Utilization of Mental Health Care among Israeli Veterans

By Shiner R. Sagi 5922704

Thesis

Submitted in partial fulfillment of the requirements for the degree of Master of Clinical Psychology in the Social and Behavioral Sciences Faculty

of the University of Utrecht

Utrecht, The Netherlands

Supervisors:

dr. Mooren, T. and dr. Knipscheer, J.W.

Table of content

Abstract

Military personnel are at high risk of exposure to traumatic events and its' outcomes. Despite efforts to provide mental health services, utilization of treatment remains low. In this study, we examined the impact of negative attitudes toward treatment, stigma and organizational barriers on treatment seeking among veterans previously serving in the Israeli military (*n*=161). We asked soldiers questions about stigma, organizational barriers, negative attitudes, symptoms of depression anxiety and PTSD and whether they sought treatment. Approximately 36% were currently experiencing symptoms of depression, anxiety and PTSD, while 73% of the sample did not seek treatment. We found that organizational barriers to care and depression scores are inversely associated with treatment seeking. Future research should examine whether the above factors predict treatment seeking among veterans from other non-western countries.

1. Introduction

1.1. Veterans mental health and utilization of care

Israel has been in a continuous conflict for over four decades and, therefore, represent a major group of soldiers and veterans who have been exposed to combat. A number of systematic studies have been done to examine the effect of combat on varied military and civilian populations (Murthy & Lakshminarayana, 2006; Yehuda & LeDoux, 2007). Research has shown that deployment stressors and exposure to combat such as being shot at, handling dead bodies, killing enemy combatants, etc. (e.g., Dobie et al., 2004; Hendin, 1984; Hoge, Auchterlonie, & Milliken, 2006 ; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Murdoch, Polusny, Hodges, & O'Brian, 2004; Smith et al., 2008) can result in a considerable risk of mental health problems, including high prevalence of post-traumatic stress disorder (PTSD) (Shlosberg, & Strous, 2005), major depression disorder, substance abuse, and impaired functioning in the social (Sayer et al., 2010) and occupational domains (e.g., Hoge et al., 2002; Hoge et al., 2004; Hoge et al., 2007; Richard et al., 1991; Schnurr, Friedman, & Bernardy, 2002).

Studies documenting the prevalence estimates for PTSD in previously deployed Afghanistan and Iraq service members ranged between 5% and 20% (Ramchand et al., 2010; Seal, Bertenthal, Miner, Sen & Marmar, 2007). in 2003, Bleich, Gelkopf and Solomon's study shows that 76.7% of veterans exposed to war-related trauma had at least one traumatic stress-related symptom, while 9.4% met the criteria for acute stress disorder (e.g., Wang et al., 2007). However, some studies have reported that the prevalence is relatively low and similar to that in the general population (McNally, 2012). The authors stated that an important reason for this prevalence discrepancy among Iraq and Afghanistan veteran population, may be that approximately half of veterans' population have received veteran health services and therefore,

the rest are not part of the sample (Seal et al., 2009; Vaughan, Schell, Tanielian, Jaycox, & Marshall, 2014).

Among U.S. veterans', 73% acknowledged their psychological problems but only 27% reported having sought treatment within the previous year, and only 16% reported that they actually went to a mental health professional (Hoge et al., 2004; Hoge et al., 2006). Different studies reveal varied statistics (e.g., Benyamini, & Solomon, 2005). However, they suggest the same trend of under-use of treatment. (e.g., Hoge et al., 2002; Hoge et al., 2004; Hoge et al., 2006; Seal et al., 2009; U.S. Department of Veterans Affairs , 2012; Vaughan et al., 2014). At this point, most data regarding utilization of mental health care after combat can be found among U.S. and European military studies.

1.2. Theory of planned behavior

In order to examine possible cognitive and emotional mediators of veterans' treatment seeking behavior, theory of planned behavior was used. The theory of planned behavior was first proposed by Ajzen (1985). It was derived from general agreement among social psychologists, that human behavior is goal- directed. According to the theory, engagement in a behavior (i.e., treatment seeking) is influenced by three different factors: (1) The overall attitude toward the behavior; (2) perceived social norms for engaging in the behavior (referred to as subjective norms), and (3) perceived control over the behavior. Britt et al. (2011) made an application of the theory to the context of military personnel, using findings from previous studies in the field. Based on their application of the original model, adding stigma and beliefs about the psychological problems and treatment as factors which influence overall attitude toward seeking treatment, and barriers to care as mediator to sense of control (Corrigan, 2004; Greene-Shortridge, Britt, & Castro, 2007; Hoge et al., 2004).

1.3. Organizational barriers to care

When reviewing determinants of treatment utilization in military personnel, most commonly reported findings identified descriptive factors (Bauer, Williford, McBride, & Shea, 2005), such as practical barriers. Practical\organizational barriers "reflect practical impediments that make it difficult for military personnel to receive treatment." (Britt et al., 2011. P. 83). Potential barriers to care may include difficulties understanding the procedures and options for getting treatment and not having the time in an already busy schedule to spend with a mental health professional (e.g., Britt et al., 2008; Kim, Britt, Klocko, Riviere, & Adler, 2011).

Few studies examined barriers to care, claim that patients with PTSD are less knowledgeable about mental health care options and eligibility for the service (Davis et al., 2008; Sayer et al., 2009), including higher negative perceptions of accessibility and delivery of services (Desai, Stefanovics, & Rosenheck, 2005). Ouimette et al.'s (2011) work supports the idea that veterans with severe mental health symptoms find it more difficult to navigate the complexities of accessing mental health care. Consequently, they perceive more barriers to care than veterans with less symptomology (Davis et al., 2008). The above findings remained stable when controlling for the effects of depression symptoms, suggesting a unique association between PTSD symptoms and perceived barriers (Hoge et al., 2004). Keeping the findings above in mind, there are still more possible determinants for treatment utilization than just organizational barriers.

1.4. Stigma and negative attitude towards treatment

The warrior culture of the military is one that values strength and resilience. Mental toughness and an expectation to master stress without difficulty are developed and reinforced as a cultural norm, with an emphasis on inner strength and self-reliance in order to "shake off"

injury and illness (Tanielian & Jaycox, 2008). Acknowledging one's problems and the need for help might be seen as a sign of weakness and incompetency (Bryan & Morrow, 2011), which possibly hinder treatment seeking (Corrigan, 2004; Corrigan et al., 2000; Corrigan & Watson, 2002; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Link, Struening, Nesse-Todd, Asmussen, & Phelan, 2001; Signorelli, 1989).

Interestingly in 2011, Kim et al. suggested that soldiers struggling with acknowledging their psychological difficulties more than acknowledging that they were suffering from physiological problems from the fear of being stigmatized (e.g., Britt, 2000; Greene-Shortridge et al., 2007; Porter & Johnson, 1994), therefore under-using mental health services. Research shows that there are unique factors among military personnel which contribute to resistance to seeking mental help (Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994), particularly the concern about how a soldier will be perceived by peers and by the leadership (Kim et al., 2010), fear of repercussions from leadership once admitting mental problem and using mental health care (Hoge et al., 2004), and the belief that one "ought to handle it on my own" (Stecker, Fortney, Hamilton, & Ajzen, 2007).

Concerns about stigma are disproportionately greater among those most in need of help and showing symptomology, possibly due to the fact that their symptoms are more salient both for them and for those around them (Corrigan, 2004; Greene-Shortridge et al., 2007; Hoge et al., 2004). In 2011, Kim et al. found that soldiers who had deployed to Afghanistan and Iraq and reported a mental health problem were up to three times more likely to endorse stigma beliefs regarding mental health services such as "It would be too embarrassing" and "I would be seen as weak". According to Sayer et al. (2009), severity of PTSD avoidance symptoms can lead to interpersonal disconnection and possibly contribute to poorer interactions with health care

professionals, which manifest in more perception of organizational and stigma-related barriers to care (Ouimette, 2011).

Perceived stigma and organizational barriers to care, are important factors for understanding non-utilization of treatment, but may not be as strong of a deterrent to seeking care, compared to attitudes about treatment. For example, Stecker et al. (2007) identified that fear of damaging one's leadership abilities by seeking treatment, was perceived as disincentives to care, emphasizing the importance of attitudes. Research suggests that the unique factors which are related to negative expectations and attitudes about treatment may provide useful insights into veterans' treatment seeking behavior (e.g., Britt, 2009; Mackenzie, Gekoski, & Knox, 2004).

Similar to stigma and organizational barriers trends (Hoge et al., 2004), soldiers endorsing negative beliefs were significantly less likely to report using any type of mental health service (Kim et al., 2011). More so, those who reported mental health problem were more likely to endorse negative attitudes toward treatment and report less use of the military mental health providers than civilian providers (Vogel & Wester, 2003). However, some studies have failed to differentiate between those who received care and those who did not. Participants who received care were less likely to believe that psychological problems tend to work themselves out (Kim et al., 2011). However, to our knowledge, no systematic studies have been examining these unique attitudes toward treatment and its association with the utilization of care among soldiers who have served in the Israeli military.

1.5. The present study

The present study aim is to broaden our understanding of treatment seeking behavior among Israeli veterans, using Azjen (1985) theory of planned behavior. In this current study we will examine how attitudes toward treatment, stigma and barriers to care are related to seeking

mental health care among multiple units of Israeli veterans who experienced or have not experienced traumatic events during their service. Based on previous studies, we assume that treatment seeking behavior will be associated with organizational barriers to care among Israeli veterans. Such practical barriers could be lack of public or private transportation to and from therapy appointments. More so, treatment seeking behavior will be related to negative stigma among Israeli veterans. Being too embarrassed about having the need to receive professional help and not being able to handle problem by yourself would have a negative effect on seeking treatment. Treatment seeking behavior will be associated with an overall negative attitude toward psychological treatment among Israeli veterans. “I do not trust mental health professionals” would be one of the factors that influence seeking help at any time point port emotional distress. Lastly, we predict that seeking treatment behavior will be associated with psychopathological symptoms among Israeli veterans.

2. Method

2.1. Design

The research design is a cross-sectional study of cohort Israeli veterans using an online survey methodology.

2.2. Procedure

Israeli participants were contacted using Facebook as a platform to spread the questionnaires. A post was published with a link to the questionnaire in multiple groups and private profiles in order to reach a varied group of veterans. Participation in the study was voluntary. At the beginning of the linked website the aim of the experiment was presented including information regarding the researcher and organizations that support the study. participants were informed about the anonymity of their responses, and the possibility to contact

the researcher at any point for questions or for summary of the findings when available. Participants filled out a questionnaire that was built with the Google Forms program and was available for use on mobile phones, computers or tablets. Participants generally completed the questionnaire within 20 minutes.

2.3. Sample

We have decided to collect $n>100$ participants, which we deemed to yield sufficient power for the analyses. In the final sample of participants, we had 161 veterans who served in the IDF (Israeli defense forces). The military service is mandatory for all Israeli citizens over the age of 18, although Arab (but not Druze) citizens are exempted if they so please, and other exceptions may be made on religious, physical or psychological grounds. More so, in general, women serve two years but the ones who volunteer for combat positions often serve for three years, due to the longer period of training. While males serve for 3 years, there are exceptions. The average age was 42.2 (*SD*=15.1), ranging from 20 to 77 years, and the gender distribution was 127 (78.9%) male and 34 (21.1%) female. Participants were excluded if they did not serve in the military for a minimum of one year, or in case they are still in active service.

The current study sample contained veterans who served in combat units (45.3%), combat support units (29.2%) and administrative branches (25.5%). The sample existed of mostly married participants 97 (60.2%) and single 36 (22.4%). Only 22 (13.7%) were in a relationship, 1 participant lost their partner and 5 (3.1%) divorced. The average of missions that have been taken part of in the sample is 45.07 (SD=128.49) and the average years in a military service was 5.6 (SD= 7.04). Only 59 people out of the whole sample reported experiencing shocking or radical events. Out of the 59 people reporting shocking events, 13 were females and 46 were males.

2.4. Instruments

All the questionnaires have been translated to Hebrew by Shiner, R.S. (July 24, 2018), and re-examined by Raviv, L. (August 08, 2018).

Post-traumatic stress symptoms. We used the Harvard Trauma Questionnaire (HTQ) which contains 17 items based on DSM-IV TR criteria for post traumatic disorder. The questionnaire is a checklist written by HPRT, that was developed to assess trauma symptoms across cultures. Participants were asked to score each item on four categories of response: “Not at all” “A little” “Quite a bit” and “Extremely” rated 1 to 4, respectively (Mollica et al., 1992). The HTQ has been tested in multiple studies and proved to have good validity and reliability. A cut-off score above 2.5 was used as an optimal way to distinguish symptoms equivalent to PTSD diagnostic criteria (Oruc et al., 2009).

Anxiety and Depression symptoms. The Hopkins Symptom Check List-25 (HSCL-25) was used to assess anxiety and depression symptoms. The questionnaire consists of 25 items: Part I of the HSCL-25 has 10 items for anxiety symptoms; Part II contains 15 items for depression symptoms. The scale for each question includes four response categories “Not at all” “A little” “Quite a bit” and “Extremely” rated 1 to 4, respectively. There are three scores computed: The total score is the average of all 25 items, and separate scores for depression and anxiety. The items correlate with the criteria from Diagnostic and Statistical Manual of the American Psychiatric Association, IV Version (DSM-IV). The HSCL-25 scale does not produce any diagnosis, even though it is common to use a cut-off score of 1.75 as an indication of symptoms equivalent with an anxiety or depressive disorder (Sandanger et al., 1998).

Stigma, organizational barriers and negative attitudes toward treatment. A questionnaire of seventeen items was used to assess stigma, organizational barriers, and negative

attitudes toward treatment. Seven items assess stigma, based on the study of Hoge et al. (2004) that provides an initial look at the mental health of members of the Army and the Marine Corps who were involved in combat operations in Iraq and Afghanistan, and Britt et al. (2008) that used two studies to examine how perceived stigma and barriers to care of psychological treatment moderate the relationships between stressors and psychological symptoms in college students and U.S. Army soldiers. Both studies were based in part on the measure used by Britt (2000) who assessed stigma of psychological problems among military personnel. Which include items such as: “It would harm my career” and “I would be seen as weak”. The Cronbach’s alpha coefficient for the scale was .91.

Four items assess organizational barriers (e.g., “I don’t know where to get help”) that were taken from Britt et al. (2009), Hoge et al. (2004), and Kim et, al. (2011). The Cronbach’s alpha coefficient for the scale was .90. Finally, six items were used to assess negative attitudes toward treatment. The attitude questionnaire was originally developed by Kim et al. (2011). Participants indicated the extent to which each potential item influenced their use of health care on a 5-point scale with 1 indicating “strongly disagree” and 5 indicating “strongly agree”. Participants who indicated that they ‘agreed’ or ‘strongly agreed’ with an item were classified as perceiving a potential barrier to care.

Treatment seeking. Participants were asked whether they have sought treatment or help for their emotional problem, using a modified version of a single item adapted from Hoge et al. (2004) to assess treatment seeking behavior. Respondents were asked; “Have you sought treatment for this stress or emotional problem?”. Veterans responded affirmatively to the question were categorized as seeking treatment. Following with verification question, asking whether they have received the help they were looking for and by whom.

2.5. Statistical analyses

All analyses are produced using R-statistics for Windows software version i386 3.5.1. Means and frequencies were calculated to describe the sample. Item scores on the HSCL-25 and HTQ were summed to compute total scores for anxiety, depression and PTSD. Sum-scores of the various scales were divided by the number of the items to yield mean scale scores. Participants with a HSCL mean scale score of >1.75, or HTQ mean scale score of > 2.5, were classified as currently experiencing mental health problems. Item scores for negative attitudes, organizational barriers and stigma were summed and divided by the number of items to provide mean scores. A binary logistic regression model was used to test each factor's (Negative attitude toward treatment, stigma, organizational barriers, PTSD, Anxiety and Depression symptoms) effect on treatment seeking behavior.

3. Results

3.1. Barriers to care

Table 1 shows mean scores of organizational barriers to care, Negative attitude towards treatment and stigma among Israeli veterans in the sample. The most common organizational barrier was; "I don't know where to get help", whereas, "Mental health services are not available" was the second most common barrier. Reported stigma views of " I would be seen as weak", and "My unit leadership might treat me differently" were mostly agreed on. The most common reported negative attitude toward treatment was "I do not trust mental health professionals", while "I would think less of a team member if I knew he or she was receiving mental health counseling" was the least agreed statement.

Finally, 106 veterans who answered positively to the question whether one or more of the views that were presented in the stigma, organizational barriers to care and negative attitude

toward psychological treatment questionnaires effected their willingness to seek help, did not seek professional help from any source. Whereas, 31 of those who answered positively to the question, did actually seek help after all.

3.2. Factors of Barriers to care and Treatment Seeking

We performed a logistic regression to examine the relationships between the three barrier factors and veterans' treatment seeking. In these analyses, we entered depression, anxiety, PTSD scores and experiences of shocking or radical as well. Organizational barriers to care (z=1.423, p=0.155), stigma (z=- 0.646, p=0.518) and negative attitudes toward treatment (z=-0.629, p=0.530), were not predictive of treatment seeking among the whole veterans' sample. However, depression symptomology was inversely related with treatment seeking. Veterans who scored low on depression symptoms, reported more seeking treatment behavior (z=2.178, p<0.05). While anxiety (z=-0.693, p=0.488) and PTSD scores (z=-0.571, p=0.568) were not significantly associated with seeking treatment behavior.

To further examine these results, we performed logistic regression with two sub-groups of participants with or without anxiety and depression symptoms, to examine whether any of the factors predicts treatment seeking. Table 2 shows that no relation was found between seeking treatment, stigma or negative attitudes. Only organizational barriers to care were positively associated with treatment seeking. More specifically, veterans without anxiety and depression symptoms and high scores on organizational barriers, reported more treatment seeking behavior, and vice versa. The association was not found in veterans with depression symptomology.

Finally, additional logistic regression was performed on two sub-groups of veterans who may or may not have experience shocking events, to examine whether any of the factors predicts treatment seeking. Table 3 shows that changes in scores of organizational barriers to care, stigma

and negative attitudes was not significantly associated with seeking treatment behavior, regardless of their service experiences.

3.3. Treatment seeking and psychopathological symptoms

Out of 161 Israeli veterans', there were 4 people with a $M>2.5$ on the HTQ. Only 19 veterans have scored $M>1.75$ (cut-off score) on the total HSCL-25 items of anxiety and depression symptoms. More so, looking at depression and anxiety symptoms separately, 21 veterans have a cut off score $M>1.75$ for depression items on HSCL-25 questionnaire. Where is, 21 veterans have passed the cut off score on the items for anxiety symptoms on HSCL-25. There were 43 veterans seeking any professional help at some point in their lives, while 118 didn't look for help from any source.

Out of the group of veterans who score positively on depression and anxiety symptoms (n=19), only 10 veterans looked for mental health care from any source at any point in time. 33 veterans who did not score positively on anxiety and depression symptoms did look for help. If we examine the reports of experiencing shocking or radical events during the military service, the numbers show that 19 veterans who experience shocking or radical events did seek help, while 40 of the veterans reporting experiencing shocking or radical events did not look for professional help.

4. Discussion

The present study assessed the effect of PTSD, anxiety and depression symptoms, and barriers to care on treatment seeking behavior among Israeli veterans who may or may have not experienced shocking events during their service. Indeed, experiences of shocking and radical events occurred in more than a quarter of the veterans, mostly for men in combat units. This was

expected since most of combat units are dedicated for men only. More so, those who served in combat units, had more violent missions that involve being shot at, handling dead bodies, etc. (Hoge et al., 2004).

A majority of those who reported experiencing shocking or radical events did not seek any professional help at any point in time since their service. This fits with the theory of natural recovery from trauma. Indeed, studies show that most traumatic experiences do not lead to any serious long-term impediments (Yehuda & LeDoux, 2007).

4.1. Organizational barriers and Treatment seeking

Veterans who appeared not to have any symptoms of anxiety or depression for the past week and accounted for higher scores of organizational barriers to care, reported more treatment seeking behavior. The current study is cross-sectional; therefore, we do not know if any of the participants experienced symptomology in the past. We can only assume at this point, that veterans who reported more organizational barriers to care, have received help in the past. Thus, are acquainted with the procedures and obstacles when seeking treatment.

Our assumption is in line with Kim et al. (2011) and Hoge et al. (2004) studies, which reported that those who received care were about twice as likely to have concerns about difficulty scheduling an appointment and getting time off work. It is possible that concerns about organizational barriers may primarily be about military facilities and not civilian facilities. If indeed our sample has experienced symptomology in the past, they encountered more difficulties navigating the complexities of accessing care, and consequently, perceived more barriers, which is supported by the study of Davis et al. (2008).

4.2. Stigma and Treatment seeking

Perceived stigma did not predict the use of care in the present study. In previous studies, stigma was a frequently reported concern among those with a mental health problem (Britt, 2011; Corrigan, 2004). However, in our analyses, the high rate of endorsement of perceived stigma of mental health care was not associated with the non-use of care. The same findings were found in 2011, by Kim et al., which did not find any association between stigma and treatment seeking. Nevertheless, findings of high scores of perceived stigma beliefs such as, "My unit leadership might treat me differently" and "I would be seen as weak" are related to the macho military culture, that endorse mental toughness and an expectation to master stress without difficulty, which indeed may hinder treatment seeking (Corrigan, 2004; Link et al., 2001). Perceived stigma may not be as strong of a deterrent to seeking care compared to one's own beliefs about organizational\practical barriers to care. However, the results of our study should be viewed with caution given the small sample size involved.

4.3. Negative attitudes and Treatment seeking

Negative attitude toward psychological treatment was not associated to seeking treatment behavior, which did not support our hypotheses. Previous studies found that soldiers who reported a mental health problem were more likely to endorse negative attitudes toward treatment (Kim et al., 2011). It's important to mention that almost a quarter of the sample agreed with the view "I do not trust mental health professionals" which may explain why so few seek help. It is possible that since most of the veterans in the study did not report any symptomology, the findings from previous studies do not apply in a healthy sample.

In addition, when asked whether one of the statements from the organizational barriers, negative attitude toward psychological treatment and stigma questionnaires had affected their

willingness to seek help when needed, most veterans that responded positively to the question, did not report seeking help at any point in time. Therefore, veterans might prefer self-treatment over treatment from a mental health professional (Kim et al., 2011). Stemming from the belief that mental health difficulties should be handled by oneself or just by getting social support, are not sufficiently severe to warrant seeking treatment from a professional (Hoge et al., 2004).

4.4. Psychopathological symptoms and Treatment seeking

Symptoms of depression were not associated with treatment seeking behavior in the current sample. Nevertheless, it is possible that some veterans who scored high on depression symptoms did not get treatment yet. This can be explained by the fact that almost half of the veterans in the study of Wang et al. (2007) who sought care indicated that the estimated time it took to seek care after they first experienced mental health problems was more than 60 months. This delay in treatment seeking behavior is not unique for the military. It is estimated that the delays to seek mental health care range from 1 to 14 years for mood disorders and from 3 to 30 years for anxiety disorders. Experiencing symptoms of depression or any other mental disorder and acknowledging the problem, does not necessarily mean that the individual will be more motivated to seek help (Hoge et al., 2004; Hoge et al., 2006).

PTSD symptoms were not common among the sample, in fact, only four veterans scored positive on symptoms of PTSD in the past four weeks. An association was not found of symptoms of PTSD depression and anxiety with treatment seeking, which is not in line with our hypotheses. However, the results of the study should be viewed with some caution given the small sample size involved. Studies show that symptoms of PTSD can occur after trauma, but usually recover in time, since most people are resilient (Bleich, Gelkopf, & Solomon, 2003; Shlosberg & Strous, 2005). This fits well with veterans reports of experiencing complaints in the

past, but not currently. Another possible explanation for the findings could be that Israeli military service is obligatory duty, therefore, veterans' families and friend are aware of the outcomes of traumatic combat experiences and the need of support. Which has possibly been beneficial after their traumatic experiences. This could explain why at this time point, most people who may have experienced shocking and radical events during their service, do not show significant symptoms of PTSD.

4.5. Strengths

A major strength of this study is that we used multiple military unites (Navy, Air-Force etc.), as well as the use of both treatment-seeking as non-treatment-seeking participants, which was not common in most previous studies. Most previous studies used either treatment-seeking samples or random samples from specific deployments such that the findings may not always be generalizable to the whole sample.

4.6. Limitations

There are limitations that need to be acknowledged and addressed regarding the present study. First, a small sample of veterans with PTSD, Anxiety and depression symptoms was used in this study, which may have prevented significant results. That also can be cause by using self-reports, which allows for exaggerated or underreported rates of mental health problems. However, each respondent was assured of confidentiality, which enables minimizing inaccuracies. Another important limitation is the inclusion of wide range of military units and operations in the sample. In combination with a small sample size may have led to more inter-individual differences in the sample. Next, the instruments that were used have been translated to Hebrew, which possibly effected the content validity. Lastly, our analyses are based on a cross-sectional design, which limits our ability to draw any definitive causal interpretations. Therefore,

we can't be sure that soldiers who sought treatment developed more barriers to care rather than the reverse causal order.

4.7. Future research

Studies examining negative attitudes, stigma and organizational barriers to care present an important research narrative regarding the ongoing problem of the underutilization of care among veterans. The present study emphasizes the importance of examining the reasons why veterans do not seek mental health care. There is a need to further assess whether negative beliefs, stigma and organizational barriers to care predict mental health care utilization among countries that are less prone to research. Such studies may shed different light on the phenomena, since cultural differences exist for example, between Western countries and the middle east. Additionally, interventions will have to work on reducing negative mindset regarding treatment, emphasizing that service members need to seek treatment when their symptoms begin to interfere with their daily lives and that the failure to seek treatment early on may lead to extended impediments.

5. References

Ajzen I. (1985) From Intentions to Actions: A Theory of Planned Behavior. In J. Kuhl & J. Beckmann (Eds.), *Action Control: From cognition to behavior*. SSSP Springer Series in Social Psychology. Springer, Berlin, Heidelberg Kessler.

Bauer, M.S., Williford, W.O., McBride, L., McBride, K., & Shea, N.M. (2005). Perceived barriers to health care access in a treated population. *International Journal of Psychiatry and Medicine, 35*(1), 13–26.

Benyamini, Y., & Solomon, Z. (2005). Combat stress reactions, posttraumatic stress disorder, cumulative life stress, and physical health among Israeli veterans twenty years after exposure to combat. *Social Science & Medicine, 61*(6), 1267-1277. doi:10.1016/j.socscimed.2005.01.023

Bleich, A., Gelkopf, & M., Solomon, Z. (2003). Exposure to Terrorism, Stress-Related Mental Health Symptoms, and Coping Behaviors Among a Nationally Representative Sample in Israel. *JAMA, 290*(5), 612-620.

Britt, T.W. (2000). The stigma of psychological problems in a work environment: Evidence from the screening of service members returning from Bosnia. *Journal of Applied Social Psychology, 30*, 1599–1618.

Britt, T.W. (2009). *Why do service members not get needed mental health treatment?* Invited address to the Combat Stress Intervention Program Research Conference at Washington & Jefferson College, Washington, PA.

Britt, T.W., Bennett, E.A., Crabtree, M., Haugh, C., Oliver, K., McFadden, A., & Pury, C.L.S. (2011). The Theory of Planned Behavior and Reserve Component Veteran Treatment Seeking. *Military Psychology, 23*(1), 82-96.

Britt, T.W., Green-Shortridge, T.M., & Brink, S. (2008). Perceived stigma and barriers to care for psychological treatment: Implications for reactions to stressors in different contexts. *Journal of Social and ClinicalPsychology, 27*(4), 317–335.

Bryan, C.J., & Morrow, C.E. (2011). Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned from the Defender's Edge Program. *Professional Psychology: Research and Practice, 42*(1), 16-23.

Corrigan, P. (2004). How stigma interferes with mental health care. *American psychologist, 59,* 614-625.

Corrigan, P.W., River, L., Lundin, R.K., Wasowski, K., Campion, J., Mathisen, J., … Kubiak, M.A. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology, 28*, 91–102.

Corrigan, P.W., & Watson, A.C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology—Science and Practice, 9*, 35–53.

Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I., & Rowlands, O.J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4–7.

Davis, R.G., Ressler, K.J., Schwartz, A.C., Stephens, K.J., & Bradley, R. G. (2008). Treatment barriers for low‐income, urban African Americans with undiagnosed posttraumatic stress disorder. *Journal of Traumatic Stress, 21*(2), 218-222. Retrieved from https://doi.org/10.1002/jts.20313

Desai, R.A., Stefanovics, E.A., & Rosenheck, R.A. (2005). The role of psychiatric diagnosis in satisfaction with primary care: Data from the Department of Veterans Affairs. *Medical Care, 43*(12), 1208–1216. doi: 10.1097/01.mlr.0000185747.79104.90

Dobie, D.J., Kivlahan, D.R., Maynard, C., Bush, K.R., Davis, T.M., & Bradley, K.A. (2004). Posttraumatic Stress Disorder in Female Veterans Association with Self-reported Health Problems and Functional Impairment. *Arch Intern Med, 164*, 394–400. doi: 10.1001/archinte.164.4.394

Greene-Shortridge, T.M., Britt, T.W., & Castro, C.A. (2007). The Stigma of Mental Health Problems in the Military. *Military Medicine, 172*(2), 157-161.

Hendin, H. (1984). Combat Never Ends: The Paranoid Adaptation to Posttraumatic Stress. *American Journal of Psychotherapy,* 38, 121-131.

Hoge, C.W., Auchterlonie, J.L., & Milliken, C.S. (2006). Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning From Deployment to Iraq or Afghanistan. *Original Contribution*, 1023–1031.

Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. *The New England Journal of Medicine, 351*(1), 13-22.

Hoge, C.W., Lesikar, S.E., Guevara, R., Lange, J., Brundage, J.F., Engel, C.C. Jr., …Orman, D.T. (2002). Mental disorders among US military personnel in the 1990s: association with high levels of health care utilization and early military attrition. *The Journal of American Psychiatry, 159*, 1576–1583.

Hoge, C.W., Terhakopian, A., Castro, C.A., Messer, S.C., & Engel, C.C. (2007). Association of Posttraumatic Stress Disorder with Somatic Symptoms, Health Care Visits, and Absenteeism Among Iraq War Veterans. *Am J Psychiatry, 164*(1), 150-153.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry, 52*(10), 48–60.

Kim, P.Y., Britt, T.W., Klocko, R.P., Riviere, L.A., & Adler, A.B. (2011). Stigma, Negative Attitudes About Treatment, and Utilization of Mental Health Care Among Soldiers, *Military Psychology, 23*(1), 65-81.

Kim, P.Y., Thomas, J.L., Wilk, J.E., Castro, C.A., & Hoge, C.W. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatric Services, 61*, 572–588.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A., & Pescosolido, B.A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*, 1328–1333.

Link, B.G., Struening, E.L., Neese-Todd, S., Asmussen, S., & Phelan, J. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illness. *Psychiatric Services, 52*, 1621–1626.

Mackenzie, C.S., Gekoski, W.L., & Knox, V.J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health,* 10(6), 574-582.

McNally, R.J. (2012). Are we winning the war against posttraumatic stress disorder? *Science, 336*, 872–874.

Mollica, R.F., Caspin-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Indochine refugees. *The journal of nervous and mental disease, 180,* 110-115.

Murdoch, M., Polusny, M.A., Hodges, L., & O'Brien, N. (2004). Prevalence of in-service and post-service sexual assault among combat and noncombat veterans applying for

department of veterans' affairs posttraumatic stress disorder disability benefits. *Military Medicine, 196*(5), 392-39.

Murthy, R.S., & Lakshminarayana, R. (2006). Mental health consequences of war: a brief review of research findings. *World Psychiatry, 5*(1), 25–30.

Oruc, L., Kapetanovic, A., Pojskic, N., Miley, K., Forstbauer, S., Mollica, R.F., & Henderson, D.C. (2009). Screening for PTSD and depression in Bosnia and Herzegovina: Validating the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist. *International Journal of Culture and Mental Health, 1,* 105-116.

Ouimette, P., Vogt, D., Wade, M., Tirone, V., Greenbaum, M.A., Kimerling, R., & Rosen, C.S. (2011). Perceived Barriers to Care Among Veterans Health Administration Patients with Posttraumatic Stress Disorder. *Psychological Services, 8*(3), 212-223.

Porter, T.L., & Johnson, W.B. (1994). Psychiatric Stigma in the Military. *Military Medicine*, *159*(9), 602–605. Retrieved from https://doi.org/10.1093/milmed/159.9.602

Ramchand, R., Schell, T.L., Karney, B.R., Osilla, K.C., Burns, R.M., & Calderone, L.B. (2010). Disparate prevalence estimates of PTSD among service members who served in Iraq and Afghanistan: possible explanations. *Journal of Traumatic Stress, 23*, 59– 68.

Richard A.K., William, S., John, F., Jordan, B.K., Richard, H., Marmar, C., & Weiss, D. (1991). Assessment of posttraumatic stress disorder in the community: Prospects and pitfalls from recent studies of Vietnam veterans. Psychological Assessment. *Journal of Consulting and Clinical Psychology, 3*(4), 547-560.

Sandanger I., Moum T., Ingebrigtsen G., Dalgard O.S., Sorensen T., & Bruusgaard D. (1998). Concordance between symptom screening and diagnostic procedure: the Hopkins

Symptom Checklist-25 and the Composite International Diagnostic Interview. *social psychiatry and psychiatric epidemiology, 33*, 345-354.

Sayer, N.A., Friedemann-Sanchez, G., Spoont, M., Murdoch, M., Parker, L.E., Chiros, C., & Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation in veterans. *Psychiatry*, *72*, 238-255. doi: 10.1521/psyc.2009.72.3.238

Sayer, N.A., Noorbaloocji, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration Problems and Treatment Interests among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care. *Psychiatric Services, 61*(6), 589-597.

Schnurr, P.P., Friedman, M.J., & Bernardy, N.C. (2002). Research on posttraumatic stress disorder: epidemiology, pathophysiology, and assessment. *Journal of Clinical Psychology, 58*, 877–889.

Seal, K.H., Bertenthal, D., Miner, C.R., Sen, S., & Marmar, C. (2007). Bringing the War Back Home: Mental Health Disorder Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities. *Archives of Internal Medicine, 167*(5), 476-482.

Seal, K.H., Metzler, T.J., Gima, K.S., Bertenthal, D., Maguen, S., & Marmar, C.R. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans using Department of Veterans Affairs health care, 2002–2008. *American Journal of Public Health, 99*, 1651–1658.

Shlosberg, A., & Strous, R. (2005). Long-Term Follow-Up (32 Years) of PTSD in Israeli Yom Kippur War Veterans. *The Journal of Nervous and Mental Disease, 193*(10), 693-696. doi: 10.1097/01.nmd.0000180744.97263.d3

Signorelli, N. (1989). The stigma of mental illness on television. *Journal of Broadcasting and Electronic Media, 33*, 325–331.

Smith, T.C., Wingard, D.L., Ryan, M.A.K., Kritz-Silverstein, D., Slymen, D.J., & Sallis, J.F. (2008). Prior Assault and Posttraumatic Stress Disorder After Combat Deployment. *Epidemiology, 19*(3), 505-512.

Stecker, T., Fortney, J.C., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatric Services, 58*, 1358–1361.

Tanielian, T., & Jaycox, L.H. (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 492. Retrieved from http://veterans.rand.org

U.S. Department of Veterans Affairs. (2012). *Analysis of VA Health Care Utilization Among Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn Veterans.* Washington, DC, Veterans Health Administration, Office of Public Health. Retrieved from http://www.publichealth.va.gov/epidemiology

Vaughan, C.A., Schell, T.L., Tanielian, T., Jaycox, L.H., & Marshall, G.N. (2014). Prevalence of Mental Health Problems Among Iraq and Afghanistan Veterans Who Have and Have Not Received VA Services. *Psychiatric Services, 65*(6), 833-835.

Vogel, D.L., & Wester, S.R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology, 50*, 351–361.

Wang, P.S., Aquilar-Gaxiola, S., Alonso, J., Angermeyer, M.C., Borges, G., Bruffaerts, R., … Ustün, T.B. (2007). Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry, 6,* 177–185.

Wells, J.E., Robins, L.N., Bushnell, J.A., Jarosz, D., & Oakley-Browne, M.A. (1994). Perceived barriers to care in St Louis (USA) and Christchurch (NZ): reasons for not seeking professional help for psychological distress. *Social Psychiatry and Psychiatric Epidemiology, 29*, 155–164.

Yehuda, R., & LeDoux, J. (2007). Response Variation following Trauma: A Translational Neuroscience Approach to Understanding PTSD. *Neuron Review, 56*, 19-32.

6. Tables

6.1. Table 1

Organizational Barriers, Negative Attitude and Stigma

	Mean Score	Standard Deviation
Negative Attitude:		
I do not trust mental health professionals	2.2484	1.28467
My leaders discourage the use of mental health services	1.7081	.94631
Psychological problems tend to work themselves out without help	1.9689	1.08641
Getting mental health treatment should be a last resort	2.1553	1.28238
A fellow soldier's mental health problems are none of my business	2.0062	1.05769
I would think less of a team member if I knew he or she was receiving mental health counseling	1.3292	.75644
Organizational Barriers:		
Mental health services are not available	2.4099	1.24234
I don't know where to get help	2.2609	1.36712
It's difficult to get an appointment	2.5590	1.34557
It's difficult to get free from work for an appointment	2.2547	1.23632
Stigma:		
It would be too embarrassing	2.1615	1.29856
It would harm my career	2.0870	1.21136
Members of my unit might have less confidence in me	2.0994	1.23088
My unit leadership might treat me differently	2.2609	1.27731
My leaders would blame me for it	1.8199	1.06000
I would be seen as weak	2.2919	1.35388
It might affect my security clearance	2.0994	1.25102
Valid N (listwise)		

6.2. Table 2

Regression Model: Treatment Seeking by HSCL-25

	Estimate	Std..Error	z.value	Pr...z..
(Intercept)	-2.14871	0.59892	-3.58763	0.00033
Mean Stigma	-0.20247	0.24027	-0.84267	0.39941
Type	3.43192	1.83133	1.87400	0.06093
Mean Attitude	0.06631	0.22299	0.29734	0.76620
Mean Barriers	0.55401	0.22798	2.43008	0.01510
Type: Mean Stigma	0.42997	0.56070	0.76685	0.44317
Type: Mean Attitude	-0.76170	0.52901	-1.43984	0.14991
Type: Mean Barriers	-0.85063	0.53927	-1.57736	0.11471

Note: The stigma questionnaire is from Hoge et al. (2004); the Attitude (Negative Attitude Towards Psychological Treatment) by Kim, Britt, Klocko, Riviere & Adler (2011); the Barriers questionnaire (Organizational\Practical Barriers to Care) were taken from Hoge et al. (2004), Britt et al. (2009) and Kim et, al. (2011); Hopkins Symptom Check List-25 (HSCL-25) to assess anxiety and depression symptoms by Sandanger, Moum, Ingebrigtsen, Dalgard, Sorensen, and Bruusgaard (1998); Type refers to participants with mean>1.75 on HSCL-25; Seeking treatment refers to yes or no answers to the question "Have you sought treatment for stress or emotional problems?" from Hoge et al. (2004).

6.3. Table 3

Regression Model: Treatment Seeking by Shocking experiences

	Estimate	Std..Error	z.value	Pr...z..
(Intercept)	-1.83365	0.79202	-2.31516	0.02060
Mean Stigma	0.09701	0.30980	0.31315	0.75416
Type	-0.09706	1.07298	-0.09046	0.92792
Mean Attitude	-0.21291	0.26728	-0.79658	0.42570
Mean Barriers	0.23971	0.29981	0.79953	0.42398
Type: Mean Stigma	-0.45430	0.44243	-1.02683	0.30450
Type: Mean Attitude	0.64909	0.46071	1.40889	0.15887
Type: Mean Barriers	0.41245	0.42241	0.97641	0.32886

Note: The stigma questionnaire is from Hoge et al. (2004); the Attitude (Negative Attitude Towards Psychological Treatment) by Kim, Britt, Klocko, Riviere & Adler (2011); the Barriers questionnaire (Organizational\Practical Barriers to Care) were taken from Hoge et al. (2004), Britt et al. (2009) and Kim et, al. (2011); Hopkins Symptom Check List-25 (HSCL-25) to assess anxiety and depression symptoms by Sandanger, Moum, Ingebrigtsen, Dalgard, Sorensen, and Bruusgaard (1998); Type refers to yes or no answers to the question " Did you experience shocking or radical events during your military service"; Seeking treatment refers to yes or no answers to the question "Have you sought treatment for stress or emotional problems?" from Hoge et al. (2004)

7. Appendix

7.1. Appendix A: Information letter for the Participants

Dear sir\madam,

Thank you for agreeing to participate in the study “Utilization of mental health care among IDF veterans”.

My name is Sagi Rachel Shiner. I am an IDF veteran and a master student at the university of Utrecht, in The Netherlands. As part of my studies in the clinical psychology department, I have been focusing on utilization of mental health care among people who served in the army. My interest drives from my own personal experience with emotional difficulties during my service. It is highly important for me to understand what prevents or drive people to ask for needed help.

The goal of this project is to contribute to my career and understanding of mental health care utilization and possible barriers to care among Israeli veterans. The importance of this study stems from researchers understanding that veterans and soldiers do not always receive help in time. Therefore, effecting other aspects of life for those in need, such as occupation, family function and relationship impediments that occur due to emotional distress.

This project is supported by Utrecht University, the Department of Clinical Psychology. The results of the study will be used for a thesis project as part of Utrecht Clinical Psychology master program, as well as for a collaborative project with Foundation Centrum '45, The Netherlands.

In the questionnaire you will look back at your military service, experiences before, during and after your service, possible consequences of the service for you and / or your family. But above all the focus will be on your experiences and views on treatment.

The questionnaire will only take 20 minutes. Your responses will be dealt with completely anonymously. You will not be asked to share any identifying information.

For any question or help needed while filling in the questionnaire, and in case you would like to receive a summary of the findings from the study, you can contact Sagi Rachel Shiner at: s.r.shiner@students.uu.nl

Your participation is highly appreciated!

7.2. Appendix B: Questionnaires

Please answer the following questions by ticking on the correct answer or filling in the answer in the open-ended question space

Gender: Male \ Female

Age ……

Marital status:

- Married cohabiting
- Unmarried cohabiting
- LAT relationship
- Widow / widower
- Divorced

Profession in the military:

- Combat
- Supporting combat
- Administrative

Number of years in service: .....

Number of missions: .....

You may experience or have experienced complaints or problems with your health, during or after your military service.

1. Did you experience shocking or radical events during the military service?

Tick the correct answer.

You can give an explanation on the dotted lines.

No

Yes, namely……

The following complaints are sometimes mentioned by people after experiencing painful or frightening events.

To what extent did you yourself experience the following complaints in the past seven days?

Tick the correct answer.

	1 Not at all a burden	2 A bit of a burden	3 Quite a lot of trouble	4 A lot of trouble
1. Recurring thoughts or memories to the painful or frightening events	1	2	3	4
2. Feel like the events take place again	1	2	3	4
3. Recurring nightmares	1	2	3	4
4. Detached or withdrawn feeling from others	1	2	3	4
5. Unable to feel anything	1	2	3	4
6. Feeling nervous, being frightened	1	2	3	4

7. Difficult to concentrate	1	2	3	4
8. Difficulty sleeping	1	2	3	4
9. On your guard	1	2	3	4
10. Being irritated or have anger outbursts	1	2	3	4
11. Avoiding occupations that relates to the painful or frightening events	1	2	3	4
12. The painful or frightening events can't be remembered completely	1	2	3	4
13. Have less interest daily activities	1	2	3	4
14. Feel like you have no future	1	2	3	4
15. Avoiding thoughts and feelings that remind you of the painful or frightening events	1	2	3	4
16. Sudden feelings or physical reactions when remembering the painful or frightening events	1	2	3	4

2. If you do not experience any complaints (for the past week), has there been a moment since your military service that you have been experiencing one or more of the aforementioned complaints?

No

Yes, namely .....

Below are complaints that people have sometimes.

To what extent did you yourself experience the following complaints in the past seven days?

Tick the correct answer.

	1 Not at all a burden	2 A bit of a burden	3 Quite a lot of	4 A lot of trouble
1. Suddenly startle or frightened	1	2	3	4
2. Feeling scared	1	2	3	4
3. Feeling dizzy or weak	1	2	3	4
4. Nervous or shaky inside	1	2	3	4
5. Pounding or fast beating heart	1	2	3	4
6. Vibrations	1	2	3	4
7. Feeling tense or excited	1	2	3	4
8. Headache	1	2	3	4

9. Attacks of anxiety or panic	1	2	3	4
10. Feel restless, can't sit still	1	2	3	4
11. Have little energy	1	2	3	4
12. Blaming yourself on all sorts of things	1	2	3	4
13. Mood change quickly	1	2	3	4
14. Loss of sexual interest or pleasure	1	2	3	4
15. Have little appetite	1	2	3	4
16. Difficulty falling asleep or being able to sleep	1	2	3	4
17. Feeling desperate about the future	1	2	3	4
18. Feeling dejected	1	2	3	4
19. Feeling lonely	1	2	3	4

20. Considered making an end to your life	1	2	3	4
21. You feel entangled or trapped	1	2	3	4
22. Too much to worry about	1	2	3	4
23. Not interested in anything	1	2	3	4
24. Feeling that everything takes effort	1	2	3	4
25. Feelings that you worth nothing	1	2	3	4

3. If you do not experience any complaints (for the past week), has there been a moment since your broadcast that you have experienced one or more of the aforementioned complaints?

No

Yes, namely .....

4. Did or did you experience any other complaints or problems than mentioned above (e.g., problems related to alcohol or drug use)?

No

yes, namely .....

In the following section, you will be asked more extensively about your experiences with mental health services.

First, please answer to what extent you agree with the following views on assistance in mental health care.

Tick the correct answer.

	1 Completely disagree	2	3	4 Completely agree
1. I do not trust aid workers	1	2	3	4
2. Assistance is not available	1	2	3	4
3. I do not know where I can find help	1	2	3	4
4. It is difficult to make an appointment	1	2	3	4
5. It is difficult to get free from work for the treatment	1	2	3	4
6. It would be too embarrassing	1	2	3	4
7. It would damage my career	1	2	3	4
8. Colleagues from my unit would have less confidence in me	1	2	3	4
9. My commander of the unit would treat me differently	1	2	3	4

10. My supervisors would blame me for the problem	1	2	3	4
11. I would be seen as weak	1	2	3	4
12. It would affect my power security	1	2	3	4
13. My supervisors discourage the use of mental health care	1	2	3	4
14. Psychological problems will resolve themselves without help	1	2	3	4
15. Treatment is a last resort	1	2	3	4
16. Psychological problems of a colleague are not my concern	1	2	3	4
17. I would look down on a colleague if he or she is being treated	1	2	3	4

5. Has one or more of these views impeded your willingness to seek help and if so which?

.....

6. Have you sought treatment for stress or emotional problems at some point in life?

No

Yes, namely……..