

# Applying Behavior Change Theory to Technology Promoting Veteran Mental Health Care Seeking

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Despite the availability of effective mental health interventions, the vast majority of veterans with a mental disorder underutilize psychological services. Contemporary research has revealed that several factors such as low education, stigma, stoicism, lack of knowledge, and negative beliefs about mental health services are associated with veterans' underutilization of services. In this article, the authors provide an overview of factors that affect symptomatic veterans' decisions about whether to seek mental health services. Second, they describe the theory of planned behavior (Ajzen & Fishbein, 1980), a useful model for understanding mental health care seeking that can inform the development of technology-based interventions designed to increase veterans' willingness to seek psychological services. Third, the authors describe the development of *Considering Professional Help*, a personalized web-based tool developed by the Department of Veterans Affairs, which has been designed to promote mental health care seeking in veterans with mental health problems.

*Keywords:* mental health care seeking, theory of planned behavior, web-based interventions, educational interventions, access to care

Over 40% of veterans entering the Veterans Affairs (VA) health care system are diagnosed with a mental disorder (National Alliance on Mental Illness, 2009). Data from large-scale epidemiologic studies further indicate that 13%–21% of Veterans entering the VA health care system received a diagnosis of posttraumatic stress disorder (PTSD; Cohen et al., 2010; National Alliance on Mental Illness, 2009; Seal, Bertenthal, Miner, Sen, & Marmar, 2007); 12%–14% major depression (National Alliance on Mental Illness, 2009); and 7%–10% alcohol abuse or dependence (Cohen et al., 2010; Seal et al., 2011). Moreover, among a nationally representative sample of 3,157 U.S. veterans of all war eras, 34.5% of veterans screened positive for one or more current mental disorders (PTSD, major depression, generalized anxiety disorder, or alcohol abuse or dependence; Pietrzak, Goldstein, Southwick, & Grant, 2011). Similarly, a study of a representative sample of

2,160 outpatients from Department of Veterans Affairs clinics found that 40% screened positive for at least one of these mental disorders (Hankin, Spiro, Miller, & Kazis, 1999).

Mental health interventions are available that have been demonstrated to effectively treat these mental disorders. However, veterans with mental health problems often underuse mental health services. For example, in a national study of veterans of any era who received a new PTSD diagnosis in VA between 2004 and 2005, 36% never attended a mental health appointment or received psychotropic medication (Cohen et al., 2010; Hawkins, Lapham, Kivlahan, & Bradley, 2010). In this study, only 39% of veterans received counseling, and 50% received psychotropic medication. In a national sample of Iraq and Afghanistan Veterans who received a new mental health diagnosis in VA between 2002 and 2008, over 33% never attended a mental health appointment in the year following their diagnosis (Seal et al., 2010). Among VA patients who screened positive for an alcohol use disorder, more than half did not seek treatment (Hawkins, Lapham, Kivlahan, & Bradley, 2008). Current rates of mental health service use among veterans with depression also suggest that services are underused. For example, among VA patients 50 years or older who received a new diagnosis of depression (Burnett-Zeigler et al., 2012), over one third (35.9%) did not seek mental health services in the year following their diagnosis.

Although some Veterans receive care outside of VA health care system, the percentage of veterans who use community mental health services is low. For example, among a nationally representative sample of veterans from all war eras (Pietrzak et al., 2011), the majority (68%) of those who screened positive for a mental

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disorder had never received any mental health treatment. Among community-based veterans aged 21–39 years who met screening criteria for major depression, 40% had not sought any mental health services (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008). Reasons for not seeking services are not necessarily because of a lack of a perceived need. For example, in a community-based sample of Iraq and Afghanistan veterans residing in Hawaii, 36.9% of veterans who indicated they needed help for an emotional problem reported that they had not sought VA or community-based services for their problem (Whealin et al., 2014).

Promoting mental health care seeking among symptomatic veterans is important, as untreated mental disorders are associated with poor functioning, work disability, and quality of life (Pittman Goldsmith, Lemmer, & Kilmer, 2012); increased risk for chronic physical health disorders (Schnurr & Green, 2004); divorce, domestic violence, homelessness (Shalev, 1997); and suicidal ideation and attempts (Research Letter, 2008; Kang & Bullman, 2009; Kessler, 2000). To address high rates of underuse of mental health services, the VA has made a number of institutional changes designed to increase availability of mental health services. These changes include hiring additional clinical mental health staff, increasing hours that mental health services are provided, and implementing outreach efforts (Department of Veterans Affairs, 2013). At the same time, the VA has invested in innovative e-health tools to improve veterans' access to mental health services. To this end, psychoeducational tools designed to help veterans overcome internal barriers to seeking mental health services are being developed, implemented, and disseminated nationally. The goal of such tools is to enable individuals to make informed decisions about whether and when to seek mental health services.

Most approaches to changing attitudes about mental health services involve educational interventions, and a growing number of studies have shown that stigma-related beliefs can be altered through education (Albarracín et al., 2005; Noar, Benac, & Harris, 2007). However, in many cases, the magnitude and duration of the effects tend to be small (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012). It is thought that the general nature of these interventions may, at least in part, account for these weak effects, as they are not personalized to the specific needs and attitudes of the individual toward whom they are targeted (Noar et al., 2007). Alternatively, interventions that are tailored (i.e., that adapt their content to the responses of the individual at several levels to specifically address an individual's unique needs and attitudes) have been found to be more robust than nontailored educational interventions (Albarracín et al., 2005). A recent meta-analysis of 57 studies indicated that tailored educational messages are more likely to be read, understood, recalled, rated more highly, and rated as more credible than messages that are not tailored (Noar et al., 2007). This research suggests that veterans may view interventions that are tailored to address individual barriers as personally relevant and hence give them increased attention.

In this review, we briefly summarize the current knowledge base about effective approaches to promoting mental health treatment seeking among veterans. First, we provide a brief overview of contemporary research on barriers to care seeking in veterans. Second, we discuss the theory of planned behavior (Ajzen & Fishbein, 1980), which provides a theoretical model of prerequisites necessary to help-seeking behavior. Third, we describe a tool

developed by the VA called *Considering Professional Help*, which is designed to reduce health care disparities by addressing knowledge and attitudes that prevent mental health service seeking among veterans with mental health problems.

### Contemporary Research on Barriers to Mental Health Care Use

Over the past decade, several models have been developed to provide a framework for conceptualizing health care seeking and use (Fortney, Burgess, Bosworth, Booth, & Kaboli, 2011). Additionally, empirical research has identified veteran beliefs that are associated with underuse of mental health services. For example, Ouimette et al. (2011) surveyed 490 Vietnam and later era veterans who had been newly diagnosed with PTSD but who had not received VA services for PTSD. Results of this study revealed that a greater number of veterans rated "discomfort with help seeking" and "concerns about social consequences" as more salient than other factors, such as logistical barriers to care and thus suggest that such beliefs may be important barriers to mental health service use among veterans with PTSD.

Emerging studies that have evaluated symptomatic veterans' reasons underlying their decision not to seek mental health services (e.g., Sayer et al., 2009; Stecker, Fortney, Hamilton, & Ajzen, 2007) highlight the role of beliefs related to stigma and stoicism. For example, during in-depth interviews with National Guard Members (Stecker et al., 2007) and Vietnam and Iraq- and Afghanistan-era veterans (Sayer et al., 2009), concerns about social stigma and the need to handle problems on one's own emerged as predominant reasons for forgoing treatment. Similarly, among 127 Iraq and Afghanistan veterans with PTSD, 82.1% identified an internal reason, such as stigma or career concerns, as the primary concern that prevented them from seeking treatment rather than external (e.g., institutional) factors such as access or cost-eligibility, which were endorsed by only 15.7% of veterans (Nelson et al., 2014).

Although specific reasons why symptomatic veterans forgo treatment tend to vary based on an individual's situation, frequently endorsed factors associated with mental health care seeking have been identified. Internal factors that have consistently been found to influence veterans' decisions about whether to seek mental health services include stigma, stoicism, and knowledge deficits—negative beliefs regarding the helpfulness of mental health services (Britt et al., 2008; Hoge et al., 2004; Maguen & Litz, 2006; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Each of these categories of barriers to seeking care is described in greater detail below.

#### Stigma

*Stigma* refers to negative beliefs that people hold about the attributes of those with mental disorders (Corrigan & Wassel, 2008). In one of the first articles that examined the barriers to mental health care use in a sample of active duty veterans of the wars in Iraq and Afghanistan (Hoge et al., 2004), the majority of those who screened positive for a mental disorder such as PTSD or depression endorsed stigma-related beliefs. Specifically, being seen as weak (reported by 65% of service members) and being negatively viewed by their superiors (63%) and peers (59%) were

the most commonly endorsed barriers to seeking mental health services in this sample (Hoge et al., 2004). This finding is consistent with qualitative work by Stecker and colleagues (2007), which revealed that 70% of National Guard Veterans identified stigma-related factors (i.e., concern about being “labeled”) as primary concerns that prevented them from seeking mental health services.

### **Stoic Attitudes**

Stoicism-related beliefs and behaviors include the suppression of emotion, denial–lack of recognition of health problems, and preferences related to solving problems on one’s own (Wagstaff & Rowledge, 1995). Qualitative data have revealed that beliefs related to self-reliance and lack of mental health problem recognition are factors that discourage seeking mental health care (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). For example, in their work with National Guard Veterans, Stecker, Fortney, Hamilton, and Ajzen (2007) found that 13 out of the 20 veterans in their sample reported that beliefs that they should not have a problem or that they ought to handle their problems on their own had prevented their seeking services. Similarly, Iraq or Afghanistan veterans with PTSD cited “stubbornness,” “denial,” and “feeling less of a man” as underlying their decision not to seek care (Nelson et al., 2014).

### **Knowledge Deficits and Negative Beliefs About Mental Health Services**

A third prominent factor that prevents mental health care seeking includes lack of knowledge or negative beliefs about mental health services and professionals. In a nationally representative sample of U.S. veterans, the second most commonly reported barrier to care was lack of trust of mental health professionals, which was endorsed by 22% of symptomatic veterans who were not receiving services (Blais, Tsai, Southwick, & Pietrzak, 2014). These findings accord with data from a community-based sample of Iraq and Afghanistan veterans in Connecticut (Pietrzak et al., 2009). In this study, negative beliefs about mental health services were found to be the strongest predictor of not seeking mental health services, even after adjustment for demographic characteristics, psychosocial variables such as social support, and mental disorders. Similarly, active duty service members who screen positive for a mental health problem and who hold negative attitudes about mental health services are less likely to use mental health services than those who hold more positive attitudes (Brown, Creel, Engel, Herrell, & Hoge, 2011).

### **Underserved Populations**

Recent investigations have examined predictors of underutilization of mental health services in subgroups of veterans. This research has consistently identified male gender and lower symptom severity (e.g., Hoerster et al., 2012) as associated with low mental health service use. Another group that has been disproportionately underserved are veterans residing in rural locations (Cully, Jameson, Phillips, Kunik, & Fortney, 2010; Cully et al., 2008; Mohamed, Neale, & Rosenheck, 2009; Wallace, Weeks, Wang, Lee, & Kazis, 2006; Weeks, Mahar, & Wright, 2005). For example, a recent study examining records of over 414,000 veterans

with PTSD (Brooks et al., 2012) found that veterans from rural or highly rural areas had 19% and 25% fewer VA visits, respectively, compared with urban veterans.

Research on the role of ethnoracial status on mental health care use is mixed, with European American ethnoracial status positively associated with mental health service use among veterans in some studies (e.g., Elhai, Reeves, & Frueh, 2004; Spont, Hodges, Murdoch, & Nugent, 2009). In contrast, other research has found higher use of VA psychotherapy services among African American and Native Hawaiian–Pacific Islander veterans compared with European American veterans (e.g., Chermack et al., 2008; Spont, Hodges, Murdoch, & Nugent, 2009) or no differences between groups (e.g., Brooks et al., 2012; Grubaugh, Slagle, Long, Frueh, & Magruder, 2008).

Another group of potentially underserved veterans are those with low education. Recent studies of Iraq and Afghanistan veterans found that, when controlling for other relevant factors, veterans with lower education were less likely to use mental health services than veterans with higher education (Hoerster et al., 2012; Whealin et al., 2014), a finding consistent with studies of general population samples (e.g., Jones-Hazledine, McLean, & Hope, 2006; King & Canada, 2004; Steele, Dewa, Lin, & Lee, 2007).

General population studies have found that individuals who are less knowledgeable about mental health services have more stigma-related beliefs about psychotherapy than those who have knowledge about mental health services (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012). Those without a college education often have less exposure to formal education about mental health disorders, as well as less exposure to individuals with advanced college degrees in mental health care, and thus less opportunity to learn about mental health services. Given that several studies have now found that veterans’ attitudes about stigma, stoicism, and beliefs about mental health care are linked to reduced mental health service use, corrective information regarding these attitudinal barriers to care may help motivate positive attitude and behavior change related to mental health care in symptomatic veterans who are not engaged in mental health services.

### **Theoretical Framework for Understanding Help-Seeking Behaviors**

The theory of planned behavior (Ajzen & Fishbein, 1980) has been shown to be a useful tool for promoting individual behavior change related to health service attitudes and use (Glanz, Riner, & Viswanath, 2008). The theory assumes that people’s actions are a function of their intentions, which are in turn influenced by their beliefs. According to this theory, human behavior is guided by three specific types of considerations: (a) expectations about the likely consequences of a behavior, (b) normative expectations of other people, and (c) beliefs about the presence of factors that may further or hinder performance of the behaviors (also called *perceived control factors*). Perceived control factors may include not knowing where to go for help (Hoge et al., 2004) and readiness and self-efficacy related to accessing mental health services (Ajzen, 2002).

In delineating the theoretically based constructs that are important to behavior change, and building on veterans’ barriers to care research to date, an attitude and behavior change tool could usefully be based on each of the following:

1. Expectations about the likely consequences of seeking mental health services.

Research on veterans (e.g., Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009) and the general population (Jorm, 2012) has shown that many people view mental health services, including those providing evidence-based treatments and recommended by health care professionals, with suspicion or mistrust. Stigma-related beliefs and knowledge deficits related to mental health services may be an even stronger barrier for older veterans, who are less likely to have exposure to antistigma public health campaigns or to peers who have used mental health services. Psychotherapy models of which many veterans are familiar are often examples portrayed in movies and TV programs. For example, media depictions of psychotherapy are often entirely fictitious or no longer prevalent (e.g., traditional psychoanalytic approaches). Other familiar models are based on sensationalized media portrayals (e.g., *The Dr. Phil Show*; Dickstein, Vogt, Handa, & Litz, 2010). Thus, it is not surprising that the general public often views peers, family members, and counselors as more helpful than licensed mental health professionals, despite that professionals are rigorously trained in the treatment of mental disorders (Jorm, 2012).

2. Normative expectations of other people.

In addition to studies examining exposure, knowledge, and attitudes, expectations about others' normative behavior may also influence health behaviors (Alvidrez, 1999; Berkman & Glass, 2000). Normative expectations of others can result in conformity because of the desire to fulfill others' expectations, often to maintain acceptance (Meyers, 2012, p. 312). Veterans have identified others' negative view of mental health seeking (i.e., as a weakness) as a deterrent to seeking formal services (e.g., Sayer et al., 2009). For example, research has found that individuals who do not access mental health care compared with those who do are less likely to view their mental health disorders as normal and more likely to fear how others will react if they did seek services (Addis & Mahalik, 2003).

Some interventions that target stigma have sought to address normative expectations by confronting users' stereotypes and tendencies to socially distance themselves from those with mental health problems. For example, an intervention in which persons with a mental health problem helps viewers to understand their problem has been shown to effectively decrease stigma-related attitudes (Corrigan, Edwards, Green, Diwan, & Penn, 2001). These findings are particularly relevant to underserved groups that have internalized stigma-related attitudes.

3. Control factors.

Factors that hinder access to care and that are specific to certain populations should also be included in an intervention designed to promote mental health service seeking. Ideally, an intervention might address a variety of instrumental barriers to care, such as time devoted to work and other responsibilities that are unique to each veteran's situation. Psychological factors such as readiness and self-efficacy for engaging in health care, as well as pragmatic factors such as having health insurance, should also be addressed

in interventions, as they may help motivate initiation of mental health service use (Ajzen, 2002; Stecker, McGovern, & Herr, 2012).

A growing number of interventions are being developed and disseminated currently that are informed by the theory of planned behavior. In one study, theory of planned behavior constructs described above accounted for up to 34% of the variance in actual use of mental health resources, and personal attitudes about mental health service use were the strongest predictor of mental health resource use (Andrykowski & Burris, 2010). Using a model based on the theory of planned behavior, Stecker, McGovern, and Herr (2012) developed a brief telephone-based CBT intervention designed to increase treatment initiation for veterans with an alcohol use disorder. Participants in the intervention group were administered a single-session, telephone-based cognitive-behavioral intervention addressing beliefs about care, whereas participants in the control group were read a pamphlet about the dangers of alcohol abuse. Compared with the control group, those receiving the intervention were 2.6 times more likely to attend treatment in the following 3 months. Other studies (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008; Stecker, Fortney, & Sherbourne, 2011) have similarly shown that cognitive-behavioral interventions are effective in decreasing self-stigma; however, there were no control groups or long-term follow-up assessments in these studies.

### Advantages of Web Delivery

Delivering public mental health tools through the internet offers a number of advantages. Foremost, use of the internet enables organizations to efficiently reach a large number of veteran consumers in need. Few technologies have been disseminated as quickly or become so widely used as computers and the internet. This finding is especially important in reaching the large proportion of symptomatic veterans residing in the community who are not engaged in mental health services and who might not otherwise come in contact with mental health professionals. Several studies that have evaluated online interventions have found that they tend to be as effective as in-person care (Andersson, 2009; Rooke, Thorsteinsson, Karpin, Copeland, & Allsop, 2010). Second, web-based interventions are able to incorporate video- and audio-streamed presentations, which are of interest to consumers. Related to this, and as mentioned previously, individuals with low education are underserved in terms of mental health care use (e.g., Jones-Hazledine et al., 2006; King & Canada, 2004; Steele et al., 2007). Because nearly half of the U.S. population exhibits low levels of literacy, visual patient educational material can be better understood than written materials (Kirsch, Jungeblut, Jenkins, & Kolstad, 1992). Third, unlike printed or online written materials, e-health interventions that are interactive allow users to answer questions, enter data, and choose to consume sections of the program that are relevant to them and ignore those that are not. Interactive e-health interventions that cater to the individualized needs of the user are more effective and may produce longer lasting effects compared to printed materials (Dickstein et al., 2010). Fourth, web-based interventions are anonymous and can therefore be used to overcome concerns related to confidentiality and perceived stigma. Fifth, web-based interventions are inexpensive. Once a web-based intervention is developed and empirically validated, there is little cost associated with their upkeep and



maintenance. As broadband internet connection and cell phone availability increases throughout the United States, organizations can better serve large groups of veterans and other groups by providing web-based public health education tools.

To date, little data are available regarding the effectiveness of public health interventions delivered through the internet in promoting attitude and behavioral change toward mental health service use. One exception is a randomized controlled trial that compared the effects of an interactive educational website ([www.bluepages.anu.edu.au](http://www.bluepages.anu.edu.au)), an interactive website that included cognitive-behavioral techniques ([www.MoodGYM.anu.edu.au](http://www.MoodGYM.anu.edu.au)) and a wait-list control condition in changing understanding of mental health treatment in a general population sample (Christensen, Griffiths, & Jorm, 2004). Results of this study revealed that the educational website significantly increased participants' understanding of mental health services compared to the cognitive-behavioral website and wait-list control condition.

### **Considering Professional Help: A VA Tool to Promote Attitude and Behavior Change Related to Mental Health Service Use**

Because of the serious challenge of effectively engaging veterans in need of mental health services, federal organizations and key experts in research, education, and dissemination have begun to develop web-based educational tools designed to encourage veterans to seek and engage in care. One exemplar of such a tool is the web-based psychoeducational program *Considering Professional Help*, which was designed and developed by a team of experts at the VA's National Center for PTSD, Dissemination and Training Division (Kuhn, Drescher, & Hoffman, 2013).<sup>1</sup> *Considering Professional Help* uses a tailored, interactive format to address key barriers to mental health care that have been well established in research with veterans, including lack of problem recognition, stoicism, lack of knowledge or negative beliefs about mental health services, instrumental barriers, stigma about mental illness and mental health services, and lack of information (e.g., not knowing where to get care).

*Considering Professional Help* is informed by motivational interviewing principles as well as cognitive-behavioral and social-cognitive theory. Within this framework, an actor-narrator portraying a helpful veteran provides guidance and attempts to normalize common mental health symptoms and adjustment difficulties that veterans often experience. The product's content was developed with the input and actual words of veterans so that its print, audio, and visual stimuli are applicable to the needs, worldviews, and values of veterans. Videos of actors, who are diverse in terms of gender, race, ethnicity, and military branch, portray veterans' personal accounts of their struggles with mental health issues; barriers to seeking mental health services, successful strategies they used to overcome their barriers; and the ultimate rewards they accrued as a result of seeking and remaining in care. A combat veteran served on the development team to oversee and confirm the sociocultural appropriateness and relevance of the tool to veteran groups.

Specific topics covered within *Considering Professional Help* are outlined in Table 1. The design of this tool is consistent with the recommendations of scholars in health and other persuasive education methods (Albarracín et al., 2005; Noar et al., 2007), who

suggest that interventions are needed at multiple levels of intervention (i.e., educational information from a credible source, screening tools, attitudinal arguments, contact with a relevant normative role model, tailoring to unique individual needs) to initiate and sustain behavior change. Further, based on the theory of planned behavior (Ajzen & Fishbein, 1980) and research to date, the intervention promotes attitude and behavior change by including credible sources and spokespersons who provide information to promote problem recognition, including information about the nature, course, and other expectations about services, thereby demystifying the mental health treatment process. Users choose sections that address their unique concerns and perceived barriers to mental health services (e.g., stigma, not trusting mental health providers, not having time, not knowing where to get services) or lack of efficacy (e.g., believing that mental health treatment does not work).

A pilot evaluation of the effectiveness of *Considering Professional Help* was conducted with a convenience sample of 10 veterans from the community who screened positive for a mental disorder (i.e., PTSD, depression, GAD, or substance use disorder) but were not currently engaged in mental health services. Veterans represented a range of age groups and war eras: one was 18–24 years old; two were 25–34; three were 35–44; one was 45–54; and three were 55 or older. A pretest assessment comprised of five questions from the Perceived Stigma and Barriers to Care for Psychological Treatment Scale (Britt et al., 2008), as well as a question about veterans' willingness to consider mental health treatment if they needed help, was administered before and after the intervention. Results, shown in Table 2, revealed that most of veterans reported that they learned something while using the psychoeducational tool and that the tool was helpful and easy to use. On the basis of the pilot sample of 10 veterans, the tool was associated with average large magnitude effect size (i.e., Cohen's *d*; see Table 2) reductions in veterans' perceptions related to stigma, weakness, harm to career, provider trustworthiness, and that mental health treatment is not effective for most people. A small magnitude reduction was observed for veteran's perceptions that the VA does not care about veterans' emotional needs. Finally, completing the tool was associated with an average large magnitude increase in veterans' reporting that they would consider mental health services if they needed help coping with their emotions or problems, reflecting the preliminary efficacy of this intervention.

**Applications.** Web-based psychoeducational tools such as *Considering Professional Help* have a number of potentially promising applications that could improve both outreach and engagement efforts. For example, web-based interventions could be integrated into ongoing large-scale mental health screening efforts of veterans and military service members, such as the Postdeployment Health Assessment and Postdeployment Health Reassessment programs (Warner, Appenzeller, Parker, Warner, & Hoge, 2011). Web-based tools would also be helpful if used in conjunction with free online self-screening programs. For example, a link to the *Considering Professional Help* tool could be provided to

<sup>1</sup> The course is accessible on VA's electronic personal health record website: <https://www.myhealth.va.gov/course/ConsiderProffHelpPresentation/courseware.html>

Table 1  
*Topics Covered by the Considering Professional Help Web-Based Tool*

Topic	Description
Do I need help?	This topic addresses lack of problem recognition by asking questions about symptoms of posttraumatic stress disorder, depression, anxiety, and anger as well as psychosocial functioning; sleep, eating, and alcohol–substance use habits; observations from others about user’s behavior; and suicidal ideation. If the user responses suggest they need care, they are provided feedback that these are common problems that can be improved with professional help and that they should seek it.
What is stopping me?	This topic offers users a list of questions, in everyday language, of common barriers to care that may be preventing them from getting help (e.g., Will it really work? What will people think?). Users choose statements that pertain to them. When a statement is selected, a video is shown of an actor portraying an actual veteran who describes how they had struggled with a similar concern, was able to overcome the problem, and benefit from services.
What can I expect?	The narrator provides a detailed account of mental health (MH) services and how care is typically delivered. This topic is designed to increase MH literacy, dispel common myths, decrease fear of the unknown, and normalize care.
Who can help me?	The narrator describes professionals who deliver MH services including their training and the types of MH care (e.g., medications, psychotherapy, spiritual counseling) they offer. This topic is designed to increase MH literacy, dispel common myths, decrease fear of the unknown, and normalize care offered by various MH professionals and related professionals (e.g., chaplains).
Where can I find help?	This topic provides resources for connecting users with services. It presents directories that are veteran specific, such as facility locators for VA and vet center facilities, as well as community resources, including professional organization provider finders.

those who screen positive for mental health issues as well as, more specifically, to those who have the various informational needs and concerns about seeking help. As noted previously, a large percentage of VA patients with PTSD and related mental health disorders are already receiving medical services but have not yet been identified as having a mental health problem or have not yet sought treatment for it. Thus, a web-based tool could be used in conjunction with existing screening programs. For example, VA primary care patients are routinely screened for PTSD and depression, and if positive are referred to mental health services. Although these efforts have been successful in general, many veterans offered a referral to mental health services decline it. Many others who accept a referral fail to attend a scheduled mental health visit or only attend one visit (Seal et al., 2010). Web tools could be used in primary care settings with all identified veterans in need before they make a referral decision or could be made available to veterans who have a history of positive screens but without engaging in care. The potential for primary care clinics to help address the problem of underutilization by screening and providing online education is clear. Promptly addressing perceived barriers to care and facilitating engagement in services is essential to preventing excessive costs directly resulting from untreated mental

disorders, as well as high secondary costs that affect veterans, family members, and their communities (Kessler, 2000).

**Summary and Recommendations**

The implications of applying theories of behavior change in the development of novel interventions are far reaching (e.g., Ajzen, 2011). Research to date suggests that interventions that are likely to improve veterans’ underuse of mental health services are informed by theoretically based principles of behavior change and are designed with the active involvement of consumers to provide socioculturally relevant solutions to problems. They are tailored to the individual veterans’ unique concerns and allow for individual decision making about the best treatment options for each consumer. Because web-based interventions are flexible and adaptable, they can be easily geared to address the needs of underserved or disadvantaged populations, such as veterans in rural locations. Web-based interventions are anonymous and thus address veterans’ stigma-related concerns and provide a cost-effective means to efficiently reach a large number of those in need.

Because of the excessive costs resulting from untreated mental disorders that affect veterans, there is an urgent need to reevaluate

Table 2  
*Results From a Pilot Study Evaluating Considering Professional Help in Veterans not Currently Engaged in Mental Health Services (N = 10)*

Item	Pre	Post	Effect size of change (Cohen’s <i>d</i> )
It would be too embarrassing/I would be seen as weak	3.6 (0.9)	2.4 (1.0)	1.3
It would harm my career	3.5 (0.8)	2.8 (0.9)	0.8
The VA does not really care about my emotional needs	2.7 (0.8)	2.5 (0.7)	0.3
I do not trust mental health professionals	3.7 (0.8)	2.4 (0.7)	1.6
Counseling/psychotherapy or medication for depression, PTSD, or anxiety is not effective for most people	3.2 (0.8)	2.6 (0.5)	0.9
I would consider mental health treatment if I needed help coping with my emotions or problems	2.6 (0.5)	3.4 (0.7)	1.3

*Note.* Items were drawn from the Perceived Stigma and Barriers to Care for Psychological Treatment Scale (Britt et al., 2008). Scores range from 1 (*strongly disagree*) to 5 (*strongly agree*). VA = Veterans Affairs; PTSD = posttraumatic stress disorder.

current strategies to promoting mental health care seeking in this population. Given the advantages provided by internet-based tools, randomized controlled research trials will be helpful in identifying best-practice approaches to improving veterans' knowledge and behaviors regarding mental health care, as well as promoting the use of mental health services. Additionally, the development and refinement of such tools will benefit from qualitative and quantitative analyses that evaluate specific factors associated with improved treatment-seeking behaviors among veterans in need of care.

## References

- Addis, M. E., & Mahalik, J. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*, 5–14. doi:10.1037/0003-066X.58.1.5
- Ajzen, I. (2002). Perceived behavioral control, self-efficacy, locus of control, and the theory of planned behavior. *Journal of Applied Social Psychology, 32*, 665–683. doi:10.1111/j.1559-1816.2002.tb00236.x
- Ajzen, I. (2011). The theory of planned behaviour: reactions and reflections. *Psychology & Health, 26*, 1113–1127.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice Hall.
- Albarraçin, D., Gillette, J. C., Earl, A. N., Glasman, L. R., Durantini, M. R., & Ho, M.-H. (2005). A test of major assumptions about behavior change: A comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic. *Psychological Bulletin, 131*, 856–897. doi:10.1037/0033-2909.131.6.856
- Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Mental Health Journal, 35*, 515–530. doi:10.1023/A:1018759201290
- Andersson, G., & Cuijpers, P. (2009). Internet-based and other computerized psychological treatments for adult depression: A meta-analysis. *Cognitive Behaviour Therapy, 38*, 196–205. doi:10.1080/16506070903318960
- Andrykowski, M. A., & Burris, J. L. (2010). Use of formal and informal mental health resources by cancer survivors: Differences between rural and nonrural survivors and a preliminary test of the theory of planned behavior. *Psycho-Oncology, 19*, 1148–1155. doi:10.1002/pon.1669
- Berkman, L. F., & Glass, T. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*, 843–857. doi:10.1016/S0277-9536(00)00065-4
- Blais, R. K., Tsai, J., Southwick S. M., & Pietrzak, R. H. (2014). *Barriers and facilitators of mental healthcare utilization in older U.S. veterans: Results from the National Health and Resilience in Veterans Study*. Manuscript in preparation.
- Britt, T. W., Greene-Shorridge, T. M., Brink, S., Nguyen, Q. B., Rath, J., Cox, A. L., . . . Castro, C. A. (2008). Perceived stigma and barriers to care for psychological treatment: Implications for reactions to stressors in different contexts. *Journal of Social and Clinical Psychology, 27*, 317–335. doi:10.1521/jscp.2008.27.4.317
- Brooks, E., Novins, D. K., Thomas, D., Jiang, L., Nagamoto, H. T., Dailey, N., . . . Shore, J. H. (2012). Personal characteristics affecting veterans' use of services for posttraumatic stress disorder. *Psychiatric Services in Advance*, 1–6. Retrieved from <http://ps.psychiatryonline.org/data/Journals/PSS/0/appi.ps.201100444.pdf> doi:10.1176/appi.ps.201100444
- Brown, M. C., Creel, A., Engel, C., Herrell, R., & Hoge, C. W. (2011). Factors associated with interest in receiving help for mental health problems in combat veterans returning from deployment to Iraq. *Journal of Nervous and Mental Disease, 199*, 797–801. doi:10.1097/NMD.0b013e31822fc9bf
- Burnett-Zeigler, I., Zivin, K., Ilgen, M., Szymanski, B., Blow, F. C., & Kales, H. C. (2012). Depression treatment in older adult veterans. *American Journal of Geriatric Psychiatry, 20*, 228–238. doi:10.1097/JGP.0b013e3181ff6655
- Chermack, S. T., Zivin, K., Valenstein, M., Ilgen, M., Austin, K., Wrybeck, J., & Blow, F. (2008). The prevalence and predictors of mental health treatment services in a national sample of depressed Veterans. *Medical Care, 46*, 813–820. doi:10.1097/MLR.0b013e318178eb08
- Christensen, H., Griffiths, K. M., & Jorm, A. F. (2004). Delivering interventions for depression by using the internet: Randomised controlled trial. *BMJ, 328*(7434), 265.
- Cohen, B. E., Gima, K., Bertenthal, D., Kim, S., Marmar, C. R., & Seal, K. H. (2010). Mental health diagnoses and utilization of VA non-mental health medical services among returning Iraq and Afghanistan Veterans. *Journal of General Internal Medicine, 25*, 18–24. doi:10.1007/s11606-009-1117-3
- Corrigan, P. W., Edwards, A., Green, A., Diwan, S., & Penn, D. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin, 27*, 219–225. doi:10.1093/oxfordjournals.schbul.a006868
- Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rusch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*, 963–973. doi:10.1176/appi.ps.201100529
- Corrigan, P. W., & Wassel, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing and Mental Health Services, 46*, 42–48. doi:10.3928/02793695-20080101-04
- Cully, J. A., Jameson, J. P., Phillips, L. L., Kunik, M. E., & Fortney, J. C. (2010). Use of psychotherapy by rural and urban veterans. *Journal of Rural Health, 26*, 225–233. doi:10.1111/j.1748-0361.2010.00294.x
- Cully, J. A., Tolpin, L., Henderson, L., Jimenez, D., Kunik, M. E., & Petersen, D. (2008). Psychotherapy in the Veterans Health Administration: Missed opportunities? *Psychological Services, 5*, 320–331. doi:10.1037/a0013719
- Department of Veterans Affairs. (2013). *VA hires more mental health professionals to expand access for veterans*. Retrieved from <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2428>
- Dickstein, B. D., Vogt, D., Handa, S., & Litz, B. T. (2010). Targeting self-stigma in returning military personnel and veterans: A review of intervention strategies. *Military Psychology, 22*, 224–236. doi:10.1080/08995600903417399
- Elhai, J. D., North, T. C., & Frueh, B. C. (2005). Health service use predictors among trauma survivors: A critical review. *Psychological Services, 2*, 3–19. doi:10.1037/1541-1559.2.1.3
- Fortney, J. C., Burgess, J. F., Bosworth, H. B., Booth, B. M., & Kaboli, P. J. (2011). A re-conceptualization of access for 21st century health-care. *Journal of General Internal Medicine, 26*, 639–647. doi:10.1007/s11606-011-1806-6
- Glanz, K., Riner, B. K., & Viswanath, K. (2008). *Health behavior and health education: Theory, research and practice* (4th ed.). San Francisco, CA: Wiley.
- Grubaugh, A. L., Slagle, D., Long, M., Frueh, C., & Magruder, K. (2008). Racial disparities in trauma exposure, psychiatric symptoms, and service use among female patients in Veterans Affairs primary care clinics. *Women's Health Issues, 18*, 433–441. doi:10.1016/j.whi.2008.08.001
- Hankin, C. S., Spiro, A., Miller, D. R., & Kazis, L. (1999). Mental disorders and mental health treatment among U.S. Department of Veterans Affairs outpatients: The Veterans Health Study. *American Journal of Psychiatry, 156*, 1924–1930.
- Hawkins, E. J., Lapham, G. T., Kivlahan, D. R., & Bradley, K. A. (2010). Recognition and management of alcohol misuse in OEF/OIF and other veterans in the VA: A cross-sectional study. *Drug and Alcohol Dependence, 109*, 147–153. doi:10.1016/j.drugalcdep.2009.12.025
- Hoerster, K. D., Malte, C. A., Imel, Z. E., Ahmad, Z., Hunt, S. C., & Jakupcak, M. (2012). Association of perceived barriers with prospective



- use of VA mental health care among Iraq and Afghanistan veterans. *Psychiatric Services*, *63*, 380–382. doi:10.1176/appi.ps.201100187
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*, 13–22. doi:10.1056/NEJMoa040603
- Jones-Hazledine, C., McLean, C. P., & Hope, D. A. (2006). Mental health treatment seeking in a rural community. *Journal of Rural Community Psychology*, *9*, 1–16.
- Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*, 231–243. doi:10.1037/a0025957
- Kang, H. K., & Bullman, T. A. (2009). Is there an epidemic of suicides among current and former U.S. military personnel? *Annals of Epidemiology*, *19*, 757–760. doi:10.1016/j.annepidem.2009.05.004
- Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry*, *61*, 4–12.
- King, A. C., & Canada, S. A. (2004). Client-related predictors of early treatment drop-out in a substance abuse clinic exclusively employing individual therapy. *Journal of Substance Abuse Treatment*, *26*, 189–195. doi:10.1016/S0740-5472(03)00210-1
- Kirsch, I. S., Jungeblut, A., Jenkins, L., & Kolstad, A. (1992). Executive Summary of Adult Literacy in America: A First Look at the Results of the National Adult Literacy Survey. National Center for Educational Statistics. Retrieved from <http://nces.ed.gov/pubs93/93275.pdf>
- Kuhn, E., Drescher, K., & Hoffman, J. (2013). *Consider professional help*. <https://www.myhealth.va.gov/course/ConsiderProfHelpPresentation/courseware.html>
- Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research & Theory*, *16*, 149–165. doi:10.1080/16066350701850295
- Maguen, S., & Litz, B. T. (2006). Predictors of barriers to mental health treatment for Kosovo and Bosnia peacekeepers: A preliminary report. *Military Medicine*, *171*, 454–458.
- Meyers, D. G. (2012). *Social psychology*. New York, NY: McGraw-Hill.
- Mohamed, S., Neale, M., & Rosenheck, R. (2009). VA intensive mental health case management in urban and rural areas: Veteran characteristics and service delivery. *Psychiatric Services*, *60*, 914–921. doi:10.1176/appi.ps.60.7.914
- National Alliance on Mental Illness. (2009). *Depression and veterans: Fact sheet*. Retrieved from <http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88939>
- Nelson, D. D., Whealin, J. W., Bozik-Lyman, S., Stotzer, R., Hilmes, T., & Pietrzak, R. (2014). *In their own words: Self-reported barriers to mental health care among Iraq and Afghanistan Veterans with and without PTSD residing in Hawaii*. Manuscript submitted for publication.
- Noar, S. M., Benac, C. N., & Harris, M. S. (2007). Does tailoring matter? Meta-analytic review of tailored print health behavior change interventions. *Psychological Bulletin*, *133*, 673–693. doi:10.1037/0033-2909.133.4.673
- Quimette, P., Vogt, D., Wade, M., Tirone, V., Greenbaum, M. A., Kimerling, R., . . . Rosen, C. S. (2011). Perceived barriers to care among Veterans Health Administration patients with posttraumatic stress disorder. *Psychological Services*, *8*, 212–223. doi:10.1037/a0024360
- Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2011). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: Results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Anxiety Disorders*, *25*, 456–465.
- Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Psychological resilience and postdeployment social support protect against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *Depression and Anxiety*, *26*, 745–751. doi:10.1002/da.20558
- Research Letter: Risk of suicide among US veterans after returning from the Iraq or Afghanistan war zones. [Research letter]. (2008). *JAMA*, *300*, 652–653. doi:10.1001/jama.300.6.652
- Rooke, S., Thorsteinsson, E., Karpin, A., Copeland, J., & Allsop, D. (2010). Computer-delivered interventions for alcohol and tobacco use: A meta-analysis. *Addiction*, *105*, 1381–1390. doi:10.1111/j.1360-0443.2010.02975.x
- Sayer, N., Friedemann-Sanchez, G., Spont, M., Murdoch, M., Parker, L. E., Chiros, C., & Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation in veterans. *Psychiatry: Interpersonal and Biological Processes*, *72*, 238–255. doi:10.1521/psyc.2009.72.3.238
- Schnurr, P. P., & Green, B. L. (2004). Understanding relationships among trauma, post-traumatic stress disorder, and health outcomes. *Advances in Mind-Body Medicine*, *20*, 18–29.
- Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103,788 US Veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities. *Archives of Internal Medicine*, *167*, 476–482. doi:10.1001/archinte.167.5.476
- Seal, K. H., Cohen, G., Waldrop, A., Cohen, B. E., Maguen, S., & Ren, L. (2011). Substance use disorders in Iraq and Afghanistan Veterans in VA healthcare, 2001–2010: Implications for screening, diagnosis and treatment. *Drug and Alcohol Dependence*, *116*, 93–101. doi:10.1016/j.drugalcdep.2010.11.027
- Seal, K. H., Maguen, S., Cohen, B., Gima, K. S., Metzler, T. J., Ren, L., . . . Marmar, C. R. (2010). VA mental health services utilization in Iraq and Afghanistan Veterans in the first year of receiving new mental health diagnoses. *Journal of Traumatic Stress*, *23*, 5–16.
- Shalev, A. Y. (1997). Treatment failure in acute PTSD. Lessons learned about the complexity of the disorder. *Annals of the New York Academy of Sciences*, *821*, 372–387. doi:10.1111/j.1749-6632.1997.tb48293.x
- Spont, M. R., Hodges, J., Murdoch, M., & Nugent, S. (2009). Race and ethnicity as factors in mental health service use among veterans with PTSD. *Journal of Traumatic Stress*, *22*, 648–653.
- Stecker, T., Fortney, J. C., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatric Services*, *58*, 1358–1361. doi:10.1176/appi.ps.58.10.1358
- Stecker, T., Fortney, J. C., & Sherbourne, C. D. (2011). An intervention to increase mental health treatment engagement among OIF veterans: A pilot trial. *Military Medicine*, *176*, 613–619. doi:10.7205/MILMED-D-10-00428
- Stecker, T., McGovern, M. P., & Herr, B. (2012). An intervention to increase alcohol treatment engagement: A pilot trial. *Journal of Substance Abuse Treatment*, *43*, 161–167.
- Steele, L. S., Dewa, C. S., Lin, E., & Lee, K. L. K. (2007). Education level, income level and mental health services use in Canada: Associations and policy implications. *Healthcare Policy = Politiques De Santé*, *3*, 96–106.
- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *The NSDUH report: Major depressive episode and treatment for depression among Veterans aged 21 to 39*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Wagstaff, G. F., & Rowledge, A. M. (1995). Stoicism: Its relation to gender, attitudes toward poverty, and reactions to emotive material. *Journal of Social Psychology*, *135*, 181–184. doi:10.1080/00224545.1995.9711421
- Wallace, A. E., Weeks, W., Wang, S., Lee, A., & Kazis, L. E. (2006). Rural and urban disparities in health-related quality of life among



- veterans with psychiatric disorders. *Psychiatric Services*, *57*, 851–856. doi:10.1176/appi.ps.57.6.851
- Warner, C. H., Appenzeller, G. N., Parker, J. R., Warner, C. M., & Hoge, C. W. (2011). Effectiveness of mental health screening and coordination of in-theater care prior to deployment to Iraq: a cohort study. *American Journal of Psychiatry*, *168*, 378–385. doi:10.1176/appi.ajp.2010.10091303
- Weeks, W. B., Mahar, P. J., & Wright, S. M. (2005). Utilization of VA and medicare services by Medicare-eligible veterans: The impact of additional access points in a rural setting. *Journal of Health Care Management*, *50*, 95–106.
- Whealin, J. M., Stotzer, R. L., Pietrzak, R. H., Vogt, D., Shore, J., Morland, L., & Southwick, S. M. (2014). Deployment-related sequelae and treatment utilization in rural and urban war veterans in Hawaii. *Psychological Services*, *11*, 114–123. doi:10.1037/a0032782
- Zinzow, H. M., Britt, T. W., McFadden, A. C., Burnette, C. M., & Gillispie, S. (2012). Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care. *Clinical Psychology Review*, *32*, 741–753. doi:10.1016/j.cpr.2012.09.002

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