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MILITARY SERVICE MEMBERS' AND VETERANS' PREFERRED APPROACH TO
MENTAL HEALTH SERVICES

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science
at Virginia Commonwealth University

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Abstract

SERVICE MEMBERS' AND VETERANS' PREFERRED APPROACH TO MENTAL HEALTH SERVICES

By Lisa Goldberg Looney, BA

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at Virginia Commonwealth University.

Virginia Commonwealth University, 2014

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Mental health services are greatly underutilized by military service members and veterans.

Among the reasons for this underutilization is that the services offered may not be a good fit for the specific problems facing service members/veterans and/or their families. The current study presented service members with descriptions of several approaches to treatment and asked them to indicate the likelihood of using each. Service members indicated the highest likelihood for using self-directed services, followed by individual treatment with a professional. They reported being least likely to use group approaches. These results may inform decisions about the implementation and dissemination of information about existing and new services.

Military Service Members' and Veterans' Preferred Approach to Mental Health Services

The United States is currently engaged in the longest continuous period of war in our nation's history. Over two million service members have served in Afghanistan and Iraq, with many having been on multiple deployments (Danish & Antonides, 2013). Some studies suggest that military veterans are a high risk population for mental health disorders, with as many as 42% of veterans meeting criteria for disorders such as posttraumatic stress disorder, depression, anxiety, and substance abuse (Hoge et al., 2004; Milliken, Auchterlonie, & Hoge, 2007; Thomas et al., 2010). Other research suggests that military service members are actually quite resilient, with more than 80% demonstrating little or no increase in post-traumatic stress symptoms following deployments (Bonanno et al., 2012). Yet a study by Warner et al. (2011) asked Army soldiers to complete an anonymous survey following the mandatory Post Deployment Health Assessment (PDHA) and found that mental health problems and interest in care were two to four times more likely to be reported on the anonymous survey than on the traditional PDHA. They also found that 20% of soldiers indicated they were not comfortable reporting honestly on the routine, mandatory screening. This suggests that service members may actually be experiencing more problems than they are reporting.

Whether estimates of mental health problems affecting service members are underestimated or overestimated, it is clear that only a small percentage of veterans seek mental health treatment. In the general population, less than half of those with mental health symptoms seek treatment (Alonso et al., 2007). This under-utilization is amplified in the military, with only about 30% of those who meet criteria for a disorder seeking care (Brown, Creel, Engel, Herrell, & Hoge, 2011; Hoge et al., 2004; Kim, Britt, Klocko, Riviere, & Adler, 2011).

While past studies have examined unique challenges that exist for service members and

veterans, very few have focused on what services, if any, service members and veterans use. Studies do suggest, however, that service members/ veterans are often reluctant to self-disclose and seek services (Bonar & Domenici, 2011; Church, 2009).

As will be seen, several factors have been shown to influence the underutilization of mental health treatment in the general military population, including stigma, negative impact on one's career, and perceived effectiveness. However, researchers have yet to explore the question of whether services currently offered to service members/ veterans and their families are a good fit for the population and for the specific problems they face. Service members and veterans have a distinctive culture and therefore may need unique approaches to treatment, and current services offered may not be a good fit for the specific problems facing service members/veterans and their families.

The aims of this exploratory study are: (1) to assess which, if any, of a variety of treatment approaches is preferred for specific problems service members/ veterans face; (2) to assess whether this population prefers one approach over others across all problems or select different approaches for different issues; and (3) assess which of several previously identified factors (i.e. stigma, career impact, perceived effectiveness) are most influential for treatment approach preferences. It is the hope of the researcher that a more thorough understanding of service members' and veterans' treatment approach preferences will inform the development, implementation, and utilization of future treatment options for veterans.

Review of the Literature

I will begin by discussing military culture and exploring the unique challenges of being a service member or veteran. I will then introduce several factors that have been shown to negatively affect the use of mental health treatment by service members and veterans and present the recent research exploring the role of these factors. Further, I will suggest that existing treatment approaches may themselves act as a barrier to help-seeking, as they may not be appropriate for the issues service members/veterans and their families face. I will then provide a brief review of several different approaches to treatment. I will conclude with the rationale for the current study as well as its aims.

Military culture and help-seeking

Military culture discourages treatment seeking. For instance, various service branches have creeds that encourage service members to avoid demonstrating vulnerability, such as the Soldier's Creed which states "I am ... physically and mentally tough." The culture of "Army Strong" and Marines' *Semper Fidelis* likely discourages treatment utilization by discouraging the appearance of needing help (Danish, Hamilton, Conley, Antonides, & Lang, in press). Burns and Mahalik (2011) suggest that masculinity norms, such as being independent and unemotional, may play a role in military service men not seeking help. These beliefs are incredibly ingrained in the military culture.

In 2008, the RAND Corporation completed a report that identified several barriers to care for military service members (Tanielian & Jaycox, 2008). In this report, Burnam et al. (2008) discuss how service members must develop a culture of "toughness, independence, not needing help, not being weak, and expecting to be able to master any and every stress without problems" (p.276) and may have trouble acknowledging a problem even to themselves, let alone to others.

Recognizing and seeking treatment for mental health problems flies in the face of these attitudes and values. Many military service members try to ignore the problem because they feel that admitting a mental health problem or seeking treatment is a sign of weakness (Burnam et al., 2008).

Related to the military culture of not showing weakness, many service members are unwilling to ask for help from others. A commonly reported barrier to care is the belief that “I ought to handle it on my own” (Stecker, Fortney, Hamilton, & Ajzen, 2007). In fact, Kessler et al. (2001) found that the most frequently reported reason for failing to seek treatment and for treatment dropout was the desire to solve the problem on one’s own.

Stigma

Several barriers to mental health care have been identified for the general population and for military service members and veterans. Much of the literature focuses on stigma, which can be defined as extreme disapproval based on some characteristic that distinguishes an individual from others. Stigma includes concerns about social consequences of help seeking, and studies have found that service members often believe seeking treatment would be embarrassing, cause harm to their career, and/or cause their fellow unit members to have less confidence in them (Britt, Wright, & Moore, 2012). Stigma can be divided into two types: *public* or *perceived stigma* and *self-stigma*. Public stigma is the prejudice and discrimination endorsed by the general population, while self-stigma is the internalized prejudice a person feels (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012). Others have defined self-stigma as “the perception of oneself as inadequate or weak if one were to seek professional help” (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012).

Corrigan (2004) was the first to distinguish between public and self-stigma and examined how these factors interact to influence decisions to seek help. Those in need may choose not to

seek treatment in order to avoid being labeled, prejudged, and discriminated against. They may also internalize public beliefs about mental illness and avoid treatment because it leads to feelings of shame, inadequacy, and inferiority.

Hoge et al. (2004) administered an anonymous survey examining psychological symptoms, treatment utilization, and perceived barriers to seeking care by three combat infantry Army units and one Marine Corps unit either before or after deployment and found that those who screened positive for a mental health disorder were twice as likely to endorse stigma-related barriers to treatment as those without mental health symptoms. This finding suggests that those most in need of help are also those who are most aware of the negative consequences of being viewed through the lens of a label.

Brown et al. (2011) anonymously surveyed Active Duty Army and Marine servicemen, probing for mental health symptoms, recognition of a problem, interest in receiving help, past care, perceived barriers, and unit and deployment characteristics. Of those who screened positive for a mental disorder, over 75% recognized a problem but only 40% expressed interest in receiving help. As expected, negative attitudes toward mental health care, or self-stigma, were correlated with lower interest in receiving help. However, negative perceptions of unit stigma— i.e. perceived stigma— were associated with increased interest in receiving help, a result opposite of what had been predicted. The authors explain this unexpected finding by suggesting that interest in care may make individuals more aware of public stigma. Therefore, it is not that perceived stigma acts as a facilitator to seeking treatment, but that those most in need notice stigma more than those not interested in care, consistent with previous findings (Hoge et al., 2004). Furthermore, Brown and colleagues (2011) recognize that interest in receiving help may not be the same as actually following through. It is entirely possible that the heightened

awareness of public stigma did in fact act as a barrier to treatment even for those interested in seeking help.

Kim et al. (2011) collected data on treatment use and mental health risk for soldiers from brigade combat teams 6 months post-deployment and asked them to rate several proposed barriers to mental health treatment utilization. They found that soldiers' own negative attitudes toward treatment, or self-stigma, served as a barrier to care, while public stigma did not strongly predict whether or not one sought treatment. However, this is not to say that public stigma does not influence treatment utilization. Vogel, Wade, and Hackler (2007) found that public perceptions of stigma strongly influence the development of self-stigma, which then predicts whether or not an individual will seek treatment. Therefore, both public and self-stigma pose significant barriers to seeking care and both need to be addressed.

Stigma-related barriers to treatment have been documented in various branches of the service, including Active Duty (Brown et al, 2011) and Reserve Army (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), National Guard (Gorman, Blow, Ames, & Reed, 2011; Kim et al., 2010; Stecker et al., 2007), Marine Corps (Hoge, 2004), Navy (Tanielian & Jaycox, 2008), and Air Force (Rowan & Campise, 2006), as well as in veterans who have separated from the service (Ouimette et al., 2011). Many efforts have been made to challenge both public and self-stigma (Adler, McGurk, Bliese, Hoge, & Castro, 2009; Corrigan et al., 2012; Stecker et al., 2011), but stigma continues to be a major impediment to treatment.

Harm to Career

While some researchers characterize *harm to one's career* as a subcategory of stigma, the impact of receiving treatment on one's career may merit additional consideration beyond that of stigma for the military population. A Department of Defense *Survey of Health Related Behaviors Among Military Personnel* (1998) found that most soldiers believed receiving mental health counseling would hurt their career. Tanielian and Jaycox (2008) found that over 40% of service members surveyed were concerned that seeking treatment would constrain future job assignments and prevent military career advancement.

Schell & Marshall (2008) presented statements taken from three prior studies of barriers to care to OEF and OIF veterans from the Army, Navy, Air Force, and Marine Corps in 24 geographic areas of the United States and asked them, "If you wanted help for an emotional or personal problem, which of the following would make it difficult?" They found that over 40% of veterans endorsed the belief that seeking care could harm their career, restrict current or future occupational opportunities and promotion, and prevent them from obtaining a security clearance.

Historically, mental health issues affected service members' security clearances and determined whether service members were labeled "ready" to do their job or "ill" and unfit for duty (Dingfelder, 2009). However, in recent years the Department of Defense changed their policy to allow those who have sought care for an emotional or mental health condition to choose not to report it on the security clearance questionnaire (Department of Defense, 2008). In addition, the military has adopted a new model with more leniency that incorporates the categories of "reacting" and "injured" and allows for continued service despite mental health issues.

Furthermore, research has shown that concern about the impact of mental health diagnoses and treatment on one's career is unfounded as it is uncommon for treatment use to result in negative career consequences or loss of security clearance. Rowan and Campise (2006) retrospectively examined records from Air Force Life Skills Support Centers in order to assess career implications for service members who either self-referred or were referred by others, such as command. They found several benefits to self-referring early and on one's own initiative, including increased confidentiality, dramatically lower likelihood of negative career repercussions, and increased likelihood of being diagnosed with transitory problems rather than serious disorders. Nonetheless, the fear of negative career repercussions remains a prominent barrier to care.

Perceived Effectiveness

Another factor that may serve as a barrier to treatment utilization is a person's belief that the treatment will be ineffective. The National Comorbidity Study (NCS; Kessler et al., 2001) identified several barriers to mental health treatment in the general population using a cross-sectional, nationally representative, household survey and found that 45% of those who recognized that they had a mental health problem reported a belief that care was ineffective. In 2008, the RAND Corporation completed a report that identified as a barrier to care the uncertainty that treatment would be adequate (Tanielian & Jaycox, 2008). In the study by Schell & Marshall (2008), nearly 40% of service members endorsed the belief that family or friends would be more helpful than a mental health professional, about 30% believed religious counseling would be more helpful than mental health treatment, 25% responded that mental health care is not effective, and close to 20% reported past treatments had not been beneficial.

Studies have shown that the belief that mental health care is ineffective is correlated with decreased likelihood of use (Pietrzak et al., 2009).

Unique culture and unique problems

There may be an additional factor that works in conjunction with the various barriers to care identified above. Perhaps another reason for low utilization is that the services currently available to service members do not fit the needs of the military community. Several researchers have discussed how military culture has its own unique customs, cultural norms, vocabulary, and rank structure (Danish & Antonides, 2013; Danish et al., in press; Dickstein, Vogt, Handa, Litz, 2010; Hoge, 2004; Tanilien & Jaycox, 2008). Military service members have different concerns from the general population and the existing treatment modalities may not be appropriate for the issues they face. It is also possible that different problems facing this community each require different types of services. Whereas individual therapy by a licensed profession is the most common treatment modality, other modes of treatment could potentially be more suitable for the military community. Some alternative treatments include technology-assisted self-treatment, group treatment, and the use of peer mentors.

Alternative Approaches to Treatment

Self-directed approach. Technology-assisted self-treatment utilizes technology, such as the internet or compact discs, to allow self-administration of empirically tested treatments. This approach is designed to allow the user to proceed at his or her own pace and on his or her own schedule. One example is the F.R.E.E. 4 VETS program (Danish, 2010) which is made up of 17 workshops that provide information and teach skills that may help individuals resolve major re-entry issues following deployment: family or relationship issues and interactions, work/employment difficulties, and an overall lack of focus or purpose (Danish, 2010).

Several studies have demonstrated the efficacy of technology-based interventions (Litz, Engel, Bryant, & Papa, 2007; Tsai & Rosenheck, 2012; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). Studies have also reported soldiers' and veterans' willingness to use a technology-based approach (Tsai & Rosenheck, 2012; Wilson, Onorati, Mishkin, Reger, & Gahm, 2008). In fact, one third of soldiers unwilling to talk to a professional in person reported they would use a technology-based approach (Wilson et al., 2008). While no studies have evaluated the level of stigma associated with self-directed approaches to treatment, this intervention may potentially reduce stigma, as it can be completed in the privacy of one's home without the knowledge of others. In addition, self-treatment may be a better fit for military populations as it is in line with the idea that one should handle the problem on his or her own.

Peer Approaches. Another approach that may be a better fit for the military community would be to use the peer community to address mental health and reintegration issues. Talking with one's peers may not be viewed as harshly as talking with a professional. In addition, service members often feel that someone who has not experienced what they have been through cannot understand their problems. Peer approaches, such as a peer mentor approach or peer-led group therapy may therefore be favored over talking with a professional.

Peer-Mentor Approach. In the peer mentor approach, a veteran who is experiencing challenges meets with a fellow veteran who has faced the same or similar situation or issues and has experienced significant improvement. This fellow veteran serves as a peer mentor, typically meeting one-on-one with the individual experiencing challenges in order to provide support and a positive example of someone who has overcome similar difficulties (Chinman et al., 2008; Jain, McLean, & Rosen, 2012; Money et al., 2011). Often, peer mentors receive training in communication skills, available resources, and steps to take if a situation requires expertise

beyond their level of training, although there are also peer mentor models that do not require the peer mentor to undergo training. Research is needed to assess attitudes about stigma, career impact, effectiveness, and likelihood of utilization.

Peer group approach. Group treatment involves meeting with several other individuals with similar experiences in order to share and learn from each other's experiences and gain social support (Money et al., 2011). Participating in a peer group provides the opportunity to share coping strategies with others currently managing the same situation. Groups can be small or large and may meet only once or over the course of several regular meetings. Group formats involve sharing emotional responses and normalizing these reactions; in this way, they may combat stigma (Raphael & Wilson, 2000). However, while group approaches have been found to efficacious, there is limited research on the feasibility and effectiveness of group-based approaches in the military (Zinzow et al., 2012).

Talking to a professional. Talking to a professional refers to either individual or group sessions with a trained practitioner. This may include meeting with a licensed counselor, marriage and family therapist, social worker, psychologist, psychiatrist, or any other professionally trained provider. It does not include speaking with a friend, family member, or religious personnel. The practitioner could work at the Veterans Administration, on base, at a university, or at a private practice.

Group approach with a trained practitioner. This approach would be similar to the peer-led group approach with the differences being that groups are led by a professional and are treatment-oriented. Like peer-led groups, additional research is needed to assess the feasibility and effectiveness of group-based treatment in the military, as well as associated stigma. One example of the group model that has been empirically tested with service members and veterans

is Battlemind Training, developed by the Walter Reed Army Institute of Research and commonly used in the Army (Adler et al., 2009). Group leaders, who are trained in a behavioral health field such as psychology, psychiatry, or social work, provide information about transitioning home as well as strategies for positive coping to platoons of 18 to 45 or larger groups of soldiers. The soldiers are asked to identify and describe their thoughts about difficult experiences, describe the worst part of the experience, and discuss both positive and negative changes since returning from deployment. In addition, participants are provided a positive framework for thinking about the deployment and mental health resources are identified. While group leaders of Battlemind Training are professionally trained in a helping field, they also are often military officers with deployment experience, blurring the lines between professional and peer-led group therapy. Additional research is needed to assess service members' and veterans' interest in using professionally-led group treatment.

The Current Study

The current study sought to describe the preferences of service members/ veterans among several treatment approaches across various challenges commonly faced by this population. In addition to exploring treatment preferences, the study also explored which factors have the strongest influence over which treatment options service members and veterans prefer to use.

We presented service members and veterans with descriptions of the various treatment approaches and brief examples of challenges service members/veterans may have or face and asked them to indicate the likelihood of using each approach by rating each approach on a likert type rating scale for each challenge example. No prior study has assessed what treatment approach best fits challenges faced by military veterans, such as difficulty transitioning home after deployment, role adjustment, or uncertainty about life after separating from the service. The

present study also asked participants to indicate the single most important factor determining which approach(es) they rated the highest.

Research Question 1: The study will report the average rating of how likely service members are to use each treatment approach across all scenarios as well as by category of problem: alcohol and substance use, relationship issues, pathology, and identity/ future.

Research Question 2: The study will provide frequencies with which service members/ veterans indicate the various factors (i.e. stigma, effectiveness, potential career impact, logistical barriers, etc.) that most influence their preference for a given treatment approach.

Method

Participants

Participants were eligible for the study by virtue of being an active-duty or reserve service member or veteran of the United States military with service during the time of the Afghanistan and Iraqi wars. They were recruited from many sources through multiple methods. Study personnel contacted leaders of military and veteran organizations nationwide through email and social media and requested assistance with the dissemination of a recruitment blurb and flyer. Recruitment materials were also posted directly on message boards and emailed to listservs for national military and veteran organizations, including several student veteran associations and the American Psychological Association Division of Military Psychology. These recruitment efforts had the potential to reach hundreds of prospective eligible participants.

Twenty-six service members in the active-duty Army ($n = 7$), Navy ($n = 6$), Marines ($n = 11$), Air Force ($n = 1$), and Army National Guard ($n = 1$), whose total years of service ranged from 1 to 20 years ($M = 6.93$, $SD = 4.83$) participated in the study. Most of the participants (73.1%) had been deployed at least once, with as many as 6 deployments, and 34.6% had been in

combat. Participants were 76.9% male ranging in age from 20 to 47 years ($M = 29.88$, $SD = 7.02$). The majority (65.4%) were students, with 38.5% full-time undergraduates, 7.7% part-time undergraduates, 7.7% full-time graduate students, and 11.5% part-time graduate students. Respondents identified as white (73.1%), Hispanic/ Latino (23.1%), and Pacific Islander (3.8%). Fewer than half (42.3%) report having used behavioral or mental health services in the past.

Procedure

The study was approved as exempt status by the Institutional Review Board at Virginia Commonwealth University. Participants completed an online survey through Research Electronic Data Capture (RedCap), a browser-based survey tool. The survey informed participants that their completion indicated their consent to the study. Participants were presented with generic stems ranging from statements about substance use to relationship challenges to issues concerning identity and reintegration (see Appendix). Participants were asked to indicate the likelihood of using a given type of intervention for each situation by ranking the approach options described above (self-directed approach, group approach, peer mentor, or talk to a professional) as well as the options of no treatment or other, in which case they were asked to write in the alternative. They also were asked to select from a list of possible barriers to treatment which factor had the strongest influence on their ratings of the various approaches. Finally, participants were asked to provide demographic information. No identifying information was associated with the individual questionnaires. The survey took approximately ten minutes to complete.

Measures

Operationalization of treatment approaches. Participants were provided with descriptions of various approaches to treatment (see Appendix). The self-directed approach was

operationalized as self-directed, technology-based, manualized interventions designed to let individuals proceed at their own pace and on their own schedule via the internet or CD. The peer-mentor approach was operationalized as meeting one-on-one with a fellow veteran who will provide support and a positive example of someone who has overcome similar difficulties and experienced significant improvement. The peer group approach involves meeting with several other individuals with similar experiences in order to share and learn from each other's experiences and gain social support. Finally, talking to a professional was operationalized as individual or group sessions with a trained practitioner, either through the VA or implemented privately. This may include meeting with licensed counselors, marriage and family therapists, social workers, psychologists, psychiatrists, or any other professionally trained providers. It does not include speaking with a friend, family member, or religious personnel.

Challenges and treatment option preference. Participants were presented with examples of challenges service members/veterans may have or face, including problems with substance use, mental health concerns, relationship challenges, and questions pertaining to one's identity and future. Items were adapted from intake forms taken from an Army base following consultation with a panel of experts including a university professor, graduate students, military service members, and a military service member's spouse. See Appendix for survey items.

Participants were asked to indicate the likelihood of using each approach for every situation presented, with options ranging from *would definitely not use* (1) to *would definitely use* (6). In addition to the approaches described above (self-directed, group, peer mentor, or talk to a professional) participants were asked to rate the likelihood of selecting "no treatment" or "other" for each scenario and were asked to write in the alternative if they were to select "other."

Participants were required to rate the likelihood of using each treatment approach, but had the option not to rate the likelihood of “no treatment” and “other.”

Demographic information. Participants were asked to report their age, gender, race/ethnicity, marital status, branch of service, rank in the military, years of service, whether or not they have been in combat, student status, and whether or not they have ever received behavioral or mental health treatment in the past (see Appendix).

Results

Statistical Analysis

In order to compare service members’ and veterans’ ratings of one approach to another, average scores were created by summing the ratings for each intervention approach for items 1-27 in the questionnaire and dividing by the total number of items: 27.

In order to assess whether service members and veterans preferred the same approach across problem areas or favored different treatments for distinct challenges, survey items were categorized into four broad areas: *substance use*, *relationship problems*, *pathology*, and questions about one’s *future and identity*. Average scores were then created within each category for each approach to treatment as follows.

Substance Use. Survey items 1, 8, 14, and 21 were categorized as problems relating to substance use. Average scores were created for each intervention approach within the problem area of *substance use* by summing the ratings for that approach for items 1, 8, 14, and 21 and dividing by the total number of items: 4.

Relationships. Survey items 2, 16, 24, and 27 were categorized as relationship issues. Average scores were created for each intervention approach within the problem area of

relationships by summing the ratings for that approach for items 2, 16, 24, and 27 and dividing by the total number of items: 4.

Mental health. Survey items 3, 5, 9, 10, 13, 18, 20, 23, and 25 were categorized as mental health problems. Average scores were created for each intervention approach within the problem area of *mental health* by summing the ratings for that approach for items 3, 5, 9, 10, 13, 18, 20, 23, and 25 and dividing by the total number of items: 9.

Identity/ Future. Survey items 4, 6, 7, 11, 15, 17, 19, 22, and 26 were categorized as problems related to one's future or identity. Average scores were created for each intervention approach within the problem area of *identity* by summing the ratings for that approach for items 4, 6, 7, 11, 15, 17, 19, 22, and 26 and dividing by the total number of items: 9.

Group Comparisons. In addition to examining mean ratings of each approach overall and by category of problem, the current study examined potential differences in overall ratings for men versus women, students versus nonstudents, and those who have used treatment in the past versus those who have not. T-tests were used for each of these comparisons.

Overall Preferred Approaches

Average scores for each intervention approach were analyzed to answer the research question of which approach would be preferred by service members and veterans across all problems. The most highly-rated treatment approach overall was the self-directed approach ($M = 3.85$, $SD = 1.14$), indicating that of all the approaches, service members and veterans are most likely to choose self-directed treatment. The next highest rated approaches were individual therapy with a professional at the VA ($M = 3.71$, $SD = 1.33$) and in the community ($M = 3.68$, $SD = 1.33$). The lowest rated approaches were peer-led ($M = 2.81$, $SD = 1.11$) and

professionally-led ($M = 2.85, SD = 1.17$) group treatment in the community. Table 1 displays means and standard deviations for the ratings of the various approaches to treatment.

Because participants were required to rate the likelihood of using each treatment approach, but had the option not to rate the likelihood of “no treatment” and “other,” all participants rated every approach but only a select few provided responses for “no treatment” or “other.” Participants indicated a lower likelihood of using “other” services ($M = 2.77, SD = 1.57$) than any of the treatment approach options rated above. Participants who chose to write in another service they would use indicated they might go to religious leaders (endorsed once for each of 17 out of the 27 scenarios), family ($N = 1$), and Military OneSource (endorsed once for each of 2 out of the 27 scenarios). It is difficult to interpret participants’ ratings for “no service” ($M = 2.91, SD = 1.71$), as it is possible some may have interpreted the option of “would definitely use” to mean they would definitely select no service, whereas others may have chosen “would definitely not use” to mean that they would definitely not use any service. Therefore, “no service” was not included in the main analyses.

Table 1. *Means and standard deviations for overall preference ratings.*

Approach	Mean rating (standard deviation)
Self-directed	3.85 (1.14)
Individual professional (VA)	3.71 (1.33)
Individual professional (community)	3.68 (1.33)
Peer mentor	3.54 (1.12)
Peer-led group (VA)	3.03 (1.12)
Professionally-led group (VA)	2.93 (1.16)
Professionally-led group (community)	2.85 (1.17)
Peer-led group (community)	2.81 (1.11)

Preferred Approaches by Category of Problem

As mentioned above, the various scenarios presented in the survey can be categorized into four broad topics of problems service members and veterans may face: substance use, relationship problems, pathology, and questions about one's future and identity. In order to assess whether or not treatment preferences were different within each category of problems, average scores were created within each category for each approach to treatment. Patterns of preferences were similar across categories, although there were some differences (see Table 2).

Substance Use. For problems related to substance use, the most highly-rated treatment was the self-directed approach ($M = 3.91$ $SD = 1.16$), followed by individual therapy with a professional at the VA ($M = 3.70$, $SD = 1.27$) and in the community ($M = 3.69$, $SD = 1.34$). The lowest rated approaches were peer-led ($M = 2.81$, $SD = 1.11$) and professionally-led ($M = 2.85$, $SD = 1.17$) group treatment in the community. The main difference in the pattern of ratings of services for substance-related problems compared to the overall pattern reported above was that the lowest rated approach overall (peer-led group in the community) was the second least preferred approach for substance use problems, while the lowest rated approach for substance use problems (professionally-led group in the community) was the second least preferred overall. Please see Table 2 for means and standard deviations.

Relationships. The only departure between the pattern of preferred approaches overall and for relationship issues was that the approach preferred overall (self-directed) was the second highest rated for relationship issues, while the second highest approach overall (individual treatment with a professional) was the most preferred approach for relationship issues. All other service approaches followed the same pattern of ratings as described above.

Mental health. The top rated approaches for mental health problems were treatment with an individual professional at the VA or in the community followed by the self-directed approach. The least preferred approaches were peer-led groups at the VA and in the community, followed by professionally-led groups in the community and at the VA.

Identity/ Future.. The top rated approach for problems related to one's future and identity was the self-directed approach, just as it was overall and for substance use problems. The second preferred approach was the peer mentor approach, which for all other problems was ranked as the fourth highest-rated approach. Ratings for individual treatment with a professional at the VA and in the community were nearly identical for future/ identity problems and were the third preferred approaches. The four remaining approaches were rated in the same order as they were overall.

Table 2. Means and standard deviations for preference ratings

	substance use	relationships	mental health	identity/ future	overall
Self-directed approach	3.91 (1.16)	3.66 (1.16)	3.69 (1.27)	4.02 (1.22)	3.85 (1.14)
Individual professional at VA	3.70 (1.27)	3.77 (1.42)	3.96 (1.53)	3.47 (1.38)	3.71 (1.33)
Individual professional (Civilian)	3.69 (1.34)	3.61 (1.44)	3.85 (1.44)	3.47 (1.44)	3.68 (1.33)
Peer Mentor	3.65 (1.16)	3.43 (1.20)	3.52 (1.18)	3.56 (1.17)	3.54 (1.12)
Peer-led group at VA	3.02 (1.20)	2.96 (1.17)	2.22 (0.89)	3.00 (1.12)	3.03 (1.12)
Professionally-led group at VA	3.02 (1.25)	2.89 (1.21)	2.99 (1.25)	2.88 (1.20)	2.93 (1.16)
Professionally-led civilian group	3.01 (1.19)	2.87 (1.21)	2.87 (1.29)	2.86 (1.20)	2.85 (1.17)
peer-led civilian group	3.03 (1.17)	2.70 (1.24)	2.79 (1.21)	2.85 (1.10)	2.81 (1.11)

Group comparisons

In order to examine whether or not differences in treatment approach preferences existed between males and females, two-tailed independent samples t-tests were conducted for each treatment approach with an alpha level of .05. Females ($M = 4.75$, $SD = 1.09$) were significantly more likely to use individual therapy with a professional in the community than were males ($M = 3.33$, $SD = 1.23$), $t(22) = -2.52$, $p = .02$. There were no other significant difference in preferences for treatment approaches for males versus females.

T-tests were also conducted to examine potential differences between students and nonstudents as well as between those who have used behavioral or mental health services in the past and those who have not. However, no significant differences were found in any of these comparisons.

Factors Influencing Likelihood of Service Utilization

Overall. Participants were asked to indicate which of several factors was most influential in rating how likely they would be to use the various approaches. This was asked across all treatment approaches. Nearly half of the participants (47.86%) reported *effectiveness* as the most important factor. The next most cited factors overall were *impact on one's future or career* (17.52%) and *stigma* (12.39%).

By Category of Problem. Interestingly, for mental health problems, stigma was not nearly as commonly endorsed (5.56%) as it was for other categories of problems, while logistical barriers (7.26%) were somewhat more common in the category of mental health problems than in other problem areas (see Table 3 and Figure 1). Overall, 6.55% of participants endorsed *other factors*, including comfortability, confidentiality, not believing the issue described would be a problem, believing it could be solved on one's own, and believing it is nobody's business, as important in making decisions about the likelihood of using each treatment approach.

Table 3. Percentage of respondents indicating each factor as the most important in determining the preferred approach to services, presented by category.

	Substance Use	Relationship	Mental Health	Future/ Identity	Overall
Effectiveness	45.19	42.3	48.29	50.77	47.86
Impact future/ career	22.12	15.38	17.52	16.54	17.52
Ease of access	11.54	13.46	10.68	7.31	9.97
Stigma	12.5	19.23	5.56	15.77	12.39
Logistical Barriers	3.85	2.88	7.26	4.62	5.13
Other	4.81	5.77	9.83	4.62	6.55

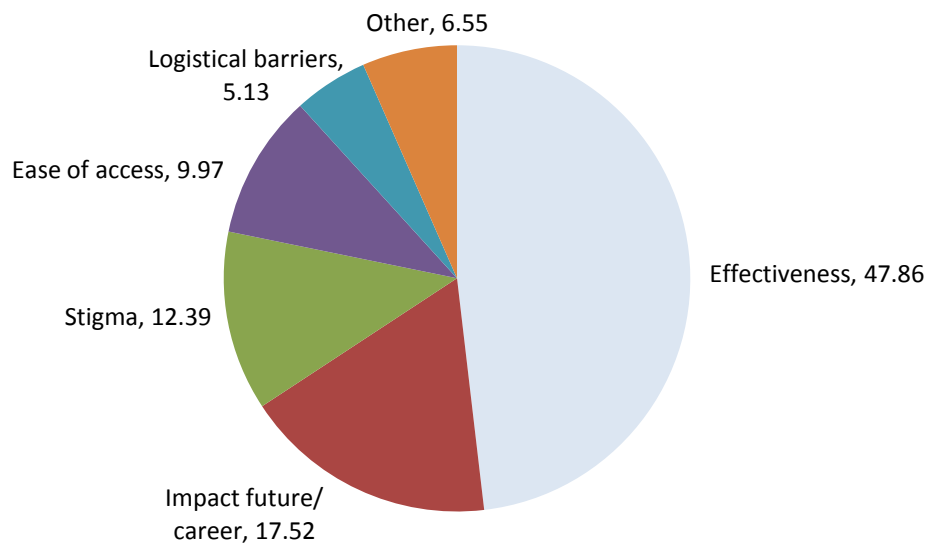


Figure 1. Most important factors taken into consideration when deciding how likely service members would be to use the various approaches to treatment.

Discussion

The present study provides information about treatment preferences for service members for a variety of problems they may face, including substance use, issues with relationships, mental health problems, and challenges related to one's future and identity. Overall, across categories of problems they may face, service members reported the strongest preference for self-directed services, followed by individual therapy with a professional, and the peer mentor approach. Professionally and peer-led groups at the VA and in the community were rated as least likely to be utilized compared to the other approaches. In addition, the results indicate that when given the option of receiving services at the VA or in the community, service members and veterans prefer services at the VA. The results also identify the frequency of previously identified barriers to treatment being rated as the most important factor taken into consideration when deciding how likely service members would be to use the various approaches to treatment.

Overall Preferred Approaches

Self-directed Approach. Service members and veterans were most likely to choose self-directed treatment over all other approaches. One reason for this finding may be that this study itself used technology and was somewhat "self-directed." Those who completed the study online may be biased to prefer services that are offered online and may also be technologically savvy enough to benefit from the services. Future studies might use a paper and pencil survey and examine whether or not participants similarly endorse self-directed treatment over other approaches.

Past studies have suggested that alternative treatment modalities may reduce barriers to care. For example, Zinzow and colleagues (2012) suggest that technology-assisted self-care may reduce stigma and improve access to care for those that use them. Perhaps this approach was

preferred in the current study due to the ability to complete the treatment in the privacy of one's own home, at one's own pace, on one's own schedule, and with the convenience of not having to travel to complete the treatment. Past studies have reported soldiers' and veterans' willingness to use a technology-based approach, even for those who are unwilling to talk to a professional in person (Tsai & Rosenheck, 2012; Wilson et al., 2008). Self-treatment may also be a better fit for military populations as it is in line with the idea that one should handle the problem on his or her own, as was found in past research (Kessler et al., 2001; Stecker et al., 2007). Several studies have demonstrated the efficacy of technology-based interventions (Litz, et al., 2007; Tsai & Rosenheck, 2012; Zinzow et al., 2012).

Individual Treatment with a Professional. Individual treatment with a professional at the VA and/or in the community was the approach rated as most likely to be used after self-treatment. Past research has found that patients expect face-to-face therapy to meet their needs, be helpful, and provide personal support (Musiat, Goldstone, & Tarrier, 2014), all factors supporting positive evaluations of individual therapy. In addition, perhaps one-on-one treatment with a professional was commonly preferred in the present study due to it being the most well-known approach presented in the study. Past research has supported humans' preferences for the familiar (Zajonc, 1968) as well as fear of the unknown (Trautmann, Vieider, & Wakker, 2008), and literature examining treatment preferences found a modest influence of past knowledge of treatment on ratings of acceptability, suitability, tolerability, expectation of positive benefit, appropriateness, and other factors labeled as "endorsement" (Tarrier, Liversidge, & Gregg, 2006). Retrospective studies examining actual treatment use via chart reviews have shown that individual therapy with a professional is more common than other forms of treatment such as group psychotherapy (Cully, Tolpin, Henderson, et al., 2008; Mott, Barrera, Hernandez, Graham,

& Teng, 2013). As one-on-one treatment with a professional is a very common and well-known treatment approach, it makes sense that it would be preferred over lesser known alternatives.

Group Approaches. The lowest rated approaches were peer-led and professionally-led group treatment in the community. While these approaches are intended to provide the opportunity to share and learn from each other's experiences, gain social support, and normalize reactions (Money et al., 2011; Raphael & Wilson, 2000), perhaps instead participants saw group approaches as situations that would force them to publicly admit to weakness in the presence of others. Fear about opening up in the presence of others has certainly been documented in non-military group work (Parcover, Dunton, Gehlert, & Mitchell, 2014). Participants in the present study may also have been concerned about the effectiveness of group versus individual treatment, as is often a concern in non-military settings, such as university counseling centers (Parcover et al., 2014). Individuals often seek treatment with the expectation of individual therapy (Slocum, 1987) and believe that group work is inferior to individual therapy (Parcover et al., 2014). They may be concerned that the group will lack structure or is intended only for serious mental illness (Parcover et al., 2014). While group approaches have been found to be effective (Bowen, Shelley, Helmes, & Landman, 2010; Foy et al., 2000), more work is clearly needed to educate service members and veterans about the potential benefits of group work.

Preferred Approaches by Category of Problem

When participants' responses were examined within each category of problem rather than overall, the patterns of responses were largely the same with a few notable exceptions. For problems related to substance use and identity/ future, the preferred approach was the self-directed approach, as it was across categories of problems. This may be due to service members seeing these problems as issues that are personal and do not require outside help. Past research

has found that service members and veterans often feel that their problems are not severe enough to warrant treatment and that they should handle their problems on their own (Visco, 2009; Britt et al., 2011). For substance use, the preference for self-directed treatment may also be related to requirements in certain branches of the military that providers refer service members with alcohol and drug abuse or dependence to substance abuse program (Hoyt, 2013). Participants may prefer to treat themselves rather than admit to a professional that they have a problem and risk documentation on their record.

Another interesting departure from the pattern observed across categories was that for problems related to identity/ future, the second preferred approach was the peer mentor approach, which for all other problems and overall was ranked after self-directed and individual therapy approaches. Perhaps the peer mentor model was preferred for identity and future problems because that category of problems involves feeling disconnected from oneself and one's goals, and past research suggests that peer support may provide social connectedness and instill empowerment and hope (Jain et al., 2012).

While the self-directed approach was preferred overall and for problems related to substance use and identity/ future, the top preferred approach for relationship and mental health problems was individual treatment with a professional at the VA, followed closely by individual treatment with a professional in the community. As noted above, the familiarity with individual one-on-one treatment for these issues may have made this approach an obvious choice for participants (Cully et al., 2008; Mott et al., 2013; Tarrier et al., 2006). A second factor explaining the preference for individual treatment with a professional may be that participants believed that the more disruptive nature of mental health and relationship problems merited intervention by a professional versus simply self-help. In a study examining the acceptability of internet-based

treatment in a non-military sample, 10% of participants preferred face-to-face treatment over internet therapy and 9% described their problems as too severe to be treated online (Wootton, Titov, Dear, Spence, & Kemp, 2011).

Group Comparisons

In this study of 26 participants, men and women had similar ratings of treatment approaches, with the only significant difference being that women were more likely than men to seek individual treatment with a professional in the community. Past findings examining the role of gender in treatment preferences and likelihood of using services are mixed. While some studies suggest there is no independent effect of gender on treatment preference (Leaf & Bruce, 1987), others have found that women have more positive attitudes about and are more likely than men to seek mental health services (Kessler, 1981; Vogel, Wester, & Larson, 2007). In one of only few studies that have examined the effect of gender on preferences for one treatment approach over another, it was found that women show greater preference for individual over group therapy than do men (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). Unfortunately, the small sample used in the current study may be a factor in the lack of significant differences between preferences for men versus women in the current study.

The small sample may also account for a lack of significant differences for treatment preferences for those with and without past treatment experience. While some studies suggest that previous mental health treatment may not be related to perceived barriers to care (Ouimette et al., 2011), other studies provide evidence that past use predicts future use. For example, Brown et al. (2011) found that service members who had received mental health care in the past year were twice as interested in receiving future services compared to those who had not recently

received care. Therefore, it is again suggested that comparisons between those with and without past treatment experience be attempted with a larger, more representative sample.

The present study attempted to determine whether or not preferences differed for students versus nonstudents, as well. Many service members and veterans pursue a higher education, either while still serving or after they have separated from the military. In 2008, for example, nearly half a million veterans, active duty, and reservists used military education benefits to go to college (Lum, 2009). Whether they choose to return to school during or after completing their service, student service members and veterans may encounter many challenges, including transitions, dual roles, identity shifts, feelings of isolation and being misunderstood, and lacking social support (Bonar & Domenici, 2011; Strickley, 2009). Whiteman and colleagues (2013) longitudinally tracked changes in emotional support from peers over three consecutive semesters and found that student service members/veterans reported less peer emotional support than their civilian counterparts as measured by the Friend subscale of the Perceived Social Support Inventory. Whiteman et al. (2013) also found very little change in psychological adjustment for student veterans even with increased social support from university friends and concluded that the protective effect of emotional peer support was stronger for civilians than for service members/veterans.

While studies suggest that student service members/veterans are often reluctant to self-disclose and seek services (Bonar & Domenici, 2011; Church, 2009), very few studies have focused on what services, if any, student service members/ veterans use or prefer. In the present study, no significant differences were found between student versus nonstudent respondents. However, once again this could be a function of power rather than a true absence of differences,

and future studies might further explore whether or not there are differences in treatment preferences based on student status.

Use of Services at the VA versus in the Community

In the present study, participants indicated that they would be more likely to utilize services at the VA than those same services in the community or with a civilian provider. Historically, there have been concerns about access to care within the VA system ranging from maintenance issues, lack of oversight and medical management, difficulty for veterans in navigating the complicated process by which to access care, and limited eligibility (Luo, 2007). The Veterans' Health Care eligibility Reform Act of 1996 extended eligibility to all veterans who are not dishonorably discharged and today all U.S. veterans are eligible for free care through the VA for five years following deployment (Panangala, 2006). Nonetheless, in 2001, 76.6% of veterans reported receiving care entirely from non-VA providers compared to only 7.4% who use only services at the VA and 16% who utilize both VA and non-VA services (U.S. Department of Veterans Affairs, 2001). In more recent years it appears that increasing numbers of service members and veterans are using VA services, perhaps due to the wars in Afghanistan and Iraq. Shriner, Drake, Watts, Desai, & Schnurr (2012) estimated roughly 58% of veterans from Afghanistan and Iraq with PTSD have used VA services and suggest that over time, these veterans have been more likely to use VA services.

Hepner et al (2010) assessed veterans' satisfaction with care for VA services and found it to be mostly favorable, with 73.9% of patients reporting that treatment was helpful, 49.6% reporting timeliness of care, and 42.3% reporting overall satisfaction with care. However, the authors found that satisfaction ratings for mental health care accessed through public and private insurance plans was typically higher than reported for the VA, suggesting a potential preference

for services in the community. Unfortunately, there is a dearth of research investigating utilization rates of community services by service members and veterans, making it difficult to compare to the rates of VA service use.

One reason that services were preferred at the VA over those in the community in the present study may be due to the fact that services at the VA are free, while community care requires fees or copayments. Another attraction of the VA is that it offers professionals who specialize in military and veteran issues, whereas the community may not offer specialized knowledge of such issues. The VA adjusts its treatment approaches and programs as the needs of returning troops change and offers a network of more than 200 specialized treatment programs and trauma centers (Burnam et al., 2008). Sayer et al. (2010) examined the types and prevalence of issues common in combat veterans and noted that while VA providers typically have the skills and training to address these issues, the problems identified may fall outside of the scope of general medical practices. Future research might further investigate rates of use for services at the VA compared to those offered in the community as well as possible motivations for each.

Other Suggested Services

Participants were given the option to select and write in a service they would prefer to use other than those provided in the survey. Participants indicated they would use religious leaders, family, and Military OneSource for support across problems. This finding fits with past studies that have found some service members prefer to seek help from family, friends, and clergy rather than formal mental health services (Schell & Marshall, 2008). Schell and Marshall found nearly 40% of surveyed service members endorsed the belief that family or friends would be more helpful than a mental health professional, while nearly 30% believed religious counseling would be more helpful than a mental health professional. A common example of religious counseling in

military populations is the use of chaplains. Chaplains train and deploy with military units and therefore have a deep understanding of the unit's needs (Burnam et al., 2008). They offer nonclinical counseling that is completely confidential, making them an attractive treatment modality for service members. A study examining the use of chaplains, mental health, or both found that 31% of those surveyed solely relied on chaplains for their mental health needs, compared to 44% who used only mental health care and 25% who used both (Besterman-Dahan, Gibbons, Barnett, & Hickling, 2012).

Military OneSource is another option for care for service members, veterans, and their families that provides information, consultation, and up to six prepaid counseling sessions with master's level, licensed professionals through the Department of Defense (Burnam et al., 2008). A benefit of this service is that it is confidential- the military is not alerted to service members' use of Military OneSource (Burnam et al., 2008). Future assessments of preferred treatment modality might incorporate these services (family, religious personnel, and Military OneSource) in order to learn if any of these alternative services are preferred over those described in the present study. Future research may also consider how to integrate religious leaders, family, and resources from Military OneSource into other treatment approaches described in this study.

Factors Influencing Likelihood of Service Utilization

Effectiveness. Service members most frequently identified *effectiveness* as the primary factor impacting their treatment approach decisions. Interestingly, Kehle, et al. (2010) found that of several factors including *self-stigma*, *others' stigma*, and *practical barriers*, only the factor called *Mental Health Treatment Doesn't Work* was significantly related to reported psychotherapy treatment seeking and medication use. Based on past findings such as Kehle and colleagues, as well as those from the current study, it is important to address concerns about

effectiveness when presenting treatment options to service members. This is especially evident given that past research has found high percentages of service members with and without mental health problems reporting the belief that mental health treatment is ineffective or that past treatments have not been beneficial (Kessler et al., 2001; Schell & Marshall, 2008).

Many services offered today are evidence-based, meaning their effectiveness is supported by research and practice. Some of these services include exposure therapy, systematic desensitization, cognitive therapy, cognitive processing therapy, assertiveness training, and psychodynamic therapy (Burnam et al., 2008). The finding that effectiveness was a central concern in the current study suggests the importance of using evidence-based treatments with service members and veterans and advertising them as such. Future research may focus on how to best present information about the effectiveness of treatments to service members and veterans. For example, future studies may examine whether there is an increase in perceived effectiveness after presenting statistics about improvement following treatment to service members and veterans or whether simply encouraging open dialogue about the effectiveness of treatments enhances perceived effectiveness. Past studies suggest that positive testimonials may make effective treatments more appealing to those without prior treatment experience (Pruit, Zoellner, Feeny, Caldwell, & Hanson, 2012), but additional research could be conducted to further investigate how such testimonials influence the perceived effectiveness of treatments, particularly with those who have prior treatment experience.

Impact on Future/ Careers. Many service members also expressed concern about the impact treatment would have on their futures or careers, consistent with findings from past studies. As described above, most soldiers surveyed believed that mental health counseling would hurt their career (Department of Defense, 1998), and over 40% expressed worry that

seeking treatment could harm their career, restrict current or future occupational opportunities and promotion, and prevent them from obtaining a security clearance (Schell & Marshall, 2008). This continued concern found in the present study demonstrates the need to further educate service members on how seeking services will and will not affect their careers and futures.

Past research has actually found several benefits to self-referring early and on one's own initiative (Rowan & Campise, 2006). These benefits include increased confidentiality, dramatically lower likelihood of negative career repercussions, and increased likelihood of being diagnosed with transitory problems rather than serious disorders. It is important to make such findings common knowledge in order to highlight the benefits of seeking care. It may also be helpful to encourage high-ranking officials who have sought treatment in the past to come forward to share their stories of seeking treatment without negative consequences. Perhaps future studies could examine additional methods of addressing this concern about treatment affecting one's career and determine the best way to disseminate accurate information on the topic.

Unfortunately, some of the concern about treatment impacting one's career and future is warranted, as confidentiality in the military has serious limitations including command notification and duty limiting profiles (Hoyt, 2013). Service members are often required to sign waivers providing their command access to their records. While in recent years the Department of Defense changed their policy to allow those who have sought care for an emotional or mental health condition to choose not to report it on the security clearance questionnaire (Department of Defense, 2008), as well as new models to allow more leniency to those who have reported mental health issues to continue to serve, the limited confidentiality is a serious concern for many service members and prevents them from seeking the help they need (Brown, 2013; Dao & Frosch, 2009). It may be that now is the time for another policy change to ensure greater

confidentiality to service members to give them the peace of mind to seek treatment without fear of destroying their career advancement and future aspirations.

Stigma. Stigma has been shown in past research to influence decisions to seek treatment (Brown et al, 2011; Gorman et al., 2011; Hoge, 2004; Kim et al., 2010; Ouimette et al., 2011; Pietrzak et al., 2009; Rowan & Campise, 2006; Stecker et al., 2007; Tanielian & Jaycox, 2008). In fact, stigma has been documented as a significant barrier to care in more than 100 peer-reviewed empirical articles (Clement et al., 2013). In the present study, however, just over one in ten participants selected stigma as the most influential factor in determining how likely they would be to use a specific treatment approach. Perhaps stigma is becoming a less prominent barrier to care, which may in turn suggest a reduction in the stigma associated with mental health issues. This may be due to campaigns intended to decrease stigma and increase awareness about mental health.

In recent years, there have been many campaigns intended to reduce stigma in the United States and other areas of the world (Evans-Lacko, Henderson, Thornicroft, & McCrone, 2013; Rusch, Angermeyer, & Corrigan, 2005; Thornicroft, Wyllie, Thornicroft, & Mehta, 2014; Woods & Joseph, 2014). For example, the National Alliance of the Mentally Ill (NAMI) educates the public about mental illness and campaigns for the protections of the rights of persons with mental illness. A campaign in New Zealand called *Like Minds, Like Mine* encourages involvement and leadership by people who have suffered from mental illness (Thornicroft, et al., 2014). In a study of this program's effectiveness, 48% of respondents thought the program had reduced discrimination "moderately" or "a lot" (Thornicroft, et al., 2014). In England, it has been shown that an anti-stigma campaign called *Time to Change* is able to positively alter perceptions of mental illness (Evans-Lacko et al. 2013).

While overall, stigma was only endorsed in the present study by twelve percent of participants as the primary consideration in their treatment preferences, there was variability across the four categories of problems (substance use, relationship, mental health, and future/identity). Roughly twelve and fifteen percent endorsed stigma as the primary factor influencing their treatment preferences for substance use and identity/ future problems respectively, while nearly twenty percent endorsed stigma as influencing their treatment decisions for relationship problems, and just over five percent of participants endorsed stigma for mental health problems. In the context of the above findings suggesting that anti-stigma campaigns targeting stigma related to mental illness have been moderately successful, the low number of participants endorsing stigma in the current study as a primary consideration in treatment selection for mental health problems makes sense: the campaigns intended to decrease stigma and increase awareness about mental health issues appear to be successfully reducing the stigma associated with mental health issues. That the percentages of participants who endorse stigma are much higher for the remaining categories of problems suggests that perhaps these campaigns are too narrowly focused and only effective in the domain of mental health problems. Therefore, campaigns may be needed to target the reduction of stigma for substance use, identity concerns, and most notably relationship issues. It is important to increase awareness about how common these categories of problems can be and to spread the message that it is acceptable to seek help for them.

Implications

The knowledge gained from this study about service members' and veterans' treatment approach preferences has several implications. Study findings, if replicated in a larger, more representative sample, could potentially be used to direct resources towards the preferred treatment approaches. Results support the use of evidence-based practices and better

communication to service members and veterans about the evidence demonstrating the effectiveness of treatments. Findings suggest service members and veterans would profit from knowing the benefits of seeking care early and on one's own initiative in regards to protecting one's future and career. Results further highlight the potential need for policy change in regards to the confidentiality of service members' mental health records. The findings of this study additionally reveal that campaigns may be needed to target stigma towards seeking treatment for substance use, identity concerns, and relationship issues.

Perhaps the most common approach to services currently is individual treatment with a professional, and this approach was rated as most likely to be used by service members in the present study for problems related to relationships and mental health. If this finding is further supported in future research using larger and more representative samples, it may be advisable that resources continue to go towards development, implementation, and dissemination of information about individual services with a professional. For substance use and problems related to one's identity and future, service members indicated a preference for self-directed treatment. Again, pending further support for this finding from additional larger studies, perhaps new programs and modules that service members can complete on their own should also be created and additional resources directed towards their implementation. Resources may also be needed for the dissemination of information about how to access and use such programs. Additionally, further research could be funded to ensure effectiveness of self-directed treatment approaches.

The present study demonstrated the potential importance of perceived effectiveness in the likelihood of using mental health services. It is therefore recommended that practitioners suggest and use evidence-based practices and address concerns about effectiveness when presenting

treatment options to service members. Familiarity with services has been correlated in the past with increased perceived effectiveness and utilization (TARRIER et al., 2006). Therefore, perhaps practitioners should strive to better circulate information about evidence-based practices in order to increase familiarity and thereby improve perceived effectiveness and likelihood of utilization.

The current study highlighted the continued concern that seeking mental health treatment will negatively affect one's career and/or future. Therefore, it is recommended that practitioners make known the benefits of seeking care early on own initiative, those of which include increased confidentiality, lower likelihood of negative career repercussions, and increased likelihood of being diagnosed with transitory problems rather than serious disorders. In addition, it may be that a policy change is needed to ensure greater confidentiality to service members by eliminating their command's ability to review their mental health records. Changing this policy would likely give service members the peace of mind to seek treatment without fear of hurting their career and future goals.

Finally, the data from this study suggest that stigma against mental health treatment may have declined, perhaps as a result of campaigns promoting mental health awareness. Nonetheless, there continue to be high levels of stigma towards treatment for substance use, identity concerns, and relationship issues. Perhaps additional campaigns ought to target stigma specifically for these issues. Such campaigns might begin by increasing awareness of the prevalence of these issues and normalizing and validating them as acceptable areas for treatment.

Limitations and Future Directions

The present study has some limitations. Participants were sought through contacting leaders of military and veteran organizations nationwide, posting on message boards and in Facebook groups, and through listservs with the potential of reaching several hundred eligible

service members and veterans. Yet only twenty-six service members and veterans participated in the study. One barrier to enrollment may have been that the study lacked incentives for participation—there was neither financial gain nor course credit offered for participation. Instead, recruitment relied on an altruistic motivation to contribute information that could eventually inform new policies and treatment approaches. In addition, recruitment relied on service members and veterans opening emails or browsing discussion boards and then taking action. It is possible that recruitment would have been more successful if it was done face-to-face, in which case the researcher could be assured that the message was received and it may be more difficult for potential participants to decline the request.

Another reason that service members and veterans were difficult to recruit may have been due to their distrust of outsiders in general and mental health professionals in particular (Hoge et al., 2004; Bryan & Morrow, 2011). Despite the current study offering complete anonymity and confidentiality, it is possible that service members and veterans chose not to participate due to concern about providing information related to mental health issues for fear that their responses could be traced back to them and have a negative impact on their careers.

With a final sample of 26 service members and veterans, the study lacks power to make comparisons across branch of service or other demographic variables. Future studies should use a larger sample with sufficient power for these comparisons, as it would be useful to know if factors such as branch of service, deployment history, gender, ethnicity, marital status, student status, and past treatment usage influence treatment preferences. Also due to the small sample, we must be cautious in generalizing the results to the entire population of service members and veterans. It is suggested that future studies attempt to collect this data with a larger, more representative sample.

Another limitation of the study is that while feedback from service members, family members, and expert researchers was provided in the initial development of the study and survey items, no systematic feedback was given on the final questionnaire or study materials. It would have been beneficial to have performed a pilot study in which service members could have provided feedback on their experience of taking the survey as well as their understanding of the items. Because no such data was collected, it is possible that not all items were understood as they were intended. Future studies might seek feedback and make culturally sensitive changes prior to data collection. In fact, it is recommended that future studies incorporate the military and veteran community not only in piloting the study, but in all phases. Community-based participatory research (Bogart & Uyeda, 2009) seeks input from the population being studied—in this case, military service members and veterans—in order to better engage and more accurately meet the needs of that community. Perhaps using this approach for future studies would allow service members and veterans to feel less distrustful of the research and more willing to participate.

While the present study garnered useful information about which of several factors (effectiveness, impact on career, stigma, logistical barriers, etc.) was most influential in choosing a preferred approach to treatment, the study did not examine the associations of these factors with the various approaches to treatment. For example, it may be useful to know which approach is perceived by service members and veterans as the most effective, least associated with stigma, and has the least influence on one's career and future. Future studies may ask participants to rate the various approaches to treatment for each of these factors.

Additional directions for future research as suggested above include comparing the rates of utilization for services at the VA versus those offered in the community as well as the

motivations for each. Other future studies may assess whether family, religious personnel, and/ or Military OneSource are preferred over the treatment approaches described in the present study and may consider how various treatment modalities might be integrated with one another to provide more comprehensive care. It is recommended that additional research be conducted on how to best present information about the effectiveness of treatments to service members and veterans. In addition, future studies might attempt to find more effective methods to disseminate accurate information on how mental health services impact one's career and future in the military.

Final Thoughts

The present study provides useful information about the preferences of service members in multiple branches of the military for various approaches to treatment for challenges related to substance use, relationships, mental health, and future/ identity. Results indicate that service members in this sample were most likely to use self-directed treatment overall and for issues related to substance use, identity and future. Participants were found to be most likely to use individual treatment with a professional for mental health and relationship challenges. Results also address how effectiveness, impact on one's career, and stigma influence treatment decisions. Resources may be needed to provide more education to service members and veterans about each of these factors, and policy changes may be warranted to further encourage service members and veterans to seek treatment. The findings from this study should be replicated with a larger, more representative sample, after which they could potentially be used to direct the distribution of resources to hopefully increase treatment utilization and satisfaction with treatment, and to help improve the lives of service members and veterans suffering from these challenges.

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Appendix

I am seeking information to help service members and veterans. You will not benefit personally from completing this survey, but **if you answer honestly it may help a fellow service member or veteran** in the future. Your answers are completely confidential and voluntary.

Below are some examples of challenges service members and veterans may have or face. Please indicate which approach you would choose to address the problem by ranking each of the options. Descriptions of services can be found below. If none are appropriate, is there another service that you would want to choose?

Self-directed Approach:

Self-directed approaches can be technology-based, manualized interventions designed to let you proceed at your own pace and on your own schedule via the internet or CD. One example is the F.R.E.E. 4 VETS program developed by Dr. Steven Danish, which is made up of 17 e-workshops that provide information and teach skills that may help individuals resolve major re-entry issues following deployment: family or relationship issues and interactions, work/employment difficulties, and an overall lack of focus or purpose.

Group Approach:

The group model involves meeting with several other individuals with similar experiences in order to share and learn from each other's experiences and gain social support. Participating in a peer group provides the opportunity to share coping strategies with others currently managing the same situation. One example of the group model is Battlemind Training, developed by the Walter Reed Army Institute of Research, in which groups of soldiers are asked to identify and describe their thoughts about difficult experiences, describe the worst part of the experience, and discuss both positive and negative changes since returning from deployment. Group leaders provide information about transitioning home as well as strategies for positive coping.

Peer Mentor:

A peer mentor is a fellow veteran who has faced the same or similar situation or issues as you and has experienced significant improvement. The peer mentor typically meets with you one-on-one in order to provide support and a positive example of someone who has overcome similar difficulties. Often, peer mentors receive training in communication skills, available resources,

and steps to take if a situation requires expertise beyond their level of training, although not all peer mentors undergo training.

Talking to a Professional:

Talking to a professional refers to individual sessions with a trained practitioner, such as a licensed counselor, marriage and family therapist, social worker, psychologist, psychiatrist, or any other professionally trained provider. However, this does not include speaking with a friend, family member, or religious personnel.

Professionally-led Group: This approach is identical to the group approach, but rather than being entirely comprised of peers, it is led by a professional such as a licensed counselor, marriage and family therapist, social worker, psychologist, psychiatrist, or any other professionally trained provider.

No Service: I would not seek services of any kind for this issue. You are asked to rate how likely or unlikely it is that you would not seek services.

Other: If you would choose another service or approach, please select “other” and write in a description of that service.

For each of the following scenarios, FIRST, please indicate the likelihood of using each service, with

1= would definitely not use; 2= extremely unlikely; 3= somewhat unlikely; 4= somewhat likely; 5= extremely likely; 6= would definitely use.

SECOND, identify which single factor you consider to be most important in the choice you made.

1. If you were to find yourself drinking 6-8 beers a day and found it to interfere with daily activities (social life, employment, etc):

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____

Talk to a Professional at the VA ____ Civilian Provider ____
 Professionally led group at the VA ____ Civilian Provider ____
 No Service ____
 Other ____ (please specify) _____

What is the single most important factor determining which approach(es) you rated the highest?

Effectiveness ____
 Impact of approach on your future/ career ____
 Ease of access ____
 Stigma ____
 Logistical barriers (time, transportation, cost) ____
 Other (please specify) _____

2. If you were to find yourself not getting along with significant others in your life (spouse, children, parents, friends):

Self-directed Approach ____
 Peer Group Approach at the VA ____ Civilian Provider ____
 Peer Mentor ____
 Talk to a Professional at the VA ____ Civilian Provider ____
 Professionally led group at the VA ____ Civilian Provider ____
 No Service ____
 Other ____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness ____
 Impact of approach on your future/ career ____
 Ease of access ____
 Stigma ____
 Logistical barriers (time, transportation, cost) ____
 Other (please specify) _____

3. If you were to have thoughts of harming yourself or others:

Self-directed Approach ____
 Peer Group Approach at the VA ____ Civilian Provider ____
 Peer Mentor ____
 Talk to a Professional at the VA ____ Civilian Provider ____
 Professionally led group at the VA ____ Civilian Provider ____

No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

4. If you were to feel that you lack structure in your life:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

5. If you were to have problems with nerves, panic, or overwhelming discomfort:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____

Impact of approach on your future/ career _____
 Ease of access _____
 Stigma _____
 Logistical barriers (time, transportation, cost) _____
 Other (please specify) _____

6. If you were to feel a sense of loss of identity:

Self-directed Approach _____
 Peer Group Approach at the VA _____ Civilian Provider ____
 Peer Mentor _____
 Talk to a Professional at the VA _____ Civilian Provider ____
 Professionally led group at the VA _____ Civilian Provider ____
 No Service _____
 Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
 Impact of approach on your future/ career _____
 Ease of access _____
 Stigma _____
 Logistical barriers (time, transportation, cost) _____
 Other (please specify) _____

7. If you were to feel concerned about your financial situation:

Self-directed Approach _____
 Peer Group Approach at the VA _____ Civilian Provider ____
 Peer Mentor _____
 Talk to a Professional at the VA _____ Civilian Provider ____
 Professionally led group at the VA _____ Civilian Provider ____
 No Service _____
 Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
 Impact of approach on your future/ career _____
 Ease of access _____
 Stigma _____
 Logistical barriers (time, transportation, cost) _____
 Other (please specify) _____

8. If you were to feel guilty about drinking or using other substances:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

9. If you were to feel stressed because you have nightmares, feel constantly on guard, or easily startled:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

10. If you were to feel down, depressed, or hopeless which approach would you choose:

Self-directed Approach _____

Peer Group Approach at the VA ____ Civilian Provider ____
Peer Mentor ____
Talk to a Professional at the VA ____ Civilian Provider ____
Professionally led group at the VA ____ Civilian Provider ____
No Service ____
Other ____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness ____
Impact of approach on your future/ career ____
Ease of access ____
Stigma ____
Logistical barriers (time, transportation, cost) ____
Other (please specify) _____

11. If you were to feel that you lack direction in your life:

Self-directed Approach ____
Peer Group Approach at the VA ____ Civilian Provider ____
Peer Mentor ____
Talk to a Professional at the VA ____ Civilian Provider ____
Professionally led group at the VA ____ Civilian Provider ____
No Service ____
Other ____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness ____
Impact of approach on your future/ career ____
Ease of access ____
Stigma ____
Logistical barriers (time, transportation, cost) ____
Other (please specify) _____

12. If you were to feel guilty or ashamed that you returned home while others did not:

Self-directed Approach ____
Peer Group Approach at the VA ____ Civilian Provider ____
Peer Mentor ____
Talk to a Professional at the VA ____ Civilian Provider ____
Professionally led group at the VA ____ Civilian Provider ____
No Service ____

Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

- Effectiveness _____
- Impact of approach on your future/ career _____
- Ease of access _____
- Stigma _____
- Logistical barriers (time, transportation, cost) _____
- Other (please specify) _____

13. If you were to avoid people because you are concerned you might experience a sudden surge of overwhelming discomfort or anxiety:

- Self-directed Approach _____
- Peer Group Approach at the VA _____ Civilian Provider ____
- Peer Mentor _____
- Talk to a Professional at the VA _____ Civilian Provider ____
- Professionally led group at the VA _____ Civilian Provider ____
- No Service _____
- Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

- Effectiveness _____
- Impact of approach on your future/ career _____
- Ease of access _____
- Stigma _____
- Logistical barriers (time, transportation, cost) _____
- Other (please specify) _____

14. If others were to criticize or be annoyed by your drinking or use of other substances:

- Self-directed Approach _____
- Peer Group Approach at the VA _____ Civilian Provider ____
- Peer Mentor _____
- Talk to a Professional at the VA _____ Civilian Provider ____
- Professionally led group at the VA _____ Civilian Provider ____
- No Service _____
- Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

15. If you were to feel concerned about your future:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

16. If you were to feel detached from others or unable to emotionally connect:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____

Other (please specify) _____

17. If you were to have difficulty adjusting to being home:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

18. If you were to re-experience an uncomfortable or scary event through intrusive thoughts, flashbacks, or nightmares:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

19. If you were to feel that you lack purpose:

Self-directed Approach _____

Peer Group Approach at the VA ____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA ____ Civilian Provider ____
Professionally led group at the VA ____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

20. If you were to be often angry at situations:

Self-directed Approach _____
Peer Group Approach at the VA ____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA ____ Civilian Provider ____
Professionally led group at the VA ____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

21. If you were to feel that you should cut down on your drinking or use of other substances:

Self-directed Approach _____
Peer Group Approach at the VA ____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA ____ Civilian Provider ____
Professionally led group at the VA ____ Civilian Provider ____

No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

22. If you were to feel concerned about your career:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

23. If you were to feel numb or detached from activities and/or your surroundings:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____

Impact of approach on your future/ career _____
 Ease of access _____
 Stigma _____
 Logistical barriers (time, transportation, cost) _____
 Other (please specify) _____

24. If you were to feel that no one understands you or what you have been through:

Self-directed Approach _____
 Peer Group Approach at the VA _____ Civilian Provider ____
 Peer Mentor _____
 Talk to a Professional at the VA _____ Civilian Provider ____
 Professionally led group at the VA _____ Civilian Provider ____
 No Service _____
 Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
 Impact of approach on your future/ career _____
 Ease of access _____
 Stigma _____
 Logistical barriers (time, transportation, cost) _____
 Other (please specify) _____

25. If you were to avoid places, conversations, or situations because you are concerned you might experience a sudden surge of overwhelming discomfort or anxiety:

Self-directed Approach _____
 Peer Group Approach at the VA _____ Civilian Provider ____
 Peer Mentor _____
 Talk to a Professional at the VA _____ Civilian Provider ____
 Professionally led group at the VA _____ Civilian Provider ____
 No Service _____
 Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
 Impact of approach on your future/ career _____
 Ease of access _____
 Stigma _____

Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

26. If you were to feel that you do not know what to do with your civilian life after having separated from the service:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

27. If you were to be often angry at people:

Self-directed Approach _____
Peer Group Approach at the VA _____ Civilian Provider ____
Peer Mentor _____
Talk to a Professional at the VA _____ Civilian Provider ____
Professionally led group at the VA _____ Civilian Provider ____
No Service _____
Other _____ (please specify) _____

What is the most important factor determining which approach(es) you rated the highest?

Effectiveness _____
Impact of approach on your future/ career _____
Ease of access _____
Stigma _____
Logistical barriers (time, transportation, cost) _____
Other (please specify) _____

Vita

Lisa Diane Goldberg Looney was born on October 15, 1985 in Boston, Massachusetts and is an American citizen. She graduated from Burlington High School in 2004 and received her Bachelor of Arts in Psychology from Brandeis University in Waltham, Massachusetts in 2008. After graduation, she worked as a full-time research assistant for Bradley Hospital in Providence, Rhode Island for two years. She subsequently worked for two years as a resiliency services coordinator for a military resiliency training program called Families OverComing Under Stress (FOCUS) through UCLA, located on a naval base in Coronado, California.