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THERAPEUTIC TREATMENTS FOR PTSD: DOES TYPE OF TREATMENT
IMPACT HELP SEEKING BEHAVIORS IN A MILITARY SAMPLE?

By

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M.S., Emporia State University, 2010

A Dissertation
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College of Education and Human Development of the University of Louisville
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University of Louisville
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A Dissertation Approved on

June 27th, 2016

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DEDICATION

For my mother, Mary Lou, she being the reason that I am,
and the one who sacrificed the most for
the life I have been privileged to have.

I did it, Mom!

ACKNOWLEDGMENTS

This dissertation and the doctoral degree to which it is the capstone would not have been possible were it not for my wife and best friend, Rebecca Halford. To her goes the most credit as she endured as much as I did through this process!

Dr. Jesse Owen unequivocally deserves equal consideration. He pushed me very hard through my years as a developing clinician. I know I caused him frustration many times, but he always believed in me and endured this process with me, and for that I have not the words to express the magnitude of my appreciation.

I am grateful for the other members of my dissertation committee, for their commitment and dedication to this project.

I would be remiss to omit acknowledging my Father in Heaven and my Savior, Jesus Christ. This process has made it challenging for me to remain unashamed of Their reality, and I have countless times drawn from Their strength through this process.

Lastly, my outstanding parents deserve acknowledgement now and always. My father relentlessly expressed his pride for me, which fueled me greatly. My beloved mother may not have had the opportunity to provide me praise as I crossed this finish line, but I would never have crossed it had she not raised me the way she did.

ABSTRACT

THERAPEUTIC TREATMENTS FOR PTSD: DOES TYPE OF TREATMENT IMPACT HELP SEEKING BEHAVIORS IN A MILITARY SAMPLE?

Tyler Conley Halford

June 27th, 2016

There are several known barriers that people face that decrease the likelihood of seeking professional psychological help. The present study sought to identify whether certain treatment types for PTSD serve as barriers to seeking psychological help. It specifically sought to identify trauma-focused treatments as potential barriers due to their perception of being emotionally challenging. A survey was administered to 84 respondents. Of the respondents, 41 were randomly assigned to read a treatment protocol for an exposure-based, trauma-focused psychotherapy for PTSD, which 43 were randomly assigned to read a protocol for a trauma-avoidant psychotherapy for PTSD. Measures of attitudes toward seeking help and mental health stigma were then administered, with treatment type serving as two levels of an independent variable. We hypothesized that participants in the trauma-focused condition would subsequently report higher levels of stigma and more negative attitudes toward seeking help. MANCOVA results did not support our hypothesis as both groups were shown to have equal reactions to the protocols. This held true when controlling for four potential covariates: PTSD symptoms, avoidant coping

styles, conformity to masculine gender norms, and previous PTSD treatment history.

Treatment implications and future directions were discussed.

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CHAPTER I: INTRODUCTION

It is estimated that only about one-third of individuals experiencing mental health problems actually receive professional help (Kessler, 2005). There are several known barriers to receiving help for mental health related concerns, such as socio-economic status, lack of qualified treatment providers, poor access to care due to rural geographical context (Jackson et al, 2007), personal reasons (e.g., attitudes, opinions, gender socialization; Mackenzie, Erickson, Deane, & Wright, 2014), and even cultural norms and influences (Mallinckrodt, Shigeoka, & Suzuki, 2005; Chen & Mak, 2008). One particular subpopulation that has a high prevalence of not seeking help is persons serving in the U.S. military (Dickstein et al., 2010; Green-shortage, Britt, & Castro, 2007; Hipes, 2012; Hoge et al., 2004; Kim et al., 2011). The present study wishes to explore whether popular treatment types—particularly models of psychotherapy for treating PTSD—may serve as another potential barrier to seeking help or may be deterring people from entering treatment for PTSD.

The Military Culture: Help Seeking, PTSD, and PTSD Treatment

When a culture is defined or categorized as including a unique language, a code of manners, norms of behavior, belief systems, dress, and rituals (Reger et al., 2008), then the military can certainly be deemed a culture, with culture-specific and culture-unique influences and characteristics. Hall (2013) stated:

The members of the US Military are, indeed, a diverse group of people in American society that must be understood as uniquely different from the civilian

world. Virtually every author or expert on military life reviews the characteristics of military culture as a foundation for understanding the military (p. 22).

With this framework in mind, cultures in general have been shown to shape how members identify themselves, how they will solve their problems, and may influence how they choose to seek help for medical or mental issues (Chen & Mak, 2008). The military culture is one that is not well suited for promoting seeking help when needed. Many of the attitudes and beliefs that are instilled to prepare military personnel for combat readiness are in opposition of seeking self-help (Tanielian & Jaycox, 2008). For example, toughness, mission focus, and self- and group-based sufficiency are frequently instilled into the psyches of service members, and all of these characteristics may inhibit seeking mental health services (Dickstein et al., 2010).

Several studies have highlighted the help-seeking issues in military populations. In a study by Hoge et al. (2004), at least half of the military members surveyed who met criteria for a mental health disorder reported that seeking help would lead to them being perceived as being weak, being blamed for their problem, being treated differently by unit leaders, and may be detrimental to their career opportunities. Sareen et al. (2010) found that 20% of military personnel with unmet mental health care needs reported concerns for how others might perceive them should they seek treatment. “Discomfort with seeking help” was found to be the most common barrier in a study by Stecker and colleagues (2007). In a study by Kim et al. (2011), 2618 military members were surveyed and asked 17 questions designed to assess perceived barriers to care. Among all the participants surveyed, whether they met criteria for a mental health disorder or not, the

three most endorsed barriers were “my unit leadership might treat me differently,” “I would be seen as weak,” and “members of my unit might have less confidence in me.”

Although some military members believe that treatment is not the right choice for them, an overwhelming majority (88%) of military personnel respondents believed that mental illness can be treated, while 90% reported that they believed mental health treatment could help them get control of their lives (APA, 2008). Further findings showed that over 90% of military personnel surveyed endorsed that they know that help is available and know where to find it (Kim et al., 2011). Thus, the issue of help-seeking in the military does not appear to revolve around whether mental health disorders can be improved via treatment. It appears that holding the belief that treatment works and is readily accessible does not override the many perceived barriers should help be needed by a person in the military.

The issues of help-seeking in the military are even more concerning when highlighting the reality that military personnel have a higher probability of experiencing a traumatic or life threatening event than civilian populations (e.g., Magerøy et al., 2008). The military population is an “at-risk group” for suffering psychological distress (Langston, Gould, & Greenberg, 2007) and being prone to concerns such as depression, family violence, substance abuse, and anxiety disorders. “Mental disorders” are among the leading causes of occupational dysfunction in this population (Hoge et al., 2002). Aside from depression, the most prevalent mental health disorder afflicting military personnel returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) is posttraumatic stress disorder (PTSD; Hoge et al., 2004; Hoge, Auchterlonie, & Milliken, 2006; Thomas et al., 2010).

There are several different psychotherapeutic and medical treatment approaches for PTSD. FDA approved drug treatments such as the selective serotonin reuptake inhibitors (SSRIs) sertraline and paroxetine (Stein et al., 2000) are commonly used, though there appears to be no consensus on their effectiveness (Institute of Medicine, 2008). Psychotherapy treatments for PTSD have a broad assortment of approaches, theories, and modalities. Some of the most commonly known psychotherapy treatments for PTSD are Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), Mindfulness based interventions, Skills Training in Affect and Interpersonal Regulation (STAIR), Present-Centered Therapy (PCT), and Psychodynamic Therapy, to name a few. Among the psychotherapeutic treatments for PTSD, there is one element that creates a general separation among treatments: whether or not the trauma memory/experience is the primary focus of the treatment.

Virtually all therapies intended to treat PTSD can fit on a spectrum ranging from completely trauma avoidant (i.e., the experience does not need to be shared) to strong emphasis on the trauma account (i.e., the trauma experience is shared, sometimes with high frequency and great detail) as part of their treatment approach and theory of change. However, this classification and distinction of trauma-focused versus non trauma-focused can at times be difficult to make (see Wampold et al., 2010). According to the National Institute of Clinical Excellence (NICE) Guidelines for classifying a therapy as trauma focused, “The relevant consideration for the classification was whether or not the treatment *mainly* focused on the trauma memory and its meaning” (National Collaborating Centre for Mental Health, 2005, p. 54). Thus, if a treatment only *partially*

focuses on the trauma memory or experience, it may be difficult to classify as trauma-focused. It is additionally worth distinguishing what are commonly referred to as “exposure based” treatments from “trauma focused” treatments. When a therapy is considered “exposure” based, this is generally in reference to the usage of the behavioral technique of exposure as the change mechanism. Exposure based therapies rely on repeated levels of trauma revisitation, as well as exposure to external trauma event reminders, as a technique designed to desensitize the aversive emotional reaction caused by these cues. A treatment for PTSD can be trauma-focused but not necessarily exposure based. However, if a treatment is considered exposure-based, it is certainly categorized as trauma-focused. Table 1 was adapted from both Wampold et al. (2010) and Bisson et al. (2007) and is a classification of treatments that have been distinguished by trauma focus.

Table 1

Treatments for PTSD

<i>Trauma Focused Treatments/ Techniques</i>	<i>Not Trauma Focused</i>
Imaginal Flooding	Stress Inoculation Training (without 3 rd phase)
Implosive Flooding	Applied Muscle Relaxation
Trauma Desensitization	Progressive Muscle Relaxation
Neurofeedback Training	Affect Management
EMDR	Psychodynamic
Virtual Reality Exposure	Hypnotherapy
Image habituation training	Supportive Counseling
Gradual Exposure and CR	Interpersonal Therapy
Imaginal Exposure	Present Centered Therapy
Brief Eclectic Therapy	Active Listening
Trauma Focused CBT	
Cognitive Processing Therapy	
Prolonged Exposure	
Immediate Cognitive Therapy	
Narrative Exposure Therapy	

A large body of research has been conducted to show which treatments for PTSD have the most appeal and preference. Evidence generally shows a preference for

therapeutic treatment over medication treatment (Angelo, Miller, Zoellner, & Feeny, 2008; Becker, Darius, & Schaumberg, 2007; Becker et al., 2009; Cochran et al., 2007; Feeny, Zoellner, Mavissakalian, and Roy-Byrne, 2009; Jaeger et al., 2010; Reger et al., 2013; Roy-Byrne et al., 2003; Zoellner et al., 2003). Some studies have explored preferences among the different therapeutic approaches for PTSD (Becker, Darius, & Schaumberg, 2007; Becker et al., 2009; Reger et al., 2013; Tarrier, Liversidge, & Gregg, 2006). Within the PTSD therapy preference literature, a common theme emerges: either exposure therapy or a cognitive-based therapy is the preferred therapeutic treatment choices for PTSD, selected above treatments such as psychodynamic therapy, EMDR, and virtual reality therapy. However, only one of these studies used a military/veteran sample (Reger et al., 2013). Other treatment preference studies used college samples (Becker, Darius, & Schaumberg, 2007; Tarrier, Liversidge, & Gregg, 2006) and a law enforcement sample (Becker et al., 2009).

The military sample treatment preference study by Reger and colleagues (2013) sought to address PTSD treatment preference among two exposure therapy packages (Virtual Reality Therapy and PE) and medication, and they also explored some potential mediating treatment stigma variables within treatment preference. Their findings were consistent with other PTSD treatment preference studies in that the participants preferred therapy to medication, with no significant difference between Virtual Reality Therapy and PE. However, some reasons for the preference of therapy over medication were that therapy treatments may be perceived as more acceptable to work colleagues. Respondents also reported that there would be higher risks of their careers being impacted should they choose medication treatment over therapy. Results also indicated that there was a less

likelihood of feeling embarrassed or ashamed should they seek an exposure therapy over medication. The Reger and colleagues study is one of the few known studies that has examined stigma associated with specific treatments of PTSD.

It is noteworthy that in most of these preference studies, the top treatment choices were generally treatments that were advertised as having the best research support compared to their counterparts. To highlight, in Becker et al. (2009), participants were given descriptions of treatments prior to choosing their preference. CPT was illustrated to have “undergone rigorous scientific evaluation and has been supported by clinical trials” (pp. 252). Exposure Therapy was described as having been “thoroughly and scientifically tested. Several controlled studies have shown it to significantly reduce PTSD symptoms” (pp. 252). CPT and Exposure were the top two choices in this study. The third preference was Psychodynamic, which was described as “generally has not been rigorously evaluated in research trials because treatment tends to focus on psychological processes as opposed to people’s symptoms” (pp. 252). Brief Eclectic Psychotherapy (BEP) was the 4th therapy choice and was described as, “Since BEP is new, it has not been rigorously tested” (pp. 251). The last therapy choice was EMDR, which was described as “Some research supports the use of EMDR” (pp. 251).

Some of the preference studies did examine reasons why certain treatments were selected, and “perceived efficacy of treatment” was a strong predictor of treatment choice (Angelo et al., 2008; Cochran et al., 2007; Zoeller et al., 2003). In a literature review intended to highlight factors associated with treatment preference for PTSD, Jeager et al. (2010) concluded that:

Though we would expect that individuals are more likely to choose treatments they feel will be helpful at addressing their symptoms, the importance of efficacy suggests that clients are conscientious consumers who when provided relevant information, are carefully weighing their treatment options before choosing (pp. 299).

Independent Variables

Treatment types: trauma focused and trauma avoidant. There is no known empirical study to date that has shown that the trauma focus element of treating PTSD (or even the mere knowledge of needing to explore the traumatic event in therapy) may deter persons from entering therapy for PTSD. There is, however, abundance of clinical opinion that may suggest that people may be prone to avoiding therapy that will include the revisiting of a traumatic experience. There are professionals who are concerned that exposure-based therapies can lead to symptom exacerbation, and that treatments for PTSD should be applied in ways that fit the variations of symptoms and traumatic experiences of each client (McFarlane & Yehuda, 2000). The exposure elements of treatment and their effects on progress certainly appear to be recognized as something that needs to be overcome and dealt with for better outcomes. To highlight examples, when describing the rationale for PE, Peterson, Foa, & Riggs (2011) stated, “PTSD patients typically go to extreme measures to avoid the traumatic memory, and doing so only perpetuates PTSD symptoms” (pp. 43). These “extreme measures to avoid” may likely translate into avoiding therapy altogether. Bleiberg and Markowitz (2005) reported, “experts acknowledge that direct re-exposure to reminders of traumatic events frightens many traumatized patients and deters them from treatment” (pp. 181). Kilpatrick and Best

(1984) suggested that the anxiety produced by using exposure may lead to clients avoiding returning to treatment. A recent correspondence with a psychologist who works with persons with PTSD for the VA reported, “I have known many patients who have avoided treatment or dropped out due to the fear of revisiting the trauma (M. Sweeney, personal communication, August 8th, 2014).”

These ideas indicate to some degree that the potential fear and anxiety produced during exposure is something clients will seek to avoid. There may also be some empirical support to back these ideas. A meta-analytic finding has indicated that therapies with exposure packages have poorer retention than non-exposure based treatments (Imel et al., 2013). It is worth noting, however, that treatment attrition is not necessarily defined as “avoiding” therapy, nor does it capture persons who never began treatment. Though lower attrition rates in non-exposure therapies may well be due to the fears and anxieties produced by the exposure elements of exposure therapies, with this study I want to better understand if these avoidance factors may present *before* entering therapy. A finding that shows that exposure based therapy has poorer retention rates than non-exposure based therapies does not provide any evidence as to which treatment is more likely to be avoided to begin with, or whether any knowledge that the trauma has to be revisited is deterring people from entering therapy.

The issue of whether it is necessary to focus on traumatic experiences or memories when treating trauma survivors is not a settled issue (Schnurr et al., 2007; also see Wampold et al., 2010). Some PTSD treatments have the exposure element at both the core of the treatment technique and the theory of change (e.g., Prolonged Exposure Therapy [PE, see below] and Virtual Reality Therapy). Others, like Cognitive Processing

Therapy (CPT), may still be considered by some as “exposure based,” but this may only mean that some elements of the treatment are considered exposure techniques (i.e., clients are instructed to write the trauma account and read it in session), while the theory may be more grounded in cognitive thought processes that have been altered *due to the trauma*. In fact, there is a form of CPT called Cognitive Processing Therapy-Cognitive (CPT-C) wherein the trauma account is not written or read in session, but CPT is still applied without actually revisiting the trauma (Resick et al., 2008). Comparison studies have shown that CPT-C is equally as effective as CPT (Walter et al., 2014) and has been shown to have lower attrition rates than CPT (Resick et al., 2008)

On the opposite end of the spectrum, nontrauma-focused treatments are distinct in both theory and application. The trauma is not the focus of treatment, and in some cases, if the discussion of trauma is breached in a therapy session that is adhering to a non-trauma protocol, the protocol dictates that the topic be changed or redirected away from the revisitation. For example, in a manual designed to distinguish trauma- versus non-trauma-focused group treatments, the protocol for the non-trauma technique—when faced with a situation where a client shares their trauma experience—instructs therapists to redirect to the here-and-now and focus on what is currently being experienced by the client and the group (Classen, Butler, & Spiegel, 2001). This example classifies both a non-trauma-focused approach as well as a trauma-avoidant approach to working with PTSD.

Trauma-focused treatments. Trauma-focused treatments for PTSD are widely used and popular, particularly among military populations. Exposure therapies have been termed the “gold-standard” therapy for PTSD (Campanini et al., 2010). The Veterans

Health Administration/Department of Defense clinical practice guidelines

“recommend[s] that patients who are diagnosed with PTSD should be offered one of the evidence-based trauma-focused psychotherapeutic interventions that include components of exposure and/or cognitive restructuring; or stress inoculation training (VA/DoD, 2010).” Among the most commonly promoted and empirically supported treatments for PTSD are PE and CPT.

PE has roots in cognitive behavior theory, exposure therapy principles, and emotional processing theory (Foa & Kozak, 1986). PE has four recognized treatment components: (1) repeated revisiting of the trauma memories (i.e., imaginal exposure), (2) repeated exposure to avoided situations (i.e., in vivo exposure), (3) education about common reactions to trauma, and (4) breathing retraining (Peterson, Foa, & Riggs, 2011). Rationale is grounded on automated fear responses, which feed into various cognitive beliefs, leading to overgeneralizations of certain environmental cues. For example, the smell of diesel fuel, if present at the time of trauma, may cue trauma memories. Along with these perceptions comes the development of negative cognitions, such as “the world is a dangerous place” or “what happened during the trauma is my fault.” Confronting the memory (via a PE technique called *in vivo* exposure)—as opposed to avoiding it—provided clients with opportunity of correcting these cognitions. It is further theorized that continued re-exposure to the memory will eventually help desensitize the person with the trauma and they will eventually start to learn that they are no longer in unsafe places and their “fight or flight” responses are no longer needed.

Several randomized clinical trials have shown support for PE (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa et al., 1999, 2005; Resick et al., 2002; Schnurr, 2007;

Bryant 2008). One of the earliest studies evaluating PE used a rape victim sample (Foa et al., 1991). In this study, participants were randomly assigned to PE, stress inoculation training (SIT), supportive counseling (SC), or to a wait-list control. At post treatment, SIT was shown to be significantly above the rest in terms of better outcomes. However, after a 3 ½ month follow-up, PE was shown to have superior outcomes on PTSD symptoms.

CPT is based on a social cognitive theory of PTSD that combines elements of information processing and social schema theories (Williams et al., 2011; Lang, 1977; McCann, Sakheim, & Abrahamson, 1988). This theory posits that all incoming information is organized into schemas (i.e., stored bodies of knowledge). These schemas then serve as the mechanisms for how humans make sense of the world, interpret new information, and formulate expectations. It is theorized that individuals who have developed PTSD have experienced significant disruptions to preexisting beliefs. CPT uses cognitive therapy techniques to address faulty cognitions relating to traumatic events (Williams et al., 2011). Certain phases of CPT treatment require clients to provide written accounts of the trauma, as well as written accounts explaining why the trauma occurred, which provides the clinicians with tools to help the client identify faulty cognitions. However, under certain circumstances, the exploration of the trauma may be disregarded in CPT (e.g., if the person cannot recall the details of the trauma; Williams et al. 2011). Nevertheless, the focus of CPT is centered on the modification of beliefs about the meaning and implications of the traumatic event (APA, 2006).

CPT has two decades worth of research support (Williams et al., 2011). The first published CPT study used a female sexual assault sample in a group treatment format and

showed promising support (Resick & Schnicke, 1992). A landmark study by Resick et al. (2002) compared CPT with PE and a wait-list control. Participants in this study consisted of a community sample of female sexual assault survivors. Both treatments outperformed the wait-list with regard to PTSD symptom reduction. CPT showed significantly greater improvement than PE for both guilt cognitions and health related concerns (Resick et al., 2002; Galovski, Monson, Bruce, & Resick, 2009). CPT has also been examined with veteran populations and has demonstrated efficacy (Monson et al., 2006; Chard et al., 2010; Owens, Chard, & Cox, 2005; Zappert & Westrup, 2008).

Non trauma-focused treatments. Treatments that are not trauma-focused are not as popular, but are starting to gain momentum in the research and have frequently been used in RCT's that include a trauma-focused comparison (Classen et al., 2011; McDonagh et al., 2005; Schnurr et al., 2003; Suris et al., 2013). An emerging treatment for PTSD that does not explore the trauma experience/ memory is *present-centered therapy* (PCT; also known as present-focused therapy). PCT does not appear to be a therapy grounded in any specific or well-known theory, but is rather a therapy that is primarily founded on providing common therapeutic techniques and elements. PCT was originally developed in a group format to provide a non-trauma focused approach in randomized control trials of PTSD treatments (Schnurr et al., 2001). It appears that Schnurr and colleagues (2001) are the first to use the term "present centered therapy." The goal of this treatment for a control group was to provide a therapy with several common therapeutic factors, such as supportiveness and instillation of hope. Schnurr et al. (2001) described their rationale for the creation of a therapy like PCT by referring to PCT as a "placebo therapy" or a "care as usual" therapy that excludes the experimental

aspects of the therapy it is tested against (e.g., exposure). PCT was considered a “credible” and “clinically acceptable” treatment condition in its original development (Schnurr et al., 2001).

Since its development, PCT has evolved to include the creation of treatment manuals and trainings designed to demonstrate faithful implementation in research trials (e.g., Classen et al., 2011; McDonagh et al., 2005; Schnurr et al., 2003; Schnurr, et al., 2007; Suris, Link-Malcolm, Chard, Ahn, & North, 2013). According to the present-centered approach, the principal mechanisms of change are grounded in altering present maladaptive relational patterns/behaviors, providing psychoeducation regarding the impact of trauma on the client’s current life and regarding PTSD symptomatology, and teaching the use of problem-solving strategies (Classen et al., 2011; McDonagh et al., 2005; Schnurr et al., 2003). The role of trauma and the connection between trauma and current difficulties is acknowledged in PCT, but the trauma itself is not the focus (McDonagh et al., 2005).

In a treatment manual for survivors of sexual trauma, Classen, Butler, & Spiegel (2001) reported:

In the present-focused treatment the assumption is that by focusing on the here-and-now survivors can alter their current functioning and thereby address the impact of their abuse history. In present-focused treatment the goal is to help survivors identify and modify the maladaptive patterns of behavior in their current lives that have arisen as a result of their traumatic past, and to restructure their damaged view of self and others. By focusing on the here-and-now, survivors can

alter their current functioning and thereby address the impact of their abuse history. (pp. 15)

McDonagh and colleagues (2005) add that

[PCT] is a collaborative therapeutic intervention in which the therapist's information and expertise are used to assist the client in addressing current life difficulties. It does so by helping the client to recognize the impact of her trauma history on her present coping style and by teaching her a systematic approach to problem solving to enhance coping. (pp. 518)

PCT is currently recognized by Division 12 Society of Clinical Psychology of the American Psychological Association (APA) as a treatment for PTSD that has "strong research support" (Society of Clinical Psychology, 2012). "Strong research support," as described by APA Division 12, means that a treatment meets criteria for what Chambless et al. (1998) define as "well-established" treatments. The Society of Clinical Psychology also designates PE and CPT as treatments with "strong research support." Recent meta-analyses have also shown support for PCT. A meta-analysis by Frost, Laska, and Wampold (2014) examined 5 randomized clinical trials that compared PCT to existing evidence-based treatments for PTSD. Their meta-analysis showed that treatment effects for PCT, when compared to evidence-based treatments, were small and non-significant. They also found that PCT was superior to other evidence-based treatments in terms of lower drop-out rates. Results from a study by Imel and colleagues (2013) provide additional meta-analytic support for PCT having lower attrition rates than exposure-treatments.

Other treatments that are categorized as non-trauma-focused are emerging but are still in stages of having limited research support. Two studies have shown that interpersonal approaches to treating PTSD have demonstrated efficacy (Bleiberg & Markowitz, 2005; Campanini et al., 2010). Both of these studies were undertaken as attempts at providing alternative treatments to PTSD that did not require exposure, and both were grounded in similar theoretical rationale for treating PTSD with an interpersonal focus. Both studies also recognized the potential need for an alternate therapy due to potential fears of revisiting trauma that may be associated with exposure-based treatments.

The treatment foci for both the interpersonal studies proved similar in process and goals. The focus of the treatment approach for Bleiberg and Markowitz (2005) was on interpersonal sequelae of trauma, such as interpersonal hypervigilance, difficulty trusting and confronting others, and the manner in which PTSD symptoms, such as avoiding reminders of the trauma, interfere with current functioning and relationships. Essentially, the interpersonal approach to treatment for Bleiberg and Markowitz was to decrease symptoms by improving social functioning. Similarly, Campanini and colleagues (2010) sought to improve social functioning by focusing on four key areas of treatment: role transition (i.e., disruptions in social inclusion due to role changes from traumatic experience), grief (the loss of someone close in a violent way), role disputes (confrontations with close relatives that have emerged after the trauma and contribute to maintenance of PTSD symptoms), and interpersonal sensitivity (focus on areas that may have already been flawed prior to the trauma).

Dependent Variables

Stigma. Stigma has been defined in various ways. One source defines stigma as a negative or erroneous attitude about a person or thing; a prejudice or a negative stereotype (Corrigan & Penn, 1999). The definition can also expand to include a sign of disgrace or discredit which sets a person apart from others (Byrne, 2000). When associated with mental health and psychotherapy, stigma has various classifications. Three commonly cited mental health stigmas are social-, public-, and self-stigma. Social stigma is defined as the fear of being judged, stereotyped, labeled, or discriminated against by other members of one's direct social network (Vogel, Wade, & Aschman, 2009). Public stigma is the reaction of the general public toward people with mental illness (Corrigan and Watson, 2002). Self-stigma is defined as a decrease of one's self-esteem or sense of self-worth due to a perception that their actions are socially unacceptable (Corrigan, 2004). Regardless of the type or definition of stigma, all share the same foundation: stereotypes, discrimination, and prejudice. Higher levels of stigma have been associated with negative help-seeking attitudes and lower intentions to seek help (Pattyn, Verhaeghe, Sercu, & Bracke, 2014; Tucker et al., 2013; Lally et al. 2013; Conner et al., 2010), lower self-esteem (Link & Phelan, 2001), lower treatment compliance (Fung & Tsang, 2010), and higher depression rates (Manos, Rüsçh, Kanter, & Clifford, 2009).

Help Seeking Attitudes. Help-seeking is a concept that appears to have no agreed upon definition, despite the rapid growth in research and interventions focused on help-seeking (Rickwood & Thomas, 2012). Help-seeking definitions have included concepts such as behavioral actions (e.g., requesting assistance or services [Unrau & Grinnell, 2005] or actively searching for relevant resources [Zartaloudi & Madianos,

2010]), taking initiative in a social context (Shirom & Shperling, 1996), decision making and choice (Neighbors, 1985), or a coping process designed to obtain assistance (Rickwood & Thomas, 2012). Furthermore, help-seeking has been measured in various ways (e.g., attitudes toward receiving help, past help-seeking experience, or intentions to seek help). Rickwood & Thomas (2012) refer to help-seeking attitudes as an antecedent to the behavioral component: “The hypothesized process is that attitudes predict intentions, which in turn predict behavior, and is therefore consistent with the theory of planned behavior” (pp. 180). Following this model seems to be the best methodological approach in the present study. The target sample is not intended to consist of persons who are in need of psychological help, nor is the interest focused on whether they will be seeking help in the near future. Thus, the focus should be on the attitudinal component of help-seeking. If the independent variable is shown to influence help-seeking attitudes in general, it can be expected to generalize to future help-seeking behaviors.

As mentioned above, stigma has been shown to predict help-seeking attitudes and behaviors. To highlight, a study by Kim et al. (2011) showed that negative perceptions of self and from others were among the most common reasons for avoiding help in a military sample. In other words, concepts of self and social stigma (i.e., stereotype and discrimination) were associated with avoiding help. Stigma can therefore be seen as a mediator to help-seeking.

Additional Variables/ Covariates

There could be several potentially meaningful variables that may coincide with the directionality of the outcomes in this study. The variables that appear most salient will be examined to help inform the theoretical findings and understanding of treatment

type as a help-seeking barrier. These variables will also be examined to help control for potential threats to validity. The variables in question are conformity to masculine norms, PTSD symptomatology, avoidant coping styles, and prior treatment experience.

Gender Norm Conformity. Gender and gender norms have been shown to play a role in the help-seeking process. In addition to cultural influences and stigma in the military culture, gender issues may likely be another variable impacting help-seeking in military personnel. For example, the majority of service personnel in the United States Armed Forces are male (85%; Office of the Deputy Under Secretary of Defense, 2012), and compared to women, men are less likely to seek help, have been shown to demonstrate less confidence in mental help services, and view therapy as more stigmatizing (Leong & Zachar, 1999; Mansfield, Addis, & Mahalik, 2003; Robertson & Fitzgerald, 1992; Vogel, Wade, & Haake, 2006; Vogel et al., 2009). Indeed, fear of stigma has been shown to be one of the most significant barriers to men's decisions to seek help (Mahalik, Good, & Englar-Carlson, 2003). Furthermore, men have even been shown to avoid help when facing significant distress (Addis & Mahalik, 2003; also see Andrews, Issakidis, & Carter, 2001). Thus, with a population that is mostly male, in conjunction the aforementioned issues with men seeking help and a military culture that promotes toughness, this adds further evidence that the military population is certainly at a high risk for being a population who does not seek help when needed.

Examining the help-seeking gender phenomenon through a gender socialization lens helps shed light on reasons for this gender disparity. Reasons for men being less inclined to seek help have been tied to conformity to gender norms. For example, men may refuse help because they are typically socialized to conform to the masculine norms

of being independent, self-reliant, and better at being “in control” (Kaplan, 1987; Mahalik, Good, & Englar-Carson, 2003; Ogrodniczuk, 2006). The development of these gender socialization norms likely has roots in traditional Western culture. Men likely view seeking help as a conflict with traditional Western male gender roles such as avoiding the appearance of being weak or unmanly, demonstrating competence in handling their own problems, and being in control of their emotions (Pederson & Vogel, 2007; O’Neil, 2008; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Thus, it may make sense that seeking help is more stigmatizing for men, as their social mores dictate that seeking help may be admitting an inability to handle things on their own, which could certainly manifest as a loss in self-esteem (Addis & Mahalik, 2003). Providing a measure of the level of conformity to masculine norms can help control for a clearer understanding of reported stigma and help-seeking attitudes and their relationship with the independent variables of the study.

PTSD Symptomatology and Treatment History. In a PTSD treatment preference study by Becker and colleagues (2009), 90% of the sample selected CPT and exposure as their top two choices, which were consistent with other preference studies. However, when Becker and colleagues controlled for PTSD symptoms, CPT was still the top choice, but both psychodynamic therapy and brief eclectic therapy were preferred above “exposure therapy.” Though only a small percentage of the participants in this study met criteria for PTSD (9.5%), this finding still tends to indicate that actually having a PTSD diagnosis or the presence of PTSD symptoms may influence a treatment preference. In the case of Becker and colleagues, exposure was less preferred. Given the assumption that exposure in therapy is expected to raise avoidance levels, and a common

symptom of PTSD is avoidance of persons/ places/ external stimuli that may elicit trauma memories or exacerbate PTSD symptoms, then PTSD symptoms could be expected to be negatively associated with the idea of exposure as a process to treatment. Thus, using PTSD symptoms as a potential moderating variable could prove beneficial, as higher levels of PTSD may produce more of an aversion toward the exposure element of therapy.

Previous treatment experience may additionally be seen as a factor that can impact the outcome in this study. Perhaps persons in the sample have had direct experience with these treatments—or any therapy in general—and already have preconceived opinions or experiences that will shape their responses. If, for example, a respondent has already had a negative experience with exposure therapy, they may view exposure therapy as less desirable, which could influence their reports of stigma and help-seeking attitudes. Measures will be included in the demographics section that can easily assess prior experiences with therapeutic or medical treatment.

Avoidance. The way in which the participants in this study already avoid or cope (i.e., the way they respond to or approach stressful situations; Lazarus, 1966) can be expected to influence the findings. With the expectation that each respondent is unique in their methods of coping, controlling for their coping styles may prove to be a beneficial methodological step. Two common approaches to dealing with distressing events are problem-focused coping and emotion-focused coping. Problem-focused approaches are generally active ways of coping, i.e., problem solving, seeking information about the issue, taking action, and seeking help (Karekla & Panayiotou, 2011). Emotion-focused ways of coping refer to ways of managing the emotional reactions of the stress by

distancing one's self emotionally, seeking social support, self-blame, venting, or avoidance of interpersonal interaction (Folkman et al., 1986). Thus, for example, if a participant in this study is predisposed to cope with problems by avoiding emotional engagement of any kind (e.g., therapy), then their reactions to the treatment vignettes may be influenced by this coping style.

Studies have shown that avoidant coping is positively associated with higher symptoms of PTSD (Krause, Kaltman, Goodman, & Dutton, 2008; Ullman, Townsend, Filipas, & Starzynski, 2007). With the use of military/veteran samples, studies have further supported the notion that the use of avoidant coping strategies during deployment is positively correlated with a later PTSD diagnosis (Benotsch et al., 2000; Solomon, Mikulincer, & Flum 1988; Stein et al., 2005; Wolfe et al., 1993). Furthermore, problem-focused coping has been shown to be negatively associated with stress-related symptomatology, whereas emotion-focused coping is positively associated with stress-related symptomatology in military veterans (Suvak et al., 2002). This is highlighted by additional research on military/veteran samples that have shown that higher reliance on emotion-focused coping (versus problem-focused) is negatively associated with alcohol dependence/ abuse (Levin, Ilgen, & Moos, 2007), depression (Desmond & MacLachlan, 2006), and lower mortality rates (Wolf and Mori, 2009).

Research Question and Hypotheses

In this study I sought to address whether certain therapeutic treatments for PTSD may predict stigma and help-seeking barriers. Specifically, I examined whether the trauma-focus element of therapy may be deterring people from entering therapy. The

formal research question this study seeks to answer is: does the exposure element of therapeutic treatments for PTSD impact help seeking behaviors in a military sample?

Hypothesis 1: Higher levels of stigma will be significantly associated with negative attitudes toward help-seeking in both conditions.

Hypothesis 2: Compared to individuals in the non-trauma-focused therapy condition, individuals in the trauma-focused therapy condition will report higher levels of stigma and higher negative attitudes towards seeking help.

Hypothesis 3: The effects for Hypothesis 2 will remain after controlling for PTSD symptoms, conformity to gender norms, avoidant coping, and prior treatment experiences.

CHAPTER II: METHOD

Participants

For the duration that the survey was available online, 119 survey responses were recorded. Of these, 84 participants finished the survey and were thus included in the analysis. Each participant endorsed being a member of the U.S. Military or currently a member of a University-affiliated ROTC program. Of the 84 included in the analysis, 78 endorsed being currently enlisted in a branch of the U.S. military, while 6 endorsed current membership in a University affiliated ROTC program. Demographics of participants used in the analysis are as follows: 18 identified as female, 65 as male, and 1 declined to report sex. For reported age, 60% of participants were between the ages of 18 and 30; 24% were between the ages of 31-40; 14% were between 41-50; 2% were between the ages of 51-60; 0% reported an age range of 61 or higher. The demographics by branch or service program were represented as follows: Air Force = 14% (N=12), Army = 42% (N=35), Marines = 12% (N=10), Navy = 8% (N=7), Coast Guard = 0%, National Guard 17% (N=14), and ROTC = 7% (N=6). Lastly, 25% (N=21) of participants endorsed having participated in therapy for PTSD in their lifetime. To determine an adequate number of needed participants, a power analysis was conducted to determine a desired sample size. The *G*Power Data Analysis* software (Faul et al., 2007) was used to calculate a desired sample size. An *A priori* power analysis was calculated using the following parameters: $\alpha = 0.05$, power (1- β error probability) = 0.95, number of groups = 2, number of covariates = 4, and a desired effect size ranging from medium to large ($f^2 =$

.25 to .40). The output parameter determined that a total sample size of 80-140 participants would achieve these desired effect sizes.

Measures

PTSD Checklist – 5 (PCL-5). The PCL-5 is a widely used measure of PTSD symptoms. The measure is frequently used as a screening device within the VA healthcare system, and permission was granted from the VA to use this measure for this study (see Appendix C). The PCL-5 is a 20 item questionnaire that measures self-reported PTSD symptom presence. Each question requires respondents to indicate “how much they have been bothered” by a specific symptom (e.g., “feeling jumpy or easily startled”) “in the past month,” with five response rating options for each question: 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, or 4 = extremely. Responses are then added for a total symptoms severity score. The PCL-5 assesses all the DSM-5 symptom clusters for PTSD (intrusions, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity) with the exception of Criteria A: exposure to a traumatic event. The PCL-5 has demonstrated good internal consistency with a veteran sample ($\alpha = .96$; Bovin et al., 2015) and a military sample ($\alpha = .95$; Wortmann et al., 2016). The present study yielded an internal consistency alpha of $\alpha = .97$.

The Conformity to Masculine Norms Inventory-22 (CMNI-22). The CMNI-22 is a shortened (22-item) version of the original 94-item CMNI (CMNI-94; Mahalik et al., 2003). The CMNI-94 was designed to identify a range of masculine norms. The 11 validated masculinity norms identified by the CMNI-94 were Winning, Emotional Control, Risk-Taking, Violence, Dominance, Playboy, Self-Reliance, Primacy of Work, Power Over Women, Disdain for Homosexuality, and Pursuit of Status. The CMNI-22

was then created by taking the two highest loading items from the 11 masculine constructs. In addition to yielding a range of masculinity constructs, the CMNI-94 can also be used as an overall scale of masculine conformity by simply using a total score (see Mahalik & Rochlen, 2006). The present study will focus on the utilization of the CMNI-22 as an overall measure of masculine conformity. The CMNI-22 total score has been shown to correlate well with the CMNI total score (.92). In the present study, internal consistency rating for the CMNI-22 was $\alpha = .71$. This compares consistently with previous alpha reports of .65 (Rochlen et al., 2008) and .70 (Burns & Mahalik, 2007).

The Brief Experiential Avoidance Questionnaire (BEAQ). The BEAQ (Gómez et al., 2014) is a 15-item instrument designed to assess the construct of experiential avoidance. The BEAQ was originally developed to offer a briefer alternative to the 62-item Multidimensional Experiential Avoidance Questionnaire (MEAQ; Gómez et al., 2011). The MEAQ comprised of six subscales: Behavioral Avoidance (situational avoidance of physical discomfort and distress), Distress Aversion (non-acceptance of or negative attitudes toward distress), Procrastination (delaying activities that may cause distress), Distraction/Suppression (attempts to ignore or suppress distress), Repression/Denial (distancing and dissociating from distress), and Distress Endurance (willingness to engage in behavior that is consistent with one's values even when in distress; Gómez et al., 2011). In the initial development and validation study for the BEAQ (Gómez et al., 2014), the BEAQ was shown correlate moderately to highly with each of the six MEAQ subscales in clinical, student, and community samples. The BEAQ had alphas ranging from .80 to .89 among 7 samples, which demonstrates good internal consistency. The present study yielded an internal consistency rating of .88.

The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF). The ATSPPHS-SF is based on the original 29-item Attitudes Toward Seeking Professional Psychological Help (ATSPPHS) scale developed by Fischer and Turner (1970). With the premise to make a shorter, more research-friendly 10-item version, the ATSPPHS-SF was created by Fischer and Farina (1995). Like the ATSPPHS, the ATSPPH-SF is designed to measure four dimensions of help-seeking attitudes: 1) the recognition of need for psychological help; 2) stigma tolerance; 3) interpersonal openness; and 4) confidence in mental health professionals. The ATSPPH-SF uses a 4-point Likert scale (0 = *Disagree*; 1 = *Partly Disagree*; 2 = *Partly Agree*; 3 = *Agree*), with half of the items are reverse scored. Example items include “If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy” and “Personal and emotional troubles, like many things, tend to work out by themselves.” Fischer and Farina’s (1995) initial evaluation yielded a 1-month follow-up test-retest reliability at .80. and an adequate internal consistency alpha of .84 (compared to .88 in the current study).

Military Stigma Scale (MSS). The MSS was developed by Skopp and colleagues (2012) with the intention of capturing military culture interplay in the potential presence of mental health stigma. The military culture was primarily captured in the public stigma domain of the MSS. For example, in the development of the public stigma portion of the scale, items focused on military personnel’s concerns regarding their (a) public image if they were to seek care, (b) ramifications on their career, (c) concerns with confidentiality, and (d) impact on how peers, leaders, and other military personnel would perceive them (Skopp et al., 2012). For the measurement of self-stigma within the MSS, Skopp and

colleagues (2012) assumed that self-stigma is an individualized experience and should not differ between civilians and soldiers. Thus, to measure self-stigma, the MSS adapted items from the previously developed 10-item Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006). The MSS was developed using a sample of 520 Army Soldiers. It was then tested again in a confirmatory group of 518 Army Soldiers. The public and self-stigma scales for the exploratory and confirmatory groups demonstrated good internal consistency ($\alpha = .94$ and $.89$; $\alpha = .95$ and $.87$, respectively). These results are in line with previous help-seeking findings demonstrating the presence of two kinds of stigma (i.e., public and self; Vogel et al., 2006). For the present study, the internal consistency alpha for the total MSS was $\alpha = .96$; the self-stigma subscale was $.94$; the public-stigma subscale was $.96$.

Case Vignette and Treatment Protocols. A case vignette and two treatment protocols (see Appendix B) were created by the principal investigator. The case vignette was intended to closely resemble a military serviceman who has developed PTSD after combat experiences. It was further written in a way that was intended to have the participant imagine themselves as the person in the vignette (e.g., it was written with “you” pronouns). This was done to try to elicit a first-person/real world experience for the participants, which was hoped to then capture more closely their own personal reactions to the treatment option. At the conclusion of the vignette, the person in the vignette has decided to seek help for his presenting symptoms, so he explores therapeutic treatment options for PTSD but finds his options are limited. The vignette says, “You look at your health options and based on your insurance, the only access you have that is feasible is through a local VA clinic. Openings for an appointment for you were limited

but you were finally able to schedule an appointment.” This appearance of limited options was done to provide the respondent with a notion that this is the treatment they will be receiving. This idea is somewhat congruent to actual real-world situations where, for many veterans, the only feasible or affordable options for PTSD treatment are through the VA, wherein they may be highly encouraged to receive an evidence based therapy (should they choose therapy over medication) that has a trauma-revisitation component.

Two treatment protocols were created with the intention of serving as the two levels of an independent variable. They were designed to capture a distinct trauma-focused and distinct trauma-avoidant treatment. One protocol mirrors the treatment protocols and techniques of PE (Treatment A), as adapted from the Prolonged Exposure Therapy for PTSD treatment manual (Foa, Hembree, and Rothbaum, 2007). The second protocol was adapted from a group PCT manual (Classen, Butler, & Spiegel, 2001) and closely resembles the techniques of PCT (Treatment B). The intention was that whichever protocol was read by a participant, it was clear to them that that treatment emphasizes either an exposure (or trauma-revisitation) element or emphasizes the avoidance of exploring or retelling of the trauma experience. We also kept both protocols neutral in terms of usage of language regarding treatment efficacy or level of research support.

Procedure

The data for this study was collected via a survey method. The survey was administered through *Qualtrics*, an Internet-based survey system. The survey commenced by providing details of informed consent to participate, followed by asking participants to endorse that they are currently members of the U.S. Military or an ROTC program. There

were no exclusions with regard to age, race, or any other cultural variables. Each participant completed a demographics section, a series of measures designed to serve as covariates, and then read the case vignette of the soldier who has experienced combat trauma. Following the reading of the case vignette, participants were then randomly assigned to one of two treatment groups. Randomization was generated by randomization software in the *Qualtrics* program. One group read the trauma-focused treatment protocol as a therapeutic option for treatment for the person in the vignette, the other group read the trauma-avoidant treatment protocol as a therapeutic option for treatment for the person in the vignette. Both groups then completed the final two dependent variable measures (MSS and ATSPPH-SF). Upon survey completion, an option was given to enter a raffle for a gift card.

Recruitment. Participant recruitment procedures came through several channels. The first outlet was through the University of Louisville Office of Military and Veteran Student Services. An email was forwarded by the program coordinator of this office to 263 U of L student military members, inviting them to voluntarily participate in the research study. The email informed interested participants of the potential to voluntarily enter a raffle for a \$20 Visa Gift card upon completion of the survey. This similar email recruitment method was also done through the University of Louisville (U of L) ROTC program, with the program coordinator agreeing to forward a recruitment email to the U of L ROTC members. Social media outlets were also utilized. A general recruitment request was submitted through the *Facebook* social media outlet, requesting that individuals currently enlisted in the U.S. Military please volunteer their time to take the survey. The survey was also posted on the U.S. Army Fort Campbell *Facebook* page.

Geographic demographics were not assessed for in the survey, however, a GeoIP location software was included in the University of Louisville Qualtrics Survey program which provided the geographic location of respondents. This software indicated that 92% of survey respondents were from the greater Louisville area. This data seems to indicate that the most fruitful of all recruitment outlets were the U of L affiliated methods.

CHAPTER III: RESULTS

For Hypothesis 1, we predicted that higher levels of stigma would be associated with negative attitudes toward help-seeking in both conditions. This was assessed via a correlation method whereupon our Hypothesis was met with a significant negative relationship, $r = -.60, p < .01$ (note: this relationship was negative as *lower* self-reported scores on the ATSPPH-SF indicate elevated negative attitudes toward help seeking, while higher self-reported scores on the MSS indicate *elevated* stigma). See Table 2 for all correlation data of the measures used in this study.

Table 2
Correlations, Coefficients, and Psychometric Data for All Scales (N=84)

Scale	1.	2.	3.	4.	5.	6.	7.
1. PCL-5	---						
2. BEAQ	.44**	---					
3. CMNI-22	.09	.10	---				
4. ATSPPHS-SF	-.02	-.22*	-.28*	---			
5. MSS	.32**	.29**	.28**	-.60**	---		
6. MSS-S	.15	.23*	.34**	-.78**	---	---	
7. MSS-P	.37**	.28*	.20	-.40**	---	.56**	---
<i>M</i>	25.7	49.1	55.1	17.5	62.9	22.4	40.6
<i>SD</i>	20.5	12.7	6.2	6.4	17.7	7.3	12.5
α	.97	.88	.71	.88	.96	.94	.96

Note. PCL-5 = PTSD checklist – 5; BEAQ = Brief Experiential Avoidance Questionnaire; CMNI-22 = Conformity to Masculine Norms Inventory-22; ATSPPHS-SF = Attitudes Toward Seeking Professional Psychological Help Scale-Short Form; MSS = Military Stigma Scale; MSS-S = Military Stigma Scale-Self Stigma; MSS-P = Military Stigma Sale-Public Stigma.

* $p < .05$; ** $p < .01$

For Hypothesis 2, we predicted that, compared to individuals in the non-trauma-focused therapy group, individuals in the trauma-focused therapy group would report higher levels of stigma and higher negative attitudes towards seeking help. To assess for

this hypothesis, a MANOVA was conducted to compare treatment group difference for both the attitudes toward help-seeking and stigma dependent variables. The results of multivariate tests (Wilks' Lambda = .99, $F(2, 81) = .148, p > .05$) did not show a significant multivariate effect of treatment group on the dependent variables combined. These findings preliminarily indicate that the independent variables of type of treatment did not have an apparent impact on the dependent variables of reported stigma and attitudes toward seeking help.

Table 3
Treatment Condition Dependent Variable Means, Standard Deviations, and Effect Sizes

Dependent Variable	Group	<i>M</i>	<i>SD</i>	<i>d</i>
Help-seeking Attitudes	Trauma Focused	17.41	6.64	.02
	Trauma Avoidant	17.56	6.28	
Mental Health Stigma	Trauma Focused	62.22	17.33	.08
	Trauma Avoidant	63.65	18.15	

Notes. Effect sizes are based on Cohen's $d = 0.20 =$ small effect, $0.50 =$ medium effect, $0.80 =$ large effect. Multivariate Tests for Hypothesis 2 MANOVA: Wilks $\Lambda = .966, F(2, 81) = .148, p = .862,$ partial eta squared = .004. Multivariate Tests for Hypothesis 3 MANCOVA: Wilks $\Lambda = .966, F(2, 77) = .074, p = .929,$ partial eta squared = .002.

For Hypothesis 3, we predicted persons in the trauma-focused therapy group would report higher stigma and higher negative attitudes toward help-seeking when controlling for four covariates: prior treatment history, PTSD symptoms, avoidance coping styles, and conformity to gender norms. To test this main effect, a two-way MANCOVA was utilized. The basic assumptions germane to a MANCOVA were all met, including linearity between the covariates and the dependent variables, homogeneity of variance-covariance, and homogeneity of regression slopes. There was, however, a concern with equal groups prior to the introduction of the independent variables. Participants in the trauma-exposure condition had a significantly higher PCL-5 score than participants in the trauma-avoidant condition prior to the introduction of the Independent Variable. Potential for unequal groups is not uncommon when a sample size is under 100.

Nonetheless, while controlling for the four covariates, the results of multivariate tests did not show a significant multivariate effect of treatment group on linear combinations of attitudes toward seeking help and mental health stigma, Wilks' Lambda = .99, $F(2, 73) = .164$, $p > .05$ (See Table 3 for all outcome data from the multivariate analyses). Given self- and public-stigma were highly correlated ($r = .56$, $p < .01$), stigma was treated as a single dependent variable based on a total Military Stigma Scale score. Regardless, we analyzed the data utilizing self- and public-stigma as separate variables and the findings did not change.

An additional analysis was conducted wherein only participants with elevated PCL-5 scores (i.e., scores above the cut-off score of 33, which is a positive screen for PTSD) were compared for group mean differences. The respondents in the trauma-avoidant condition contained 21 elevated PCL-5 scores, while the other condition contained 13. Even when persons with reported PTSD-level of symptomatology were compared, the multivariate results remained the same between conditions while controlling for the four covariates: $F(2, 27) = .7$, $p > .05$. Cohen's d effect sizes between the groups was .24 for the help-seeking dependent variable and .06 for the stigma dependent variable.

CHAPTER IV: DISCUSSION

There is no known research to date that has explored whether persons may be avoiding therapeutic treatment for PTSD due to a presumption that they would have to talk about their traumatic experience. There is, however, strong support that therapies that do have an element of revisiting the trauma lead to higher drop-out rates when compared to therapies where the trauma revisitation is not required (Frost, Laska, and Wampold (2014; Imel et al., 2013). Furthermore, the diagnosis of PTSD assumes symptoms of avoidance, with specific aspects such as attempts to avoid the thought/memory of the traumatic experience and behavioral attempts to avoid external reminders of the trauma (APA, 2013).

The primary aim of this study was to explore the hypothesis that knowledge of therapeutic treatments for PTSD could influence a person's attitude toward help-seeking and stigma towards mental health. More specifically, we wanted to explore the concept that having an understanding that therapy for PTSD may likely involve having to revisit the trauma memory, or perhaps engaging in experiential activities of daily living that may remind a person of the trauma, could likely be a variable that may lead to persons avoiding entering therapy altogether. We further wished to examine this phenomenon within the military culture, as this is a culture that is currently highly susceptible to the development of PTSD. Our experimental design randomly assigned military personnel to two different conditions. One group read the treatment protocol and rationale for a trauma-avoidant therapy (i.e., a therapy where the trauma memory is not revisited) while

the other read a trauma-focused therapy protocol (i.e., a therapy where revisitation of the memory is a main ingredient for change). Our findings indicated that these treatment conditions did not influence reported help-seeking attitudes or reported stigma; there was virtually zero effect size difference between the groups ($d = .02$ and $.08$ respectively). This held true even when controlling for levels of PTSD symptoms, avoidant coping styles, adherence to masculine gender norms, and any prior PTSD treatment history.

Given this study is the first known attempt at empirically testing whether treatment types for PTSD can be a barrier to seeking help, a null finding is not entirely unexpected. Nonetheless, the findings still offer good insight into the many barriers people face when seeking help. First, describing the ingredients of PTSD treatment do not seem to influence a person's general attitudes and stigma about help-seeking. That is, having an understanding of the process of the kind of work exposure-based treatments may include did not seem to make the concept of psychotherapy seem less appealing or more stigmatizing. It is additionally worthwhile to have this understanding brought to light in a military culture where PTSD is recognized as a prevalent issue (Hoge et al., 2004). It is further noteworthy that even attitudes and stigma for persons in this study with elevated PTSD symptoms per the PCL-5 do not appear to be influenced by treatment type. This finding may indicate that regardless of whether a person actually may or may not have PTSD or a need for PTSD treatment, learning about an available PTSD therapy treatment likely may not influence their willingness to engage in therapy. This finding from this study with persons with elevated PTSD symptoms, however, should not be strongly interpreted as the sample size ($N = 34$) for this subsample was quite small.

There are other potential explanations for the null finding worth highlighting. When considering the sample demographics, our participants were primarily male, young adult-aged, and each are currently affiliated with the military culture. In addition to aforementioned research supporting male gender identity and military membership as factors impacting help-seeking attitudes, empirical research has also shown that younger adults tend to have more negative attitudes toward help-seeking compared to older adults (Mackenzie, Gekoski, & Knox, 2006; Berger et al., 2005; Sirey et al., 2001). We therefore had a sample of participants who are already prone to having higher levels of negative attitudes toward seeking help or viewing help as more stigmatizing. Taking this further, it is possible that opinions of stigma and attitudes toward help-seeking are state-like traits and are not highly malleable. Given that possibility, each participant likely had a clearly defined level of stigma and attitudes toward help-seeking going into the study. Thus, utilizing these constructs as dependent variables could have potentially decreased any amenability to change or manipulation.

Another potential explanation for a null finding could be related to the influence of the military culture. The military culture is one that trains persons to be fearless to challenges and always being willing to handle difficulty. Prolonged Exposure therapy could certainly be viewed as a challenging approach to treating PTSD. Thus, reading about the PE protocol could have been perceived as something potentially worth undertaking as it could be structured consistent with the military culture. Given this hypothesis, the military culture influence could have led to PE not only being less aversive, but possibly more desirable for persons assigned to that treatment condition.

Implications

Though the experimental design and outcomes of this study did not initially identify PTSD treatment type as a potential help-seeking barrier, there are still some implications that can be gleaned. This study seems to indicate that should a clinician choose to educate a perspective client on the diverse treatment options for PTSD—specifically trauma-focused versus trauma-avoidant treatments—the client may not incur any heightened negative attitudes toward help-seeking or increased stigma. This does not mean, however, that a clinician should omit educating perspective clients about the challenging emotional work that therapy may entail, particularly the emotionally challenging nature of exposure-based therapies, as well as a stronger potential to avoid returning or dropping out of treatment once commenced. The findings from this study should not imply that there is little importance in providing perspective therapy clients education about the treatment options available for achievement of treatment goals.

Limitations

Although the findings from this study can add useful information to a new concept (i.e., treatment type/options) in the help-seeking and therapy modality literature, there are limitations worth acknowledging. The first and aforementioned concern was having unequal group differences in PCL-5 scores prior to the introduction of the independent variable. This outcome could have been reduced or avoided with a larger sample size.

Another limitation that this study encountered was a lack of generalizability in several notable areas. The sample was mostly male and focused specifically on persons affiliated with the military culture. Though our sample was congruent with other military samples in terms of male and female proportions, the geographic range for this study was

narrow, as most participants were from the same large Midwestern city. Perhaps the most glaring generalizability error from this study was we failed to assess for a variety of additional demographics, including ethnicity/racial affiliations, education level or status, marital/relationship status, or military cultural specific demographics such as combat experience or duration of military membership. Thus, no generalized assumptions can be applied or ruled-out in these areas.

The design of this study presented further limitations. Though it properly adhered to an experimental design in that there was randomization to treatment conditions, the independent variable manipulation may not have effectively induced any change. The different treatment protocols—each of which were only a single paragraph (206 and 216 words respectively)—served as the sole independent variable in the design, making it indeed possible that any number of participants could have had minimal reactions to the protocols. Furthermore, the protocols were introduced after roughly 63 questions had already been asked and the 300+ word case vignette had been assigned to be read. Thus, treatment fatigue could have been a concern at the time the IV was introduced. We additionally did not provide any manipulation checks, such as inquiries about whether or not the vignettes or protocols were actually read by participants.

Future Research Direction

Future research on this topic could benefit from the following suggestions. First, a stronger independent variable could possibly yield a stronger effect. This could be done by better illustrating the emotionally challenging aspects of a trauma-focused or exposure-based therapy. For example, the in vivo and imaginal exposure techniques of Prolonged Exposure Therapy could be illustrated with experiential or clinical examples to

highlight the process of these exposure techniques with greater detail and depth. The present study simply outlined the protocol of PE but did not offer examples of what these techniques might look like. One example of highlighting imaginal exposure might look like: “This technique asks that you close your eyes and verbally tell your trauma story with as much detail as possible, including any sensory details you recall. Once the story is told, you will be asked to retell it again with more detail, if possible. This cycle of telling and retelling the story is expected to last for at least 45 minutes in duration, for as many as 8 weekly sessions.” It might further be worthwhile to highlight the tendency for persons who are being treated with PE to engage in “safety behaviors;” i.e., behaviors during in vivo exposure which increase safety and reduce anxiety (Fina et al., 2014), to further highlight the potentially emotionally challenging work of PE.

Another suggestion would be to include different participant demographics, as the present study focused on participants in the military. A college student sample of non-military personnel or non-veterans, for example, may potentially capture an audience with less understanding of PTSD and potentially less knowledge of or bias toward treatments for PTSD. It could further capture an audience less prone to stigma and avoidance of help-seeking. This methodology could then include optional trauma vignettes (e.g., a sexual assault victim or any variety of near-death trauma accounts could be utilized). This expansion of options could reduce the lack of generalizability this study failed to avoid.

Lastly, future research may better address the question of whether persons avoid treatment for PTSD due to the perception that they have to address the trauma memory by simply assessing that concept directly. For example, simply asking a respondent, “Do

you avoid going to therapy because you do not want to talk about the details of the traumatic event?” A question of this nature posed to a veteran or military participant would have strong face validity and would be more specific. It would be additionally informative to assess person’s general understanding of PTSD treatment and whether there is even knowledge that treatments can be effective without revisiting the trauma. By tying together a study that directly assess prior knowledge of PTSD treatment options, while also assessing whether persons endorse avoiding help due to a perception that they have to share their trauma, would provide us a better understanding of how these constructs may be affecting persons help-seeking behaviors.

Conclusion

The present study sought to further our understanding of why persons may avoid seeking help. It specifically sought to address this phenomenon empirically within the military culture by investigating whether types of treatments for PTSD may be specific barriers to seeking help. Our ensuing design intended to address whether trauma-focused treatments, or the idea of needing to revisit the trauma in order to receive help, could be seen as a potential reason persons do not seek help for PTSD. The results of this study did not indicate that knowledge of trauma-focused versus trauma-avoidant therapies for PTSD has any impact on attitudes toward seeking help or stigma about mental health.

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APPENDICES

Appendix A: Measures

Attitudes Toward Seeking Professional Help—Shorted Version

Instructions: Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

0 = Disagree 1 = Partly disagree 2 = Partly agree 3 = Agree

_____ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

_____ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

_____ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

_____ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

_____ 5. I would want to get psychological help if I were worried or upset for a long period of time.

_____ 6. I might want to have psychological counseling in the future.

_____ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

_____ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

_____ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

_____ 10. Personal and emotional troubles, like many things, tend to work out by themselves.

- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 12.) I would be afraid that my peers will find out what I tell my mental health provider.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 13.) I would feel worse about myself if I could not solve my own problems.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 14.) It would make my problems worse if my peers knew I was seeing a mental health provider.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 15.) I would feel inadequate if I went to a therapist for psychological help.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 16.) Seeking psychological help would make me feel less intelligent.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 17.) My peers would think less of me if they knew I was getting help from a mental health provider.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 18.) If I went to a therapist, I would be less satisfied with myself.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 19.) I'd lose the respect of my subordinates if they found out I was receiving mental help.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 20.) There are things I am afraid to talk about because of what others will think.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 21.) A person seeking mental health treatment is seen as weak.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 22.) It would make me feel inferior to ask a therapist for help.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 23.) I am afraid that my chain of command would find out what I told a mental health provider.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 24.) My peers would think I was unreliable if they knew I was receiving mental health treatment.
- | | | | |
|----------------------------|--------------------------|-----------------------|-------------------------|
| Definitely Disagree | Somewhat Disagree | Somewhat Agree | Definitely Agree |
| 1 | 2 | 3 | 4 |
- 25.) My self-confidence would NOT be threatened if I sought professional help.

Brief Experiential Avoidance Questionnaire

Please indicate the extent to which you agree or disagree with the following statements using the following scale:

1-----	2-----	3-----	4-----	5-----	6-----
strongly	moderately	slightly	slightly	moderately	strongly
disagree	disagree	disagree	agree	agree	agree

1. The key to a good life is never feeling any pain
2. I'm quick to leave any situation that makes me feel uneasy
3. When unpleasant memories come to me, I try to put them out of my mind
4. I feel disconnected from my emotions
5. I won't do something until I absolutely have to
6. Fear or anxiety won't stop me from doing something important
7. I would give up a lot not to feel bad
8. I rarely do something if there is a chance that it will upset me
9. It's hard for me to know what I'm feeling
10. I try to put off unpleasant tasks for as long as possible
11. I go out of my way to avoid uncomfortable situations
12. One of my big goals is to be free from painful emotions
13. I work hard to keep out of upsetting emotions
14. If I have any doubts about doing something, I just won't do it
15. Pain always leads to suffering

Scoring: reverse key item 6 and then sum all items.

CMNI-22

The following items contain a series of statements about how men might think, feel or behave. The statements are designed to measure attitudes, beliefs, and behaviors associated with both traditional and non-traditional masculine gender roles.

Thinking about your own actions, feelings and beliefs, please indicate how much **you personally agree or disagree with each statement** by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree", or SA for "Strongly agree" to the right of the statement. There are no correct or wrong answers to the items. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

1. My work is the most important part of my life	SD	D	A	SA
2. I make sure people do as I say	SD	D	A	SA
3. In general, I do not like risky situations	SD	D	A	SA
4. It would be awful if someone thought I was gay	SD	D	A	SA
5. I love it when men are in charge of women	SD	D	A	SA
6. I like to talk about my feelings	SD	D	A	SA
7. I would feel good if I had many sexual partners	SD	D	A	SA
8. It is important to me that people think I am heterosexual	SD	D	A	SA
9. I believe that violence is never justified	SD	D	A	SA
10. I tend to share my feelings	SD	D	A	SA
11. I should be in charge	SD	D	A	SA
12. I would hate to be important	SD	D	A	SA
13. Sometimes violent action is necessary	SD	D	A	SA
14. I don't like giving all my attention to work	SD	D	A	SA
15. More often than not, losing does not bother me	SD	D	A	SA
16. If I could, I would frequently change sexual partners	SD	D	A	SA
17. I never do things to be an important person	SD	D	A	SA
18. I never ask for help	SD	D	A	SA
19. I enjoy taking risks	SD	D	A	SA
20. Men and women should respect each other as equals	SD	D	A	SA
21. Winning isn't everything, it's the only thing	SD	D	A	SA
22. It bothers me when I have to ask for help	SD	D	A	SA

To score the CMNI-22: (a) score Strongly Disagree items as 0, Disagree as 1, Agree as 2, and Strongly Agree as 3; (b) recode the scoring of 9 items (i.e., 3, 6, 9, 10, 12, 14, 15, 17, 20) as 0 = 3, 1 = 2, 2 = 1, 3 = 0; then (c) sum the 22 items. Higher scores reflect greater conformity to traditional masculine norms.

Appendix B: Case Vignette and Treatment Protocols

Case Vignette

Imagine you are a member of a combat military unit that has recently returned from deployment to the Middle East for combat. You spent a year in combat, and during that time you were directly exposed to several kinds of combat experiences, including bomb blasts and gun fire. You were even close enough to some blasts that you sustained very mild injuries but nothing requiring serious medical attention. Upon returning home, you are finding it extremely difficult to “get back to normal.” You are having trouble sleeping, often jumping awake scared and having nightmares. Your nightmares consist of memories of reliving your combat experiences. You also find it difficult to be in crowds of people; not even a trip to Walmart feels safe and makes you very nervous. After a while of this same daily pattern, you eventually start to have recurrent, involuntary, and intrusive memories of your combat experience during the day while you are wide awake. Certain noises and smells trigger these memories, and each time the memory intrudes on your mind, you feel as if you are reliving the experience and you become nervous and agitated. You have been home now for a year and these experiences are still continuing so you have decided it is time to seek help. You look at your health options and based on your insurance, the only access you have that is feasible is through a local clinic. Openings for an appointment for you were limited but you were finally able to schedule an appointment. At your clinic, you check-in for an appointment and meet with your new therapist for an intake evaluation, whereupon you share with your therapist the reasons for your visit. Your therapist then gives you a breakdown of the treatment process that

will be used for you and describes how the therapy will look and how it will work. Your therapist describes this treatment as follows:

Treatment A

This treatment is a therapy that has been shown by research to be effective in reducing the symptoms you are experiencing. The treatment works by exploring the details of your combat experience and helping you understand how that experience changed your life and how it has led to the experiences you are having now. This treatment provides you with education about common reactions to trauma. This therapy is designed to help you stop avoiding thoughts or experiences relating to your traumatic experience but rather encourages you to confront trauma related thoughts and situations. The treatment includes various methods that will help you revisit your experience. One way is to revisit the traumatic experience in your imagination and recount the experience aloud. Another way is to enter situations you avoid in real life settings (for example, the Wal-Mart situation described above). This therapy will also help you deal with the presence of unhelpful, disturbing thoughts and beliefs and will seek to instill more realistic perspectives about what happened to you and what it means to you now. The idea behind this therapy is that the experience needs to be revisited and altered in your mind and your understanding in a way that will allow you to start to heal from your current experiences that you are having.

Treatment B

This treatment is a therapy that has been shown by research to be effective in reducing symptoms you are experiencing. This treatment provides you with education about what your experiences mean and why you are having them. This therapy works by focusing on

your present behaviors and relationship patterns and teaches you skills you need to change the way you are acting interpersonally. The therapy focuses on what is called the “here-and-now” and not the past. In other words, this therapy tries to work on the issues you are having currently (avoidance of places or people, poor interpersonal relationships due to your experiences, flashbacks and how you are reacting to them), and does NOT require you to discuss any events or details from your combat experience. Should you feel the desire to share your combat experiences in detail, this is acceptable, but is not required nor will you ever be asked to do so. In the event that you do share your experience, this treatment will focus on how you feel about it now and will not explore what was going on for you during that event. Ultimately, this therapy focuses on your current views of relating to and thinking about events in your current life.

Appendix C: PCL-5 Permission

PTSD Assessments



Mott, Juliette M. <Juliette.Mott@va.gov>

2/27/2015

'tyler.halford@louisville.edu' ✉



Reply all | ↘

Greetings, and thank you for your assessment instrument request.

You may access National Center for PTSD assessment measures by following the link below:
http://www.ptsd.va.gov/professional/assessment/documents/ptsd_trauma_assessments.asp

These assessment tools were created by government employees and therefore are not copyrighted. In accordance with the American Psychological Association's ethical guidelines, these instruments are intended for use by qualified health professionals with advanced graduate training in psychodiagnostic assessment.

Please let us know if you have any difficulties downloading these instruments. Also, no thank you email is necessary.

Sincerely,
National Center for PTSD Staff

Subscribe to the PTSD Monthly Update
<http://www.ptsd.va.gov/about/subscribe.asp>

Juliette Mott, PhD
Psychologist/Education Specialist
[National Center for PTSD](#), Executive Division
[White River Junction, VT](#)
(802) 295-9363 x5621

Appendix D: Informed Consent

IRB #: 15.0197

IRB Reference #: 345938

Dear Participant,

You are being invited to participate in a research study by answering the attached survey about barriers to seeking help for PTSD. This study requires current membership in the U.S. military or a military-affiliated ROTC program. There are no known risks for your participation in this research study. The information collected may not benefit you directly. The information learned in this study may be helpful to others. The information you provide will enhance our understanding of why some people avoid seeking help for mental health concerns. The survey will take approximately 25 minutes time to complete. *Your responses to this survey will be anonymous; there will not be any questions that can identify who the participants are in the study.*

Individuals from the Department of Educational & Counseling Psychology, Counseling, and College Student Personnel, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), and other regulatory agencies may inspect these records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Upon completion of the survey, you will be given the option to voluntarily provide a contact email address should you wish to be included in a gift card raffle for 1 of 5 \$20 Visa gift cards. If you are selected to receive a Visa gift card, the University of Louisville may collect your name, address, social security number, and keep records of how much you are paid. You may or may not be sent a Form 1099 by the University. This will only happen if you are paid \$600 or more in one year by the University. This will not include payments you may receive as reimbursement, for example mileage reimbursement. We are required by the Internal Revenue Service to collect this information and you may need to report the payment as income on your taxes. *You can still be in the study even if you don't want to volunteer for the gift card drawing.*

Taking part in this study is voluntary. By completing this survey you agree to take part in this research study. You do not have to answer any questions that make you feel uncomfortable. You may choose not to take part at all. If you decide to be in this study you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify.

If you have any questions, concerns, or complaints about the research study, please contact: Patrick Hardesty, PhD. patrick.hardesty@louisville.edu, (502) 852-6887.

If you have any questions about your rights as a research subject, you may call the Human Subjects Protection Program Office at (502) 852-5188. You can discuss any questions about your rights as a research subject, in private, with a member of the Institutional Review Board (IRB). You may also call this number if you have other questions about the research, and you cannot reach the research staff, or want to talk to someone else. The IRB is an independent committee made up of people from the University community, staff of the institutions, as well as people from the community not connected with these institutions. The IRB has reviewed this research

study.

If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call 1-877-852-1167. This is a 24 hour hot line answered by people who do not work at the University of Louisville.

By selecting "yes" below, you agree to participate and acknowledge that you are a member of the U.S. military or a military affiliated ROTC program:

Sincerely,

Tyler Halford, M.S.
Patrick Hardesty, Ph.D.

Appendix E: IRB Approval



Human Subjects Protection Program Office
MedCenter One – Suite 200
501 E. Broadway
Louisville, KY 40202-1798
Office: 502.852.5188 Fax: 502.852.2164

DATE: August 26, 2015
TO: Patrick H Hardesty
FROM: The University of Louisville Institutional Review Board
IRB NUMBER: 15.0197
STUDY TITLE: **Therapeutic Treatments for PTSD: Does Type of Treatment Impact Help Seeking Behaviors in a Military Sample?**
REFERENCE #: 345938
DATE OF REVIEW: 08/26/2015
IRB STAFF CONTACT: Name: Jacqueline S. Powell
Phone: 852-4101
Email: jspowe01@Louisville.edu

The Chair of the Institutional Review Board (IRB) has reviewed this study and determined that before it may be approved, the following stipulations are needed:

1. Between the second paragraph ("Individuals from the Department..") and third paragraph (Taking part in this study is voluntary...), insert the following text as a separate paragraph:

"You will be given the option to voluntarily provide a contact email address should you wish to be included in a gift card raffle for 1 of ??? \$??? Visa gift cards. If you are selected to receive a Visa gift card, the University of Louisville may collect your name, address, social security number, and keep records of how much you are paid. You may or may not send a Form 1099 by the University. This will only happen if you are paid \$600 or more in one year by the University. This will not include payments you may receive as reimbursement, for example mileage reimbursement. We are required by the Internal Revenue Service to collect this information and you may need to report the payment as income on your taxes. You can still be in the study even if you don't want to be paid."

(Note: please replace the question marks with 4 or 5 & 25 or 20, depending on which is correct.)

2. IRIS application items 9.4 & 17.1 indicate that the raffle will be for 5 \$20 gift cards, while item 13.3 and the email response to Ms. Powell indicate that the raffle will be for 4 \$25 gift cards. Please reconcile the IRIS items
3. Since the survey will be administered online, the investigators may copy/paste the following text from the old consent document to the new one:

"I agree to participate and acknowledge that I am a member of the U.S. military or a military affiliated ROTC program:
 Yes
 No"

Alternatively, since the new consent document already contains the statement, "By completing this survey you agree to take part in this research study", the investigators could simply add "buttons" for "Continue" and "Exit".

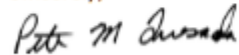
4. In the IRIS application, section 8.1, please change this to Expedited, Category 7. This study is minimal risk.
5. In the IRIS application 17.1 please paste the new consent wording into this section. In the IRIS application, 18.1 change this to minimal risk.

Once these changes have been made, please **add or** modify the version date on the bottom of all pages for each changed document. A tracked and clean copy of all changed documents is required or the item will not be reviewed. When received, the study will continue for final approval processing.

If you have any questions, please contact the HSPPO at (502) 852-5188 or hspofc@louisville.edu

Thank you for your submission.

Sincerely,



Peter M. Quesada, Ph.D., Chair

Social/Behavioral/Educational Institutional Review Board

PMQ/jsp

CURRICULUM VITA

TYLER CONLEY HALFORD, M.S.

Department of Behavioral Health
VA Montana Healthcare System

PERSONAL INFORMATION

Work Address: VA Montana Healthcare System
3687 Veterans Drive
Fort Harrison, MT 59636

Email: tyler.halford@louisville.edu

Home Address: 259 Westwind Way
Helena, MT 59602

Phone Number: (775) 742 2010

EDUCATION

2011-present **Doctor of Philosophy in Counseling Psychology (expected 2016)**
University of Louisville, Louisville, KY
APA Accredited Counseling Psychology Program
Dissertation: Therapeutic Treatments for PTSD: Does Type of Treatment Impact Help Seeking Behaviors in a Military Sample?
Advisor: Jesse Owen, Ph.D.

2008-2010 **Master of Science in Clinical Psychology**
Emporia State University, Emporia, KS

2004-2007 **Bachelor of Arts in Psychology**
Brigham Young University- Idaho, Rexburg, ID

CLINICAL & RELEVANT WORK EXPERIENCE

Psychology Pre-doctoral Intern **07/2015 - present**
VA Montana Healthcare System – Ft. Harrison, MT
Major Rotation: Trauma Residential Rehabilitation Treatment Program (RRTP)
Supervisor: Dudley Blake, Ph.D.

- Currently leading or co-leading group treatments that cover topics of moral injury, PTSD & substance use, anger management, life-span trauma narrative, and Cognitive Processing Therapy (CPT). Treatments are being provided to veterans

- with diverse trauma histories, including childhood trauma, combat, and military sexual trauma.
- Creating a mindfulness-based group treatment curriculum for veterans with PTSD. Pilot protocol will begin in the RRTP program in September, 2015, wherein I will function as group leader.
- Conducting individual weekly therapy with veterans in the RRTP program.
- Participating in/observing Native American treatment approaches for veterans, including sweat lodges, smudging, and tipi talking circle.
- Participating in interdisciplinary treatment team meetings to discuss treatment progress, appropriate interventions, individual recovery, and discharge plans for veterans in the RRTP program.
- Conducting intake assessments as part of an interdisciplinary biopsychosocial intake process for incoming residents; assessments include measures of depression, PTSD, and mental status exams.
- Conducting diagnostic evaluations for potential residents, including specialized training in the CAPS interviewing assessment.

**Psychology Pre-doctoral Intern
present**

07/2015 -

VA Montana Healthcare System – Bozeman, MT

Minor Rotation: PTSD Outpatient Team

Supervisor: Gretchen Lindner, PhD

- Receiving training and supervision in the implementation of evidence-based PTSD treatments (both Prolonged Exposure Therapy and Cognitive Processing Therapy) for veterans in an outpatient setting.
- Providing treatment for veterans in multiple levels of care, including triage, intake assessment, treatment planning, treatment provision, and termination.

**Psychology Practicum Student
05/2015**

08/2014 –

Louisville VA Medical Center – Louisville, KY

Substance Abuse Residential Rehabilitation Treatment Program (SARRTP)

Supervisor: Shay Kirkpatrick, Psy.D.

- Facilitated and/or co-facilitated process, mindfulness, relapse prevention, and coping skills groups with residential and outpatient veteran populations with substance-use disorders.
- Participated in a weekly Substance Abuse Teaching Conference, also referred to as “journal club;” members of the SARRTP team alternated presenting on seminal and recently published articles related to substance abuse and addiction treatment issues and developments. Medical and clinical based journals were utilized.
- Participated in consultations with inpatient treatment teams to determine needed treatments for veterans with substance abuse disorders.
- Participated in daily interdisciplinary treatment team meetings to formulate working hypotheses of veterans’ presenting problems and determining appropriate interventions.
- Participated in “fish-bowl” format process group therapy with residential veterans.
- Conducted evidence-based individual psychotherapy with veterans (e.g., CBT).

- Conducted diagnostic intake evaluations to determine needed level of care within SARRTP program (i.e., outpatient, IOP, or residential).

Psychology Practicum Student

08/2014 –

06/2015

Associates in Counseling and Psychotherapy – New Albany, IN

Outpatient Community Mental Health

Supervisor: Jessica Heutt, Psy.D.

- Conducted therapy for family, couple, child, and adult populations.
- Collaborated with the Indiana Department of Child Services (DCS) on DCS cases requiring psychotherapy.
- Provided written reports to DCS regarding therapy progress of DCS cases.
- Interviewed and obtained comprehensive biopsychosocial history for clients needing psychological evaluations and/or therapy.
- Conducted school-referred safety evaluations for children and teens.

Psychology Practicum Student

08/2013 – 5/2014

University of Louisville Counseling Center – Louisville, KY

College Counseling Center

Supervisors: Juan Pablo Kalawski, Ph.D.; Terry White, Ph.D.

- Conducted long-term individual psychotherapy with college student populations presenting with a range of concerns.
- Determined appropriate DSM-V diagnosis and selected appropriate treatment for clients.
- Interviewed and obtained comprehensive biopsychosocial history of clients presenting to the counseling center.
- Participated in case conference meetings and reported on clients' cognitive and emotional functioning.
- Reviewed and updated the clinic's self-injury/suicide risk protocol policy.
- Participated in the planning and implementation of various Outreach events, including programs focused on self-harm, depression, and victims of sexual assault.

Psychology Practicum Student

05/2013 - 09/2013

Louisville VA Medical Center – Louisville, KY

DuPont CBOC Neuropsychology Clinic

Supervisor: Melissa A. Boyles, Ph.D.

- Conducted psychological assessments with a variety of veteran referrals including mood disorders, developmental disorders, and ADHD.
- Interviewed and co-interviewed veterans for the purpose of obtaining accurate biopsychosocial information.
- Shadowed a neuropsychologist conducting neuropsychological evaluations for veterans presenting with dementia symptoms.
- Scored and interpreted results of psychological and neuropsychological instruments.
- Wrote integrative psychological reports and determined appropriate recommendations.

Psychology Practicum Student

08/2012 - 05/2013

Department of Defense—Fort Knox – Ft. Knox, KY
Department of Behavioral Health Outpatient Clinic
Supervisor: Charles G. Thomas, Psy.D.

- Conducted individual psychotherapy with active-duty servicemen.
- Utilized evidence-based treatments (i.e., CPT) to provide short-term individual therapy for a serviceman with PTSD.
- Co-facilitated skills training group therapy for servicemen in an intensive outpatient program.
- Co-facilitated a process group for servicemen with PTSD.
- Administered, scored, and interpreted psychological assessments.
- Wrote psychological reports to provide diagnostic clarification and treatment recommendations.
- Co-facilitated Fitness for Duty evaluations for servicemen with high risk behavioral or mental health concerns.

Psychology Practicum Student/ Research Lab Member **02/2012 - 4/2014**

Couple and Individual Therapy Research Study – Louisville, KY
Research and Psychotherapy (RAP) Lab
Supervisor: Jesse Owen, Ph.D.

- Conducted co-therapy for couples from the community presenting with various relationship issues as part of couple therapy process study.
- Provided individual therapy utilizing a psychodynamic approach in a RCT study.
- Used video-taped sessions in both individual and group supervision.
- Received specialized couple therapy training in weekly lab meetings.
- Tracked therapy and alliance outcomes, as well as couple commitment level progress using validated tests.

Psychosocial Rehabilitation Specialist **08/2010 - 07/2011**

CenterPoint Behavioral Health – Nampa, ID
Children’s Behavioral Health Center

- Created and implemented behavior modification programs with child/ adolescent clients and their families.
- Collaborated with treatment teams on medication management and treatment plans for clients.
- Taught children and adolescent clients social and daily living skills.
- Worked directly with clients in community and home settings on establishing healthy community functioning skills.

Masters-level Clinical Psychology Intern **11/2009 - 07/2010**

Mental Health Center of East Central Kansas – Emporia, KS
Outpatient Mental Health Services

- Conducted co-therapy for children and provided individual therapy for adults with a variety of presenting issues.
- Conducted comprehensive biopsychosocial interviews with child, adolescent, and adult patients referred for psychological testing.
- Administered, scored, and interpreted psychological assessments, as well as wrote integrative reports used in treatment planning and referral decisions.

- Co-conducted group dialectical behavior therapy for adults with borderline personality traits.

RESEARCH EXPERIENCE

Research Team Member 2014

8/ 2011 – 6/

Advisor: Jesse Owen, Ph.D.

- Research and Psychotherapy (RAP) Lab, Department of Education and Counseling Psychology, University of Louisville.
 - Participated in weekly consultative research lab meetings exploring projects looking at commitment levels in romantic relationships and couple therapy process.
 - Participated in data analysis using SPSS and HLM.
 - Participated in grant proposal writing process for lab research funding.
 - Participated in multiple IRB proposal writing processes.
 - Participated in process of writing and submitting documents and book chapters for publication.

Graduate Research Assistant - 6/ 2014

8/ 2012

Advisors: Ginevra Courtade, Ph.D.; Robert Pennington, Ph.D.

- Department of Special Education, University of Louisville, Louisville, KY
 - Assisted in grant writing processes.
 - Assisted in preparation of annual Rural Special Education conference.
 - Assisted in proofing documents being prepared for publication submission.

Graduate Research Assistant – 7/ 2012

8/ 2011

Advisors: Nancy Cunningham, Ph.D.; Patrick Hardesty, Ph.D.

- Department of Educational and Counseling Psychology, University of Louisville, Louisville, Kentucky, August 2011- August, 2012.
 - Assisted in research processes including data collection, data cleaning, and grant proposal writing for studies exploring the effects of school bullying.

EDITORIAL ACTIVITY

Peer reviewer 2014

1/

Journal of Family Issues

PUBLICATIONS & WORKS UNDER REVIEW/ IN REVISION

Nienhuis, J. B., Owen, J., Valentine, J. C., Black, S. W., **Halford**, T. C., Parazak, S. E., Budge, S., & Hilsenroth, M. J. (in press). Therapeutic alliance, empathy, and genuineness in individual adult psychotherapy: A meta-analytic review. *Psychotherapy Research*.

Strokoff, J., **Halford**, T. C., & Owen, J. (2016). Men and psychotherapy. In Y. J. Wong,

S. R. Wester, Y. J. Wong, S. R. Wester (Eds.), *APA handbook of men and masculinities* (pp. 753-774). Washington, DC, US: American Psychological Association. doi:10.1037/14594-034

Halford, T. C., Owen, J., Duncan, B., Anker, M., & Sparks, J.A. (2014). Pre-therapy relationship adjustment, gender and the alliance in couple therapy. *Journal of Family Therapy*, doi: 10.1111/1467-6427.12035

Valentine, J. C., Parazak, S. E., Lao, T., & **Halford, T. C.** (2014) Treatment foster care for improving outcomes in children and young people: meta-analytic implications (Cochrane Collaboration review). Meta-analysis complete, manuscript under review

Halford, T. C., Rea, C., & Grover, C. (2009). An empirical study of the effectiveness of PowerPoint in the college classroom.

Halford, T. C., & Gee, E. (2008). The effects of prior expectations on marital satisfaction. Survey based study conducted at BYU-Idaho, 2008. Created measurement tools, collected and interpreted data under the supervision of Eric Gee, PhD.

PROFESSIONAL PRESENTATIONS

Halford, T. C., & Mayor, M. (2012). *An examination of the links between aspirations to succeed in school, video games, and parent education level*. Poster presented at the Spring Research Conference, University of Louisville, Louisville, KY.

Halford, T. C. & Sandhu, D. S. (2012). *The Seven Stages of Spiritual Development: Implications for Therapists*. Oral presentation at the Annual Kentucky Counseling Association Conference, October, 2012, Louisville, KY

Sandhu, D.S. & **Halford, T. C.** (2012). *Spirituality in the Counseling Process*. Oral presentation at the Annual Kentucky Counseling Association Conference, October, 2012, Louisville, KY

Halford, T. C. (2012). *The impact of marital distress on the working alliance in couple therapy*. Poster Presented at the Spring Research Conference, University of Louisville, Louisville, KY.

Halford, T. C., & Montie, B. (2010). *A review of the current literature on the various treatments and outcomes for seasonal affective disorder*. Paper presented at annual Association for Psychological and Educational Research in Kansas (PERK). Emporia, KS.

- Halford, T. C., & Higgins, S. (2010).** *Approaches to couples treatment where one or both partners have depression.* Paper presented at annual Association for Psychological and Educational Research in Kansas (PERK). Emporia, KS.
- Halford, T. C. (2010).** *The military culture in America.* Poster presented at the Emporia State University Psychology Department Research Luncheon, Emporia, KS.
- Rea, C. & **Halford, T. C. (2010).** *An empirical study of the effectiveness of PowerPoint in the college classroom.* Poster presented at the Great Plains Psychology Conference, St. Joseph, MO.
- Elliott, D., **Halford, T. C.,** Montie, B., & Peters, J. (2010). *Preparing for the graduate record exam (GRE).* Oral Presentation at the monthly Professional Development Session. Emporia State University, Emporia, KS.
- Halford, T. C. (2009).** *A behavior modification intervention for a chronic hair puller.* Paper presented at the Emporia State Psychology Department Research Luncheon, Emporia, KS.
- Halford, T. C. (2007).** *A review of four pre-marital factors that affect marriage satisfaction.* Poster presented at the Annual Brigham Young University-Idaho Undergraduate Research Conference, Rexburg, ID.

INVITED PRESENTATIONS/ WORKSHOPS

- Halford, T.C. (2014).** *The cognitive-interpersonal cycle: how to recognize it and work with it using a cognitive-interpersonal framework.* Guest lecturer in ECPY 629: Theories and Techniques of Counseling, University of Louisville, Louisville, KY.
- Halford, T. C.,** Manthos, M., Quirk, K. (2012). The role of alliance with racial/ethnic minority couples in relationship education. In Jesse Owen (Discussant), *Learning to love: Impacts of alliance and content in couples' therapy and relationship education.* Symposium conducted at the Great Lakes Counseling Conference, Purdue University, Lafayette, IN.
- Quirk, K., **Halford, T. C.,** Manthos, M. (2012). Impact of relationship distress on the therapeutic alliance in couple therapy. In Jesse Owen (Discussant), *Learning to love: Impacts of alliance and content in couples' therapy and relationship*

education. Symposium conducted at the Great Lakes Counseling Conference, Purdue University, Lafayette, IN.

Manthos, M., Quirk, K., **Halford**, T. C. (2012). Listen to me: The relational benefits of structured communication skills. In Jesse Owen (Discussant), *Learning to love: Impacts of alliance and content in couples' therapy and relationship education*. Symposium conducted at the Great Lakes Counseling Conference, Purdue University, Lafayette, IN.

Halford, T. C. (2010). *The profession of a clinical psychologist*. Guest speaker for the course
PY 102 Introduction to the Psychology Major; Presentation on the clinical psychology profession.

Halford, T. C. (2009). *Classical and Operant Conditioning in the Lab*. Guest presenter for
visiting Flint Hills Technical College Introductory Psychology class, Emporia, KS.

TEACHING & SUPERVISION EXPERIENCE

Adjunct Faculty **4/2015 – 7/2015**

American National University, Louisville, KY

- Instructor for two sections of introductory psychology.
- Conducted class lectures, held open office hours.
- Created and administered course quizzes, assignments, and tests.

Graduate Supervisor

Department of Educational and Counseling Psychology **1/2015 – 4/2015**

University of Louisville, Louisville, KY

- 1 masters-level student supervisee

Graduate Research Assistant **8/2012 – 7/2014**

University of Louisville, Louisville, KY

- Served role of co-instructor for three online graduate-level courses in special education.
- Graded student discussion posts and online quizzes.
- Assisted with preparing and conducting of class lectures.

Graduate Teaching Assistant **8/2008 – 4/2010**

Emporia State University, Emporia, KS

- Course instructor.
- Created course syllabi, quizzes, tests, assignments etc.
- Prepared and administered class lectures.

- Courses taught: Introductory Psychology (2 sections), Introductory Psychology Online (1 section), and Introductory Psychology Laboratory (4 sections).

Undergraduate Teaching Assistant

4/2007 –

7/2007

Brigham Young University- Idaho, Rexburg, ID

- Assisted Eric Gee, Ph.D., in administering class lectures in Introductory Psychology.
- Graded student papers.
- Created quizzes and assignments.

AWARDS & SCHOLARSHIPS

- Samuels Family Scholarship Recipient, University of Louisville, 2014
- First Place: poster presentation at the Great Plains Psychology Conference, 2010
- David Leipold Memorial Scholarship, Outstanding Psychology Student, Emporia State University, 2009
- Second Place- poster presentation at the Annual Brigham Young University-Idaho Undergraduate Research Conference
- BYU-Idaho Psychology Scholarship, 2007
- BYU-Idaho Service Scholarship, 2005

EXTRACURRICULAR ACTIVITIES & LEADERSHIP

- American Psychological Association
 - Undergraduate and Graduate Student affiliate
 - Division 17: Society of Counseling Psychology
 - Division 29: Society for the Advancement of Psychotherapy
- Psi Chi
 - Student affiliate, Emporia State University chapter
- Brigham Young University-Idaho Psychology Society
 - Education Committee Chair Member, August 2006-April 2007

LANGUAGES

Tagalog (Filipino): Fluent speaking, adequate reading and writing