis in their research regarding influential alliances. Many military veterans felt those they served with during their enlistment enabled them to have an innate connection between those who also served in the military, regardless of being in the same unit (Ahern et al., 2015). Using this connection allows extension to the alliance, expanding and enabling more robust connections within this demographic (Ahern et al., 2015). The concept of a shared story is further exemplified by Caddick et al. (2015) who discussed the common narrative of service as a way for veterans to align their identity with another in that group, building closer relationships and experiencing an empowering connection.

Therapist and Client Matching

Ensuring a secure foundation for positive therapeutic outcomes is essential to any successful practitioner of mental health (Cabral & Smith, 2011). When attempting to

successfully match a therapist and client, factors such as personality, experiences, and culture are reported as components that lead to successful matching and is generally preferred in all forms of therapy by clients (Cabral & Smith, 2011; Wiseman & Tishby, 2014). Social psychology accounts for the matching of a therapist and client through the concept of social identity theory (Cabral & Smith, 2011; Wiseman & Tishby, 2014). Social identity theory is the perception that those who are similar to an individual's assumed identity will be viewed as part of their schema or group and thus enable inclusion to their inner group with minimal resistance (Cabral & Smith, 2011). The social identity theory then can directly impact the alliance potential and positive treatment outcomes (Cabral & Smith, 2011; Wiseman & Tishby, 2014). Research has indicated therapists have emphasized the need for cultural congruence when accounting for the therapeutic alliance, specifically regarding interpersonal identification and how this promotes the formation of positive integrations between identities (Cabral & Smith, 2011; Catherall & Lane, 1992). Instead of viewing the therapist as a veteran and a therapist, an integrative personality forms the identity of the veteran therapist (Botero et al., 2020; Catherall & Lane, 1992). Combining these two distinct identities through the perception of a veteran client enables a profound foundation for the therapeutic alliance to form (Catherall & Lane, 1992).

Tying together therapist-client matching, cultural competency, and peer reconnection, a veteran therapist is able to establish, increase, and successfully use an innate therapeutic alliance with a veteran client (Ahern et al., 2015; Botero et al., 2020; Cabral & Smith, 2011; Caddick et al., 2015; Catherall & Lane, 1992; Johnson et al., 2018). When the client knows their therapist matches them at a core level regarding

similar experiences, personality, and cultural understanding, this will establish a more positive therapeutic alliance (Cabral & Smith, 2011; Johnson et al., 2018). The disclosure of the therapist as a veteran is likely to reduce stigma, normalize the veteran client experiences, and increase feelings of being understood (Johnson et al., 2018; Levitt et al., 2016; Pietrzak et al., 2009; Stecker et al., 2007).

In addition, the veteran therapeutic alliance can provide the opportunity to reduce stigma regarding mental health treatment and may also aid in the reduction of posttraumatic stress symptoms, suicidal ideation, and suicide attempts (Bryan et al., 2012; Kim et al., 2011; Levitt et al., 2016). Increasing rates of suicide for veterans establishes the need for further research and forming a clearer path toward suicide prevention and reduction (Ahern et al., 2015; Johnson et al., 2018). Providing the needed clarity and data to reduce the veteran suicide epidemic should be a top priority for therapists and larger service entities, and this can be accomplished through bolstering veteran-to-veteran care models (Hinojosa & Hinojosa, 2011; Johnson et al., 2018; Joseph et al., 2014; Koo et al., 2016; Taber et al., 2011). A strong therapeutic alliance is only one path to reducing veteran suicides; this may be achieved through a veteran therapist more than a civilian therapist based on current research findings (Ahern et al., 2015; Botero et al., 2020; Johnson et al., 2018).

Therapeutic Alliances and Treatment Outcomes

A strong therapeutic alliance has been shown to increase client participation and lead to more positive and lasting treatment outcomes (Bachelor, 2013; Joseph et al., 2014). The therapeutic alliance contributes to positive clinical outcomes to the same degree that evidence-based therapeutic approaches do, further reinforcing the need for not

only establishing the therapeutic alliance early but also finding ways to build it efficiently and positively (Lavik et al., 2017; Levitt et al., 2016; Taber et al., 2011). Poor client attachment can hamper the initial stages of therapeutic alliance creation and can be observed through inappropriate disclosures, personality differences, and a lack of military cultural competency (Dean, 2001; Hall, 2011; Levitt et al., 2016; Reger et al., 2008; Wiseman & Tishby, 2014). A civilian therapist may unintentionally hamper the alliance by attempting to relate with a veteran client through self-disclosures and contribute to further isolating the veteran or service member. However, disclosure by a veteran therapist would potentially aid in the perception of normalizing clients' experiences (Cabral & Smith, 2011; Caddick et al., 2015; Hall, 2011; Reger et al., 2008). Furthermore, the skepticism many veterans have toward civilian therapists is reinforced due to a variety of predicaments. The potential of being misunderstood, relevant past military experiences, and struggling to reveal how the veteran or service member truly feels due to a distrust of civilian therapist's lack of military experience are poignant examples of military and veteran skepticisms regarding health care (Caddick et al., 2015; Coll et al., 2011).

Impact on Treatment Outcomes by a Veteran Therapist

Research has shown veteran therapists have a direct positive impact on treatment outcomes with active duty military, National Guard service members, and veteran clients (Botero et al., 2020; Johnson et al., 2018). A study found both male and female veteran therapists are preferred over their civilian counterparts based upon a theoretical alliance questionnaire and a randomized therapist vignette (Houghton, 2018). The potential impact brought forth by the subtle details of military service by the provider can

drastically and positively impact treatment participation, goal setting, bonds, and the overall impact of treatment (Houghton, 2018; Johnson et al., 2018). Defining how the therapeutic role interacts with components of a therapeutic alliance is essential in establishing the efficacy of the role and improvement of veteran mental health care for future providers (Houghton, 2018; Johnson et al., 2018; Taber et al., 2011).

Therapists Understanding Veterans

Research has found a therapist who is unaware of the cultural experiences, settings, and general structure of the military may have difficulty in obtaining or maintaining a positive therapeutic alliance with veteran clients (Ahern et al., 2015; Hinojosa & Hinojosa, 2011; Johnson et al., 2018). A shared story of service enables a veteran therapist to have a distinct edge over other (civilian) therapists, as many of the themes of service are similar across military branches, and mutual understanding generally leads to a sense of increased understanding and well-being for the client (Ahern et al., 2015; Caddick et al., 2015; Hinojosa & Hinojosa, 2011; Lavik et al., 2017; Stecker et al., 2007). However, there is not enough research currently to conclude military service alone is a significant factor, or whether the gender of the therapist or client alters potential early alliance creation and establishing the congruency of personalities through therapist disclosure (Johnson et al., 2018; Pfeiffer et al., 2012; Taber et al., 2011). Reintegration for service members through the social identity theory can be implemented during deployment, civilian, and societal reintegration events through the facilitation of a veteran therapist who can better empathize with the service members and veterans they are serving (Caddick et al., 2015; Hinojosa & Hinojosa, 2011; Russell & Russell, 2018).

Lack of Resources

There are currently no resources that encourage or support military service members to enter careers in the mental health field. There are some programs such as enlisted to officer (Green to Gold), and general health provider scholarships in various services, but a specific focus on mental health professional training is missing (Moore & Reger, 2006). These programs currently tend to recruit civilians into a miniature military culture by teaching civilians' significant concepts and cultural norms of the armed forces through expedited training tracks (U.S. Army, 2019). The difficulty with current programs is they inherently imbue the therapist with authority over a service member, and the whim of a commanding officer of the service member's unit (Moore & Reger, 2006). When the therapist is at the beck of a higher ranking officer, such as the commander of a service member's unit, confidentiality practices can be breached leading to personal mental health information being disclosed (Moore & Reger, 2006).

Compounding the issue of seeking mental health care is the potential cultural disparity between an officer and the broader array of enlisted service members (Moore & Reger, 2006). Disparity in experiences a civilian-to-military therapist may encounter include a lack of basic training, advanced individual training, deployments, and other indoctrination experiences of the military (Moore & Reger, 2006; Reger et al., 2008). The lack of these experiences afforded to officer candidates through the typical commissioning route does not lead to an authentic and personal understanding of military culture, thus minimizing cultural competency and congruency of cultural experiences for providers (Moore & Reger, 2006). In addition, the resources provided by service organizations, although useful, do not provide empirical or measurable therapeutic

outcomes for mental health treatment regarding veterans (Russell & Russell, 2018). There is a need for resources to be reallocated toward programs that encourage prior service members to pursue degrees and licensure in psychology. The potential to improve the lack of military veterans in the psychology field, and enable more viable therapeutic alliances for severe symptoms, positive treatment outcomes, and reduction in veteran isolation and suicidal ideation, is feasible through investing in programmatic and scholarship opportunities for prior service members in the mental health field (Johnson et al., 2018; Moore & Reger, 2006).

Defeatist Culture and Stigma

Within the culture of the military and veteran communities, it becomes difficult to want, obtain, or maintain mental health care due to an array of perceived barriers (Kim et al., 2011; Moore & Reger, 2006; Pietrzak et al., 2009; Reger et al., 2008). Fostering a defeatist culture where mental health is seen as a crutch is an example of a significant barrier service members face (Kim et al., 2011; Kim et al., 2010). The defeatist culture is further exemplified through the disconnect service members and veterans face when they feel a therapist does not understand the experiences they discuss during sessions (Hinojosa & Hinojosa, 2011). However, this can be corrected using veteran therapists—ones who understand what the veteran client is experiencing and who can convey authentic empathy (Hinojosa & Hinojosa, 2011; Lavik et al., 2017). In contrast, the service member who is a psychologist and treating other service members can be portrayed as part of the command structure and thus increase feelings of stigma regarding the receipt of mental health care (Moore & Reger, 2006; Reger et al., 2008).

For this study, stigma is primarily associated with barriers to care such as perceptions of being weak, and feelings of not being understood despite seeking care (Caddick et al., 2015; Pietrzak et al., 2009). The perception or feeling of weakness lowers the quality of services due to a lack of client participation, and being perceived as an outcast by peers further explains the negative impacts of stigma (Kim et al., 2011). Stigma impacts both veterans and service members seeking care, obstructing them from attaining positive treatment outcomes, and increases the prevalence of psychiatric disorders (Kim et al., 2011; Pietrzak et al., 2009). Feelings of stigma are potentially increased by the lack of similarities with a civilian therapist and may be reduced by aligning with a veteran therapist who shares similar and unique experiences (Botero et al., 2020; Johnson et al., 2018; Levitt et al., 2016; Reger et al., 2008).

An innate understanding of what veteran clients' experience and feelings of camaraderie are likely to decrease feelings of stigma from obtaining mental health care (Kim et al., 2011; Levitt et al., 2016). In contrast, a civilian therapist may result in a veteran client reexperiencing similar stigmas they experienced during service (Kim et al., 2011). This may be exacerbated by symptoms of their trauma, potentially resulting in censored thoughts, attempts at emotional concealment, and poor therapy participation (Coll et al., 2011; Johnson et al., 2018; Joseph et al., 2014). Due to the various types of stigma (self-stigma, perceived stigma, enacted stigma), the creation of negative beliefs and attitudes regarding help seeking behaviors in the military and after military service, and a strong therapeutic alliance through client matching may serve as a protective factor (Blais et al., 2014; Blais et al., 2015).

Rationale for Increased Alliance Potential Research

There are significant concerns regarding the increase in veteran suicides that have been linked to the stigma associated with seeking mental health care, lack of effective reintegration practices, and a failure to innovate suicide reduction programs nationally (Ahern et al., 2015; Hinojosa & Hinojosa, 2011; Johnson et al., 2018; Pietrzak e al., 2009; U.S. Department of Veterans Affairs, 2019). Symptoms resulting from posttraumatic stress, moral injury, anxiety, substance use, and depression continue to increase within the veteran populace (Pietrzak et al., 2009; U.S. Department of Veterans Affairs, 2019). Although no single intervention has been found to be universally effective on symptom reduction, the impact of a therapeutic alliance has shown to be as equally effective as any manualized intervention (Joseph et al., 2014; Lavik et al., 2017; McLaughlin et al., 2014). Research has continued to show the therapeutic alliance can improve participation in treatment, positive treatment outcomes, and longer symptom reductions postintervention, which are all factors in the effective reduction of veteran suicides (Joseph et al., 2014; Keller et al., 2010; McLaughlin et al., 2014; Taber et al., 2011).

Currently, there is only one study that directly analyzed the relationship between a veteran therapist and a military client, but it did not evaluate for the gender of the therapist or client, nor separate veterans specifically, but only active service members (Johnson et al., 2018). Another limitation with the study is regarding the insufficient sample size, hampering an appropriate assessment of the impact of mental health care for service members and veterans (Johnson et al., 2018). By using the customized therapeutic alliance measure and multiple psychologist vignettes that control for gender and military

service, the current study will provide the necessary context to better understand the veteran-to-veteran therapeutic alliance. The importance of the findings of this study can help illuminate issues surrounding the reduction of veteran suicides and increase the use of mental health services by military service members and veterans. Limitations evident within this study are the theoretical scenarios that do not use actual therapy. However, based on the findings, the next steps would be to track the client and therapist alliance within real sessions. The findings should be analyzed in conjunction with the perceptions of stigma for seeking care, what may protect against this perception, and how to make barriers less prevalent in the military and veteran communities.

A new study sought to analyze ways in which the stigma of veteran mental health could be broken through, emphasizing a resource known as Vet Centers (Botero et al., 2020). The study centered around the community (health providers, business leaders, and various professionals) needing to understand the resources available for veterans, especially resources that work toward decreasing the mental health stigma that veterans experience (Botero et al., 2020). The study further discussed the implications of posttraumatic stress being defined as a "combat only" condition, which fails to be inclusive of moral injuries, sexual assault, natural disasters, and other traumatic events (Botero et al., 2020).

Three individuals from different war eras (Korean War, Vietnam War, Persian Gulf/Iraq War) provided feedback and insights to obtaining and engaging in mental health services with the Vet Centers to include stigmas and barriers they experienced (Botero et al., 2020). The statements these veterans provided credibility to how the Vet Center model can effectively increase mental health engagement, retention, and

therapeutic outcomes by incorporating the veteran therapist (Botero et al., 2020). Vet Centers work toward veterans treating veterans, which assist in client-therapist matching (Botero et al., 2020). The key takeaway from the study was that without establishing a course of action to reduce the concerns about stigma, there will likely be a continuing lack of positive therapeutic outcomes for veterans in mental health (Botero et al., 2020).

Research Questions and Hypotheses

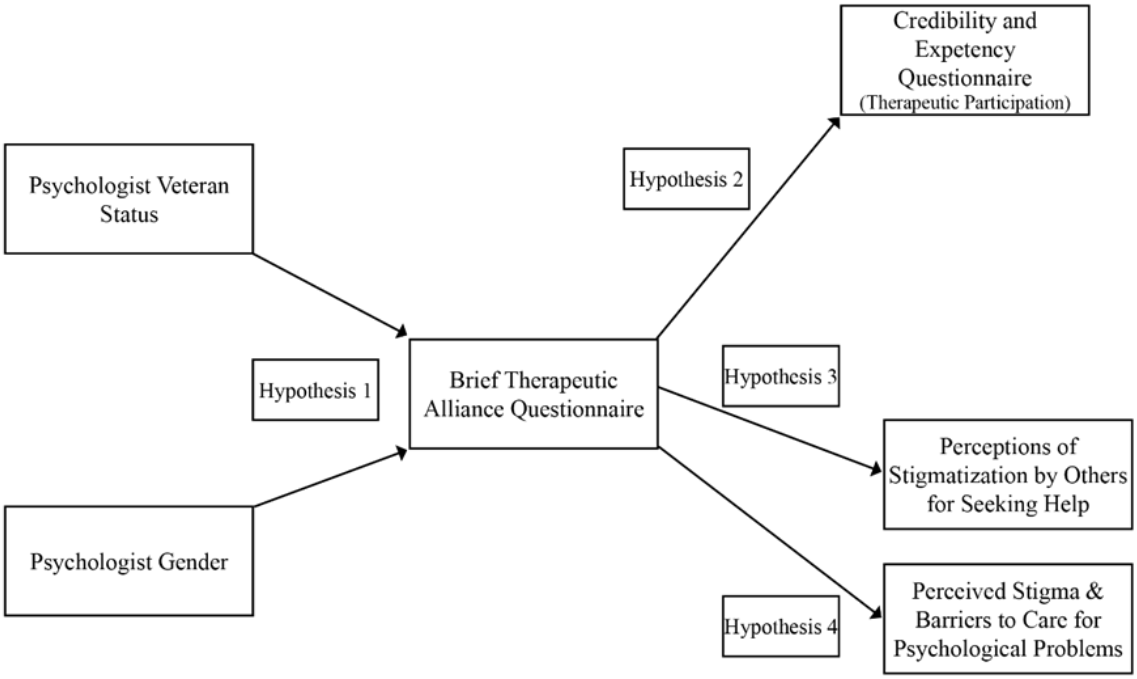
The need for increased mental health use is evident in the military and veteran communities. Due to a culture of stigma, career degradation, and barriers to care, military and veteran suicide rates continue to increase, and this is coupled by a significant underutilization of mental health resources (U.S. Department of Veterans Affairs, 2019). The purpose of this study was to evaluate potential therapeutic alliance between a veteran psychologist and military or veteran client and what factors may moderate this relationship. Research has shown congruency between persons increases early therapeutic alliances being built and thus increases the potential for therapeutic participation and positive treatment outcomes (Bachelor, 2013; Bordin, 1979; Catherall & Lane, 1992; Stecker et al., 2007). The lack of current research to explore these alliance factors continues to impact the veteran and military communities, leading to ineffective implementation of resources and mental health administrative hiring.

This study is hypothesized to show significant effects of the perceived potential therapeutic alliance by veteran clients toward the male and female veteran therapists compared to the male and female civilian psychologists. It is also hypothesized that an increased perception of the alliance will increase potential therapy participation. Furthermore, it is hypothesized that perceptions of stigma and barriers to care will be

reduced through the veteran-to-veteran therapeutic alliance. The model of the hypotheses is depicted in Figure 1.

Figure 1

Therapeutic Alliance Impacts on Treatment, Stigma, and Barriers



Chapter 2

Research Design

The research design for this study used quantitative survey methodology. Determining the relationship between a potential psychologist when controlling for gender and veteran status, and how this could impact the perceived therapeutic alliance and subsequently the treatment participation, stigma, and barriers to care. Correlations were employed to analyze the relationship between the psychologist profile, level of perceived therapeutic alliance, and the positive and negative impacts on perceived stigmatization, perceived barriers to care, and perceived treatment participation. A path analysis also analyzed the interconnectivity of these measures and how the perceived therapeutic alliance moderated the effects of the outcome measurements.

Participants

Participation in this study was reserved for service members and military veterans, specifically those of the modern era of combat operations. Modern combat operations were defined as The Gulf War and Global War on Terrorism, which began in August of 1990, and persist to present day through various operations such as Operation Enduring Freedom. Participants identified which combat operation, if any, they deployed in support of during the demographic survey questionnaire. Participants were accepted from all age ranges within the federal guidelines for active duty service, or federally activated service (National Guard and Reserves). Sexuality, religion, socioeconomic status, and marital status were not requested and were not part of the inclusion criteria for participants in the survey.

Participants were recruited through convenience and snowball sampling via social media. Participants initially were recruited through military and veteran Facebook groups such as Husky Veterans: Past, Current, and Future, PNW Vets, William C. Stacey American Legion Post 206, The American Legion Department of Washington, Ballard Eagleson VFW Post 3063, We Are The Mighty, Disgruntled Veterans, The Mission Continues, and then through peer referral of survey participants. All survey responses will remain anonymous, and there was no use of deception in the study.

There was an open window of participant recruitment and response gathering from January 18, 2020, through March 15, 2020. The minimum participant recruitment for the data to be viable was 104 based upon a power analysis. The sample of participants were not discriminated against other than through the inclusion criteria of military service, consent to the survey, and completion of the survey. No compensation for participation or completion of the survey was offered. Participants who did not complete the survey in its entirety were excluded from the dataset.

The online survey was completed by 163 individuals. Of the respondents, over half were female (51%) and the remainder were male (49%). Most participants identified their service with the U.S. Army (49.7%), 19.6% identified the U.S. Navy, 16% U.S. Marine Corps, 9.8% U.S. Air Force, and 4.9% with the U.S. Coast Guard. At the time of this survey, the U.S. Space Force did not have any possible veterans due to its formation in December of 2019 and no active recruitment until April of 2020. Participants ranged in age from 23 to 60, with a mean age of 38.63 (SD = 8.93); however, age was approximated as only the year of birth was gathered from the survey to protect participant anonymity. The level of education participants indicated showed those with a bachelor's

degree was most common (33.1%), followed by associate degrees (24.5%), master's or other graduate degrees (21.5%), high school diploma/GED (17.8%), and doctorate degrees (3.1%).

Of the sample, respondents indicated their service in various operations, which were combined to indicate service in either Iraq, Afghanistan, the Persian Gulf, unlisted conflicts, or a combination thereof. Most respondents served in both Iraq and Afghanistan (26.4%), followed by Afghanistan only (25.2%), Iraq only (21.5%), nonlisted conflicts (12.3%), the Persian Gulf only (8%), the Persian Gulf, Iraq, and Afghanistan (4.9%), and the Persian Gulf and Iraq (1.8%). Respondents were assigned at roughly the same rate to 1 of the 4 psychologist profiles (male veteran, female veteran, male civilian, and female civilian; see Appendix A and B) through blind random assignment. Of the participants, 27% were assigned to the female civilian profile, 25.2% to male civilian profile, and 23.9% to both the male veteran and female veteran profiles.

Measures

Demographic Questionnaire

The demographic questionnaire (see Appendix C) for this study asked if participants had been discharged after completing in entry-level training and/or advanced level training. The questionnaire then asked what year they were born to establish an approximate age, branch of service, gender, participation in a modern conflict (the Persian Gulf, Afghanistan, and Iraq Wars), and if they had deployed in support of any operations (e.g., Operation Iraqi Freedom, Operation Enduring Freedom).

Therapeutic Alliance

The Brief Therapeutic Alliance Questionnaire (B-TAQ; see Appendix D) was developed based on the assessment items of the two versions of the Helping Alliance questionnaire (HAq-I and HAq-II), the Dutch Outcome Rating Scale (ORS), and the Session Rating Scale (SRS; Hendriksen et al., 2010; Janse et al., 2014; Luborsky et al., 1996). The B-TAQ was validated through statistical reliability analysis utilizing SPSS (see Table 1). The assessment measure had an overall α of .805. Based on standardized items of the measure, its rated α is .810. An alpha rated at this level is considered to have good internal consistency.

A principal component analysis (PCA) validated pilot study data regarding the B-TAQ. Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy yielded a result of .861 (see Figure 2). A component plot in rotated space showed 6 of the 7 measures were found to measure the same intended construct, with the reverse coded question acting as an outlier. The reverse coded question "The therapist relates to me in ways that may slow up the progress of the therapy" was altered to "The way the therapist relates to me could be a barrier in my treatment" to increase readability and measure consistency in this current study.

The seven scales of the B-TAQ included dependability, similarity, liking, barrier (previously slowing-up), relationship, experienced, and working-out. All questions in the B-TAQ were answered through a Likert scale with a rating of 1 (*strongly disagree*) and 6 (*strongly agree*). The overall score for each B-TAQ measure was combined and analyzed through mean response scores by therapist type and overall effects. The scales all measured different areas of the therapeutic alliance, as defined by Bordin (1979) and

through session feedback measures (Luborsky et al., 1996). The measures variables are meant to interact with the therapist type and result in an increase (positive) or decrease (negative) in potential alliances for survey participants. The variables of the B-TAQ were intercorrelated very well on initial testing, but altering the wording for the slowing-up question was intended to increase the utility of the measure significantly (Houghton, 2018). This change was implemented in the new iteration of the B-TAQ in the current study and was expected to increase the reliability of the measure.

Dependability was designed to measure if the client perceived the assigned therapist as being emotionally dependable in therapy. Similarity was designed to measure how a veteran perceived the assigned therapist regarding similarity of personality, experiences, and identity. Liking was designed to measure the level participants liked what they knew about the assigned therapist based upon the profile vignette. Barrier was the reverse coded question, which was designed to measure if participants perceived the assigned therapist profile as potentially hindering their mental health care. Relationship explicitly asked the veteran to evaluate the potential relationship they felt would be possible with the assigned therapist profile. Experienced was designed to measure the perception of the assigned therapist profile being experienced in treating others like them and whether they have the skill set to succeed in therapy. Lastly, working-out was designed to measure the perception of a participant wanting to work out any current symptoms with the assigned therapist profile based upon their perception of them.

Perceptions of Stigmatization

The Perceptions of Stigmatization by Others for Seeking Help (PSOSH; Blais & Renshaw, 2013; Blais et al., 2014; Vogel et al., 2009; see Appendix E) was modified to

measure the anticipated stigma from military and veteran sources for the population in the survey. The instructions had been altered to be generalized for the military and veteran communities, as unit leadership may not have been present any longer, but fragments of the stigma may still have been active (Blais & Renshaw, 2013; Blais et al., 2014). A sample item includes, "To what degree do you believe that others would react negatively to you?" (Blais et al., 2014). The PSOSH is based on a 5-point Likert scale rated from 1 (*not at all*) to 5 (*a great deal*; Andersen & Blais, 2019; Blais et al., 2014). There is a total scale score created, which ranges from 5-25, with lower scores indicating fewer perceptions or anticipation of stigma, and higher scores indicating greater perceptions or anticipation of stigma (Andersen & Blais, 2019). The scale has good validity and internal reliability (Cronbach's α of .78 to .91), as analyzed by Vogel et al. (2009).

Perceived Stigma and Barriers to Care

The Perceived Stigma and Barriers to Care (PSBC; Britt, 2000; Britt et al., 2008; see Appendix F) is an 11-item assessment using a 5-point Likert scale between 1 (*strongly disagree*) and 5 (*strongly agree*). Six of the 11 items were designed to assess perceived stigma, and the remaining five items were designed to assess the perceived barriers to care (Britt et al., 2008). In this iteration of the assessment, it was molded to the military (soldiers) and used some of the barriers to care Hoge et al. (2004) noted as being prevalent in most combat veterans of the Iraq and Afghanistan wars. The validity component of the perceived stigma scale has a Cronbach's α of .82 and the barriers to care scale has a Cronbach's α of .70 (Britt et al., 2008). This measure was intended to assist in defining any moderating variables regarding care seeking, stigma, self-

stigmatization, and how these stigmas and barriers interacted with the perception of a therapeutic alliance and the assigned therapist during the survey.

Credibility and Expectancy Questionnaire

The Credibility and Expectancy Questionnaire (CEQ; Borkovec & Nau, 1972; Devilly & Borkovec, 2000; see Appendix G) is a 6-item self-report assessment that measures the credibility toward treatment and the expectancy of a client for therapeutic improvement. The first four items of the questionnaire were rated on appraisal, whereas the last two items were rated on the feeling toward and about the therapy (Newman & Fisher, 2010). The items used a mix scale of measurement with Question 1, 2, 3, and 5 using an 8-point Likert scale between 1 (*not at all confident/logical/useful*) and 8 (*very confident/logical/useful*); other questions are based on a 10% rating schedule from 0%-100% regarding perceived improvement (Newman & Fisher, 2010). The items were standardized for analysis due to the ratings being on different scales and then averaged to form the expectancy and credibility factor (Devilly & Borkovec, 2000; Newman & Fisher, 2010). The CEQ has an internal consistency with a standardized α between .79 and .90 for the expectancy factor, an α between .81 and .86 for the credibility factor, and an α between .84 and .85 for the overall scale (Devilly & Borkovec, 2000; Newman & Fisher, 2010). Measures from this assessment were expected to reveal the perception of a credible therapist and treatment, and the expectancy toward therapy being positively impacted by a stronger alliance.

Analysis

A path analysis was used to analyze positive and negative therapeutic alliances toward the therapist type associated with military service in comparison to the civilian

counterparts. The therapist type was intended to act as a moderator through gender (Group 1) and military service (Group 2). The dependent variable of alliance was evaluated using the B-TAQ variables (dependability, similarity, liking, barrier, relationship, experienced, and working-out). Therapist type (male/female civilian and male/female veteran) were evaluated as the independent variable that the BTAQ measure, which contained the seven dependent variables and subsequently the BTAQ would impact the CEQ, PSOSH, and PSBC.

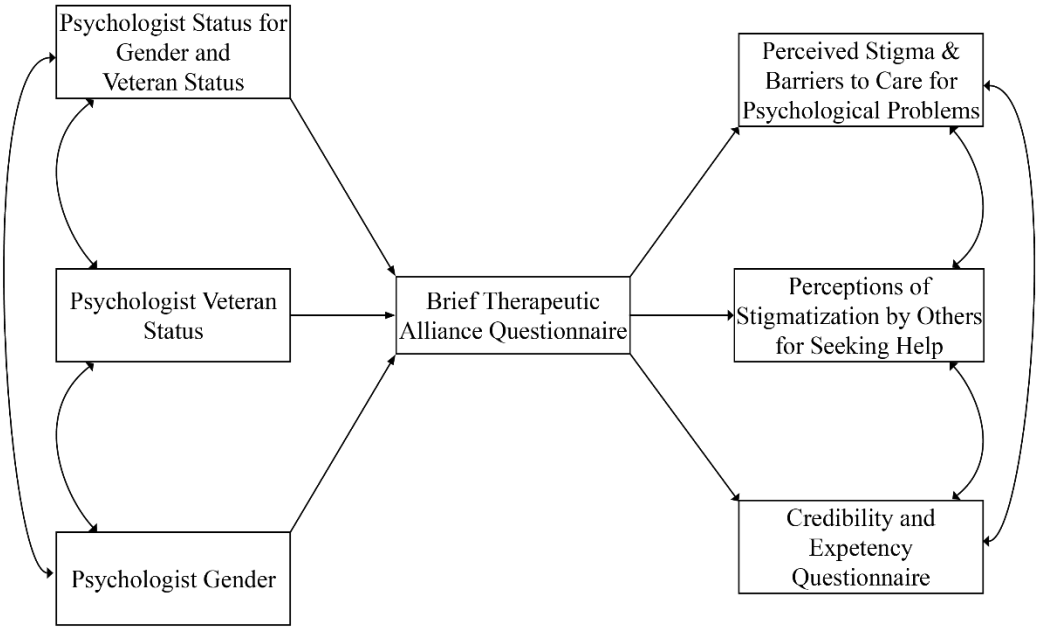
In this path analysis model, it was hypothesized that the veteran therapist profiles would increase the overall B-TAQ measure. Gender was also hypothesized, in context of the therapist profile, to moderate the relationship based on prior study data showing a higher perceived alliance with the female veteran profile, followed by the male veteran, male civilian, and lastly the female civilian, but this may alter with a larger sample size (Houghton, 2018). Furthermore, it was also hypothesized that an increased perception of the alliance (B-TAQ) would increase potential therapeutic participation due to credibility and expectancy (CEQ) for more positive therapeutic outcomes. It was also hypothesized that a positive scale score of the B-TAQ would reduce the perceptions of stigmatization (PSOSH). Lastly, it was hypothesized that a positive scale score of the B-TAQ would reduce the perceptions of barriers to care (PSBC).

A multiple regression was used in this study to analyze respondent data. After controlling for therapist type, the therapeutic alliance was then evaluated as a moderator for reducing perceptions of stigma and barriers to care and improving potential treatment participation. Therapeutic alliance was measured through the B-TAQ, perceptions of stigma by the PSOSH, barriers to care by the PSBC, and potential treatment participation

and credibility of treatment by the CEQ. The hypothesized moderation model is depicted in Figure 3.

Figure 3

Path Analysis Model – The Therapeutic Alliances Impact on Treatment Participation, Barriers to Care, and Perceived Stigmas



In this model, it was hypothesized that the perception of a positive therapeutic alliance would occur after controlling for the therapist type, thus decreasing stigma perception, barriers to care, and increasing treatment expectancy. Finally, it was predicted the moderation analysis and path analysis would support the relationship of the therapeutic alliance impacting the overall outcomes and how certain therapist types are more beneficial, negative, or neutral. Specifically, the higher the perception of a therapeutic alliance would indicate more positive feelings toward the reduction of stigma and barriers to care and increasing treatment expectations and participation.

Procedures

Organizations, groups, and points of contact used in the initial pilot study were again implemented in the current study. All groups are associated with current or prior military service members of varying ages, gender, cultures, and socioeconomic backgrounds. Following the approval by the Institutional Review Board (IRB) of Northwest University on January 17, 2020, the organizations, groups, and point of contacts were given the survey link and a brief description of the study purpose and how to participate. The survey was conducted through Qualtrics, and participants were required to click the survey link to participate. The survey was anonymous in its entirety with no use of deception nor monetary value offered to participants. Data were stored on a multifactor encryption login for Qualtrics and a password-protected Microsoft Excel sheet and IBM SPSS data sheet. This is intended to reduce any potential data contamination or sensitive data loss. The data collection phase of this study was between January 18, 2020, and March 15, 2020.

The survey began with a consent form describing the study (see Appendix H). Information regarding points of contact within the studies administration were listed and required potential participants to agree to the consent form to move forward in the survey. If they did not consent to the survey, they were terminated from the survey at that time by clicking “I do not consent” at the bottom of the form. A demographic questionnaire consisting of seven questions was administered next, asking if they had been discharged from the U.S. Armed Forces, year of birth, the branch of service, gender, highest level of education, modern conflict era of service, and what operation (if any) did they deploy in support of while in the military.

Participant were then assigned by blind random assignment to 1 of the 4 therapist profiles: male veteran, female veteran, male civilian, or female civilian. Upon assignment in Qualtrics of the therapist profile, they were asked to carefully read the profile and answer the subsequent questionnaires in the survey. Administration of the B-TAQ, PSOSH, PSBC, and CEQ were then conducted in this order. The demographic and measures information consisted of a total of 36 questions on the Qualtrics survey. Participants completed the entirety of the survey, on average, in 8 minutes.

Once the final data set was obtained from Qualtrics, a path analysis, multivariate analysis of variance, one-way multivariate analysis of variance, hierarchical multiple regressions, and pairwise comparison were used to analyze the data. The analyses provided interpretive data regarding the perceived therapeutic alliance by participants toward assigned therapists, and the effect size of the therapist type on the B-TAQ scaled score. Furthermore, the analyses also aided in evaluating the effect of stigma perceptions, perceived barriers to care, and the credibility and expectancy of the participant based upon the therapist type and perceived therapeutic alliance. IBM SPSS Statistics 25 and RStudio were used to perform the statistical analyses of the data set.

Power Analysis

A power analysis was conducted to estimate the required sample size to produce a significant effect size. Assuming an effect size of 0.07, a significance level of $\alpha = .05$ and a statistical power level of .95, with four groups, seven predictors, and nine response variables, a minimum of 104 participants were required.

Analytic Strategy – Path Analysis

A path analysis was used to analyze the data (Rosseel, 2011). The path analysis analyzed the relationship of the assigned therapist profile and how that impacted perceptions of the therapeutic alliance. The subsequent score associated toward the alliance was then used to analyze the directed dependencies among the outcome variables of perceptions of stigma, treatment participation, and perceived barriers to care. This analysis was then used to determine relationships between all variables and how that may be impacted by the independent variables.

Chapter 3

Chapter 3 presents the data collected to examine how military veterans perceived a potential alliance with a therapist and how that potential alliance impacts the relationships between perceived stigmatization, barriers to care, and treatment participation. The primary functions of the therapist were their biological sex (male or female) and their veteran status (veteran or civilian) and what impact this may have on the overall therapeutic alliance and subsequent outcome measures.

Descriptive Statistics

Data were collected from 163 veterans of the Persian Gulf, Afghanistan, and Iraq war periods. Incomplete participant surveys were excluded from analysis. The entirety of the surveys collected were both completed fully and then reviewed for coding errors regarding score entries, of which none were noted. The responses to the CEQ measure two different scales that were *z* scored during the data analysis and derived an overall mean to use in the path analysis. No other measures were required to be *z* scored or altered in data analysis.

The B-TAQ measure was not impacted by either the gender or the military status of any therapist profile throughout the survey. A total of 39 individuals were assigned to the female veteran profile ($M = 4.38$, $SD = .84$) as well as the male veteran profile ($M = 4.59$, $SD = .85$). A total of 41 individuals were assigned to the male civilian profile ($M = 4.16$, $SD = .71$), and a total of 44 participants were assigned to the female civilian profile ($M = 4.29$, $SD = .67$). Means and standard deviations for each variable used in the study are presented in Table 2. Again, it is noted that the CEQ required the data to be *z* scored to find an overall mean, and this is noted in the table. All descriptive statistics met the

assumptions of normality. The bivariate correlations between variables are presented in Table 3 signifying the significance of the variables being intercorrelated as measures on the overall survey.

Table 2

Descriptive Statistics

Variable	*M*	*SD*
CEQ	.00 (*Mdn* = -.003)	.802
PSOSH	2.48	.890
PSBC	2.76	.793
B-TAQ	4.35	.776

Note. CEQ = Credibility and Expectancy Questionnaire; PSOSH = Perceptions of Stigmatization by Others for Seeking Help; PSBC = Perceived Stigma and Barriers to Care; B-TAQ = Brief Therapeutic Alliance Questionnaire.

Table 3

Correlations

Variable	PSOSH	PSBC	CEQ
B-TAQ	-.190*	-.176*	.652**
PSOSH	--	.329**	-.218**
PSBC	--	--	-.234**

Note. ** Correlation is significant at the 0.01 level (2-tailed). *Correlation is significant at the 0.05 level (2-tailed).

A path analysis was conducted to investigate the hypothesized model as presented in Figure 1. Gender did not interact with the overall therapeutic alliance in a significant way, η_p^2 (.001), $F(1, 163) = .10$, $p = .75$. Veteran status also did not interact with the

overall therapeutic alliance in a significant way, η_p^2 (.028), $F(1,163) = 4.63$, $p = .03$. Gender and Veteran status when combined did not interact with the overall therapeutic alliance in a significant way, η_p^2 (.012), $F(1, 163) = 1.92$, $p = .17$.

Inferential Statistics

The inferential statistics and covariates are presented in Tables 4 and 5, respectively.

Table 4

Inferential Statistics

Variable	Estimate	*SE*	*z*	*p*	Std. All
B-TAQ (Gender)	-0.128	0.165	-0.780	0.435	-0.083
B-TAQ (Veteran)	0.092	0.167	0.554	0.50	0.060
B-TAQ (Gender & Veteran)	0.334	0.238	1.402	0.161	0.184
CEQ ~ B-TAQ	0.673	0.061	10.967	0.000	0.652
PSOSH ~ B-TAQ	-0.217	0.088	-2.465	0.014	-0.190
PSBC ~ B-TAQ	-0.180	0.079	-2.283	0.022	-0.176

Table 5

Covariances

Variable	Estimate	*SE*	*z*	*p*	Std. All
CEQ ~ PSOSH)	-0.037	0.042	-1.611	0.107	-0.127
CEQ ~ PSBC	-0.075	0.037	-2.010	0.044	-0.159
PSOSH ~ PSBC	0.208	0.056	3.736	0.000	0.306

Note. Covariance is the amount of shared variance between measurements.

The overall covariate adjustments for the B-TAQ are illustrated in Figure 4.

Results

The hypothesis analysis and interactions are depicted in Figure 5 and described in the following sections.

Hypothesis 1 – Therapist Impact

The path analysis for the first hypothesis measured how the B-TAQ was impacted by the gender of the therapist, military status, or a combination. The analysis indicated neither gender, veteran status, nor a combination had a significant impact on the alliance.

Hypothesis 2 – Alliance Impact on Credibility and Expectancy

The path analysis for the second hypothesis measured how the B-TAQ measure, when scored higher, would positively impact the CEQ measure. The analysis indicated there was a significant impact on the CEQ when the B-TAQ was rated higher.

Hypothesis 3 – Alliance Impact on Stigma

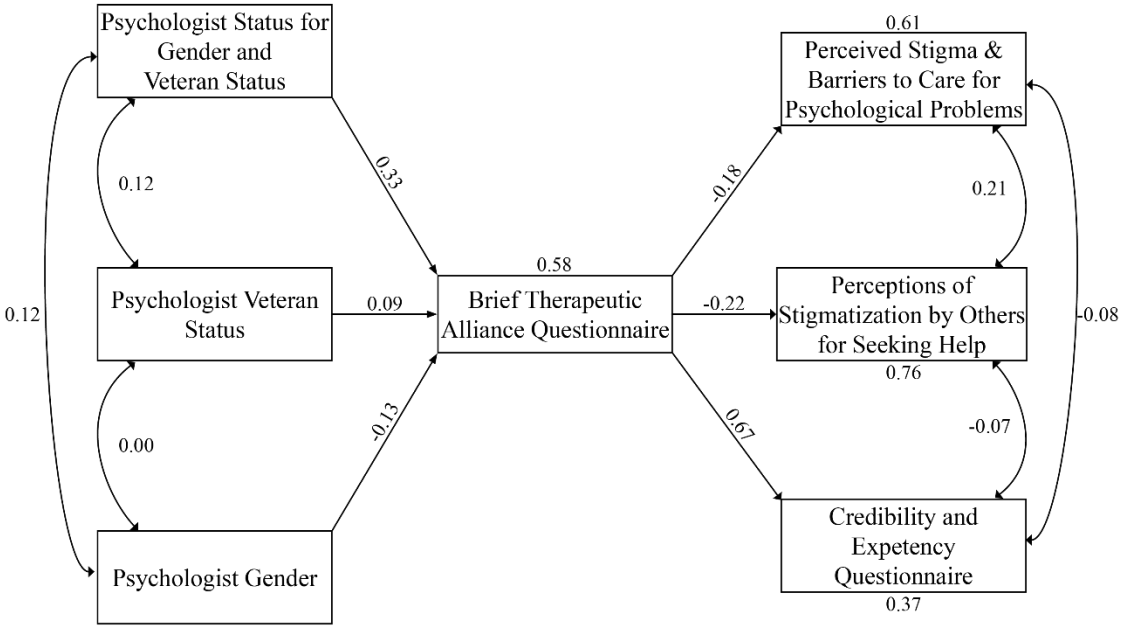
The path analysis for the third hypothesis measured how the B-TAQ measure, when scored higher, would reduce the impact of the PSOSH measure. The analysis indicated there was a significant impact on the PSOSH when the B-TAQ was rated higher.

Hypothesis 4 – Alliance Impact on Barriers to Care

The path analysis for the fourth hypothesis measured how the B-TAQ measure, when scored higher, would reduce the impact of the PSBC measure. The analysis indicated there was a significant impact on the PSBC when the B-TAQ was rated higher.

Figure 5

Path Analysis of the Therapeutic Alliances Impact on Measures



Chapter 4

The primary goals of this study were to evaluate the relationship between the military background of a potential therapist and the perceived therapeutic alliance, and how this would influence treatment participation, perceptions of stigmatization, and perceptions of barriers to care. This study is the only study that this research is aware of that is examining the influence of an alliance between veteran therapist and veteran clients, and further specifying increases and decreases to the variables of treatment. The findings of this study partially support the hypotheses and previous findings of existing literature.

The hypothesis that a therapist profile that contained subtle indications of prior military service, regardless of gender, would indicate a positive impact toward participants' perception of an alliance was shown not to be supported. However, the hypotheses that predicted a higher perception of a therapeutic alliance would increase treatment participation, decrease perceptions of stigma, and decrease perceptions of barriers to care were supported. Overall, findings of this study suggest participants' perceptions of an alliance were the most significant factors in increasing their potential participation in treatment and reducing feelings of stigma and barriers to care, regardless of the gender or military background of their assigned therapist.

Discussion

The first hypothesis of the study was disconfirmed, and this result was inconsistent with previous research (Botero et al., 2020; Johnson et al., 2018). The gender nor veteran status of the therapist appeared to have an impact on the perception of a therapeutic alliance. The second, third, and fourth hypotheses were supported by findings

of the study. The hypotheses investigated if an increase of the perception of a positive therapeutic alliance (B-TAQ) would increase treatment participation (CEQ), decrease perceptions of stigma (PSOSH), and decrease perceived barriers to care (PSBC). Prior research does support that a higher therapeutic alliance would result in increased treatment participation and care-seeking behaviors (Johnson et al., 2018; Kim et al., 2011), decreased perceptions of stigma (Blais & Renshaw, 2014; Blais et al., 2014; Johnson et al., 2018; Pietrzak et al., 2009), and decreased perceived barriers to care (Britt et al., 2008; Hoge et al., 2004; Johnson et al., 2018; Pietrzak et al., 2009), thus supporting the creation of a treatment model that better controls for these variables.

Therapist Type and Therapeutic Alliance Impacts

Perceptions of the therapeutic alliance were not found to be significantly impacted by either the gender, veteran status, or a combination of these two variables, thus not supporting the first hypothesis of this study. This finding may imply the relationship for veterans to their therapist may not be accurate in hypothetical situations and require more direct and in-person analysis regarding gender and veteran status. A more robust sample could potentially alter the impact veteran status and therapist gender has upon participants as well. Additionally, it is possible participants in the study may explicitly have not wanted a veteran therapist and would prefer a civilian therapist. This finding is contradicted by previous research indicating veteran status was statistically significant when matching a therapist and veteran client (Botero et al., 2020; Houghton, 2018; Johnson et al., 2018). However, in the Johnson et al. (2018) study, there was a specific question that queried, “I would prefer a psychologist who is a veteran,” whereas this present study was intentionally subtle in defining a therapist as a veteran or civilian.

Although there was a significant attempt by this study to not overtly indicate a therapist was a veteran or civilian, the study did not attempt to assess in an explicit measure whether veteran participants felt misunderstood by civilian providers (Ahern et al., 2015) or if they preferred a therapist who was a veteran (Johnson et al., 2018). These specific questions may have had the ability to influence participants' responses and suggest questions being asked directly instead of passively may yield more appropriate results (Johnson et al., 2018).

Therapeutic Alliance and Treatment Participation

Treatment participation was measured through the CEQ and was positively impacted by a higher perceived therapeutic alliance as measured by the BTAQ. These findings supported the second hypothesis of the study and conform to previous findings in research based upon increased treatment participation for veterans (Ahern et al., 2015; Botero et al., 2020; Johnson et al., 2018). Although there has been a variety of studies that evaluated for credibility and participation in treatment, the most recent study was conducted in 2000 and included 126 participants of which 68 were male Vietnam veterans and 58 female spouses, and consequentially did not specifically evaluate for current veteran perceptions (Devilly & Borkovec, 2000). Based on the present study, the credibility and expectancy variable, as a whole measure, was positively impacted by the perception of a positive therapeutic alliance, again, supporting the second hypothesis of this study. Although Devilly and Borkovec (2000) found credibility was unrelated to treatment outcomes, but rather that expectancy of treatment was more impactful as a predictor, this is in partial contrast to the current study's findings.

One confounding variable present is certain questions asked in the CEQ measure are more oriented toward actual therapeutic sessions and typically are offered as a post-session measurement (Devilly & Borkovec, 2000). This measure would be more accurately evaluated through future research in actual therapy sessions as recommendations of treatment to a peer are not as easily conceptualized in a theoretical survey, such as this study used.

Therapeutic Alliance and Perceived Stigmatization

Findings in this study supported the third hypothesis, indicating there was a significant relationship between a higher perceived therapeutic alliance and subsequent reduction of the perceptions of stigma by veteran participants. This finding is supported by prior research indicating higher perceptions of stigma, whether imposed by oneself or by peers, would lead to less help-seeking behaviors (Blais & Renshaw; 2013; Blais et al., 2014; Johnson et al., 2018). Johnson et al. (2018) did not directly assess for self-stigmatization due to the potential distress that could be invoked onto participants, and this study found it necessary to evaluate for stigma through the PSBC and PSOSH specifically due to the crucial missing component of stigma measures and barriers to care in prior research. The importance of reducing stigma through any means, especially through perceived therapeutic alliances, has been researched significantly in active duty, National Guard, and veteran populations (Hoge et al., 2004; Kim et al., 2010; Kim et al., 2011).

These findings in conjunction with previous research further indicate the importance of reducing stigma and how stigma, whether self-imposed or experienced by exterior sources, is a primary barrier to accessing effective mental health care (Kim et al.,

2011). Although stigma is typically measured in-session or post-session, it is important to create a model that effectively considers ways to improve care seeking behaviors, which stigma is directly in opposition to (Hoge et al., 2014; Kim et al., 2011). This is further emphasized by the transitional period that military service members are exposed to in both returning from deployments and exiting the military (Ahern et al., 2015). Typically, service members and veterans have reported the difficulty of transition due to the stigma of unit leadership, peers, family, and the perceptions that their mental well-being is not of importance and the admission of seeking care is typically met with negative actions (Ahern et al., 2015; Hoge et al., 2014; Kim et al., 2011).

Therapeutic Alliance and Barriers to Care

This study sought to evaluate if a higher level of a perceived therapeutic alliance would result in a lower perception of barriers to care. Findings of the study supported the fourth hypothesis and confirmed there was a significant reduction in perceptions of barriers to care based upon a higher therapeutic alliance by participants. This finding is further supported by prior research indicating a veteran therapist may aid in the reduction of perceptions of barriers to treatment, increase more help-seeking behaviors, and reduce enacted stigma for service members and veterans (Johnson et al., 2018; Kim et al., 2011; Pietrzak et al., 2009). Although the original hypothesis attempted to evaluate the reduction in negative factors of therapy would be further reduced by the presence of a veteran therapist; this portion of the overall hypothesis was not supported by the study's findings.

Although Johnson et al. (2018) found barriers were reduced by explicitly asking if participants would prefer a psychologist that is a veteran, this study did not use a similar

measure or question. A key finding of this study as well as Johnson et al.'s (2018) is reducing barriers to care is directly correlated with the perception of a stronger alliance. This result assist in reinforcing the need for a more collaborative and favorable engagement opportunity for veterans seeking mental health, especially as it pertains to creating a positive treatment environment and treatment outcomes (Ahern et al., 2015; Hoge et al., 2004; Johnson et al., 2018).

Limitations

The present study has a variety of limitations that should be addressed prior to future research taking place. The lack of any in-person therapy sessions likely impacted the potential strength or weakness of perceived therapeutic alliances by participants. Indications of an individual's military background or lack thereof can be more appropriately measured through in-session alliance measures as well as post-session alliance measures when compared to hypothetical vignettes. Veterans could be asked whether they knew their therapist was a veteran or civilian, and whether that influenced their effort in therapy, feelings of stigma regarding mental health, and any perceptions of barriers to receiving mental health care.

An additional limitation was no data were collected on participants socioeconomic status, ethnicity, or sexuality. This could lead to better insights regarding the impact of whether a therapist was matched well with the client outside of their status as a veteran or civilian. This would conform with prior research that did evaluate for therapist-client matching based upon similar demographics as well as qualitative studies investigating veteran engagement in therapy with a veteran therapist (Botero et al., 2020; Cabral & Smith, 2011).

Lastly, a significant limitation is the potential lack of attention to the therapist profile participants were given. Although the profiles were intended to be brief, it is possible participants skimmed the profile or entirely moved past it without reading it. The subtle nature of the therapist profile when indicating their status as a civilian or veteran could easily be overlooked and could have impacted participants' responses. Additionally, it is possible veterans who participated in this study explicitly did not want a therapist who was a veteran and would prefer a civilian therapist instead.

Future Directions

Although there have been a variety of other studies that attempted to examine the relationship between veteran clients and veteran therapists, there has not been any study that has used actual in-session measures or post-session measures (Botero et al., 2020; Johnson et al., 2018). Continuing to improve the method of data gathering to include collaboration with veteran treatment entities is the most appropriate direction to lead research toward. Collaboration with Vet Centers, Veterans Affairs health systems, and state funded veteran treatment facilities would enable more accurate and objective data to be gathered through in-session and post-session measures with veteran clients.

Additional factors should also be included within future research regarding demographic information. Demographic factors that should be gathered include socioeconomic status, ethnicity, marital status, type of trauma experienced, and the branch of the therapist. Defining the therapeutic alliance in consideration of the clients being specifically veterans could also aid in improving measures such as the B-TAQ, HAq-II, the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) through norming on the veteran population (Houghton, 2018; Janse et al., 2014; Luborsky et al.,

1996). Although some of the measures in this study were initially normed or revised to measure stigma, credibility, and barriers to care for veterans, this has not been done with other session measures with a credible sample size (Britt et al., 2008; Kim et al., 2010; Newman & Fisher, 2010; Pietrzak et al., 2009).

Particular attention should be given to the impact of the therapeutic alliance toward actual barriers to care, perceptions of stigma, and credibility and expectancy toward therapy. Results of this study indicated there were significant correlations between the CEQ, PSBC, and PSOSH measures, as influenced by the perception of the therapeutic alliance. The reduction of perceptions of stigma, and thus barriers to care, is observed directly through the rating of a higher alliance and higher credibility of the therapy potential. Although there was a clear positive correlation between a higher alliance lowering negative perceptions and increasing positive expectations, this should be further analyzed in individual therapy sessions, group therapy sessions, and the differences between in-person and virtual (telehealth) therapy. Other studies have only used hypothetical scenarios (Houghton, 2018; Johnson et al., 2018) or qualitative post-session interviews (Botero et al., 2020), which further purports the necessity to evaluate in-person therapy and telehealth therapy for veterans.

Furthermore, existing literature has suggested cultural models may enhance overall treatment participation, development of the therapeutic alliance, and aide in positive outcomes (Cabral & Smith, 2011; Leibert & Dunne-Bryant, 2014; Schim & Doorenbos, 2009). Investigating the impact demographic factors such as military experience, gender, ethnicity, socioeconomic status, and more is in line with previous research on the matching factor of clients and therapists (Cabral & Smith, 2011). A new

model could be developed to emphasize the cultural factors that explicitly influence treatment for veterans and their providers as well as other significant factors that may lead to increased perceptions of an alliance, such as accessibility, language, and other demographics, thus creating a formal framework to be used by mental health services.

In essence, continued evaluation of formal models of treatment for veterans should be developed and implemented to increase mental health engagement and reduce veteran suicide rates. Furthermore, the continued exploration of how client-therapist matching can improve development of a therapeutic alliance and thus increase treatment completion is imperative to understanding veterans' mental health engagement.

Conclusions

This study investigated the significant factors thought to contribute to veteran engagement in mental health treatment. The study sought to evaluate the importance of the therapeutic alliance and the potential positive impact it would have upon the study's variables of treatment participation, stigma, and barriers to care. Stigma continues to be a primary concern regarding help-seeking behavior for mental health in military and veteran populations (Kim et al., 2011; Pietrzak et al., 2009). The primary findings of this study suggest the therapeutic alliance, in theory, will increase the credibility and expectancy of mental health treatment for veterans. This expectancy and credibility can further increase the likelihood of veterans initiating treatment, maintaining treatment, and further reducing the effects of stigmatization for seeking help (Hoge et al., 2004; Kim et al., 2011). As veterans perceive less barriers to care, primarily regarding stigma, the potential for decreasing the veteran suicide epidemic becomes a more attainable goal (Botero et al., 2020; Johnson et al., 2018).

The continued stigmatization that occurs from unit leadership, societal standards, and peers continues to be a significant factor impacting the positive engagement of military and veteran clients (Blais et al., 2014; Kim et al., 2011). This study provides further context for avenues of positive participation in therapy for veterans, building from previous studies that sought to discover if a veteran therapist is preferred and can increase the overall level of engagement (Johnson et al., 2018).

The model currently in place for veterans to engage with veteran therapists is most often seen in the "Vet Center" model; these centers are open to only a minority of veterans but are striving to widen their treatment capabilities (Botero et al., 2020). However, the Vet Center is not a widely known resource in comparison to military hospitals, Veterans Affairs health care systems, and private mental health services (Botero et al., 2020). Although there is a variety of resources available for mental health engagement in both active military and veteran models, there is a disjointed approach plagued with a lack of advertisement, appropriate staffing levels, and continues to be impacted by stigmatization of receiving mental health care by leaders and peers (Johnson et al., 2018). This study illustrates and defines the exact parameters that will mitigate barriers to care for veterans, increase help-seeking behavior, and begin forming the foundation necessary to achieve the goal of reducing veteran suicides. In conjunction with research by Johnson et al. (2018) and Botero et al. (2020), future research can further refine an appropriate treatment model to best serve military and veteran demographics and hopefully reduce the number of veterans and military service members lost to suicide every day.

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Table 1

Reliability Statistics of the B-TAQ

Variable	*M*	*SD*
Dependability	4.41	1.17
Similarity	4.18	1.08
Liking	4.44	1.09
Slowing Up	3.94	1.18
Relationship	4.43	1.06
Experienced	4.49	1.06
Work-Out	4.17	1.16

Note. Cronbach's α of the B-TAQ is .805; Cronbach's α based on standardized items is .810.

Table 2

Descriptive Statistics

Variable	*M*	*SD*
CEQ	.00 (*Mdn* = -.003)	.802
PSOSH	2.48	.890
PSBC	2.76	.793
B-TAQ	4.35	.776

Note. CEQ = Credibility and Expectancy Questionnaire; PSOSH = Perceptions of Stigmatization by Others for Seeking Help; PSBC = Perceived Stigma and Barriers to Care; B-TAQ = Brief Therapeutic Alliance Questionnaire.

Table 3

Correlations

Variable	PSOSH	PSBC	CEQ
B-TAQ	-.190*	-.176*	.652**
PSOSH	--	.329**	-.218**
PSBC	--	--	-.234**

Note. ** Correlation is significant at the 0.01 level (2-tailed). *Correlation is significant at the 0.05 level (2-tailed).

Table 4

Inferential Statistics

Variable	Estimate	*SE*	*z*	*p*	Std. All
B-TAQ (Gender)	-0.128	0.165	-0.780	0.435	-0.083
B-TAQ (Veteran)	0.092	0.167	0.554	0.50	0.060
B-TAQ (Gender & Veteran)	0.334	0.238	1.402	0.161	0.184
CEQ ~ B-TAQ	0.673	0.061	10.967	0.000	0.652
PSOSH ~ B-TAQ	-0.217	0.088	-2.465	0.014	-0.190
PSBC ~ B-TAQ	-0.180	0.079	-2.283	0.022	-0.176

Table 5

Covariances

Variable	Estimate	*SE*	*z*	*p*	Std. All
CEQ ~ PSOSH)	-0.037	0.042	-1.611	0.107	-0.127
CEQ ~ PSBC	-0.075	0.037	-2.010	0.044	-0.159
PSOSH ~ PSBC	0.208	0.056	3.736	0.000	0.306

Note. Covariance is the amount of shared variance between measurements.

Figure 1

Therapeutic Alliance Impacts on Treatment, Stigma, and Barriers

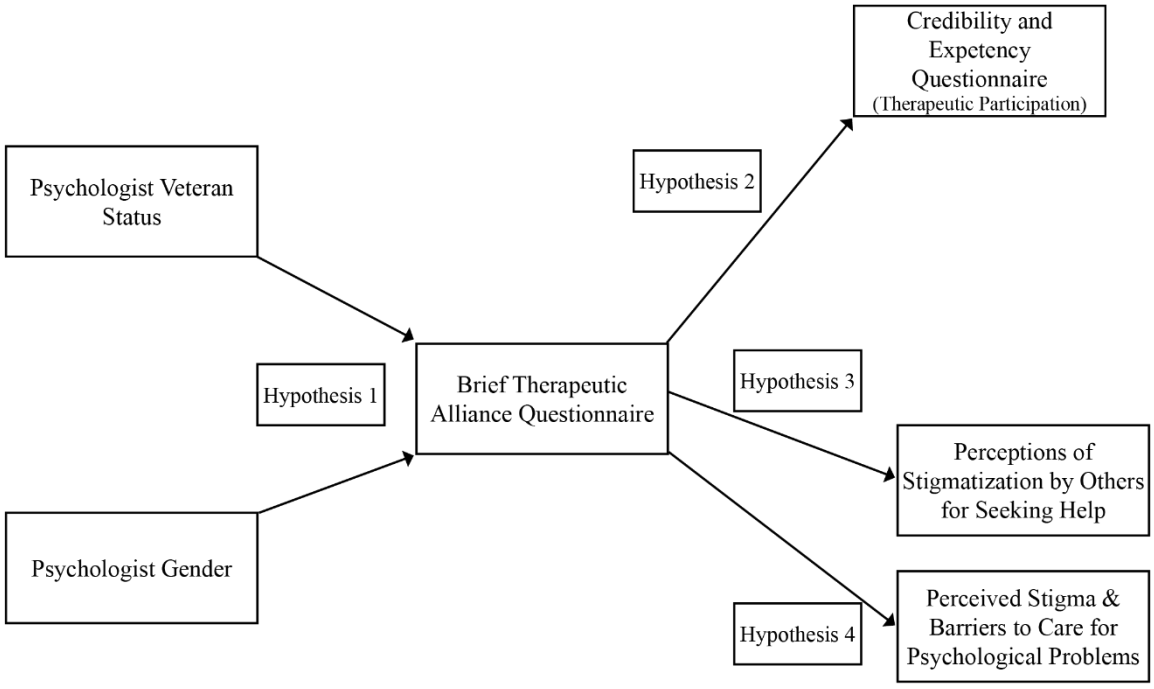
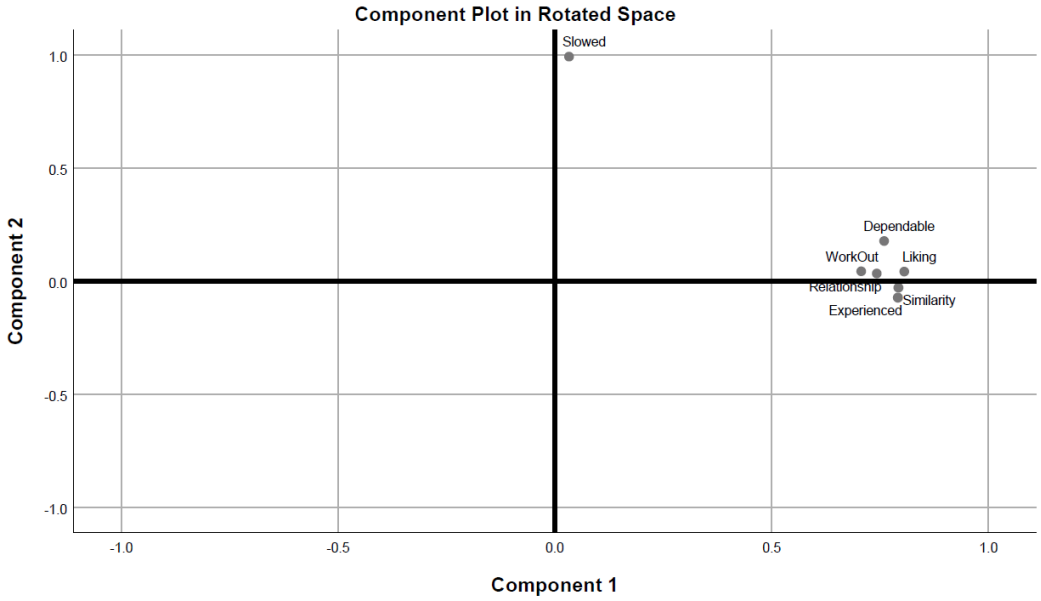


Figure 2

B-TAQ Statistics Establishing the Measures Validity



Note. The KMO Measure of Sampling Adequacy was rated at .861, $p = .000$

Figure 3

Path Analysis Model – The Therapeutic Alliances Impact on Treatment Participation, Barriers to Care, and Perceived Stigmas

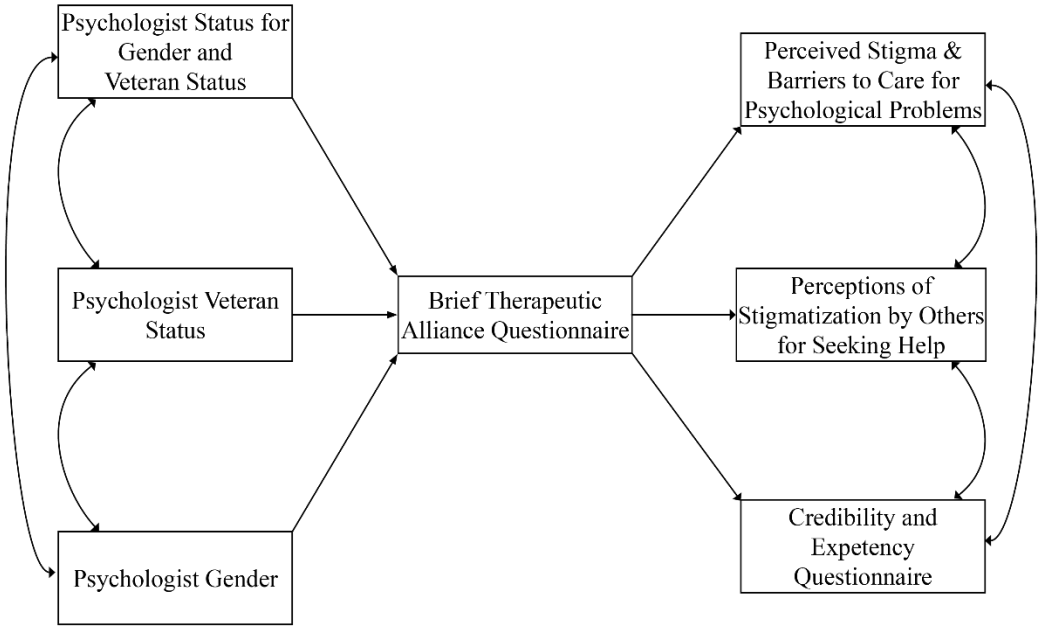


Figure 4

B-TAQ Estimated Marginal Means of Error

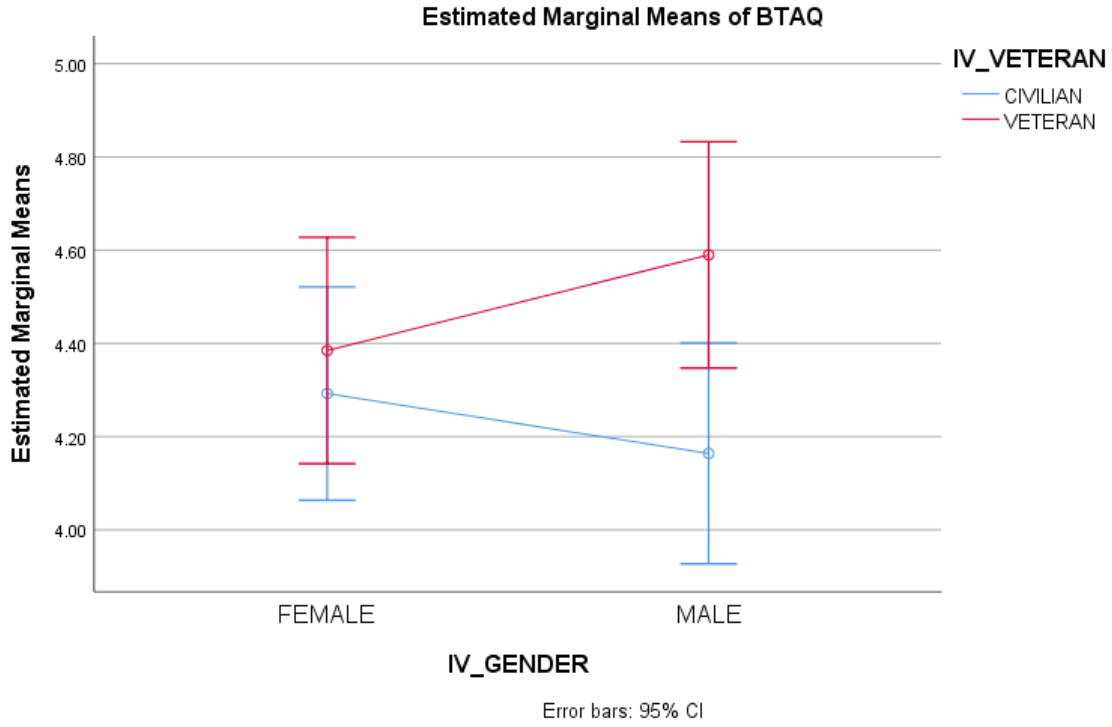
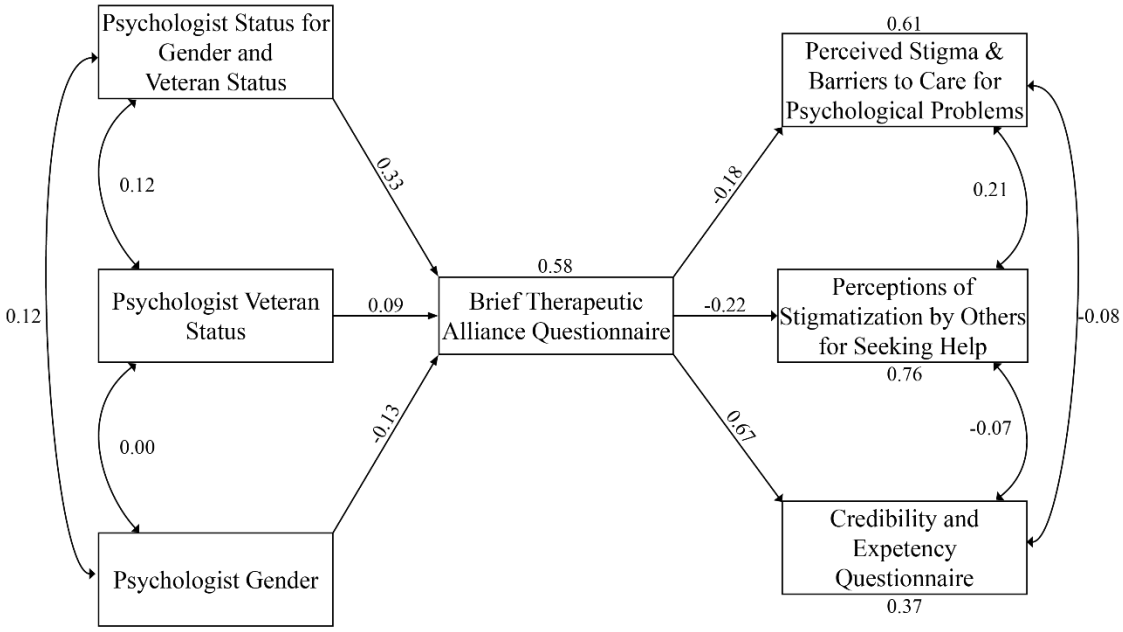


Figure 5

Path Analysis of the Therapeutic Alliances Impact on Measures



Appendix A

Therapist Profiles – Veteran

Directions: Please read the following profile of your potential therapist and then answer the questionnaire below regarding your potential therapist.

There are no right or wrong answers, but please read and answer each question carefully.

Profile 1 (Male Veteran):

Dr. William Smith is a Washington State licensed psychologist with experience in the treatment of anxiety, depression, posttraumatic stress disorder, substance use disorder, alcohol use disorder, and couples' therapy. Dr. Smith served in the military as a medic, then enrolled at the University of Washington in 2009, earning his doctorate in 2014. Since then, he has worked at the Seattle Vet Center, providing treatment to veterans and their spouses, to include those who served overseas or experienced military sexual trauma (MST). Dr. Smith performed his internship at the University of Washington counseling center in 2013, then his post-doctoral training at the Veterans Affairs Puget Sound Hospital in 2014.

Profile 2 (Female Veteran):

Dr. Michelle Smith is a Washington State licensed psychologist with experience in the treatment of anxiety, depression, posttraumatic stress disorder, substance use disorder, alcohol use disorder, and couples' therapy. Dr. Smith served in the military as a medic, then enrolled at the University of Washington in 2009, earning her doctorate in 2014. Since then, she has worked at the Seattle Vet Center, providing treatment to veterans and their spouses, to include those who served overseas or experienced military sexual trauma (MST). Dr. Smith performed her internship at the University of Washington counseling center in 2013, then her post-doctoral training at the Veterans Affairs Puget Sound Hospital in 2014.

Appendix B

Therapist Profiles – Civilian

Directions: Please read the following profile of your potential therapist and then answer the questionnaire below regarding your potential therapist.

There are no right or wrong answers, but please read and answer each question carefully.

Profile 3 (Male Veteran):

Dr. William Smith is a Washington State licensed psychologist with experience in the treatment of anxiety, depression, posttraumatic stress disorder, substance use disorder, alcohol use disorder, and couples' therapy. Dr. Smith enrolled at the University of Washington in 2009, earning his doctorate in 2014. Since then, he has worked at the Seattle Vet Center, providing treatment to veterans and their spouses, to include those who served overseas or experienced military sexual trauma (MST). Dr. Smith performed his internship at the University of Washington counseling center in 2013, then his post-doctoral training at the Veterans Affairs Puget Sound Hospital in 2014.

Profile 4 (Female Veteran):

Dr. Michelle Smith is a Washington State licensed psychologist with experience in the treatment of anxiety, depression, posttraumatic stress disorder, substance use disorder, alcohol use disorder, and couples' therapy. Dr. Smith enrolled at the University of Washington in 2009, earning her doctorate in 2014. Since then, she has worked at the Seattle Vet Center, providing treatment to veterans and their spouses, to include those who served overseas or experienced military sexual trauma (MST). Dr. Smith performed her internship at the University of Washington counseling center in 2013, then her post-doctoral training at the Veterans Affairs Puget Sound Hospital in 2014.

Appendix C

Demographic Questionnaire

1. Have you been discharged from the United States Armed Forces after attending entry-level or advanced training?
   - ☐ Yes
   - ☐ No

2. What year were you born?
   - ☐ Drop Down Menu (1960-2002)

3. What is your highest level of education obtained?
   - ☐ High School Diploma / GED
   - ☐ Associate's Degree
   - ☐ Bachelor's Degree
   - ☐ Master's Degree
   - ☐ Doctorate Degree

4. What branch of the military did you serve in?
   - ☐ Army
   - ☐ Navy
   - ☐ Marine Corps
   - ☐ Air Force
   - ☐ Coast Guard

5. Do you identify as a male, female, or do you prefer not to say?
   - ☐ Male
   - ☐ Female
   - ☐ Prefer not to say

6. During which modern conflict did you serve?
   - ☐ Gulf War (1990 – 1991)
   - ☐ Afghanistan War (2001 – Present)
   - ☐ Iraq War (2003 – 2011)
   - ☐ None of the above

7. If you have deployed, what operations was it in support of, if any?
EX: OEF, OIF, OND
   - ☐ Operation Enduring Freedom (OEF)
   - ☐ Operation Iraqi Freedom (OIF)
   - ☐ Operation Freedom's Sentinel (OFS)
   - ☐ Operation Resolute Support (ORS)
   - ☐ Operation New Dawn (OND)
   - ☐ Operation Inherent Resolve (OIR)
   - ☐ Operation Desert Shield/Storm/Sabre

Appendix D

Brief Therapeutic Alliance Questionnaire (B-TAQ)

1. I feel I could depend upon my therapist

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

2. I believe we may have similar ideas about the nature of my problems

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

3. I like what I know about the therapist as a person

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

4. The way the therapist relates to me could be a barrier to my treatment

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

5. A good relationship could be formed with the therapist

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

6. The therapist appears to be experienced in helping people like me

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

7. I would like to work out my problems with the therapist

Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
○	○	○	○	○	○

Appendix E

Perceptions of Stigmatization by Others for Seeking Help (PSOSH)

Imagine you had an issue related to your military service that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would...

1. React negatively to you

Not at all	A little	Some	A lot	A great deal
O	O	O	O	O

2. Think bad things of you

Not at all	A little	Some	A lot	A great deal
O	O	O	O	O

3. See you as seriously disturbed

Not at all	A little	Some	A lot	A great deal
O	O	O	O	O

4. Think of you in a less favorable way

Not at all	A little	Some	A lot	A great deal
O	O	O	O	O

5. Think you posed a risk to others

Not at all	A little	Some	A lot	A great deal
O	O	O	O	O

Appendix F

Perceived Stigma & Barriers to Care for Psychological Problems (PSBC)

Using the scale provided, rate each of the possible concerns that might affect your decision to seek treatment for a psychological problem from a mental health professional:

1. It would be too embarrassing

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

2. It would harm my career

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

3. My peers might treat me differently

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

4. My peers would blame me for the problem

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

5. I would be seen as weak

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

6. People important to me would think less of me

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
O	O	O	O	O

7. I don't know where to get help

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
O	O	O	O	O

8. I don't have adequate transportation

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
O	O	O	O	O

9. It is difficult to schedule an appointment

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
O	O	O	O	O

10. There would be difficulty getting time off for treatment

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
O	O	O	O	O

11. Mental health care costs too much

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
O	O	O	O	O

Appendix G

Credibility and Expectancy Questionnaire (CEQ)

1. At this point, how logical does the therapist offered to you seem?

Not at all logical — Somewhat logical — Very logical

○ ○ ○ ○ ○ ○ ○ ○ ○

2. At this point, how successfully do you think this treatment will be in reducing your mental health symptoms?

Not at all useful — Somewhat useful — Very useful

○ ○ ○ ○ ○ ○ ○ ○ ○

3. How confident would you be in recommending this therapist to a friend who experiences similar problems?

Not at all confident — Somewhat confident — Very confident

○ ○ ○ ○ ○ ○ ○ ○ ○

4. By the end of the therapy period, how much improvement in your mental health symptoms do you think will occur?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

For this set, close your eyes for a few moments, and try to identify what you really feel about the therapy and its likely success. Then answer the following questions:

5. At this point, how much do you really *feel* that the therapist will help you to reduce your mental health symptoms?

6. By the end of the therapy period, how much improvement in your trauma symptoms do you really *feel* will occur?

Appendix H

Consent Form

PERCEPTIONS OF POTENTIAL THERAPEUTIC ALLIANCES

Welcome to "Perceptions of Potential Therapeutic Alliances," a web-based survey that examines the relationship between multiple therapeutic measures and how they may be affected by the perception of a military veteran. Before taking part in this study, please read the consent form below, click on the "I agree" option at the bottom of the page if you understand the statements, and freely consent to participate in the study. You may exit the survey at any time.

This study involves four web-based questionnaires designed to understand your demographic background and your views of a potential therapist. Jordan G. Houghton is a doctoral student at Northwest University and is conducting the study as part of his doctoral dissertation research. The Northwest University Institutional Review Board has approved the study. No deception is involved, and the study suggests little to no perceived risk to participants (i.e., the level of risk encountered in daily life). The risks faced may be emotional distress due to answering questions regarding mental health.

Participation in the study typically takes 10–12 minutes and is strictly anonymous. You will begin by answering a series of biographical questions, followed by reading the profile of a therapist and then responding to questions regarding the potential of working with the assigned therapist. You will then be asked about your perception of seeking help and potential stigmas around that help seeking. Your responses will be treated confidentially and will not have any identifying information. You may discontinue the questionnaire at any time if you wish without any penalty.

If participants have further questions about this study or their rights, or if any questions or concerns arise, they may contact the principal investigator, Jordan G. Houghton, at e-mail at xxxxx@northwestu.edu. You may also reach Dr. Nikki Johnson, Northwest University College of Social and Behavioral Sciences at nikki.johnson@northwestu.edu. If any questions or content of this questionnaire bring up personal questions, confusion, or anxiety, please contact your campus counseling center. You may also seek further help by contacting the Seattle Vet Center at (877) 927-8387, or the Puget Sound VA Medical Center at (206) 762-1010. Thank you for considering participating in this study.

Jordan G. Houghton, MA	Nikki Johnson, PsyD
Doctoral Student in Counseling Psychology	Assistant Professor
(XXX) XXX-XXXX	(425) 889-5753
xxxxx@northwestu.edu	nikki.johnson@northwestu.edu

Please print a copy of this consent form for future reference.