Understanding Barriers to Mental Health Care for Recent War Veterans Through Photovoice

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Abstract

Despite an urgent need for mental health care among U.S. service members returning from deployments to Iraq and Afghanistan, many veterans do not receive timely or adequate treatment. We used photovoice methods to engage veterans in identifying barriers to utilizing mental health services. Veterans described how key aspects of military culture and identity, highly adaptive during deployment, can deter help-seeking behavior and hinder recovery. Veterans' photographs highlighted how mental health symptoms and self-coping strategies operated as barriers to care. Many veterans' photos and stories revealed how negative health care encounters contributed to avoidance and abandonment of treatment; some veterans described these experiences as re-traumatizing. Visual methods can be a powerful tool for engaging recent war veterans in research. In particular, community-based participatory research approaches, which have rarely been used with veterans, hold great promise for informing effective interventions to improve access and enhance provision of patient-centered care for veterans.

Photovoice is an approach to using visual data in qualitative health research, where participants' photographs and descriptions of their photographs facilitate discussion of potentially difficult or sensitive topics and provide the foundation for shared knowledge-building (Padgett, Smith, Derejko, Henwood, & Tiderington, 2013; Wang, Cash, & Powers, 2000). Photovoice methods reflect core tenets of community-based participatory research (CBPR), including a commitment to empowerment of participants and balancing research with action, and have been gaining traction as an effective means to address a variety of public health concerns (Baker & Wang, 2006; Cabassa et al., 2012; Wang et al., 2000). By stimulating dialogue, photovoice enables participants to convey their worldviews and experiences to multiple audiences and to advocate for themselves and others in their community (Carlson, Engebretson, & Chamberlain, 2006). The increasing inclusion of photovoice and other visual-narrative research methods in health research stems from an appreciation of how subjective views and experiences shape people's conceptions of health and impact their treatment-seeking behaviors (Rigg, Cook, & Murphy, 2014).

In this article, we report on findings from a photovoice project with veterans who served in Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), with a focus on extending current understandings of veterans' perspectives and attitudes toward seeking and engaging in mental health care. Our research objectives were to use photovoice methods to (a) further explore barriers to mental health care identified in previous studies that used more traditional quantitative research methods and (b) generate suggestions for improving patient-centered post-deployment care that are informed by real-world experiences of veterans.

This work is part of a larger CBPR study, in which we collaborated with a group of OEF-OIF veterans to help them communicate their experiences and views to health care providers and policymakers around four broad issues: the impact of military service and deployment on health, challenges in making the transition home after deployment, facilitators and impediments to

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getting health care needs met, and key sources of support and strength in moving forward. Our study is among the first to engage veterans of the wars in Iraq and Afghanistan using a CBPR approach and photovoice methods.

Nearly 2.5 million American service members have deployed in support of the wars in Afghanistan and Iraq (commonly referred to as OEF-OIF). Although many OEF-OIF veterans return in good health and without physical or mental injury, others are not so fortunate. A number of researchers have reported high rates of mental health diagnoses among this cohort; it is estimated that up to 43% of OEF-OIF veterans have at least one diagnosable mental health disorder (Milliken, Auchterlonie, & Hoge, 2007; Tanielian & Jaycox, 2008).

Despite the documented need, a substantial proportion of OEF-OIF veterans have not accessed available mental health services. In a national survey of post-9/11 veterans, Elbogen et al. (2013) found that only 25% had ever sought outpatient mental health care (46% from a Department of Veterans Affairs [VA] facility, 37% from a non-VA facility, and 16% from both). Hoge et al. (2014) found that, among veterans with a diagnosis of post-traumatic stress disorder (PTSD), less than half had received any mental health treatment in the past 6 months. This is a major concern because early detection and completing an adequate course of evidence-based treatment can prevent development of more chronic symptoms and related sequelae, including unemployment, homelessness, and suicide (Kehle et al., 2010; Seal et al., 2010; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012).

Improving access to mental health services for OEF-OIF veterans has become a top public health priority. The Department of Defense (DoD) and VA have introduced several initiatives to increase referral of recently separated veterans to existing health services (Amdur et al., 2011; Spelman, Hunt, Seal, & Burgo-Black, 2012). Some of these programs are aimed at universal screening of returning service members, including DoD's Post-Deployment Health Reassessment and VA's adoption of clinical reminders in the electronic medical record to screen veterans for symptoms of mental health disorders. With a majority of veterans receiving at least some of their care from a non-VA provider, there have been recent calls for universal standards and training to guide community providers in taking a military health history, including asking about service-related mental health symptoms (Brown, 2012; Lee, Sanders, & Cox, 2014). Screening alone, however, cannot ensure successful linkage to needed mental health services (Hoge, 2011; Milliken et al., 2007). Improving access to treatment requires understanding and addressing barriers to care, in particular the role of veterans' negative perceptions of mental health care.

A number of researchers have identified factors that contribute to OEF-OIF veterans' low utilization of care and, in particular, low engagement in evidence-based mental health care (Blais & Renshaw, 2013; Elnitsky et al., 2013; Maguen, Madden, Cohen, Bertenthal, & Seal, 2012). Hoge et al. (2004) were among the first to report very low rates of mental health treatment-seeking among this group of veterans. Deterrents to seeking care identified in past research include perceived social stigma (e.g., concerns about being seen as weak, losing confidence from military unit leadership or peers, and possible negative impact on current or future employment), self-stigma, and practical barriers (e.g., time constraints, distance from clinic; Blais & Renshaw, 2013; Gorman, Blow, Ames, & Reed, 2011; Mittal et al., 2013). Expanding on this work, Stecker and others found that, in addition to different forms of stigma and logistical issues, discomfort with specific treatment modalities (e.g., group therapy) and lack of readiness (e.g., denying need for help) also deterred veterans from seeking treatment (Mittal et al., 2013; Stecker, Shiner, Watts, Jones, & Conner, 2013).

Most of these studies involved either cross-sectional survey-based methods or retrospective analyses of large VA or DoD data sets (Di Leone et al., 2013; Maguen et al., 2012). Our work is informed by Castro's (2014) framework for meeting mental health needs of U.S. service members, which identifies important gaps in health services research around understanding of person-centered factors influencing access to and utilization of care. In particular, questions remain about how military cultural norms influence veterans' attitudes and beliefs about help-seeking and how veterans' prior health care experiences impact their decisions to enter treatment. Through photovoice methods and a CBPR approach, we sought to engage OEF-OIF veterans in answering these questions and furthering our understanding of how they make health-relevant decisions (Rigg et al., 2014). Our ultimate goal is to generate dialogue between veterans, health services researchers, health care providers, and organizational leadership that will inform the design of effective interventions to improve delivery of mental health care to veterans.

Method

Study Setting and Recruitment

This project took place at a large, urban VA Medical Center. To achieve representation of OEF-OIF veterans from diverse backgrounds, we kept our inclusion criteria deliberately broad: Any person who had served at least one deployment in support of OEF or OIF was eligible to participate.

We developed recruitment methods in consultation with partners in VA clinics serving post-deployment veterans, as well as community-based Veterans Service Organizations to ensure inclusion of veterans who did not use VA services. Our goal was to enroll 40 veterans to allow for a diverse sample in terms of branch of service and deployment experiences. We developed an informational flyer, which we posted in prominent locations and distributed to potential participants via our recruitment partners (by hand and by email). A number of veterans also contacted the study team after hearing about the project from enrolled participants who told their peers about the project without prompting from study staff.

A total of 56 veterans inquired about the study; of these, 2 were ineligible because they had not served at least one deployment in support of OEF or OIF, and 14 declined to enroll after hearing details about study participation (10 were "too busy," 4 were "not interested"). The 40 eligible veterans who opted to join the study met with a member of the research team at a time and location convenient for the veteran to complete the informed consent process.

Data Collection

Stage 1: Initial interview. A member of the research team with expertise in qualitative interviewing met with each veteran individually to review the purpose and methods of the study and gather basic demographic and military service information. Interviewers used orientation materials developed to facilitate discussion of a number of topics, including introduction to photovoice, key study questions, ethical and safety issues, how to operate the digital camera, and how to obtain consent from persons they wished to photograph.

Stage 2: Photo collection period. During the 2-week period following the initial interview, veterans took photographs and selected photos from their personal collections (including photos taken prior to study participation) to illustrate the impact of military service and deployment on their health, health care needs and experiences, and sources of recovery and support. Once or twice during this period, a member of the research team contacted each participant by phone or email (depending on the veteran's preference) to discuss their progress, answer questions about the process, and address any issues encountered.

Stage 3: Photo review and interview. Approximately 2 weeks after the initial meeting, veterans met individually with a member of the study team to review their collected photos. Participants were asked to choose the photographs that best conveyed their experiences and perspectives and to relate the story behind each image. Interviewers used an unstructured interview guide based on the work of Wang

and others, beginning with an open-ended question about each photograph ("Can you tell me the story of this photograph?") and posing follow-up probes to elicit each individual participant's deployment and post-deployment reintegration experiences, with a particular focus on current health care needs and barriers to meeting them (Minkler & Wallerstein, 2008; Wang & Burris, 1997). All interviews were audio-recorded with permission. At this second meeting, the interviewer uploaded the veteran's photos from the digital camera to a secure, encrypted laptop computer and collected any signed Consent to Photograph forms. Each veteran completed an Authorization for Release of Photo and Voice and an additional consent form allowing use of photographs and narratives in study dissemination activities (e.g., manuscripts, presentations, exhibits). The second form provided a place for participants to indicate which photos they wished to withhold from dissemination and whether they preferred to use a pseudonym for any or all of their photos.

Stage 4: Group discussion of themes. Following initial review of the photographs and narratives by the research team, veterans were invited to participate in a small-group meeting with up to nine other participants. Through these meetings, we elicited veterans' feedback on preliminary findings about themes present in the data and on which photographs and quotations most exemplified these themes. Group meetings took place at the VA Medical Center or a space provided by one of our community partners; these discussions were audio-recorded with veterans' permission and lasted approximately 90 minutes.

Participants were compensated US$20 for their attendance at any of the above meetings (group or individual); the digital camera was theirs to keep on completion of the second interview. Data collection took place between December 2011 and September 2012. Study methods and materials were reviewed and approved by the VA Medical Center's Institutional Review Board, as well as an Advisory Committee consisting of OEF-OIF veterans, VA clinicians and researchers with expertise in post-deployment health, and outside advisors experienced in CBPR.

Data Management and Analysis

Interviews and group meetings were transcribed verbatim by a professional service, after which a member of the study team checked each transcript against the original audio-recording for accuracy. We provided each participant with a copy of their transcribed interview and an opportunity to correct or amend their interview as they wished. A few participants asked to correct factual errors made when discussing details of events experienced during deployment; all corrections were reflected in the final interview transcript used for analysis.

We imported all photos and transcripts into Atlas.ti to facilitate data management, coding, and analysis (Muhr, 2010). All coding was completed by three research assistants, trained and supervised by the first author, following a two-phase, collaborative coding process to ensure reliability and transferability of findings (Creswell & Miller, 2000). During the first phase, coders linked photos to relevant quotations in the interview transcript (via the hyperlink function) and created a synopsis of each veteran's story by segmenting the text of each transcript, identifying the main topics of these segments, and then drafting a summary of each veteran's photo-narrative. By way of "member checking," we sent the resulting summary to participants and requested feedback about whether the summary accurately captured the essence of their photovoice contribution (Mays & Pope, 2000).

In the second phase, coding focused on identifying themes or "recurrent, unifying concepts or statements" present across the data (Bradley, Curry, & Devers, 2007, p. 1760). The first and second authors read through the transcripts separately and agreed on an initial list of codes, which were applied to segments of text in the interview transcripts. As a team, we examined coded text to define relationships between codes, group-related codes into categories, and identify and describe themes pertinent to our research questions. After presenting preliminary themes and exemplar photo/quote pairs to veterans during the small-group meetings described above, we incorporated their feedback into further refinement of themes. We report here on a subset of the themes and subthemes thus identified, focusing on those most relevant to veterans' engagement in mental health care.

A total of 40 veterans consented to participate in the study; 30 completed study participation by contributing photos and participating in a photo review interview. One veteran contributed one photograph (of his young son) and participated in an interview but later withdrew from the study, citing stress related to an ongoing custody dispute; his photo and interview transcript were omitted from the final data set. Ten participants were lost to follow-up after the initial informed consent meeting and contributed no photo or interview data to the study.

Of the 29 veterans whose photos and interviews were analyzed for this article, the median age was 31 years (range = 26–57 years). Six were women, and 17 self-identified as members of minority racial/ethnic groups (10 as African American, 3 as Hispanic/Latino, 1 as Native Hawaiian/Pacific Islander, 1 as Asian, and 2 as mixed-race/ethnicity [American Indian/African American]). All branches of the U.S. Armed Forces (except the Coast Guard) were represented; 12 veterans had deployed at least once as members of National Guard/Reserve units.

Figure 1. "Sandstorm" by Owen.

Median number of years of service was 7 years (range = 2–28 years); about two thirds had deployed more than once.

Interviews typically lasted 90 minutes. All but three veterans contributed at least 10 photos; the number of photos contributed per individual ranged from 6 to 67. In the case of 5 photos, the veteran asked that the photo be attributed to "Anonymous"; there were no cases where a veteran requested that a photo be completely excluded from dissemination.

Results

Here, we present three themes that emerged from veterans' contributions to the photovoice project regarding barriers to seeking mental health care after a deployment and factors that contribute to avoidance or abandonment of mental health treatment. We illustrate how veterans contributed new insights into the formative experiences, values, and mores that inform their health care decision-making, both as individuals and as members of a larger military community. Although most veterans chose to use their real names, all names used here are pseudonyms in accordance with the journal's standards.

Key Aspects of Military Culture and Identity Can Deter Help-Seeking

Veterans contributed numerous photographs from their years of military service, including time served on deployments to war zones. Their descriptions of the meaning behind these images illustrated how military cultural norms of stoicism, self-reliance, and prioritizing the needs of the unit over the needs of the individual can shape views about health, illness, and treatment-seeking. Owen, who deployed to Iraq with the Army, used his photo of a sandstorm in Iraq (Figure 1) to talk about how being mission-focused and under near-constant threat of severe bodily harm resulted in soldiers ignoring or downplaying health concerns during deployment:

You're constantly breathing in dust and dirt and everything. They burn everything there . . . trash, feces, everything. I developed a nasty cough [but] you get used to it. You have more serious things to worry about than what you're breathing in.

Similarly, Amanda articulated the persona of invincibility that many service members assume to survive a deployment and make it home. Referring to a photograph taken during her deployment to Iraq in which she is wearing full body armor, carrying her M-16, and looking sternly into the camera, Amanda said,

> This is . . . me, trying to look hardcore. I am locked and loaded, [but] I am not really so hardcore at all. I always had this mentality like, if it is me or you, I want to go home, but I never wanted to kill anybody.

Amanda, Owen, and other veterans talked about how norms instilled during Basic Training and solidified during a combat deployment continue to influence attitudes and decision-making around mental health treatment even after separation from military service. Amanda developed PTSD and major depression as a result of her deployment experiences, but she delayed seeking care because doing so clashed with her self-image as a Marine. She took a photo of a tree with thick, peeling bark to represent the necessity of shedding aspects of her military identity and training to get help:

> So that tree . . . caught me because the bark is stripping away from it. It made me think about layers stripping, and dealing with a lot of things. Like parts of me have been stripped away, whether I wanted them to be or not, and parts of me maybe needed to be stripped away in some cases.

Tabitha, a retired Army Lieutenant Colonel, described how "Battlemind"—the state of mental toughness instilled during military training—persists for many soldiers on returning home from deployment and contributes to denial of mental health problems. Discussing a photo taken with her daughter, who had just received her first commission as an officer in the Army, Tabitha reflected on her own struggles with PTSD and her 5-year delay in seeking mental health treatment:

> Asking for help is hard to do when you have worked so hard to be successful in your career—you don't want to be perceived as weak or less than 100% mission-ready. It took me a long time to realize that being strong and putting on a brave face was killing me inside. My daughter commissioning . . . made me realize that I needed to acknowledge that my experiences had changed me.

Many veterans spoke about how military culture emphasized mission accomplishment above the welfare of any individual soldier. A number of Marine and Army

Figure 2. "Speak no evil . . . " by Harriet.

combat infantry soldiers in particular shared stories about the variety of medications they were prescribed while deployed to keep them combat-ready. John served two combat deployments with the Army; after returning home, he suffered from severe PTSD, a traumatic brain injury, and was addicted to heroin. Explaining why he avoided seeking treatment for years, he recalled a post-deployment debriefing during which his unit was told to "leave the VA services for the guys who really need it" and not to talk about events that had occurred on deployment. John's self-portrait—a close-up of his solemn face beside a large globe that appears balanced on his shoulder—illustrated his experiences; he said,

> When you're an Infantry guy, they give you whatever you want to either stay up, or to go to sleep, or to not feel the pain. I was taking Percocet. I was taking Morphine. I was taking Valium. I was taking Klonopin, Dilaudid. One medication they gave me was like speed; I think it was Ritalin. After a while, you just get addicted. Then they just cut you off when you get back. They tell you—this was our briefing—"Whatever happened over there stays over there, cool?" . . . I feel like I've got the weight of the world on my shoulders.

Despite official DoD policies aimed at destigmatizing mental health treatment, many veterans, particularly those in combat units, reported hearing variations of "whatever happened over there stays over there" as they transitioned home after a deployment. This message can be especially detrimental for veterans who continue to serve in the National Guard or Reserves, who might defer seeking treatment for fear of jeopardizing their chances for career advancement. Harriet, who deployed twice with the Army Reserves, discussed a "code of silence" around reporting sexual assaults that occurred during deployment. Commenting on her photo (Figure 2), Harriet observed how reluctance to violate this code, even after separation from military service, led many veterans to avoid mental health treatment for conditions such as military sexual trauma:
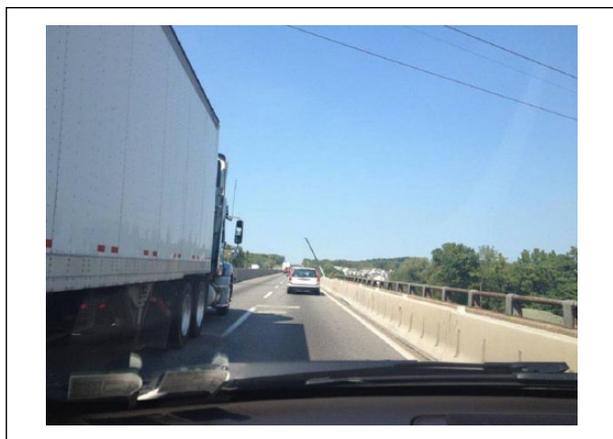
Figure 3. "Driving on the Northeast Extension" by Tabitha.

We had a lot of females that got raped. We had males that got raped. You're in that situation where people don't want to see, don't want to hear, don't want to speak. . . . So, it's not reported. And when the soldiers come back, they're living with that. A lot of them have jobs where they could lose their job. Seeking help could be a flag in your record.

Like Harriet and John, many veterans observed a connection between the military's emphasis on compartmentalization—putting up a wall between deployment and post-deployment life—and barriers to engaging in mental health treatment after returning home.

Veterans' Symptoms and Coping Strategies as Barriers to Mental Health care

Veterans illustrated how the symptoms they experienced as a result of PTSD and other mental health problems created challenges to accessing care for those very conditions. Many participants took photos out of car windows as they drove along highways and city streets—of overpasses, potholes, and trash strewn along the roadside. These pictures spoke to the difficulty they experienced driving themselves to and from health care appointments, because of intense anxiety related to memories of roadside bombs and other driving dangers during deployment. Tabitha talked about canceling appointments on days when she awoke feeling too anxious to drive; she illustrated her feelings through a photo (Figure 3.) taken while driving in slow traffic on the highway, her car hemmed in by concrete barriers on one side and a large semi-truck on the other:

Five years after leaving Iraq I still have anxiety driving. When I am confined with no way to escape, it feels like I am being funneled into a kill zone.

Paul, a veteran of the Army and the Marines, developed PTSD after two combat tours during which he

Figure 4. "Seeking Numbness" by Paul.

witnessed the severe injuries and deaths of close friends. He contributed a photo (Figure 4) depicting the combination of vodka and ZzzQuil, an over-the-counter sleep-aid, he drank every night to block out traumatic memories and cope with his insomnia, commenting,

I have an alcohol problem. I'm not going to lie . . . You feel like you're drowning. You can't come up for air. Alcohol makes me numb. For me, numb is as good as it gets sometimes.

Paul explained that he stopped going to his mental health appointments after his doctor, concerned about Paul's excessive drinking and the effects it was having on his body, declined to prescribe medications for anxiety and sleeplessness until Paul agreed to inpatient alcohol abuse treatment. Although his provider's decision might have been clinically warranted, Paul felt incapable of giving up his primary coping mechanism; he discontinued mental health treatment and opted to "go it alone" instead.

Caroline contributed an anonymous photo of a flyer announcing a marijuana treatment study and described how she and fellow veterans used marijuana to cope with anxiety and insomnia in lieu of taking prescription medications. She worried about the possible health consequences of her marijuana use but felt she could not discuss her concerns with her health care providers:

Figure 5. "Cocoon" by Dan.

> A lot of [veterans] are looking to heal in other ways including marijuana use. But how do you know if you are abusing it? Am I self-medicating? Is there somebody I can talk to about that? I don't know, and you cannot ask [health care providers]. You cannot ask that because you will be in big trouble.

Dan, an Army infantryman who experienced the deaths of several close friends during an extended combat deployment, photographed a cocoon (Figure 5) to represent his tendency toward self-isolation, a coping strategy common to many veterans with PTSD and other anxiety disorders:

> [The cocoon] echoes a fear of mine, that stage of hiding yourself away. A lot of times, I put myself into that sort of a cocoon, and I shut people out.

Like many veterans with PTSD and other anxiety disorders, Dan self-isolated to avoid potentially stressful social situations; however, this coping mechanism also interfered with his ability to seek and remain consistently engaged in treatment that could help him develop less compromising ways of coping.

Negative Health Care Encounters Contribute to Avoidance and Abandonment of Treatment

Although many veterans spoke of positive encounters with health care providers and institutions, others conveyed experiences that left them feeling alienated or like they were "just a number." Lewis, an African American Staff Sergeant who served two tours in Iraq with the Army, took a photo of a printout from his patient medical record at the VA, which listed his race as "White" and named all the VA medical centers on record as "treating facilities," including one that he had never visited. Speaking of his difficulties accessing consistent outpatient care for severe PTSD, he noted,

Figure 6. "Mushroom" by George.

> I was in Walter Reed Hospital for about a year and a half, and [since] I left there . . . it was an uphill fight. I've been switched to other hospitals. I was [all] over the place. Here's where the hospitals [are listed]. And the thing about it [is], I've never been to Martinsburg, and I'm not White. Even though I've been home since 2005, I'm still going through stuff . . . [I feel] like I'm lost. Like I'm lost in the cracks or something. Like they just don't know that I exist.

Many veterans focused on the bureaucracy of the health care system as a key impediment to accessing care. Nearly every veteran contributed photos of piles of accumulated paperwork: documentation of service-related health problems, treatment records from various health care facilities, and bills for health care services. A common refrain in individual interviews, reinforced in the small-group discussions, centered on the difficulties of navigating the transition from the DoD system of care (known as TRICARE) to the VA or a community provider after separation from military service. George deployed twice to Iraq as a medic and worked in health care after leaving the military. He took a photo of a mushroom growing in the woods (Figure 6) to convey how overwhelmed and unsupported he and his fellow veterans felt in trying to access benefits:

> You've heard the expression: "I'm a mushroom. They keep me in the dark and feed me crap." A lot of times, you feel like you're not getting all the information you need. The government prints enough paper to destroy the entire world's forest population; even though [the information] is all there at our fingertips, we get overwhelmed. You sit in your little corner and try to absorb what you can, but a lot of it you're going to miss.

Veterans also shared how they often felt overwhelmed, alienated, and in some instances re-traumatized by the questions asked during medical appointments, in terms of
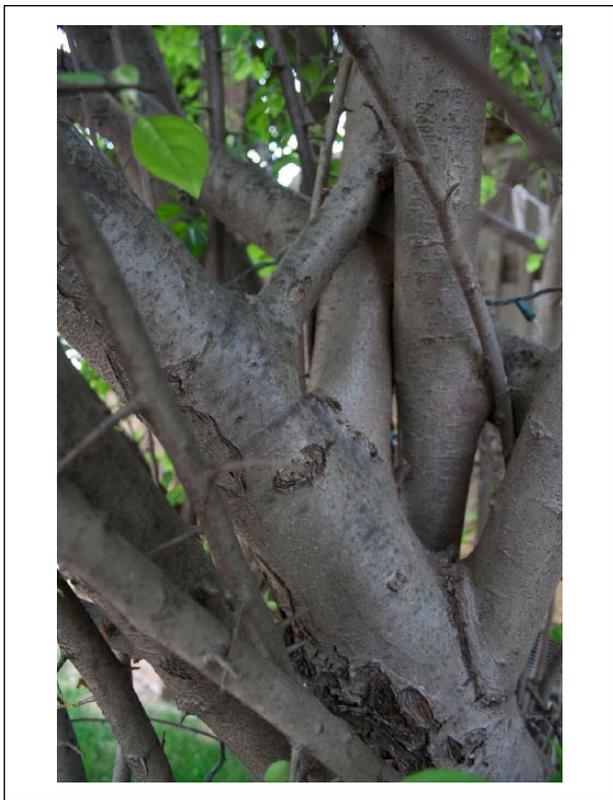
Figure 7. "Tangled" by Amanda.

the nature and number of questions, the manner in which they were asked, and the response (or lack of response) from those asking the questions. In particular, these negative experiences often occurred in the context of mental health intake appointments or Compensation and Pension interviews (the multi-day assessment process to determine the amount of a veteran's future compensation and pension benefits related to service-connected injuries and conditions), which led some veterans to avoid future mental health care. Amanda said of one of her photos (Figure 7),

> I shot this to express how I feel about the VA; it is like a maze. The system is not set up for people to talk through things. When I finally got a doctor through the VA, my practitioner was asking me this battery of really intrusive questions, but there was no space to work it out. There is a serious lack of listening at the VA. People will ask you questions, but no one is listening to you.

Dan, the Army infantryman who sought mental health care for his PTSD and depression, talked about how he and other veterans felt unsupported and traumatized by the assessment process, temporarily exacerbating their already-severe mental distress:

So within a space of 10 or 15 minutes, [you're asked to] please remember everything traumatic that happened in the past few years, and then [you] walk outside feeling like you could jump off a bridge or something.

Veterans often described negative interactions with health care staff and providers who made assumptions about them or the nature of their military service without knowing anything about what they might have experienced or accomplished on deployment. Tabitha, the retired Army Lt. Colonel who served combat deployments to the Gulf War, Iraq, and Afghanistan over a long military career, delayed seeking treatment for PTSD and depression for 5 years. Once she did enroll at the VA for care, she had several encounters with staff whose false assumptions about her military background and state of health exacerbated her ambivalence about getting care through the VA. Tabitha captured this in a photo of her favorite designer purse, the sight of which had once prompted a VA employee to tell her she "clearly didn't need" to seek care at the VA. She commented,

> The VA is a reflection of society as a whole—it is difficult to see a female veteran as someone exposed to the horrors of war. Care providers look at me and immediately make assumptions: "You look like you can afford to get a mammography in the civilian sector." "Were you a nurse?" "A pretty girl like you—you didn't see combat did you?" "Are you here for a job?" It is hard enough to understand the language and bureaucracy of the VA, but when you are a woman, they assume you have not earned the right to be there. They assume since you are dressed appropriately that you could not possibly have depression [or] PTSD. Getting providers to listen to my history, my symptoms and my issues is a huge challenge.

Several veterans with a history of a substance use disorder described feeling stigmatized by staff and providers who did not know their whole story. For example, John, the infantryman who became addicted to medications prescribed during his deployments and subsequently underwent addiction treatment through the VA, photographed a pile of commendations and awards he received for his actions during multiple deployments, which told a very different story about him than what most people saw:

> I received every single award you can receive, so I took a picture of [them] to show how dedicated I was while I was in [the Army] . . . No one knows what I did on 300-plus [combat] missions. I lost friends, I [got] PTSD, I got a traumatic brain injury, I lost my hearing. Here [at the VA] I'm just another addict. What am I supposed to do . . . stick [my awards] on my shirt and walk around?

Veterans discussed the challenges of taking medications prescribed as part of their mental health treatment, and they perceived their health care providers as unaware of or unconcerned with these conflicts. Many said they stopped taking a medication or reduced the dose without telling their provider because the side effects were intolerable or conflicted with other important aspects of their lives, such as ability to function at home, school, or work. Several veterans contributed photos to convey their experiences with serious adverse reactions to medications they had been prescribed. Noah, an Army veteran who served two infantry combat deployments to Iraq and was receiving treatment for PTSD, depression, and anxiety, took several self-portraits of his swollen face and body parts—so severely swollen that his skin had cracked in places—and explained,

> That's after a medication reaction. It has happened 6 or 7 times. They're not sure what causes it. My face would get so big that the pressure would hurt, you know? So now I'm very careful about what I take. If anything, I don't take medications I'm supposed to because I don't want that happening again.

Simone, a single mother who deployed twice to Iraq with the Air Force while her daughter was very young, experienced major depression after returning home from her last deployment. She used a series of photos of her daughter to illustrate the conflict she experienced between caring for her daughter and getting treatment for her depression:

> I sent [my daughter] to stay with my parents because . . . I was depressed majorly during this time. . . . The VA's answer to my depression was to put me on medication. But I was afraid that if I took the meds I wouldn't be in [the] right frame of mind to take care of my daughter or myself.

Like Noah, Simone ultimately decided to stop taking her medications so she would feel capable of caring for her daughter. Noah, Simone, and other veterans felt their health care providers did not appreciate how profoundly medication side effects could affect their quality of life. This perceived lack of understanding helps explain why several veterans reported that they had stopped taking their medications as prescribed without informing their doctors, missed mental health follow-up appointments, or abandoned care altogether.

Discussion

Our findings suggest that many of the cultural values and norms (e.g., stoicism, self-reliance) that serve soldiers well on the battlefield can be detrimental to mental health care engagement. Others have written about the challenges veterans face in making the transition to civilian life, when some of the values, norms, and behaviors that were adaptive on the battlefield turn to liabilities when they persist beyond the context of war (Adler & Castro, 2013; Hoge, 2010; Koenig, Maguen, Monroy, Mayott, & Seal, 2014; Smith & True, 2014). The veterans who participated in this project demonstrated a high degree of self-awareness about the need to remove the once-protective armor of Battlemind to get the help they needed and support their mental health recovery.

Many veterans shared stories of health care encounters that left them feeling reluctant to engage. In particular, standard intake and screening questions that appear routine and necessary to providers are often experienced as insensitive by many veterans, some of whom avoid or delay further interactions as a result. This highlights the importance of careful consideration of clinical setting, choice of wording, and provider response to disclosure when it comes to asking veterans about deployment experiences or symptoms of mental health conditions. Ganzini et al. (2013) reported similar findings regarding OEF-OIF veterans' experiences with being asked suicide-risk screening questions. Veterans understood the neccessity of screening, but in the absence of a trusting relationship with the person conducting the screening, many veterans perceived the experience as perfunctory and disrespectful.

Stigma has been identified in prior literature as a key contributor to low utilization of mental health care by veterans (Blais & Renshaw, 2013; Elbogen et al., 2013; Gorman et al., 2011; Hoge, 2011; Hoge et al., 2014; Mittal et al., 2013; Stecker, Fortney, Hamilton, & Ajzen, 2007; Stecker et al., 2013); photographs and narrative descriptions from veterans in our study elucidate the multi-faceted ways in which stigma operates as a barrier to care. Amanda, for example, delayed seeking treatment because doing so challenged her self-identity as a "locked and loaded" Marine, while Tabitha expressed the concern that others would not see her as "100 percent mission-ready." John illustrated concerns about stigmatization by others, including health care providers and staff, while Harriet referenced veterans' concerns about the stigma and possible negative consequences of reporting military sexual trauma.

Other investigators using survey methods have identified "logistical issues" such as distance from a health care facility as impediments to receiving mental health treatment (Elnitsky et al., 2013; Garcia et al., 2014). Our work expands on this concept by illustrating the ways in which veterans' mental health symptoms and self-management strategies pose challenges to initiating or following through on mental health care appointments. Given how difficult it is for some veterans to even call for an appointment, the impact of negative clinical encounters may be amplified to such a degree that veterans avoid future care. Moreover, many veterans rely on "word-of-mouth" when

it comes to making health care decisions (Snipes, Ingram, & Jiang, 2005; Tu & Lauer, 2008); for example, one participant described how she and other veterans use forums on social media sites to exchange information and endorse or critique specific mental health therapies, health care facilities, and providers. Thus, the potential impact of one veteran's negative encounter might reverberate throughout his or her social network.

Study Limitations and Strengths

Our findings should be interpreted within the context of the study's limitations. We conducted all data collection through face-to-face interviews, and in many cases, individual veterans met with a member of the research team multiple times; thus, interviewer effects and social desirability bias are a possibility. We mitigated these effects by emphasizing the importance of veterans sharing their honest thoughts, opinions, and experiences as expert "consumers" of post-deployment health care. Interviewers were trained and closely supervised by the first author, an experienced qualitative researcher who conducted many of the interviews and facilitated the small-group discussions. Generalizations should be made with caution because this was a non-probability sample of veterans. Although data gathered in this study are not necessarily representative of all veterans throughout the United States, it is reasonable to assume that the data described here resembles the experiences of other veterans who face challenges to accessing post-deployment mental health care. Finally, our selected focus on veteran-identified barriers to engagement in care drew attention primarily to individual and system-level factors; while many veterans' photos and narratives also conveyed the impact of community, social, and familial factors on post-deployment care and reintegration, a discussion of these broader family and social context themes is beyond the scope of this article.

We used qualitative methods of data collection and analysis, an approach well-suited for exploring the "hidden" nature of these phenomena. In particular, the use of photovoice allowed for a deeper understanding of mental health care barriers that would have been difficult to capture through a structured questionnaire. To our knowledge, this is the first photovoice study with OEF/OIF veterans which used a CBPR approach by partnering with local community-based Veterans Service Organizations and individual veteran participants to help shape the research questions, methods, and interpretation of findings. We continue to build on our partnerships with veteran contributors through research and advocacy activities, including a traveling exhibit titled "From War to Home: Through the Veteran's Lens" and accompanying presentations and panel discussions on military

cultural competency (for more information, visit http://www.va.gov/FromWarToHome/).

Conclusion

The finding that some of the strategies veterans use to self-manage and cope with mental distress (self-isolating, shunning crowded areas, avoiding driving) can operate as impediments to accessing care is relevant to the design and delivery of mental health services; engagement can be enhanced by anticipating and identifying possible barriers at the time of enrollment and addressing these proactively in treatment planning and by offering veterans different modes of care delivery (e.g., telehealth or telephone-based counseling) and alternatives to VA-based care (e.g., partnering with community-based therapists). This is consistent with the ideas of Charles Hoge (2011) who has written about the importance of health care organizations and providers "meeting Veterans where they are" by identifying and addressing their primary health concerns as a means to more successfully engage them in care. Our findings also align with Balbale, Morris, and LaVela's (2014) work, which found that veterans defined patient-centered care as both holistic and responsive to individual needs and concerns.

In addition, Sandra Bloom's (2013) work on the concept of *sanctuary trauma* has relevance to our findings; sanctuary trauma occurs when an individual who is seeking help in response to experiences of trauma(s) encounters what was expected to be a supportive and protective environment and discovers only more trauma. This resonates with many experiences described by veterans in our photovoice study who had experienced traumas related to military service and deployment and suggests that efforts to make care more patient-centered and safe for veterans need to go beyond simply improving the customer service skills or basic knowledge and competencies of clinicians and staff. These might include staff trainings aimed at identifying and addressing unconscious bias among staff and providers, especially around assumptions concerning specific groups of veterans (women, minority veterans, veterans with a history of substance abuse). Hausmann et al. (2014) recently developed and pilot tested unconscious bias training for members of VA patient care teams, although these trainings are not yet in wide use.

As demonstrated by Ganzini and colleague's study of suicide screening within VA and our findings reported here, establishing some level of rapport between veterans and their providers is essential prior to asking screening questions about traumatic experiences, mental distress, and suicidal thoughts. Without such an environment of trust, there is a risk that veterans will not give full and truthful answers to these important questions and might even feel re-traumatized by the screening experience,

resulting in missed opportunities for referral to treatment, barriers to engagement in care, and further harm (Ganzini et al., 2013). While our recommendations are specific to veterans, many of them may also be generalizable to any person who has experienced trauma(s) and encounters impediments to accessing care.

Given that only about half of all veterans are enrolled in care through the VA, and of those roughly three quarters receive at least some of their care outside the VA health care system, our findings are relevant for health care providers, policymakers, and public health researchers across VA and community settings. Veterans' insights concerning barriers to mental health care, stimulated through use of visual methods, can directly inform ongoing and future efforts to improve access to high-quality, patient-centered care for those who have served.

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