



## Understanding veteran barriers to specialty outpatient PTSD clinical care

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### ABSTRACT

**Objective:** Veterans seeking treatment for posttraumatic stress disorder (PTSD) commonly report general and veteran-specific barriers to treatment such as stigma and challenges with navigating the Veterans Health Affairs (VHA) system. This study aimed to characterize barriers endorsed by a national sample of veterans seeking care in VHA PTSD specialty outpatient clinics, as well as to examine the impact of demographics on endorsed barriers. **Methods:** This study included 17,069 veterans referred to PTSD specialty outpatient clinics in the VHA during Fiscal Year 2019. Barriers to care, demographics, clinical concerns, and PTSD symptom severity (PCL-5) were assessed at intake.

**Results:** Veterans (mean age=47.6 years, 83.3% male) endorsed an average of 2.39 barriers. The most commonly endorsed barriers included difficulty interacting with others (37.9%), difficulty being in public (33.8%), work (30.3%), concern for finances (20%), and difficulty getting out of bed (19.5%). A significant minority of veterans (22%) endorsed no barriers. Male sex (23.1%) and White race (23.6%) were associated with a greater likelihood of reporting no barriers.

**Conclusions:** These findings indicate the need for a comprehensive approach to addressing multi-faceted barriers for veterans seeking treatment in PTSD specialty clinics. Findings also highlight the potential importance of tailoring strategies to reduce barriers based on demographic and clinical characteristics such as race, sex, and degree of avoidance. Future research should seek to longitudinally examine the impact of barriers on treatment engagement.

### 1. Introduction

Posttraumatic stress disorder (PTSD; [American Psychiatric Association, 2013](#)) is a mental health disorder frequently diagnosed in military personnel. Estimated lifetime prevalence rates of PTSD range from approximately 10% to over 30% depending on the service era (e.g., [Fulton et al., 2015](#); [Kang et al., 2003](#), [Kulka et al., 1990](#); [Tanielian & Jaycox, 2008](#)). PTSD is associated with adverse functional outcomes

including difficulties within intimate relationships employment, health-related problems, suicide, and comorbid chronic pain (e.g., [Allen et al., 2018](#); [Asmundson et al., 1998](#); [Kubzansky et al., 2007](#); [Palyo & Beck, 2006](#); [Taft et al., 2011](#); [Sharp & Harvey, 2001](#)). Given the rates of PTSD and associated negative impact on veterans, understanding barriers to receiving treatment is critical. Barriers to treatment often play a critical role in initiating and continuing mental health treatment and span several domains including personal, logistical, and institutional

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barriers (e.g., Andrade et al., 2014; Kessler et al., 2001; Mojtabi et al., 2011). Personal and worry-related barriers often include negative beliefs about mental health treatment, concerns and worries related to personal issues, and stigma. Logistical barriers may include financial and transportation limitations, work and work schedule, childcare, and school-related barriers. Institutional barriers may include factors such as limited availability of services, mistrust of an agency, and negative experiences with staff. Previous research has identified similar personal, logistical, and institutional barriers across samples of veterans seeking or receiving PTSD treatment in a variety of settings and formats (Held et al., 2020; Hundt et al., 2018; Sayer et al., 2009; Stecker et al., 2013).

Veterans seeking treatment for PTSD endorse a number of barriers to initiating and continuing treatment. On average, veterans have reported between 4 and 33 barriers to care within different VHA PTSD treatment programs (Garcia et al., 2014; Hundt et al., 2018; Possemato et al., 2018). However, differences in average numbers of reported barriers may reflect differences in measurement approaches or sample characteristics. Personal and logistical barriers often identified for veterans include financial limitations, scheduling difficulty, transportation challenges, concerns about stigma, negative experiences with treatment, and limited knowledge about mental health (Cheney et al., 2018; Doran et al., 2021; Garcia et al., 2014; Sayer et al., 2009). Veterans with PTSD also report experiencing barriers that are unique to their veteran status and to institutions such as the VHA. Specific VHA-related barriers such as difficulty navigating the system, mistrust of the system, and negative experiences with the system are common among veterans who were referred to or utilized VHA services (Cheney et al., 2018; Harpaz-Rotem et al., 2014; Hundt et al., 2018; Sayer et al., 2009). The types of reported barriers also differ based on service era. For example, Garcia and colleagues (2014) indicated that OEF/OIF veterans were more likely to endorse employment conflicts and negative attitudes towards treatment as barriers than Vietnam or Gulf War veterans.

Veterans with PTSD may also encounter barriers related to their psychopathology. Central features of PTSD, including avoidance, hyperarousal/reactivity, and emotional concerns can act as barriers to treatment. Veterans with PTSD, for example, may avoid being in public and interacting with others. Additionally, they may believe they are unready for treatment and that it will overwhelm their coping abilities or that avoidance of treatment is helpful (Hundt et al., 2015; Sayer et al., 2009; Stecker et al., 2013). Greater PTSD symptom severity has also been shown to be associated with greater perceived barriers (Ouimette et al., 2011; Sayer et al., 2009). Avoidance symptoms, specifically, have been found to act as a key factor in not seeking PTSD treatment (Sayer et al., 2009). A stronger understanding of symptom-related barriers will be important in identifying ways to increase support for veterans with PTSD.

When veterans experience barriers, they may be less likely to initiate and receive an adequate dose of evidence-based PTSD treatment, which has been shown to target and reduce both PTSD symptoms and suicidality (e.g., Rozek et al., 2022). Identifying and addressing barriers to continued care and treatment may therefore help decrease the gap between treatment need and initiation. Historically, veterans from underrepresented groups including Black/African American and Hispanic/Latinx populations are shown to initiate treatment at lower rates than veterans who are White (for review see: McClendon et al., 2020). However, there is little data to examine if these groups are associated with specific barriers. Similarly, although women tend to utilize services more often within the VHA, little is known about what specific barriers women veterans face compared to men veterans (e.g., Tsai et al., 2015). It is therefore possible that the barriers encountered and their impacts may differ across veterans with different demographic and clinical characteristics. Understanding these differences would provide foundational information on ways tailor programs to veterans to reduce barriers and support treatment engagement.

Given the VHA's widespread rollout of evidence-based treatment for PTSD and creation of PTSD-specific clinics (Cook et al., 2020), the

overall goal of the current study was to utilize a large, national sample of veterans referred to care in PTSD specialty clinics to help characterize current perceived barriers to treatment in VHA PTSD specialty clinics by examining barriers encountered and their relationship to demographic and characteristics. This initial characterization of barriers can lay the groundwork for future, more systematic examinations of barriers encountered and the ways in which they interact with different stages of the process of seeking treatment at VHA PTSD specialty clinics. There were two specific aims. First, this study aimed to identify and quantify barriers identified by veterans referred to treatment in VHA PTSD specialty clinics. Second, person-level characteristics (e.g., race, sex) were used to identify differences among these characteristics on barriers to care.

## 2. Method

### 2.1. Participants and procedure

Participants were veterans ( $N = 17,069$ ) referred to PTSD specialty clinics in the Department of Veterans Affairs for Fiscal Year 2019 (October 1, 2018 through September 30, 2019) across the country. Veterans may self-refer to PTSD specialty clinics or receive referrals from medical or mental health providers. As part of program evaluation, the Northeast Program Evaluation Center collects the PTSD Status Form (PSF, described below), which is collected at the intake appointment at the PTSD specialty clinic. Additional patient information was collected through medical records. This study protocol was approved by the local Institutional Review Board.

### 2.2. Measures and sample characteristics

The PSF is a standardized template in the electronic medical record that clinicians used to record veteran responses as part of intake procedures in PTSD specialty clinics. This form was completed by veterans with at least one visit in a PTSD specialty clinic and contains veteran-level characteristics including demographics, barriers to care, and presenting problems for clinical care. The PSF also includes a range of potential barriers to care: none, work, school, volunteer work schedule, childcare, custody issues, concerns about finances, concerns about employment, concerns about housing, transportation difficulties, mistrust of the VHA, not getting along with family, not getting along with friends, difficulty getting out of bed, difficulty being in public, difficulty interacting with others, and criminal justice concerns. Veterans were asked to identify the barrier(s) to treatment that were applicable for them. Clinicians were able to note if the information could not be collected from the veteran. Race and ethnicity data were collected because previous research has suggested racial/ethnic disparities in PTSD treatment initiation, retention, and outcomes (Gross et al., 2021; Lester et al., 2010; Spont et al., 2014), and this data allowed for examination of whether different racial groups endorse different barriers to care. The PSF race variable options ("White," "Black," "American Indian/Alaskan," "Asian," "Pacific Islander," and "Other") were not mutually exclusive. To meaningfully interpret the race-related findings, all veterans who endorsed Black race, including biracial or multiracial veterans, were included in the Black category ( $n = 5016$ , 30.2%). The White group ( $n = 10,437$ , 62.8%) did not include multiracial identities. Due to small cell sizes in the American Indian/Alaskan ( $n = 428$ , 2.5%), Asian ( $n = 373$ , 2.2%), Pacific Islander ( $n = 169$ , 1.0%) and "Other" ( $n = 601$ , 3.5%) categories, they were collapsed into an Other race group ( $n = 1170$ , 7.0%). Options for ethnicity included Hispanic ( $n = 2012$ , 11.8%) and not Hispanic ( $n = 15,057$ , 88.2%). Veterans also identified all periods of service that were part of their identities, with options including pre-Vietnam ( $n = 104$ , 0.6%), Vietnam ( $n = 2723$ , 16.0%), post-Vietnam ( $n = 2644$ , 15.5%), Persian Gulf ( $n = 4931$ , 28.9%), and OIF/OEF/OND ( $n = 10,362$ , 60.7%). Approximately 80% of veterans in the current sample endorsed serving in only one era. As the majority of

veterans served during OIF/OEF, service era was represented with a dichotomous variable indicating OEF/OIF versus Other; anyone endorsing OEF/OIF was included in that category even if their service spanned multiple periods. Additional patient information (age and sex) was collected from veteran medical records. Clinicians rated veterans' presenting problems across 9 categories (select all that apply: Need for PTSD Specialty Care; History of Traumatic Brain Injury (TBI); Military Sexual Trauma (MST); problematic medication issues; co-occurring alcohol use disorder; co-occurring substance abuse other than alcohol; co-occurring other Axis-I disorder; complex personality traits/disorder; other). Additionally, veterans were asked to report their pain level and how much their pain interfered with their activities (both on 0–10 scale with higher numbers indicated more pain/interference).

Symptoms of PTSD were measured using the PTSD Checklist for DSM-5 (PCL-5; [Blevins et al., 2015](#)). The PCL-5 is a 20-item self-report measure that corresponds to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition ([American Psychiatric Association, 2013](#)) PTSD criteria. Items are rated on a 0-to-4-point scale with higher scores indicating greater symptom severity. The PCL-5 has demonstrated good psychometric properties and is widely used to measure symptoms of PTSD, with a cut score of > 33 indicating a likely PTSD diagnosis ([Bovin et al., 2016](#)). For the current study, only PCL-5 total sum scores were used, as item-level data was not available.

### 2.3. Analytic plan

Analyses were conducted using SPSS version 26.0. Descriptive statistics were run to identify means and frequencies of barriers and veteran-level variables, including veteran characteristics (e.g., service era, sex, race) and clinical aspects (e.g., PTSD symptoms, pain level and interference, and presenting problems). A series of 18 binary logistic regressions with each barrier as the outcome variable was conducted to determine significant differences in the endorsement of barriers based on demographic variables (i.e., era, sex, race, and ethnicity). Due to large sample size and multiple analyses, a *p* value of < .001 was adopted for all analyses.

### 3. Results

The study included 17,069 veterans referred to VHA PTSD specialty clinics across the nation in Fiscal Year 2019. The sample was predominantly male (*n* = 14,225; 83.3%), White (*n* = 10,437; 62.8%), non-Hispanic (*n* = 15,057, 88.2%), and reported serving during OEF/OIF (*n* = 10,362; 60.7%). Mean age was 47.60 years (*SD*=14.18). Veterans reported average PTSD symptoms above clinical threshold indicative of PTSD (*M*=53.46; *SD*=14.51) and, on average, over two barriers to care (*M*=2.39, *SD*=2.27). See [Table 1](#) for descriptive information on sample demographics, PTSD symptoms, and presenting problems for the overall sample and by demographic groups.

[Table 2](#) displays the frequencies and percentages of each barrier for the full sample and by demographic group. The most commonly endorsed barriers were difficulty interacting with others (37.9%), difficulty being in public (33.8%), work (30.3%), concern for finances (20%), and difficulty getting out of bed (19.5%). Roughly 1 in 5 veterans reported no barriers (22.3%). The bolded values in [Table 2](#) represent significant differences in individual binary logistic regression models (one regression model per line) of each barrier regressed simultaneously on the four demographic variables (OEF, race, ethnicity, and sex). For race, White was the reference category. Thus, bolded values for Black or Other race represent differences as compared to White veterans. OEF/OIF, female, and Black and Other race veterans were less likely to endorse no barriers to treatment. OEF/OIF veterans were more likely to endorse work, school, childcare, custody issues, concerns for employment, trouble getting out of bed, difficulty being in public, and criminal justice concerns as barriers. Black veterans were more likely to endorse concerns about housing, not getting along with family and friends,

**Table 1**  
Mean Scores and Percentages of Principal Variables by Demographic Category.

Demographics	n(%)	Mean (SD)		Presenting Problems n (%)											
		PTSD	Pain rating	Pain interference	Sum barriers	Sum presenting problems	*Need for PTSD Specialty Care	*History of TBI	*Military Sexual Trauma	*Problematic Medication Issues	*Co-occurring Alcohol Use Disorder	*Co-occurring substance abuse	*Co-occurring other Axis-I Disorder	*Complex Personality Traits/ Disorder	*Other
Entire Sample	17,069	53.46 (14.51)	5.18 (2.90)	4.88(3.20)	2.39 (2.27)	1.48(0.81)	15,170 (88.9)	1060 (6.2)	2139 (12.5)	174 (1.0)	1397 (8.2)	1063 (6.2%)	2519 (14.8)	512(3.0)	1230 (7.2)
OEF/OIF*	10,362 (60.7)	53.55 (14.43)	5.04 (2.83)	4.76(3.16)	2.60 (2.31)	1.50(0.81)	9526 (91.9)	883(8.5)	1116 (10.8)	105(1.0)	898(8.7)	647(6.2)	1508(14.6)	297(2.9)	612 (5.9)
Black Race	5016 (30.2)	55.92 (13.96)	5.83 (2.95)	5.47 (3.21)	2.50 (2.28)	1.51 (0.81)	4496 (89.6)	223 (4.4)	854 (17.0)	46 (0.9)	433 (8.6)	356 (7.1)	722 (14.4)	139 (2.8)	320 (6.4)
Other Race	1170 (7.0)	55.58 (14.33)	5.47 (2.78)	5.26 (3.13)	2.80 (2.45)	1.48 (0.81)	1044 (89.2)	79 (6.8)	156 (13.3)	13 (1.1)	90 (7.7)	60 (5.1)	163 (13.9)	40 (3.4)	91 (7.8)
White Race	10,437 (62.8)	52.02 (14.59)	4.82 (2.82)	4.54 (3.16)	2.31 (2.23)	1.48 (0.80)	9352 (89.6)	735 (7.0)	1087 (10.4)	110 (1.1)	849 (8.1)	632 (6.1)	1590 (15.2)	327 (3.1)	790 (7.6)
Not Hispanic	15,057 (88.2)	53.26 (14.59)	5.16 (2.89)	4.86 (3.20)	2.38 (2.27)	1.48 (0.81)	13,310 (88.4)	912 (6.1)	1903 (12.6)	152 (1.0)	1240 (8.2)	956 (6.3)	2312 (15.4)	454 (3.0)	1114 (7.4)
Hispanic	2012 (11.8)	54.91 (13.88)	5.27 (2.91)	5.03 (3.21)	2.44 (2.27)	1.45 (0.80)	1860 (92.4)	148 (7.4)	236 (11.7)	22 (1.1)	157 (7.8)	107 (5.3)	207 (10.3)	58 (2.9)	116 (5.8)
Women	2844 (16.7)	54.65 (14.35)	5.22 (2.99)	4.85(3.30)	2.43 (2.15)	1.82(0.95)	2442 (85.9)	95(3.3)	1489 (52.4)	37(1.3)	149(5.2)	137(4.8)	534(18.8)	152(5.3)	143 (5.0)
Men	14,225 (83.3)	53.22 (14.53)	5.17 (2.88)	4.88(3.18)	2.38 (2.29)	1.41(0.76)	12,728 (89.5)	965(6.8)	650(4.6)	137(1.0)	1248(8.8)	926(6.5)	1985(14.0)	360(2.5)	1087 (7.6)

Note. \*Categories are not mutually exclusive so numbers can sum to over 100%

**Table 2**  
Bivariate Frequencies of Barriers to Care by Demographic Groups-Bolded Values Indicate Significant Differences from Binary Logistic Regressions of Each Barrier onto Demographic Variables.

Barriers to care	Group			Race*						Ethnicity						Sex	
	Entire sample			Black		Other		White		Not Hispanic		Hispanic		Women		Men	
	n	%	OEF/OIF	n	%	n	%	n	%	n	%	n	%	n	%	n	%
None	3811	22.3	<b>1907</b>	<b>1046</b>	<b>20.9</b>	<b>204</b>	<b>17.4</b>	2506	24	3383	22.5	428	21.3	531	18.7	3280	23.1
Work	5168	30.3	<b>3961</b>	1412	28.1	351	30	3300	31.6	4449	29.5	719	35.7	882	31	4286	30.1
School	1178	6.9	<b>1089</b>	297	5.9	118	10.1	728	7	983	6.5	195	9.7	<b>304</b>	<b>10.7</b>	874	6.1
Volunteer Work Schedule	325	1.9	194	76	1.5	23	2	218	2.1	283	1.9	42	2.1	59	2.1	266	1.9
Childcare	1764	10.3	<b>1522</b>	<b>424</b>	<b>8.5</b>	<b>143</b>	<b>12.2</b>	1148	11	1494	9.9	270	13.4	<b>439</b>	<b>15.4</b>	1325	9.3
Custody Issues	437	2.6	<b>371</b>	109	2.2	29	2.5	286	2.7	377	2.5	60	3	55	1.9	382	2.7
Concern for finances	3406	20	<b>2075</b>	1048	20.9	267	22.8	2013	19.3	2994	19.9	412	20.5	524	18.4	2882	20.3
Concern for employment	2225	13	<b>1557</b>	678	13.5	<b>190</b>	<b>16.2</b>	1309	12.5	1935	12.9	290	14.4	314	11	1911	13.4
Concern for housing	1189	7	<b>662</b>	<b>435</b>	<b>8.7</b>	<b>126</b>	<b>10.8</b>	598	5.7	1075	7.1	114	5.7	184	6.5	1005	7.1
Transportation difficulties	1798	10.5	<b>957</b>	588	11.7	171	14.6	1008	9.7	1610	10.7	188	9.3	333	11.7	1465	10.3
Mistrust of VA	2304	13.5	<b>1373</b>	742	14.8	182	15.6	1337	12.8	2064	13.7	240	11.9	393	13.4	1911	13.4
Not getting along with family	3047	17.9	<b>1817</b>	<b>1037</b>	<b>20.7</b>	<b>256</b>	<b>21.9</b>	1690	16.2	2685	17.8	362	18	398	14	<b>2649</b>	<b>18.6</b>
Not getting along with friends	1788	10.5	1056	699	13.9	142	12.1	911	8.7	1586	10.5	202	10	207	7.3	<b>1581</b>	<b>11.1</b>
Difficulty getting out of bed	3321	19.5	<b>2147</b>	<b>1096</b>	<b>21.9</b>	<b>287</b>	<b>24.5</b>	1886	18.1	2950	19.6	371	18.4	<b>754</b>	<b>26.5</b>	2567	18
Difficulty being in public	5768	33.8	<b>3678</b>	1712	34.1	439	37.5	3520	33.7	5126	34	642	31.9	963	33.9	4805	33.8
Difficulty being interacting with others	6464	37.9	<b>4041</b>	<b>2041</b>	<b>40.7</b>	496	42.4	3809	36.5	5731	38.1	733	36.4	1060	37.3	5404	38
Criminal justice concerns	598	3.5	<b>418</b>	170	3.4	52	4.4	370	3.5	520	3.5	78	3.9	49	1.7	<b>549</b>	<b>3.9</b>
Unable to collect information	174	1	<b>82</b>	46	0.9	15	1.3	112	1.1	158	1	16	0.8	21	0.7	153	1.1

Note: The numeric table values represent bivariate frequencies and percentiles. The bolding indicates significant group differences ( $p < .001$ ) resulting from 18 binary logistic regressions of each barrier onto the demographic variables (bolding in each row represents one simultaneous logistic regression for that barrier).

\*White is the reference category. Bolded values for Black or Other race represent significant differences as compared to White race.

trouble getting out of bed, and difficulty interacting with others. Other race veterans were more likely to endorse concerns for employment, housing and transportation, not getting along with family and friends, trouble getting out of bed, difficulty interacting with others. Finally, female veterans were more likely to endorse school, childcare, and trouble getting out of bed whereas male veterans were more likely to endorse concerns for employment, not getting along with family and friends, and criminal justice concerns.

#### 4. Discussion

This study examined barriers to care in a national sample of veterans referred to PTSD specialty treatment clinics within the VHA. Increasing access to care is a priority for the mental health field and specifically for the VHA, and identifying barriers is a critical step in this process. The findings of the present study demonstrated that approximately 80% of veterans reported at least 1 barrier and that slightly over 20% of veterans reported no barriers. Findings also indicated that there was significant variability in the endorsement of barriers to care; endorsement of barriers varied by demographic characteristics. On average, veterans endorsed 2.39 barriers. The top five barriers identified across the sample were (1) difficulty interacting with others, (2) difficulty being in public, (3) work, (4) concerns for finances, and (5) difficulty getting out of bed. The identified barriers are consistent with previous research indicating that veterans with PTSD may encounter barriers related to logistics and PTSD symptoms and extend these findings to the specific subpopulation of veterans seeking specialty care in the VHA (Hundt et al., 2018; Ouimette et al., 2011; Sayer et al., 2009). Taken together, these findings suggest that veterans seeking treatment in a PTSD specialty clinic may encounter several barriers to engaging in treatment and that their experiences may vary based on their demographic characteristics, although further research is needed to understand the ways these barriers impact the process of seeking treatment. Targeting multiple potential barriers may help address these issues and inform patient-centered care by improving access to care for veterans seeking treatment in a PTSD specialty clinic.

Barrier endorsement varied based on person-level characteristics (i.e., era, race, and sex). Specifically, veterans from OEF/OIF were less likely to report no barriers to treatment. Consistent with previous research, other eras (e.g., Vietnam, Persian Gulf, etc.) identified logistical barriers at higher rates, whereas OEF/OIF veterans reported greater barriers in nine other domains (e.g., Garcia et al., 2014). Additionally, as seen in previous literature, barriers differed by sex (e.g., Ouimette et al., 2011). In the current study, female veterans were less likely to report no barriers to treatment and more frequently endorsed logistical barriers including school and childcare, as well as a symptom-related barrier of getting out of bed. Male veterans were more likely to endorse barriers such as interpersonal difficulty and criminal justice involvement that may be related to PTSD symptoms. Finally, White veterans most frequently endorsed no barriers to treatment as compared to Black and non-White/Black veterans. This extends previous work demonstrating racial/ethnic disparities in PTSD treatment retention and raises the possibility that differences in barriers encountered may contribute to different rates of treatment initiation and retention across groups (Lester et al., 2010; Spooon et al., 2014). Given that individual demographic characteristics are related to differences in barriers, programs supporting reduction of barriers to treatment should be tailored to the both the demographics served by different clinics within the VHA and also to the individual veterans, as a one-sized-fits-all approach may not appropriately address barriers.

Overall, the most frequently endorsed barriers were ones that are conceptually related to PTSD and mental health symptoms. In particular, characteristic symptoms of PTSD (i.e., difficulty interacting with others, difficulty being in public) were frequently endorsed as barriers to initiating treatment and were significantly related to veteran self-reported PTSD symptoms (i.e., PCL-5 scores), which is consistent with

previous research on barriers encountered by veterans at different stages of seeking treatment within the VHA (e.g., [Ouimette et al., 2011](#); [Sayer et al., 2009](#)). Frontline treatments recommended in both military (The US Department of Veterans Affairs and Department of Defense, 2017) and community (American Psychological Association [APA], 2017) settings include Cognitive Processing Therapy (CPT; [Resick et al., 2016](#); [Cusack et al., 2016](#)) and Prolonged Exposure (PE; [Foa et al., 2019](#); [Cusack et al., 2016](#)). These psychotherapeutic approaches rely on interacting with a therapist and confrontation of avoidance; thus, interacting with others is a primary concern.

Finding ways to reduce symptom-interfering barriers to care is critical and can potentially be addressed through the use of technology. Options such as telehealth treatment for PTSD are becoming more widespread and may reduce barriers by providing treatment directly to the veteran's home ([Morland et al., 2020](#)), especially during the current ongoing pandemic. However, solely engaging in telehealth as an alternative to in-person treatment may have the adverse consequence of reinforcing avoidance behaviors if such behaviors are not adequately addressed ([Jones et al., 2020](#)). Phone applications such as VA PTSD Coach are feasible to potentially address initial distress about interacting with others ([Milner et al., 2016](#)). Although PTSD Coach may not be a standalone treatment, incorporating the use of it and other applications may provide skills necessary for veterans with PTSD to increase treatment readiness. Research has also demonstrated that intensive outpatient programs, which deliver treatment daily for one to three weeks, are a novel and promising PTSD treatment delivery format that produce comparable outcomes to traditional, weekly formats and reduced dropout rates (e.g., [Yamokoski et al., 2022](#); [Zalta et al., 2018](#)). Intensive outpatient programs may reduce the impact of common barriers such as cost and travel by housing patients near the treatment site and covering travel-related costs and may reduce symptom-related barriers by producing rapid symptom reductions early in the course of treatment ([Held et al., 2020](#)). Improved use of and development of interventions delivered intensively and/or using technology may help reduce barriers to care for veterans with PTSD and improve their engagement and outcomes in recovering from PTSD.

Difficulty getting out of bed was another commonly endorsed clinical symptom that served as a barrier. Although it has been reported that depressive symptoms are associated with reductions in PTSD symptoms over the course of PTSD treatment (e.g., [Brown et al., 2018](#); [Ronconi et al., 2015](#)), veterans with elevated depressive symptoms may benefit from the integration of more targeted interventions such as Behavioral Activation. The skills of activity planning and scheduling may help reduce symptoms that act as barriers to care and may facilitate treatment attendance and engagement ([Hershenberg et al., 2018](#); [Wagner et al., 2019](#)). Furthermore, the VHA has a strong continuum of care which includes various treatment settings such as outpatient, intensive outpatient, residential, and inpatient. If a veteran is unable to get out of bed, clinicians may also consider whether a referral to a higher level of care such as residential treatment might be warranted. This level of care may be appropriate for the veteran's symptom presentation and has the potential to be more accessible due to the reduction of barriers such as travel and work demands. Previous research has demonstrated that dropout rates are lower for residential PTSD treatment than for traditional outpatient treatment ([Smith et al., 2019](#)), suggesting that residential treatment is a feasible alternative to traditional outpatient care. The prevalence of this barrier in the present sample indicates the importance of assessing for symptoms of depression during the process of initiating care for PTSD, particularly among groups at higher risk for co-occurring PTSD and depression. If addressed early on and with suitable recommendations, the impact of this symptom as a barrier could be reduced.

A significant minority of veterans reported no barriers to care (22%), which was among the top third of frequently endorsed answers. It is important to note that veterans who reported no barriers to care were primarily White, Black, or male and that additional research is needed to

understand more about the differences and programs that can help address these issues. However, this finding is promising and indicates that a proportion of veterans referred to PTSD specialty clinics did not experience significant concerns related to access to care. Recent VHA initiatives such as the MyVA Access Initiative, the Veterans Transportation Service, campaigns to reduce stigma, and legislation to reduce wait times have attempted to increase access to treatment both within and outside of the VHA and additional programs should be developed (Department of Veterans Affairs, 2011; [Department of Veterans Affairs, 2014a](#); [Department of Veterans Affairs, 2014b](#); [Department of Veterans Affairs, 2019](#)). When considering the findings of the present study in the context of these initiatives, it is possible that the initiatives have successfully contributed to the reduction or elimination of barriers for some veterans. Developing a better understanding of the path to treatment and the experiences of veterans who do not experience barriers to care will help to highlight the strengths of current processes and will be important for future efforts to improve access to mental health treatment and to tailor initiatives to groups who are likely to endorse barriers.

When interpreting these results, it must be taken into account that the administrative data was entered by clinicians, which resulted in varying degrees of completeness. Although the PSF was a standardized form, it might not have been filled out correctly, used, or fully understood. Additionally, not all barriers were represented. Some caution must therefore be used when interpreting these data. Importantly, the veterans included in the present study were seeking treatment in a specialty PTSD clinic and may not be representative of the population of veterans with PTSD. Although similar barriers to treatment have been reported in studies of veterans seeking treatment in different formats and at different settings (e.g., [Held et al., 2020](#); [Hundt et al., 2018](#)), it is possible that different groups of veterans with PTSD would not endorse the same barriers as those in the present study. For example, as the veterans in the present study had already attended at least one visit, it may be that they encountered fewer barriers or encountered different barriers than those who did attend an initial appointment. Additionally, this study categorized sex as "male" and "female," and data on gender was not collected. While dichotomizing this variable accounts for the biological basis of sex, this is not representative of individuals whose gender identity differs. Participants were asked to select all that apply for their self-identified race, which resulted in small cell sizes. For this reason, racial groups were reported as Black, White, other and limits our ability to examine specific ethno-racial groups. This also creates potentially overlapping groups as individuals may be part of two groups. Another limitation of this study is that the measure for barriers to care is not standardized, and the overall interpretation of the measure questions (e.g., "work") might have been ambiguous. It must be taken into consideration that individual interpretation may play a role in the variability between participant responses, and future research should focus on development of a more standardized measure of barriers to PTSD care. Finally, based on the design of this study, we are unable to identify those who ultimately received treatment.

Additionally, the sample in the current study were receiving care in the VHA. The barriers identified were for individuals who were engaged in care, had been referred for treatment, and attended an intake session in the PTSD specialty clinics. Because of this, the barriers identified here may be more specific to barriers of individual who are treatment seeking and engaged in care at some level, regardless of if they continued/initiated PTSD specific treatment. These barriers might be different for individuals who drop out of treatment, do not initiate treatment, and/or for those who are not receiving any care in a healthcare system. The distinction among these groups (and others types of barriers) should be examined to see if and where there are differences. Although the current barriers to treatment literature often uses these terms interchangeable, future research should work to establish consistent terms and measurement points to create consistencies in terminology and clarity of the results found.

Despite these limitations, identifying and understanding the rates of

barriers to care is an important area that should be examined and updated over time. This study provides a useful examination of barriers to treatment in VHA PTSD specialty clinics from a national sample and includes differences based on demographic variables. Clinically, understanding the potential barriers and differences in barriers provides clinicians and clinics with helpful data on potential barriers to target to increase access to care. As the present study focused on veterans seeking treatment at VHA PTSD specialty clinics, it will be of benefit for future studies to examine barriers to PTSD treatment for veterans who are seeking treatment in other mental health settings and at different stages of seeking treatment, as well as to compare reported barriers across groups to facilitate the development of tailored strategies to minimize the impact of barriers to PTSD treatment. Future research should also seek to examine reported barriers to care longitudinally in order to enrich our understanding regarding the impact of reported barriers to care on treatment seeking behaviors in PTSD specialty clinics.

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## Previous presentation

The data in this publication have not previously been presented at any professional meeting or peer-reviewed manuscript.

## Data Availability

Data will be made available on request.

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