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Mini Review

Implications of Stigma as a Barrier to PTSD Care

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Abstract

Post-Traumatic Stress Disorder (PTSD) is reported to affect 6.8% of the population of the United States, but often goes undiagnosed due to perceived stigma. Left untreated, PTSD has deleterious effects on quality of life, harming families, employers, and taxpayers with loss of life, loss of productivity, and elevated risk for criminality and addiction. Health care providers and employers play a vital role in reducing stigma, which derives, in part, from the nature of the trauma. Expanded routine screening, psychoeducation of stakeholders, and computer-mediated therapy may diminish stigma-related costs and improve access to care. The implications of stigma as a barrier to treatment should be considered in further research on the public health outcomes of PTSD.

ABBREVIATIONS

PTSD: Post Traumatic Stress Disorder

INTRODUCTION

Post-Traumatic Stress Disorder (PTSD) is a condition in which response to a traumatic stimulus persists well after the stimulus is gone [1]. This condition is often related to people who have served in combat zones in the military. The lifetime prevalence of PTSD is reported to affect 6.8% of the population of the United States [2]. According to the U.S. Department of Veterans Affairs the prevalence is much higher among the veteran population, 30.9% in male veterans and 26.9% in female veterans [3]. This higher prevalence is not surprising as those that serve in the military are far more likely to be exposed to traumatic and stressful events. Actual rates of PTSD may be underestimated because stigma—a commonly held stereotype about a population—is attached to the diagnosis [4]. Stigma inhibits help-seeking behavior among symptomatic individuals and, if left untreated, inflicts a burden on society. Expanded routine screening, psycho education of stakeholders, and computer-mediated therapy may diminish stigma-related costs and improve access to care.

Stigma discourages people from seeking help. Over half of U.S. soldiers deployed to Afghanistan or Iraq who met criteria for a PTSD diagnosis did not seek treatment [5]. Left untreated, PTSD can result in a dramatic reduction in quality of life [6]. Studies link PTSD and heart disease [7]. Veterans suffering from prolonged traumatic stress report emotional impairment and lower physical functioning [6,7]. Serious adjustment problems may arise within families, such as intimate partner violence, poor parenting, and divorce [7]. Untreated PTSD is likely to inhibit the attainment of educational goals and could lead to unemployed working-age individuals [7, 8]. Albeit severe, the negative impact of stigma is pernicious—the desire to avoid cultural connotations of instability, incompetence, and weakness [5] obscure the source of symptoms.

People avoid the stigma of a mental health disorder because stereotypes and prejudice can preclude social opportunities. The potential instability of intimate relationships [7], coupled with frustrated efforts to secure gainful employment [9-11], harms self-esteem. Employers are reluctant to hire individuals who have a psychiatric diagnosis [9]. Mental health stigma has been shown to have a deleterious impact on income [10] and status among colleagues [11]. Avoidance of a PTSD diagnosis is a response to discriminatory behavior in the workplace. Without evidence-based interventions, symptomatic individuals impact the bottom line via a loss of productivity [12]. If an employee feels ashamed to seek treatment for PTSD prior to being hired, there is a potential for subsequent Workers Compensation claims [13]. Employers foot the bill when PTSD-related stigma obstructs a positive pathway to recovery, and these costs will likely be passed on to consumers.

The diminished quality of life of untreated PTSD among individuals aggregates as a financial burden that strains the fiscal health of the United States. One estimate accrues $6.2 billion in costs to society from veterans with PTSD and depression within two years post-deployment [12]. This estimate is an aggregation of medical costs associated with suicide attempts and treatment, loss of value in completed suicides, and loss productivity. The suicidal death of a loved one shears the fabric of families; bereavement may manifest as parental neglect of children [14] and greater risk for psychopathology in children and adolescents [15]. In other words, when PTSD-related stigma blocks access

to care and results in the suicide of symptomatic individuals, the quality of life of their families diminishes. If one factors in disability payments and caregiver burden [7, 12], then the costs to society are likely higher. Since stigma impairs an individual with PTSD from securing affordable housing [16], costs stemming from homelessness and reliance on public assistance also contribute to the burden placed on taxpayers.

Untreated PTSD can manifest as criminal behavior [7, 17]. It is well documented that American prisons are holding cells for vulnerable individuals struggling with mental illness [18, 19] . Two symptoms of PTSD—hypervigilance and anger—are not adaptive in civil ian society. Previous research has shown that PTSD is considered a condition which merits a treatment-based approach instead of incarceration in the criminal justice system [20-22]. One study reported that prosecutors are willing to consider treatment in place of a trial for a defendant who suffers from PTSD [20]. For defendants that do go to trial, it has been shown that jurors have a bias towards treatment for veterans diagnosed with PTSD [21]. This bias is qualified by the timing of the diagnosis. Veterans who were diagnosed after an arrest were not shown a bias towards treatment. That bias existed only when the defendant had been diagnosed prior to an arrest [22]. Early diagnosis and intervention have the potential to reduce PTSD symptoms before they are labeled as criminality.

Though the stigma associated with PTSD diagnosis results in some people avoiding treatment to avoid the "mental illness" label [23-25], avoiding a label does not negate the effects of PTSD. Individuals living with PTSD require some sort of intervention [26-29, 37, 38]. If the treatment does not come by way of health care professionals, then people may "self-medicate" using drugs or alcohol. The self-medication hypothesis has been supported in previous research. One study, for instance, demonstrated drug use as a method of self-medication in Persian Gulf War veterans [24]. Other research links substance abuse with untreated PTSD [6, 7, 12, 25].Once again, when stereotypes and prejudice prevent symptomatic individuals from accessing appropriate care, the costs incurred by society are substantial. Since addiction harms communities by elevated rates of unsafe driving, sexually transmitted infections, unemployment, and criminal conduct, it is imperative that we address PTSD-related stigma as a public health concern.

Little attention is given to non-veterans with PTSD. Among non-veterans, the most frequently reported traumatic events are childhood sexual abuse, exposure to a dead body, and domestic violence [27]. Etiology may vary, but there is no reason to believe that effects of PTSD symptoms on quality of life differ between veterans and non-veterans. Early intervention would lead to better outcomes for both populations. Current research has demonstrated that early intervention, in the form of a modified prolonged exposure intervention, resulted in symptom reduction at one- and three-months after the traumatic event [26]. Unfortunately, individuals with lifetime PTSD typically do not receive treatment until 4.5 years after the onset of symptoms [27]. The lack of early intervention methods as a prophylactic measure to avoid the onset of PTSD is noted in previous reviews [28]. The benefit to both patients and society on the humane and financial dimensions are clear and dramatic [29]. Individuals with PTSD who undergo and adhere to evidence-based interventions show significant improvement [29-37, 38]. Pervasive stigma remains the challenge.

DISCUSSION & CONCLUSION

Health care personnel in a variety of settings can aid in the reduction of stigma through routine screening for PTSD. Since PTSD is associated with substance abuse and past-month disability [27], efforts to diagnose the condition may be effective at recovery residences, rehabilitation programs, and pain clinics. Compared to men, women are more likely to develop PTSD [6], so screening for this condition should take place at shelters for battered women, family planning organizations, and pregnancy clinics. Veterans from Operation Iraqi Freedom tend to utilize community clinics more than the VA system [31] and, in general, symptomatic individuals tend to present trauma-related problems during visits with their primary care physician [32]. If we normalize screening for PTSD at these locations, then we present a message that it is common to discuss this disorder and fewer undiagnosed cases may persist.

A report released by the U.S. Government Accountability Office in 2016 made seven recommendations for addressing stigma within the Armed Forces [33]. Many of these recommendations might be difficult to translate into the private sector. However, the proposal of an established, consistent measure to gauge stigma could be helpful for employers. Use of this measure could improve workplace culture by highlighting psycho educational needs and providing a means to track progress. Evidence suggests that psycho educational management strategies reduce PTSD-related stigma and improve help-seeking behavior [34, 35]. Additionally, if supported by anti-discriminatory legislation and insurance, the tool could provide a pathway to care for individuals suffering from PTSD. Similar to screening, this top-down approach diminishes the shame of mental illness, signaling to employees that help-seeking is not a punishable offense. Indeed, PTSD symptoms improve when employees perceive organizational support [36]. A cost-benefit analysis for implementation of such a measure is warranted.

The stigma of PTSD derives, in part, from the nature of the trauma. Previous traumatic events that involuntarily intrude into the minds of civilian patients are frequently taboo, involving uncomfortable subjects such as sexual abuse or assault by an intimate partner [27]. The challenge is that nurses and primary care physicians may lack the training needed to properly respond to disclosures of trauma. One inadequate response is enough to inhibit further attempts to seek treatment. Among veterans, psychological characteristics that were adaptative during deployment, such as hypervigilance, impede reintegration. A warrior mentality does not allow for admissions of needing help [4, 7, 23, 31].The belief that civilians cannot comprehend the tribulations of war [23] can complicate discussions of trauma between veterans and their health care providers. Psychoeducation and sensitivity training for local healthcare professionals may breakdown stigma-related barriers to PTSD care.

Finally, resources should be directed to research on the innovative use of technology to circumvent stigma. Computer-

mediated therapy delivered over the Internet is a promising area of research. Studies demonstrate the efficacy of digitally delivered exposure therapy [37] and cognitive therapy [38] for patients meeting PTSD criteria. In addition to improving symptoms, computer-mediated therapy is an effective form of outreach and raises retention rates. Exploring the breadth of this research is beyond the scope of this article, but it should be noted that, despite a decade of research in this area, this option is poorly publicized. If this intervention becomes cost effective and well-known, then the harms caused by undiagnosed PTSD can be addressed discretely. Privacy concerns are negligible when patients can manage their care from the comfort of their home.

A public health model for reducing PTSD-related stigma should screen for symptoms, disseminate psychoeducation, and fund virtual counseling. Stigma discourages people from seeking help and following through with referrals to mental health professionals. It indirectly inflates the incarceration rates of veterans suffering from PTSD. Despite the efficacy of early intervention and treatment, shame and self-blame stop diagnosable patients from accessing treatment. Without treatment, symptoms manifest as costs to society. Professionals in the health care ecosystem may be able to reduce stigma and concomitant social costs by screening for PTSD at certain locations. Employers may be able to reduce absenteeism, enhance productivity, and improve morale by evaluating PTSD-related stigma and sponsoring psychoeducation initiatives. Human resource departments, community organizations, and health care facilities should raise awareness on computer-mediated therapy. As researchers continue to explore the positive outcomes of different treatment approaches for PTSD, stigma must be considered. The best modalities cannot heal a patient too ashamed to enter treatment.

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