ORIGINAL ARTICLES

Peers and Peer-Based Interventions in Supporting Reintegration and Mental Health Among National Guard Soldiers: A Qualitative Study

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ABSTRACT   National Guard soldiers experience high levels of mental health symptoms following deployment to Iraq and Afghanistan, yet many do not seek treatment. We interviewed 30 National Guard soldiers with prior deployments to Iraq or Afghanistan to assess mental health treatment barriers and the role of peers in treatment engagement. Interview transcripts were analyzed by a multidisciplinary research team using techniques drawn from grounded theory. The following themes were identified: (1) personal acceptance of having a mental health problem rather than treatment access is the major barrier to treatment entry; (2) tightly connected, supportive peer networks can decrease stigma related to mental health problems and encourage treatment; however, soldiers in impoverished or conflicted peer networks are less likely to receive these benefits; and (3) soldiers are generally positive about the idea of peer-based programs to improve treatment engagement, although they note the importance of leadership support, peer assignment, and unit specialty in implementing these programs. We conclude that some, but not all, naturally occurring peer networks serve to overcome stigma and encourage mental health treatment seeking by soldiers. Formal peer-based programs may assist soldiers not sufficiently benefitting from natural peer networks, although there are barriers to implementation.

INTRODUCTION

Approximately 40% of Army National Guard soldiers have an identified mental health problem 3 months after returning from deployment to a combat zone, and yet only 50% of these soldiers access mental health services.[1] National Guard soldiers experience further increase in mental health problems during the 12 months postdeployment, likely because deactivated National Guard soldiers face the challenges of reintegrating into civilian work and family life and are no longer embedded in a military infrastructure that provides continuous social support and easily accessible mental health services.[2,3]

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Given the high rate of mental health needs among National Guard service members and limited access to military treatment facilities, reducing the barriers to engaging in community care is likely a critical step in improving outcomes. Soldiers have reported stigma, negative perceptions of mental health treatment, and logistical concerns (e.g., scheduling appointments, getting time off work) as the primary barriers to mental health treatment seeking.[4] Stigma, particularly being perceived as "weak," was reported as a concern by 65% of soldiers returning from Iraq and Afghanistan who screened positive for a mental health problem. National Guard veterans who served in Iraq also reported concerns that seeking mental health treatment could result in being labeled as "crazy" and affect perceptions of one's leadership abilities, fitness to be deployed, or likelihood of promotion.[5]

Organized peer outreach among National Guard soldiers may be one method for reducing stigma and increasing engagement in care for those with mental health needs. Peers could also limit treatment seeking by reinforcing stigma or, alternatively, by reducing stress and the perceived or actual need for

treatment.[6] To date, data on the acceptability and potential efficacy of formal peer programs in helping soldiers cope with mental health problems or seek treatment are limited.

We conducted a series of focus groups and individual interviews of National Guard soldiers who recently returned from deployment in Iraq or Afghanistan to assess the role of peers and peer-based interventions in addressing stressors and mental health conditions that arise during reintegration. The study was intended to provide useful information for military organizations considering implementing formal peer support services.

METHODS

Study Participants

We recruited a convenience sample of National Guard soldiers in a Midwestern state for focus groups and individual interviews during reintegration weekend events or during drill weekends at National Guard armories. Participants were recruited through sign-up sheets after the study was verbally described in a group presentation. Potential participants were informed the purpose of the focus groups/interviews was to "better inform services intended to improve the emotional health of returning soldiers and their families." Soldiers were given the option of participating in person or by phone. Any National Guard member with a deployment since 2001 was eligible for participation. The study was conducted with approval from a Veterans Affairs Health System and two university institutional review boards.

Data Collection

Focus groups and semistructured individual interviews were conducted from April 2009 to December 2010. Data collection protocols were developed by study team members based on the research questions and using an iterative process (P.P., M.V., and A.B.) to address the following domains: soldiers' experience with mental health problems, perceived barriers to treatment, possible solutions to these barriers, and the role of peers and peer services. Protocols for interviews and focus groups were identical except for minor changes to wording and ordering. Examples of specific interview guide questions are included in Table I. Interview and focus group sessions were led by four of the authors (P.P., A.B., M.V., and J.F.) and two master's level research assistants. Focus groups and in-person interviews were conducted at two university settings. Study researchers decided to include individual interviews in addition to focus groups because of concerns that participants may be less willing to discuss sensitive aspects of mental health in group settings. Phone interviews were conducted for those who indicated that they were not able to participate in person. Sessions lasted 20 to 80 minutes and were digitally audiorecorded. Participants were provided $50 gift cards after completing the interview or focus group.

Data Analysis

Digital recordings of the focus groups and interviews were transcribed verbatim. Data collection and analysis were conducted concurrently. For each transcript, at least 2 study team members, including a study team member who had not conducted the interview or focus group, read through and completed a structured memo (developed by J.F.) summarizing initial prominent themes from the interview in relation to the primary research questions. Memos were then discussed by the team, and cross-cutting themes were identified using a group consensus process to facilitate and enrich data interpretation and document team findings.[7] Interview guides were modified approximately halfway through the study to collect data on new themes discovered during data collection and concurrent analysis and to further explore prominent themes that were included in the original interview guide.[8] Additional interviews and focus groups were completed until informational saturation of themes had occurred. Codes and their definitions were developed for the identified themes by two study team members (P.P. and J.F.) to exhaustively identify data relevant to each theme. Two study team members (P.P. and E.M.) independently coded three transcripts, compared coding, and achieved consensus on application of the codes to the data. The remaining transcripts were coded by one study team member (E.M.). The codes were then applied to the text of each transcript using NVivo 8 software. Summaries of the text in each code were used by the team to

TABLE I. Interview Guide Domains and Sample Questions

Domain	Sample Question
Experience with mental health problems	Have you or someone else you know in the National Guard had experiences in dealing with significant emotional problems? If so, can you tell me about whether you/they got into treatment and how that decision was made?
Perceived barriers to treatment	It seems that a number of soldiers are struggling with serious emotional problems but do not get help. What are your thoughts about that?
Possible solutions to barriers	What do you think would be the best way for the National Guard, or other interested organizations, to help make sure soldiers with emotional problems get help?
Role of peers and peer services	To what degree do soldiers in your unit look out for each other? What do you think of a buddy system where fellow soldiers "check in" with each other periodically to see whether someone might be having problems or need additional help?

verify the validity of the themes and ensure understanding of variation within themes.[8]

Methodological rigor was enhanced through participation of team members from several disciplines (i.e., psychology, psychiatry, public health), rigorous data collection and code development, and the iterative consensus process.

RESULTS

We conducted 14 individual interviews and 4 focus groups, collecting data from a total of 30 participants. Twelve individual interviews were conducted in person and 2 were conducted by phone. Participants were predominantly male and married, and they had a diverse range of military experience (Table II). The major themes identified from the analyses were (1) personal acceptance of having a mental health problem, rather than treatment access, was the major barrier to treatment seeking; (2) the role of peers in treatment seeking depends on the characteristics of a soldier's peer network, which varies from highly supportive to impoverished or conflicted; and (3) soldiers generally had positive responses to the idea of a peer-based program to identify postdeployment mental health treatment needs but were concerned about how it would work in practice.

Major Barriers to Treatment Seeking

The most frequent reason for not seeking help for mental health concerns was described as soldiers failing to recognize or having difficulty admitting to themselves that they needed help. This was often described in the context of military culture and training, which encourages self-reliance and perseverance. Difficulty in personally accepting having a mental health issue was more often described as a form of self-stigma (i.e., viewing oneself as weak), rather than explicit concern about being judged or treated differently by others

TABLE II. Participant Characteristics

Characteristic	Percent
Male (N = 30)	97
Age (N = 18)	
22–30	67
31–40	6
41–50	22
51–60	6
Married (N = 28)	79
Rank (N = 20)	
Junior Enlisted and Squad Leaders (Rank E1–E4)	40
Noncommissioned Officers of Rank E5 and Higher	55
Commissioned Officer	5
Years in Military[a] (N = 30)	
0–4	30
5–10	30
11–20	20
21–30	17
30+	3

[a]Includes service periods before National Guard involvement.

(i.e., external stigma). A squad leader who had been with the Guard for 3 years described the process soldiers go through in deciding to seek help as: "I think some of them are unsure that, they don't really know if they have a problem or not. I guess it's really sitting down and convincing themselves that they have a problem or that there is an issue. I mean you want to lie to yourself about, 'I don't need any help, I'm good', but I think that's probably the biggest thing."

External stigma, i.e., concerns about being treated differently for addressing a mental health problem, were described as declining within the military and progressively less of a barrier to treatment. Participants noted that the overall Army, the Army National Guard, and high-ranking officers encouraged soldiers to seek treatment if needed and that the necessary information and resources are available. However, participants reported that they believed the consequences of disclosing mental health problems or treatment seeking varied depending on rank and responsibilities. As one participant in a transportation unit said "We're just a bunch of truck drivers and mechanics and no security clearance needed, so I can't imagine anything would affect a career at all." In contrast, some respondents described soldiers being reluctant to seek mental health treatment because they were concerned that it would harm their career—for example, it could be the deciding factor when competing for a promotion when everything else was equal. A minority of respondents reported being skeptical of increased acceptance of mental conditions and treatment in the military culture, exemplified by the statement, "regardless of what all the reports say, regardless of what the Army says, there absolutely is a stigma associated with seeking help."

Living far away from military or veteran counseling resources, timeliness and flexibility of appointments, and mismatch with treatment providers were also mentioned as barriers but were generally described as problems with continuing care rather than affecting the initial decision to seek treatment.

Role of Peer Networks on Treatment Seeking

Participants varied considerably on their assessment of the degree to which social ties formed during deployment could play a role in later help seeking. Based on the respondents' descriptions, we have characterized these informal, naturally occurring support networks among soldier peer groups as one of three types: tightly connected and supportive, impoverished, and conflicted.

Tightly Connected and Supportive Networks

These networks were described by several participants and were characterized by frequent contact among soldiers who served together during deployment. Contact could occur either in-person, by phone, e-mail, or on social network sites like Facebook. Participants in supportive peer networks shared problems with each other related to reintegration and

mental health. A typical interaction was described as, "One of my friends, he has been going to the VA and getting help as well, he and I talk where he's, you know, had a blow-up at Wal-Mart because some lady cut in front of him with her cart or something and so we share our funny stories like that. We're like, we might've overreacted in that instance but we're able to discuss and say, 'Hey, that's not right, we probably shouldn't do that next time.'"

When a mental health problem becomes known or suspected, participants in supportive networks described checking in more frequently with that soldier and offering to talk or socialize, as one participant put it, "Even if it's just pick him up and have a few beers with him and let him spill. That might be all they need." When problems appeared to be escalating or severe, respondents described sometimes intervening as a small group to influence a soldier to get help. One such encounter was described as "We use peer pressure and just you know, a couple of us will get together and be like, 'So what you gonna do, just grow a beard and live in a basement? Like control yourself,' and it just, and it clicked with them like, man, this guy, you know obviously we care enough to ask and we've already saw a pattern of that behavior developing while we were over there because of issues and then you say, 'Okay, hey man? You want to live like a hermit or something?' That's when they start saying, 'Yeah, you know what? Maybe I need to go get some help.'"

Another participant described contact from a peer as potentially lifesaving, "One night I found myself in my house with a handgun in my hand and bullet in the chamber, pointing it at my face and fortunately a very good friend of mine called me just to see how I was doing and I went and got help ... [He] just happened to call me at home and say, you know, 'How's it going? Everything going okay', you know, and 'we haven't talked in a couple of days' and it was, I don't know, I don't know if anyone here believes in divine intervention but there's a reason that person called me that day and I'm not saying that you know, that somehow magically the angels came down and I felt better and everything but I realized that that wasn't the way to deal with it."

Impoverished Networks

Several participants reported losing contact with other soldiers after deployment, usually as a result of living a long distance from those with whom they deployed or because fellow soldiers were promoted to serve with other units. In some cases, particularly if strong family support was lacking, these participants felt isolated and would have preferred greater interaction with their peers. Participants also described some soldiers (or themselves) as outliers, either "loners" or "the asshole of the group," who were readily identifiable but never integrated into a support networks before, during, or after deployment.

Conflicted Networks

These networks were characterized by competing cliques within the network, such that individuals felt supported by a few close peers but could not trust members of the other cliques. Unit leadership was sometimes described as encouraging this competition or picking favorites. Participants who experienced these networks described a chilling effect when it came to discussing or seeking help for mental health problems because of the concerns that sharing sensitive personal information could eventually be used against you. One participant described his unit as made up of these networks: "This unit actually that I'm in now which, I mean it's, there's a few guys, a few teams in squads that stick together and look out for each other and help each other but I'd say the majority of them are a bunch of backstabbers, being that the smallest mistake, everybody somehow knows about ... That's actually a way to tell how tight the team is, is whether they talk about serious personal issues so there's only a few occasions where that's mentioned and that just goes to show ya that nobody talks about that stuff because there's nobody to talk to or it may be used against you later on down the road."

Peer-Based Programs to Improve Treatment Seeking

Participants were generally supportive of the concept of a formal peer-based program to monitor soldiers for mental health concerns and facilitate treatment seeking, often responding that it is a good idea and has the potential to help reduce both self and external stigma. One respondent suggested that a peer-based program would be particularly effective at addressing stigma if a soldier who was respected for being strong discussed his own issues; other soldiers may then be more willing to accept that their own problems are not a sign of weakness and join in the discussion. Eventually this could lead to soldiers being more likely to seek treatment because, "the first step is being receptive to talking about it with their buddies, then they certainly [w]ould be more accepting [of] discussing it with somebody else."

Successful Implementation of a Peer-Based Program May Vary by Support Network

Participants noted that the effectiveness of a peer-based program to improve treatment seeking would depend on the soldier's existing social group or network. For participants already in tightly connected in supportive networks, there was concern that a peer-based program would be redundant with what was occurring naturally and that formalizing their interactions (e.g., requiring soldiers to call one another at regular intervals or complete check-in reports) might introduce an unnecessary or counterproductive element of artificiality. For participants in conflicted networks, a peer program was considered unlikely to be effective because of the concerns that sharing information could be used against them.

A peer-based program was thought to be particularly likely to be helpful to participants within impoverished networks who would prefer more support but were no longer in regular contact their peers because of geographic separation, operating out of different units, or lacking initiative to maintain ties over

time. However, for outliers who never integrated into soldier support networks, respondents expressed skepticism about whether a peer-based program after deployment could successfully reach them. Participants frequently stated that if someone does not want help then there is nothing that anyone else can do for them. A minority of participants felt that there could be a chance for success in reaching out to service members who had not developed strong natural supports, but that it would take a particularly savvy peer soldier to accomplish this. One participant addressed this issue by saying, "You can't approach an asshole with a submissive mindset. It's almost like being able to read the person, your adaptability .... If you approach them as a result-oriented person and say, 'You look like a person that needs results. Well let's get you some results' and then you start introducing them your ideas ... they might be more receptive to it .... Some people are just like, 'Well he's an asshole and that's how it's going to be' so they don't even try to get him help because they think he's unreachable. But he's still human, so, everybody's reachable."

Other Concerns Regarding Implementation of a Peer-Based Support Service

In general, participants indicated that whether or not someone would discuss a mental problem with a peer would be largely related to the existing relationship they have with the peer contacting them and whether they trusted and respected that person. As one participant described, "It'd depend upon who it was that called me. If it was some officer from a section that I don't even know, I might hesitate ... Buddy to buddy, so friend to friend, person that you know to person that you know, not someone assigned to the unit as a secondary duty. And you're going to call everyone in the entire unit? Some of the people you don't even know how to pronounce their names, let alone know what they look like, and you're going to ask them how they're doing? You're probably going to get a response with 'Well fine sir, but who are you? I don't even know who you are.'"

The success of a peer-based program was noted also to depend heavily on local implementation in terms of how it is presented and supported by leadership. Implementation strategies may also need to be tailored according to the operational role or specialty of units. As one participant described, "Well the buddy system is actually a brilliant idea but unfortunately that is out of your hands and that's down to the unit itself, it's how the unit works. You're going to have better luck with that with combat arms units than you are with an admin unit. I mean admin, it's all office politics, all day every day. The combat arms unit, it's like, 'you know what, let's get this shit over with, so let's all work together.'"

DISCUSSION

Our findings provide new insights into a culture of increasing awareness and acceptance of mental health problems within the National Guard, the variable role of peer networks in detecting and supporting mental health concerns, and the potential role of peer-based interventions to improve mental health treatment seeking.

Knowledge of mental health problems experienced either firsthand or by fellow soldiers was commonplace among those we interviewed, indirectly suggesting mental health concerns among soldiers often were not hidden out of shame or fear of repercussions. When asked directly about the consequences of seeking mental health treatment, there were mixed opinions regarding whether it could potentially affect career advancement or result in judgment by peers, but there were very few examples of soldiers actually experiencing negative consequences. This is in contrast to a qualitative study of National Guard soldiers conducted in 2006 which reported greater concerns among soldiers about being labeled or experiencing adverse career consequences for receiving mental health treatment.[5] Soldiers we interviewed also perceived military leadership as working to raise awareness and encourage soldiers to get treatment. Together, these findings suggest the military culture overall has moved in the direction of accepting and openly addressing the mental health needs of soldiers. Despite the decline in external consequences for seeking mental health care, self-stigma (i.e., sense of oneself as being "weak" for seeking help) remained as a primary barrier to treatment.

We found the role of naturally occurring peer networks in counteracting stigma likely depended on whether soldiers existed in one of three types of peer networks. Soldiers with tightly connected and supportive peer networks described instances of sharing mental health concerns with one another and banding together to pressure soldiers into seeking treatment when problems become severe. Thus, when these natural support networks work well, they could play an important role in providing social support that buffers against the development of mental health conditions while also normalizing and facilitating mental health treatment when necessary.[9,10] Soldiers in impoverished or conflicted peer networks appeared much less likely to seek mental health treatment based on interactions with their peers. In impoverished peer networks, soldiers have less frequent interactions with other soldiers and therefore fewer opportunities for support, normalizing, or encouragement for treatment. In conflicted networks, soldiers may obtain support from their few closest peers but may be more concerned about seeking mental health treatment because of a greater possibility of negative repercussions.

Peer-based interventions could address some of the shortcomings of natural support networks and enhance mental health treatment engagement; however, many challenges to implementation were raised. Regardless of the peer network, the success of formalized peer support intervention would largely depend on whether the soldiers had a preexisting trusting relationship. Soldiers are unlikely to disclose mental health concerns to other soldiers, including leaders, they do not trust and would prefer to choose who will be involved in their peer support network. Some soldiers will simply not discuss mental health concerns with other soldiers.

Unfortunately, soldiers with mental health needs are more likely to be concerned about stigma, and therefore, the soldiers most likely to benefit from peer outreach may also be the most resistant to it.[4] Alternative methods such as direct involvement by unit leadership or attempts to involve non-National Guard supports may be more successful when a problem is suspected and peer outreach is unsuccessful. Soldiers in impoverished networks who are the "loners" or "assholes" are likely to fit into this category.

Peer-based interventions deployed in conflicted networks may have a greater chance for success if there is also a concerted effort from leadership to disabuse the perception that mental health treatment seeking could be used against someone or affect their career in any way.

This study is limited in that participants who volunteered to discuss mental health issues within the military may not be representative of National Guard soldiers in general. As with most qualitative studies, our goal was to understand a phenomenon, rather than to generalize findings from the study sample to a population. Therefore, we recruited participants from whom we could learn the most about the topic under study or "information-rich cases."[8] Nonetheless, soldiers who did not volunteer to participate may perceive greater stigma related to mental health treatment or may view peer services less favorably. Our sample also included only one female soldier. Additional studies are indicated to assess the barriers to mental health treatment and the role of peers among women and other minorities in the military. We note, however, that our sample consisted of soldiers from different units and geographic regions, included soldiers of different ages and ranks, and had a wide range of views and experiences related to mental health treatment.

In summary, peer-based interventions to augment natural soldier social support networks were regarded as acceptable to National Guard soldiers during the challenging period of reintegration when mental health problems are prevalent and treatment seeking is limited, potentially because of self-stigma. The effectiveness of peer-based interventions is likely to be dependent on the type of existing peer networks into which the interventions are deployed. Peers

conducting outreach should have an established trusting relationship with soldiers they are contacting. Alternative outreach strategies should also be considered for soldiers unwilling to discuss apparent mental health problems with their peers.

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REFERENCES

1. Gorman LA, Blow AJ, Ames BD, Reed PL: National Guard families after combat: mental health, use of mental health services, and perceived treatment barriers. Psychiatr Serv 2011; 62(1): 28–34.
2. Thomas JL, Wilk JE, Riviere LA, McGurk D, Castro CA, Hoge CW: Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. Arch Gen Psychiatry 2010; 67(6): 614–23.
3. Riviere LA, Kendall-Robbins A, McGurk D, Castro CA, Hoge CW: Coming home may hurt: risk factors for mental ill health in US reservists after deployment in Iraq. Br J Psychiatry 2011; 198: 136–42.
4. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL: Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. N Engl J Med 2004; 351(1): 13–22.
5. Stecker T, Fortney JC, Hamilton F, Ajzen I: An assessment of beliefs about mental health care among veterans who served in Iraq. Psychiatr Serv 2007; 58(10): 1358–61.
6. Maulik PK, Eaton WW, Bradshaw CP: The effect of social networks and social support on mental health services use, following a life event, among the Baltimore Epidemiologic Catchment Area cohort. J Behav Health Serv Res 2011; 38(1): 29–50.
7. Barry CA, Britten N, Barber N, Bradley C, Stevenson F: Using reflexivity to optimize teamwork in qualitative research. Qual Health Res 1999; 9(1): 26–44.
8. Patton MQ: Qualitative Research and Evaluation Methods, Ed 3. Thousand Oaks, CA, Sage Publications, 2002.
9. Brewin CR, Andrews B, Valentine JD: Meta-analysis of risk factors for posttraumatic stress disorder in trauma exposed adults. J Consult Clin Psychol 2000; 68: 748–66.
10. Ozer EJ, Best SR, Lipsey TL, Weiss DS: Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. Psychol Bull 2003; 129: 53–73.