BARRIERS AND FACILITATORS OF TREATMENT-SEEKING: CASE STUDIES OF FILIPINO ACTIVE DUTY SOLDIERS DIAGNOSED WITH COMBAT-RELATED PTSD

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ABSTRACT

Military personnel face mental health challenges as they are continually deployed, and oftentimes engage in actual combats. One mental health diagnosis identified from soldiers, posttraumatic stress disorder (PTSD), has escalated along with their deployment. But albeit many soldiers suffer from mental health problems, only few seek treatment. This is disturbing, because acquiring treatment is necessary for a healthy and effective workforce. To this end, studies investigated barriers and facilitators of mental health treatment-seeking, but those studies had limitations. Using a case study design, this study aims to investigate on the mental health treatment-seeking barriers and facilitators of three Filipino active duty soldiers diagnosed with combat-related PTSD. It employed data triangulation of multiple data sources from all the interviews with the participants, participants' significant others, attending nurses, and resident psychiatrist. Findings reveal two mental health treatment-seeking barriers of the participants: (a) belief about health care personnel and (b) stigma. Meanwhile, the participants' mental health treatment-seeking facilitators are as follows: (a) recognition of PTSD symptoms' severity, (b) desire to regain former self, and (c) social support. Discussion on these findings and implications for practice are provided.

Keywords: *mental health treatment-seeking barrier, mental health treatment-seeking facilitator, mental health care, military personnel, soldiers, combat-related PTSD*

INTRODUCTION

Military personnel are constantly deployed to different places in protecting a nation. They are faced with mental health challenges, as they are at a high risk of being exposed to traumatic events (e.g., war), which then may incite posttraumatic stress disorder

(PTSD). For instance, simply being deployed to Iraq or Afghanistan increases the risk for PTSD. In fact, a deployment that lasts more than 180 days increases the occurrence of PTSD by 1.11 times to 2.84 times among active duty soldiers (Shen, Arkes, Kwan, Tan, & Williams, 2010).

PTSD was one of the three major mental health diagnoses positively screened among those military personnel deployed to areas of conflict (i.e., combat areas), such as Iraq and Afghanistan. In this regard, traumatic combat exposure was one noted factor associated with heightened odds of developing PTSD (Mustillo et al., 2015). PTSD is a potentially debilitating disorder that may develop following a traumatic event. It includes symptom clusters of intrusion, avoidance, negative alterations of cognitions and mood, and alterations in arousal and reactivity (American Psychiatric Association [APA], 2013). Specifically, in relation to the post deployment mental health burden experienced by military personnel, combat-related PTSD is a diagnosis that may be developed after being exposed to traumatic event(s) in a war zone (Fragedakis & Toriello, 2014). Combat-related PTSD was previously known as *battle fatigue, combat fatigue syndrome, war zone stress*, and *shell shock* through World War I, World War II, and the Korean War, when soldiers reported to have collapse of mental and physical resources after battling in war (Nolen-Hoeksema, 2014). After a war, soldiers' mental health burden may not easily end right away, as PTSD may be a chronic disorder and can continuously be acquired long after the war has ended. In fact, a longitudinal study by Marmar et al. (2015), bares that 40 or more years after the Vietnam War, a significant number of combat veterans have exacerbating PTSD symptoms and these veterans outnumbered those whose PTSD symptoms have improved.

Surprisingly, even though combat deployments lead to prevalent mental health problems in the military personnel, soldiers of the armed forces are hesitant to initiate mental health care-seeking (Adler, Britt, Riviere, Kim, & Thomas, 2015). Many soldiers with PTSD do not seek nor receive mental health treatment (Steenkamp, Boasso, Nash, & Litz, 2014), and almost half of recently deployed soldiers do not seek mental health services as demonstrated in several studies (Hoge, Auchterlonie, & Milliken, 2006; Kehle et al., 2010; Tanielian et al., 2008).

It is also perplexing that if they do, most of them do not continue treatment after their initial referral to mental health care. This is alarming, since the military population's great need for treatment does not equate the rate of those seeking for it (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). In the Philippines, the Armed Forces of the Philippines (AFP) soldiers are also hesitant to seek treatment. In fact, they are "too shy" to even admit that they are experiencing mental health issues. That is why most of the time, these soldiers keep their problems to themselves, until such time that their behavior would be very unusual, as it appears to their troops, and that it could no longer be denied that they are indeed suffering from mental illness (G. Cariaga, personal communication, February 23, 2015).

To address soldiers' reluctance to seek mental health care, it is important to identify the determinants for mental health treatment-seeking among the military population. For purposes of discussion, *barriers* of mental health treatment-seeking are defined as the factors that dishearten the soldiers from acquiring and staying in mental health care, whereas *facilitators* of mental health treatment-seeking are factors that encourage soldiers to acquire and stay in mental health care (Acosta et al., 2014). Although a number of studies have explored on these determinants, there were some limitations. For instance, Sayer and colleagues. (2009) mentioned that most of the studies about barriers of treatment -seeking were quantitative, and provided only simple checklists that did not capture all the possible barriers experienced by soldiers. With regard to facilitators of treatment-seeking, the existing studies were mostly quantitative and, according to Zinzow, Britt, McFadden, Burnette, and Gillispie (2012), very few studies explored on the facilitators of mental health treatment-seeking in the military population, and only little research focused on active duty service members. Moreover, Kim, Thomas, Wilk, Castro and Hoge (2010) recommended continuous efforts in the access of mental health care to active duty soldiers, since there is greater stigma among them than among National Guard soldiers. Doing this shall help them recover from their wounds from war. Sayer and colleagues (2009) also recommended that future studies investigate more on the facilitators for initiating PTSD treatment-seeking among soldiers, including interviewing some of the clients' family members, and other key informants.

In determining the factors connected to soldiers' seeking mental health treatment, it is helpful to look at the *behavioral model of health service use* that postulates predisposing, enabling, and need factors. *Predisposing factors* are those that exist in an individual before the onset of his illness (e.g., demographics, social structural characteristics, and health beliefs), and make the individual more likely to seek health care. *Enabling factors* are the resources that may allow or deter an individual to acquire health services (e.g., income, health insurance, and number of health facilities and personnel). *Need factors* refer to the individual's need for health services, because of his perceived illness, or his illness (i.e., diagnosis) as evaluated by a health care personnel (Anderson &Newman, 1973).

One of the barriers that dissuade the military personnel to seek mental health services is *stigma*. In fact, it was evident that compared to those without any diagnoses, soldiers with PTSD symptoms endorsed stigmatizing beliefs about mental health care, such as 'it would be too embarrassing' (Iversen et al., 2011). Further, the model of stigmatization explains that when soldiers develop PTSD, they may experience societal stigma, wherein other soldiers may prevent being close to those known to have mental health problems. When soldiers with PTSD internalize such stigmatizing behaviors of their troops, they then develop self-stigma. Because self-stigma makes soldiers internalize the negative beliefs of the public, they develop low self-esteem. They are then now unlikely to seek mental health care (Greene-Shortridge, Britt, & Castro, 2007). In fact, soldiers fear that they may be seen as weak. They are also concerned that they may be viewed negatively by their unit leaders, that their comrades may have low regard for them, and that their careers may be badly affected (Britt, 2000; Hoge et al., 2004; Kim et al., 2010). There are also *practical barriers* that impede soldiers to seek treatment. These include having no time to go to a health care facility, having problems in terms of scheduling an appointment, and lack of financial resources (Hoge et al., 2004; Kim, Britt, Klocko, Riviere, & Adler, 2011). Other barriers to care include the beliefs of soldiers that their illness is not that severe to seek treatment for PTSD, and that they can manage the illness on their own (Hoge et al., 2014). Beliefs toward mental health treatment, such as health care providers may not understand them, treatment may not make them well, and that medicines may have detrimental side effects, also hinder soldiers to acquire treatment (Hoge et al., 2004; Kim et al., 2011; Sayer et al.,2009).

To overcome these barriers, it is important to know and understand the facilitators of mental health treatment-seeking. By doing so, the exigency of treating soldiers at the onset of their mental illness—which becomes a simultaneous dilemma, as long as barriers to care remain unresolved—shall also be addressed. Few studies have explored mental health care treatment-seeking facilitators. For example, active duty soldiers who felt that their military units were intact, and their leaders proficient, were more unlikely to be stigmatized about mental health care, and to communicate regarding practical barriers to care (Wright et al., 2009). Another study (Britt, Wright, & Moore, 2012) argued that non-commissioned officer leaders, rather than commissioned officer leaders, strongly predicts soldiers' stigma and barriers to care. Specifically, higher levels of non-commissioned officer leaders' positive behaviors lead to lower practical barriers, and higher levels of non-commissioned officer leaders' negative behaviors lead to higher stigma among the service members. Other facilitators of treatment seeking were explored by Fikretoglu, Brunet, Schmitz, Guay, and Pedlar (2006). In their study, having multiple types of trauma, cumulative trauma exposure, and greater PTSD interference to one's functioning, increases the likelihood of treatment-seeking. Also, married and lower-income earning soldiers are more likely to seek treatment than those single and higher-income earning soldiers. In one study that sampled 174 treatment-seeking veterans (Elhai et al., 2007), a history of inpatient mental health treatment use, but not PTSD symptom severity, was found to be associated with future procurement of mental health care. Meanwhile, a qualitative study on 44 Vietnam and Operation Enduring Freedom/Operation Iraqi Freedom veterans by Sayer and colleagues (2009) suggests that soldiers' perception about their mental illness, soldiers' feelings that health care providers can be trusted, and that the treatment may be helpful, may facilitate treatment-seeking.

With the aforementioned recommendations for future research and the evidence from previous studies, the study aims to investigate the mental health treatment-seeking barriers and facilitators of three active duty soldiers diagnosed with combat-related PTSD. To the authors' knowledge, this is the first peer-reviewed study with Filipino soldiers and their mental health treatment-seeking barriers and facilitators.

This study is also part of a bigger study that aimed to develop and implement a novel and tailor-made psychotherapy for the participant-soldiers (Fajarito & De Guzman, submitted for publication). Further, this study contributes to the scarcity of qualitative studies about the determinants of mental health treatment-seeking, as well as the scarce research done on mental health treatment-seeking facilitators, especially in active duty military personnel and soldiers diagnosed with PTSD.

METHOD

Study Design

The approach for this research involves a qualitative one that uses the case study methodology. Qualitative case study enables the researcher to explore a phenomenon within its context using multiple sources of data. As the researcher employs a variety of data, a guarantee is built that the issue being explored has not been understood through one lens alone, but rather through different lenses that reveal an understanding of the multiple facets of the phenomenon (Baxter & Jack, 2008).

Further, a case study is executed within the boundaries of one social system (the case), or within the boundaries of few social systems (the cases), such as people. The phenomenon should occur in the case's natural context by gathering information during a certain period (Swanborn, 2010). Hence, case studies are often useful to examine atypical, extreme, or significant events. And in circumstances where events are complex and dynamic, a researcher may opt to use a case study approach. As such, an in depth-investigation may ensue (Yin, 2003).

To add rigor to the study and take the opportunity of gathering data from various sources that characterize a case study, multiple data sources were applied, which included: a) interviews with the participants, b) interviews with the participants' significant others, c) interviews with attending nurse per participant, and d) interviews with the resident psychiatrist. Additionally, PTSD assessments were used to validate the PTSD diagnoses of the participants.

Participants and Sampling Technique

Participants were purposively sampled. As a result, only three met the inclusion criteria. The participants were three Filipino male active duty soldiers diagnosed with PTSD. Two were confined at the Psychiatry ward of the Armed Forces of the Philippine Medical Center (AFPMC) and one at the Heroes ward of AFPMC. Inclusion criteria include: a) having combat-related PTSD diagnosis, b) aged 18 and above, c) understands English and Filipino language, and d) currently seeking inpatient treatment in a mental health facility. Exclusion criteria include: a) having any comorbid disorder, and b) having any brain injury and psychosis that would disallow them to answer the PTSD assessments and participate in the interviews.

Procedures

The study was approved by the Ethics Review Board Committee of AFPMC. The participants, significant others, nurses, and the resident psychiatrist gave their written consents to participate in the study. The rules in the Psychiatry ward pertaining to the specific schedules wherein their patients may be assessed and/or interviewed were considered. Moreover, anytime that a specific schedule became inconvenient for the participant (e.g., he wanted to have some more time to watch television), or anytime that a participant's significant other might suddenly not be available at the time that the interview schedule should already begin (e.g., the family member went out of the hospital to run unexpected urgent errands), the assessment and/or interview was then rescheduled. The first author—who does not have any existing conflict of interest with the participants (i.e., the first author is neither affiliated with AFPMC nor worked with the participants prior to the study)—gave the PTSD assessments to the participants to validate their PTSD diagnosis and to ensure that their PTSD was combat-related. After having validated their combat-related PTSD diagnosis, the first author individually interviewed the participants and then the key informants. Each interview lasted from 1 to 1.5 hours and was done for around three times per participant and per key informant. The first author read the interview questions to each participant and key informant (only on the day of the scheduled interview), audio-recorded the interviews, and transcribed them verbatim.

Instruments

For purposes of discussion, index trauma is defined as the Criterion A of the diagnostic criteria for PTSD. To validate the PTSD diagnosis of the participant-soldiers, and to identify if their index trauma was combat-related, the following measures were administered: Clinician-Administered PTSD Scale (CAPS-5), Life Events Checklist (LEC-5), Trauma Symptom Inventory (TSI), and Harvard Trauma Questionnaire (HTQ). Semi-structured interview schedules were given to the participants and the key informants with regard to the participants' perceived barriers and facilitators of mental health treatment-seeking. Open-ended questions with regard to what made the participants not seek mental health treatment before, and what finally led them to initiate seeking mental health treatment, were employed.

Data Analysis

In the process of the analysis, data from all the multiple sources were collected and integrated (instead of dealing with the data individually) to holistically understand the phenomenon under study. Such data convergence creates strong findings, as varied data from multiple sources are combined to achieve a more valuable understanding of the case (Baxter & Jack, 2008). Open coding, and axial/analytical coding were done, as well as within-case and cross-case analyses. These generated conceptual categories or themes. Member checks or respondent validation were also conducted by the researcher, wherein feedbacks with regard to the findings of the study were solicited from the participants.

Ensuring Trustworthiness of the Case Study

To sustain data credibility or "truth value" of the study, three strategies were carried out. First, data sources were triangulated, and evidences from multiple sources of data were corroborated to strengthen internal validity of the study. Second, rapport was established first before the conduct of interviews to avoid the possibility that participants would respond in a socially desirable way. Third, member checking was done after the data analysis.

Findings

The findings of this study shall be presented through case reports that would also reflect the summary of the participants' accounts with regard to their barriers and facilitators of mental health treatment-seeking. Data analyses reveal that the treatment-seeking barriers the participants had were: (a) beliefs about health care personnel and (b) stigma. Their treatment-seeking facilitators, on the other hand, were: (a) recognition of PTSD symptoms' severity, (b) desire to regain former selves, and (c) social support. The case reports shown below present their unique presentations of their barriers and facilitators of mental health treatment-seeking. At the same time, the case reports reveal how these determinants of mental health care-seeking hold true for all the cases. Client 1, Client 2, and Client 3 were used as the names of the participant-soldiers to provide anonymity of their identities.

Case Reports

Client 1

A married, 28-year-old Private First Class Army soldier was admitted to the Armed Forces of the Philippines Medical Center (AFPMC) Psychiatry ward with the diagnosis of PTSD. He hails from Mindanao and is a Roman Catholic. He had low socioeconomic status, and had college-level educational attainment. He had been serving the Philippine Army for eight years, and had four war encounters at the time of the data gathering. His index trauma was a close encounter with the Abu Sayyaf Group (ASG) terrorists. The barrier to care of the client was ***'belief about the health care personnel':***

> I did not want to seek treatment before, because I felt that I could no longer trust others, like the doctors or the nurses at the hospital… I could not trust them… They might also give me medicines that might poison me… I wanted to just go home and be with my wife and son… I just wanted to stay at home… Seeking for treatment never occurred to me…

The client's wife relayed:

> He did not want to talk about what had happened to him, except with me… He was suspicious about others' intentions… that's why he did not like to be treated by doctors and nurses... He had doubts about them…

However, during his stay at home, he realized that he was no longer the same father and husband that he used to be. He noticed that his condition was affecting his daily functioning already. He then thought of seeking treatment already. His first facilitator was ***'recognition of PTSD symptoms' severity':***

> I no longer mingle with my wife and son, the way I did before… I do not look after my hygiene…I lock myself in my room even during family reunions… I love my wife, but I suspected her to be conniving with the ASGs… I held knives at night in fear that enemies might arrive… even if I was beside my wife and son at bedtime…I would ask them both to drop and hide whenever there were thunderstorms as I thought it was war again… They got afraid of me... It was terrible… I knew then that something was wrong with me… I decided I need to be treated already…

The client's wife also shared that the client was recognizing the impact of PTSD on his daily functioning:

> One instance, in the middle of the night, when I was still awake because he was still holding knives, he asked me worriedly, 'Why can't I sleep?... How come no matter how hard I try, I cannot sleep?... This is no longer normal…'

Besides recognizing his PTSD symptoms, the client had another treatment-seeking facilitator, ***'desire to regain former self':***

> I would like to be the father and husband that I was before… We go out and do our usual bonding activities… take a shower, go to the market, shop together, eat together… When we go home, we play with our dog, we run around the garage of our house… We were so happy… I can play with my son all day even at the garage or inside the house with the windows and doors open… But with my condition, I can see how my wife and son are sad as well, because I can no longer do those things with them again… I want to recover and be my old self…

In wanting to regain his former self, he also wanted to be the soldier that he was:

> I am proud to be a soldier… It is a challenging job… But I feel I am already different… I no longer have the morale that I used to have… I want to be cured so I can go back to my unit fully recovered already… so that I may function well already and not cause harm to my comrades… If I go back there untreated, I might kill my comrades unintentionally, because of my condition… I do not like that to happen…

The third facilitator the client had was ***'social support'*** in the midst of him having PTSD:

> My wife never left me even though I was acting very different already… Even though I suspected her to be conniving with the ASGs… She continued to understand and love me… She said there was nothing wrong with seeking treatment… My commanding officer (CO) also said that I needed to take some time off from work…

Client 2

A single, 29-year-old Private First Class Army soldier was a battle casualty and admitted to the AFPMC Heroes ward due to injuries of fractured leg and blinded eye, and not because of PTSD. In looking for another participant in different wards of the AFPMC (since only two were found in the Psychiatry ward), the first author met a patient from the

Heroes ward, who became Client 2, since he was diagnosed by the first author to have combat-related PTSD, and later gave his written consent to participate in the study. To remove bias on the diagnosis, the resident psychiatrist of the AFPMC Psychiatry ward validated the first author's diagnosis on Client 2.

Client 2 hails from Luzon and is a Roman Catholic from low socioeconomic status, and with a college-level educational attainment. At the time of the data gathering, he had already served the Philippine Army for eight years and had 10 war encounters. He had a history of gunshot wounds in 2011 and 2015. From his index trauma of war encounter and ambush through a landmine explosion in 2015, he acquired several injuries, such as blinded eye, fractured leg, disfigured mouth and tongue, among others. During his confinement at the Heroes ward, the nurses already noticed that he might need mental health treatment. At first, he did not like to be referred to the Psychiatry ward because of ***'stigma'***, his barrier to care:

> Yes, I know the Psychiatry ward here… I can see it from here (pointing to his room's window from his hospital bed)… It looks like it is just for those soldiers who went crazy already… Those who went amok and could no longer be talked with …

His sister, who was tending to him at the hospital, added:

> Sometimes we hear and see those soldiers who are being admitted there, since we can easily see the ward from the window… One time we saw a soldier shouting and saying incomprehensible words. He was in a hospital bed and was being brought inside the ward… My brother and I perceived that the soldiers being referred there (Psychiatry ward) had gone crazy already…

Despite this barrier called 'stigma', the time came when the client discerned that he needed to seek treatment already. This occurred to him through his first facilitator, ***'recognition of PTSD symptoms'*** severity':

> I am always sad… I always feel guilty about my comrade's death… I am angry, ashamed, and guilty… I could no longer sleep… If I sleep, I would have nightmares… I tried to cope, but it's too difficult… Helping myself is not enough… I realized I need help, too…

His nurse shared:

> Sometimes, he would always talk about his friend who died… Then he will be teary-eyed… He often lacked sleep…He looks like he is thinking of something very deeply… Because of his condition, he agreed to the idea of seeking help already…

Besides realizing the severity of his PTSD symptoms, the client had ***'desire to regain former self'***, his second facilitator:

> I miss those times I can joke around and mingle with people around me… Now it's different… I no longer had the urge to do those things… I just wanted to be in my room… But I wanted to bring back that energy and vibrancy in me before… The way I bring life in a group of comrades or with people close to me… The way I was with my family… not this way of being irritable or moody…

In yearning to bring back his previous self, the client also expressed how he wanted to return to how he was before as a soldier:

> I am proud of being a soldier... Having all these wounds meant that I defended our country for a greater cause… My injuries as a battle casualty were because of my commitment to my work… However, I want to recover soon so I can go attend military school, have promotions and achievements as a soldier…I can never have those things without getting well… I will also regain my morale then… Yes, I provide for my family, but it feels a lot different if I provide for them while I am well already…

His nurse and psychiatrist added:

> Sometimes he would talk about the combat wars he had been through… He expresses the desire to be able to get well soon so he can do his duties and responsibilities again as a solider…

Besides these facilitators, social support also encouraged the client to seek help. His sister expressed his third facilitator, ***'social support'***:

> The nurses here are friendly and caring to him… They acknowledged the pain and sacrifice my brother bestowed during the war… At the same time, they always encourage him that he would get well soon… And that he should seek treatment…

The client described:

> My family expressed their care for me… My sister did not go to work anymore to tend to my needs…My officer visited me. He cried and even fed me like a little child… Some comrades visited or rang me to make sure I was alright... They understood what I was going through and they never let me feel that I am crazy or something… They all encouraged me to recover in ways that I can do… It made me think that seeking treatment is not for crazy people after all…

Client 3

A married, 45-year-old Corporal Army soldier was admitted to AFPMC Psychiatry ward as having PTSD diagnosis. Client 3 hails from Mindanao and is a member of an indigenous group, whose recognized religion is Palen. He was of socioeconomic status, and a high school graduate. He had served the Philippine Army for 14 years and had 18 war encounters at the time of the date gathering. He had three index traumas: a) an 11-day intermittent war encounter with ASGs in 2005, b) an ambush through a landmine explosion that led to their vehicle toppling down in 2008, and c) a war encounter with the ASGs in 2015.

He expressed his treatment-seeking barrier, 'stigma':

> I never thought of seeking treatment before, because unlike other soldiers, people can still talk to me… I still know what I am doing or talking about… It is just for those soldiers who have gone wild or crazy…

The nurses and psychiatrist added:

> Usually soldiers are afraid to be admitted here, because they will be called crazy by their other troops in their unit… The stigma is there… When they are admitted here, sometimes others would see them as weak or incapable soldiers… Also, sometimes they believe that the medicines we give would make them worse, or that the medicines are for crazy ones…

Nevertheless, the client became willing to seek treatment already, because of his first facilitator, ***'recognition of PTSD symptoms' severity'*:**

> It came to a point where I already told my officer that I needed to be treated for my condition… I got worried, because I knew it was no longer normal to always feel nervous even if I should not be… I could no longer work… I was having negative thoughts… I was always tense…

The desire to return to his previous functioning also dawned on him. He described his second facilitator, **'desire to regain former self':**

> Before, my wife and I used to be happy always… I would also drive my motorcycle without any fear and take her for a ride… We would go to the farm with our son… We would also cook together… But because of my condition, sometimes I feel disinterested even in the intimacy between us, even though I know I love her… I wanted to recover so I can be the way I was before to my wife and to my family…

In his eagerness to bring back his previous self, the client also had the longing to do soldiers' tasks and activities the way he was able to do before:

> I wanted to recover, because I want to be physically and mentally fit again, just like before… I want to have the energy I had before… I jogged, I was strong, I was not ashamed of myself, I had the morale of a soldier… I also wanted to be able to mingle with my troops again, as a fully recovered soldier…

His wife shared:

> He decided to seek treatment, because not only did he recognize the impact of his trauma to his functioning, but he also wanted to recover to be able to return to his work and provide a good future for his son, whom he loves so much.

His nurse and psychiatrist also added:

> He would always mention to us his intention to get better soon so that he could go home, be with his family, and return to work already.

Besides these facilitators, the client had **'social support'**, his third facilitator. His wife narrated:

> I told him it is alright if he gets treatment and if the hospital is far away from us… What is important is for him to get well soon…

The client expressed:

> My wife has always been there for me… She understood why I was already different… She did not leave me… She has faith that I would return to my previous functioning and get better…

DISCUSSION

The study aimed to identify the barriers and facilitators of mental health treatment-seeking of three Filipino male active duty soldiers diagnosed with combat-related PTSD. The treatment-seeking barriers of the participant-soldiers illustrate how they can be held back from seeking help, and how their treatment-seeking facilitators can embolden them into acquiring and staying in mental health care.

One of the treatment-seeking barriers of the participant-soldiers was the *belief about health care personnel.* Because having PTSD would sometimes affect how the client would trust another, as negative belief about others is one of the core symptoms of PTSD, trusting the health care personnel would sometimes be a struggle. As a result, soldiers may not also easily welcome medicines. According to McLean, Yeh, Rosenfield, and Foa (2015), distrust towards other people is one of the negative beliefs associated with PTSD symptoms and is known to maintain PTSD. Given that distrust towards health care providers is a barrier, it may be overcome if providers would approach the soldiers with respect. In the study of Butler, Linn, Meeker, McClain-Meeder, and Nochajski (2015), the approach to a soldier by a health care provider influences how the soldier would feel as a client. This means that clients feel they are respected when the practitioners recognize their unique military identities and experiences, treat them with compassion and care, and be interested in helping them recover. Hence, the barrier to care, such as mistrust, is invalidated and the client may pursue his initiation to seek treatment.

Another treatment-seeking barrier of the participant-soldiers was *stigma.* Participants had the belief that those being admitted in the psychiatry ward are those that had gone crazy. This is consistent with the literature on care-seeking barriers (Sayer et al., 2009; Sharp et al., 2015; Zinzow et al., 2013). Soldiers perceived that being crazy and weak are both equivalent to being diagnosed with a mental illness (Zinzow et al., 2013), and that soldiers who are severely disturbed or perceived as crazy are the only ones who need mental health treatment (Sayer et al., 2009). These stigmatizing beliefs may have been ingrained already among soldiers who have indirectly learned the masculine culture, beliefs, and behaviors in the military since the start of their military training (Sharp et al., 2015).

And if service members incurred PTSD, like the participants in this study, these stigmatizing beliefs then become amplified. This is because the negative belief in oneself, and negative emotions (such as shame) are hallmark symptoms of PTSD. These PTSD symptoms may then influence the intensity of probable barriers of seeking mental health treatment.

Nevertheless, even though there were barriers of mental health care, participant-soldiers still sought help because of their treatment-seeking facilitators. First, they realized the severity of their PTSD symptoms. This is parallel with the findings of Zinzowet al. (2013) wherein soldiers thought that symptoms would warrant treatment only if they reached the highest point of severity.

Another facilitator of mental health treatment-seeking of the participants had was the desire to regain their previous normal functioning. Interestingly, the clients' *desire to regain their former selves* mainly included a compelling reason to recover for (a) their families, and (b) their profession as soldiers. Their previous positive experiences of being a good father and a husband, or a son, flashed back to their senses. Their previous morale as a soldier, especially during the time when they garnered achievements, and other positive challenging military experiences, also emerged as an underlying factor of their yearning to return to their old selves.

It is salient from the accounts of the participant-soldiers that their families became witnesses to their PTSD symptoms and, despite of their condition, their families still loved and accepted them. The love and understanding of their families in the midst of their extreme PTSD symptoms made the participants recognize and accept the severity of their condition. At the same time, it made them have the motivation to regain their previous functioning. The urge of giving back to their families developed, too. They wanted to be able to once again perform their duties and responsibilities as a father, a husband, or a brother to their families. According to Zinzow et al., one of the care-seeking facilitators of soldiers is to become "better" for their families. Further, the Filipino *stereotypic or ideal masculine trait* of being dependable (Chruch & Katigbak, 2000) can be depicted from the

participant-soldiers, who wanted to continuously provide and become better for their families. Participant-soldiers also had the Filipino value of *pagiging maka-pamilya* (being family-centered) (Andres & Ilada Andres, 1986), because they wanted to recover and return to their former selves with intact overall functioning, not for themselves alone, but for the benefit of their families as well. In this regard, a Filipino value called, *utang-na-loob* (gratitude/solidarity) (Enriquez, 1977), can be portrayed from the behavior of the participant-soldiers, as they are very thankful for the love and acceptance that their families have shown them through the latter's *social support,* which also became their treatment-seeking facilitator and shall be expounded later in this discussion.

The desire of the participant-soldiers to regain their previous occupational functioning as soldiers was also striking in this research. It might have been instilled already in the minds of the soldiers that when they entered the military, they should remain to be committed to their profession even until they are out of service already. Being a soldier gives them a sense of pride and honor, and upholding the warrior ethos, a part of the military culture, has been their pledge already. Hence, the warrior ethos may have already been marked in their identities, and deviating from such identity may make them feel not being one with the military. All these factors may have been intrinsic rewards for them in the military. And such intrinsic rewards motivate them to regain their previous functioning of being the soldiers that they were, or better soldiers than before. In this desire of regaining their former selves, they realized that they needed to seek treatment. As Redmond et al. (2015) contested, the instilling of warrior ethos goes along with the encouragement to service members to be: persevering, responsible for other people, able to make trade-offs, adapt, and depend on others. In a similar vein, Kuehner (2013) argued that the Army core values of loyalty, duty, respect, selfless service, honor, integrity, and personal courage are taught to the soldiers to be maintained in their values and behaviors for the duration of their service and beyond.

Further, as Filipinos, participant-soldiers felt that they had lost their *dangal* (honor from within) when they had PTSD, and through their facilitator of *desire to regain former self,* they wanted to regain the feeling of having that *dangal.*

In Filipino language, *dangal* is honor from within (Salazar, 1985b). In the case of the participant-soldiers, this means that even without the extrinsic achievements they receive from the military, they can still have a sense of their true worth that permeates within them. However, this *dangal* might have been lost from the time they had PTSD, because their PTSD symptoms included having low morale as soldiers, and negative belief about themselves. And then, through their facilitator of treatment-seeking, *desire to regain former self,* they believed that they can still regain that previous feeling of *dangal*, which they had when they did not have PTSD yet. The Filipino value of *pagtugon sa pananagutan* (social justice) (Chua & Nazareno, 1992) was also evident from the participant-soldiers because they want to become fully functioning soldiers again so that they can once again do their duties and responsibilities as Filipino soldiers for the benefit and good of the whole Filipino society.

Support from the participants' social networks also encouraged them to seek treatment. Family, friends, and officers showed their compassion towards them. Such approach of acceptance and compassion made clients conquer the stigma they had. It gave them hope towards recovery. This is similar with the argument of Cloitre, Jackson, and Schmidt (2016), which states that positive support from social networks helps facilitate the recovery in PTSD. Hence, if this is the case, social support is a facilitator that initiates mental health treatment-seeking in soldiers towards recovery. This is consistent with the literature, which states that social support, usually from the soldier's spouse (Zinzow et al., 2013; Chase, McMahon, & Winch, 2016) is the strongest facilitator towards receiving treatment (Chase et al., 2016) Moreover, besides support from family, friends, and comrades, leadership support proves a critical facilitator, as well (Zinzow et al., 2013).

In the context of Filipino culture, besides the Filipino value of *pagiging maka-pamilya* (family-centered) (Andres & Ilada Andres, 1986), a sense of security emanates from the support that comes from a family, and that the family is considered a source of emotional support (Medina, 1991). This suggests that the social support coming from their immediate families gave the participant-soldiers a reason to move forward and initiate seeking help, most especially that their families let them feel that it is all right to seek treatment.

In terms of the support the participant-soldiers received from their troops, the Filipino value of *kapwa* (shared identity) can be portrayed. According to Enriquez (1978, 1992, 1994), *kapwa* is at the heart of Filipino values and is understood as an "inner self shared with others." In *pakikipagkapwa*, a person is regarded as a fellow human being or *kapwa*, and can be placed in the category of *hindi-ibang-tao* ("one of us") (Enriquez, 1978, 1994). This research also notes that *stigma* is a barrier of treatment-seeking, and that having a mental disorder makes a soldier feel a failure in his own military environment that exudes a masculine culture, has been noted. Consequently, receiving support from fellow troops—whom they consider as their "biological brothers"—and being regarded as *kapwa* and *hindi-ibang-tao* is a strong factor which can indeed facilitate them into seeking and remaining in mental health care. This kind of support makes them feel that they are not any lesser soldiers, and that they are still respected and honored the way they were treated before having PTSD.

It is noteworthy to know the limitations of this study. First, the type of mental health problem the participants had was combat-related PTSD. The participants were enlisted military personnel and they all came from the army branch of military service. The types of treatment-seeking barriers and facilitators may be different when it comes to other types of PTSD, non-enlisted personnel, and other military service branches. This may be due to the fact that the air force, navy, and marine corps have their own unique sets of military ethos that may be taken into consideration when evaluating the emergence of treatment-seeking barriers and facilitators. Second, the interviews were all based on retrospective accounts of the participants and the key informants, which may have biases. Third, the participants were all confined at the AFPMC, two from the Psychiatry ward and one from the Heroes ward. As such, treatment-seeking barriers and facilitators may be different with outpatient participants. Fourth, the limited number of participants limits the generalization of findings. Given these limitations, future studies may include participants with a different type of PTSD, non-enlisted military personnel, soldiers from different branches of the military service, and those who utilize outpatient health services. Moreover, future studies may further explore the current study's findings and may use varying methodologies, specifically quantitative as well as qualitative, to explore the said phenomena.

Notwithstanding the aforementioned limitations, the study has its strengths. First, case study design was utilized to allow data triangulation or corroboration of evidences from multiple perspectives. This reveals a holistic understanding of the phenomenon being studied. Second, the type of PTSD investigated in unravelling treatment-seeking barriers and facilitators was combat-related PTSD in active duty soldiers. Studies about mental health treatment-seeking facilitators in active duty soldiers with PTSD are scant, hence, making this study significant in contributing to existing literature. Third, the study is qualitative. It provides rich descriptions and understanding of the phenomena. Also, the findings give an analytic generalization to other settings in the military, where soldiers experience the same type of mental health treatment-seeking barriers and facilitators determined in the study. Fourth, the biggest branch of military service is the army.

The quantity of soldiers being deployed, and later on incurring combat-related PTSD, may benefit from the experiences of the study's participants, who were not defeated by their treatment-seeking barriers. And fifth, the findings provide guidelines to military units and health care personnel on how to handle the emergence of mental health problems of their soldiers, especially combat-related PTSD. The findings also suggest the approaches military units and health care providers may apply to encourage mental health treatment-seeking among soldiers.

Having determined that some PTSD symptoms might influence or augment mental health treatment-seeking barriers, it is pertinent that soldiers be given psychoeducation on the nature of PTSD and mental health treatment-seeking (Gould, Greenberg, & Hetherton, 2007). Labelling, such as using the word 'crazy' towards others, should be restricted in the military units, because it reinforces societal stigma and leads to anticipated stigma. Health care providers should also advocate an approach of mindful respect and empathic listening to whatever clients' conditions may be, to encourage mental health treatment-seeking. Being so, trust towards health care personnel may be cultivated. In this regard, it is suggested that health care providers strive to not only understand the clients' military culture and index traumas (Fajarito &De Guzman, in press; Fajarito & DeGuzman, submitted for publication), and clients' risk factors for combat-related PTSD

(Fajarito &De Guzman, submitted for publication), but also clients' culture in terms of their nationality.

In instances where indigenous methods towards care may be warranted, like in the case of the current study where Filipino soldiers were the participants, it will be helpful to express the Filipino value of *pakikiramdam* (sensitivity) (Mataragnon, 1987) and *alalay* (assistance) (Decenteceo, 1999) in relating to soldier-clients. In *pakikiramdam*, a health care professional becomes highly aware and sensitive to the feelings and situation of another person, hence, it was defined as "feeling for another" (Mataragnon, 1987). This value includes being carefully sensitive to nonverbal behavior (Mataragnon, 1987), a type of behavior typical in Filipinos, since Filipinos sometimes have their intricate ways of indirectly communicating through euphemisms, body language, and voice intonations (Maggay, 2002; Mataragnon, 1987). Related to *pakikiramdam* is *alalay*, which entails a caring attitude by guiding and empathizing with clients, without having to own clients' problems, hence it means "moving together with another person" (Decenteceo, 1999).Further, at the core of any relational aspect is *tao* (human person) or the "belief in the dignity and worth of a human person." Tao is a fundamental principle in indigenous Filipino culture and values. Applying the concept of *tao* empowers people—especially distressed clients—to believe that even though they have lost their self-esteem, they are still worthy to be respected and regarded with dignity, because they are indeed *tao* (Jocano, 2001).

Military units should also allow easy access to mental health care services and provide early treatment to those having probable PTSD symptoms, or other mental health issues. This ensures encouragement of treatment-seeking. Furthermore, families, fellow comrades—most especially if the participants' culture comes from a collectivist society—as well as the soldiers' career, may be regarded as soldiers' positive resources. Capitalizing positively on these resources may not only buffer them from combat stress, but may encourage them more to seek treatment once they have mental health challenges. The support from social networks, such as families, friends, and military officers, should be continuously fostered to strengthen the initiation to seek and continue treatment towards full recovery.

Importantly, given that one of the symptom clusters of PTSD is avoidance of trauma-related stimuli (APA, 2013), it should then be understood that soldiers may have a treatment-seeking barrier, such as avoiding treatment in fear that their trauma-related negative thoughts and emotions may be triggered in the process (Sayer et al., 2009). Clinicians should pay careful attention to this fact that the presence of even just this barrier may detrimentally affect the will of a soldier to seek help. Hence, clinicians should always be cognizant of soldiers' mental health treatment-seeking facilitators, so that there would be avenues to encourage soldiers to initiate seeking treatment. Such facilitators may not only help them initiate accessing mental health care, but may also be a pathway for them to continue getting treatment until they recover to their overall normal functioning. Facilitators of mental health care may also possibly remove the stigma that they have with their condition of having PTSD.

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