**HOW VETERANS AT AN ELEVATED RISK FOR SUICIDE PERCEIVE THEIR MENTAL HEALTH CARE: A THEMATIC ANALYSIS**

by

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Submitted to the Graduate Faculty of

Graduate School of Public Health in partial fulfillment

of the requirements for the degree of

Master of Public Health

University of Pittsburgh

2016

**ABSTRACT**

UNIVERSITY OF PITTSBURGH

GRADUATE SCHOOL OF PUBLIC HEALTH

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April 25, 2016

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**HOW VETERANS AT AN ELEVATED RISK FOR SUICIDE PERCEIVE THEIR MENTAL HEALTH CARE: A THEMATIC ANALYSIS**

Matthew W. Georg, MPH

University of Pittsburgh, 2016

**BACKGROUND:** Suicidal behavior in Veterans is a significant public health concern. In 2007, the Department of Veteran Affairs (VA) implemented a number of suicide prevention measures to combat rising suicide rates. Since these measures have been implemented, some reports have suggested a decrease in the relative suicide rates of Veterans who utilize Veterans Health Administration (VHA) services when compared to Veterans not utilizing VHA services. However, in 2010, the suicide rate for Veterans was still nearly three times higher than that of non-Veterans. The objective of this study is to examine how Veterans at an elevated risk for suicide perceive their mental health care.

**METHODS:** Veterans were outpatients whom suicide prevention coordinators of the VA Pittsburgh Healthcare System had placed on a “high risk” list for suicide. The Veterans participated in a semi-structured interview assessing their current treatments for their depressive and suicidal symptoms, preference for providers, and thoughts on using technology in their treatments. Coders analyzed the interviews using thematic analysis with a realistic method and inductive approach to identify themes.

**RESULTS:** Fifteen Veterans participated in the interviews. The median age was 51 years with a range of 24 to 71 years; 20% percent were women; and 53.3% were non-Hispanic whites. The four themes identified were: 1) Perceived Benefits of Treatment for Suicidality, 2) Perceived Barriers to Successful Treatment, 3) Perceived Facilitators of Successful Treatment, and 4) Technology May Help Remove Barriers and Promote Facilitators of Successful Treatment.

**PUBLIC HEALTH IMPACT:** Veteran participants reported that treatments for suicidality can positively impact factors theorized to be necessary for suicidal behavior. We also identified a number of factors Veterans believe help or hinder their mental health treatment. Chief among these is that providers need to foster trust with the Veterans they see and listen to their input in their mental health care. Additionally, technology and text-based communication may be beneficial in helping Veterans communicate and be open and honest about their psychiatric symptoms to providers. Findings from this study may help shine light on questions we need to ask Veterans to further improve the VA’s suicide prevention measures.

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preface

**ACKNOWLEDGEMENTS**

The VA Pittsburgh Healthcare System and the Veterans Integrated Service Network 4 Mental Illness Research, Education, and Clinical Center provided partial support for this project. The contents of this paper do not represent the views of the U.S. Department of Veterans Affairs or the U.S. government.

# Introduction

Suicidal behavior in Veterans is a significant public health concern. The Department of Veterans Affairs’ (VA) response to escalating suicide rates has included enhanced mandated monitoring, creation of high-risk suicide lists and a 24-hour hotline, and the placement of suicide prevention coordinators in every Veterans Health Administration (VHA) hospital (Department of Veterans Affairs, 2007). Since this policy implementation, the VA has reported that suicide rates of Veterans who utilize VHA services have remained stable at about 36 per 100,000 (Kemp & Bossarte, 2013; Kemp, 2014). However, some recent reports have suggested a decrease in the relative suicide rates of Veterans who utilize VHA services when compared to Veterans not utilizing VHA services (Hoffmire, Kemp, & Bossarte, 2015; Katz, McCarthy, Ignacio, & Kemp, 2012). Despite the VA’s efforts, Veterans’ overall crude suicide rate in 2010 was still nearly three times higher than that of non-Veterans (35.9 vs. 12.4 per 100,000) (Hoffmire et al., 2015). Thus, further efforts are needed to reduce suicide rates among Veterans.

The Health Buddy © is an electronic telehealth system used to help monitor symptoms. It has been used to monitor a wide range of health issues (Chumbler et al., 2005; Kobb, Hoffman, Lodge, & Kline, 2003). Our research team has begun developing it as a new approach to suicide prevention for Veterans. The Health Buddy provides a useful means of outreach to patients at an elevated risk for suicide and with psychiatric comorbidities. Using this intervention builds on VA suicide risk management by providing daily monitoring of suicide risk factors, daily connection to the hospital-system with psychoeducation, and swift provider intervention, if necessary. Our team has developed and pilot-tested this approach in a sample of Veterans with a recent history of suicidal ideation and/or suicide attempt and have found promising preliminary results, including reductions in levels of suicidal ideation (Kasckow et al., 2014, 2015a & b, 2016).

There are major barriers preventing Veterans from seeking mental health treatments and from participating in suicide prevention interventions. Hoge et al.’s (2004) research found that only about 30% of Veterans who met screening criteria for mental illnesses had received treatment. They found that Veterans who met screening criteria cited concerns about others seeing them as weak or treating them differently as barriers to seeking treatment. Additionally, the Veterans in their study cited a lack of trust in mental health professionals. Trust in providers has been found to be an important facilitator in the disclosure of suicidality during health screenings of Veterans (Ganzini et al., 2013). In a study of Veterans who had completed suicide, over 70% (13/18) who had been recently screened for suicidality at a VHA hospital had denied any suicidal thoughts (Denneson et al., 2010). This finding highlights the need to better understand why Veterans fail to disclose their suicidal symptoms during screening.

As an avenue to explore Veterans’ attitudes about self-disclosure of suicidal thoughts, the current study aimed to investigate how Veterans who are at an elevated risk for suicide perceive their mental health care. To examine this, we interviewed a sample of Veterans who were on the VA “high risk” list for suicide and who had been recruited for a feasibility study focused on use of the Health Buddy telehealth system. Prior to starting the three-month intervention, Veterans completed a semi-structured interview that inquired about their current treatments for depressive and suicidal symptoms, preferences for providers, and thoughts on using technology in their treatment. We conducted a thematic analysis of verbatim transcriptions of the interviews to identify emergent themes relevant to Veterans’ perceptions regarding their behavioral health care.

# Methods

## Sample

Participants were outpatients whom suicide prevention coordinators of the VA Pittsburgh Healthcare System (VAPHS) had placed on a “high risk” list. In order for these patients to be placed on the list, clinicians at the VAPHS needed to have been concerned about the risk for suicidal behavior in these patients. These patients are then referred to suicide prevention coordinators for a systematic assessment of suicide risk. Most Veterans placed on the “high risk” list have a history of a suicide attempt. Recruitment for this study took place at the VAPHS from February 2015 through July 2015. Eligibility criteria for participation in the study were as follows: 1) evidence of active or passive suicidal ideation on the Scale for Suicidal Ideation (SSI; Beck, Kovacs, & Weissman, 1979) within the past week as evidenced by a positive score (>1) on items four or five on the SSI or a reported suicide attempt within the past month; 2) absence of a marked cognitive impairment based on a Mini Mental Status Scale (MMSS; Folstein et al., 1975) score > 21; and 3) absence of a serious active medical and/or psychiatric disorder that could seriously impact safety or adherence to participation in the study. The VAPHS Institutional Review Board approved all study procedures.

## Data collection

After providing written informed consent, participants were asked to provide demographic and clinical information. The Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) was administered to determine the presence of any DSM-IV psychiatric disorders. The Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960) was used to assess the presence and severity of depressive symptoms. The Clinical Global Impressions Scale (CGI; Guy, 1976) was used to assess overall impairment due to psychiatric disorder(s).

Eligible participants then completed a semi-structured interview. A research assistant conducted the interviews by following a script of open-ended questions and asking follow-up questions when necessary. The one-on-one interviews were conducted in a private room. On average, the interviews lasted nine minutes. The interview length ranged from four and a half minutes to 21 minutes.

The interview started with a description of the purpose of the interview. Then participants were asked about their current treatments with questions such as, “What do you feel has been the best treatment for your depressive symptoms?” and “Why was this helpful?” Participants were then asked about their mental health care providers. This section included questions like, “Which type of provider do you prefer talking to regarding your psychiatric symptoms?” and “Do you generally trust what they [their providers] are saying?” Next, the interviewer asked participants about their views on using technology in their mental health treatment, especially as it pertains to suicide risk management. The subsequent section of the interview asked participants about their preferred suicide management intervention. Having learned about the Health Buddy during the informed consent process, the participants were asked whether they felt they would prefer: 1) using only the standard VA care for Veterans at an elevated risk for suicide, 2) to have this care augmented with the Health Buddy telehealth monitoring technology, or 3) to have it augmented by an additional weekly phone call from a nurse. The standard VA care included weekly contact with the suicide prevention coordinator during the first month of placement on the “high risk” list and monthly telephone assessments for the second and third months. The Health Buddy telehealth intervention, which Bosch Health Care markets and is one of the VA-approved telehealth devices, allows participants to answer daily questions pertaining to symptoms of depression and suicidal ideation, as well as other questions pertaining to medication adherence and potential substance/alcohol use and recovery. Also included in the Health Buddy intervention, VAPHS nurses check a secure website every four hours to monitor the Veteran’s response and, if necessary, alert clinicians to help the participant if their symptoms are worsening. In addition to stating their preferred intervention, participants also elaborated on the reasons for their choice. The final section of the interview provided participants a chance to talk about any negative experiences they had during their mental health care.

## Thematic Analysis

The interviews were audio-recorded and then transcribed. Two coders used thematic analysis with a realistic method and inductive approach to identify themes (Braun & Clarke, 2006). The realistic method allowed the coders to create codes based on the Veterans’ reality or perspective. The inductive approach meant that the codes were created without trying to fit into a pre-existing coding framework. The coders were graduate-level students. An expert in qualitative analysis oversaw their coding process. The coders started by reading and rereading the interviews to gain familiarity with the content. Each coder then independently assigned a code to each statement made in the interviews. Codes were based on what the participants explicitly stated. Once both coders had finished coding all of the interviews, they met to discuss their codes. They discussed each discrepancy in their codes until they reached consensus. The coders then independently determined the themes within the data and sorted their coded data into those themes. After completing this, the coders met again to discuss any differences and reached consensus on the themes. To identify the sub-themes in the data, the coders independently reviewed the transcripts and repeated the consensus review process.

# Results

## Descriptive Statistics

A total of 21 Veterans were invited to participate in the study. Five declined to participate in the study. One Veteran consented to participate, but did not meet inclusion criteria at the baseline interview. Fifteen eligible Veterans participated in the interviews. The participants’ median age was 51 years with a range of 24 to 71 years; 20% percent were women; and 53.3% were non-Hispanic whites (Table 1). The participants had a mean of 4.93 (SD = 1.87) concurrent psychiatric disorders. This sample had relatively high levels of depressive symptoms (HAM-D mean score = 26.07; SD = 7.61) and suicidal ideation (SSI mean score = 8.50, SD = 5.99). On the CGI, over half (53.3%) of the sample were rated as having ‘Marked Impairment’ (Table 2).

Table 1. Demographics (n=15)

|  |  |
| --- | --- |
| Age (yrs), median (range) | 51.0 (24-71) |
| Female, n (%) | 3 (20.0) |
| Ethnicity, n (%) |   |
|  White | 8 (53.3) |
|  Black | 6 (40.0) |
|  Latino | 1 (6.7) |
| Education, n (%) |   |
|  High school/GED | 8 (53.3) |
|  Associate's Degree | 4 (26.7) |
|  Bachelor's Degree | 3 (20.0) |
| Marital Status, n (%) |   |
|  Never Married | 5 (33.3) |
|  Married | 3 (20.0) |
|  Divorced/Separated | 5 (33.3) |
|  Widowed | 2 (13.3) |

Table 2. Psychopathology (n=15)

|  |  |
| --- | --- |
| Most frequent current disorders, n (%) |   |
|  Agoraphobia | 8 (53.3) |
|  Alcohol/Substance Dependence | 7 (46.7) |
|  Major Depressive Disorder | 7 (46.7) |
|  Post-Traumatic Stress Disorder | 7 (46.7) |
|  Panic Disorder | 5 (33.3) |
|  Bipolar I/II | 2 (13.3) |
|  Schizophrenia/Schizoaffective | 2 (13.3) |
| Number of concurrent disorders, mean (sd) | 4.93 (1.87) |
| Hamilton Depression Rating Scale, mean (sd) | 26.07 (7.61) |
| Scale for Suicidal Ideation, mean (sd) | 8.40 (5.99) |
| Clinical Global Impressions, n (%) |   |
|  Mild | 1 (6.7) |
|  Moderate | 6 (40.0) |
|  Marked | 8 (53.3) |

## Qualitative analysis

The qualitative analysis yielded four main themes with underlying sub-themes (Figure 1). The four main themes were: 1) Perceived Benefits of Treatment for Suicidality, 2) Perceived Barriers to Successful Treatment, 3) Perceived Facilitators of Successful Treatment, and 4) Technology May Help Remove Barriers and Promote Facilitators of Successful Treatment. The themes and subthemes are presented in the following sections with illustrating comments. The following terms were used to indicate the number of participants that made statements in a sub-theme: *most* meant that more than half of the participants (8/15) said it; *many* meant more than four, but fewer than eight said it; and *couple*, *few*, *some*, *handful*, and *small portion* indicated more than one, but fewer than four participants made statements representing that sub-theme. Occasionally, more specific wording, such as *one* or *all*, was used.

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Figure 1. Themes and Subthemes

Using thematic analysis (Braun & Clarke, 2006), four themes and two to four subthemes per theme were identified from semi-structured interviews with Veterans at an elevated risk of suicide about their perceptions of their mental health care.

### Theme 1: Perceived Benefits of Treatment for Suicidality

During the section of the interview focusing on what the Veteran felt was the best treatment for their depressive and suicidal symptoms, they expressed a number of perceived benefits of their previous treatments.

#### Sub-theme 1.a: Improved Mental Health Symptoms

Most of the Veterans noted that previous or current treatments had helped alleviate their symptoms. When talking about psychotherapy, one Veteran stated:

*One thing I like about doing this is it’s kind of like when you’re in a leaky boat and you reach out and grab the pier, the boat had been shaking violently and you don’t know when you’re getting tossed out or when it’s breaking, but you get a hold on one thing that’s still; you can ground yourself, you can go from there, you can maybe pull yourself up to that dock, there’s a lot of things you can do to save yourself.*

Additionally, a couple of Veterans talked about how psychotherapy taught them skills to help control their symptoms. About seeing their psychiatrist, one stated:

*That’s been helpful in helping me process and understand my symptoms; especially as things have been rising over the past year. So I guess that’s been pretty helpful.*

A few of the Veterans also talked about the benefits of medication in their mental health treatment. One Veteran noted, “I feel like it changed my mood and offsets negativity, negative thoughts.” Another Veteran said medication helped, “…because it stopped me from hearing voices and having depression.”

#### Sub-theme 1.b: Reduced Feelings of Isolation

Some Veterans talked about how previous or current treatments helped them connect with others. A handful of Veterans mentioned feeling relieved when talking to someone else about their symptoms. One Veteran commented:

*Talking to my counselor. He, like, usually I keep everything to myself. And since I’ve been talking to him about what’s really going on with me, it seems like there are these weights being lifted off of me.*

Another also mentioned that treatment was beneficial, “Just allowing me [to] express you know how I’ve been feeling or whatever with someone.”

One Veteran talked at length about how a follow-up “caring letter” from the suicide hotline helped them:

*Like I got an envelope the other day with a card with flowers on it that said ba ba ba ba. I’m like where is this coming from and I saw it was from the hotline. So I said, “Wow, this is cool. They ain’t forgot; they still checking on me.” So I think that and a phone call might help someone or save someone. And that’s pretty cool.*

A couple of Veterans also talked about the benefits of group therapy with other Veterans. One commented that:

*… (F)or me getting into the program [group therapy], that’s a little light at the end of the tunnel. Then I get to talk in there every now and again to where not only does it help me, but maybe it’ll help somebody else. Because things that helped other people in there has helped me too. So it’s building and it’s edifying, I guess.*

Another mentioned that interacting with Veterans was enlightening, “Sometimes I’ve found support from older veterans that has really surprised me and been kind of empowering.”

### Theme 2: Perceived Barriers to Successful Treatment

At various points throughout their interviews, over half of the Veterans mentioned various barriers they had encountered in their mental health care.

#### Sub-theme 2.a: Discomfort with and/or Distrust of Provider

About halfof the Veterans mentioned discomfort or distrust of providers as a barrier to their care. One Veteran said they only “50%” trust their providers. Another said, “I don’t trust any of the psych doctors. Nothing against them. I just don’t trust them.” One Veteran described the difficulty of finding a provider they trusted: “I’ve had a lot of psychiatrists here [at the VA] that I don’t trust. The one at …, I won’t even see. I see my regular psychiatrist there, Dr. …[from outside the VA].” This Veteran went on to say, “Well, I have a psychiatrist [outside the VA] that I really like and trust. And I had a hard time finding that at the VA.”

A couple of the Veterans felt their providers were not valuing their input into their care. As one Veteran noted about their provider, “I just didn’t feel like he was hearing me.” They went on to say, “Just lack of psychiatric doctors listening. That’s the biggest problem.” Another Veteran said the issue with their provider was that he was “not working with me, just kind of working against me. Telling me what I need to take. I asked for the Prozac, but it took a long time for him to give it to me. I had to like beg.”

A handful of Veterans talked about discomfort with their providers as a barrier to their care. When asked if they had any trouble adhering to treatments one Veteran noted, “No, No. I’m okay now. I wasn’t before. I mean, I didn’t feel the doctor was a good fit for me. You know what I mean, but now [their doctor is a good fit].” Another Veteran did not feel comfortable with an ethnically different doctor:

*It depends on that relationship.  It’s hard when the VA it seems like, I don’t know if they do it on purpose, and I’m not racist by no means, but it seems like they try to pair us Iraq and Afghanistan guys up with the … [ethnically different] doctors and that drives me nuts.*

Another Veteran felt they experienced sexual harassment at the VA that interfered with their care:

*There’s a male nurse right now that I told you about earlier who is intimidating as hell and he’s like the only person there at night sometimes next to my pod. And when I was here on …, that was also with patients and providers. Like it was different with providers, well, I don’t know, I feel like people were really insensitive about sexual trauma and they’ll say really invalidating things about rape in general. And that’s just too triggering for me and I just don’t like to be in environments where I feel like I’m being judged, whether it’s directly or indirectly. Like that same male nurse at …, like he knows my medical history, but he still makes these weird comments about like whether or not people are soliciting harassment or soliciting sex and then like changing their mind. Just victim blaming statements and I just feel like there’s a general overall lack of awareness and sensitivity. And very few people stick up or say something or things like that.*

#### Sub-theme 2.b: Being Open about One's Feelings is Difficult for Veterans with Suicidality

A small portion of Veterans talked about having difficulty discussing their mental health issues. In particular, a couple of Veterans commented on how difficult it is for providers to know if they are being honest about their mental health. One said:

*The main thing is for them to be honest. Not with just you, but with themselves. If they don’t, you know, I can lie to you, okay, but I can’t lie to me. And there’s nothing you can do about my lying. You see what I mean? So I have to deal with me. Like I can appreciate your concern. Which is appreciated. But it’s the idea that I have to deal with my concern. And face them.*

Another talked more about how they would try to lie to get out of inpatient care:

*Usually, the problem is the doctor. Usually, if I tell the doctor I’m alright, everything is fine, and stuff like that. And I’m not. It’s usually the problem comes up a lot of times or sometimes to where I’m really not honest sometimes with the doctors. I guess. It’s like, how, it’s like manipulating the doctors sometimes. I can sometimes manipulate the doctors to get what I want. I think of times where I want to be discharged, I want to go home. And I’ll tell them that everything’s fine, it’s just great, oh boy everything’s just great doc, I want to go home, and this and this and this. The doctor can only go by what you’re telling them and stuff. And it’s like the biggest problem I have is being honest and truthful with the doctor.*

Sometimes Veterans stated that they would downplay the severity of their symptoms instead of lying about them. One Veteran said:

*I think for me and probably a lot of other Veterans we can be good at putting on a good face. I guess like when I say when I’m not doing very well. It usually means more like something like I’m drowning and I can’t get out… Yeah, or like, I feel like, to me, I’m not doing very well means I’m doing really, really bad. And I guess I think like maybe just putting that in the context of Veterans and I think Veterans who are minorities of any kind are usually better at putting that face on.*

#### Sub-theme 2.c: Access to Care Issues

Some of the Veterans talked about issues with accessing care as a barrier. For some, it was the physical distance. When discussing issues with their care, one Veteran said, “And because I was in …, PA. For my mother. I just couldn’t get nowhere, you know.” Another talked about lack of transportation being an issue, saying:

*Some of it, I’m not blaming the VA but, it’s like a, I would like to come up here more often than I do, but transportation is a real problem for me getting up here. That’s the biggest. If I lived right around the block from here I’d come in all the time. Getting here is the biggest problem I have.*

One of the Veterans had trouble accessing care due to the therapist's hours conflicting with their work hours:

*Most of the time I can’t get to treatment because they offer treatment, or therapy between eight and four. And I work. And if I don’t work I don’t get paid. And if I don’t get paid, I don’t pay the bills. So I have to weigh what’s more important, paying the bills or going in therapy. Most of the time it’s going to work.*

### Theme 3: Perceived Facilitators of Successful Treatment

Throughout the interviews, Veterans mentioned a number of topics that could help facilitate treatment of their mental health disorders.

#### Sub-theme 3.a: Being Comfortable with and/or Trusting Provider

When addressing whether they trust providers, most Veterans said “yes.” A couple of Veterans talked in depth about how trust helped facilitate their treatment. One Veteran in particular felt that finding a provider they trusted was pivotal in their care. That Veteran went on to describe some of the aspects that helped them trust him:

*I feel like you have to kind of pick through until you find somebody that you find trustworthy enough to talk about things. And I guess one thing I like about him in particular is that I feel that our sessions are very patient-led. And he asks my opinions about things first and shares his insights instead of just talking at me or just writing prescriptions and letting me go. So that’s the, and even when I’m not making my other appointments, that’s the one I’m most likely to make. And I think that’s based primarily on trust and on the fact that it’s patient-led and that he’s just very affirming and very helpful. And he doesn’t treat me like I am my diagnosis. He looks more at treating my symptoms and helping me understand them and understand my medications. He’s very conscientious about things that interact with each other; things that might agitate me more... I mean, like I said, I’m pretty particular with who I trust and open up to. And another reason I trust Dr. … is because I’ve been seeing him for about two years and I feel like we’ve built up rapport.*

Another Veteran also conveyed the importance of a provider listening: “I like the fact that they listen to me in regards to not being medicated.”

A few Veterans mentioned that the fit between the providers’ and patients’ personalities was important. When talking about providers one said, “Yeah, she’s someone I can talk to. It appears that way, like my case-manager she’s a straight shooter; she comes right at me.” Again, when talking about a past provider they liked, that same Veteran noted, “Yeah. He was just an easy, laid back kind of guy. I like that kind of person.” Another Veteran talked about how feeling like the provider cared about them was important, “Like this doctor back here, he seems like he cares. So I’m gonna walk that walk with him.”

#### Sub-theme 3.b: Peer Support and/or Interaction

Some Veterans found that group therapy and interacting with other Veterans were helpful in their treatment. A couple of them mentioned that the shared experiences helped. One said about other Veterans in group therapy, “I feel like I can talk to people about things without having to explain anything and know that we have this shared experience.” Another mentioned, “’Cause I can talk to them and they have an understanding of what I’m going through. What we’ve been through together. Maybe not together, but you know.”

A common refrain was that other Veterans had a better understanding of them than providers. One Veteran said, “Us combat guys understand each other more than just the medications or the psychiatrists do.” Another felt that, in addition to other Veterans having a better understanding, Veteran groups helped build a Veterans’ community and leadership:

*I heard there’s a Veteran-led drop-in group here three days a week and I’ve been thinking about trying that because I think like we know ourselves and we know each other better than most of the providers. And building more leadership in our community I think is really healthy too. So I guess that’s how I would provide or prefer to get treatment. Like some mix between Veteran led groups and my psychiatrist.*

#### Sub-theme 3.c: Being Open to Trying Different Treatments

Many of the Veterans expressed openness to trying different treatments. When talking about other treatments one Veteran said:

*Whatever works. You know whatever, if it’s something new I’m willing to try it. Other than that, I’ll just keep taking my medicine and continue doing one-on-ones or however they want me to do it.*

Similarly, one Veteran said, “Yeah, sure I’d give it a try. I’d give anything a try.” Another said, “Whatever works. You know whatever, if it’s something new I’m willing to try it.”

#### Sub-theme 3.d: Knowing What Kinds of Treatment Options are Available

Additionally, a couple of Veterans expressed knowledge of existing treatments to treat mental disorders. In particular, one said, “I’ve heard of most of them I guess. But I don’t have any great preference for one or the other.” Another Veteran was aware of other medications that might be helpful, “Yeah, for bipolar I know there’s other medication to help with that. Like lithium, things like that.”

### Theme 4: Technology May Help Remove Barriers and Promote Facilitators of Successful Treatment

In the section focusing on technology, Veterans identified a number of ways that technology could help to overcome barriers to treatment or help to facilitate treatments.

#### Sub-theme 4.a: Texted-Based Communication Can Increase Patient Comfort

One Veteran specifically referenced how text-based communications had helped them more effectively communicate their mental health problems:

*A lot of times I prefer it. I’d rather use the secure messaging system most of the time than calling. I haven’t had a phone for quite a while any way. But sometimes I just need like distance. And I’d rather either have distance or communicate face-to-face and I don’t really like anything in between that… Also, like the only time I’ll use the crisis line is either through the computer or through texting. I don’t like to talk to somebody about stuff when I can actually hear them. I like it to be impersonal, if that makes sense.*

#### Sub-theme 4.b: Technology Helps Patients Track Mental Health Symptoms

All of the Veterans expressed an interest in using technology to monitor their mental health symptoms. In particular, a few of them mentioned the potential advantage of technology providing feedback on their symptoms. One Veteran said:

*I like to know where I’m at. If I’m moving forward or if I’m just playing a game with myself, I’m stagnant just not going nowhere. I like to know where I’m advancing so I get better.*

Another one of the Veterans mentioned that technology had helped them maintain perspective:

*Well, that and I also I feel like it gives me a better picture of how I’m doing on like a regular basis. In fact, I did use to, when I had a smart phone, I had the PTSD app that the VA created and sometimes I found that helpful.*

#### Sub-theme 4.c: Technology Improves Patient Access to Care between Appointments

All but one Veteran expressed interest in using technology to communicate with providers. Among those interested, a couple of the Veterans felt that text-based technologies provided better access to their providers. One of them said, “Yeah, ‘cause they don’t respond. I mean, you call them and leave a message they don’t get it. If you email them they most likely get it.” One Veteran also noted that it allows them to have constant contact with providers, “Because it can be done all the time. Where if you try to call your provider it’s a lot harder to get a hold of somebody.”

# discussion

This qualitative study explored how Veterans at an elevated risk for suicide perceived their mental health care. One of the themes identified was the benefits that mental health treatments provide, including improved mental health symptoms and reduced isolation. In addition, Veterans identified a number of barriers they faced in their mental health treatment, such as discomfort or distrust of providers, difficulty with opening up about their mental health issues, and troubles with accessing treatment. The Veterans also identified factors that aided in their mental health treatment. These included being comfortable with or trusting their providers, peer support or interaction, being open to treatments, and having knowledge of available treatments. The Veterans also discussed how technologies may aid in their mental health treatment. Some reported that technology could make them more comfortable in communicating with providers, help them track their mental health symptoms, and improve access to their providers.

Some Veterans noted that treatments helped lift feelings of isolation and helped them connect with peers. According to Van Orden et al.’s (2010) Interpersonal Theory of Suicide, feelings of “Thwarted Belongingness” and “Perceived Burdensomeness” are necessary components of suicidal behavior. Statements Veterans said in our subthemes, “Reduced Feelings of Isolation” and “Peer Support and/or Interaction,” support the notion that mental health treatments they received can positively affect these areas. One Veteran described the mechanisms of how “caring letters,” which have been shown to be effective at preventing suicides (Motto & Bostrom, 2001), work by helping them feel connected. Their statements about group therapy also suggested that it helped them feel a sense of belonging. A few participants mentioned that other Veterans had a better understanding of what they were going through. Previous interviews with Veterans have also shown that they feel more connected with other people that have served (Brenner et al. 2008). Participating in group therapy with other Veterans may help them feel like less of a burden to providers and help them feel like they belong.

Trust with providers was an important theme that Veterans cited as both a facilitator and barrier to treatment. This echoes the findings of Ganzini et al. (2013), who found that trust is the basis for effective suicide screening in Veterans. Furthermore, some Veterans in this study noted that it was important for them to feel like their providers were listening to them. One Veteran gave voice to the notion that it was difficult to trust providers who were ethnically different than themselves. Another Veteran talked about how they felt sexual harassment from providers interfered with their care. Exploring if Veterans trust their providers more when they are able to choose them based on certain attributes, such as ethnicity and gender, may be useful.

Military culture has a reputation for being hyper-masculine. Addis (2008) talks in depth about how masculinity impacts mental health. He discusses the concept of masculine persons masking their mental health. As seen in our subtheme “Being Open about One's Feelings is Difficult for Veterans with Suicidality,” it is important to take into account how difficult it can be for Veterans to reveal their mental health issues. As one of the Veterans stated, when they got to the point where they felt the need to ask for any help, it meant that they were really struggling. With the difficulties of relying on persons with a military history to self-report their mental health issues (Denneson et al., 2010; Warner et al., 2011), it is imperative to develop sensitive and effective screening measures that take this into account. Questionnaires that account for differences in expression of psychiatric symptoms based on gender, such as the Gender Inclusive Depression Scale (Martin, Neighbors, & Griffith; 2013), may be useful in capturing mental illness in this population. Additionally, further development of tools like the Implicit Association Task (Glenn & Nock, 2014; Nock et al., 2010) and predictive models of suicide (McCarthy et al., 2015) that do not rely on Veterans to self-report their symptoms may be pivotal in preventing suicide in Veterans.

The theme “Technology May Help Remove Barriers and Promote Facilitators of Successful Treatment” suggests that Veterans who participated in this study felt that utilizing technology may improve their mental health treatment. All of the Veterans in this study expressed interest in using technology to monitor their mental health symptoms. However, this interest is likely skewed, as these Veterans had already agreed to participate in an intervention using the Health Buddy. Nevertheless, research has shown that Veterans have high levels of interest in using technology in their mental health treatment (Erbes et al., 2014). Tele-health monitoring systems, like the Health Buddy, can also be useful in decreasing suicidal ideation in Veterans (Kasckow et al., 2015a; Kasckow et al., 2016). Some of the Veterans in this study felt more comfortable using text-based technologies than telephones to disclose their suicidal symptoms. Text-based technologies may be particularly useful as a third of soldiers surveyed who were reluctant to talk to a counselor in person were willing to use technology for mental health treatments (Wilson, Onorati, Mishkind, Reger, & Gahm, 2008). There was a strong interest among the Veterans in this study in the use of technology to help track their mental health symptoms in order to help them understand how they were progressing through treatment. Augmenting treatment with technology may increase Veterans’ interest and adherence to mental health treatments. Kasckow et al. (2015a & 2016) found high adherence rates for Veterans using the Health Buddy in their suicide prevention interventions. Some of the Veterans in this study also felt that it was easier to get in contact with their providers using text-based or web-based technology rather than over the phone. For these Veterans, implementing system-wide, text-based communications with providers may improve their continuity of care and, in doing so, reduce suicide rates.

## Limitations

This study sample had several limitations. First among them is its relatively small size. Only 15 Veterans participated in the interviews. Although this sample size can be adequate to obtain thematic saturation, the point at which additional interviews do not add new themes, in a qualitative study, saturation is not a measure of the representativeness of the opinions and attitudes conveyed. The sample’s lack of diversity in regards to sexual orientation and gender identification limits the representativeness of the findings. In particular, there were no Veterans who identified as transsexual in our study. This is of some importance as Veterans who identify as transsexual are at an elevated risk for suicide and they may face unique barriers in their treatment (Blosnich et al., 2013). However, a strength of our sample was the over-representation of other minority Veteran groups. Nearly 50% of the Veterans were non-white. In addition, females made up 20% of the sample. Another limitation was that the Veterans in this study represented only a single site. The problems they cite may not be representative of what Veterans in other locations experience. For instance, other sites may have more flexible hours or better public transport that makes it easier for Veterans to access care. Lastly, the Veterans in this study are those who ultimately received care for their suicidal ideation or behavior. Given the stigmatization of mental health care in the military (Greene-Shortridge, Britt, & Castro, 2007; Hoge et al., 2004), how those who seek or receive mental health care view their care may be different from those who do not seek or receive help prior to completing suicide. However, many of those in this study did discuss their struggle to trust providers and be honest with providers about their symptoms; these issues may be applicable to those who do not seek help.

There are also a few limitations in regards to the study design and thematic analysis of the interviews. The interview questions were not designed to answer a specific hypothesis. Therefore, we cannot deduce that modifying any of the themes identified will improve suicide prevention measures in Veterans. However, a strength of using the inductive approach in the thematic analysis is that it allows for an exploratory analysis of how Veterans at an elevated risk for suicide perceive their mental health care. This can be very useful for generating new hypotheses worthy of exploration in future research.

## Public health implications

This study has identified a number of factors that Veterans believe help or hinder their mental health treatment. Chief among these is that providers need to foster trust with the Veterans they see and listen to their input in their mental health care. Veteran-centered approaches, in which providers convey concern and listen closely for any signs of emotional distress, no matter how seemingly small, may be crucial in suicide prevention among Veterans. Additionally, technology and text-based communication may be beneficial in helping Veterans communicate and be open and honest about their psychiatric symptoms to providers. Utilizing Veterans’ interest in the ability of technology or mobile apps to track psychiatric symptoms may also be a useful tool in maintaining their interest in, and/or adherence to, treatment. Thus, findings from this study suggest that there are both interpersonal and technological improvements that can be made to the mental health care of Veterans. Further research in both of these areas is needed to understand the magnitude of their effect on facilitating mental health care in Veterans. Also, some Veterans voiced how group therapy with other Veterans and “caring letters” can be helpful for reducing feelings of isolation and being a burden. It may be useful to measure the specific effect those interventions have on these constructs, as both have been theorized to be necessary components of suicidal behavior (Van Orden et al., 2010). Moreover, with the VA’s continued effort to prevent suicides in Veterans, this study is important as it gives voice to the opinions and attitudes of Veterans who are at an elevated risk for suicide. Findings from this study may help shine light on questions we need to ask Veterans to further improve the VA’s suicide prevention measures.

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