

IDENTIFYING BARRIERS TO TREATMENT FOR PTSD AMONG RESERVE COMPONENT VETERANS IN RURAL PENNSYLVANIA: AN ANALYSIS OF FIVE FOCUS GROUPS

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ABSTRACT

Deployment into a combat zone can cause the lives of service members and their family members to change in significant ways. Although deployment imposes a psychological burden on service members (and upon family members), all too frequently those affected not receive needed behavioral health treatment. In this study, five focus groups comprised of the family members and loved ones of service members returning from overseas theaters of operations to rural areas during the period 2003–2008 provided insight into reasons combat veterans were not seeking or receiving the care they may need. The barriers to care perceived and expressed by the focus group participants are conceptualized using the theory of planned behavior and include stigma, career implications, difficulty navigating the overall behavioral health system, a lack of belief in formal treatment, and fear of delayed homecoming, among others. The family members also suggested ways to reduce or eliminate these barriers. The authors conclude that while some of these barriers have recently been addressed with military policy and procedural changes, other barriers continue to prevent service members from seeking and receiving treatment.

INTRODUCTION

Combat is a life changing experience that can impose a psychological burden upon returning veterans. The cognitive, emotional, and physical demands of a combat environment place enormous stress on even the best-prepared military personnel (Hoge, et al., 2004; Milliken, Auchterlonie & Hoge, 2007). This experience affects service members, their jobs, their family members, their social networks, and their local community (Tanielian et al., 2008). Much of the recent conflicts have been fought by Reserve Component troops who are citizen-warriors facing the challenge of rotating between civilian and military life (www.defenselink.mil). This rotation between military and civilian worlds can create additional stressors (Griffith, 2008). When Reserve Component service members return to a rural civilian environment, the psychological burden may be even greater (McDonald, Harris & LeMesurier, 2005). Seeking and accepting appropriate treatment and support for this psychological burden may be critical to the service members' effective reintegration back into their civilian lives.

In the United States, the frequency of behavioral health diagnosis including major depressive disorder, generalized anxiety disorder, and Post Traumatic Stress Disorder (PTSD) among combat veterans is increasing (Hoge, Auchterlonie & Milliken, 2006; Hoge, et al., 2004). Additionally, there is an increase in data reflecting concerns about alcohol misuse and interpersonal conflict (Jacobson et al., 2008; Milliken, Auchterlonie & Hoge, 2007; Thomas et al., 2010). The most prevalent disorder in members of this population face is PTSD (Stecker, Fortney, Hamilton & Ajzen, 2007). Moreover, symptoms of PTSD have been found to increase at a significantly higher rate following return from deployment for National Guard soldiers than for Active Component soldiers (Thomas et al., 2010).

Current research on PTSD indicates that early intervention leads to more effective mitigation of symptoms and a decrease in diagnosable pathology (Brewin, Andrews & Valentine, 2000; Bryant, 2003; Ozer, Best, Lipsey & Weiss, 2008). Despite a wide variety of behavioral health services available both within and outside the Department of Defense (DOD), many combat veterans do not receive adequate behavioral health treatment (Spoont, Hodges, Murdoch & Nugent, 2009). As of fiscal year 2008, 39% of veterans enrolled in the Veterans Administration (VA) reside in rural areas—where access to behavioral health treatment may present especially challenging obstacles (Department of Veterans Affairs, 2010).

The first objective of the family focus group study under discussion was to garner perceptions—derived from opinions, beliefs, knowledge, values, self-efficacy, norms, and attitudes—that influence the intention and perceived ability to seek behavioral healthcare treatment. The second objective of the study was to gather input from rural veterans' family members and significant others regarding ways to eliminate perceived and actual barriers to receiving treatment for PTSD. Five family focus groups were comprised of family members and significant others (collectively referred to as "family members") of service members who had recently returned from deployment to Iraq or Afghanistan.¹ The participants were volunteers who responded to notices in the newspaper, public service announcements on cable and radio, community posters, or flyers distributed in the targeted area of Southwestern Pennsylvania. In addition, Family Readiness Groups were contacted by telephone and e-mail and invited to attend. This summary will address the findings from the family focus groups and conceptualize them using the theory of planned behavior (Ajzen, 1991).

The theory of planned behavior postulates that human action is guided by an individual's personal motivation (intention) and by his or her access (perceived control) to the opportunity and resources necessary to carry out the action (Ajzen, 1991). Intention to engage in a specific behavior—in this case treatment seeking—is conceptualized as formed by the service member's attitude toward the behavior, the subjective norms of his or her family and peer group, and the individual's perceived behavioral control over the behavior. Engaging in the targeted behavior is theorized to be influenced by this intention and also directly by the individual's perceived control over the requisite resources and opportunities to succeed in the behavior. According to this theory, attitudes are the individual's beliefs about the consequences of the behavior (e.g., I want to seek help because then I will feel better), while subjective norms are beliefs about the expectations of significant others (e.g., do I believe my partner will be supportive of my seeking treatment) and may either support or oppose the attitude. Perceived behavioral control is defined as the individual's perceptions of barriers that facilitate or prevent performance (e.g., I do have

insurance that would cover behavioral health care; I don't have transportation) (Ajzen, 1991; Stecker et al., 2007). Britt et al., (in press), have used this model to explore the role of service members' perceptions of stigma and barriers to care on treatment seeking behavior. It is thus anticipated that using this conceptual model will enhance an understanding of the perceptions of service members as seen through the eyes of their loved ones.

METHOD

Instrument

The focus group questions were developed primarily from prior work by Hoge et al. (2004); Britt, Greene-Shorridge, and Castro (2007); and McDonald, Harris, and LeMesurier (2005). Situational factors, including an individual's knowledge base, level of awareness, existing coping skills, and his or her general life circumstances, were investigated. A semi-structured script designed to tap into these factors was used by the facilitator to guide each group's discussion of the participants' beliefs about the following domains: attitudes expressed by the family members that influenced veterans' treatment seeking behaviors, subjective norms that influenced their treatment seeking behaviors, and perceived control over the treatment seeking process.

Participants

Participants in the focus groups consisted of adult family members and significant others of National Guard and Reserve members who had returned from deployment from 2003 through December 2007. The five group discussions included in this summary were held at two separate sites in rural Southwestern Pennsylvania between May 2008 and November 2008 with a range of three to seven participants per discussion for a total of 24 respondents (see footnote 1).

Focus Group Facilitation and Data Collection

A professor of psychology served as the focus group facilitator. The professor used a semi-structured script to guide each two-hour discussion, posing questions to elicit participants' beliefs about the domains described above. A student research assistant unobtrusively attended each group session to record the discussion. The recordings were later transcribed into text documents for use in qualitative analysis.

Analysis

Transcripts from the five focus group discussions were analyzed by a team of four researchers who used *Atlas.ti* qualitative analysis software for the initial and subsequent codings.

Approximately 100 common code themes were initially identified and integrated into a unified code list. The researchers used this list during a second round of coding of the transcripts, a process in which each member of the team worked independently. After conducting a pre-test of intercoder reliability, the research team discussed all codes that had low reliability, revised their coding guidelines, and retrained three coders on use of the revised guidelines.

The researchers collaborated to code 80% of the data, a process that helped them to become even more familiar with the new coding guidelines. They then independently recoded the remaining

portion of the transcripts (20% of the data) and tested it for intercoder reliability. The final intercoder reliability results indicated high levels of agreement among coders and demonstrated that the revised coding guidelines effectively led different coders to equivalent conclusions. The Average Pairwise Cohen's Kappa and the Krippendorff's Alpha coefficients ranged from 84% to 100%, indicating very high agreement.

RESULTS

The theory of planned behavior (Ajzen, 1991) was used to group and understand the codes once they were developed. Treatment seeking behavior was understood to be influenced by the service member's attitude toward the targeted behavior (in this case treatment seeking), subjective norms, and perceived control. The perceived control (opportunities and resources) needed to seek treatment are understood to influence not only the service member's intention, but also his or her actual control over engaging in the behavior. It is understood that these key elements of the theory of planned behavior account for considerable variance in actual behaviors (Ajzen, 1991).

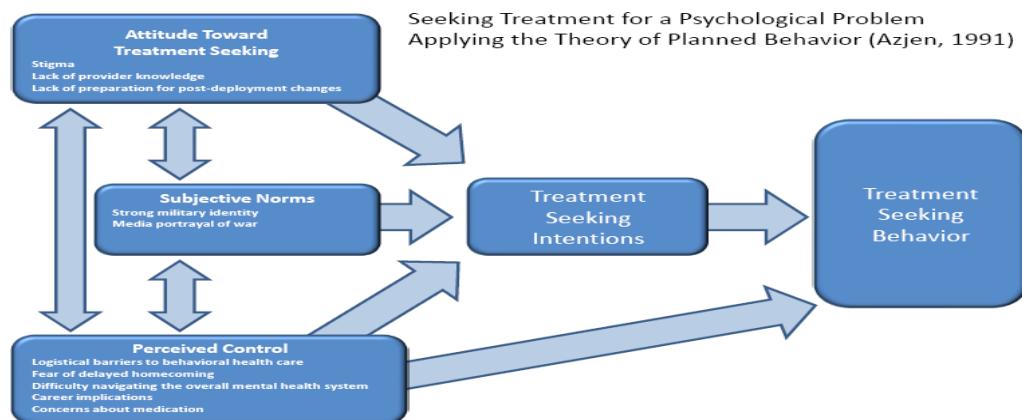
The themes identified in the focus groups fell into the following domains:

Attitudes expressed by the family members that influenced their service member's treatment seeking behaviors included stigma, a belief that providers lacked knowledge of their issues, a belief that their service members were not prepared for post-deployment changes, and the family members' belief they were not prepared for the change in their service members.

Subjective norms that influenced their service member's treatment seeking behaviors included their strong military identity and the media's portrayal of the war to the larger community.

Themes that emerged about the family's perceived control were the barriers they were confronted with in seeking behavioral health care, their fear of a delayed homecoming, the difficulty of navigating the overall behavioral health system, their worries about the career consequences of seeking treatment, and concerns about the impact of medications (see Figure 1).

Figure 1.



Attitude toward Treatment Seeking

When service members return home to their families and communities they face a multitude of barriers to care. Their attitude toward a particular treatment seeking behavior refers to the degree to which a person has a favorable or unfavorable evaluation or appraisal of the behavior (Ajzen, 1991). Focus group participants discussed how specific attitudes created obstacles that decreased the likelihood a service member would actually receive needed treatment.

Stigma. Participants reported that stigma was one of the most consistent and pervasive barriers to service members seeking behavioral health care. The power of stigma is such that other research has shown it can dissuade a service member from seeking this type of care (Britt, Greene-Shortridge, Brink, Nguyen & Rath, 2008; Britt, Greene-Shortridge & Castro, 2007). Past research suggests that Soldiers and Marines who screened positive for a behavioral health disorder were twice as likely to endorse stigma as a concern than those who did not show indications of a behavioral health disorder (Hoge et al., 2004). Stigma may be more profound in rural areas, due in part to the perceived lack of confidentiality where “everyone knows what everyone does” (Brown & Herrick, 2002). Recent research suggests that positive military leadership can actively reduce perceptions of stigma and its resulting barriers to care (Wright, Cabrera, Bliese, Adler & Hoge, 2009).

Corrigan (2004, p. 615) identifies stigma as a significant barrier to seeking behavioral health treatment and frames it as four social-cognitive processes: cues, stereotypes, prejudice, and discrimination. Cues are the process by which the general public observes seemingly inappropriate affect or bizarre behaviors in order to conclude that an individual has behavioral health problems. These cues may elicit stereotypical thinking about the potential danger or weak character of the individual acting inappropriately or bizarrely, which in turn can elicit prejudice—and even discrimination against an individual who has received a behavioral health diagnosis.

Belief in the power of the social-cognitive processes associated with stigma was strongly expressed in each of the five focus groups. As one family member in our study said:

It's embarrassing because they feel like they're alone. They feel like they're the only ones going through it. Which makes them even more reluctant to seek treatment because they feel that because they're the only ones going through that so they're—they're weak or there must be something wrong with them that this affected them and not anybody else. (Group 1, 492).²

While the perceived stigma associated with seeking behavioral health treatment has a basis in the culture at large, it is intensified in military culture (Britt, et al., 2007; Britt, et al., 2008). This pervasive sentiment was reflected in the focus groups through the following comment:

If you would go seek the help and an employer finds out that you are seeking the help, you know, they're not going to want to hire you... I mean there's help out there. I believe there is. But a lot of times that help's going to hurt you (Group 5, 730).

In the fourth focus group, considerable dialogue was generated concerning stigma associated with female veterans seeking behavioral health support. In the VA health care system, male veterans receive a PTSD diagnosis 3.4 times more often than do female veterans (Pereira, 2002).

Murdoch et al. (2003) found that female veterans with a DSM diagnosis obtain a smaller proportion of their care from VA facilities than do male veterans with a DSM diagnosis. Researchers have hypothesized that this disparity may be due in part to women being less likely than men to be given a psychiatric diagnosis related to combat service. While combat injuries in men and women are linked to a high level of PTSD claim approval (90%), women who developed PTSD symptoms resulting from sexual assault were far less likely to receive a PTSD diagnosis. The focus group participants' assertion that the stigma of seeking care was greater for female veterans was grounded in the belief that the female veterans would be perceived as weaker if they sought support. As one participant observed, "She has to suck it up even more because she does have a lot more to prove" (Group 2, 702).

Lack of Provider Knowledge. Participants in all five focus groups articulated the belief that many behavioral health professionals have limited experience treating service members, and that the health providers possess inadequate knowledge of military practice and culture. This perceived lack of experience and understanding could very well dissuade a service member from seeking help. Moreover, family members in each group worried that providers who lacked experience with the military would have difficulty establishing credibility with veterans. Focus group participants frequently stated that their veterans would not trust—or even return—to a provider who did not exhibit competency in military culture. As one family member explained, "When a soldier comes back, they're going to want to talk to somebody that understands what they're talking about" (Group 5, 894). One woman described the frustration of her son's experience: "He hated talking to the psychiatrist because he felt he would go there and that they could not even begin to understand what was going on in his head" (Group 4, 471). Another woman described a similar sentiment from her husband: "I know my husband, he's like 'you didn't go through it so why should I even talk to you'" (Group 4, 803). At the same time, family members in all of the groups appeared to be divided over the necessity of the health provider having firsthand military experience.

Lack of preparation for post-deployment changes. The focus group participants discussed the emotional challenges they faced during pre-deployment, deployment, and post-deployment, and during their reunion with their service members. Family members in all of the focus groups expressed frustration with not being prepared for the changes they saw in their service members post-deployment; they also believed that this problem was compounded by service members not being prepared for the changes they found in their family members, some of whom had learned to function independently. This experience echoed a theme heard throughout the focus groups, namely that combat is a life-changing experience that can impose a psychological burden both upon returning veterans and on their family members. Participants believed better preparation for these changes could have helped with the reintegration process. One wife recalled: "Well, I made the comment, 'I gave you my husband, you gave me a stranger.' And he said, 'I left a wife that needed me and come (sic) home to an independent woman'" (Group 1, 310).

Family members discussed their awareness of combat stress and their concern that PTSD had impacted many of their returning veterans. In the words of one family member in reference to PTSD: "I would say everybody has something close to it, or similar" (Group 4, 905). Although many family members stated that they were knowledgeable about PTSD and reported that they had been able to find information about combat stress and PTSD on a variety of websites, they frequently noted that their service members denied the validity of the family members' concerns.

In addition to having observed in their service members the classic PTSD symptoms of re-experiencing, avoidance, and increased arousal (American Psychiatric Association, 2000), participants also described many combat stress and PTSD-related symptoms that they believed were preventing or slowing the veteran's re-assimilation into civilian life. These symptoms represented often significant changes from the veteran's pre-deployment behavior; and included changes in eating and sleeping habits, suicidal ideation, increased alcohol usage, personal guilt, survivor's guilt, a feeling of isolation, separation from people who understood them, discomfort in crowds, increased financial difficulties, a loss of belief in the efficacy of spiritual support, decreased trust, paranoia, an increase in reckless driving, increased forgetfulness, increased anger, a loss of patience, an increase in irritability, and an increase in expressions of frustration. Spouses reported a decrease in their partner's libido and an increased difficulty with commitment. The military identity exhibited by their service members appeared stronger during post-deployment, and was often accompanied by a loss of previously held beliefs, such as the belief that the service member deserved to be happy.

In addition to the cognitive and emotional changes the family members saw in their returning service members, they noted physical changes that resulted in a different way of being. While some of these physical changes were the result of life changing injuries, many consisted of physical complaints such as headaches, sleep dysfunction, and disordered eating that were not traceable to a physical cause. One family member characterized the changes in a service member's behavior as follows: "It's like having two personalities" (Group 2, 746).

Stigma, the belief that many providers lack sufficient knowledge about the military, and the perception that family members and service members were ill-prepared for the changes wrought by deployment and combat are three key factors affecting service members' attitudes toward seeking and receiving treatment for behavioral health issues. Together with the subjective norms and lack of perceived control, these attitudes contributed to a decrease in service members' intention to seek or receive treatment, regardless of how badly the family members believed treatment was needed.

Subjective Norms

Intention to seek treatment is also influenced by the service members' subjective norms, a term referring to the perceived social pressure to perform or to not perform a behavior. Focus group participants reported that beliefs about the expectations of significant others had an impact on their service members' decisions about treatment seeking. The most prevalent subjective norms discussed in the focus groups were the concept of a strong military identity, along with resentment of what participants described as the negative impact of the media's inaccurate portrayal of the war.

Strong military identity. Participants in each of the focus groups perceived a highly developed and strong set of military values in their service members. Pietrzak et al. (2010) found that a greater sense of purpose and control protected against suicidal ideation and other symptoms of behavioral health disorders, even after adjusting for risk factors, in veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). A strong military identity and sense of purpose is useful and even necessary to military effectiveness. However, strong military

identity can also serve as a barrier to obtaining behavioral health care when service members believe seeking treatment is counter to the identity of a strong warrior, could harm their credibility and career, and cause them to be perceived as weak (Hoge, et al., 2004). One family member summed up her service member's fear of being seen as weak this way: "When they're in basic training, they're taught it's a weakness. So how much is it also the military banging into their heads that, you know, if you can't suck it up and get over it, then you shouldn't be here and be a man" (Group 3, 0721).

This subjective norm is reinforced by the attitude that non-military providers who have not been through their experience are unable to understand and support them. Group members reported that talking over problems with another veteran with a similar strong military identity is the normative way of dealing with concerns. As one family member stated, "Where there's camaraderie, he will talk" (Group 4, 467). Other family members regarded fellow OIF/OEF veterans, family members who are veterans, and veteran members of the American Legion and Veterans of Foreign War (VFW) as acceptable outlets for returning veterans to discuss personal behavioral health issues.

Media portrayal of war. Distrust between the military and the media dates back to the conflict in Vietnam (Jones & Wessely, 2007). Focus group participants expressed the concern that life was made harder for them and their service members by the media's inaccurate and inappropriate portrayal of the current conflicts in Iraq and Afghanistan. The military has attempted to increase the accurate portrayal of events with the "embedded journalist" program allowing members of the media to work alongside the military for extended periods of time. Some research has indicated this collaboration has increased the level of trust between the media and the military as the embedded journalists begin to understand and become more knowledgeable about the military (Tumber & Palmer, 2004). Although the level of mistrust may not be as great as it was during the Vietnam era, the family members shared their perception that the media's portrayal made a stressful situation more difficult. In addition to believing the media does not capture accurately the dedication, the pride, and the personal experience of the service members, three of the family focus groups brought up the issue of the media being intrusive following their service member's return.

I say the same thing when someone tells me thank you. I tell them, you know, that's my job. I work every day. It is my job. I volunteered -- and that's probably the biggest thing people -- some of the stuff I heard coming back, they should bring all of our boys home, we should come home. You know, why are they keeping them there? The poor soldiers. And I'm always -- and I'll be the first one to turn around and say you know what, nobody put a gun to my head and told me to sign on that dotted line. Nobody sent a piece of paper to my house and said you go do this. So I explain to them anybody that's there right now volunteered to be there. Anybody that went volunteered that went. They knew the consequences when they signed the line that someday this would happen. ... And that's why negative things -- she {his wife} didn't like people saying well, you know, they shouldn't be there. We're not doing what we're supposed to. We're just following. We follow policy. Our policy is when we are called; you go to perform a duty. And just general public understanding exactly what's going on and that has a lot to do with how the media's played it down. (Group 4, 407)

Family members expressed the belief that this inaccurate portrayal was in part to blame for their civilian communities' failure to understand the depth of the problems service members can face after coming home. They expressed their perception that their community projects stereotypes onto service members, and harbors discrimination and prejudice. While participants in all of the focus groups expressed gratitude for support offered by their community, they also discussed some of the hurtful comments to which their service members had been subjected. Most upsetting, according to the family members, was the frequency of civilians asking the veteran how many people he or she had killed during their deployment. Family members in all of the focus groups also felt that the community, including civilian employers, expected that once the service members were home, they would quickly assimilate back into their previous lives:

They come back, they feel useless because one, people don't understand them and where they've been. They just see it as -- let's say, for example, a person works in a store. You know, somebody comes in. They don't know. That customer doesn't know that person, you know... just came [home] say let's say six months ago from Iraq. You know what I mean? And if they say something, it just keeps them high strung. Keeps them on the lookout like I don't need to be here. I need to be back there. My people. The people who know where they've come from, anything like that, that's what they need. (Group 5, 144)

Perceived Control

The third antecedent of intention in the theory of planned behavior is perceived control, which refers to the seeming ease or difficulty of the treatment seeking behavior (Ajzen, 1991). Family members provided valuable insights into how their service members perceived their ability to seek and receive behavioral health treatment. These perceptions of control were expressed in many forms: some barriers were internal, perceptual, and individual, while others were more external and tangible. The following section details the barriers family members of returning service members reported prevent them from seeking or receiving behavioral health care.

Logistical Barriers to Behavioral Health Care. Considerable dissatisfaction was articulated in all five groups over logistical difficulties encountered when trying to access services. For these rural family members, frustration was expressed over driving long distances to utilize military-approved resources when certified civilian providers were easily accessible. The resulting time off from civilian employment created an additional obstacle for their service members according to these family members. Additionally, they reported high turnover in military providers that made continuity of care difficult, if not impossible. Family members reported long waiting times for approved providers. They expressed dismay over limitations in coverage for behavioral health and concern about the actual financial cost. The difficulty in taking the necessary time off from their civilian jobs was an additional barrier cited.

Exacerbating this problem is the common phenomenon of PTSD with delayed onset—in which at least six months have passed between the traumatic event and the onset of the symptoms (Adams & Boscarino, 2006; American Psychiatric Association, 2000; Wolfe, Erickson, Sharkansky, King & King, 1999). Delayed onset PTSD may account for as many as 38.2% of

military cases of PTSD (Andrews, Brewin, Philpott & Stewart, 2007). Frequently, unmanageable symptoms may not manifest until years after a traumatic event when service members believe that their benefits have expired. In the words of one family member, "I know the Army, they have your 20 years to get your full benefits and that, but I think anybody that goes into war, that should be -- they should get it no matter what, how many years they have in" (Group 3, 975).

Fear of delayed homecoming. An issue affecting service members' perceived behavioral control factor, was the belief, strongly expressed by members of each of the focus groups, that returning service members who admit to psychological issues will experience a delayed homecoming. In an effort to facilitate the early identification of medical and behavioral health difficulties, the U.S. Military administers the Post-Deployment Health Assessment (PDHA) to soldiers immediately upon return from deployment (Warner, Appenzeller, Mullen, Warner, & Grieger, 2008). Focus group participants reported that their service members were reluctant to acknowledge problems on the PDHA due to the fear that this acknowledgement would cause them to be sent to a treatment program rather than to be allowed to return home. As one group member explained, "...It's almost a punishment if they do try to get help when they first come home. It is a punishment. You don't get to go home and see your family. You have to stay while everybody else gets to go home" (Group 1, 252). Thus in addition to the perceived expectation that they be tough, and the negative impact they believe seeking help will have on their careers, many returning veterans remain silent in order to get home as soon as possible. However, staying silent may mean that these veterans will continue to experience unresolved psychological problems.

Difficulty navigating the overall behavioral health system. When a service member decides to seek treatment, he or she faces the perceived behavioral control question of the ability to find an appropriate service provider. In each of the focus groups, family members related tales of confusion and frustration when attempting to navigate the military behavioral health system on behalf of themselves and for their service members. Many comments were similar to this one:

You have to fish around on websites just to find links to find numbers to call people to even try to get help. And it's not like they're advertising a lot of times either. I mean I've been researching this for a long time and I have trouble finding a lot of information and phone numbers and places to go. (Group 1, 542)

Still others stated that they were aware of military and civilian resources for symptoms of combat stress and related behavioral health problems, but that they had difficulty determining which service best fit their needs:

Once again, the whole thing is just finding those and coming through the realization that they are -- you know, like pinpointing them down. You know there's this magical world of resources out there, but how exactly do I get there? What road do I take to get there? What number do I call? You know, what door do I walk in? (Group 5, 686)

Even when family members and service members were able to find the appropriate service, some reported difficulty accessing those services because of other factors such as driving distance or waiting lists:

We called to request him changed and there was -- he was put on a waiting list. There were 63 people on the waiting list to get changed from this one psychologist. They had one psychologist that people would accept to see when my husband went because all of the other psychologists had the same viewpoint. And it took about four months until we finally got to see that psychologist. He saw him once. I think once. But he didn't truly get help until he had snapped and attacked me... (Group 1, 228)

...If you don't have healthcare, you're going to go to the VA and you're going to go to (a VA outpatient clinic). And when you go to (a VA outpatient clinic), they're going to say oh, now you got to drive to Pittsburgh (VA Hospital) for two hours, you know. And it's a real pain for people to get to Pittsburgh. And if it's an emergency, all you got is the VA. Then you're kind of stuck because it's a two-hour drive, you know. (Group 5, 424)

Career impact. Corrigan (2004) discusses perceived incompetence as a commonly-held stereotype about people with a behavioral health illness. Family members in all five of the focus groups expressed concern that a service member's career would suffer if he or she sought treatment. Focus group participants described their worries about the potential for discrimination in the civilian workplace; however, the dominant concern stemmed from the fear that their service members would be declared unfit for future military duty: "You know, if you have a psych on there—a psych consult on there—for security, you're done" (Group 2, 620). Participants' belief that seeking treatment would harm job security or job advancement was reinforced by other attitudes and norms, such as service members feeling they needed to be responsible for handling their own problems, and that their commanders, peers, and the troops they supervised would think of them as weak and less competent if they were to acknowledged combat stress-related symptoms. This strongly held cluster of beliefs has resulted in many family members believing that their service members would choose not to accept behavioral health support, even if other barriers were removed.

Concerns about medication. Family members in each of the focus groups believed that their service members avoided seeking support because of the perceived negative consequences of taking medication. As the focus group participants explained, service members worried that medication would change them or otherwise limit their normal functioning in some way. One woman describes her husband's experience with antidepressants and sleep medications after his return from combat and questioned whether the prescribing of medication was actually an inadequate substitution for therapy: "Here. Trazodone. It's just drugs. More drugs. We'll just keep you sedated and knocked out" (Group 1, 230).

Also described were service members' worries that if they were prescribed certain medications, they would lose their medical/behavioral health clearances and would be relieved of their duties:

I know a Marine...having a hard time. And he got on medication and they told him that so and so above him found out he was on this medication...His sergeant told him 'you

don't need that medication, throw it away.' That's what he told me. Then when he continued to take it, they said 'well, if you're on that in six months, you're out. You're getting discharged. Because we don't need somebody that's depressed to be on medication' (Group 2, 522).

Some participants did state that medication had helped family members who were suffering from combat stress. So while medication was seen as both helpful and needed, the potentially negative consequences were also believed to be strong enough to prevent service members from accepting this form of help.

The theory of planned behavior proposes that perceived behavioral control influences treatment seeking intentions and directly influences treatment seeking behaviors. Thus, the service member's perceived control or lack of it over the logistics of treatment seeking, the individual's fear of a delayed homecoming if he or she seeks treatment, the individual's concerns over career implications and the individual's concerns about the impact of medications will influence both the service member's intentions and directly influence the treatment seeking behaviors he or she chooses to pursue.

Suggestions from Family Members for the Military

Focus group participants believed that their service members were not receiving the treatment they needed and deserved. While not versed in the theory of planned behavior, the participants demonstrated an awareness of how attitudes, subjective norms, and perceived control influenced their service members as they considered whether to seek treatment. Suggestions offered by family members for ways the military could make it easier for service members to seek and receive treatment address several of these attitudes, norms, and perceived lack of control. Perhaps because attitudinal issues such as stigma and social norm such as military identity seem both complex and pervasive, most of the suggestions related to improving perceived control by making it easier to seek help. The following sections detail some of the more common and recurring suggestions.

Mandatory counseling for all returning service members. According to family members, their service members were likely to deny the need for counseling due to the attitudes, subjective norms, and perceived control issues described above. Many participants saw mandatory post-homecoming counseling as a way to circumvent the factors influencing their service member's lack of intention, while also increasing the likelihood that PTSD and other combat stress related concerns would be recognized and treated:

It's frustrating because he's going to the VA because he has flashbacks and stuff and he goes to the VA, but he has to take days off work with no pay to go to the VA to get help. And even then he hesitates because you're supposed to be a tough guy if you're in the Marines or if you're in the Army. And so I personally think that they should have mandatory psychology counseling for everybody that returns for so many months. Mandatory! Paid! When they complete the program, give them a bonus for completing it. (Group 2, 48)

And if they said okay, here, we're scheduling you an appointment, we're not going to make you be away from your family to do this. We're going to do it somewhere in your local community. Six months from now you will have an appointment. You're going to get a letter five months from now that says that you have an appointment on this day at this time to go speak to someone and...you have to do it. Don't make it a voluntary thing. (Group 4, 573)

Participants agreed that making counseling mandatory would remove the stigma and lessen service members' fears of being judged as weak or mentally ill for wanting to seek treatment.

Just what I said earlier, I think it should be mandatory. That would be the -- I've said that over and over so many times that it should be mandatory for everybody. And nobody, you know, singled out for weaker or -- and then it wouldn't be able to be part of the record because if everybody does it, it's not -- you know, if everybody has to go for the counseling, it's not on the record as seeking out counseling or whatever. (Group 2, 706)

Although most group participants agreed that mandatory counseling should take place, they had differing ideas of when it should occur. Many suggested that it happen immediately upon return—"when they come back" (Group 4, 935)—or within the first week back from combat. Others suggested mandatory counseling six months after the return from active duty. It is worth noting there is some debate in the literature over the efficacy and ethics of mandatory counseling (Gilbert & Sheiman, 1995).

Delayed psychological assessment. Andrews et al. (2007) found that service members can experience a delay in experiencing symptoms from several weeks to many years, a finding that is consistent with the DSM-IV-TR criteria for PTSD with delayed onset (American Psychiatric Association, 2000). In one of the focus groups, the husband of a female service member reported it took "six months—maybe longer" before he "first started noticing something" wrong with his wife after she returned home (Group 4, 951). Family members used this discussion point to emphasize that in order to return home as quickly as possible, service members tended to be less than honest about their psychological difficulties on the PDHA—even if the service members were experiencing problems. During homecoming and reintegration, family members asked their service members about the psychological issues they were facing; however, the service members frequently rebuffed family members' concerns. Family members noted that because some of their service members did not display immediate signs or symptoms of combat stress, they would not necessarily feel that mandatory counseling immediately after homecoming was necessary.

One family member argued that veterans simply need time to reintegrate before they realize that they are having problems:

Not right away. Give them some time to wind down. Because they're not going -- first six months -- first couple weeks they're going to spend with their family. Then they're going to spend the next couple weeks with their extended family. Then they're going -- after about three months they're going to be trying to get back into the job and get settled into the job. So they're not even thinking about anything else. (Group 4, 937)

In general, focus group participants suggested that the military implement a delayed psychological assessment after the initial post-deployment health assessment (PDHA). This second assessment would create an opportunity for service members to answer the assessment more truthfully, report delayed symptoms, and allow time for reintegration at home, at work, and into the community. Delayed onset PTSD research indicates that mandatory assessment and counseling sessions at more than one point post deployment would be optimal (Andrews et al, 2007).

Improve military insurance practices. Some of the complaints about disorganization were clearly directed at military insurance programs. Family members indicated that military insurance programs—such as Tricare—not only limit the time in which service members have to seek treatment, but also impose limitations on where a veteran may receive help, the number of visits that can be made to a doctor, and what type of treatment can be received. A majority of the family members agreed with the sentiments of a participant who stated, “Don't put a timeframe on them. Because, you know, truthfully that's what they've done is put a timeline. You have a year to get all this, you know -- if you want that service, you have one year after that” (Group 3, 967).

Provide better support for selecting services. While a large majority of the family members agreed that a wide range of behavioral health care programs and services was available to veterans, they also agreed that this array of services—each with its own particulars, stipulations, and limitations—could be difficult to navigate without help:

Having a lot of programs, I don't think is a problem at all. I think it's informing them of the programs. They say okay, well you can get help, but they don't tell you where. You know, they don't tell you how to get in touch with anyone. The only thing they get is in their debriefing, they get a thing on the VA, but that's it. (Group 1, 544)

Focus group members believed that the military could do a better job of helping family members and service members identify and select behavioral health resources in two key ways: by providing more detailed information about the various programs, and by ensuring that this information be provided to all returning service members.

Improve the debriefing process. Focus group participants indicated that the debriefing process could be improved for all involved. Participants acknowledged that their service members paid little attention to debriefing because they viewed the process as yet another impediment to their return home. At the same time, as with the array of health service information noted above, the military provided a great deal of information for the service member to process in a short amount of time. To address both of these deficiencies, focus group participants suggested that spouses and/or family members be allowed to attend the debriefing with service members, because “the spouse might see some things the soldier doesn't” (Group 5, 550). As one focus group member explained,

They can take their family member dependent with them. That way they're getting the same

information that the soldier's getting. The solider, like I said, he might have taken information and threw it in the duffle bag and the spouse is never going to see it. (Group 5, 542)

Focus group participants also suggested that delaying the full debriefing until after the initial homecoming period would enable service members to absorb more of this valuable information—especially if a family member or loved one could participate in the debriefing.

DISCUSSION

The suggestions shared by the family members in these five focus groups also fit the model conceptualized by the theory of planned behavior (Ajzen, 1991). Attitudes toward the behaviors, subjective norms, and the individual's perceived control are understood to influence the service member's intention to engage in a specific behavior. This theory also takes into account non-motivational factors that directly influence an individual's ability to engage in a particular behavior. Examples of the relative ability to control specific behaviors have been noted, such as the extent to which the service member has the resources and opportunities to succeed in carrying out a behavior. The Department of Defense has implemented changes intended to facilitate the actual control service members have over treatment seeking behaviors.

Military Changes

Prior to and since the family focus group discussions took place, the military has acted to address difficulties within the system, instituting policy and procedural changes to improve the chances of combat-related behavioral health issues being detected and treated. Many of these changes address problems discussed in the family focus groups, demonstrating that our sample accurately conveyed some of the most pressing issues regarding the military behavioral health structure. It can be said that the military has prioritized giving service members increased control over access to treatment, and on influencing attitudes and the subjective norms toward service members seeking treatment. One example of efforts to influence attitude and subjective norms has been the number of senior military leaders, such as General Carter F. Ham, who have spoken publically about their need for and success with behavioral health treatment (Montgomery, 2009).

Post-deployment health reassessment (PDHRA). Validating one of the principal beliefs expressed by the family focus groups, U.S. Army studies of the PDHA have found that the rates of reported deployment-related symptoms may increase with time after return from deployment. This finding has resulted in the creation of an additional screening tool, the Post-Deployment Health Reassessment (PDHRA), which is now used to reevaluate veterans 3 to 6 months after their return from a combat zone.³ Milliken et al. (2007) found that both active and Reserve veterans reported more behavioral health concerns and were referred at significantly higher rates after the PDHRA than after the PDHA. Among Reserve component veterans, 42.4% were identified by clinicians as requiring behavioral health treatment based on the combined screening. Although the PDHRA revealed a significant increase in symptoms, it also revealed that approximately half of the veterans who had reported PTSD symptoms on PDHA reported improvements by the time they took the PDHRA.

Department of Defense and Veterans Affairs policy changes. In late 2008, U.S. Secretary of Defense Robert Gates announced the military would implement a provision of the 2008 Defense Authorization Act calling for service members who were medically retired for post-traumatic stress disorder be rated at least 50 percent disabled. This change represented an improvement over past practice, suggested an article in the *Navy Times*, since “in the past, according to Army documents, many soldiers with PTSD have been found unfit for service, rated 10 percent disabled and immediately booted out” (Kennedy, 2008). However, the rating change did not allay the concern that a diagnosis of PTSD would harm—or terminate—military careers, a concern articulated by many members of the family focus groups.

Prior to 2008, it was standard practice for the Department of Defense to ask individuals applying for security clearances whether they had ever received treatment for behavioral health issues. If an individual checked “yes,” he or she would have to provide more details about the treatment, unless that treatment was strictly grief, marital, or family counseling. The perception—and at times the reality—was that answering “yes” to this question could prevent a service member from obtaining a security clearance, a key to military job security and career advancement. In May 2008, the question was reworded to ask only about behavioral health treatment received during the past seven years, and specifically excluded treatment sought because of service in a combat zone. As Secretary Gates explained, “For far too long and for far too many, this question has been an obstacle to care” (Miles, 2008), a statement supported by research findings (Baker, 2008).

In July 2010, the Department of Veterans Affairs announced that it would change the claims process for veterans with PTSD. Previously, a veteran was required to prove that he or she had actually experienced a stressor related to hostile military activity. Under the new rule, the veteran needed only to have the diagnosis of PTSD confirmed by a psychiatrist or a psychologist, along with confirmation by that provider that the veteran’s symptoms were consistent with a military stressor (Wilson, 2010).

Also in 2010, the Department of Veterans Affairs Office of Rural Health released their five-year strategic plan for 2010-2014. Goals outlined in the document include improving access and quality of care for rural veterans, expanding service options for rural veterans, and optimizing the use of technology to assist veterans (Department of Veteran Affairs, 2010a). When these goals come to fruition, they will undoubtedly help to eliminate some of the barriers facing rural service members who wish to obtain behavioral health care.

In November of 2010 the VA announced the release of a new personalized Veterans Health Benefits handbook (Department of Veterans Affairs, 2010b). The goal of the new handbook is to provide a comprehensive, easy to understand roadmap of available benefits. This may help to address the concern expressed by many family members that navigating the wide array of services can be confusing. The new handbooks are scheduled for full distribution in the fall of 2011.

Future Recommendations

The intent of this qualitative research was to understand, describe, and explain—from the perspective of their concerned family members—barriers to behavioral health care for returning reserve component troops. The U.S. military has made important strides in the past few years to improve the behavioral health treatment process and is committed to continuing these improvements, yet there is still work to be done.

A current service member who does not begin to show signs of PTSD for 3 years after his return misses out on the benefits afforded to him by military health insurance during his first year home. Research supports the anecdotal evidence given by family members that symptoms of PTSD can manifest more than three years after traumatic exposure (Andrews et al, 2007). The military and the VA are encouraged to partner with rural health care providers in order to provide more flexible options for treatment. Currently, many rural veterans must travel to urban centers to seek treatment from unfamiliar health care personnel. This process is not only inconvenient, but also a deterrent to obtaining necessary behavioral health care.

Limitations

A limitation of the current study is the small sample size in relation to the target population. This was a convenience sample comprised entirely of volunteers who responded to a request for participation. Based on this study, it is not possible to determine if this sample of focus group volunteers had specific qualities that created a difference—as compared to a true random sample—in the perception of barriers to behavioral health care among returning rural service members.

Future Directions

These recommendations have been forwarded to the Department of Defense. A regional community education campaign that addresses the concerns identified in the focus groups was also launched in the research area. The theory of planned behavior has been useful in understanding barriers to seeking and receiving treatment and may be useful in designing solutions targeted toward adaptive treatment seeking intentions and increased perception of behavioral control over treatment seeking behaviors. The format of family focus groups has proven to be a useful tool for gathering from these family members the predispositional perceptions—opinions, beliefs, knowledge, values, self-efficacy, norms and attitudes—that influence the intention and ability of their service members to seek behavioral healthcare treatment and ways to eliminate barriers to accepting and receiving treatment and can be successfully used in future research.

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Footnotes

¹ Six focus groups were originally conducted. One of the focus groups (July 12, 2008) included current National Guard members, veterans and their family members and as such did not meet

the inclusion criteria (adult family members/significant others of Reserve Component members who have returned from deployment from January 2003 to December 2007) for this study, thus the information from this group was not discussed in this analysis.

² Quotes attributed to focus group members are cited by the group number and the line number of the transcript in which the statement was made. Due to confidentiality measures outlined in the IRB protocol, these transcripts cannot be made publicly available.

³The PDHRA was implemented in 2005, so many of the service members represented in the focus groups returned prior to this time and did not receive this assessment.

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