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Mental Health Literacy in Veterans: What Do U.S. Military Veterans Know About PTSD and Its Treatment?

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Given military veterans' underutilization of posttraumatic stress disorder (PTSD) treatment, it is important to explore factors that may facilitate or stand in the way of treatment seeking for this population. The purpose of this study was to provide an initial examination of military veterans' mental health literacy as it relates to PTSD and its treatment. One-hundred and 32 post-9/11 veterans were recruited for this web-based study. A vignette-based approach was employed to examine veterans' mental health literacy and relationships between mental health literacy and dimensions of stigma. Consistent with hypotheses, results revealed relatively higher levels of PTSD problem recognition, and lower levels of knowledge about evidence-based treatments and self-help strategies within this veteran sample. Correlational results provided partial support for our hypotheses: Mental health literacy was inversely associated with negative beliefs about mental health problems and treatments, but not significantly related to other dimensions of stigma. This study highlights potential targets for mental health literacy interventions and points to the value of additional research on the role of mental health literacy in veterans' treatment seeking.

Impact Statement

This study examined post 9/11 veterans' PTSD specific mental health literacy. Results indicated high rates of knowledge regarding PTSD symptoms and diagnosis, and lower levels of knowledge about evidence-based treatments and self-help strategies. In addition, mental health literacy was inversely associated with negative beliefs about mental health problems and treatments, but not significantly related to other dimensions of stigma. This study highlights potential targets for mental health literacy interventions and points to the value of additional research on the role of mental health literacy in veterans' treatment seeking.

Keywords: mental health literacy, PTSD, service use, veterans

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Fewer than half of all military veterans who experience mental health problems such as posttraumatic stress disorder (PTSD) indicate that they are interested in or seek professional mental health care (Elbogen et al., 2013; Erbes, Westermeyer, Engdahl, & Johnsen, 2007; Hoge, Auchterlonie, & Milliken, 2006). Along with access-related barriers, concerns about anticipated stigma (e.g., "People will think I am crazy"), as well as negative beliefs about treatments (e.g., "Treatment doesn't work"), treatment-seeking (e.g., "A problem would have to be really bad for me to seek treatment"), and mental health problems, (e.g., "People with mental health problems can't be counted on") may all serve as salient barriers to care for veterans who would benefit from mental health treatment. In addition, research has found that these beliefs are empirically related to lower likelihood to seek mental health care among veterans experiencing distress (Fox, Smith, & Vogt, 2018; Vogt, Fox, & Di Leone, 2014).

Therefore, *mental health literacy* may be an important target to reduce stigma-related barriers to mental health care among veterans. This perspective is consistent with social psychological theories of stigma reduction, which have highlighted the role of mental health knowledge in decreasing mental health stigma (Corrigan et al., 2001). Mental health literacy was originally defined by Jorm and colleagues as "knowledge about mental disorders which aid in their recognition, management, and prevention" (Jorm et al., 1997, p. 182), including knowledge related to: (a) mental health

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problem identification, (b) risk and protective factors, (c) effective coping strategies, (d) prognosis or course of the mental health condition, and (e) evidence-based treatments and treatment-seeking. As reflected in this definition, mental health literacy is distinct from mental health-related beliefs, which are influenced by attitudes and opinions that are acquired over time and may or may not be based on factual information (O'Connor, Casey, & Clough, 2014). Mental health literacy has been measured in a myriad of ways, and to date, there is no "gold-standard" tool of measurement (Wei, McGrath, Hayden, & Kutcher, 2017). Despite this, the research that is available suggests that mental health literacy is influenced by a number of background characteristics. These include educational attainment, which may be a proxy for socioeconomic status (Holman, 2015), gender, with women reporting higher levels (Cotton, Wright, Harris, Jorm, & McGorry, 2006), and type of presenting mental health problem, with lower mental health literacy observed for psychotic disorders like schizophrenia than mood disorders like depression (Furnham, Annis, & Cleridou, 2014), However, mental health literacy related to PTSD is relatively understudied in all of these areas.

Given that mental health literacy levels may vary by presenting problem, it is important to examine mental health literacy within the context of specific mental health problems. This is especially important for warfare-exposed veterans, who are at particularly high risk for PTSD (Mota et al., 2019). Additionally, stigma related to experiencing a mental health problem or seeking treatment, may be a salient concern for former service members, even more so than their civilian peers due to their exposure to an organizational culture that places a strong emphasis on self-control, self-reliance, and emotional toughness (Krill Williston, Roemer, & Vogt, 2019; Weeks, Zamorski, Rusu, & Colman, 2017). While these values may serve well in a combat situation, they may also discourage veterans from acquiring needed knowledge about mental health problems like PTSD and evidence-based treatments, such as cognitive processing therapy (Resick, Monson, & Chard, 2016) and prolonged exposure (Foa, Hembree, & Rothbaum, 2007) once on the home front.

Studies that have examined PTSD-specific mental health literacy in civilians have found that trauma type is particularly important in PTSD problem recognition, with greater odds of correctly identifying PTSD when information is provided within a military combat rather than a civilian accident context (Merritt, Tharp, & Furnham, 2014). One study that examined PTSD-specific mental health literacy in both civilians and veterans revealed that both groups were more frequently able to identify symptoms of PTSD and potentially traumatic events than to demonstrate knowledge of evidence-based treatment options (Harik, Matteo, Hermann, & Hamblen, 2017). Further, individuals who had received prior PTSD treatment were better able to identify PTSD symptoms, and interestingly, veterans demonstrated lower knowledge of evidence-based treatment options than their civilian peers. This finding *highlights the need for additional attention to mental health literacy in veterans. However, with the exception of the subsample of veterans included within that study, there is no other study that has examined mental health literacy specifically among veterans to our knowledge.*

The dearth of research on this topic highlights the importance of additional investigation of veterans' knowledge about PTSD and its treatment. Therefore, the purpose of this study was to provide an examination of PTSD-specific mental health literacy among veterans. Based on prior research, we hypothesized that veterans would show relatively higher levels of PTSD problem recognition, and lower levels of knowledge about evidence-based treatments and treatment-seeking. In addition, we examined associations between mental health literacy, anticipated stigma, and negative mental health beliefs, as emerging research has highlighted the link between these constructs (Williston, Bramande, Vogt, Iverson, & Fox, 2019). We hypothesized that mental health literacy would be inversely associated with negative beliefs about mental health problems, treatments, treatment-seeking, as well as anticipated mental health stigma from loved ones and coworkers.

Method

Procedure

A community sample of veterans who served in the U.S. military after 2001 (i.e., post-9/11 veterans) were recruited via social media (Facebook, Rallypoint), research e-mail blasts (e.g., student listservs), and snowball sampling through veteran organizations in the area, and invited to complete an online questionnaire through PsychData. Questions about military unit and military occupational specialty were included to verify veteran status. If participants could not provide this information their data were excluded. Veterans first read the informed consent form and then once consent was obtained, completed the questionnaires in a confidential online survey. Veterans who completed surveys were invited to enter a raffle to win a $50 gift card. This study was approved the by University of Massachusetts, Boston, Institutional Review Board.

Participants

One hundred thirty-four post-9/11 veterans completed the survey. The *majority identified as White, male, and served in the U.S. Army, with the average age of 34.89 (SD = 12.44).* For full demographic information, see Table 1.

Measures

UMB Comprehensive Demographics Questionnaire (adapted from Suyemoto et al., 2016). This demographic measure assesses race, ethnicity, age, education, and socioeconomic status. In addition, specific items regarding military experiences (e.g., branch, deployment dates) were added to be relevant to the veteran population under study.

Negative beliefs about mental health problems (Endorsed and Anticipated Stigma Inventory, EASI Scale 1; Vogt, Di Leone, et al., 2014). This scale consists of eight items that assess the degree to which individuals endorse negative beliefs about individuals with mental health problems (e.g., "People with mental health problems cannot be counted on") on a Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). This scale demonstrated structural, convergent, and discriminant validity in veteran samples, as well as good reliability (Vogt, Di Leone, et al., 2014). The scale demonstrated adequate internal consistency in the current study (Cronbach's $\alpha = .79$).

Negative beliefs about mental health treatment (Endorsed and Anticipated Stigma Inventory, EASI Scale 2; Vogt, Di Leone, et al., 2014). This scale consists of eight items that assess the degree to which individuals endorse negative beliefs

Table 1
Demographic Characteristics

Characteristic	*n* (%)
Self-identified race[1]	
Asian	14
Latinx-non-White	2
Latinx-White	13
Black	9
Pacific Islander	1
Multiracial	3
Other[2]	4
White	97
Self-identified ethnicity	
Latinx/Latinx-American[3]	13
African American/African Immigrant[4]	9
Asian/Asian American[5]	9
South Asian/Southeast Asian	4
European American	77
Missing[6]	23
Education	
High school diploma	101 (49.3)
Some college	101 (49.3)
College degree	3 (1.4)
Sexual orientation	
Bisexual	9 (6.7)
Gay/lesbian	1 (.7)
Other[6]	3 (2.2)
Heterosexual	121 (90.3)
Gender identity	
Female	32 (24.2)
Male	99 (75.0)
Gender queer	1 (0.7)
Missing	2 (1.5)
Current annual household income	
$0–25,000	37 (27.8)
$25,000–50,000	17 (30.3)
$50,000–100,000	43 (32.3)
>$100,000	12 (5.9)
Age *M (SD)*	34.89 (12.44)

[1] Self-identified race and ethnicity are presented as frequencies, and therefore sums do not equal total sample sizes, and percentages are not calculated. [2] Four participants selected "other" for their racial identity, and those that wrote in their self-identified race identified as: American of African Descent, White and Mediterranean, Irish and Scottish, and German American. [3] Collapsing responses categorized as: Latin American (6), Central American (2), South American (1), Caribbean Latinx American (4). [4] Collapsing responses categorized as: African American (5), African Immigrant (3), Afro-Carribean (1). [5] Collapsing responses categorized as: Asian American (4), East Asian American (5). [6] Collapsing responses coded as: uncodable (18) and missing (5).

about mental health treatment (e.g., "Mental health treatment just makes things worse") on a Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). This scale demonstrated structural, convergent, and discriminant validity in veteran samples, as well as good reliability (Vogt, Di Leone, et al., 2014). The scale demonstrated good internal consistency in the current study (Cronbach's α = .88).

Negative beliefs about mental health treatment-seeking (Endorsed and Anticipated Stigma Inventory, EASI Scale 3; Vogt, Di Leone, et al., 2014). This scale consists of eight items that assess the degree to which individuals endorse negative beliefs about mental health treatment-seeking (e.g., "I would think less of myself if I were to seek mental health treatment "), on a Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). This scale demonstrated structural, convergent, and discriminant validity in veteran samples, as well as good reliability (Vogt, Di Leone, et al., 2014). The scale demonstrated good internal consistency in the current study (Cronbach's α = .91).

Anticipated stigma from friends and loved ones (Endorsed and Anticipated Stigma Inventory, EASI Scale 4; Vogt, Di Leone, et al., 2014). This scale consists of eight items that assess the degree to which individuals endorse concerns about experiencing stigma from friends, family and/or loved ones (e.g., "If I had a mental health problem and friends and family knew they would think less of me"), on a Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). This scale demonstrated structural, convergent, and discriminant validity in veteran samples, as well as good reliability. The scale demonstrated excellent internal consistency in the current study (Cronbach's α = .94).

Anticipated stigma from coworkers (Endorsed and Anticipated Stigma Inventory, EASI Scale 5; Vogt, Di Leone, et al., 2014). This scale consists of eight items that assess the degree to which individuals endorse concerns about experiencing stigma from coworkers (e.g., "If I had a mental health problem and people at work knew about it my job/career options would be limited"), on a Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). This scale demonstrated structural, convergent, and discriminant validity in veteran samples, as well as good reliability (Vogt, Di Leone, et al., 2014). The scale demonstrated excellent internal consistency reliability in the current study (Cronbach's α = .94).

PTSD mental health literacy test for veterans (Williston, Roemer, & Vogt; unpublished measure). This 12-item test was developed *for the current study* to assess veteran's mental health literacy related to PTSD, as there is no publicly accessible measure of mental health literacy that has demonstrated construct validity or psychometric reliability across settings or populations (O'Connor & Casey, 2015). This measure was designed *for the current study* to assess the domains of mental health literacy identified by Jorm (Jorm et al., 1997), including knowledge related to (a) mental health problem identification/diagnosis, (b) risk and protective factors, (c) effective coping strategies, (d) prognosis or course of the mental health condition, and (e) evidence-based treatments and treatment-seeking. Item content was adapted from several more general measures of mental health literacy, including Reavley and Jorm's (2011) *National Survey of Mental Health Literacy and Stigma Main Survey,* (Reavley & Jorm, 2011), Compton and colleagues' *Multiple Choice Knowledge of Mental Illnesses Test* (Compton, Hankerson-Dyson, & Broussard, 2011), and the *Mental Health Literacy Questionnaire for the Anxiety Disorders* assessment (Coles, Coleman, & Heimberg, 2008). This test used a multiple-choice assessment format with one correct response per question for most items, so that sum scores can be calculated, *with participants accruing 1 point for each correct answer.* The exception to this was knowledge of evidence-based treatment options: This domain included two correct answers (both "CPT" and "PE"), as reflected in Figure 1, and veterans received 1 point for each correct answer. The measure begins with a brief vignette that describes a veteran experiencing a range of symptoms consistent with *DSM–5* criteria for a diagnosis of PTSD, and items assess aspects of mental health literacy related to the vignette.

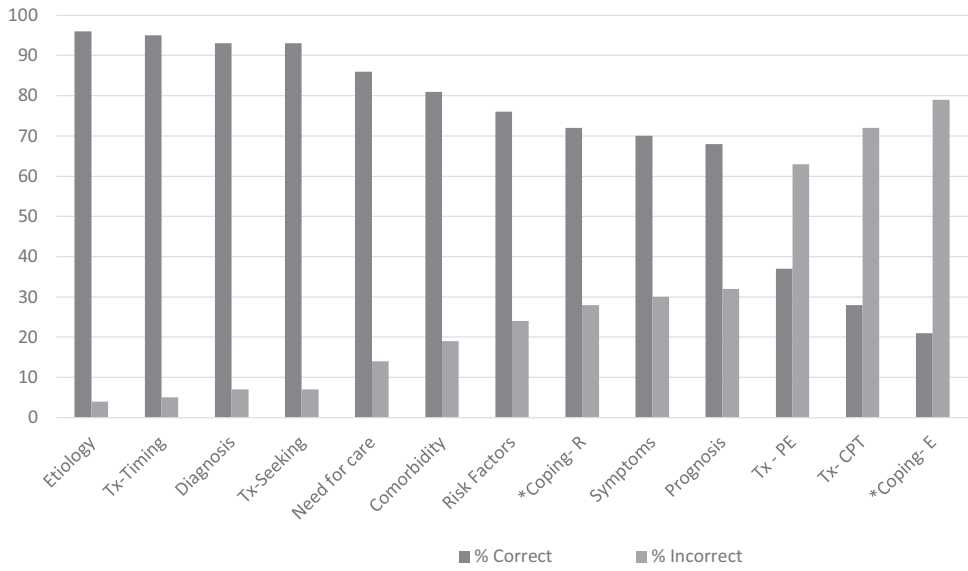

Figure 1. Etiology = knowledge about traumatic events as cause of PTSD; Tx-timing = knowledge about when to seek help; Diagnosis = Correctly labelling symptoms as PTSD; Tx-Seeking = knowledge about formal mental health providers as best way to learn about treatments; Need for care = Perceiving a need for care in vignette; Comorbidity = knowledge of common comorbidities in PTSD; Risk factors = knowledge low social support as a risk factor; Coping-R = knowledge about relaxation; Coping-E = knowledge about behavioral exposure; Symptoms = knowledge about intrusive symptoms as sign of potential PTSD; Prognosis = Knowledge about course of symptoms without treatment; TxPE = knowledge about PE as EBP; PxCPT = Knowledge about CPT as EBP.

Higher scores indicate higher mental health literacy (see Table 2). See Appendix for the full measure.

Analytic Plan

We examined frequency ratings for each item on the mental health literacy scale to provide descriptive information on veterans' knowledge and understanding of different dimensions of PTSD and its treatment. We next examined correlations between *sum scores* of mental health literacy, and *sum scores* of negative beliefs about treatments, treatment-seeking, and mental health problems, and anticipated stigma to evaluate the relationships among these constructs.

Table 2
Correlations of Mental Health Beliefs, Stigma, and Mental Health Literacy

Scale	EASI1	EASI2	EASI3	EASI4	EASI5	MHL
EASI 1	1					
EASI 2	.40**	1				
EASI 3	.18*	.55**	1			
EASI 4	.27**	.29**	.40**	1		
EASI 5	.35**	.31**	.30**	.61**	1	
MHL	−.20**	−.21**	−.14	−.07	−.12	1

Note. EASI1 = negative beliefs about mental health problems; EASI2 = negative beliefs about mental health treatments; EASI3 = negative beliefs about mental health treatment-seeking; EASI4 = concerns about anticipated stigma from friends; EASI5 = concerns about anticipated stigma from coworkers; MHL = mental health literacy.
* $p < .05$. ** $p < .01$.

Results

Figure 1 presents the rates of mental health literacy from highest rates of literacy (etiology) to lowest (evidence-based treatments and self-help strategies) across domains assessed in the current study. Each bar in Figure 1 represents the percentage of veterans who answered the item about that domain of mental health literacy correctly. Specifically, over 95% (127 veterans) identified "exposure to life-threatening traumatic events" as an etiological factor of the mental health problems presented in the vignette. Notably, on this item regarding etiology, less than 5% believed the cause of symptoms to be due to things such as "personal weakness." Regarding treatment-seeking, nearly all veterans 126 (94%) believed it appropriate to seek formal mental health care "within 6 months of symptom onset." With regard to problem identification and diagnosis, 125 (93%) correctly identified the mental health problems presented in the vignette as PTSD. Additionally, nearly all veterans 125 (93%) believed the most effective strategy to learn about treatments would be to "talk to a mental health professional," as opposed to friends, or self-help books, and 115 (86%) believed that the veteran in the vignette was in need of formal mental health treatment. In terms of comorbidity and risk-factors, 109 (81%) correctly identified alcohol use disorder as a common comorbidity and 101 (76%) correctly identified poor social support as a likely risk factor which could make the problem worsen. Regarding symptom identification, 91 (70%) veterans correctly identified intrusive memories as an early warning sign and symptom of

PTSD. In terms of prognosis, the majority of veterans 90 (68%) believed the symptoms would persist without any intervention.

Mental health literacy regarding self-help and coping strategies was more mixed. While 96 (72%) correctly identified deep breathing as an effective self-help tool to cope with PTSD, only 28 (21%) identified behavioral exposure (or "doing things even when you feel anxious about them") as a helpful self-help strategy. Knowledge about effective mental health treatments was lowest, with only 50 (37%) correctly identifying Prolonged Exposure as an effective treatment and 37 (28%) correctly identifying cognitive processing therapy as an effective treatment, the lowest area of mental health literacy observed in this sample.

Correlation results revealed that mental health literacy was inversely associated with negative beliefs about mental health problems, $r = -.20$, $p = .02$, and negative beliefs about mental health treatments, $r = -.21$, $p = .02$. Contrary to our hypotheses, mental health literacy was not significantly related to negative beliefs about treatment-seeking, $r = -.14$, $p = .12$ or anticipated mental health stigma from friends/family ($r = -.07$, $p = .45$), or coworkers, $r = -.12$, $p = .18$.

Discussion

Findings suggest that there is relatively high knowledge of symptoms, diagnosis, risk factors, and etiology of PTSD among military veterans. Knowledge regarding self-help coping strategies (specifically reducing avoidant behaviors and "doing things even when you feel anxious") and knowledge of effective evidence-based treatment options (e.g., prolonged exposure and cognitive processing therapy) was more limited. Interestingly, while over three quarters of the sample perceived that the veteran in the vignette needed care and thought that talking to a mental health professional was the best course of action, less than half of this sample knew which sort of treatment would be indicated. These findings highlight a potentially important gap in knowledge in the provision of effective PTSD treatments to veterans. Without knowledge about the most efficacious care, veterans' efforts to seek needed care, or recommend care to others, may not translate into positive treatment-seeking experiences.

The finding that mental health literacy was inversely related to two elements of what may be considered internalized stigma—negative beliefs about having a mental health problem and negative beliefs about treatments—supports theory and research suggesting that mental health literacy may buffer against the internalization of stigma (Corrigan & Calabrese, 2005; Fox et al., 2018). At the same time, findings did not show an association between mental health literacy and anticipated stigma, suggesting that concerns about being stigmatized by others may not be impacted by increases in mental health literacy, and may be influenced by other potential mechanisms or processes, perhaps more interpersonal in nature. Together, these findings suggest that mental health literacy promotion may be a more effective approach for addressing internalized stigma than reducing concern about how others will react in response to one having a mental health condition.

Limitations

There are several limitations to this study. Although the mental health literacy measure was based on a sound theoretical framework and derived from other validated measures, it has not yet been validated and therefore requires further investigation. It is also possible that treatment-seeking knowledge may differ when an individual is reporting on another person versus themselves, as this measure was based on veterans' responses to a hypothetical scenario (vignette). Perceiving a need for care, especially, may be different when an individual is reflecting on their own symptom severity versus another's symptoms. Further, the use of a prototypical vignette depicting a combat veteran may have led to higher rates of diagnosis recognition than would have emerged for another type of trauma exposure such as military sexual trauma. In addition, because this is a cross-sectional study, we cannot confirm the directionality of the relationship between stigma and mental health literacy, and we were not able to examine how mental health literacy relates to service use or is impacted by veterans' own mental health in this study. The sample was also recruited from a university setting in New England *using convenience and snowball sampling* and included more male than female veterans; therefore, *the sample may not be generalizable to the larger population of post-9/11 veterans nationally.* Finally, we did not examine the role of *psychological distress and PTSD diagnostic status*, *prior use of VA services*, and educational attainment in veterans' mental health literacy, which will be important to address in future research.

Future Directions and Clinical Implications

Given the importance of connecting veterans with effective PTSD treatments, veterans' mental health literacy is a critical area for further study. A valuable direction for future inquiry will be to examine mental health literacy in larger, representative samples of veterans and to explore longitudinal relationships between mental health literacy and PTSD treatment initiation and retention among veterans experiencing PTSD. Additionally, further investigation of the mental health literacy of military/veteran leaders and members of service members' and veterans' social support network may be important given veterans' high risk for experiencing trauma during military service and the role that others in one's social network may play in identifying the need for treatment and facilitating treatment referrals.

Another area for future inquiry is the examination of how stigma reduction and mental health literacy efforts may work together at different stages of the treatment-seeking process and motivational stage (e.g., contemplation, action, etc.) or varying levels of symptom severity, *as the current study was not able to examine these nuances due to a cross-sectional design*. As suggested by Zisman-Ilani, Barnett, Harik, Pavlo, and O'Connell (2017), these factors (e.g., motivation, symptom severity) may be important moderators of these processes and therefore are important to consider in future research. Finally, a recent study found that mental health literacy increased female veterans' service use vis a vis a reduction in their endorsement of treatment-seeking stigma (Williston et al., 2019), a finding that highlights the importance of attending to both direct and indirect effects of stigma and mental health literacy factors in future research.

In terms of clinical application, one potentially promising approach may be through direct-to-consumer marketing to individuals who may benefit from enhanced mental health knowledge. Many veterans and potential mental health care consumers cannot be reached through formal care delivery settings and therefore

could benefit from brief public service announcements via brochure, poster, or even radio or TV. This approach can also be used to reach family members, peers, and coworkers of veterans with mental health concerns, who often play a key role in alerting individuals to the need for treatment and providing information about relevant resources. Interventions such as Mental Health First Aid (Morgan, Ross, & Reavley, 2018), and other public health interventions are also particularly important for future study to determine their effect on mental health literacy, mental health stigma, and service use.

Conclusion

This is the first study to our knowledge to examine the mental health literacy of post-9/11 veterans. Consistent with our hypothesis, veterans reported higher knowledge of the nature of PTSD than of evidence-based treatments. Despite their reduced knowledge of treatment options, most veterans did believe that seeking formal treatment was indicated within 6 months of symptom onset. With additional attention directed at enhancing veteran's knowledge of evidence-based treatments for PTSD, veterans' effective help seeking and related health and well-being can be improved.

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Appendix

PTSD Mental Health Literacy Test for Veterans

Bryan is a 30-year-old Army Veteran. Recently, he has been feeling increasingly irritable, and can't understand why. He has also been feeling jumpy, and on edge, even at home. He can't sleep very well at night, and often has vivid nightmares from a convoy attack on his deployment. Before the service, he used to be very social, but lately he has been avoiding going out, even to see friends, and is spending a lot of time alone in his room. These things started happening around 9 months ago when he came home from his 12 month deployment to Iraq. He refuses to talk about what happened, and his friends feel he is shutting them out.

1) Which of the following best describes Bryan's problem (diagnosis)?

   a) Depression

   b) Nervous breakdown

   c) Stress

   d) Panic disorder

   e) **Post-traumatic stress disorder**

2) What is one early warning sign of this problem (symptoms)?

   a) **Intrusive memories**

   b) Poor appetite

   c) Thoughts of suicide

   d) Low energy

   e) Racing thoughts

3) Which of the following is the most likely cause of this problem (etiology)?

   a) Poor leadership

   b) Difficult experiences in childhood

   c) **Exposure to life threatening event(s)**

   d) Personal weakness

   e) Brain imbalance

4) Which of the following is most likely to be a risk factor for this problem to worsen (risk factors)?

   a) **Low social support**

   b) Unemployment

   c) Crowds

   d) Poor self-discipline

   e) Talking about it with others

(*Appendix continues*)

5) Bryan is at most risk to develop which of the following other problems (comorbidity)?

   a) Bi-polar disorder

   b) **Alcohol use disorder**

   c) Psychosis

   d) Obesity

   e) Psychopathy

6) When Bryan feels jumpy and very tense, one thing he could do that may make him feel better is (coping-r):

   a) Isolate from others

   b) Take nutritional supplements

   c) Eat a large meal

   d) **Deep breathe**

   e) Distract himself

7) Which strategy is most likely to be helpful for Bryan (coping):

   a) **Doing things even when he feels anxious about them**

   b) staying busy

   c) distracting himself when he feels stressed

   d) suppressing his feelings

   e) none of the above

8) Over time without any treatment, Bryan's problem is most likely to (prognosis):

   a) **Persist**

   b) Lead to psychosis

   c) Lead to permanent disability

   d) Go into complete remission

   e) Get better on its own

9) Which of the following are treatments that are known to work for this problem (check all that apply) (Tx-CPT, Tx-PE)?

   a) **Prolonged Exposure therapy**

   b) Supervision by a life coach

   c) Long-term institutional care

   d) **Cognitive Processing therapy**

   e) Music therapy

10) What is the most effective way for Bryan to learn about treatments known to work for this problem (tx seeking)?

   a) Talk to a friend

   b) Test out his own self-help strategies

   c) Read a self-help book

   d) **Talk to a mental health professional**

   e) None of the above

11) Do you think Bryan needs to seek formal mental health treatment at this time (need for care)?

   a) **Yes**

   b) Not yet, if it continues for several more months

   c) Unsure

   d) No, definitely not

   e) Not yet, if it continues for several more years

12) How soon after this problem beginning is it appropriate for Bryan to seek professional help (tx timing)?

   a) Never, this is best handled independently

   b) 1 week

   c) 2 years

   d) **6 months**

   e) 5 years

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