Early Mental Health Treatment-Seeking Among U.S. National Guard Soldiers Deployed to Iraq

All U.S. Veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), including those activated from the National Guard, are eligible for free Department of Veterans Affairs (VA) health care for five years following deployment. Although a substantial proportion of OEF/OIF returnees are using VA health care, many OEF/OIF troops, particularly those with mental health problems, may not be seeking needed treatment (Hoge et al., 2004). Additionally, there have been no studies examining associations between facilitators or barriers to mental health treatment-seeking and actual care utilization among OEF/OIF soldiers or Veterans. Thus, our goals were to determine the rate of reported mental health treatment-seeking in a panel of returning OIF National Guard soldiers and to examine potential barriers to and facilitators of such treatment-seeking.

Participants were 424 U.S. National Guard soldiers recruited for a larger longitudinal project. Data for the current analyses were collected using self-report mailed surveys administered approximately 2-3 months after the soldiers’ return from a 16-month combat deployment to OIF. The outcome measure was self-reported use of VA and non-VA psychotherapy and psychiatric medication use since return from OIF (yes / no). Using Andersen’s behavioral model of health care utilization (Andersen, 1995), we assessed a range of potential predisposing (e.g. combat experiences and perceived threat, attitudes towards mental health treatment, stigma, practical barriers, overall health and in-theater injury), enabling (e.g. social support, postdeployment stressors, use of in-theater mental health services), and need (e.g. PTSD and depressive symptomology) characteristics.

Approximately one third (34.7%) of the respondents reported receiving some type of mental health services since returning from Iraq. Nearly one quarter (22.9%) of the respondents indicated they had received psychotherapy only, 4.5% indicated psychiatric medications only, and 7.3% indicated both psychotherapy and psychiatric medications. Compared to the soldiers who screened negative for PTSD, a higher percentage of 66 soldiers who screened positive for PTSD indicated that they were receiving psychotherapy (44% vs. 27%) or medications. A similar pattern was shown by the 50 soldiers who screened positive for depression. Compared to those who screened negative, a higher percentage indicated that they were receiving psychotherapy (50% vs. 28%) or medications (36% vs. 9%).

We examined unadjusted associations between the hypothesized predictor variables and reported postdeployment psychotherapy. We then conducted a forward conditional logistic regression using all significant univariate factors (receiving therapy prior to deployment, receiving therapy in-theater, higher levels of combat and perceived threat, in-theater injury, greater illness-related need [e.g. PTSD and depressive symptomology], poorer health, greater postdeployment stressors, more positive attitudes regarding mental health treatment, and negative beliefs about the efficacy of mental health treatment. Final variables independently associated with self-reported postdeployment psychotherapy included in-theater injury, positive
attitudes about mental health treatment, illness-related need, and receiving therapy in-theater, which had the strongest association.

Next, we conducted the same analyses using postdeployment psychiatric medication use. All significant univariate factors (injury in-theater, receiving therapy in-theater, receiving psychiatric medications in-theater, higher levels of combat, greater illness-related need, poorer health, greater postdeployment stressors, poor social support, and negative beliefs about the efficacy of mental health treatment) were entered into a forward conditional logistic regression. Final variables associated with self-reported psychiatric medication use included the illness-related need, in-theater injury, negative beliefs about the efficacy of mental health treatment, and use of psychiatric medication in Iraq. Having been injured in Iraq had the strongest association.

Reports of receiving mental health care appear to be higher in this panel than in a sample of active duty OIF soldiers (Hoge et al, 2004). While greater treatment-seeking may be partially due to greater need among National Guard soldiers (Milliken et al., 2007), different postdeployment environments may also play a role. Active duty component soldiers may have less time between deployments to engage in mental health services and may have greater concerns about the impact of receiving mental health care on their military career. The difference may also be due to contextual changes that have occurred in the five years since the Hoge et al. study, including the extension of VA benefits, campaigns to foster and encourage access to treatment, and an accumulation of individuals who have experienced multiple deployments. Direct comparison between National Guard and active duty troops who were deployed at the same time and who have equal access to care would be required to address this scientifically.

Attitudes regarding mental health treatment were significantly associated with both self-reported psychotherapy and medication treatment-seeking. Providing education regarding efficacious treatments for PTSD and making those treatments more widely available to returning soldiers may improve attitudes towards mental health treatment and possibly encouraged treatment-seeking. Injury in-theater was also strongly associated with both psychotherapy and medication treatment-seeking. This may be because Veterans who are presenting for physical problems resulting from an injury are more likely to be screened for mental health problems and referred for mental health care. Further, within settings such as VA medical centers in which physical and mental health services are delivered at the same location, practical barriers for receiving mental health care may be lessened once the Veteran is already accessing physical health services.

An unexpected finding was the lack of a relationship between stigma and self-reported mental health treatment-seeking. Our analyses indicate that, while concerns about stigma were present, these concerns were not associated with reported treatment-seeking behavior. This finding is tempered by the fact that the measure we used to assess stigma and barriers lacks formal validation. Future research should further examine the association between stigma and treatment seeking. Further, research should examine the quality of both treatment engagement and services because these variables are likely to be more strongly related to symptom improvement than treatment initiation alone.