

Treatment-Seeking Barriers for Veterans of the Iraq and Afghanistan Conflicts Who Screen Positive for PTSD

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Objectives: Barriers associated with the decision not to seek treatment for symptoms of combat-related posttraumatic stress disorder (PTSD) were examined. **Methods:** Participants were 143 military men and women who served in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) and who screened positive for posttraumatic stress disorder (PTSD), as assessed by the PTSD Checklist–Military Version, and who had not sought treatment for PTSD. During a cognitive-behavioral telephone intervention, participants were asked about their beliefs concerning seeking PTSD treatment. **Results:** Four categories of beliefs were associated with the decision to seek treatment, including concerns about treatment (40%), emotional readiness for treatment (35%), stigma (16%), and logistical

issues (8%). **Conclusions:** This work suggests areas for intervention efforts to minimize barriers to treatment for PTSD for OEF/OIF veterans. (*Psychiatric Services* 64: 280–283, 2013; doi: 10.1176/appi.ps.001372012)

Roughly two million troops have been deployed to the conflicts in Iraq and Afghanistan since September 2001 (1). Hoge and colleagues (2) showed that up to 30% of troops returned with mental health problems leading to postdeployment adjustment difficulties. Reports have documented increasing rates of posttraumatic stress disorder (PTSD) (20%), anxiety disorders (18%), depression (15%), and substance use disorders (30%) among Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans.

Although the U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense (DoD) offer options for treatment, many veterans (defined in this report as a member of the military who has been deployed to a war zone) and military personnel who have PTSD or other mental disorders do not receive mental health treatment (3). Only one-quarter of active-duty troops with psychiatric diagnoses actually receive treatment services (2,4). And among those who do seek treatment, many do not receive evidence-based treatments or an adequate amount of them (2). This situation represents an opportunity for improve-

ment. The negative impact of these mental health issues includes high rates of unemployment, alcohol abuse, poor health, and domestic violence (5), and treatment can lead to improved symptomatic and functional outcomes (6).

Findings from previous studies have shown that stigma contributes to the negative view of mental health treatment among troops (2). Stigma, including self-stigma, public stigma, and stigma within a service member's unit, is a major factor in low treatment utilization (4). Perceptions of service availability and personal beliefs about treatment also have been reported as barriers to care (7). Veterans also have reported obstacles in interacting with the VA, such as hassles with scheduling, waiting times, paperwork, transportation, and navigating the health care system in general (7).

With the high rate of mental health problems, it is critical to increase treatment seeking among OEF/OIF service members. The literature is limited concerning the beliefs held by those in need of treatment who are not seeking it. Here, we report exploratory qualitative analyses to identify the most common beliefs associated with not seeking treatment. Our hope is that these insights can be used to tailor interventions to reduce barriers and increase treatment utilization.

Methods

Eligible participants were military personnel (active duty, National Guard and reservists, and separated) who

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screened positive for PTSD after a deployment to Iraq, Afghanistan, or both and who had not initiated PTSD treatment. Participants were recruited through visits to armories and through social media advertisements. Initial screenings for PTSD were conducted with the Mini-International Neuropsychiatric Interview–PTSD subscale (MINI) (8). Participants who screened positive for PTSD and were interested in participating gave their consent to do so. Individuals were excluded from participation if they had already been or were in PTSD treatment. To determine symptom severity, we used the PTSD Checklist–Military Version (9), a reliable and valid assessment of PTSD (10), and the Physicians Health Questionnaire (PHQ-9), a reliable and valid measure of major depressive disorder (11). This study was approved by the Committee for Human Subjects Protection at Dartmouth’s Medical School.

To elicit beliefs about PTSD treatment, we administered by telephone one-on-one intervention sessions that lasted 45–60 minutes. During the session, participants heard a brief introduction to cognitive-behavioral therapy (CBT), which was described as a theory suggesting that thoughts, feelings, and behaviors interact with each other (12) and that thoughts about certain situations influence behavior. Because thoughts are modifiable, the introduction explained, changing thoughts about situations may change behavior in those situations. For example, the thought “I don’t need treatment” might become “I might need treatment, considering how hard it is to sleep and the impact it is having on [my] relationships and job” or “I am drinking a lot to avoid thinking, so maybe treatment could help me deal with my memories better.” Sessions addressed a maximum of three beliefs in this manner. Participants identified beliefs most influential in their treatment-seeking behavior.

Three hundred participants were recruited for the study in between November 2009 and January 2012, and about half received the intervention. Data presented in this report contain only those from intervention sessions (N=143).

We recorded on a worksheet the beliefs that respondents identified during

each intervention session. We used standard thematic analysis to code the worksheets. Thematic analysis is the systematic examination of text by identifying and grouping themes, coding them, and developing categories (13). The first step in the coding process involved open coding by a two-rater coding team who reviewed intervention sheets and coded beliefs by theme. The coding team developed thematic codes inductively as they reviewed successive transcripts, allowing the data to dictate the analytic categories. They continued reading and revising until no new codes emerged from the data. All items were coded by the two raters, who discussed all discrepant codes until they reached consensus. When the coding team could not reach consensus, they brought the discrepancy to a research team meeting, where consensus was reached through discussion.

Results

Most participants (N=143) were male (84%, N=120) and Caucasian (67%, N=95). Thirteen percent of the sample were African American (N=19), and 9% identified as Latino (N=13). The sample represented 48 of 50 states and all branches of service. The mean \pm SD age of the sample was 28.0 ± 5.2 , ranging from 19 to 50. The sample had moderate to severe PTSD symptoms, with PTSD Checklist–Military scores of 59.4 ± 11.6 . Possible scores range from 17 to 85, with higher scores indicating more severe symptoms of PTSD. There were also moderate depressive symptoms, with mean PHQ-9 scores of 16.4 ± 4.7 out of 27, with higher scores indicating more severe symptoms of depression. None of the participants had received treatment for PTSD.

We elicited a total of 189 beliefs about treatment from 143 participants, with most participants identifying one or two beliefs during intervention sessions. Four primary themes emerged from the analysis. These themes were labeled concerns about treatment, emotional readiness for treatment, stigma, and logistical issues (Table 1). When discussing treatment seeking, participants typically did not separate beliefs concerning treatment seeking for one mental disorder or another (PTSD versus depression, for example). Ac-

cordingly, we present themes concerning mental health treatment generally, given that this was our participants’ naturalistic view. An exception was the theme of emotional readiness, which was more specific to PTSD.

Concerns about treatment were frequently reported as a barrier to treatment seeking (40%). The most frequently reported concern about treatment was that it would require prescription of a medication (26%). Participants frequently resisted medications as treatment for psychiatric symptoms, stating, for example, “I don’t want [medications]” or “Mental issues are not medical issues, so medications are not needed,” or “Medications are just a complete waste of time.” Believing a provider would prescribe a medication without listening to the patient’s story was a primary barrier to seeking help.

In addition to beliefs about medications, participants reported a variety of beliefs about treatment that affected treatment seeking. These included wanting individual treatment versus group treatment (13%) and believing that providers would not understand their situation (13%). Some service members indicated that they would feel understood only by individuals who had also been deployed to war.

More than one-third of the participants reported that even though they were suffering with PTSD symptoms, they were not emotionally ready for treatment (35%). More than half of these participants indicated that they believed they didn’t need treatment (52%). Participants stated beliefs such as, “The VA is there for you, but you can get drunk instead” or “Going to treatment would mean I really have a problem.” The primary theme in this category was the perception of a lack of need. Service members commonly identified “coping skills,” which primarily indicated their use of drugs or alcohol to treat symptoms, and they asserted that these “skills” were adequate to manage their symptoms.

Nearly one-quarter of the beliefs pertaining to emotional readiness were related to the idea that it would be too difficult to talk with someone about their symptoms of PTSD (22%). For example, service members indicated that talking about the trauma was too

Table 1

Beliefs among 143 OEF/OIF veterans about treatment for posttraumatic stress disorder^a

Category and frequently reported beliefs ^b	N	%
Concerns about treatment	76	40
"I don't want medications."	20	26
"The doctors can't relate to me."	10	13
"I don't want group therapy."	10	13
Emotional readiness	67	35
"I don't need treatment."	35	52
"It is too hard to talk to someone."	15	22
"I am not ready for treatment."	7	10
Stigma	31	16
"Self-stigma"	12	39
"I will get in trouble if I go to treatment."	12	39
"Fear of being labeled"	7	23
Logistical issue	15	8
"I don't have time."	9	60
"I am too far away from the VA."	3	20
Family issues	3	20

^a OEF/OIF, Operation Enduring Freedom and Operation Iraqi Freedom

^b N=189 beliefs were collected.

hard, that they didn't want to be "emotionally triggered" or "relive the trauma," or that they would "go crazy" if they talked about it. Finally, 10% of the beliefs categorized within emotional readiness were beliefs specifically about readiness. For example, participants stated that they were "not ready" or that they needed "courage" before seeking treatment.

Less than one-fifth of the identified barriers involved beliefs about stigma (16%). Beliefs about stigma fell into two main categories, including self-stigma (39%) and the idea that treatment would result in consequences (39%). Concepts related to self-stigma included "Going to treatment would mean that I was weak" and that it would be "hard to ask for help because of pride." Some participants phrased this self-stigma as needing to "man up."

Perceptions about consequences for treatment seeking were also categorized within the stigma theme. Respondents indicated they believed they would "get into trouble" if they went to treatment. They expressed concerns that mental health treatment could result in loss of their security clearance, in loss of future deployments, and in adverse actions from commanding officers and that it could limit future employment prospects. One participant reported that his military physician informed

him that even though he is currently on the waiting list to receive a kidney donation, he would not be able to receive one if he sought treatment for PTSD or depression. The physician told him that the VA would not give a kidney to someone "who was likely to only kill himself" afterward.

Another set of frequently reported beliefs related to stigma (23%) pertained to the fear of a label. Examples of these beliefs include "don't want to be labeled a crazy vet" and "can't be truthful or else I will be put away."

Only 8% of the beliefs reported concerned beliefs about logistical issues. Beliefs in this category included beliefs about not having time for treatment (60%), being too far away from treatment (20%), and about family issues (20%).

Discussion

We examined beliefs about mental health treatment seeking in a sample of OEF/OIF veterans who screened positive for PTSD—a sample that also showed moderate depressive symptoms but had not sought treatment. Our methodology created an opportunity for veterans with PTSD symptoms to discuss concerns about treatment in their own words, with respect for their own knowledge in understanding what prevents them from seeking treatment. We

determined that these veterans did not seek treatment for four major reasons, in descending order of prevalence: concerns about treatment, emotional readiness, stigma, and logistical issues.

Concerns about the anticipated treatment experience were most prevalent, with 40% of participants voicing such concerns. Within this category, fears of being prescribed psychotropic medications were most common. One strategy to lower this concern of veterans with PTSD is to make available effective, evidence-based behavioral treatment for PTSD (14), such as prolonged exposure or cognitive processing therapy, for veterans who do not wish to take medications. There are also effective, evidence-based behavioral treatments, such as CBT, for major depressive disorder (14), which was also prevalent with this sample. Equally important are education and media campaigns that address veterans and emphasize that treatments may take different forms, including approaches that do and do not require medications (15). In coordination with such efforts, it will be important that veterans with PTSD symptoms who seek care are given choices or are referred to providers who will make choices available (15). However, it might be important to acknowledge that the VA and DoD emphasize receiving care in primary care, which might exacerbate fears about taking prescription medication. Other treatment concerns raised suggest the premium that veterans with PTSD symptoms place on having choices, including their preference for individual (versus group) treatment, receiving treatment from a fellow veteran, and being listened to and understood.

"Emotional readiness" was also a common barrier to seeking treatment, reported by 35% of participants. This category encompassed two types of concerns: the perception that discussing difficulties would provoke a high level of anxiety, thus creating an impulse to avoid or delay treatment, and the concern that they did not need treatment and preferred some potentially maladaptive coping strategies. Media campaigns may help if they emphasize that treatment provides a safe environment where individuals can work at

their own pace, that evidence-based treatments for PTSD help reduce symptoms, and that avoiding traumatic memories and the associated anxiety contributes to, or even increases, ongoing difficulties. The latter barrier (the perception that treatment is not necessary) may be difficult to overcome. For example, some veterans perceive their alcohol use as helping them cope. This coping skill may be effective on a temporary basis, yet if used long-term it may lead to other problems. Veterans should be encouraged to build their repertoire of coping skills so that they can effectively manage symptoms without overrelying on one, especially if that coping skill is potentially harmful.

We found it interesting that stigma was the third most common reason for not going to treatment—by only 16% of participants—yet was the most widely cited reason for resisting mental health treatment (2). A potential explanation for the low prevalence of concerns about stigma is that campaigns targeting stigma have had some positive impact. Prior studies on treatment seeking have largely focused on stigma (and logistical barriers), potentially setting the stage for conclusions about the importance of reducing stigma (in other words, one tends to find what one searches for). It is also possible that the relative lack of concern regarding stigma relates to a wider trend of growing acceptance of mental health diagnoses and treatments in the U.S. population. This effect may have been amplified by the youth of our sample, because younger veterans may not have been exposed to the previous generation's attitudes toward treatment.

Only 8% of the sample raised logistical issues as a barrier to treatment seeking. Military service members returning from a tour of duty are eligible for services at the VA for five years after discharge from military service, and such ease of access likely contributed to the perception that logistical concerns were not a major impediment. It is also possible that an awareness of logistical problems only occurs after one begins the process to obtain treatment.

This study had several limitations. Generalizability to veterans without PTSD symptoms or to civilian populations is unclear. The sample size was moderate and could be

influenced by idiosyncratic experiences. Further research on our four-category organization of concerns about treatment is needed with future samples. For example, the emotional readiness category may be somewhat broader than the other groups, with potential for refinement. Likewise, future studies should consider race-ethnicity and gender differences.

The study was limited by its cross-sectional nature and reliance on self-report data. It is possible that beliefs about treatment change over time. It is also possible that using a gold-standard diagnostic interview such as the Clinician-Administered PTSD Scale would have helped decrease clinical heterogeneity and increased the reliability of results. However, such a lengthy assessment was not feasible given the nature of our brief CBT via telephone intervention. There were also noteworthy strengths of the study, including the use of a qualitative procedure allowing veterans to share perspectives in their own words, double coding of responses with a consensus process to resolve discrepancies, and having a compelling sample of returning veterans with clinically significant PTSD symptoms who, despite their symptoms, were not in care.

Conclusions

The results of this study show that in order to increase mental health treatment seeking among veterans returning from duty with PTSD symptoms, providers must first clarify for veterans what they can expect from treatment and the treatment options available and address their concerns about readiness for treatment. Our results suggest that addressing stigma and logistical barriers are somewhat less important in this effort.

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