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Seeking Treatment for PTSD: the Post 9/11 Service Member's Experience

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SEEKING TREATMENT FOR PTSD:
THE POST 9/11 SERVICE MEMBER'S EXPERIENCE

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ABSTRACT

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Posttraumatic-stress disorder (PTSD) remains one of the most pervasive health conditions to affect the 2.7 million United States service members deployed to Iraq and Afghanistan since 2001. Untreated and/or inadequately treated PTSD can further lead to an array of health risks including anxiety, depression, substance abuse, social and occupational impairments, poorer quality of physical health, decreased overall perception of quality of life, and increase the risk of suicide. Considering these risks, the Department of Veterans Affairs (VA) and Department of Defense (DoD) created the VA/DOD Clinical Practice Guidelines (CPGs) for the Management of PTSD and Acute Stress Reaction (ASR), highlighting the strongest evidence-based approaches to treatment for clinicians providing care for service members. The CPGs further outlines the importance of providing clients/patients with psychoeducation regarding PTSD and treatment options, offering a client-centered approach through a Shared Decision-Making Model (SDM), while also illustrating known barriers to treatment, and concerns regarding early termination. Successful implementation of the CPGs is expected to enhance assessment of client's/patient's needs and assist in determining and providing effective care. The number of veterans suffering with PTSD continues to be an alarming concern, one with life-threatening implications. While this concern is recognized among clinicians, statistics continue to highlight the vast number of those suffering with PTSD and PTSD related conditions, further pressing the

need to explore additional ways to improve the efficacy of treatment. The purpose of this study is to explore the post 9/11 military population's experience in seeking treatment, as reflected by the CPGs recommendations, while further exploring their views regarding ways to improve the efficacy of assessing and treating PTSD. This dissertation is available in open access at AURA, https://aura.antioch.edu/, and Ohio Link ETD Center, https://etd.ohiolink.edu/.

Keywords: Posttraumatic-stress disorder (PTSD), Clinical Practice Guidelines (CPGs), Shared Decision-Making (SDM), Veterans Affairs (VA), Department of Defense (DoD)

Dedication

To all who serve and to those who love them. May we continue to find ways to grow in our strength, courage, and understanding. Thank you, Staff Sergeant Bowser, Stephen.

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CHAPTER I: INTRODUCTION

Overview

Among United States service members deployed to Iraq and or Afghanistan, roughly 4–17% are estimated to experience posttraumatic-stress disorder (PTSD) symptoms, depending on study methodology, definitions utilized in the study, and level of combat intensity experienced (Kip & Diamond, 2018). Untreated and/or inadequately treated PTSD can further lead to a wide range of health-related risks, such as depression, social and occupational impairments, poorer quality of physical health, decreased overall perception of quality of life, substance abuse disorders, and increased suicide risk.

PTSD remains one of the most prevalent health conditions to affect the 2.7 million U.S. service members deployed to Iraq and Afghanistan since 2001 (Armenta et al., 2018). With these concerns in mind, the Department of Veterans Affairs (VA) and Department of Defense (DoD) created the VA/DOD Clinical Practice Guidelines for the Management of Post-Traumatic Stress (PTSD) and Acute Stress Reaction (ASR), outlining recommended approaches to treatment (VA & DoD, 2017).

Rationale

The focus of the presented research examines the experiences of the post 9/11 military population, defined as active, reserve, national guard, and veterans, who sought treatment for PTSD after the VA/DoD CPGs were published. Through exploring how their experiences lined up with the recommendations presented in the CPGs and what worked for them, this study aims to expand on the research of effective treatment.

Research Questions

1. What is the experience of the post 9/11 military population seeking treatment for PTSD?
2. How do post 9/11 military populations perceive the quality and/or usefulness of information they received regarding PTSD diagnosis and treatment options?
3. How can their experience help inform clinicians of ways to improve effectiveness of therapy?

Purpose of Study

The number of veterans suffering with PTSD continues to be an alarming concern, one with life-threatening implications. While this concern is recognized among clinicians, the persistent statistics press the need for further research to explore additional ways to improve the efficacy of therapeutic treatment. This study used a qualitative approach to interview and explore the experience of post 9/11 service members who have sought treatment for PTSD. Specifically, looking into their perspectives regarding the education they received about PTSD and related symptoms, the treatment approaches available to them, a collaborative approach, as well as their views regarding treatment efficacy, and what worked for them.

The VA together with the DoD speak to the duty we have to provide our service members effective care and created evidence-based guidelines to assist with doing so (VA & DoD, 2017). The CPGs present three evidence-based approaches as the most recommended, psychopharmacology, as well as noting less researched nonconventional approaches that show efficacy, and place a heavy emphasis on the importance of the SDM model to treatment. The CPGs acknowledge the need for further research looking into the SDM model. Specifically in the areas of treatment decision making and how this choice can impact motivation, engagement, and completion rates (VA & DoD, 2017). Ultimately, the goal of this study is to explore ways

clinicians, the VA, and DoD can learn and improve treatment to better serve and treat service members.

CHAPTER II: REVIEW OF LITERATURE

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is outlined in the Diagnostic Statistical Manual (DSM) as follows:

Table 2.1

DSM-5 Diagnostic Criteria for Posttraumatic Stress Disorder

DSM-5 Diagnostic Criteria for PTSD
Criterion A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s) 2. Witnessing, in person, the event(s) as it occurred to others 3. Learning that the traumatic event(s) occurred to a close family member or close friend **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse) **Note:** This does not apply to exposure through electronic media, television, movies or pictures unless this exposure is work-related.
Criterion B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred. 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s) 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s) 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum with the most extreme expression being a complete loss of awareness of present surroundings) 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) 5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
Criterion C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s) 2. Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

DSM-5 Diagnostic Criteria for PTSD

Criterion D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred as evidenced by two or more of the following:

1. Inability to recall an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs)
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad.", "No one can be trusted.", "The world is completely dangerous.", "My whole nervous system is permanently ruined.")
3. Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, shame)
5. Markedly diminished interest or participation in significant activities
6. Feeling of detachment or estrangement from others
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, loving feelings)

Criterion E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep)

Criterion F. Duration of the disturbance (symptoms in Criteria B, C, D, and E) is more than one month.

Criterion G. The disturbance causes clinically significant distress or impairment in social, occupation, or other important areas of functioning.

Criterion H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individuals symptoms must meet the criteria for PTSD and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream, feeling a sense of unreality of self or body, time moving slowly)
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted)

DSM-5 Diagnostic Criteria for PTSD
Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures). **Specify if:** With delayed expression: If the full diagnostic criteria are not met until at least six months after the event (although the onset and expression of some symptoms may be immediate).

Note. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596 Reprinted with permission.

PTSD in the Military

Combat-related stress has been identified and characterized many ways throughout history. Individuals exposed to traumatic events and left with distressful symptoms, have been given many names to explain their symptoms, while others try to make sense of their experiences. The American Revolution or U.S. Civil War referred to such conditions suffered by soldiers as irritable or soldiers' heart, then during World War I it was called shellshock, World War II it was known as battle fatigue, while the Vietnam War characterized the symptoms listed above as Vietnam Syndrome (Marmar, 2009). In Europe, during the 19th Century, railroad crashes of epidemic proportions left trauma survivors with similar symptomology. At the time, conditions were thought to be brought on by spinal cord compression and became known as railroad spine (Marmar, 2009).

In 1865, President Lincoln spoke on behalf of those who served and the government's obligation to care for them and their loved ones with the words, "To Care for Him Who Hath Borne the Battle, and His Widow and His Orphan." This was adopted as the U.S. Veterans Affairs (VA) motto in 1959 (U.S. Department of Veterans Affairs, n.d.). These words are proudly displayed on a pair of metal plaques at the entrance to the VA headquarters in Washington, D.C., affirming the government's responsibility to continue to care for those injured during war and service and provide for the families who have lost their loved ones.

The awareness regarding the effects of exposure to traumatic events continued to grow. In the 1980s, the American Psychiatric Association (APA) included PTSD in the third edition of the Diagnostic and Statistical Manual (DSM-III; APA, 1980), under the domain of anxiety disorders. This decision was largely due to the key features of PTSD being associated with re-experiencing the events, a sense of numbing, avoidant behavior, heightened state of hyperarousal, as well as the symptom onset time and impact of distress the symptoms had on one's functioning (Marmar, 2009).

Growing Concern

Justin Miller, a high school trumpet player, was recruited into the 2nd Marine Aircraft Wing Band based in Cherry Point, NC (Wax-Thibodeaux, 2019). After returning home from Iraq, his family reported noticing a difference immediately, noting he was incredibly tense, easily agitated, and often overreacting to criticism. Over time, he confided to his sister that he suffered from severe PTSD, recounting orders to shoot a man who was approaching the base, who was believed to have a bomb. According to the VA inspector general's investigation, Miller called the Veterans Crisis Line to report suicidal thoughts. He was informed to go to the VA emergency department and to have someone hold onto his guns for him. He was discharged four days later, designated as "intermediate/moderate risk" for suicide. It was noted "patient does not currently meet dangerousness criteria for a 72-hour hold." His father, Greg Miller, was quoted saying "my son served his country well … but they didn't serve him well. He had a gun in his truck the whole time."

John Toombs, a 32-year-old former Army sergeant and Afghanistan veteran, hanged himself on the grounds of the Alvin C. York VA Medical Center in Murfreesboro, TN, the morning before Thanksgiving 2016 (Wax-Thibodeaux, 2019). His father reported John had

enrolled in an inpatient treatment program for PTSD, substance abuse, depression, and anxiety. His father stated, “John went in pledging that this is where I change my life; this is where I get better.” He was kicked out of the program for not following instructions, being late to collect medications. Just hours before John took his life, he posted on Facebook that he was “feeling empty,” with a distressed emoji. John added, “I dared to dream again. Then you showed me the door faster than last night’s garbage … to the streets, homeless, nights before the holidays.”

Gary Pressley, 28, took his life in the parking lot of a Department of Veterans Affairs hospital (Wentling, 2020). He served in the Navy from 2008 to 2012, reported to have excelled as an Aviation Ordinanceman, handling and servicing weapons and ammunition for Navy aircraft. His evaluations described him as “dedicated and hardworking,” “focused and productive,” and “a total team player who produces quality results with little to no supervision.” His military career ended following a car wreck in 2012, leaving him in chronic pain with opioids as part of his pain management routine. Pressley’s mother shared her son’s story pressing, “I definitely need his story to be told, because this was uncalled for. He didn’t need to take his life if he would’ve gotten the help he needed.”

These are just three stories to illustrate the many who served and struggled to receive the help needed through the VA and private doctors, ultimately taking their lives in the VA parking lots. Veteran suicides have been recognized as a desperate form of protest; against a system they feel has failed them. Eric Caine, director of the Injury Control Research Center for Suicide Prevention at the University of Rochester was quoted saying “veterans who take their own lives on VA ground often intend to send a message ... these suicides are sentinel events” (Wax-Thibodeaux, 2019). PTSD has been identified as a prospective predictor of suicide risk (Bullman & Kang, 1994). Comparing Vietnam veterans, those with PTSD are nearly four times

more likely to die by suicide than those without PTSD. PTSD was also found to be associated with completed suicides among all Department of Veterans Affairs Health Administration (VHA) users (Ilgen et al., 2012).

The Iraq and Afghanistan Veterans of America (IAVA) released their annual report, March of 2020, showing more than two-thirds (67%) of participants reporting they knew a fellow veteran who attempted suicide (Shane III, 2020). Forty-four percent reported suicidal ideation themselves, since they had joined the military, an alarming increase from 13% in 2014. The IAVA reports showed a significant increase in members who report suicidal ideation or who knew a post 9/11 veteran who had died by suicide. Sixty-two percent reported personally knowing a veteran who died by suicide, an increase of 22% since 2014.

Since operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), suicide rates among military and veteran populations has significantly increased and remain a high concern. These high rates of PTSD in military populations, the strong association between PTSD and suicide risk, and the alarming number of those with suicidal ideation demands evaluation of current treatment. Observing the consistently high rates of PTSD among military populations further highlights how critical it is for clinicians to properly assess, treat, and monitor PTSD interventions appropriately (Schuman et al., 2018).

Clinical Practice Guidelines

In 2004, the VA and DoD established the Evidence-Based Practice Work Group (EBPWG). Their mission was to advise the "Health Executive Council on the use of clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration and Military Health Systems" (VA & DoD, 2017). Together, the VA, DoD, and EBPWG established the Clinical Practice Guidelines (CPGs), which set out to better serve the

VA and DoD populations. These CPGs were created to improve the care service members received and reduce the variation in practice.

In 2010, the VA and DoD published the CPG for the Management of Post-Traumatic Stress (PTSD) and Acute Stress Reaction (ASR), which expanded the knowledge and understanding of PTSD and effective treatment (VA & DoD, 2017). This further led to a greater depth in research to develop new and refined strategies to manage and treat patients and clients with related symptoms and conditions. In 2017, the Management of Posttraumatic Stress Disorder Work Group presented the evidence gathered the previous year, through March 2016, and presented version 3.0 (VA & DoD, 2017).

Evidence-Based Practice Approach to Treatment

The CPGs highlight the strongest evidence-based approaches to treatment and management of PTSD (VA & DoD, 2017). The system-wide goal of developing the CPGs set out to improve the health and well-being of clients and patients with PTSD by guiding clinicians and healthcare providers with recommendations supported by evidence. Successful implementation of the CPGs is expected to enhance assessment of patient's condition, assist in determining best treatment method in collaboration with the patient and optimize the patient's outcomes, while improving quality life.

Pharmacotherapy. The CPGs recommend the use of individual trauma-focused psychotherapy over pharmacotherapy, as the current research treatment indicates trauma-focused psychotherapies provide greater change in core PTSD symptoms that persist for longer time periods when compared to pharmacotherapies (VA & DoD, 2017). The Work Group considered multiple factors with this recommendation. First, there are greater risks of negative side effects or reactions to treatment with pharmacological treatments. Second, the positive effects of

pharmacological treatments diminish over time or are lost altogether once the medication is no longer taken. Third, the growing body of literature indicate a greater preference for psychotherapy over pharmacotherapy by patients. However, when psychotherapies are not available or preferred by patients, the top recommended medications include sertraline, paroxetine, fluoxetine, or venlafaxine for PTSD.

Psychotherapy. The top recommended individual trauma-focused psychotherapies include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR; VA & DoD, 2017). Specific cognitive behavioral therapies for PTSD include Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. The CPGs emphasize PE, CPT, and EMDR having the strongest supportive evidence of the trauma-focused psychotherapies while noting the other therapies have sufficient evidence to recommend them as well (VA & DoD, 2017).

Prolonged Exposure Therapy (PE). PE is an empirically supported, manualized cognitive-behavioral intervention for the treatment of PTSD (Cooper et al., 2017). The approach starts with gathering information related to the traumatic event as well as symptoms and thoughts associated with the distress. Sessions include psychoeducation about PTSD, other common symptoms and reactions to PTSD, and treatment rationale. Breathing retraining is taught to help with relaxation. PE has two exposure components: (a) confronting avoided trauma-related situations and reminders and (b) repeatedly re-visiting the trauma memory. The therapist also encourages and facilitates emotional processing afterwards, which involves discussions regarding the patient's thoughts and feelings about the experiences. Patients are provided with homework that can include imaging fear exposure and answering open-ended questions to help

explore thoughts and feelings that may be contributing to maintenance of PTSD (Cooper et al., 2017).

Cognitive Processing Therapy (CPT). CPT is among the first-line treatments of evidence-based psychotherapies recommended in the CPGs and has been shown effective for military-related PTSD (Lu et al., 2013). CPT follows a similar protocol in collecting substantial background information regarding the traumatic event and symptoms associated and providing psychoeducation regarding PTSD symptoms. CPT uses Socratic questioning of assimilated and overaccommodated cognitive distortions and works to teach clients cognitive therapy techniques to assist in challenging distorted and extreme thinking (Rutt et al., 2017). This approach to therapy addresses five common themes that can affect trauma: safety, trust, power and control, esteem, and intimacy.

Eye Movement Desensitization and Reprocessing (EMDR). EMDR is the third, most highly recommended form of treatment by the CPGs (VA & DoD, 2017). EMDR is an empirically supported treatment using eye movement desensitization and reprocessing in an eight-phase, guided therapeutic approach which addresses negative past experiences, triggers of symptoms, and any blocks to effective functioning (Silver et al., 2008). The phases include gathering the history of the problem, educating the client on the process, and an assessment with a focus on various images, cognitions, and emotional aspects of the experience.

The fourth phase is desensitization that utilizes forms of alternating bilateral stimulations (VA & DoD, 2017). This is followed by the installation phase, which helps the client consolidate the desired positive cognition. The sixth phase includes a body scan, which is a method used to check the completion of the process. A closure phase, which recognizes the need for an evaluation of the client's state prior to terminating the session, follows. The eighth and final

phase is the reevaluation phase, which assesses the overall progress of the treatment (Silver et al., 2008).

Additional Psychotherapies. The CPG recommend individual, manualized trauma-focused psychotherapies as defined as any therapy that uses cognitive, emotional, or behavioral techniques to facilitate processing a traumatic experience (VA & DoD, 2017). Beyond this, the CPG acknowledges insufficient evidence to recommend for or against additional psychotherapies, such as Dialectical Behavior Therapy (DBT), Skills Training in Affect and Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy (ACT), Seeking Safety, and supportive counseling. The CPG also notes that while there is a great deal of interest in animal assisted therapy, such as equine therapy or canine therapy, there is insufficient evidence to support the use of interventions with animals for the primary treatment of PTSD currently.

Psychoeducation. Psychoeducation is recommended both with pharmacological therapy (e.g., side effects, dosing, and safety) as well as psychotherapy regarding prevalence of PTSD and available treatments (VA & DoD, 2017). For pharmacological therapy, in-depth and patient-specific education that takes place during the medical visit is recommended along with educational material. Psychoeducation is also recommended to include a sufficient review of the many ways PTSD problems can present, the spectrum of symptoms, behavioral challenges with family and friends, occupational challenges, and the potential for substance misuse/abuse impact. The CPGs also recommend a positive message to encourage through positive ways of coping, description of simple strategies to resolve or cope with developing symptoms and challenges, as well as setting realistic expectations for recovery.

Client-Centered Approach to Treatment. The VA and DoD's CPG for the Management of Post-Traumatic Stress (PTSD) and Acute Stress Reaction (ASR) encourage a client-centered approach (VA & DoD, 2017). The moral commitment to our service members, backed by substantial research, is that we do not simply go through the protocols but explore clients' individual needs. It is also important to check in with clients/patients throughout treatment to assess the efficacy of treatment and adjust to their needs as appropriate.

Shared Decision-Making Model. The CPGs present a shared decision-making (SDM) model, which includes a patient-centered, collaborative approach to treatment (VA & DoD, 2017). This approach has been found to increase patient participation, overall success in treatment, as well as satisfaction throughout treatment (Cooper & Norcross, 2016). There is a great urge to standardize, industrialize, and mechanize the approach to treatment; however, substantial research and a moral commitment reaffirms the need to focus on the human element and attend to the patient's totality in psychotherapy (Norcross & Wampold, 2018).

The CPGs further highlight the importance and benefits of recognizing the individuality of each patient's needs, treatment goals, preferences, as well as the importance of addressing any prior treatment experience they may have had (VA & DoD, 2017). The SDM model considers the patient's preference in treatment decisions by reviewing treatment options and comparing the benefits, harms, and risks of each to collaboratively select the option that best meets the patient's needs.

The APA's definition of evidence-based practice highlights the patient's values, characteristics, culture, and preference and in doing so, encourages an active and prominent position by the patient (Cooper & Norcross, 2016). Meta-analytic findings illustrate a significant increase in not only outcome success, but satisfaction regarding treatment and decreased dropout

rates for those who received a preferred therapy, compared to those who received a non-preferred therapy. Research continues to illustrate the important role of the client's preference and involvement as it increases the experience, success of treatment engagement, and outcome, yet there is little evidence that client preferences are routinely assessed or accommodated in clinical practice (Cooper & Norcross, 2016).

A great body of literature in psychotherapy examines the efficacy of specific treatments for a given disorder; however, this can be problematic when patients are generalized to a single diagnosis (Norcross & Wampold, 2018). Simply pairing psychotherapy to a disorder is incomplete, as it does not consider the unique individual or contextual experiences of the individual, and in not doing so, cannot hold effective success rates. The APA Task Force on Evidence-based Relationships and Responsiveness holds interest in both what works as effective methods of therapy and what works for patients.

Adapting psychotherapy to a patient's transdiagnostic characteristics is highly recommended (Norcross & Wampold, 2018). Built on a great deal of literature, this approach has been found to enhance treatment and increase treatment efficacy. While there are treatments that have evidence to support their efficacy, a one-size-fits-all approach is not sufficient. Clinicians must explore the individuality of their clients' needs. This understanding, paired with the most supported evidence-based practices and clinical judgment, is essential to the success of treatment.

Barriers to Treatment

The mental health services offered by the VA typically include general mental health, PTSD specialized outpatient programs, community-based facilities, telemental health options, and intensive residential programs (Hamblen et al., 2015). While most veterans with PTSD receive general mental health, the more complex cases are referred to specialized outpatient programs. Within these settings, 54% of veterans have at least one comorbid Axis I disorder, 29% SUD, and 7% have a traumatic brain injury (TBI; Hamblen et al., 2015). Along with comorbidity, additional barriers to treatment in these settings include cognitive limitations (organic causes or TBI) and low willingness or motivations.

Those seeking trauma-focused therapy (TFT) such as PE and CPT can face several additional barriers that can interfere with treatment involvement and success (Wiedeman et al., 2020). Barriers can include fear related to stigma, low-income, distrust of mental health care providers, and readiness to seek treatment, all of which can be further influenced by co-occurring disorders and/or substance use disorder (SUD). Among the 5 million veterans seen by the VA in 2012, 34% had a diagnosis of PTSD and were three times more likely to have a co-occurring SUD. Further concerns of treatment for those with co-occurring PTSD and SUD include adaptation and effectiveness of treatment, tolerating treatment safely without relapse, and concerns regarding further stabilization prior to treatment.

Another challenge for service members seeking treatment is interpersonal trust, especially for those with PTSD (Garcia, 2017). Painful and disruptive issues around trust can inhibit one's ability to navigate within their community casually without apprehension, while it can also bring about further concerns regarding other's motives. This can lead to compromising social dynamics among family, friends, coworkers, and health care providers, and bring about

the desire to withdraw and cause reluctance to leave one's home. While this psychosocial challenge is considered a symptom or outcome of symptoms that typically fall under PTSD, the difficulties trusting others may present among returning service members who do not fully meet criteria for PTSD or even prevent them from seeking further needed treatment. Working through challenges with trust is essential to restoring adaptive interpersonal functioning, establishing, and maintaining meaningful relationships, and good emotional health (Garcia, 2017).

Early Termination

Studies looking into early termination to treatment among those with combat and terror related PTSD seeking PE therapy, show dropout averages ranging from 13% to 40% among patients (Hundt et al., 2018). However, VA outpatient clinics specializing in PTSD treatment, reflect real-world averages that are higher, with dropout rates reaching up to 50%. Dropout rates were found to be greater among open-ended and non-manualized treatments, when a specific disorder was not provided for focus during treatment, and were seen in greater averages among younger, less educated, unemployed, and substance-misusing patients. Studies further show roughly 50% to 70% of veterans using Thought Field Therapy (TFT), a more customized approach, show clinically significant improvements, with 30% to 40% no longer meeting PTSD criteria after treatment (Aupperle, 2018).

The VA/DoD Clinical Practice Guidelines recommends individualized treatment, specifically manualized trauma-focused psychotherapies, and highlights the expert review consensus of PE therapy and CPT as first-line of treatment approach (Kip & Diamond, 2018). However, treatment dropout rates range close to 40% in controlled clinical trial settings, while routine clinical settings show dropout rates to be equal, if not higher. Among the numerous

challenges to seek and receive treatment, service members are faced with entrusting clinicians to provide therapy, with less than confident success rates.

Individual Approach to Treatment

To effectively treat PTSD, a thorough assessment of symptoms is imperative (Lancaster et al., 2016). Multiple measures have been developed to assess and monitor PTSD symptoms, with the PTSD Checklist for DSM-5 and the Posttraumatic Diagnostic Scale for the DSM-5 being a couple of the most widely recognized and used. PTSD is rooted in both biological and psychological factors regarding onset, development, and maintenance of symptoms. Studies highlight biological and psychosocial differences contribute to the risk of developing PTSD, while experimental research has provided evidence that interventions, both biological and psychological, initiated closer to the time of traumatic experience had increased potential in preventing the development of PTSD.

Difference in Symptom Expression

PTSD symptoms include but are not limited to re-experiencing the traumatic event, emotional numbing or avoidance of trauma reminders, hyperarousal to trauma-related stimuli, and can lead to attention challenges, maladaptive coping, and avoidance (APA, 2013). The life pervasive severity of symptoms and their complexities has encouraged researchers to attempt to identify individual differences and factors that may predict post-war adjustment (Irving et al., 1997). For instance, those with low levels of social support have been shown to exhibit greater symptoms related to avoidance and emotional venting.

Irving et al. (1997) also found combat-related PTSD associated with feeling immobilized in efforts to achieve general life goals and goals related to PTSD treatment. In fact, in their study, administered surveys found veterans' dispositional hope scores to be one to two standard

deviations below individuals who were receiving treatment in an out-patient facility for stress-related challenges, as well as the scores of those of chronic mentally ill residents at a state hospital. For the purpose of their study, the construct of hope was defined as a global dispositional style, as it remains stable over time and encompasses one's beliefs regarding attaining goals and expands beyond specific situations or circumstances, to life domains (Snyder et al., 1991). Further concerns illustrated in this study highlight the importance of when the traumatic event or events occur in one's life as relation to one's overall outlook. For example, veterans who experienced trauma and developed PTSD symptoms during young adult years, were shown to have a higher risk of decreased hope becoming a more stable characteristic, as opposed to a transient reaction to a stressful event.

In the DSM-5, emotional numbing falls under the category of "negative alterations in cognition and mood" (APA, 2013, p. 271). When one is overwhelmed by stress, a psychobiological response is set in motion as a hypersecretion of endogenous opiates attempts to assist the body control the pain, serving as an emotional anesthesia or numbing (Glover, 1992). Numbing symptoms include disconnection, disinterest, and restricted affect and are included in PTSD criterion D in the DSM-5, as a deficiency in emotional response (APA, 2013). This emotional numbing is described as a restricted ability to experience emotions, a form of internal hyperarousal manifested as diminished or detached responses to others and one's environment. Those who have experienced these symptoms, often describe themselves as feeling estranged from others, feeling detached, exhibit a loss in interest in previously enjoyed activities, and experience challenges with feeling emotions (Glover, 1992).

Schuman et al. (2018) contributed to the growing body of literature suggesting emotional numbing (EN) is related to suicidal ideation and is associated with decreased relational

functioning among service members and veterans with PTSD. EN can negatively impact treatment outcomes, making it an important symptom to monitor throughout. Many clinicians support exposure therapy as the gold standard to treatment for combat-related trauma and PTSD. However, it has been found to be less successful when EN is present. This is due to the characteristics for EN, limiting one's ability to engage in the treatment process emotionally and ultimately interfering with treatment and recovery overall.

Another important factor in the assessment and treatment of PTSD among veterans is negative post-traumatic cognitions (Horwitz et al., 2018). The reduction in posttraumatic negative-self cognitions has shown to correspond to a reduction in suicidal ideation (SI) over the course of treatment, highlighting the significant implications for determining treatment approaches. Considering those with PTSD and comorbid SI, the process for restructuring cognitions varies with different trauma-focused treatment modalities.

The Pros and Cons of CPT and PE. Cognitive Processing therapy (CPT) and prolonged exposure therapy (PE) are considered two of the most widely studied psychological treatments for PTSD (Gallagher & Resick, 2012). Both CPT and PE are strongly supported by research according to the APA Division 12 list of Empirically Supported Treatments and have shown to produce clinically significant change in PTSD symptoms, among multiple randomized controlled trials. Despite the extensive evidence to support their effectiveness and clearly stated theoretical explanations for how treatment promotes a decrease in symptoms, the mechanisms promoting the change, is still unclear.

The proposed process for PE is to decrease PTSD symptoms through repeating imaginal and in vivo exposure exercises (Gallagher & Resick, 2012). Through PE, exposures are used to activate the fear response associated with the trauma and provide corrective information to

encourage a modified pathological fear response to decrease PTSD symptoms. CPT works to promote a decrease in PTSD symptoms by modifying maladaptive cognitions that have developed after the traumatic incident. These maladaptive cognitions can include inaccurate interpretations of the individual such as self-blame, the event itself, or distorted views of the self or world around them, such as believing nobody can be trusted. Restructuring techniques work by repeatedly challenging these maladaptive cognitions or distorted views, as one works to develop more adaptive and balanced appraisals of the traumatic event, themselves, and the world, with the hope to promote recovery from PTSD symptoms.

CPT and PE offer different approaches to treatment for PTSD, challenging maladaptive cognitions vs exposure and reframing exercises (Gallagher & Resick, 2012). The presence of hopelessness has been shown to be a particularly significant schema in promoting recovery of PTSD through CPT. Previous research has shown lower levels of hope are associated with an increase in PTSD symptoms. As a result, CPT was found to have significantly greater reduction in hopelessness compared to PE, which is linked to higher success rates in PTSD treatment, when SI was comorbid. CPT and PE show theoretically consistent evidence for how different treatments achieve similar outcomes through different means, it is important to acknowledge one may be more beneficial to some than others, due to symptom expression. Considering the high rates of PTSD among military populations and the elevated risk of suicide, it is crucial for clinicians to fully consider the complexity of differential impact of PTSD symptoms to accurately assess, treat, and monitor interventions efficacy appropriately (Schuman et al., 2018). It is imperative to fully evaluate symptoms experienced, comorbidity, and context to find the most beneficial approach to treatment.

Current Findings of EMDR and TF-CBT. A Network meta-analysis (NMA) is a technique used to compare multiple treatments simultaneously in a single analysis by combining the direct and indirect evidence obtained from randomized control trials (RCTs; Rouse et al., 2016). NMA is a more recently developed technique, which has grown in appeal among clinicians as it is believed to assist in assessing effectiveness of different treatments often used in clinical practice. Mavranezouli et al. (2020) concluded that EMDR and trauma-focused cognitive behavioral therapy (TF-CBT) were the most effective at reducing symptoms, sustaining symptom improvements following treatment, and improving remission rates in adults with PTSD.

Mavranezouli et al. (2020) analyzed 90 trials, including 6560 participants, and 22 first-line psychological treatment interventions in the NMA. This study compared pharmacological and combined pharmacological and psychological interventions, using relaxation techniques to serve as a control intervention. The analysis only focused on first-line treatment interventions for the management of PTSD and as such, did not include hypnotherapy, psychosocial interventions including meditation, mindfulness-based stress reduction, supported employment, peer and practical support, or physical interventions, such as exercise, yoga, acupuncture,
bio-neurofeedback and repetitive transcranial magnetic stimulation. Furthermore, both EMDR and TF-CBT were found to be superior to counseling, with data suggesting both interventions sustained effects at 1-4-month follow-ups.

Client-Centered Approach and SDM

Many complex factors interplay in one's experience of trauma, expression of symptoms, and efficacy of treatment. Discussing their individual needs, goals, preferences, and response to

treatment, is essential to assessing the best approach to treatment. Evidence-based practice encourages a patient-centered, collaborative approach to treatment, which includes the client's voice in decision making, as well as checking in periodically throughout treatment to assess efficacy of treatment (Cooper & Norcross, 2016). This means assessing clients' understanding of PTSD, available treatment options, and hearing their experiences throughout.

Clinician's Perspectives

Etingen et al. (2019) recognized the discrepancy between veterans seeking PTSD care and those completing treatment regimens and/or dropping out prematurely. The need to engage patients, also includes forming a relationship built on trust to help bridge the gap between those who need care and those who receive it. Barriers to engaging in care can be due to concerns of providers not considering patient preferences such as understanding them or their unique situation, specific symptoms of functional goals they would like to work on, personal or life circumstances creating more challenges to participation, as well as other logistical difficulties or avoidance, which can be common among those with PTSD.

The Institute of Medicine has encouraged a patient-centered approach to health care for more than a decade, encouraging patients' preferences, needs, and values to guide healthcare decisions (Etingen et al., 2019). The U.S. Department of Veterans Affairs (VA) has adopted this approach as their Shared decision-making (SDM) model, which encourages conversations between patients and providers to discuss treatment goals and preferences (VA & DoD, 2017). With limited research on the SDM in the treatment of PTSD, Etingen et al. (2019) conducted an exploratory pilot study consisting of semi-structured interviews with mental health providers, to identify and describe current practices used by VA mental health providers involved in PTSD treatment planning.

Etingen et al. (2019) focused on mental health providers, including psychologists, psychiatrists, and social workers, who conducted initial mental health evaluations and treatment plans for veterans with PTSD at a VA Hospital. Their goal was to gather provider perspectives on current VA recommended PTSD treatment planning practices including the diagnosis of PTSD, treatment planning process, and available PTSD treatment options, with a focus on SDM for mental health. Question topics included: how treatment recommendations were selected, extent to which patients' treatment goals and preferences were elicited, expressed, or considered during treatment planning, as well as barriers and facilitators to eliciting and incorporating patient's preferences into treatment plans.

Their findings indicated efforts by mental health providers to work within a SDM model (Etingen et al., 2019). It further highlighted the importance of building a relationship with patients, which was acknowledged by roughly 77%, with all reporting the treatment planning process as an *exchange of information* between provider and patient. Over half of participants spoke of patients' functional goals and how they consider these in the treatment planning and goal setting process. One participant added: "for some people it's work, some people it's play, some people it's relationships. Getting them back to a place where … the symptoms aren't causing them problems in that area of life again (Etingen et al., 2019)."

The area of logistical reasoning was brought up by nearly half and was described as life responsibilities that had an influence on treatment planning and preferences, including patients having children or work schedules (Etingen et al., 2019). The process of establishing a treatment plan was described as a "fluid" ongoing process by one participant, noting: "For me, treatment planning is every time I see the patient, because that's fluid for me. It all depends on how the

patient is doing, how [the patient] has responded to what we've treated [the patient] with in the past."

Etingen et al. (2019) explored mental health providers approach to treating veterans with PTSD to provide insight into how they incorporate the SDM model throughout their treatment planning process . Overall, their findings suggest mental health providers work to establish rapport and consider individual needs, which is in line with the SDM. Their results were found to be consistent with current literature, highlighting the importance of additional elements of the SDM model, including patient values and preferences, as well as engaging patients in a collaborative approach to planning and goal setting. This further emphasizes individualizing treatment to optimize efficacy of treatment.

CHAPTER III: METHODOLOGY

The presented qualitative study looked into the experiences of post 9/11 service members and veterans who sought PTSD treatment after the VA and DoD presented the Clinical Practice Guidelines for the Management of Post-Traumatic Stress Disorder (PTSD) and Acute Stress Reaction (ASR). This study utilized an Interpretative Phenomenological Analysis (IPA) design, which describes the essence of an experience across several participants, by analyzing the significant and meaningful statements expressed through an interview process (Creswell, 2018). By listening to participant's share their experiences, adverse and advantageous, and comparing them to the recommendations provided in the CPGs, this research was designed to gain further insight into improving the experience and effectiveness of those seeking PTSD treatment.

This study worked from a social constructivist perspective, which seeks to explore and understand the meaning behind an experience, relying on participant's view of their encounters and situations (Creswell, 2018). Starting with broad, general, and open-ended questions allowed participants to construct the meaning of their own experiences. It also built rapport as the interview experience unfolded. This study focused on the specific context of military culture and military PTSD, while also recognizing researcher's own background as it shaped interpretations. An acknowledgement of how interpretations flow from personal, cultural, and historical experiences was essential for interpretation. The goal was to make sense of and interpret the meaning of their experiences, as it is filtered through another's social perspectives, culture, and history.

Phenomenological design of inquiry places the research as a body, in the position to describe the lived experiences of those involved in a particular phenomenon as it is described by

the participants (Creswell, 2018). These descriptions culminate to illustrate the essence of the experiences of several individuals who also experienced the phenomenon. This study design has a strong psychological and philosophical backbone as data collected from interviews fit the goal of the study which is to better understand what makes therapy work.

Goal of Study

The researcher was drawn to this scope of study from her own experiences watching family and friends face a multitude of challenges related to military PTSD. Their shared experiences navigating barriers, stigma, and seeking treatment created a curiosity in other's experiences navigating similar challenges. Understanding the fact that not all who face these challenges seek treatment, it was of most interest to understand the specific experiences of those who persevered through the stigma and barriers to explore what was deemed helpful and what was not.

This study gathered the experiences of five post 9/11 military personnel who sought treatment for PTSD and explored salient elements shared by each participant. These themes further illustrated an understanding of what it was like for each to go through the steps of seeking and receiving treatment for PTSD, compared to the recommendations in the CPGs. This understanding further providing recommendations for ways to improve assessing and treating PTSD effectively.

Ethical Considerations

The focus of the interviews was to discuss participant's experience with seeking therapeutic treatment, not to discuss their experience with PTSD. This was clearly stated in the Facebook account, informed consent, and restated at the beginning of each interview. In the event a participant became triggered, the researcher was prepared to evaluate next steps to

mitigate potential and/or additional harm. The researcher was prepared to stop the interview, assist with redirecting discussion to minimize distress, and provide additional sources for support to help the participant find needed support. Of note, these steps were not deemed necessary at any point in this study, as all participants remained on topic and fully engaged in discussion throughout.

To protect privacy and encourage open responses, confidentiality was of high importance. Communication occurred through the created research Facebook account and research Facebook account messenger, as well as email, and Zoom. Only the first names were obtained by the primary researcher, for the purpose of communication and interview rapport. After the interviews were conducted, participants were given a numeric and alphabetical association by the head researcher, based on order of recruitment, with the reference stored separately and not shared with the second coder or anyone else.

Sample

Post 9/11 military population includes active, reserve, national guard, and veterans who sought treatment for PTSD after the VA/DoD CPGs were published in 2010. For recruitment, a Facebook account was created for the sole purpose of this study, clearly stating the intentions of the research and inclusion criteria. This account was used to recruit through Facebook military population groups and networking. Following IRB approval, the site was created. Roughly 40 military research groups were contacted, approved by group leaders, followed by posts created for recruitment. Additional networking assisted with connecting research interests with willing participants for further recruitment. Email was utilized for the purpose of direct confidentiality, where inclusion criteria, DoD numbers, and PTSD diagnoses were verified, consent was signed and returned, and Zoom sessions were scheduled.

A total of five participants met inclusion criteria, provided all required information, and engaged in interviews for this study. The sample included four who identified as male and one as female. All participants were no longer on active-duty, but their length of military service ranged from 4 to 29 years. The branches of military service represented include the U.S. Air Force, U.S. Army reserves, regular U.S. Army, and the U.S. Navy. The sample represented both enlisted and officer ranks with such diverse military occupations as Chaplain and Special Forces.

Data Collection

Individual, semi-structured interviews were conducted via Zoom video meetings. Each participant signed and verbally consented, at the beginning of each interview, to recording and participation in the interviews. Interviews ran roughly 45 minutes to an hour in length. The interviews started with one, open-ended question to encourage participants to express their experience as organically as possible. This was to address the first research question, regarding the experience of the post 9/11 military population's experience of seeking treatment for PTSD. Five prompts were used to further assist with covering specific topics, encourage conversation in a more directed purpose, and highlight topics in line with the study's research goal. Topics included participant's experience with receiving psychoeducation specific to PTSD, knowledge of treatment options available, a collaborative approach to treatment, barriers, and stigma to seeking and/or receiving treatment, as well as what they would like for clinicians to know about their experience.

The first four prompts were created to offer a sense of direction, create rapport, and mirror the CPGs recommendations. These prompts also assisted to answer the first and second research questions regarding experiences seeking treatment in the domain of perceived quality and usefulness of information they received regarding PTSD diagnosis and treatment options.

The last interview question was created to answer the final research question of this study. This question was to highlight their perception of how their experiences might help inform clinicians of ways to improve the effectiveness of therapy. Following this semi-structured interview, three debriefing questions were presented to encourage reflection of the conversation and provide room for any final thoughts regarding their experiences. The interviews were designed this way as an attempt to follow the participant's experience of meaning, offer guidance to explore specific topics, and provide room to reflect and explore greater depth of meaning and significance. Interview structure was as followed:

1. Interview Question - How would you describe your experience seeking treatment for PTSD?
    a. Do you believe you understood what PTSD was when you were receiving treatment?
    b. What treatment options did you know about?
    c. How would you describe your involvement in treatment?
    d. Do you believe you faced challenges related to stigma and/or barriers to receiving treatment?
    e. What do you think would have helped improve your treatment? What would you like clinicians to know about your experience?
2. Debriefing Exit Questionnaire
    a. What resonated from this discussion?
    b. What did you notice that you hadn't thought of before?
    c. Was there anything else that you wanted to discuss or share?

The audio recordings were then transcribed using a Transcription software by Wreally©. The transcripts were then edited while reviewing the audio recordings for accuracy and data immersion into the participant's expressed experience. The transcriptions, along with the researcher's notes and memos, were analyzed and outlined using Excel Spreadsheet for organization. A second coder, fellow PsyD student at Antioch University, was sent the transcriptions to assist with a second set of interpretation of themes, also utilizing Excel Spreadsheet for clarity and consistency in data organization and interpretation. This second coder was utilized to assist in decreasing researcher's bias and personal influence with interpreting the data. Both sets of data were reviewed by the first researcher, compared, and combined to create the themes expressed in the interviews.

CHAPTER IV: RESULTS

The study was open to any participant who met the inclusion criteria, with minimal demographic information collected. Of note, there were four males and one female who participated. Ages of participants ranged from early 40s, up to late 50s, with years of military experience ranging from 4 to 29 years of service, as stated through interview historical context. These are noted as they seemed to contribute to a few of the emergent themes regarding experience in the military, opportunities for seeking treatment, and the evolution of the participant's personal understanding of the self, the self with PTSD, and seeking treatment over the years. Those who shared a longer history of seeking treatment offered dates of reference to serve as timelines. This was helpful to assist with outlining their evolution of experiences, understanding of their journey, and the meaning they have created from their experiences over the years.

Response to Clinical Practice Guidelines

The first three interview prompts outlined the VA and DoD Clinical Practice Guidelines (CPGs) recommendations for psychoeducation, treatment options offered and or discussed, and a collaborative approach to treatment through the SDM model. Participants echoed a need for improvement regarding psychoeducation and the importance of a self-directed search. Each participant spoke to the many options provided through different organizations, with most help coming from Outreach and unconventional methods. Regarding the collaborative approach, there were different experiences expressed. While some felt heard and involved in their treatment, others found disrespect and a disjointed approach to their treatment.

The CPGs recommends clients receive psychoeducation regarding the prevalence of PTSD, available treatments options, ways PTSD problems can present, the spectrum of

symptomology, potential behavioral challenges with family and friends, possible occupational challenges, and caution regarding substance misuse/abuse (VA & DoD, 2017). The CPGs also encourage a positive message regarding coping, description of simple strategies to resolve or cope with developing symptoms and challenges, as well as realistic expectations for recovery. Participants shared their experiences with psychoeducation provided by professionals over the years, as well as the challenges with identifying with PTSD and seeing how it was expressed and experienced for them individually. Overall, participants noted being informed to some extent over the years of seeking treatment, with most of the helpful information being found on their own. Additionally, they each shared their own journey learning about themselves and what PTSD was to them over years of work, including past trauma that came to light along their path to healing.

A couple participants shared specific disappointment with the psychoeducation they received from clinicians. Participant 2B explained:

> unless you are seeking the education, someone coming and telling you, will you get it? Probably not, because you're not really seeking a cure or seeking like, relief from it. Because it's exhausting living with PTSD. It's exhausting for people around you. So, education is one of the biggest, biggest keys honestly, but you got to be willing to get help. (personal communication, August 31, 2021)

He went on to express the need stating, "the education piece should be there. It should be briefed to the guys getting out. Like, hey, here's all these different modalities for mental help that you don't even know about and they should be available. Period." (Participant 2B, personal communication, August 31, 2021).

Participant 3C echoed this disappointment stating:

> that was the issue. Yeah, so again, when I came home from Afghanistan, basically, got up to my unit, dropped off my weapons, went home, and that was it. I had no debrief, you know, no physical when I got back, or any of that. And, what I think, I think a lot of that should be mandatory. (personal communication, August 31, 2021)

Conversely, participant 4D spoke positively about her experience receiving insightful and helpful information from clinician. She shared:

> The therapist said, "Do, you know, you have PTSD?" and I said, "no," and I said, "there's no way that could happen for me" and they were just incredulous and saying, "are you kidding me?" ... and it was a very intensive educational time for me. (Participant 4D, personal communication, September 3, 2021).

The CPGs recommends individual trauma-focused psychotherapies including Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR; VA & DoD, 2017). The CPG also speaks to an interest in animal assisted therapy, such as equine therapy or canine therapy, though there is insufficient evidence to fully recommend. Participants expressed a variety of experiences regarding their awareness and understanding of treatment options for PTSD. This was further divided into what was offered at different organizations, therapy modalities, as well as unconventional paths to treatment. Each participant shared experiences trying a variety of approaches, though learning about these different approaches seemed to predominately come over time and from the participant's searching on their own.

The CPGs encourages a collaborative approach as a shared decision-making (SDM) model, which includes a patient-centered, collaborative approach to treatment (VA & DoD, 2017). Research has presented evidence to support this approach as it increases patient participation, overall success in treatment, as well as satisfaction throughout treatment (Cooper & Norcross, 2016). Participants offered very different experiences, expressing a sense of feeling

heard and involved in their treatment, while others shared disappointment and a lack of respect that created a further divide. Participant 4D shared her appreciation for her and her husband's therapist's attempt to collaborate over the years.

> I really, really liked it and that with my own therapy and my husband and I had [a] great therapist. Having choices placed in front of me and opportunities, and my health care team. I felt, I had choices. I had a voice. I was involved in my care, and it made me sensitive also to what I thought would work and every now and then, to tell you the truth, I was very surprised. Some things that I would say, "I don't want to do that," and you know, my healthcare team was like, "just give it a try." You know? One of those things was, was yoga. They had me doing yoga, meditation, journaling, and art therapy. And I was like, "I'm not going to, I'm sorry, I'm not going to color circles for you." And they would [say], "just give it, just give it a try." "Okay." "Just give it a …" so those were very self-exploratory, and it was very good. They were all positive. They had me do Equine Therapy with a horse. They had me do some [of] what they call Weekend Adventures, these ski trips, things like that. And just trying to open your perspective, "you've been a little closed, too narrow," and they were all positive, very, very positive. Very relational. They really did a great job and then the big thing they found, they were always trying to find something for me, but I have a lot of safety restrictions on me, due to epilepsy. And then it came up with golf and that was the end and it hit every bell for me. But yes, that collaborative, of course the talk therapy. (Participant 4D, personal communication, September 3, 2021)

> A notion of disrespect was expressed causing a divide in a collaborative approach. Talking to a doctor, say, you had a bad day. Okay, and you know, I joke to you, they would just say something, and it seemed to be like, almost like you're reading off of a cue card, "how does that make you feel?" "What did you do, when that happens?" (Participant 3C, personal communication, August 31, 2021)

He further shared examples of his experience hearing comments of minimization by his provider, stating, "so and so has it worse or somebody's having a worse day. Not what I want to hear" (Participant 3C, personal communication, August 31, 2021).

Participant 2B shared the lack of options while active duty and anger for the disrespect his therapist showed him.

> No, no, not while active duty, no. It was dictated to me what I did. I got dictated what I was going to do and force-fed what you're going to do, and I knew there had to be something other than fucking sitting in front of somebody. Like, tell me "How's that make you feel?" Like, I got you, I respect. I respect the work you're doing but, you know, to have some 22-year-old, Boone, North Carolina University graduate sitting in front of

> you, staring at a computer screen. Sitting 90-degree opposite to you asking, “How’s that make you feel?” Not even to look at your patient in the eye. Number two, how the fuck do you think it makes me feel talking about the worst day of my life. Right? (Participant 2B, personal communication, August 31, 2021).

Theme Analysis

The fourth interview prompt explored perceived and experienced stigma, and barriers to seeking treatment. The ongoing concerns and challenges became so pervasive in the interviews, it was used to create the first theme. The fifth prompt and following debriefing questions, further assisted with specific theme development for this study. The first question of the interview helped outline an organic flow of themes from their experiences, touch on points reflected in the CPGs, while the debriefing questions assisted with providing room for reflection and final thoughts.

Table 4.1

Themes

Super-ordinate themes	Sub-ordinate themes
fear and shame	stigmatizing military protocol internalized shame career killer perpetuated by public figures minimizing symptoms
frustration	limitations of conventional methods poor coverage - insurance and disability% burden of proof goodness of fit COVID
turning point	quality therapist trying new things unconventional methods active participant in own healing
evolving understanding	pivotal moment awareness of self and trauma individual differences noticeable improvements with systems
intentionality	personal accountability giving back recommendations from experiences

Fear and Shame

There were many accounts discussed where participants experienced or witnessed detrimental consequences to showing signs of distress or needing help. This was at times internalized where some questioned their own abilities or defectiveness, while others minimized symptoms to hide from persecutory judgment. This was noted to only be further exacerbated by the threat of losing one's career, benefits, and livelihood.

Stigmatizing Military Protocol. Each participant spoke of stigma, through personal and/or professional experiences. Most were clear about their understanding of the potential ramifications of seeking help or showing that you needed help. Participant 5E shared his stories on deployment, seeing individuals showing signs of PTSD being singled out and outed as *compromised,* as standard protocol. He went on to share:

> It was stigmatized. I can say that with some confidence from not just an experiential perspective, but from a professional perspective. So, my job, my role, I was a chaplain assistant. So, I'm not certified as a clinician, but we worked with clinicians all the time on deployments and after deployments. And just the structure and the way in which mental health was discussed. It made it seem like it was such a stigma for folks to talk openly and honestly about their experiences and what they needed to just be themselves and be safe and healthy. On deployment, and it's maybe something that you've heard before, but if there was an individual having difficulty, we would actually take away their weapons. And so, not just take them away, but then give them fake weapons. Dummy weapons. So, they are like, rubberized blue colored M16s and M4s … They would be removed from any sort of duty that would carry any sort of responsibility at all. (Participant 5E, personal communication, October 8, 2021)

Others spoke of their challenges they faced from peers judging their ability to handle the job at hand and assessing signs of distress as a deficiency. Participant 1A stated:

> It's frowned upon but quite frankly, you know, I mean … it sucked. I lost some friends because they prejudged. But I've come to the conclusions, if it was really a friend, they'd say, yeah, you know, 'I want you to feel better.' But it's viewed in part, that peer group of the military, for the most part, as a sign of weakness. Like what the fuck is wrong with you? you should be tough, level-up. (personal communication, February 18, 2021)

Shame. There were further experiences of questioning one's own ability as some internalized their struggle with PTSD. Participant 5E shared personal experiences, as well as his professional experiences as a Chaplain Assistant working with clinicians. He stated, "it was scary because from an emotional perspective, I had to admit to myself there was something wrong with me" (personal communication, October 8, 2021). Reflecting on the protocol for those showing signs of PTSD, he added:

> You could see it in their body language. There was a lot of shame associated with it. From the perspective of the individual, being isolated, and basically saying "this person, we should just not talk to them. They don't belong and are a threat to themselves and others. (Participant 5E)

Career Killer. Many participants spoke to the potential threat of losing all they had worked for, their career, and/or retirement, if they spoke up while active duty. Participant 2B shared his perspective working in Special Forces, where showing any signs of PTSD, asking for help, or seeking treatment was simply a "career killer" (Participant 2B, personal communication, August 31, 2021). He expanded to share:

> It is extremely difficult, especially in the area that I worked in. I was in Special Operations, and I mean there's no, it's no secret there. You know, there are some things that are secret, but for 14 of my 22 years in Special Operations and the second that you say you have a problem or that you need help, that's a death sentence for your career. So, you don't. You just shut up and keep going and keep doing your job and so the second that I did raise my hand and ask for help, it caused a death sentence. I was over 20 years at that point, so, it really didn't matter to me. My retirement was safe. I was good to go. To be honest with you, I was exhausted, I was done. But career-wise, it is detrimental to your career to ask for help while active duty.

Participant 3C shared his understanding of the loss of one's future income, stating:

> I think it is because stigmatism, you have security clearances and all kinds of stuff that guys are afraid to say anything. They're afraid it is going to impact their livelihood. Are you going to be discharged? Are you going to not be able to do the job you're going to do? The military has to fix that. (personal communication, August 31, 2021)

Perpetuated by Public Figures. The thoughts of this ongoing stigma were expressed as being perpetuated, not only by military protocol, but also by what the public hears. Participant 2B spoke of stigma being further distorted by Hollywood, creating a general fear of those with PTSD.

> You know, I'm gonna be honest with you, Hollywood has done us no justice. Rambo, Special Forces dude with PTSD. They all think I'm crazy. This is the stigma. Hollywood has put that stigma out there already. They don't understand. Like, I tell people, "'Yeah, I got PTSD." And they're like, "holy shit." Like, oh no, you know a veteran with PTSD standing near you. You know, so sorry to ruffle your feathers but yeah, there are a lot of us, and we all have it. (Participant 2B, personal communication, August 31, 2021)

Even political figures and leaders have furthered the stigma according to Participant 3C. He stated, “national leaders, I mean, I remember one congresswoman in California, Feinstein, made a comment, you know, “they’re all crazy and shouldn’t have guns” (Participant 3C, personal communication, August 31, 2021).

Minimizing Symptoms. It became apparent that a strategy for avoiding the repercussions was to downplay distress and camouflage symptoms. Participant 5E shared:

> From my recollection, there was a question asked I think either as we got back from deployment or as we were leaving, getting ETS (expiration term of service) and leaving the military. That basically, I remember folks saying, “just say no to everything, so you can go back and see your family as fast as possible.” And the assumption was that if we acknowledge that something’s happening to us or that we experienced stuff, it was just going to prolong or delay us from being able to just go and hang out with our family, post deployment. (personal communication, October 8, 2021)

Frustration

Throughout each interview, participants spoke of their own disappointment, sense of feeling disrespected and dehumanized, as well as shared stories where they and/or others faced challenges with anger and resentment for their service. The significance of this frustration being how it created an additional barrier to treatment and further reflected the concern for the overall failure to reach others who need treatment and struggle to see past this barrier. Most concerning are those who have given up.

Limitations of Conventional Methods. There was a theme of frustration expressed by many, regarding the limitations within the military and VA’s outdated, structured systems. Further, the frustration within this rigid system has left many to feel insignificant and neglected in their distress after their years of service. All participants spoke of finding more flexibility and efficacy in nonconventional systems. Participant 1A illustrated the differences, stating the

> government is more structured, it just has a lot more limitations and what they can and can't do, than private practice. I think the outreaches are a little bit in-between and I'm grateful for them for that reason, they're literally lifesavers. (personal communication, February 18, 2021)

Participant 2B shared further:

> I mean when I say standard, like standard like, is fucking archaic and I'm going to be honest with you. I'm going to say this now, the VA could give two shits if I blow my brains out right now or in 50 years from now. It, it's cheaper to pay out my life insurance policy than it is to take care of me and that's the sad fucking truth about it, and that's how I feel. I can tell you this now, I can put you on the phone with, shit, a hundred other fucking dudes right now and a hundred dudes that I served with who will all tell you the same damn things. That's fucking sad. And that's sad coming from a Special Operations guy, to the basic infantry grunt. (personal communication, August 31, 2021)

Poor Coverage. Participant 2B further shared his disgust for the military's disproportionate concern for property and lack of effort to care for their people, stating:

> the military does a really good job of doing maintenance on your weapons and on your radios and on your trucks and on the helicopters … except this. One of the most important weapons on the battlefield is the mind. (personal communication, August 31, 2021)

Participant 4D further shared her continuous struggle with the VA over the years. She spoke with such relief to finally receive validation for her distress and disillusionment with how hard she had to fight for it:

> 57 years old and you know, it's good to have resources available as you know. But it was like, finally I … you know, I can breathe. It's not going to change. It's not going to be taken away from me. You know, it's a hell of a thing. When somebody says, yes, you have a serious illness called PTSD and waiting, so many years, for that temporary rating to go to permanent, and that's a very dehumanizing thing. (personal communication, September 3, 2021)

Burden of Proof. Multiple participants spoke of the struggle to not only acknowledge they needed help, to go against the potential consequences, but to then try to prove they qualified for treatment. Participant 5E shared his experience stating:

> The VA's process of me saying, "this is something I believe I have," that even felt uncomfortable. I didn't know much about. I didn't know from a DSM level or anything like that, what it was. I didn't really know what it meant for me individually, going through the experience, dealing with it, but I just knew something was different. So, even going through the claims process. It was almost like you have to prove this is something you've experienced and we're going through, you have to prove it instead of us recognizing that you probably did. So, it felt like you're almost being judged and again, this could just be my own experience going through the claims process of like, just … it didn't feel like "thank you for coming here and let's get you some help that you need or here's some options for you." It was more like, "tell us about your experiences and we're going to see where you fall on this rating scale." (personal communication, October 8, 2021)

There were further challenges expressed with obtaining disability coverage and the distress with proving one's level of distress related to percentage of coverage in the VA. Participant 4D shared her ongoing battle to obtain treatment security and full access to care. She shared the dehumanizing effect of having to fight to receive treatment after almost 30 years of service:

> I had retired from the Army after 29 years and it was right about then, we had fought a lot with the VA for my findings. I would seem to be 100%, but it wasn't permanent. And finally, about 2015/2016. They gave me my rating as permanent. And until then, if it's not permanent, they could take it all away. You know, you can lose it all. And finally, they gave me the permanent rating and it made me feel like finally, somebody believes in this. And it just, it just gave me a sense of finally somebody believes in this, and I had more access to VA programs and until that point, there was some legislature, you know? … and that's how I felt, it was very dehumanizing. Especially as a woman in Haiti … they were … I went through some extremely violent, it was very violent that I went through, and then the assault and, you know … it is very dehumanizing. It takes away a lot. You get all of this treatment and education, only for the VA, letter after letter … you know? Thank you for today. Was like it finally came, and it just seemed finally … the chapter closed. I can live life. I'm not always having to reach back. (personal communication, September 3, 2021)

Goodness of Fit. Participants spoke of their challenges navigating different treatment methods. The continuous efforts to find what worked for them and which environments were not a good fit, further prolonging distress and hindering treatment efficacy. Participant 4D shared her experience of how one's rank and gender during active duty can further create stumbling blocks

to appropriate treatment environments. She added how seeking help was, at times, returned with questions of "what is she doing here?" Trying group therapy, she shared her understanding of her position and conflict in the room, stating "Lieutenant Colonel medical service, that can be pretty weird with a group of guys, enlisted guys, with the woman there, and an officer" (personal communication, September 3, 2021).

The military culture presents another layer of complexity when determining goodness of fit. Participant 2B shared his view regarding the gap working with civilian therapists, stating:

> I don't think the civilian therapists that are out there right now, unless they have a military background or came from a military family, I don't think they'll truly understand. They can have empathy, but I don't think they will truly understand. I think they're going to overwhelm very rapidly. Cuz, look, we're bringing a lot of heavy shit, you know what I mean? And as a civilian therapist, like God bless the one I had. She needed fucking therapy after she had me, you know what I mean? She would straight up tell me, "I'm taking two weeks off, for our next appointment" … and … got it. It's some horrific shit that I bring up week in and week out. But it's also horrific shit that I have to live with. You know what I mean? So, it's a double-edged sword. And the burnout. I see from the people I've been around, my friends, the burnout rate between the civilian populace and the veterans seeking help is high, very high. (personal communication, August 31, 2021)

COVID. The Coronavirus pandemic created another layer of unique interference. In some cases, it presented further distance and isolation, as well as frustration for those who dislike and/or find navigating technology challenging. It also was seen for others to offer an increase to access and new opportunities to explore, through telehealth resources available from their home. Simply put, "COVID, that kind of threw a wrench in a lot of things" (Participant 5E, personal communication, October 8, 2021). Participant 1A shared challenges with receiving treatment over the phone, stating:

> when Corona struck, first started, I was doing phone interviews, it wasn't really working for me. So, I tried that for about six months and finally said to him [therapist], "look, I don't think this is gonna work, we should go our own separate ways for other reasons." He was like, "yeah, okay, fine." Which kinda upset me because he was like, "okay, you're someone else's problem now. (personal communication, February 18, 2021)

Participant 2B shared both positive and negative aspects.

> I think COVID was a two-edge sword for veterans. It isolated everybody home, so, the mental health of this country kinda took a hard hit … but I can actually do a therapy session and guess what? If they ain't cutting it? I'll go find another one. (personal communication, August 31, 2021)

Additional challenges shared were related to technology, while offering more access, it also created less connection with therapy at times. "COVID has made it a lot easier to seek out over the phone, FaceTime to FaceTime therapy … I'm an old-school dude, I like to look people in the eye. So, it really didn't work for me" (Participant 2B, personal communication, August 31, 2021). Echoed further,

> I'm 59 years old, so, I'm not old, but I'm not a kid and this is, this isn't the norm for me … I can see the Vietnam generation having a very hard time with the electronic portion of it and actually just shutting down. (Participant 3C, personal communication, August 31, 2021)

He clarified the problem for him:

> they were doing it on the phone, a home group for a while, which I didn't like at all. Everybody was just stepping on each other. I think the Zoom environment has a tendency to step on each other and it isn't the best you can get for personal connection. (Participant 3C)

Turning Point

The theme of a turning point emerged as participants shared their story of seeing hope. There were stories of a therapist who was warm and offered something different or a new modality that clicked and rapped into something new. Many highlighted the appreciation for flexibility and personal touch offered through unconventional methods, as they were received more favorably. There was further an impression of taking accountability and direction in one's life and journey to healing.

Quality Therapist. Each participant spoke of a turning point to their treatment that changed their outlook, whether life experiences, an individual therapist, or specific program that was a better fit for them. The definition of a quality therapist was different for each, though the common themes included warmth, respect, flexibility, and feeling heard and cared for. Participant 1A spoke of his life experiences signaling a need for change and finding a therapist who was able to provide him with quality care. He shared:

> 2014, I finally said, hey, look, this isn't working. I'm having a lot of issues, interpersonal relationship issues, issues at work. I can't do this. I need more. And at that point, that's when I filed for disability… I was doing law enforcement. I was doing work for the state for a long time. It was really triggering a lot. So, my psychiatrist at the VA in 2014 said, okay, well, I can refer you to this other therapist back at the Outreach centers and fortunately she had been doing it for years. She was very warm. She had different techniques. She didn't have the standards that the VA had. She was kind of free flowing for the Outreach centers. (Participant 1A, personal communication, February 18, 2021)

Trying New Things. Four out of five participants spoke to the variety of techniques and modalities they tried over time, while all spoke to trying new things and finding out through experience what worked for them. Participant 2B shared his extensive experiences stating, "prolonged exposure, EMDR, music, equine therapy, hunting, journaling, mustang therapy, art therapy … prolonged exposure … it is brutal. Does it work? Absolutely, it works. But it is brutal (personal communication, August 31, 2021). He added, "I love Art Therapy, not the be-all, end-all. You know? Music Therapy, some days you need the music, some days you need the lyrics." Participant 3C added his preferred approach, "I would rather do it in a group environment with other veterans. Usually, same age and same experience level," with his favorite therapeutic Outreach activities being fly fishing and golf (personal communication, August 31, 2021).

Participant 4D shared her realization of the importance of a holistic approach:

> I think we're beginning to understand that now. There needs to be a comprehensive approach to really, fully address it with the veteran, with them individually, with their family. I think a big thing is dealing with the psychological aspect, the spiritual aspect, and physical aspect. I think some other things, nutrition, really guarding sleep, relationships, and work. I think it's going to be a comprehensive answer and one that's going to take time. (personal communication, September 3, 2021)

Unconventional Methods. Four out of five participants spoke specifically about their experiences with Outreach programs and appreciation for the unconventional approaches they offered. Participant 5E shared his experience of finding what worked for him more by happenstance.

> I first sought treatment, it really was, sort of an alternative approach and that was through yoga and at the time. I didn't even know that it was something that I needed. I was going there for a completely different reason, doing professional outreach, and then I just realized, well, this feels good. This feels like it's something I need in my life. It was specifically a yoga program focused on addressing trauma. (Participant 5E, personal communication, October 8, 2021)

Participant 2B shared how conventional methods were less satisfying, while unconventional methods were found to be a better fit. He shared:

> The best help that I received so far, is through nonprofits. I'll be honest with you. I've had to seek and fire a lot of therapists who are not either, are not prepared to deal with the complex PTSD that I'm bringing to the table. Like I said, I'm not a guy with one or two deployments. I'm a guy with 11 deployments, pretty horrific scenes, of seeing horrific shit, doing horrific shit to people and having shit done to me. It takes a certain level of therapist; it takes a certain level of commitment to deal with something like that. And like I said, I went through multiple till I found some that actually work for me … I used to think doctors and therapists had all the answers but the only person that can truly understand what I've gone through, is a guy that was standing beside me. The therapist is going to be able to peel away those onions, but to have true empathy, it's going to have to be a person that has walked that same ground. Done the same things. That's where peer-to-peer mentor model comes into play. (Participant 2B, personal communication, August 31, 2021)

Active Participant in Own Healing. Four out of five participants spoke to the importance of one's own role they played in their healing. Participant 3C explained,

> you have to be an active participant in your own life, whether it's work, relationships, and healing too. I mean, again, I'm not beating a dead horse, but the whole pill thing, that's like, oh, here, pop this pill to make all your problems go away. It doesn't, it's a Band-Aid. The problem is still there, and you have to constantly work at it. So, I think the personal accountability, getting involved in your own healing is huge. (personal communication, August 31, 2021)

He went on to share how it is not always easy, stating:

> I think you learn how to, and then through understanding you learn how to live with it. It's not going to undo my experiences. I also think a lot of Vets and I've had my moments too, but I think people that are resistant, when they don't get help. They're too consumed by their anger. And this is coming from a hot-headed Irish. Yeah, I think the anger part takes it away. I think they're resentful for their service. They're resentful for what's happened.

Evolving Understanding

The structure of the interviews provided a snapshot into one's perspective of seeking treatment, which took place over many years for most of the participants. This provided an awareness of the depth of understanding as it had evolved over time. Many remembered the pivotal moment they considered PTSD as it applied to them, building an awareness of themselves and their history of trauma, as well as the years of seeking and receiving treatment, as it also evolved.

Pivotal Moment. Each participant spoke to the evolution of their understanding and how over time, a greater ability to make sense and apply this understanding grew. While some were informed they had PTSD, others remember a pivotal moment when they realized they were experiencing significant distress and identified with it on their own. Participant 2B shared the first time he unintentionally found out about PTSD:

> I remember *Time Magazine* had this, you can Google it, and I remember on the front cover it talked about PTSD. I think it had a red cover on Time. It said, just the letters PTSD on it, and I was in a waiting room, my mom was in a doctor's appointment or something. I was home, on leave, you know? And I remember opening it up and it was like 15, like 15 symptoms of PTSD. That was like the surge, you know, the surge in Iraq was going on. I just got home from that. I was like, it was like 12 of the 15. I was looking

> at the paper. I was like, holy shit. I was like, I ... I'm doing every one of these. You know what I mean? And to be honest to you, I didn't have the time. It was non-stop, you know, I was only home maybe 60 days a year? Maybe? (personal communication, August 31, 2021)

Another challenge that emerged through the conversations was the discrepancy between the information that was being provided as psychoeducation and challenges with incorporating the information into one's understanding of their experience. Participant 1A shared his experience realizing his work in law enforcement was creating further challenges and he needed to try something different and needed help (personal communication, February 18, 2021). Participant 5E shared that he understood something was different for him but did not understand on a clinical level what PTSD was (personal communication, October 8, 2021). Participant 1A expressed, "I understood the definitions, what they told me. I understood the processes, but to actually … put it all together within oneself and say, "yeah, this is why I feel this way." Yeah, that's kind of challenging" (personal communication, February 18, 2021).

Awareness of Self and Trauma. Each participant spoke about the complexity of unraveling their experiences and creating awareness of themselves and how their traumatic experiences have impacted them. "Once you start picking up those breadcrumbs, you know, you start piecing things together slowly" (Participant 1A, personal communication, February 18, 2021). Participant 2B shared his experiences learning and working through additional childhood trauma, combat trauma, and CPTSD (personal communication, communication, August 31, 2021). Participant 4D shared:

> it brought up some of that old stuff and went into counseling, and it just brought up a lot. They said, "well, you've got PTSD, went through some heavy violence. And now you had again, some violence, physically, you know, placed upon you with PTSD." It can bring up a lot of things. (personal communication, September 3, 2021)

Individual Differences. Each participant spoke to unique differences they experienced in the military, how they identified with PTSD, and preferences for what effective treatment was to them. There was notable overlap in perceived stigma, barriers to treatment, and treatment modalities, as the CPGs reflect. The CPGs also highlight the importance of acknowledging individual differences and preferences, from a SDM model approach. Participants illustrated the importance of this approach as well. One spoke to their appreciation for a group environment among other Veterans, another valued a more peer-to-peer mentorship among other Veterans and Art therapy, another was a firm advocate for EMDR, while another loved golf and working with their individual therapist, and still another found the greatest value in trauma focused yoga.

To further press the importance of an individual approach to assessing and treating PTSD from a SDM model, participant 4D offered her experiences navigating resources, while learning about herself, and how PTSD can be expressed and evaluated differently among men and woman:

> It looked more like depression, and I was a very high performing, pleasing, skilled professional. It's really in 2011, really working through it, and seeing how, my life in some aspects … the only way I can say it, was frozen. I wasn't the person who was a bad behavior person, with a lot of dysfunctions, drinking, abuse, poor performance ... I wasn't that person. I was a very high-performing, skilled professional person. A person who was a nervous wreck at times. If somebody was going to get too close to me or a loud noise or is it going to be a night of nightmare and being, you know, very anxious about that, you know. I think everybody expects, with PTSD, to see that young guy in front of them. They don't expect to look at an older service member. So, even in their 30s, 40s, 50s, they don't go. The treatment between men and women and way men express PTSD is very, very different. And there needs to be an understanding, I think for women with PTSD, because I think it's very different between the two. (personal communication, September 3, 2021)

Noticeable Improvements in VA Systems. Participants also acknowledged an improvement both while active duty and through VA facilities over the years of seeking treatment. This was noted in what was provided through psychoeducation and treatment

modalities at the VA, as well as greater awareness and understanding of what resources were available through referrals. Participant 4D highlighted this, stating, “I would have to say it did get better and both outside of the army, getting care seeing a therapist and also inside the Army before retiring. I, my husband and I, were both receiving [care]” (personal communication, September 3, 2021).

Intentionality

The theme of intentionality emerged as participants shared their experiences with being aware of their frustrations and pushing through to find what worked for them. For many, this included going out on their own, finding books, networking with other Veterans, getting in touch with Outreach facilities, and giving back to other Veterans. It started with an acknowledgement of personal responsibility and ended with each participant finding what worked and making it their own. Each also took the opportunity to give their recommendations, based on their experiences, for the purpose of this study.

Personal Responsibility. As individuals shared the evolution of their individual understanding and healing journey, the theme of personal responsibility emerged. Participant 4D highlighted this by sharing:

> PTSD is very unique, and I think everyone, in time, comes to understand that the story of their PTSD, and understanding what’s going to work and not work, and learning to cope and manage it. People want to look for a cure and the magic pill. Things like that, and I think it’s more of accepting it and accepting responsibility. You didn’t cause it, but you do have it. And in learning too. You know? In terms of management, what works for you? And working with that, and strengthening the skills, and maturing with that, and understanding that. And I think that’s my, that’s my experience and my walk through life with it. I’ve found out things that, that work and don’t work in management of that. (personal communication, September 3, 2021)

Giving Back. The theme of giving back was also reflected by most of the participants as a meaningful part of their healing experience. The desire to help others, through sharing their

story was echoed in different ways, throughout the interviews. Many shared how their experiences shed light on other areas of need among Veterans and how they work to help others where they can. Participant 2B also reported assisting with other Outreach opportunities to serve. He explicitly shared his eagerness to participate in this study, sharing:

> I got a lot of time on the ground, a lot of injuries. So, please, please use me for the betterment of mankind, instead of the destruction. They've done a great job of sending us over but not a great job with taking care of us when I got home. So, anything that you're going to be able to do in this realm, I am 100% behind it. (Participant 2B, personal communication, August 31, 2021)

He went on to share the other areas he works to give back, both helping to de-stigmatize PTSD and give to those who are experiencing homelessness.

> I look at it this way, it's education. Like if I can't educate the civilian populous, like on the same block as me or at the park with me or like "we're not all fucking crazy, we're not all gonna go off the deep rails and shoot up the grocery story." Like, that's not us. You know, 99% of the guys were just like me. Cuz they try to find help, they try to seek help, then they hit road barriers, after road barrier, and you lose hope. (Participant 2B)

> He shared how he and his family reach out to other veterans in need:

> The homeless thing is big for me. Obviously, you just heard why. You can kind of figure that out. But there's a lot of homeless veterans out there. You can change a lot of people, a dry pair of socks and Ziploc bag, stuff like that. Honestly, a Ziploc bag, a dry pair of socks, and a peanut butter and jelly sandwich. That's one thing, you know. Feed them, put them in dry socks and inside of a Ziploc bag … it's one of my family and I's things that we do on a monthly basis. (Participant 2B, personal communication, August 31, 2021)

> Participant 5E shared his desire to continue his research in cultural differences in the military culture:

> From a cultural perspective, I think something that is interesting to me, obviously, because I really wanted to dig into culture for my own research, is as individuals leaves service. They're leaving, they're kind of getting forced out of their own culture. So, military culture and that sense of teaching unity and communal living and folks looking out for you. When folks leave, they leave that but they're still, often times, carry with them. And so, a study that I didn't do, but I think needs to be done, is this sense of cultural purpose to folks, still want to carry with them, some of their military values, they may feel as though they've been shamed by being kicked out or leaving, you know,

> they're kind of leaving their friends and their fellow soldiers behind. But then they're not quite sure how do they fit into a very individualized society and how this plays into this specific context is. It may feel as though individuals that used to have folks watching out for them. They could go to the different you know, parts of the unit and folks are always, you know, there to help them out. It doesn't necessarily feel like that. (personal communication, October 8, 2021)

Participant 3C shared his history of being a Guard Reserve, as well as a New York City police officer and firefighter during the tragedies of 9/11. He echoed the significance of teamwork and supporting each other throughout his career paths and how that further shaped effective therapy for him.

> I find some of the most satisfaction I get, is if I can help another veteran, that helps me. I mean, you know, pay it forward … that's why I served, that's why I stuck in so long. I mean, to help each other out because sometimes the bureaucracy or the leadership, whatever they're constrained or their ideology, sometimes it gets in the way. (Participant 3C, personal communication, August 31, 2021)

Recommendations. The last theme emerged predominantly from the last interview prompt and following debriefing questions. Together these reflections aimed to answer the third research question, seeking participant's thoughts on ways clinicians can learn from their experiences. Participants had advice for ways to improve the systems, detailing things that have not worked, and offered insight into what did work for them. These included the challenges with access to treatment, importance of continuity of care from active to the VA and referral to Outreach facilities, and the need for better health insurance. Some encouraged greater awareness of individual differences and cultural implications, including the military culture, and to consider these approaching effective treatment. Others stated the importance of continuously working to build a better understanding, to never stop learning, and showing you care.

Participant 2B added the challenges with access to care, which are further affected by insurance providers. "If I could be president for the day, I would take the mental health piece out of the VA, permanently. I would give every veteran coming out a Blue Cross and Blue Shield

card to seek mental health outside the VA" (Participant 2B, personal communication, August 31, 2021). Another option to this area of concern was presented by participant 1A, as he recalled hearing about the ability to find a therapist in private practice and honoring this through VA benefits (personal communication, February 18, 2021).

Multiple participants spoke of a comprehensive program that connects access for more seamless care. Participant 4D shared her recommendations:

> Build a comprehensive program with a continuity of care for veterans, with varying degrees in needs, and to meet those in the hospitals and the clinics. Through a specialized referral program, have a community of veterans that are receiving, you know, care. Comprehensive care between the active and the VA side and also making sure, we do have those financial programs in place, for your pay, for your insurance, for your education, for your health care needs, for those job needs. So, you're not a risk in being homeless, on the street, in a bad situation. A very holistic comprehensive 360 way. What's the life of this person look like? And how can we help them? And if somebody gives me one more gosh-darn, 1-800 number or ad to use, I'm going to friggin throw punches. Yeah, this needs to be a network of comprehensive system in the VA, you know, like Abraham Lincoln said, you know, let's leave no one behind. Well, they're lying all over the place. You're tripping over them. Get your frickin act together. (personal communication, September 3, 2021)

The instrumental impact of a personal approach to care was expressed by each participant. Of note, the added touch of follow-up to veterans, especially in times where world events may further be triggering was stated.

> I think maybe more follow-ups. Like what I have seen is, maybe like follow-ups that are not self-generated by myself. That periodically they can reach out more. Like, again, what's been going on in Afghanistan. I have got a lot of organizations that, and I've volunteered quite a bit too. So, they will reach out and said, you know, if anybody needs help, you know, thinking about you during these times. So, I think the follow-up is a very important one. (Participant 3C, personal communication, August 31, 2021).

This was further echoed by Participant 4D, stating,

> with everything that has recently happened with Afghanistan, they did an emergency Zoom and she checked in and you know put her eyes on everybody and said, how are you doing? And you know, and they have a psychologist online from the VA too. But very directly putting hands on people. Are you okay? How are you doing that? That's the kind

> of programming over time that's going to work. (personal communication, September 3, 2021)

The need to further build understanding regarding culture and diversity was shared by a few participants. "The military is a lot of people from other countries and cultures, those where English is not their second language. Those of other values and beliefs. It can be a very frightening thing. It can be a thing that is very humiliating and embarrassing. Especially for women" (Participant 4D, personal communication, September 3, 2021). Participant 5E shared his perspective on the need for greater cultural awareness, both within the military culture and the western medicine lens:

> Clinicians are providing heuristical diagnosis based on the paradigm of western medicine (mostly). These can be safe, effective, and efficient treatments, but may not address the root cause of symptomatology. From a practical standpoint, I strongly prefer to see a regular primary care provider (PCP) because of the culture of VA treatment facilities. When I walk into a civilian clinic, I am treated like a person who is there for treatment and examination (routine check-up, wart removal, pain analysis, etc.). When I walk into a VA clinic, I am treated like a damaged servicemember (are you suicidal?) regardless of why I am there. I am very aware that VA hospitals are clinical training grounds for medical residents (med/pharm/psyc). These are individuals cutting their teeth in the profession, thus continuing the culture of how they serve patients/clients. Improving treatment requires a different approach to how veterans are considered and treated. Ideally, reduce the redundancy of hospital systems. Allow veterans to attend whatever hospital they would like with a voucher (Much like the G.I. Bill). This would allow veterans to find a place they are comfortable, instead of a top-down hierarchical approach. (personal communication, October 8, 2021)

The importance of continuously learning, building an understanding, and working to create a personal touch to help veterans feel they are not alone was also pressed.

> I believe it is important for clinicians to go through training courses on diversity. We know that there is bias in how clinicians have historically treated African American patients (e.g., believing they have a higher pain threshold). I would imagine there are also biases towards how veterans are treated. Personal anecdotes are helpful, but I would like to see a systematic approach to providing evidence-based cultural training. This would allow clinicians to better meet veterans where they are at. (Participant 5E, personal communication, October 8, 2021)

Participant 1A further shared the need for continuing education, “just because they have that license that says they’re licensed therapists and that they were trained in one discipline, that doesn’t mean that their education is over. They have to add more tools to the toolbox” (personal communication, February 18, 2021). While participant 4D shared the significance in a personal touch, “always let them know you care and let them know you care and it’s not a, it’s not a job. You care. You’re here for a purpose. I’m sitting in front of you. I care and I want to help you. You’re not alone. People touching people” (personal communication, September 3, 2021).

CHAPTER V: DISCUSSION

Implications

Participants shared a variety of experiences over years of seeking treatment. Through time, these experiences evolved as individuals learned more about themselves, PTSD, and the resources available to them. Multiple participants reflected on the growth and quality of treatment approaches since the CPGs were published, both while on active duty and at VA facilities. Reviewing the common themes, further illustrated the complexity of the military population's experience being diagnosed, obtaining access to services, and receiving effective treatment for their PTSD.

Psychoeducation can be helpful, but not beyond the ability to relate context in relation to one's own experience. The gap between provided psychoeducation regarding PTSD and therapy options, and one's awareness and understanding as to how to apply this information, seems to still be lacking. Further, the way symptoms can be expressed uniquely within the individual, and the awareness of additional traumas that can potentially become uncovered in the process of treatment, are imperative for adequate treatment. Participants also spoke of how their understanding took time, and was built over years of experiences, and by experimenting with different treatment options. This further highlights the importance of creating a strong foundation of information that is digestible to the individual at that point in time, where they are. A foundation to further build on as their level of understanding and awareness grows.

The collaborative approach to treatment was further separated by what the therapist's understanding and skill set could potentially hinder, as well as the importance of mutual respect. This illustrated the challenges with training facilities, as young graduates are learning how to practice the basics in high acuity and high-volume sites. This has traditionally served multiple

purposes, providing care to Veterans and education to students in training. The additional concern with high turn-over rates among seasoned professionals was also expressed. For those who are already experiencing heightened challenges seeking and receiving care, these additional barriers were experienced as disrespectful and a disservice to their efforts.

There is ample evidence from each participant regarding barriers to receiving effective treatment for PTSD, in and out of the military. Sharing their stories and the stories of others they knew, highlighted the prevalence of stigma with mental health and seeking treatment. This has been further perpetuated as active-duty protocol creating a fear of being outed and/or isolated as a common practice. Plus, one faces additional concerns of losing their career and/or retirement status and future stability. This stigma which is further misconstrued to the public by inaccurate representations from Hollywood and opinions from national leaders, share a negative view of PTSD, creating fear and misunderstanding in the civilian population. This compounds distress and fear about showing any signs of distress and may reduce the likelihood of seeking help, while creating a dehumanizing sense of shame.

Frustration was a salient theme throughout. Specific topics included the limitations and outdated structure of the VA, the inadequate access or inappropriate fit with treatment, and the struggle of having to prove one is deserving of coverage and needed care. Unique challenges additionally presented themselves with the complications of COVID precautions, creating greater challenges and difficulties. While some were able to make these adjustments work for them, others faced increased isolation and felt further divided between the care they needed while working remotely. The greatest frustration being the overall failure of bringing effective treatment to those needing it, as seen by the many who are still not receiving the help they need and struggling with substance misuse, homelessness, and loss of hope.

Each participant spoke of a turning point for them and an evolving depth of understanding. Through these experiences, each shared what worked for them and what was highlighted as a recommendation for clinicians. The CPGs recommend further research to build on ways to improve reaching and provide effective treatment to service members. Beyond the areas covered in the CPGs, the last questions of the interview provided time for participants to reflect on their experience and explore their ideas for improvement. Many spoke of the significance of "paying it forward," helping other veterans, and sharing their story, as a significant piece to their own healing. They further shared recommendations for ways to help create a holistic, comprehensive approach to providing more seamless care to treatment.

Participants offered perspectives from personal and professional experiences regarding the need to improve understanding of cultural differences. The military offers a unique culture itself, while many within the military come from all over. With further consideration that a western cultural lens is applied to the assessment, diagnosis, and management of symptomology. It is important to continue to build an awareness of the unique, complex diversity within the military culture, along with serving those suffering from PTSD, learning from them, and building an understanding from their feedback. This further emphasized the need to provide a personal approach to care, reminding Veterans they are not alone, and they are heard. Participants encouraged clinicians to understand the consequences of military personnel not receiving adequate help and the emotional, mental, and physical risks this can lead to. These concerns are consistent with the ongoing statistics reported in research, outlining the risks of untreated and/or improperly treated PTSD.

Limitations and Further Research

There were notable limitations of this study. Minimal demographic information was obtained for the purpose of this study. Greater details of demographics could have potentially provided more understanding to the participant's experience and timeline of receiving treatment. Age for instance, along with more specific dates of receiving treatment, could have been informative considering developmental maturity factors. The majority of the participants were in an older age category, with earlier onset of symptoms and initiation of seeking treatment. This further spoke to who might be willing to participate in the study. While many spoke to giving back as being part of what was helpful in their healing process, this study may have provided more incentive for those at this level of healing as there was no additional incentive offered. This also provided some insight on one's willingness to seek treatment, while taking accountability and responsibility for their healing, and creating meaning over life events. This is not to say one is responsible for the events that occur and cause the distress, it is only stated to speak to one's willingness to take responsibility moving forward, which was highlighted in many participant's accounts.

Furthermore, while some were able to help create a timeline of services sought and received, these timelines were limited to memory recall. For several participants these timelines covered many years of experiences, while in and out of treatment, and often with additional traumatic experiences. Another area of limitation included the understanding of organizational structures and available resources, as it evolved over time for both clinicians and those seeking treatment. While participants were helpful in offering their understanding to what was offered at times of seeking treatment, these accounts are at times vague and limited again to memory recall. This is also limited to the participants' understanding of treatment available and access to

treatment at the time, as well as the unknown factor of knowledge and willingness to comply with the CPGs by the clinician, at the time of seeking services. The sample size is another limitation and replicating with a larger sample size would assist with greater generalizability.

Further research is recommended to explore the above stated areas. The topic of cultural differences is another area of recommended research. To echo participants 4D and 5E's concerns, there is a need for greater awareness into cultural and individual differences within the military, while assessing and treating PTSD, as well as the implications of a westernized medical model. Furthermore, the effects of military culture and gender differences, as PTSD signs and symptoms are expressed and experienced.

Recommendations

In addition to further research, this study highlighted the need to address multiple areas of perpetuating concerns. Specifically, the ongoing stigmatizing protocol within the military and misrepresentation of PTSD, further perpetuating fear and shame. It is recommended these protocols be examined further to determine if less detrimental steps can provide safety and reduce shame. Participants echoed frustrations with the dehumanizing treatment received seeking treatment, fighting to prove they deserve services, while trying to navigate the outdated systems and structures within the VA. It understandably takes time to make changes to such large systems, yet it is still recommended this be addressed. Outdated systems are not only frustrating to those seeking services, but they also often create frustrations internally. This can further create a negative environment for all and create additional barriers to those seeking and providing care. This can further impact accurate assessment and effective treatment, as well as a more manualized and less individual or even respectful approach to care.

Finally, there is a need to continue to improve the quality of psychoeducation, resources, and contacts for additional therapy modalities available. Multiple participants spoke to the value they found in outreaches, alternative modalities, and ways to work with and give back to other Veterans seeking help. These methods were reported to be highly effective in their healing process, and it is recommended that they be made more accessible to those seeking treatment. This not only furthers the bond in the military community to help reduce feeling isolated after returning home, but it also serves to help others in their path to healing. Overall, it is recommended these topics be further explored to assist in finding specific ways to improve the treatment provided to our service members in need.

Reviewing the research and shared experiences of those who participated in this study, illustrated the persistently high concern of the challenges with navigating through a multitude of barriers, stigma, and systems in place. This insight is further indebted to those who served our country, who faced reverberating challenges over many years, and who willingly and openly shared their experiences in this study. In a sense, they have 'served' again. There is now a more shared responsibility to all of us, out of immense gratitude and respect to these participants, and to all who have served, to utilize insights gleaned in this research to create more effective treatment to serve all our military personelle in need. It is the very least we can do.

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