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Veterans' Perceptions of Behavioral Health Services for Posttraumatic Stress

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Walden University
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Abstract

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MA, Bowie State University, 2005

MEd, Central Michigan University, 2000

BS, Wilmington University, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Behavioral health services exist for Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans diagnosed with posttraumatic stress disorder (PTSD); yet, untreated diagnoses may lead to the risk of compromised behavioral health. The purpose of this hermeneutic phenomenological study was to understand the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services for addressing PTSD. The research focus and questions were employed through the theoretical concepts of Heidegger's hermeneutic phenomenological theory, Heider's attribution theory, and Beck's cognitive behavioral theory. In-person interviews were conducted to collect data from 8 OEF/OIF veterans who had encounters with behavioral health services. To confirm accuracy, subsequent data analysis, and thematic coding were incorporated using Colaizzi's 7-step method. One key research finding was that enhanced provider skill sets may strengthen a veteran's desire to seek and retain counseling. Another finding was that female respondents preferred conferring with a female provider. Future research may help explore how veterans can better appreciate the value of behavioral health services and its positive influence on addressing PTSD. This study's implications for positive social change involve bolstering researchers' understanding of veterans' engagements with behavioral health services. Subsequent research may help motivate providers on the use of cultural competency training for improving their veteran knowledge. The key findings from this study revealed that reminders of PTSD are ever-present in OEF/OIF veterans lived experiences; counseling is necessary but finding and maintaining services with a well-matched provider remains difficult.

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Dedication

My dissertation is dedicated to God, who gave me the vision, drive, and focus to complete this journey. God's presence solidified my vision when this journey sometimes appeared insurmountable and I will continue to praise him for blessing my life.

My dissertation is dedicated to my parents William and Catherine Kirby who remain my never-ending source of comfort. They continually encouraged me to set goals and inspired me to see them through. My father did not complete high school, but he understood the importance of education and made sure I grasped opportunities. My mother would sit me down after each elementary school day, to finish my homework, stressing the importance of completing my education. Based on their teachings, I continued to grasp opportunities and amass education. My father, looking down from heaven, continues to help me succeed, while my mother continues to encourage my life pursuits. The love I have for my parents is boundless and I thank them for being my forever foundation.

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I want to thank my parents, William and Catherine Kirby, for providing a nurturing environment within our inner-city sanctuary. They instilled my drive to succeed and filled me with protective love. I am forever indebted to my wife Sonja Kirby who has encouraged me through countless endeavors and military assignments. She understands my drive to achieve and is my gentle listening ear, love you much!

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I served our nation, on active duty, for 30 years, so I want to thank the women and men who serve/served our nation doing the same. It is a unique group that raises their right hand to defend our nation, to protect our colors, and to ensure our freedoms and I want my research to benefit those veterans who have behavioral health needs. I too have those needs and understand the barriers to mental resolution.

Finally, I want to recognize Black males, myself included, who were accepted to an undergraduate school but who were unable to finish at that school. This population struggles to complete this initial educational journey due to financial, social, comprehension, disciplinary, and various elements that tragically interrupt educational completion. Often this interruption is permanent with no further attempts to secure a degree. I was lucky for I had an inner drive and family/friends encouraging me to obtain a degree(s), but others are less fortunate. I humbly urge this population, to reach inside, to

find the drive, support, and means to continue your education. If you need assistance, reach out to your support network so that brothers can achieve educational goals, eliminate stereotypes, and be properly represented within society.

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Chapter 1: Introduction to the Study

Introduction

Since 2001, close to 3 million women and men have deployed to Afghanistan (Operation Enduring Freedom [OEF]) and Iraq (Operation Iraqi Freedom [OIF]) experiencing exposure to physical and mental trauma (Fox, Meyer, & Vogt, 2015). Hayes, Degeneffe, Olney, and Tucker (2017) reported that due to the high stress and hazardous environments of Afghanistan and Iraq operations, posttraumatic stress disorder (PTSD) is of particular risk to those who supported those operations. PTSD is one of the primary injuries for OEF/OIF veterans, characterized by affected individuals reexperiencing trauma, engaging in avoidance behaviors, experiencing alterations in mood, and having persistent hyperarousal (Janke-Stedronsky et al., 2016). Although PTSD is one of the primary impairments, OEF/OIF veterans have also been found to experience depression, alcohol-related problems, social and family problems, and suicidality (Garcia et al., 2014). While these other mental health issues exist, Hundt et al. (2018) expressed that low engagement of PTSD counseling is a common theme among veterans because almost half of the diagnosed veterans fail to engage in treatment. Whealin, Kuhn, and Pietrzak (2014) confirmed that the Department of Veterans Affairs and community mental health care usage for mental health treatment is low. Barriers such as employment/college, distance, appointment avoidance, not being ready for treatment, lack of therapy buy-in, and provider discomfort contributed to failures to retain treatment (Hundt et al., 2018). Garcia et al. (2014) reported that OEF/OIF veterans, more than other era groups, were more likely to possess negative treatment-related attitudes because they

believe they should be able to handle their problems and they perceive attending treatment sessions as being labeled weak. Veterans also expressed trust issues and a lack of maintaining confidentiality as reasons for not retaining treatment engagement (Graziano & Elbogen, 2017). Thus, it is important for providers to understand symptoms and to create an atmosphere where veterans are encouraged to attend and retain visits for PTSD treatment.

The symptoms of PTSD may cause disruptions in various life domains, affecting social, personal, and professional functionality (Janke-Stedronsky et al., 2016). According to Mohler and Sankey-Deemer (2017), if veterans with PTSD are not assessed and remedied, they may face a multitude of functional obstacles including relationships, employment, and trauma cognitions. Individuals with PTSD tend to have additional dysfunctional thoughts that may maintain their symptoms, and this is partially due to maladaptive thought control strategies (Tsai, Harpaz-Rotem, Pietrzak, & Southwick 2012). As a result, treatment modalities developed by helping professionals must address the trauma and negative thinking to improve veteran cognitions (Petersen et al., 2012). Cognitive behavioral therapy has been shown to have a positive influence on PTSD symptoms (Levi, Bar-Haim, Kreiss, & Fruchter, 2015). Levi et al. (2015) affirmed that cognitive behavioral therapy concentrates on a technique that increases veterans' awareness of the content of unconscious thoughts and feelings associated with traumatic occurrences. Additional research is needed to understand the relationship between PTSD and aspects of functioning in treatment-seeking OEF/OIF veterans (Tsai et al., 2015).

In this chapter, I provide a background, problem statement, and purpose to facilitate understanding of veterans and behavioral health services. I used a theoretical framework using hermeneutic (interpretive) phenomenological theory to understand the essence of OEF/OIF veterans regarding their decision to seek and retain behavioral health services. Additionally, to support understanding the research question, I describe the application of attribution theory and cognitive behavioral theory. I provide the nature of the study, definition of terms, assumptions, scopes, delimitations, limitations, and significances. I close the chapter by presenting a summary to consolidate the information.

Background

Recent serving veterans have experienced immeasurable life challenges surrounding multiple operational deployments, and for some, significant combat exposure during OEF and/or OIF operatives (Bowen, Jensen, Martin, & Mancini, 2016). The preparation and training veterans receive for working in these highly stressful environments is intensive and demanding (Castro, Kintzle, & Hassan, 2015). However, the negative effects of deployments can manifest in PTSD, a common disabling disorder among OEF/OIF veterans (Armenta et al., 2018).

Also, PTSD is characterized by a cluster of symptoms involving reexperiencing of the trauma, avoidance of reminders of the trauma, emotional numbing, and hyperarousal (Tsai et al., 2012). Haun, Duffy, Lind, Kisala, and Luther (2016) stated that recent serving veterans are at a higher risk than the general public, for acquiring PTSD and undergoing associated symptoms that negatively impact their health-related quality of life. PTSD is one of the most prevalent behavioral health conditions with an estimated

10% to 20% of 2.7 million OEF/OIF veterans diagnosed with this condition (Armenta et al., 2018). The Department of Veterans Affairs reported that 13% to 20% of all OEF/OIF service members have developed PTSD with female veterans having slightly higher odds (as cited by Gallegos et al., 2015). PTSD harms the functioning and quality of life of veterans with this disorder and places a strain on their family dynamic (Freytes, LeLaurin, Zickmund, Resende, & Uphold, 2017).

Freytes et al. (2017) reported that the impact of deployment and the resulting changes in the veteran and the family dynamic linger years after the veterans return home after deployment and have a significant influence on family functioning. When veterans are at home, all they can think about is being deployed, and when they are deployed, all they can think about is being back home (Castro et al., 2015). Castro et al. (2015) explained that, at home, veterans report feeling unfulfilled, empty, and without purpose, despite having their family and friends near them and having employment. PTSD can negatively impact veterans' lives often resulting in significant impairment in social and occupational functioning (Doran, Pietrzak, Hoff, & Harpaz-Rotem, 2017). The majority of veterans who screen positive for PTSD acknowledged countless difficulties in their relationships, less cohesion in their families, less social support, poorer social functioning, and lower life satisfaction compared to other treatment-seeking veterans (Tsai et al., 2012). Castro et al. stated, "Everyone who has ever deployed to a war zone is changed by his or her experiences, it would be abnormal not to be" (as cited in Hoge, 2010, p. 6). As a result of these elements, behavioral health services may provide an avenue for improved social and cognitive functioning.

The Department of Veterans Affairs oversees the largest behavioral health care system in the United States with care focused on veteran PTSD treatment (Garcia et al., 2014). Castro et al. (2015) highlighted that counseling or behavioral health intervention can serve to normalize many of the reactions and symptoms that veterans might experience following their deployment. However, there are varying issues impacting treatment. For example, Fox et al. (2015) found that some veterans may believe that they are less deserving of care because they did not experience direct combat or because they believe other categories of veterans are more deserving of care. Factors associated with masculine self-identity or stoicism may contribute to less treatment use in male veterans, especially if the care is seen as threatening to their masculinity (DiLeone et al., 2013). Negative personal beliefs about mental illness and mental health treatment are also barriers to treatment (Vogt, Fox, & DiLeone, 2014). Dropout from treatment is significant among OEF/OIF veterans referred for treatment of PTSD conditions (Goetter et al., 2015).

To encourage veterans, providers should focus on psychological and physical health, cultural and demographic characteristics, knowledge of PTSD and other psychological elements (e.g., depression, substance misuse, suicidality), and social/family engagement (Elnitsky, Blevins, Fisher, & Magruder, 2017). Litz (2014) posited that numerous resources can provide counselors with information about the military experience and the multiple sources of trauma from deployments. These resources may increase the counselor's cultural competencies and knowledge of this population. Litz added that it is important for counselors to learn military acronyms and abbreviations to

better communicate during sessions. In addition to resources, cognitive-behavioral interventions are empirically supported behavioral treatment for PTSD and have been proven to help reduce symptoms (Pedersen, Callaghan, Prins, Nguyen, & Tsai, 2012). This therapy focuses on increasing the veterans' cognitive (thinking) components while decreasing the amount of exposure (recreating the traumatic event) necessary for treatment. Although resources and treatments are in place and veterans have a need for care, treatment-seeking rates among veterans remain low (Fox et al., 2015).

Multiple scholars (Elnitsky et al., 2017; Garcia et al., 2014; Graziano & Elbogen, 2017) have addressed behavioral health services and barriers toward services, but there are limited studies on OEF/OIF veterans' engagement and enrollment in behavioral health services programs, divulging a gap in the literature. As a result, this study was conducted to address this gap and provide the lived experiences of OEF/OIF veterans' perceptions of behavioral health services regarding PTSD. This study can increase the comprehension of veterans and their struggles with retaining behavioral health services and/or treatment.

Problem Statement

Since the September 11, 2001 attacks on the World Trade towers, the Pentagon, and Flight 93 over Pennsylvania, 2.5 million veterans have served in OEF/OIF or Afghanistan/Iraq operations in Southwestern Asia (True, Rigg, & Butler, 2015). Of this population, as of 2013, 14% had been diagnosed with PTSD and major depression while facing susceptibility to alcohol misuse (Fox et al., 2015). Graziano and Elbogen (2017) suggested that higher rates of behavioral health aliments typically follow deployments

and combat exposure. Vogt et al. (2014) conducted a national survey of OEF/OIF veterans and found that almost 50% who screened positive for PTSD or major depression did not obtain subsequent behavioral health care within the previous year. Moreover, Whealin et al. (2014) examined a sample of Iraq and Afghanistan veterans who received a new behavioral health diagnosis, and over one-third failed to attend follow-up appointments within 12 months of diagnosis.

Untreated behavioral health issues may affect social, emotional, and physical health, including but not limited to decreased energy, less time engaging with friends/relatives, unemployment, and increased suicide ideation (Brown & Bruce, 2015). Litz (2014) indicated that substance abuse, relationship strain, intimacy difficulties, justice-system involvement, and inattentiveness to wellness/fitness as problems attributed to unresolved behavioral health diagnoses. Although several researchers (Elnitsky et al., 2017; Garcia et al., 2014; Graziano & Elbogen, 2017) have provided insight into behavioral health and treatment barriers for this population, few if at all, focus on OEF/OIF veterans' perspectives aligned with seeking and remaining enrolled in behavioral health services programs, exposing a gap in the literature. Although behavioral health services exist for OEF/OIF veterans diagnosed with PTSD, untreated diagnoses may lead to the risk of compromised behavioral health.

Purpose of the Study

The purpose of this hermeneutic phenomenological study was to understand the lived experiences of OEF/OIF veterans' regarding their decisions to seek and retain behavioral health services. Deployments have minimized veterans' desire to seek

assistance when faced with behavioral health challenges (Bowen et al., 2016). DiLeone et al. (2013) expressed how this population does not maintain treatment and would benefit from consistent interventions. Gallegos et al. (2015) suggested that barriers stem from veterans being stigmatized for their mental illness and adverse discernments of treatment. Clement et al. (2015) added how noncompliance and early withdrawal from treatment protocols are common, possibly leading to worsening psychotic conditions, increased depressive/anxiety symptoms, and diminished quality of life.

Research Question

Research Question 1: What are the lived experiences of OEF/OIF veterans' regarding their decisions to seek and retain behavioral health services?

Theoretical Framework

In this study, I used an underpinning of hermeneutic (interpretive) phenomenological theory, attribution theory, and cognitive behavioral theory. Given that this research is a hermeneutic phenomenological study, it can be coupled with additional frameworks (Peoples, 2020). Together these theories provided the framework to analyze the data collection.

Hermeneutic (Interpretive) Theory

The hermeneutic phenomenological theory is used in research to uncover an essential, yet sometimes overlooked, element of human experiences in ways that induce sharing while eliciting introspective thinking (Crowther, Ironside, Spence, & Smythe, 2017). I selected hermeneutic phenomenology to retrieve thought-provoking experiences from veterans and because it is the sole theory that can be used with additional

frameworks without alternating the study into a hybrid study (Peoples, 2020). Peoples (2020) added that each framework is a lens that allows the researcher to separately view and translate the lived experiences of each participant. According to Heidegger (1971), there is always a movement from the participant (who is being queried) to the personal interpretations of the researcher and then back to the participant. Participants are persuaded to use narratives that articulate the intensity of the lived experience and are asked to communicate their experience of dealing with behavioral health services in as much detail as they are comfortable sharing (Quinney, Dwyer, & Chapman, 2016). By using this theory, I was able to ascertain rich, lived experience information from OEF/OIF veterans to specifically educate behavioral health providers and the behavioral health services that strive to recruit and retain veterans.

Attribution Theory

I selected the attribution theory to understand how OEF/OIF veterans might rationalize their decisions to maintain behavioral health treatment. Attribution theory's origins lie with Heider (1958) who explained that individuals search for causes to events, influencing their lives, based on personal and environmental forces. Heider explained how an individual thinks and feels about someone else, how they perceive that person and what that person does to them, what they expect that person to do or think, and how they react to the actions of the other person constitutes the thought processes that were researched. Batool, Yousuf, and Parveen (2012) added that the attribution theory is focused on how and why individuals make causal explanations that influence their

actions, achievements, and performances. Thus, OEF/OIF veterans may attribute personal and environmental experiences to behavioral health system engagement.

Cognitive Behavioral Theory

Cognitive behavioral theory is a respected theory as well as an intervention. I selected cognitive behavioral theory because prior researchers (Litz, 2014; Whealin et al., 2014) have identified the theory as assisting OEF/OIF veterans with posttraumatic stress. Beck (2011) explained that dysfunctional thinking is common to behavioral disturbances, so when individuals assess their thought-patterns in more realistic terms, they may improve their emotions and behaviors. Thus, OEF/OIF veterans' cognitions toward behavioral health enrollment should be studied for research purposes and additional comprehension. Pedersen et al. (2012) confirmed that cognitive behavioral interventions have assisted individuals in dealing with PTSD by restructuring trauma-related thoughts and event meaning.

Nature of the Study

This study was conducted using a hermeneutic phenomenological approach. Qualitative researchers consider real-world lives and experiences of research participants (Sloan & Bowe, 2014). Qualitative research takes place in a natural setting that is central to data collection (Clark & Veale, 2018). In this study, a hermeneutic phenomenological design was used to collect insights from OEF/OIF veterans with PTSD. Accordingly, the researcher is enlightened from exploring his or her own bias and understandings to be reassuring for participants, to acknowledge their experiences, and to share experiences and connect with participants throughout the interview process (Quinney et al., 2017).

Phenomenological researchers observe and scrutinize how participants experience their world while attributing meaning to those encounters (Wilson, 2015). Moser and Korstjens (2018) explained that conversational interviews, researcher questioning, and spoken-word comprehension advance data collection.

For this study, PTSD (self-reported) and behavioral health system experiences were participant eligibility requirements. Wilson (2015) and Guest, Bunce, and Johnson (2006) recommended a participant size between five and 25 participants, and I sought those who supported Afghanistan and/or Iraq operations, who self-identified with PTSD, and who were referred for behavioral health services. My goal was to interview eight to 12 OEF/OIF veterans, but if saturation was not achieved, I would have expanded the respondent pool.

Definition of Terms

Cognitive behavioral therapy (CBT): Strong front-line evidence-based treatment for PTSD (Litz, 2014).

Cognitive processing therapy (CPT): Evidence-based treatment for PTSD (Holliday, Holder, Williamson, & Suris, 2017).

Counseling: A professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, and education (Castro et al., 2015).

Department of Veterans Affairs (VA): Federal government healthcare and benefits agency committed to assisting veterans (Garcia et al., 2014).

Deployment: Service members performing duties in Afghanistan, Iraq, and other areas outside of their home stations in combat or support of national objectives (Signoracci, Bahraini, Matarazzo, Olson-Madden, & Brenner, 2014).

OEF/OIF: Operation Enduring Freedom - Afghanistan/Operation Iraqi Freedom – Iraq (Gallegos et al., 2015).

Posttraumatic stress disorder (PTSD): One of the most common psychiatric disorders among veterans returning from Iraq and Afghanistan (Tsai et al., 2012).

Reintegration: A veterans' process and outcome of resuming roles in family, community, and workplace (Elinitsky et al., 2017).

Traumatic brain injury (TBI): Characterized as a blunt or penetrating head trauma that manifests various clinical symptoms that vary based on the severity of the trauma (Akins, Golub, & Bennett, 2015).

Stigma: Negative beliefs, attitudes, and conceptions that an individual personally links to mental illness (Brown & Bruce, 2016).

Veteran: Prior serve members who were committed to serving their country (Castro et al., 2015).

Assumptions

In conducting this research, I made multiple assumptions. My first assumption was that the hermeneutic phenomenology approach was the most appropriate method for uncovering the essence of the lived experiences of OEF/OIF veterans (see Bynum & Varpio, 2017). I made this conclusion based on how phenomenologists seek to understand the phenomena as veterans experience them in their life (see Sloan & Bowe,

2014). I assumed open-ended questions would be a trustworthy resource for collecting rich stories and powerful experiences for framing responses to the research question (see Tai & Ajjawi, 2016). I assumed that data saturation was achieved when no new analytical information arose, and the study provided maximum information on the phenomenon (see Moser & Korstjens, 2018). To reach saturation, I assumed fewer than 10 interviews would be required (see Moser & Korstjens, 2018). As a result, I assumed that data collection would be thorough because collection consists of lengthy periods of gathering information directly from people and recording their personal views to portray detailed information (see Alase, 2017). Finally, I assumed my past experiences and knowledge would be valuable guides to the research (see Neubauer, Witkop, & Varpio, 2019).

Scope and Delimitations

The scope of this study included participants from the state of Delaware or a surrounding area within 30 minutes of Delaware. The sample was drawn from a population of OEF/OIF veterans, with self-reported PTSD, who had an engagement with behavioral health services. My study was further limited to the studies of Heidegger's (1971) hermeneutic phenomenological theory, Heider's (1958) attribution theory, and Beck's (1993) cognitive behavioral theory, which provided my theoretical framework.

Limitations

Participants were limited to veterans in the state of Delaware, so the research did not encompass a broad perspective. Another limitation was the use of snowball sampling, which relied on veterans referring other veterans to participate in the study (see Moser & Korstjens, 2018). Because sample sizes vary in phenomenological studies, the research

was limited by no truly defined number to gain saturation (see Tai & Ajjawi, 2016). Finally, the study was reliant on participant disclosure as veterans must be open to expressing their feelings and emotions and must understand what lies behind their emotions to achieve this (see Cole, Couch, Chase, & Clark, 2015).

Significance

The results of this hermeneutic phenomenological study may contribute to developing insights that could support programming designed to address low treatment retention rates in obtaining behavioral health services among OEF/OIF veterans. This research will contribute to the body of knowledge regarding OEF/OIF veterans and PTSD. DiLeone et al. (2013) confirmed that a sizeable number of OEF/OIF veterans would benefit from behavioral health interventions; yet they do not seek or receive treatment, suggesting that research on maintaining such treatment has not been sufficiently covered. Whealin et al. (2014) emphasized the importance of behavioral health intervention for this population because untreated behavioral health conditions are associated with poor functioning and low quality of life. I will disseminate the findings from this research at professional conferences to inform behavioral health practitioners, educators, military personnel, and human services professionals as a contribution toward positive social change.

Summary

OEF and OIF veterans defended the nation and inherited various psychiatric issues, including high posttraumatic stress symptoms (Brown & Bruce, 2016). Previous scholars discussed the symptoms, potential interventions, and barriers to treatment, but

did not explore how behavioral health services can engage and retention treatment. This chapter provided an overview of the study, which included an introduction and background on veterans and behavioral health services. To facilitate research, I provided a problem statement, the purpose of the study, and the research question. Chapter 1 continued with the nature of the study, definition of terms, and a summary to consolidate information. Chapter 2 will provide a detailed literature review to incorporate previous studies information on veterans, PTSD, and behavioral health services.

Chapter 2: Literature Review

Introduction

The purpose of this hermeneutic phenomenological study was to understand the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services. Specifically, my focus entailed understanding veterans' feedback regarding their decision to retain behavioral health services for addressing posttraumatic stress. PTSD, a possibly debilitating disease, is characterized by an individual reexperiencing trauma, physiological hyperarousal, and emotional numbing; if unaddressed, it can compromise veterans' quality of life (Levi et al., 2016). OEF/OIF veterans may face PTSD and other behavioral health challenges diminishing their postmilitary reintegration into daily routines and life in general (DeViva et al., 2016). Engagement with behavioral health practitioners and their services can serve as an intervention to address these challenges, but this population often fails to retain treatment (Doran et al, 2017).

In this chapter, I provide my literature search strategy; I then introduce three theories: hermeneutic (interpretive) phenomenological theory (Heidegger, 1971), attribution theory (Heider, 1958), and cognitive behavioral theory (Beck, 1993) to explore OEF/OIF veterans' responses to behavioral health services. Also, I provide an overview of the target population for this study, OEF/OIF veterans, from a multifaceted perspective. This perspective includes covering the specificities of PTSD and its characteristics, impact on living, as well as explain the prevalence of comorbid (coexisting) behavioral health conditions. I then cover OEF/OIF from the perspectives of

individuals serving multiple tours, the female experience, and nuances regarding minority veterans. Next, I provide one of the core foci of this study that entails behavioral health services. Then, I report insights on veteran reintegration into civilian life and within the context of their social relationships. Finally, I discuss provider engagement and summarize the chapter with concluding thoughts.

Literature Search Strategy

The literature search strategy that I used for this study comprised using a synthesis of resources retrieved from several repositories, including Walden University Library, Google Scholar, Google, and the Department of Veterans Affairs website. Primary databases included Thoreau Multi-Database Search, Academic Search Complete, ERIC, Military and Government Collection, National Alliance on Mental Illness, ProQuest Central, PsycARTICLES, PsycINFO, SAGE Journals, and Walden Dissertations. Using a majority of works within the past 5 years (2015-2019), keyword searches included *attribution theory, barriers and beliefs to behavioral health services, behavioral health providers engagement with veterans, cognitive behavioral theory (therapy), female veterans, OEF/OEF Veterans, PTSD, reintegrating into civilian life, utilization of behavioral health services, veterans' behavioral health problems, veterans behavioral health services,* and *veterans' families and relationships.*

Theoretical Foundation

Three theories that served as the foundation for my understanding of this research study, while providing the foundation for data analysis, were hermeneutic (interpretive) phenomenological theory (Heidegger, 1971), attribution theory (Heider, 1958), and

cognitive behavioral theory (Beck, 1993). The hermeneutic phenomenological theory is centered on Heidegger's concept of *dasein* when translated means *being in the world*, coinciding with how an individual believes he or she melds into society (Wilson, 2014). Attribution theory is used to explore routine causes for how individuals interpret their successes and failures collectively, rather than to address using singular viewpoints (Weiner, 2010). Cognitive behavioral theory provides insights into behavioral patterns that result from how people interpret and frame their world and react based on internalized misperceptions and cognitions (Wright, Thase, & Beck, 2014). In the following sections, I address each theory individually.

Hermeneutic (Interpretive) Phenomenological Theory

Heidegger (1971) realized that individuals are immersed in the world. For Heidegger, individuals were not separate beings or detached characters; for this reason, Heidegger called individuals *dasein* or *being there*. Heidegger posited dasein's primary way of subsisting is through involvement in dealing with the world of concern where things make sense with a meaningful whole. Wilson (2014) stated that counselors are *concerningly involved* with a world of clients, providers, and counseling which they comprehend by their training so the counseling world will be seen differently by a non-counselor. Peoples (2020) added that dasein refers to talking about self, myself, yourself, and all selves, with everyone's existence in the world. Heidegger maintained that it is impossible to comprehend an experience by being detached so he initiated hermeneutics as an alternative to bracketing a person's experiences because individuals are always in the world with others.

The hermeneutic phenomenological theory addresses a phenomenon via the hermeneutic circle or depiction of the development of understanding (Peoples, 2020). Peoples (2020) added that the circle consists of fore-sight, a preconceived knowledge, and as an individual starts to comprehend and assess information, fore-sight changes so there is a continuous circle. The theory allows researchers to comprehend deeper layers of human experience that are buried under surface awareness and uncovers how the participant's prereflective rituals influence this experience (Bynum & Varpio, 2017). As researchers assess information, they have a previous comprehension of the phenomenon, but as new information is gathered, they undergo a revision of that comprehension (Peoples, 2020). Hermeneutic phenomenology strives to examine the human way of what Heidegger (1971) called *being in the world* and how individuals reflect and make sense of being a part of that element or world. A part of interviewing is determining the world that is being researched and interviewing the participant when he or she is in that world. This theory is used to express and arouse dimensions of lived experiences by continually resisting the temptation to theorize and categorize the learned material (Adams & van Manen, 2017). An individual can avoid categorization by focusing on the participant's life as experienced versus how the researcher interprets it (Adam & van Manen, 2017). Individuals are already and continually engaged in the world, deciphering, coping with realities, and tending to life (Wilson, 2014).

Attribution Theory

Heider (1958) developed attribution theory in an attempt to understand and explain events occurring in the everyday life of individuals. Heider believed that people

are active observers, making conscious assumptions about why people do what they do. Heider posited that, rather than apply passive acceptance of behavior, individuals seek to understand the reason events occur. Heider explained that people are naturally curious, and they believe that there are reasons for thinking, behaving, and doing (in other words, there is a cause and effect for all). Weiner (2008) posited that this discovery is what connected Heider's work to social psychology.

Kelley (1973) expanded this theory by focusing on how people make causal explanations, asking themselves *why* questions to better understand their world. Kelley believed that individuals not only explain their world through cause and effect, but they also expect there to be plausible answers as explained through this type of nonscientific analysis. Kelley further explained that people use this nonscientific analysis to make causal inferences and to answer causal questions. Weiner (2008) further offered a common-sense approach to capturing and describing the application of attribution theory using nontechnical terminology.

Kelley (1973) opined that attribution theory should be articulated using simple and obvious ideas that are common sense. Weiner (2008) explained the *Kelley cube,* which assessed individual causal belief experiences by identifying the role of social norms and history in future decision making. The causal schema refers to how individuals think about probable causes relating to a given effect (Kelley & Michela, 1980). Kelley and Michela (1980) reported that causal beliefs affect attributions made for events, in addition to affecting the intake and use of causally relevant information. For example, a veteran with PTSD might attribute his or her behavioral health problems to prior military

service and refrain from seeking treatment to address the postmilitary effects (Kelley, 1973). Attribution theory defines how individuals use attributional analyses to predict, understand, and control their surroundings, which can help determine how veterans respond to behavioral health surroundings (Weary & Wright, 2017). Finally, I used attribution theory in this study as a means to understand veterans' rationale towards maintaining behavioral health interventions.

Cognitive Behavioral Theory (Therapy)

Cognitive behavioral therapy (CBT) is a form of psychotherapy with a theoretical underpinning and extensive research confirming its effectiveness in treating multiple psychiatric problems (Beck & Dozois, 2011). CBT is a first-line PTSD intervention (preferably individual setting) for encouraging personal disclosure (Falkenstein, Baca, Belon, & Castillo, 2017). Beck (2019) recalled developing CBT, in the 1960s, to understand clients' interpretations and depressed thinking after they disclosed negative cognitions. Beck shied away from psychoanalysis and carried out a collaborative conversation with the clients and discovered that their thoughts were a bridge between emotional experiences and behaviors. According to Beck, automatic thoughts were exaggerations, misconstructions, or misinterpretations of a situation so he focused on reframing the client's thought processes.

This theory, initially developed for depression, can be applied by counselors working with clients' suicide prevention, anxiety, and substance abuse (Beck & Dozois, 2011). Beck (2019) recognized that individual interpretations led to situational beliefs, so he focused on reestablishing normal thought processes. Beck (1993) stressed how CBT

techniques should modify dysfunctional beliefs and address flawed information processing. Techniques are used in conjunction with individual thoughts, feelings, and behaviors related to situations that influenced negative cognitions (Stecker, Shiner, Watts, Jones, & Conner, 2013). CBT helps individuals assess thoughts using exploration (determining meaning), examination (reviewing evidence), and experimentation (testing beliefs; Beck & Dozois, 2011). Treatment using CBT does not necessarily replace negative thoughts with positive ones; rather, it helps individuals switch maladaptive thoughts to adaptive behaviors (Beck & Dozois, 2011). Beck (2010) observed that when people process their thoughts in more realistic and adaptive ways, they can gain emotional and behavioral improvements. The theory can be used in various inpatient and outpatient settings including individuals, groups, and couples (Beck, 1993). CBT's devotion to understanding and modifying negative behavioral thoughts may improve treatment seeking consideration and minimizing posttraumatic stress symptoms (Wright et al., 2014).

Posttraumatic Stress Disorder

PTSD is linked to episodic memories acquired from exposure to serious threats to survival, risks to viability, and unparalleled effects (Litz, 2014). PTSD symptoms follow exposure to one or more traumatic events, emotional reactions (helplessness or horror) to event(s), and fear-based reexperiencing or negative cognitions (American Psychology Association, 2013). Four key areas of consideration for the current study include characteristics of the disorder, its impact on living, and the risk of comorbid behavioral health conditions.

Characteristics

PTSD is characterized by comorbidities (coexisting diseases/disorders) associated with mood and anxiety disorders (Elhai et al., 2015). The disorder overwhelms veterans biologically, psychologically, spiritually, and socially following reminders about unimaginable events (Litz, 2014). Nearly 14% of OEF/OIF veterans have PTSD exceeding the 6.8% average for U.S. nonveterans (Stecker et al., 2016). Mohler and Sankey-Deemer (2017) confirmed that Iraq and Afghanistan veterans' disorder rates are between 11% to 20%. In comparison, PTSD impacts 31% of Vietnam veterans and 10% of Gulf War veterans (Wade, 2016). Bourn, Sexton, Raggio, Porter, and Rauch (2016) added that OEF/OIF veterans have more severe symptoms than Vietnam veterans.

The disorder is a condition, suffered by OEF/OIF veterans, which is illustrated by reliving life-threatening events, reexperiencing avoidance, negative cognitions, and undesirable moods (Gallego et al., 2015). Elnitsky et al. (2017) noted that symptoms are compounded by additional and/or longer deployments. Wade (2016) found that combat-related PTSD metabolizes into chronic psychiatric disorders with relapses in the population and with lifelong reoccurrences.

The disorder generates long-term neurobiological changes that negatively impact physical and mental functioning (Armenta et al., 2018). According to Armenta et al. (2018), decreased quality of life contributes to cardiovascular disease, hypertension, obesity, and mortality. PTSD led to a 200% increase in hospitalizations for OEF/OIF veterans between 2006 and 2012 and is a primary diagnosis in the Department of Veterans Affairs' behavioral health system (Fox et al., 2015). The number of veterans

receiving disability compensation (monies for service-connected disabilities) for PTSD increased by 72% from 467,274 in 2008 to 648,992 in 2013 (Marx et al., 2017). Providers, family members, media, and veterans should recognize PTSD's distinctive origins and treatment approaches to better handle its limitations because of its impact on the veterans' living situations (Litz, 2014). Understanding the lived experience of veterans with PTSD symptoms may help this population to have greater awareness and possibly benefit their families and providers, leading to increased quality of life.

Impact on Living

PTSD symptoms impact veterans across a wide array of human functions and interactions. Veterans describe intimacy issues, social complications, marital distress, and parenting conflicts that lead to numbing, avoidance, and anxiety. They exhibit inferior social and family relationships, work absenteeism, minimal occupational success, less income, and lower education (American Psychology Association, 2013). Armenta et al. (2018) noted that PTSD advances disability decreases productivity and lessens fitness reducing physical and occupational output.

In addition to behavioral health challenges, 59 to 80% of veterans concurrently experience chronic physical complaints (Bourn et al., 2016). Bourn et al. (2016) found that veterans have frequent medical conditions, worse health quality of life, and increased somatic complaints. Williams et al. (2014) posited that PTSD-related anger, especially combat-related, causes stress, depression, anxiety, and social impairments. Disorder emotional numbness makes veterans feel socially isolated and heightens their need to handle their problems (Graziano & Elbogen, 2017). However, female veterans possess

more tormenting PTSD symptoms (avoidance, reexperiencing trauma, and hyperarousal), extreme concentration issues, or distress disturbances (Haun et al., 2016). Understanding PTSD's impact is crucial for solidifying veteran relationships, enhancing health, and wellbeing (Bowen et al., 2016).

PTSD rates are higher for veterans and personnel who are employed in trauma-based occupations with the highest rate found among military combatants (American Psychological Association, 2013). Armenta et al. (2018) explained that OEF/OIF operations personnel were strong predictors of persistent PTSD symptoms. Individuals with PTSD are 80% likely to display criteria cooccurrence with other disorders (depressive, anxiety, substance use) with OEF/OIF veterans 48% likely to have a PTSD / TBI cooccurrence (American Psychological Association, 2013). The American Psychological Association (as cited in Wade, 2016) remarked that PTSD's initial characteristics occur when facing exposure to catastrophic events with actual or perceived death or injury or a threat to physical being. Wade (2016) reported that disorder reexperiencing involves reactions (panic or despair) to the original traumatic event that turns into intrusive images (nightmares and flashbacks).

The *Diagnostic and Statistical Manual of Mental Disorders* named PTSD's four symptom clusters: reexperiencing (nightmares, flashbacks, trauma reminders), avoidance (of internal and external reminders), negative cognitions (depressed mood, guilt/blame, negative beliefs about self/others/world), and physiological hyperarousal (irritability, difficulty sleeping, hypervigilance, exaggerated startle response; as cited in Doran et al., 2017). The National Center for PTSD (2018) presented four indicators: reliving the event,

avoiding event reminders, having more negative thoughts than before, and feeling on edge that can overwhelm veterans. Wade (2016) explained that veterans use avoidance behaviors to lessen trauma-related stimuli (avoiding fireworks, military funerals, or crowded areas) that were internalized during military service. The Office of the Chairman of the Joint Chiefs of Staff (2014) pronounced that disorder diagnoses do not mean permanent impairment or inability to treat because, although challenging, veterans should not be labeled permanently damaged. To minimize PTSD's impact on veterans' living, disorder information must be shared by multiple sources to increase veterans' and caregiver knowledge.

Comorbid Behavioral Health Conditions

PTSD is not the only behavioral health condition affecting OEF/OIF veterans (Litz, 2014). PTSD garners maximum attention but other conditions of substance misuse, suicide, and risk-taking behaviors overwhelm veterans (Bowen et al., 2016). Psychological conditions (PTSD, substance use disorder, anxiety, depression, suicidality) are elevated 1 year following deployments and may increase following transition to veteran status (Elnitsky et al., 2017). The National Center for PTSD (2018) and Fox et al. (2015) highlighted how TBI, depression, substance abuse, and suicide limit veterans' positive existence. In some cases, depression (15%) and substance use disorder (30%) characterize OEF/OIF veterans' daily living (Stecker et al., 2016).

Traumatic Brain Injury

TBI, typified by head trauma, affects 15% to 23% of veterans (Aikins, Golub, & Bennett, 2015). The National Council on Disabilities added that 25% to 40% are

restricted by brain injuries and cognitive impairments and suffer reintegration adversities (as cited in Mohler & Sankey-Deemer, 2017). Similar brain injuries, which caused death in previous conflicts, now cause significant cognitive, psychological, memory, and communication impairments related to improved medical interventions (Elnitsky et al., 2017). Although TBI was not the focus of my dissertation, participants may have encountered this type of brain injury that must be considered.

Depression

Depressive features such as sad, empty, or irritable moods, accompanied by somatic (physical) and cognitive changes significantly affect an individual's functionality (America Psychological Association, 2013). Among OEF/OIF veterans seen by Veterans Affairs, between 14% and 22% are estimated to have a depressive disorder (Fox et al., 2017). Schmied, Larson, Highfill-McRoy, and Thomsen (2016) found a strong relationship between PTSD and depression. Rodina et al. (2017) substantiated the PTSD / depression relationship adding that depressed veterans have trouble identifying and tolerating negative emotions, with PTSD further weakening emotions.

Substance Misuse

Elnitsky et al. (2017) reported substance misuse like binge drinking, marijuana, and opioids are used to deal with post-deployment stressors. Binge drinking, five or more drinks during a single session, is prevalent among veterans as a self-medication option (Aikins et al., 2015). Fox et al. (2015) confirmed veteran alcohol abuse rates are high as 20 - 40% when screened positive for alcohol misuse. Of these, over half who screened positive did not pursue counseling or treatment (Whealin et al., 2014). This study

provides insights related to possible resistance to seeking behavioral health care and retaining services.

Suicide

Mohler and Sankey-Deemer (2017) reported that veteran suicide rates are escalating with the 2014 suicide rate of 35.3 per 100,000 veterans. The VA suicide prevention program stated that 18 to 22 veterans die daily by suicide (Sherman, 2014). Kukla, Rattray, and Salyers (2015) found that excessive readjustment stressors, in OEF/OIF veterans, indicted higher suicide risks. Thomas and Bowie (2016) found that 25% of veterans reported dealing with suicidal issues. The prevalence of suicide ideation speaks to the importance, relevance, and severity of comorbid behavioral health conditions that a person may have when also experiencing PTSD.

Schmied et al. (2016) highlighted that PTSD, depression, and substance misuse are often comorbid and difficult to research individually without acknowledging the other condition's influence. PTSD, substance misuse, and other psychological problems are the invisible cost of war for veterans, and they require interventions to payback sacrifices (Rishel & Hartnett, 2015). Multiple conditions accompany PTSD leaving veterans vulnerable to their combined influences. It is important to understand these elements to ensure veterans are equipped to confront their various effects.

Operation Enduring Freedom/Operation Iraqi Freedom Veterans

Military operations in Southeast Asia have involved a multitude of service members who are now veterans. Following the September 11, 2001, terrorist attacks, the U.S. military sent service members to Afghanistan for OEF and Iraq for OIF, initiating

another Middle East conflict (Hayes et al., 2017). When exploring the social phenomenon, it is helpful to partition the focus into three areas: the influence of serving tours on veterans, in general, female veterans, and minority veterans.

Influence of Serving Tours on Veterans

Since 2001, there have been 2.5 million OEF/OIF veterans deployed, with over 25% of this population deploying multiple tours, returning with psychological disorders, and social readjustment difficulties (Elnitsky et al., 2017). These individuals who accepted additional duty and returned to combat zones indicated that their willingness was based on their commitment to their country (Castro et al., 2015). DiLeone et al. (2013) found that OEF/OIF veterans face multiple deployment challenges that place them at risk for postmilitary behavioral problems. Hence, returning from deployments with PTSD, depression, and substance abuse complications are commonplace among this population (Fox et al., 2015). Also, Litz (2014) reported that veterans who return from warzones have difficulty adjusting to civilian life due to internalized war-fighter characteristics and adopted military culture. In addition to these psychological and social adjustments, OEF/OIF veterans also tend to experience higher rates of PTSD, major depression, and substance misuse than other populations (Brown & Bruce, 2016).

Compared to other eras, OEF/OIF veterans have higher PTSD development rates impeding their reintegration, socialization, and quality of life (Haun et al., 2016). In general, this population tends to be younger and are working adults who may not seek counseling because of family and employment obligations (Garcia et al., 2014). Clement et al. (2015) emphasized that posttraumatic stress is self-limiting so if veterans delay or

avoid counseling it may cause significant consequences. For example, veterans may continuously encounter symptoms due to re-exposure to traumatic events (exposure as a combatant, threatened or actual physical assault, taken hostage, terrorist attack, or prisoner of war incarceration) and as well as the anxiety of reintegrating into civilian activities (America Psychological Association, 2013). Although intervention is recommended, Brown and Bruce (2016) discovered that many veterans view counseling negatively rather than a favorable behavioral health intervention. To increase the understanding of veterans' views on counseling, I explored female and minority veterans' characteristics.

Female Veterans

Afghanistan and Iraq conflicts included more females than all other aggressions in U.S. military history (Jacobson, Donoho, Crum-Cianflone, & Maguen, 2015). Because much of the research focused on male veterans, it is important to highlight female veterans' characteristics as they may differ from the general population who are men. According to Koblinsky, Schroeder, and Leslie (2017), females encompass 14.5% of active duty military personnel and 9.4% of military veterans. Haun et al. (2016) and Koblinsky et al. reported that 14% of OEF/OIF personnel disorders are from trauma exposure, hostile actions, and rendering casualty care to injured colleagues. Females who experienced military sexual trauma, while deployed, are more likely to seek counseling (DiLeone et al., 2013). Of this overall population, Jacobson et al. (2015) explained that females are at a higher risk for developing PTSD. However, more females than males, use counseling (Doran et al., 2017; Goldstein, Bradley, Ressler, & Powers, 2016).

The number of females seeking care from the Veterans Administration (VA) has doubled since 2000 with OEF/OIF females outpacing males in seeking treatment (Doran, 2017). Fox et al. (2015) found that females may feel less comfortable with VA treatment because they are not typical patients (older male veterans). Females in specific strata or categories tend to respond to seeking treatment in different ways. For instance, DiLeone et al. (2013) found that lower-income females were considerably more likely to pursue counseling because of their financial burdens. This, combined with added other stressors, weighed in their decisions to seek psychological help. Black females are less likely to disclose issues, hindering engagement with non-Black therapists, and increasing dropout (Holliday et al., 2017). Female veterans face challenges based on their gender and serving in a male-dominated profession, so an increased understanding of behavioral health services will be beneficial for their quality of life.

Minority Veterans

Minority veterans are categorized as least likely to seek therapeutic services, sustain minimal retention rates, and receive lower PTSD service-related financial benefits. The America Psychological Association (2013) stated that Latinos, Blacks, and Native Americans (lower for Asians) have higher PTSD rates among all other populations. Therefore, Black veterans should seek treatment because they acquire the disorder more frequently than Whites and Asians (Stecker et al., 2016). Stecker et al. (2016) also reported that although Latinos and Blacks, have higher prevalence of PTSD, they had lower retention rates than Whites and were more likely to terminate sessions.

Black males veterans were found to have greater family stressors and lower levels of social (family and friends) support than White male veterans (Muralidharan, Austern, Hack, & Vogt, 2016) Muralidharan et al. (2016) uncovered that although Black and Latino female veterans reported low social support, they were shown to have greater anxiety symptoms than White females. Black veterans prefer Black psychotherapists (Holliday et al., 2017) However, Black psychotherapists only account for 2% of the profession, so this pairing is difficult (Holliday et al., 2017). Finally, there are racial disparities that impact how often Black veterans receive a PTSD diagnosis. Marx et al. (2017) indicated that consequently, Blacks receive less PTSD service-connected financial compensation than White veterans. Although the literature continues to grow in learning how minorities are affected by PTSD symptoms, less is understood about retention and early termination.

Behavioral Health Services

Afghanistan and Iraqi veterans may have access to countless behavioral health services, but quality and services rendered may vary. Brown and Bruce (2016) acknowledged that although evidence-based treatments exist, robust research is needed to understand veterans' decisions to seek treatment and to become amenable to counseling.

First-Line Treatment

There are several treatment services targeted to veterans. However, CBT is a primary intervention for addressing PTSD symptoms (Falkenstein et al., 2017). CBT is a first-line treatment for minimizing PTSD symptoms (Levi et al., 2016). CBT and cognitive processing therapy (CPT) are effective in addressing PTSD symptoms.

Holliday et al. (2017) defined CPT as an evidence-based intervention that confronted trauma-based cognitions and bolstered psychosocial functioning. CPT was used by therapists to effectively treat PTSD by restructuring veterans' cognitions and minimizing symptoms (Wade, 2016). Wade (2016) explained that counseling redirects distorted beliefs (grief or fear) about the veteran's world and self. Williams et al. (2014) presented CPT as a 12-session therapy incorporating exposure treatments to help identify and restructure distorted beliefs.

Counseling promotes methods for handling disturbing thoughts and understanding of previous traumatic events (Wade, 2016). The National Center for PTSD (2018) remarked that CPT identifies negative thoughts, alters negative feelings, acknowledges thoughts/believes are upsetting and engages counselors to contest negativity. Garcia et al. (2015) found that therapy tackled maladaptive PTSD cognitions like safety, trust, control, and self-esteem. CPT's treatment effectiveness lies within its positive influence on depression, affect regulation, and social adjustment/interaction (Williams et al., 2014). The Department of Veterans Affairs sometimes delivers CBT via group formats, and this modality is not recognized as a first-line approach to treatment (Falkenstein et al., 2017). CBT is an effective intervention for treating veterans, and it should continue to be implemented for OEF/OIF veterans.

Use of Services

Afghanistan and Iraqi veterans seek normalcy but forget how to be normal due to disorder arousals that require treatment use (Castro et al., 2015). Vogt et al. (2014) reported that veterans' problems have to be *very bad* to pursue treatment over dealing

with it personally. Usage remains low despite continuing efforts to connect veterans with counseling (Doran et al., 2017). DeViva et al. (2016) found that after initial referrals, veterans do not retain follow-up care or only attend minimal sessions because *they don't need it.* Nearly half of veterans diagnosed with PTSD avoided counseling in the previous year and only 30% of those who received initial counseling completed required sessions (Fox et al., 2015). Veterans should use counseling (typically at least nine sessions) to resolve symptoms (McGinn, Hoerster, Stryczek, Malte, & Jakupcak, 2017). Goetter et al. (2015) and Doran et al. (2017) posited that veterans do not finish sessions despite improved cognitive behavioral interventions and enhanced provider training. Stecker et al. (2013) identified four decision beliefs for using services: treatment concerns (40%), emotional readiness for treatment (35%), stigma (16%), and logistical issues (8%). Studying use methods provides targets for viable outreach and treatment concepts (Doran et al., 2017).

The National Center for PTSD (2018) declared that veterans who seek counseling services can reduce the associated symptoms and bolster their quality of life. However, these scientists acknowledged that rather than seeking services, veterans commonly believe that the symptoms will diminish. It is unlikely if the symptoms have been prevalent for more than a year (National Center for PTSD, 2018). Using services may be largely associated with the cost of care and insurance coverage (DiLeone et al., 2013). Consistent with this finding, McGinn et al. (2017) found that income is a significant predictor of counseling: The higher the income for the veteran, the more frequent the usage of services.

Low treatment engagement is a concern for behavioral health professionals because nearly half of referrals fail to engage in counseling (Hundt et al., 2018). Although many OEF/OIF veterans with posttraumatic stress need counseling services, military culture discourages treatment-seeking, and the encounters when interfacing with the Department of Veterans Affairs tend to exacerbate attitudes towards refraining from seeking care (Hayes et al., 2017). Fox et al. (2015) found that factors influencing counseling use among veterans are attitudes about VA health care, how they fit in that system, and behavioral health treatments. In contrast to the aforementioned findings, Graziano and Elbogen (2017) observed that posttraumatic stress symptoms were the strongest predictor for seeking mental health professionals. Regardless of counseling sources, scholars should encourage the use and reduction of behavioral health barriers.

Barriers to Services

There are many individual and unique reasons that veterans abstain from seeking behavioral health services. However, the most prominent reasons aligned with this research are stigma, gender-based differences in help-seeking characteristics, and personal preferences.

Stigma. Post-deployment barriers are guarded thoughts characterized by emotional readiness and stigma (Gallegos et al., 2015). Crucial barriers are stigma, negative attitudes about treatment, and organizational barriers (Kracen, Mastnak, Loaiza, & Matthieu, 2013). Stigma is divided into self-stigma or public stigma, where self refers to personal negative beliefs or cognitions and public refers to negative beliefs or attitudes thought to be from the general population (Brown & Bruce, 2016). Bowen et al. (2016)

emphasized that stigma and embarrassment associated with self-perceived weakness are strong internalized barriers. Stigma limits counseling's acceptance because veterans deem counseling unnecessary or attribute it to being soft (Gallegos et al., 2015). Garcia et al. (2014) surmised veterans' stigma perceptions and bolstered self-reliance (I can handle this) negate counseling engagement. Elnitsky et al. (2017) found that perceived or real public stereotypes minimized efforts to seek counseling and determined that veterans felt combat-related PTSD, versus other disorders, was less stigmatizing but they still avoided counseling. DeViva et al. (2016) reported that adverse counseling beliefs are associated with higher stigma levels, higher barriers to receiving care, and lower counseling use. Stigma is widely cited for avoiding counseling because veterans do not want to be labeled as a *crazy vet* (Stecker et al., 2013). Because stigma is not the sole barrier affecting help-seeking, researchers should investigate stigma reducing strategies and address other barriers by combining antistigma programs with behavioral health literacy (Clement et al., 2015).

Gender. PTSD affects veterans differently based on gender and beliefs. Duran et al. (2017) reported gender's influence as military culture emphasizes, then reinforces, masculine values of strength and stoicism to minimize emotions. Stoicism beliefs suppress emotions, ignore health-problems, and encourage resolution of a person's issues (Whealin et al., 2014). Traditional masculine traits involve negative attitudes towards behavioral health-seeking, especially for younger veterans (Garcia et al., 2014). Graziano and Elbogen (2017) found that sexes reported negative counseling thoughts based on internal barriers or thoughts of counseling effectiveness. For females, barriers include

treatment access, stigma, and availability of gender-sensitive care (Koblinsky et al., 2017). Haun et al. (2016) added limited female-centric care, inadequate support networks, and limited continuity of care. Females felt withdrawn about pursuing counseling due to feeling less deserving than male veterans (Koblinsky et al., 2017). Koblinsky et al. (2017) confirmed that female OEF/OIF veterans continue to face barriers in procuring behavioral health counseling.

Personal. Veterans may internalize negative views of counseling, thus reducing their desire to seek and retain counseling. Stecker et al. (2013) posited that veterans avoided counseling because they did not want to use medications. Along similar lines, Vogt et al. (2014) found that veteran's concerns about the side effects of psychotropic medications emphasized the importance of presenting alternative treatment options. Of those who do seek services, these veterans prefer individual counseling versus group and lacked faith in nonmilitary counselors because they are perceived as not understanding their situation (Stecker et al., 2013). Hundt et al. (2018) posited that the behavior related to counselor avoidance is an outgrowth of the veteran not being ready for counseling and not wanting to disclose personal information. Veterans rely on personal resolve, believing they can handle behavioral health challenges the same way they dealt with military service and deployments (Freytes et al., 2017). Garcia et al. (2014) found that OEF/OIF veterans, more than Gulf and Vietnam, believed that counseling made them inadequate, thinking they could not handle their problems. Privacy concerns, negative counseling beliefs, engagement fears, session costs, and scheduling conflicts minimized personal counseling consideration (Elnitsky et al., 2017). Gallegos et al. (2015) added that

treatment concerns, emotional readiness, and logistical issues also negated consideration. Brown and Bruce (2016) postulated that diminished counseling quests are related to symptoms of PTSD, depression, and substance misuse. Thus, Stecker et al. (2013) discovered that veterans avoided discussing symptoms to dodge reliving emotional traumas. Therefore, it is generally accepted that these adverse views of counseling are derived in part from fictitious, drama-driven programming, and media (e.g., Dr. Oz, Freudian psychoanalysis, movies, or television projections). Finally, reasons vary for negating services as Goetter et al. (2015) recognized adverse attitudes toward treatment, DeViva et al. (2016) cited limited social support for seeking help, and McGinn et al. (2017) added inadequate supportive relationships. Personal barriers, according to Garcia et al. (2014), indicated that OEF/OIF veterans, compared to other eras, have fewer behavioral health engagements lessening the chances to overcome symptoms.

Decision to Seek and Retain Services

Military culture reinforces the mandate for individual strength and stoicism, encouraging veterans to shut off emotions, which can impede seeking out and retaining counseling (Doran et al., 2017). Veterans most likely seek VA care when needing relief associated with stressful or high impact military experiences (DiLeone et al., 2013). However, in a civilian work environment, veterans tend to avoid asking for time off to seek treatment because they wish to avoid the perception of appearing as lazy, unmanageable, and under the stigma/ scrutiny related to the disorder's label (Brown & Bruce, 2016). McGinn et al. (2017) suggested that veterans retain counseling when involved in high satisfaction relationships. Bowen et al. (2016) found that families and

supervisors influence retention by encouraging help-seeking and maintaining support. Social supports that encourage counseling solidifies engagement and increases understanding of counseling benefits. (Graziano & Elbogen, 2017).

Mohler and Sankey-Deemer (2017) explained that providers should ask patients if they are veterans and recognize military service at initial screenings. In this study, Mohler and Sankey-Deemer suggested that staffers inquire about veteran status while making initial appointments and informing the provider to facilitate relationships. Providers covet environments that facilitate positive counseling and promote caring (Signoracci et al., 2014). Bowen et al. (2016) determined that veterans retain counseling when trusting a provider's helping abilities and when receiving positive reinforcement. Providers seek to be active (solution-focused) and interpersonal (self-disclosing) when providing counseling to veterans (Signoracci et al., 2014). Litz (2014) found that veterans do not trust counselors lacking military culture knowledge and are frustrated by explaining deployment experiences in civilian terms.

Veterans' Reintegration into Civilian Life

Returning to civilian life, following deployment or military service, can overwhelm veterans with excitement, anxiety, and fear. For example, after return to civilian life, they seek community engagement and opportunities to serve others, traits ingrained from military culture (Bowen et al., 2016). Signoracci et al. (2014) found that OEF/OIF veterans face psychosocial and transitional issues coinciding with reintegration into civilian life. Reintegration issues are compounded by disabilities or traumas requiring rebuilding of their world, self-awareness, and personal competence to

successfully reintegrate (Elnitsky et al., 2017). Kukla et al. (2015) explained that veteran self-worth, defined by military roles, significantly influences reintegration long after combat or leaving military service. Aikins et al. (2015) observed that successful civilian reintegration is impeded by behavioral health concerns known as *invisible wounds*, which are being evaluated by the Department of Defense, Department of Veterans Affairs, and Congressional studies. Reintegration involves multiple, simultaneous transitions that can be achieved through effective behavioral health services and interpersonal supports (Kukla et al., 2015). Signoracci et al. (2014) mentioned that OEF/OIF veterans are returning home with readjustment issues (financial stress and changing family roles) compounding reintegration difficulties. Signoracci et al. discovered that although reintegration is considered positive (reunions with family/friends), it presents trials splintering veterans, families, and communities. Thomas and Bowie (2016) expressed employment as the highest reintegration concern through unemployment, having a disability and unable to work, or only working part-time.

Signoracci et al. explained that work, career, and education struggles are hindered by an inability to transfer military skills into civilian aptitude. Educational interactions are restricted by stigmas and social difficulties that create exclusive dealings only with other student veterans or service members (Aikins et al., 2015). Back to employment, following reintegration, 33% of veterans (versus nondiagnosed veterans) report work problems or lower wages (job loss or working partial hours) due to behavioral health diagnoses (Kukla et al., 2015). Behavioral health symptoms interfere with employment retention and prosperous career paths. Haun et al. (2016) mentioned that symptoms

caused coworker confrontations, frequent job changes, and unemployment leading to financial losses. Veterans experienced difficulty interacting with workplace civilians due to missing the military camaraderie found during deployments or while in uniform (Kukla et al., 2015). Positive reintegration occurs when veterans find meaning in civilian positions, contribute to meaningful causes, or find a strong connection between civilian and military occupations. Castro et al. (2015) discovered that help comes from supervisors who mentor veterans through employment changes or education interests to enrich career choices. Reintegration is effectively facilitated by the pursuit of higher education. The process of maintaining education standards is the catalyst for the aforementioned success (Aikins et al., 2015). Campus veteran organizations promote school integration. Finally, future scholars should better define reintegration traits among diverse OEF/OIF populations to supplement insights on PTSD, suicidality, or TBI characteristics and counseling usage (Elnitsky et al., 2017). The Office of the Joint Chiefs of Staff (2014) emphasized the need for veterans and citizens to eliminate misunderstandings about this disorder, PTSD, to ensure veterans are incorporated to lead schools, communities, businesses, and governments.

Veterans' Family and Social Relationship Challenges

Veterans may face a host of reintegration challenges with family systems, social relationships, and additional societal challenges (employment, education, and housing). Signoracci et al. (2014) exclaimed that veterans defended the nation, returned home, but lack coping skills, which negatively impacted marriages, children, and family relations. Castro et al. (2015) found that returning veterans are simultaneously happy (home with

friends and family) and upset (previous deployment actions). Freytes et al. (2017) noted that families assist with functional recovery but struggle with rehabilitation. Freytes et al. explained how deployments and family dynamic changes affected veterans and significant others' perceptions of family functioning. Thomas and Bowie (2016) reported that 65% of OEF/OIF veterans admitted deployments and subsequent return exasperated relationship stress. Thomas and Bowie further provided details related to veterans' readjustment problems (59%), communication challenges (54%), increased conflict (41%), and financial issues (38%). However, to offset these challenges, friends and family tend to compensate for reintegration difficulties and cushion adjustment to civilian life (Kukla et al., 2015). Mohler and Sankey-Deemer (2017) remarked that families caring for PTSD veterans carry great burdens, including physical, emotional, and financial. Adding to these burdens, veterans felt families did not understand their condition or their daily struggles (Haun et al., 2016). The Office of the Secretary of Defense explained how 3 million spouses and children of OEF/OIF veterans, facing PTSD hardships, reported negative family cohesion (as cited in Freytes et al., 2017). Freytes et al. that found that ordeals negatively impacted marital satisfaction, relationship confidence, parenting cohesion, and relationship dedication. PTSD affects intimate relationships and marriages leading to decreased partner social support and worsening disorder symptoms (Armenta et al., 2018). Intimate relationship suffering stems from partners having to deal with or not understanding PTSD symptoms (Elnitsky et al., 2017). Duax, Bohnert, Rauch, and Deferver (2014) observed veterans' emotional hiding from family generated greater odds of screening positive for PTSD. Armenta et al. (2018)

posited that social relationships encouraged counseling compliance and the sharing of thoughts associated with the disorder. PTSD indicators can encourage veterans to pursue counseling to alleviate how symptoms impact families or because family members encouraged counseling (Janke-Stedronsky et al., 2016). McGinn et al. (2017) determined that effective counseling managed PTSD symptoms while decreasing relationship strife and improving partner interaction.

Providers' Engagement with Veterans

Initiating and retaining positive relationships with behavioral health providers may be the catalyst for improving veterans' mental, physical, and overall health. Rishel and Hartnett (2015) inferred that military service causes veterans to require greater behavioral health needs than the general public. Koblinsky et al. (2017) reported that veterans sought counselors with cultural competency training, knowledge about combat trauma, and understanding of service-related conditions as additional providers seek engagement with increasing veterans.

Key Statistics

Providers identified multiple veterans' problems such as psychiatric diagnoses, transitional issues, education, vocation, and financial stressors that need counseling intervention (Signoracci et al., 2014). Beck (2019) emphasized that successful counseling creates a positive relationship between the counselor and veteran. Sherman (2014) discovered that 1.3 million veterans received VA behavioral health care in 2012 compared to 927,000 in 2006, which hindered caseload management and disrupted clinical programs. Nationwide shortages of behavioral health professionals increased

difficulty of engaging veterans and establishing therapeutic relationships (Rishel & Hartnett, 2015). To address shortages, Sherman (2014) reported that the VA employs 4,000 psychologists, 10,000 social workers, and 2,900 psychiatrists while training 1,900 social workers and 3,400 psychiatry residents yearly. OEF/OIF veterans have priority within VA as providers place them ahead on counseling waiting lists and readjust schedules to expedite treatment (Signoracci et al., 2014).

Preparation of Providers

Behavioral health professionals can be better prepared by studying PTSD fundamentals to strengthen counseling and engagement abilities (Wade, 2016). Understanding elements associated with counseling use and retention helps providers identify goals for outreach and treatment planning (Doran et al., 2017). Litz (2014) found that when providers employ PTSD labels, it should be applied with clinical decision-making and not as a catch-all to avoid the diagnoses losing its clinical efficiency. Providers counseling veterans should be mindful of unique military culture, deployment experiences, and behavioral health issues connected to combat, trauma, and experiences (Wade, 2016). Elnitsky et al. (2017) discovered that providers should acknowledge veteran friendships, in supporting counseling, and build upon these veterans to veteran relationships. Providers are assisting OEF/OIF veteran populations with complex cognitive needs so they must become familiar with this population (Signoracci et al., 2014). Litz (2014) learned that veterans are leery of providers ignorant of military culture or who fail to comprehend deployment experiences. Litz emphasized that providers must understand veterans' lived experiences and post-deployment views of self. Signoracci et

al. (2014) underlined how providers can foster therapeutic relationships, conveying care, and motivating veterans toward retaining counseling engagement. Providers benefit from learning about military culture, admitting to what they do not know, and showing sincere respect for military experiences (Litz, 2014). Providers engaging PTSD veterans gain trust by addressing perceptions of available social support and understanding thoughts about disclosing emotional information (Duax et al., 2014). For female veterans, Koblinsky et al. (2017) encouraged providers to specify treatment plans based on feminine treatment needs and acknowledge differing experiences and disclosures.

Engagement

As counselors augment tools for engagement, they can help PTSD veterans reestablish family relationships, employment opportunities, and community participation (Hayes et al., 2017). Counselors seeking increased treatment use could concentrate on veterans' interface with significant others and clarify how the interface can persuade further treatments. Signoracci et al. (2014) noted that providers understand that veterans are dealing with comorbid issues including psychiatric diagnoses and psychosocial challenges (employment and family), making counseling difficult. Counselors may boost understanding via continuing education (conferences, classes, webinars) to augment knowledge of counseling approaches, military culture, and PTSD screenings (Hayes et al., 2017). Rishel and Hartnett (2015) urged counselors to address veteran concerns and fill behavioral health shortages by attending graduate education programs targeted toward these populations. Castro et al. (2015) found that veterans seek counselor understanding yet avoid discussing experiences, feelings, or thoughts that challenge counseling

interaction. Although counselors should learn military culture, they need to admit the unknown and show legitimate respect for and a desire to learn more about veterans' encounters (Hayes et al., 2014).

Stecker et al. (2013) relayed that counselors can encourage veterans to seek counseling by explaining treatment options and encouraging receptiveness to treatment. Stecker et al. emphasized learning and media campaigns to define counseling's multiple formats in assisting veterans. Veterans seek immediate symptom relief, have difficulty tolerating sessions, and lack patience for change (Signoracci et al., 2014). Clement et al. (2015) challenged counselors to train on addressing veteran stereotypes (weakness and craziness), social judgment, rejection of veterans with diagnoses, employment discrimination, and shame/embarrassment. Training focused on veteran stereotypes and negativity helps minimize counseling opposition (Signoracci et al., 2014).

Whealin et al. (2014) characterized the Department of Veterans Affairs as a focused veterans' behavioral health assistance agency. In this study, the department hired additional providers, increased service hours, and extended outreach to tackle counseling underuse and increase counseling availability. To further assist, Garcia et al. (2014) explained that the department houses 120 PTSD Clinical Teams (outpatient programs) designed to provide specialized PTSD services. Garcia et al. emphasized the significance of creating evidence-based practices (PTSD Clinical Teams and Cognitive Processing Therapy), eliminating negative provider attitudes toward manualized counseling and increasing provider care-seeking. Providers' counseling experiences are concurrently rewarding and energizing plus frustrating and overwhelming (Signoracci et al., 2014).

Providers risk burnout from continuously providing evidence-based care because it indirectly exposes them to traumatic responses, although personal disclosure benefits veterans (Garcia et al., 2014). Sherman (2014) pronounced that the military promotes an interdependent community to sculpt a *got your back* mentality among service members so a similar mentality should be embraced among behavioral health professionals caring for veterans.

Summary

In this literature review, I uncovered insights on how attribution and cognitive behavioral theories can be used as a framework to understand this study's research problem. Current literature related to OEF/OIF veterans (Brown & Bruce, 2016; DiLeone et al., 2013; Graziano & Elbogen, 2017; Signoracci et al., 2014) and their decision to seek treatment and services for PTSD reveals a greater need to understand this population's lived experiences. The majority of the scholars demonstrated that although there is a high risk of OEF/OIF veterans' exposure to conditions that lead to the prevalence of PTSD (Doran et al., 2017; Garcia et al., 2014: Koblinsky et al., 2017), this population continues to avoid seeking treatment. This is in part due to cultural disparities in diagnosis, lack of provider trust, military culture, and the stigma surrounding veterans' seeking behavioral health services.

Scholars exposed the VA as the largest provider of behavioral health, specifically PTSD, services for OEF/OIF veterans, and they are determined to handle increasing counseling expectations (Kracen et al., 2013). Veterans with PTSD suffer lower counseling engagements and internalize negative views toward counseling expectations

(Brown & Bruce, 2016). This population produces excessive counseling and treatment dropout rates (Goetter et al., 2015) while suffering from stigma and maladaptive thoughts that are barriers to retaining counseling (Vogt et al., 2014). As larger numbers of OEF/OIF veterans fail to maintain behavioral health treatments, researchers have focused on treatment engagement or retention, but future research should better understand veterans' attitudes and behaviors (Garcia et al., 2014). Faced with multiple barriers to care and retention challenges, it is important to increase counseling use to improve veterans' lives (Doran et al., 2017). The longer PTSD goes untreated, the greater the probability this disorder will result in overall health complications (Armenta et al., 2018). Further, to incorporate the maximum amounts of veterans in useful counseling, researchers must achieve understanding of veterans' perspectives about counseling availability and usage. In Chapter 3, I describe the methodology used to explore these veteran issues.

Chapter 3: Research Method

Introduction

The purpose of this hermeneutic phenomenological study was to understand the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services. This population encountered arduous deployments and combat exposure making them prime candidates for consistent behavioral health interventions (Bowen et al., 2016). I sought to understand veterans' interpretations of being referred for behavioral health services for PTSD, an extremely common and debilitating condition among U.S. service members (Armenta et al., 2018). The following research question was explored in the study: What are the lived experiences of OEF/OIF veterans regarding their decisions to seek and retain behavioral health services? In this chapter, I provide the research design and rationale. This chapter also includes a discussion of the role of the researcher and the methodology. I follow with discussions of trust and ethical procedures, and I end with a summary.

Research Design and Rationale

In this phenomenological research, I described the essence of the veterans' phenomenon by examining it from the perspective of those who have experienced it (see Neubauer et al., 2019). Researchers use phenomenology to investigate perspectives uncovering the meaningfulness of everyday life that causes a person to learn from veterans' insight (Adams & van Manen, 2017). Using this approach, I explored the experiences of veterans to consolidate and understand personal meanings. According to Neubauer et al. (2019), hermeneutic phenomenology is interpretive, so I studied the

meanings of veterans' presence in the world and how these meanings influence their choices regarding behavioral health services. Van Manen (1990) added that hermeneutic phenomenology is a human science that studies persons; thus, the science bolstered my goal of studying veterans. Hermeneutic research requires internal sensitivity and a composed attitudinal disposition for engaging the population, and this cannot be obtained through a step-by-step process (Adams & van Manen, 2017). By using this design, I provided the best representation of giving voice to the experiences of participants (see Sloan & Bowe, 2014). Hermeneutics purposefully translates from researchers' transcripts and deduces something *telling* or *meaningful*. Van Manen surmised that through hermeneutic interviews, participants invest in the research project whereby they show commitment and engagement because they care about the subject. As a result, the researcher reciprocates through the moral obligation to participants to prevent the exploitation of their situation (van Manen, 1990).

I selected phenomenology above other qualitative approaches. Phenomenology has been used in other research to understand health-related problems making it well suited for understanding PTSD issues (Neubauer et al., 2019). PTSD is an anxiety disorder resulting from experiencing a traumatic event (e.g., military combat, witnessing the loss of life, casualty support) that promotes fear, helplessness, or horror (Pedersen et al., 2012). I chose hermeneutic phenomenology because it goes beyond just describing a phenomenon and moves toward exploring and conveying the phenomenon's meaning in the context of everyday life (Bynum & Varpio, 2018).

Ethnography was not used because it concentrates on identifying cultural meanings, beliefs, and patterns of a group's daily life (Tai & Ajjawi, 2016). Although veterans are considered a culture, they have significant individual differences and my research would not benefit from their individuality and beliefs, nor a focus on daily lives. Grounded theory was not employed because it is focused on developing theoretical explanations of emerging psychosocial phenomena grounded into data (Barello et al., 2015). My goal was not to create a theory but to understand and document veterans' lived experiences. A case study was not used because it would require examination of the real-life case(s) over time with in-depth data collection among multiple information sources and reports of case descriptions and themes (Alpi & Evans, 2019). My goal was not to engage veterans over time but to secure information during face-to-face interviews.

A quantitative approach was not selected because I did not test a theory or use numerical data. During this phenomenological hermeneutic study, I used face-to-face interview practices that enabled me to honor the veterans' lived experiences while also following ethical practices that met my moral obligations as a researcher. These practices are found under the "issues of trustworthiness" section of this chapter.

Role of the Researcher

Researchers are primary instruments for qualitative studies and integrate their activities into the research endeavor (Howard & Hammond, 2018). According to Alase (2017), my primary role as a hermeneutic phenomenology researcher was to investigate, interpret, and understand the impact of the research question as I explored the lived experiences of veteran participants. Typically, researchers encourage participants to be

open and share their experiences because within that context the essence of the phenomenon is generally disclosed to the researcher (Yuksel & Yildirim, 2015). Crowther et al. (2016) suggested that hermeneutic researchers intend to illuminate essential, yet often forgotten, dimensions of the human experience in ways that compel attention and provoke further thinking. In my role, I garnered the essence of the participants' lived experience, while also developing a sense of trust and rapport. This level of trust was gained by using interviewing techniques such as those described by Rubin and Rubin (2012).

Because I am an OEF/OIF veteran, Neubauer et al. (2019) emphasized how a researcher's past experiences and knowledge are valuable guides to hermeneutic inquiries, although there is no direct relationship between myself and the participants. I was aware that the participants and I shared military values that can differ from civilians, so it bolstered dialog comprehension during the research (see Elnitsky et al., 2017). Cole et al. (2015) indicated that hermeneutic research can be emotion- and value-laden because researchers are part of the research. Therefore, Cole et al. recommended that researchers acknowledge and reflect on their emotions as they share the research journey. According to Crowther et al. (2017), the hermeneutic researcher is responsible for articulating the conditions of the research and acknowledging the power relationships that they bring to the interview. As such, I the researcher, remained cognizant of the influence of personal preexisting biases.

Sutton and Austin (2015) encouraged reflection on and articulation of personal views so that readers can better understand the analysis. Although biases exist,

hermeneutic phenomenology necessitates that researchers acknowledge their own biases, past experiences, and existing knowledge to incorporate it with the participant's perspective (Bynum & Varpio, 2017). In addition to sharing with participants, journaling through writing, reflecting, then writing again constitutes an additional release of researcher consciousness. This process helps to create an introspective cycle to develop robust analysis (Bynum & Varpio, 2017). According to Wilson (2015), phenomenology empowers people and promotes understanding of others by allowing the lived experience to emerge vicariously. I diligently conveyed information so that others can replicate the study as addressed in the methodology section.

Methodology

A key element of the hermeneutic methodology is to study a topic of personal interest, one that arises from direct experience with the phenomenon; thus, my research encompassed veterans who can share on behavioral health services (see Crowther et al., 2017). Cole (2015) emphasized that hermeneutic research is not about seeking out and finding absolute truths; it is about interpreting and understanding the research material. Research is achieved by collecting data, of sufficient depth, to understand the research question and fulfill the study's objective (Tai & Ajjawi, 2016).

Participants

A substantial number of veterans from the conflicts in Iraq and Afghanistan developed PTSD; yet their underuse of behavioral health treatment remains a noteworthy problem (Goetter et al., 2015). To investigate this concern, the respondents for this research were OEF/OIF veterans from the Delaware region. Participants were asked to

self-disclose having a PTSD diagnosis and confirm to having been referred for behavioral health treatment. According to Hundt et al. (2018), researchers need to understand participants' perspectives about treatment to explore their disclosure of information.

Participants in qualitative research are uniquely positioned to help the researcher understand what information is being received so sampling should be purposive and not random (Tai & Ajjawi, 2016). Etikan, Alkassim, and Abubakar (2015) mentioned that nonprobability sampling techniques help researchers to subjectively choose segments that represent the population under study. To gain participants, I used snowball sampling, a chain-referral method where a small number of participants recruit others from their social network to facilitate research (Valerio et al., 2016). Snowball sampling is well-suited for studying sensitive matters (e.g., behavioral health) that requires the knowledge of prior participants to recruit additional participants for the study (Etikan et al., 2015). According to Etikan et al. (2015), snowball sampling is a nonrandom sampling because not every element in the population has an equal chance of being selected as the sample. I used snowball sampling to engage veterans with comparable behavioral health services' concerns and encourage their support of other veterans sharing similar concerns. Initially, I recruited through flyers (see further description in Procedures for Recruitment) and then employed the snowball technique.

During the 5 years ending in 2018, the problem of how to determine sample size in qualitative research has engaged social scientists from many fields and led to increased concerns because it is not *one size fits all* (Blaikie, 2018). Moser and Korstjens (2018) commented that phenomenological studies require fewer than 10 interviews, but these

numbers are tentative and should be carefully considered before committing to them. According to Wilson (2015), the number of participants can be as low as one to three and commonly ranges between six and 20. My goal was to interview eight to 10 veterans, but the number would have increased if that population lacked redundancy. Tai and Ajjawi (2016) injected there is no *magic number* for the correct sample size as urgings of saturation are contested because there can be no assurances that additional participants would not introduce new experiences. Saturation can be problematic for qualitative researchers who rely on it as a means to determine sample size (Nelson, 2017). Nelson (2017) added that saturation means no additional data are found that can be developed under or along-side existing categories.

Instrumentation

An interview is a data collection technique where the researcher uses an instrument (interview guide) posed to participants who are asked questions relating to a research problem (Chu & Ke 2017). The purpose of the interview is to describe the meaning of a phenomenon that several participants share, and it is common to interview a participant more than once (Yuksel & Yildirim, 2015). My interviews were face-to-face, using open-ended questions to encourage expanded participant responses. During the interviews, it was important to ensure that I clearly understood participant answers to avoid having to conduct follow-up interviews which may have been challenging for this population. Therefore, I was sure to paraphrase the participant answers to ensure that I understood the meaning and essence of their answers to interview questions. Moser and Korstjens (2018) described the face-to-face interview as a conversation between

participant and interviewer with a focus on past, present, and personal matters. Chu and Ke (2017) specified that semistructured interviews involve the researcher asking questions from a prepared list, in addition to incorporating probing or follow-up questions.

The researcher's use of semistructured interviews can extract aspects of descriptive research that allow a comprehensive summary of events in everyday terms and allow for an in-depth exploration of a phenomenon. An advantage of interviews is they can be tailored to participants' experiences and are easier to manage and conduct (Tai & Ajjawi, 2016). During the interview as the conversation evolves, it should be a dialogue and not a strict question-answer session (Moser & Korstjens, 2018). Observation is another method for gathering data. This process entails the researcher watching and making notes about the subject being discussed during the interview (Chu & Ke, 2017). During such time, I captured field notes and participant feedback during the interview process, paying attention to the participant's nonverbal responses. Alase (2017) included that the traditional note and pen should be used for jotting down important observations during the interview. When using more than one data collection method (e.g., interview and observation), it is important to consider what added value there is and how these methods might help to answer the research question (Tai & Ajjawi, 2016). When engagement is done correctly, participants describe the interview process as cathartic, empowering, and therapeutic while expressing appreciation for the opportunity to tell their story and contribute to research (Wolgemuth et al., 2014).

Procedures for Recruitment, Participation, and Data Collection

To properly query participants, I selected veterans from a homogeneous group (based on the inclusion criteria for this study) to gain extensive lived experiences to understand the research subject (see Alase, 2017). To ensure varying veteran perspectives, I sought respondents from the Air Force, Army, Marines, and Navy and a mix of men and women by using research flyers posted in public spaces. My goal was to encourage participant interest in the study so they could voluntarily share information about their lived experiences, subsequently sharing their feelings (see Wilson, 2015). Recruitment was done through the posting of flyers, with a study description, in veteran service organizations, veteran community centers, libraries, churches, and social media. I obtained approval from agency leaders before displaying the flyers, and these organizations were not partnering in the study. Snowball sampling, where participants encourage other individuals with similar characteristics to join in the study, was an additional recruitment source (see Etikan et al., 2015). The flyer information was an initial screening document for obtaining participants for data collection. According to Alase (2017), after obtaining participants it is important to secure their written permission to participate in the study (see Appendix A). The inclusion criteria for this study entails the following:

- English speaking OEF/OIF veterans over the age of 18
- Self-identify with having PTSD
- Referred for behavioral (mental) health services

- Resident of Delaware or resident of Pennsylvania, New Jersey, or Maryland living within 30 minutes of Delaware

I interviewed veterans who were comfortable articulating information about their PTSD and interaction with behavioral health services. Veterans who met the study criteria were offered a $25.00 gift card as a thank you for participating. According to Wolgemuth et al. (2014), participants believe they feel validated, contribute to a sense of purpose, and give voice to the voiceless following the qualitative interviews. Respondents must be able to share their lived experiences without fear of distortion and/or prosecution, so confidentiality is important (Alase, 2017). I fully involved participants in the research process because it is a team effort securing data. According to Spence (2017), the researcher participates by reading, listening, pondering, analyzing, and questioning during the research process to complete the process. Thus, I embedded myself in the methodology to provide a well-rounded input of information.

The most common and useful data collection method occurs through open and deep interviews carried out in a dialogical manner that provides data for transcript analysis (Sloan & Bowe, 2014). Transcripts of audiotaped interviews and field notes are major data sources (Moser & Korstjens, 2018). I secured a private and comfortable area for one-on-one interviews, also ensuring the audio equipment was operable. When documenting, I removed extraneous details that did not add to the story, tell *what happened* and *what the experience was*, and kept sentences that held meaning (see Crowther et al., 2017). I reassured respondents that names and other identifying elements would not be used, and they would be privileged to my field notes and recorded data. The

contribution of hermeneutic phenomenology lies in creating study reports that compel thinking and invite reinterpretations of life experiences (Crowther et al., 2017). Spence (2017) reiterated that robust hermeneutic phenomenology requires opening oneself to a journey of contemplative thinking, questioning, and writing.

Data Analysis Plan

Unlike quantitative research, where data sets can be shared and calculations rerun almost instantaneously, qualitative analysis is more time-consuming (Tai & Ajjawi, 2016). According to Moser and Korstjens (2018), qualitative analysis begins with the researcher's process of arranging large amounts of data that needs to be stored in smaller and manageable units for easier retrieval. Moser and Korstjens further added that analysis is used to describe and interpret the meaning of an experience identifying essential subordinate and major themes from the interview or the participants. Cole et al. (2015) acknowledged that hermeneutic research is emotion and value laded; therefore, because researchers are part of the research, they should acknowledge their own emotions during the analysis of research material. Alase (2017) encouraged researchers to bracket themselves from the participants' lived experiences to have a clearer understanding during the analysis phase but this contradicts Heidegger's (1971) encouragement of researcher sharing. Through bracketing, promoted by Husserl from Yuksel and Yildirim's (2015) study, researchers can control their previous experiences to understand the participants' experiences, staying away from prejudgment results. In this study, I recognized and shared my military service experiences.

Coding

Coding is the term used to describe the transitional process between data collection and data analysis with the code representing a particular word or sentence that captures the features of data (Clark & Veale, 2018). Tai and Ajjawi (2016) expressed that the researcher's aim when coding is to identify patterns and organize, then describe the data into details. I analyzed data and facilitate coding via Colaizzi's descriptive phenomenological method (see Morrow, Rodriguez, & King, 2015). Colaizzi's method contains seven steps with Step 1 being the researcher familiarizes him or herself with the data by reading several times, and Step 2 involves identifying statements that are of direct relevance (Shosa, 2012). According to Morrow et al. (2015), during Step 3, the researcher identifies relevant meanings, in Step 4 the meanings are sorted into categories and themes, followed by Step 5 with writing an exhaustive description. Finally, Step 6 involves describing the phenomenon, and Step 7 secures validation from the participants by asking if their experiences were captured (Shosa, 2012). After transcribing data, I read the data multiple times to compare with audio-recordings and confirmed overall meanings.

Issues of Trustworthiness

Researchers promote trustworthiness by ensuring the research community that they have established a rationale for the study, a solid account of data collection, data analytic methods, and a viable interpretation of data (Williams & Morrow, 2009). A significant task for researchers is striving for unsurpassed quality when conducting and

describing research (Cope, 2014). Trustworthiness is solidified during research by obtaining credibility, transferability, dependability, and confirmability.

Credibility

Credibility depends on the degree to which it is understood by the participants and colleagues in the field (Toma, 2011). Cope (2014) explained that credibility is enhanced by the researcher describing his or her experience as a researcher and verifying the research findings with the participants. Techniques used to establish credibility include extended engagement with participants, persistent observation, and reflective journaling (Connelly, 2016). According to Tai and Ajjawi (2016), triangulation and participant checking is crucial for promoting credibility. I offered to show the transcripts to the participants so that they can confirm their contributions to the study. This exchange could promote additional cross-talks, supplement participant information, and solidify credibility.

Transferability

When findings can be applied to other settings or groups, it meets the transferability standard (Cope, 2014). Anney (2014) found that transferability emphasizes how much research results can be transferred to other contexts with other respondents or how much readers understand research descriptions. My accurate documentation of participants' experiences provided references for future studies both related to and not related to veterans.

Dependability

Dependability denotes the steadiness of data over time and the conditions of the study (Connelly, 2016). Cope (2014) added that it is the constancy of the data over similar conditions and can be confirmed through another researcher's replication. I asked my participants to assess the findings and interpretations of the study to make sure it accurately reflects their input and to confirm dependability (Anney, 2016). I also rechecked my notes, recordings, and participant follow-up to confirm dependability. The accuracy of my data provided a template for future researchers to follow while striving to understand their studies.

Confirmability

Confirmability is established when data and interpretations of the findings are found to be derived from data and not from the researcher's imagination or personal interpretation (Anney, 2014). Cope (2014) posited that confirmability is the researcher's ability to demonstrate that the data represents participants' responses and not the researcher's viewpoints. Cope further detailed how researchers demonstrate confirmability by unfolding how conclusions and interpretations were established and that findings were derived from data. My notes confirmed that data were derived from participants' responses and my inputs were in response to their disclosures. My responses did not overshadow the power of participants' experiences, which allowed me to maintain ethical procedures.

Ethical Procedures

Because the researcher is the primary instrument of data collection and analysis, he or she must introduce ethical considerations to protect their participants (Clark & Veale, 2018). According to Alase (2017), researchers should endeavor to do everything within their power to protect the rights, dignities, and privacy of participants because these elements should not be compromised. I took measures to ensure participants' confidentiality and privacy by minimizing personally identifiable information used during research. Oye, Sorensen, and Glasdam (2015) emphasized that research should be done in the safest manner and conditions should be carefully assessed to consider risks versus benefits. Oye et al. further noted that participants should be recruited voluntarily and should be informed of the study to freely give informed consent (preferably written). Wolgemuth et al. (2014) highlighted that being identified was a major concern for participants involved in research studies and many asked how their confidentiality would be maintained. I did not use real names or identifying characteristics and recorded interviews were stored electronically in a secure platform. To further secure information, pseudonyms were implemented to protect participant identities. Field notes and coded data were maintained in a lockbox only accessible to me. Analysis software can help manage data (e.g., helping to store) that will contribute to confidentiality and ethical management (Moser & Korstjens, 2018). Alase (2017) noted that higher institutions of learning require participant protection to include an advisement of rights, the reason for the study, an ability to excuse themselves from the study, and refusal to answer questions. I will retain coded data and participant recordings for 5 years as required by Walden

University protocol. It is my responsibility to protect veterans from harm as they volunteer to contribute to my study.

Summary

In this chapter, I provided an overview of phenomenological research and practices supporting this study. I covered the research design, the researcher's role, methodologies (participants, instruments, and procedures), issues of trustworthiness, and ethical processes. My goal was obtaining information via face-to-face interviews with veterans expanding on multiple lived experience similarities. Instrumentation, data analysis, and trustworthiness were covered, and Chapter 4 will provide details of the findings and data analysis results.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to understand the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services. A hermeneutic phenomenological inquiry was achieved using data collection from face-to-face interviews and field notes. The interviews were conducted with eight veterans, over the age of 18, who disclosed their engagement with behavioral health services for the treatment of posttraumatic stress. The research question that drove this study was the following: What are the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services?

In this chapter, I provide the results and insights of the study participants' lived experiences. Each respondent expressed personal accounts, and from that, I was able to glean similar experiences from multiple individuals in the sample. I structured this chapter to relay the setting, to display participant demographics, to explain methods for data collection, and to clarify data analysis. I conclude by exploring the elements of trustworthiness (credibility, transferability, dependability, and confirmability) and by providing a summary of the findings connected to the research question.

Setting

The study was conducted using residents of the state of Delaware. The methods used to recruit participants involved snowball sampling, chain referrals, and posted flyers. Some of the recruits were not eligible because they did not meet the inclusion criteria. After a participant was found to meet the demographic screening criteria for the study,

we agreed on a date, time, and location for the interview. The interview process, consisting of face-to-face interviews, was conducted from November 2019 through December 2019. Specifically, at the outset of the interview, each participant reviewed the demographic screening questionnaire to confirm that he or she met the criteria for the study.

Before the interview, I read the informed consent form aloud, in front of the participant, to ensure that he or she was aware of the wording and purpose of the study. All participants reviewed and signed the informed consent before participating in the study. I recorded and documented the interview data based on a unique identifier comprised of a sequence number.

Demographics

Eight participants were interviewed for this hermeneutic phenomenological study. A guiding principle, in research, is to sample until data saturation has been achieved when collected data are closed out because new data yield redundant information (Moser & Korstjens, 2017). Saturation was achieved after the completion of eight interviews, meaning that no new information was identified, data began to duplicate, and additional data collection became redundant (Hennink, Kaiser, & Marconi, 2017). Participants were all OEF/OIF veterans who had been connected with behavioral health services for self-disclosed posttraumatic stress.

Table 1

Participant Demographics

Participant	Gender	Ethnicity	State	Service branch	Time in service
#01	F	W	DE	Air Force	6 Years
#02	F	W	DE	Air Force	3.5 Years
#03	F	H	DE	Army	23 Years
#04	F	H	DE	Navy	10 Years
#05	F	B	DE	Air Force	17 Years
#06	M	B	DE	Air Force/Army	32 Years
#07	M	B	DE	Army	8 Years
#08	M	W	DE	Army	9 Years

Note: B - Black H - Hispanic W - White DE - Delaware

Data Collection

My role as a hermeneutic phenomenological researcher was participatory to gain admittance to an understanding of the first-hand accounts and lived experiences of eight participants who each experienced the same phenomenon. I, the researcher, served as the primary instrument for data collection, so I needed to understand how my biases might influence the study's outcome (see Clark & Veale, 2018). Yuksel and Yildirim (2015), relaying Husserl's transcendental phenomenology, specified that research begins with bracketing the researcher's subjectivity or clarifying prejudices associated with the study by putting aside the researcher's prejudgments. However, Peoples (2020) conveyed that Heidegger's hermeneutic phenomenology approach contradicts the use of bracketing the

researcher's experiences because scholars are always immersed with others in worldly existence. So instead of bracketing, I profited from sharing my experiences, biases, and expertise regarding the phenomenon and reflected on my exchanges with participants during data collection and analysis (see Bynum & Varpio, 2017). I also journaled my experiences, writing down my thoughts and reviewing them to gain a heightened grasp of the respondents' lived experiences.

Interviews are a data collection method in which an interviewer asks the participants questions, face-to-face, to uncover the meanings of central themes in the life of the participants (Moser & Korstjens, 2018). After the participants met the inclusion criteria, verified through their demographic screening responses, they reviewed and signed an informed consent form before interviewing. The informed consent form contained the title of the study, the description of the study, my contact information, and the IRB approval number 10-24-19-0721106 with an expiration date 10-23-2020. The informed consent form also included four interview questions and the benefits of participating in the study.

After confirming that all participants met the inclusion criteria, the participants and I agreed on a suitable time and location for the interviews. I conducted semistructured face-to-face interviews to retrieve and secure participants' past experiences to acquire a thorough grasp of the purpose of my research (see Moser & Korstjens, 2018). I used active listening, sustained eye contact, and respected personal space of participants during interviewing (see Rubin & Rubin, 2012). According to Alase (2017), the researcher must concentrate on placing participants at ease concerning

inquiring about their lived experiences, so I focused on the comfort of the veterans during our engagement by asking if they were okay during the interview.

Before initiating, recording, and taking field notes for each interview, I obtained consent from each participant. Kaiser (2009) confirmed that confidentiality, via a consent form, at the beginning of the interview is essential for building trust with participants. I explained that if discomfort was felt during the interview, the participant could cease the interview process at any time without repercussions. Before the interview, I tested the audio recorder to ensure its functionality and used a second audio recorder as a precaution. In addition to field notes, I observed participants' vocal tones, body language, and physical responses to the interview questions listening for any signs of distress that might warrant stopping the interview or checking-in. Although offered to all, only some of the participants accepted the $25.00 gift card that was available for engaging in the study.

Following each interview, I transcribed information from the audio recording on to an MS Word document and saved it to a flash drive and to cloud storage under password protection. These documents are only accessible to me. To confirm the transcription's accuracy, I repeatedly listened to the recordings and reviewed my field notes. I adhered to the data collection protocol outlined in Chapter 3.

Data Analysis

Data analysis is one of the most important, yet least understood, elements of the qualitative research process (Raskind et al., 2019). Raskind et al. (2019) further mentioned that with meticulous data analysis, the researcher can express the complexity

of human behavior and give voice to people's lived experiences. My data analysis process began immediately following the first participant interview and continued while simultaneously recruiting participants, conducting additional interviews, and scrutinizing data, as aligned with Belotto (2018). Transcripts from audio-recorded interviews and field notes constitute the researcher's major data source (Moser & Korstjens, 2018). Moser and Korstjens (2018) also mentioned a significant part of transcribing is focusing on the participant's comments, transcribing the full audio recording, carefully revisiting the recordings, and rereading the transcript. Throughout the data analysis process, the researcher should compare different transcriptions and refine the coding schemes when new or inconsistent data are introduced (Eliacin, Rollins, Burgess, Salyers, & Matthias, 2016). Participants' statements were assessed and converted into codes, which are words or short phrases that are a corresponding representation of the participants' statements (Saldana, 2016). Coding permits the researcher to simplify and focus on specific characteristics of the data (Nowell, Norris, White, & Varpio, 2017). I used hand-coding, descriptive and in vivo coding methods, both processes from Saldana's (2016) publication, to bound the participants' statements to my research question. I used colored pencils and colored highlighters to identify various codes and then consolidated similar codes into categories. Using similar color identifiers, I reviewed and organized the categories into themes. The full process is called sorting, where codes are categorized and themes are spawned based on recognized patterns from participants' statements (Clark & Veale, 2018).

The study's research question was supported via the data analysis which resulted in the organization of multiple codes into categories and then eventually into themes. Each theme emerged from the following research question: What are the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services?

The seven themes that emerged from this study include dealings with posttraumatic stress, getting veterans to counseling, relations with providers, family and/or friend involvement, enhancing the provider's skill sets, ways to retain counseling, and female veterans should only see female providers.

Theme 1: Dealings with Posttraumatic Stress

Each participant self-identified to having posttraumatic stress, which made their active service and post service lives challenging. These challenges added to the inconsistencies of seeking and maintaining behavioral health services. All participants revealed how posttraumatic stress influenced their lives.

Participant #1 remembered, during her military service, how posttraumatic stress made it difficult for her to connect with family, friends, and coworkers. During her deployment, it made her feel like she had no self-confidence, gave her constant anxiety, and an inability to perform her duties. Continuing with the concept of difficulty in connecting, Participant #8 mentioned,

> I guess the biggest issue I had with posttraumatic stress is a feeling of being detached. I remember being in a room of loved ones and my mother was there and we were having a good time exchanging some gifts. And I was just, I was just in

> the room, but she could see I wasn't there which was strange to try and describe. But she asked me, where was I? That really shook me up and I was like, you know if I'm like that with the people that I care about and my mother notices it in the room.

Participants #3 and #6 recalled their post-Iraq struggles with PTSD: Participant #3 stated,

> I had a very, very rough time dealing with personal issues when I got back (from Iraq) that I didn't have time to decompress and think about everything that I experienced and deal with everything that I experienced, not realizing that it affected me. For some reason, especially when I was driving into work, I would have to stop my car and I would just bust down and cry. You know because, you know, it's still an ugly war and like people were just like going on with their lives, like nothing's going on. I was experiencing all those emotions that I was holding in over there (Iraq) because I was being the strong leader to do my mission. So, things just started slowly affecting me when we got home.

Participant #6 illustrated,

> When I came back from Iraq, I noticed that I was more withdrawn. I stayed to myself more and I went to bed early all the time. I had a tendency when my wife would slam the door, anything would be slammed, I'd just jump. In driving on expressways, and I would go by an overpass, I'd look up. And the reason why was because when I first got in the country, every time they would go by an overpass they would stop. So, I asked, "Why are we stopping?" and he said when we first got in the country the insurgents would drop bombs on our convoys. I

> said, “Oh my God, here I am in this country for three hours and I’m already stressed out.

Participant #6 continued with,

> When I got home, I noticed more than anything else that I became more intolerant and the least little thing would upset me. If I would come home and I’d see anything on the floor, on the couch, out of place I would immediately tear into my wife. I wanted things to be (perfect) because I had been away for so long, I didn’t want to see anything out of place, nothing. Even though I would get up in the morning and I would promise myself that I would not say anything if I see something I’m just going to go ahead and pick it up. Still, it bothers me to see things out of place and I have good days, I have bad days.

Participants #2, #5, and #8 relayed how PTSD impacted routine activities. Participant #2 recalled problems retaining postmilitary employment, “PTSD is why I left my civilian job because I had severe adjustment issues. It’s just, I can’t, as highly educated as I am, I can’t work a regular job. Like simply put, I can’t work a regular job.” Participant #5 laughingly responded, “I was very rowdy, argumentative, didn’t sleep much. Dealing with PTSD, I didn’t get along with others, yeah, not very secure. Okay yes, super-aggressive, too, like I would fight at work type of stuff.” Participant #8 disclosed,

> I was really being guarded and having a difficult time sleeping. Wanting to get up and check the windows and doors when I hear a noise. You know I’d memorize the sounds of the neighbors’ cars, so I’d know it’s them when they come home.

> Then I don't have to be worried about anything." He added, "It was the unwanted thoughts and I tried to self-medicate in the past, but I had to stop doing that. You know just trying to pour one out, for the boys, kind of thing. And drinking it would end up making the situation worse because it would put me into like a depression.

Participant #7 expressed,

> I spent a good amount of time in some serious denial because of the Army way of life. Where you know, if something happens you suck it up, move on, suck it up, move on, and never turning toward an experience and addressing it. It (PTSD) was something that I would simply, experience and repress. It was the thing that I did not know would come back to revisit me in ways that would be, you know, detrimental to my success as a civilian. As a result of it (PTSD) there was a loss of, you know, primary relationships as far as divorce, estrangement from my children, foreclosure, repossession, you name it job loss. These things were the things that quickly surrounded my life and it unraveled. It was terrifying in a lot of ways because without having addressed the disorder, I was always afraid of what I would do. Only because I didn't feel like I had control of my reaction to something. I was open to seeking help once I was given a diagnosis for PTS(D) which I didn't like how I was given that diagnosis. But I was like, you know, I need to do something about this because my current coping skills aren't helping.

Overall, the research respondents shared vivid insights about how they dealt with PTSD and these insights stemmed from participation in support of deployments. They

disclosed patterns of difficulty in dealing with family, friends, employment, and thoughts. The research respondents explained how their continuous memories, from deployments, contributed to these difficulties and helped them to understand that they needed help.

Theme 2: Getting Veterans to Counseling

Each respondent explained how they or how other veterans initially encountered behavioral health services. Some proposed strategies that could encourage veterans to go to counseling. It is important to find a way to foster participation so that behavioral health issues can be assessed and eventually dealt with through recurring engagement.

Participant #8 took a public service approach:

> Like the supposed deglamorization of alcohol, in the service, military wide. I think dispelling the negative views on mental health and seeking help would do a great good. You know, having more visibility and perhaps, as much as people hate it, quarterly training and things like that. Maybe PowerPoints, however, we can get it out to service members and veterans, dispelling their negative view on getting help.

Participant #3 contributed, "I think more awareness and more acceptance of what PTSD or I know they call it PTS now, but just awareness that it's there and that it's a disease that needs treatment."

Participant #7 highlighted the importance of crisis hotlines by saying,

> I've got to get some change here because, man, it is (PTSD) making suicide look really, really fantastic. I reached out to the suicide prevention hotline and they were like, do you have a doctor? Are you safe? You know it was like that line of

> questioning, I'm like yeah, I'm okay. I don't have a plan (for suicide) but the thoughts are there, the inclination's there, the desire is there. They were like well, are you connected to the VA at all? We suggest you go over and see and I was like yeah, I've been meaning to stop over there anyway.

Participants #5 and #8 were mandated to get counseling, during active service, and believed the forced exposure to counseling helped them to better accept behavioral health services as veterans. Participant #5 recalled, "Mine was initially mandated. First of all, it was with anger management with behavioral health (clinic). That one was command directed because of my aggressive, explosive personality." Participant #8 stated,

> I was command referred for some anger issues that had come to light at work. It manifested at work, so something needed to be done about it. I was very upset when I was made to go, but what was mandated for me to go, I really enjoyed it once I completed it.

Participants #6 and #3 discussed flaws with the post-deployment process and emphasized how ordering a service member to see a provider, immediately the following deployment, could help identify behavioral health concerns. Participant #6 expressed,

> So, when you come back from a war zone, everyone gets debriefed. They ask if you have problems, but I never said anything, I never thought I needed help. I think they should have probably referred me anyway. I think they should say, okay, even though you may not have requested it, these are the stations you're going to go to. And you got to talk to these people (counselors). There are some

> questions we're going to ask you, just like you're asking me questions right now. And that's what should have happened to me, but it didn't. A mandatory post-deployment follow-up where you actually sit there and go through the actual talking with an expert on it, whatever it is.

Participant #3 contributed,

> Well even though we did out post-deployment health assessment when we came back, I think there should be some sort of mandatory mental health assessment for service members redeploying back. Even though a lot of them aren't honest because they just want to get home because it was more going through a process than actually sitting down with someone and talking with someone.

Participant #5 expressed a need for service members to see nonmilitary providers because it may increase their self-disclosure:

> I think if they outsourced a lot of the mental health issues to civilian providers it would make it easier. Off base, I can tell this person anything, when you're on the base you're still under the UCMJ (uniform code of military justice) and you can't tell them if you've had an affair and it's bothering you. That's not something you can relay to a Colonel, Lieutenant Colonel, or a Major because you're under the UCMJ. But if we had a true confidant or true therapist that we could get this stuff off, I think that would be better so outsourcing more mental health.

Participant #6 believed family inclusion would help the veteran counseling process:

> How about bringing my wife in with me? She's been the one who's caught my wrath more than anybody. She could have been a better gauge of what I was

> going through had they brought the spouse in or a child in. The person (veteran) is not by themselves, they're not on an island so whatever issues you're having your spouse should be there by your side to be able to share. Because that person might reveal more of you or might hold it against them. But I think it might be a consideration in the future that when you're going through any kind of behavioral health counseling to ask, "Do you mind if your spouse can accompany you?"

Participant #2 did not believe anything could encourage veterans to seek out counseling until they were ready for help. But if they were ready, she replied,

> Just VA providers because I don't think that a therapist that sees regular people (civilians) is the same as somebody who is geared toward our type of trauma. And I think there's a large distinction and capability and I think that having gone to a regular doctor (counselor) wouldn't have been the same outcome.

This theme focused on getting veterans to counseling, and research participants shared their experiences of engaging in counseling. Multiple counseling resources are available for veterans through the VA, community agencies, and private practices. Research respondents discussed difficulties and successes in learning about and attending counseling. The respondents who used or who are still enrolled in counseling explained how it has been helpful and they benefitted from the treatment.

Theme 3: Relations with Providers

All respondents disclosed personal accounts that highlighted experiences felt during the provider interaction. The engagements had negative and positive elements that shaped the participants' perceptions of behavioral health professionals. It is important to

understand both sides so that providers can understand their influence on maintaining the counseling relationship. Participant #1 recalled,

> When I first started seeking counseling, the first two counselors I had weren't the best. I don't think they had a lot of trauma-informed care and it felt like I wasn't getting anywhere with them. The first one was a female, she let me do most of the talking, but didn't provide a lot of feedback. She did not provide a lot of activities to do at home, so it felt like I was venting rather than getting help. The second one was a male who did remedial eye sensitizing movement. So, he tried to do that, but I don't feel like he was too knowledgeable about it because I didn't get anything out of that either. I just think he wanted to try it and put theory into practice.

Participant #6 mentioned,

> I saw two separate doctors and after I saw them, I only saw them one or two times. And I get a letter from the VA saying, you've been diagnosed with PTSD, which I knew I had anyway. The problem was there was no follow up.

Participant #5 recalled a civilian experience, "This civilian guy, didn't have military experience. I felt judged, not all the time, but you know I didn't feel like I had that connection." Participant #7 remembered,

> On the civilian side, that was not a good experience. The provider took the blanket approach of, you know what, you're feeling such and such a way, here are these pills. And you know my first question was, are these, is the pharmaceutical intervention, to address behavioral health concerns, you know, easy to get off?

> And of course, they're always going to smile and nod. And, you know, that was not a good experience. By no means should meds be the only thing that we're throwing at vets.

The participant described a similar experience after being asked about an initial VA encounter:

> Had she (provider) listened and listened to the way I wanted and needed treatment. For the first VA provider to have drugs waiting for me at the end of that interaction, it was such a turnoff. I never wanted to come back because I'm like, she's not listening and right now, I need someone to listen to me.

Participant #3 explained a negative instance that happened with another veteran:

> The mental health provider wouldn't allow their (veteran's) caregiver to go in during the session and they had to do the TBI (traumatic brain injury) test alone. The provider was being impatient with them and they weren't being empathetic. This resulted in the veteran not receiving an accurate assessment related to cognitive impairment.

Participant #7 expressed a provider's lack of knowledge in a referral process:

> Before seeking mental health treatment, I inquired via a regular doctor. So, you figure, Dr. so and so was our family physician. He saw my ex-wife, saw my kids, but what was missing was that knowledge and foundation of what a veteran's experience might be. As a result, he wasn't any help at all.

Participant #2 recollected, “I had to find the right provider, I had to fire a provider at the VA (Veterans Administration). So, it took me a while before I got the right fit. But thankfully it worked because I needed the help.”

Regarding providers, there were also instances of positive interaction. Participant #2 stated, “I connected with a counselor who literally transformed my ability to reframe and develop resilience. Then when I got here (Delaware), I continued the counseling and I was connected to someone good and we worked on empowerment.” Participant #4 explained,

> It was pretty easy. I was referred to the behavioral health clinic. The therapist there, she welcomed me, and we talked not only about (sighs) the trauma, we also talked about home health and just general health about myself and my family.

Participant #3 recalled,

> So yeah, my experience has been good, it’s just difficult for me to follow through sometimes and continue on that track. And I know it’s me because my therapist is very understanding, so it’s part of me just trying to get there a little further and further. I’m comfortable with her and I can talk to her about a lot of different things now. She knows a lot more about my life, probably more than I realized because once I start, you know, discussing it, a lot of things come out.

Participant #8 revealed,

> It was mandated for me to go and I enjoyed it once I completed that, you know, I came to enjoy it. I was very reluctant in the beginning, not liking it, but once I

> finished the program, I'd ask could I keep coming back. Because it was a relief for me, you know, weekly or bi-weekly for me to check-in and just let it out.

Participant #7 provided an insightful revelation:

> It's not the same session every time I visit my behavioral health professional. Some are, you know, uplifting, most are not so much. Because they're thought-provoking and they're ones that require me to be in a place that's not comfortable. But at the same time, I got to look at this thing from the perspective of wanting a fruit tree to grow or something that's going to feed me or that I can enjoy the shade as I'm outside.

For counseling to be productive, there must be a positive relationship with the counseling providers. This theme offered a view of what may work by highlighting the study respondents' positive and negative engagements with providers. Many study respondents explained the significance of their provider relationships because it helped them identify their issues and led to a positive resolution. Providers need to increase their understanding of the veteran's characteristics so that the provider-veteran relationship can be strengthened.

Theme 4: Family and/or Friend Involvement

Participants expressed family/friend involvement as significant, important, or nonexistent. The involvement was influential in participant consideration and engagement with behavioral health services.

In sharing a negative interaction, Participant #7 recalled:

> Even when I brought up my concerns, you know, with my stepmother, she's like, you know, you just need to pray harder son. You just need to stick it out, you just need to, it was everything but, hey, go see this behavioral health professional. So, you know, that support of family and friends from a behavioral health concern, it felt, it felt lonely.

Participants #1 and #2 both expressed how neither friends nor family provided encouragement to seek behavioral health services. Each commented on how they recognized their negative characteristics and sought treatment on their own. I, the researcher, sensed that they were disappointed with the lack of external support. Participant #5, when asked about family intervention, replied:

> Absolutely not, that was a stigma in my home and with friends, you know, mental health is a stigma. When asked to describe the feeling of not having family or friend intervention, the participant answered, "I'd been living with it for so long, I guess I didn't realize, you know.

Participant #8 disclosed a difference between friend and family involvement:

> I don't know that I've had friends recommend any sort of behavioral health service to me. As far as encouraging me to go or continue getting some sort of therapy, I would say, it's been, my mother and my ex-wife. They both sometimes ask how it's going when they know that I went (to counseling). They'll notice if my behavior starts to change and if I start to maybe slip, they'll encourage me to go back to my counselor. My ex-wife and I are back in a relationship and she'll let me know, hey, you need to go back and see somebody because I noticed this,

> or this isn't you. She'll try and very carefully let me know or give me a sign that maybe I need to go back for one of these little sessions (counseling) and she's been helpful.

Participant #6 also shared his interaction with a spouse:

> Even now my wife's telling me, you need help, she'll tell me today, you know, you still need help, don't you? And I resented it, I resented her telling me. So, what I did was I regressed, so I just turned her out, so anything she said to me after that, it simply didn't matter, I didn't care.

This theme emphasized the impact of having family and friend involvement during the counseling process. The study respondents shared how family and friend relationships were affected during their battle with PTSD. Participant disclosures ranged from being able to openly share their concerns and fears with a loved one to hiding any signs or knowledge of psychosis due to embarrassment. Family and friends, in certain situations, provide a support structure that may allow veterans to seek and retain counseling.

Theme 5: Enhancing the Provider's Skill Sets

It was important to learn, from the participants, which provider skills worked or needed improvement. If the providers are unable to properly interact with veterans, then they may not be able to address the veterans' behavioral health issues. Participant #1 commented,

> For behavioral health services, if they're coming in for war-related PTSD, I think they would need to have someone (provider) who is well versed in war PTSD as

> well as just trauma PTSD. I think that where some counselors are lacking is, they've studied only one population, one specialty. And then when they're confronted with another population, they're like, oh, how do I handle this? But then they don't want to be like I don't know how to so they might try to proceed forward but that might come off to someone like me as just a paycheck because they're not as engaged.

She further added, "Through cognitive behavioral therapy, and reframing, those counselors were aware of what was needed, and they were well diggers in different situations, instead of just one pocket or one specialty."

Other participants also mentioned specific therapies that could benefit veterans. Participant #2 advised, "What I think they need to provide is transformational healing, like art programs and things like that to help vets." Participant #7 shared,

> Offering something that veterans seem to embrace, it's called Mindfulness-Based Stress Reduction. The tools that were introduced included mindfulness in walking, mindfulness in eating, mindfulness in conversations, and dialogue. It was an intentional focus, you know, attention on whatever you were doing minus the judgment about the experience. For behavioral health approaches, it's got to be things that have nothing to do with drugs. Should be more to do with allowing us the ways and means to effectively address our trauma in ways that are supportive and nurturing.

He later explained,

> The willingness for providers to incorporate holistic approaches into behavior may not be viewed as traditional. Whether it be meditation, whether it be tai chi, whether it be yoga there are a lot of different ways to get back home psychologically. By no means should meds be the only thing that we're throwing at vets because there are so many things out there that are beneficial and positive.

Participant #6 identified a lack of commonality between counselors and veterans.

> I saw a psychiatrist, but the follow-up was poor. What I mean by that is, she let me do all the talking, but she didn't really ask me any questions and after about a month, it was over. Here's a civilian who was never even in the military, who never knew about temporary duty or deployments. She knew nothing about those things, and she couldn't relate. All she could do, which is pretty much what all doctors do, is they diagnose what you tell them. But they can't if they never had any point of reference, because that wasn't her primary job seeing military, her primary job was seeing civilians.

Participant #7 added to the commonality discussion:

> I don't think a skill set or discipline alone is enough. If there were some way to advocate for fellow veterans that walked through the door with a variety of different experiences. Have the ability to be on some path to becoming therapists or a social worker, I think it would make more substantial differences because I don't think anyone cares for us or about us like we (veterans) do. Because sometimes I don't think others have an interest or that their understanding of not only the shared experiences but also the impact of transition. Without having that

> understanding of what that something feels like or what that experience means to that veteran and those family members, they sometimes don't have enough of an informed approach to come beside that veteran to provide them with the right type of support or the right words. Because it's like, hey you know what, you never put on a uniform and because of this do you honestly understand my experiences? Do you honestly understand where my wife's coming from?

Participant #8 shared a perspective on a provider's background and training:

> Interestingly he (counselor) never served but he did specialize with veterans as he took an interest because he was located near a large military installation. He had taken an interest in veterans once he noticed a spike in clients that he was receiving referrals from. I feel like you don't necessarily need to be a veteran to speak to one. I think you just have to, just need to be tactful on how the situation is approached by listening to the issues that the service member is dealing with. A showing of transparency, "He was humble in that respect letting us know that he was not perfect, he was vulnerable, as well he's a person and not just some God to be revered in a therapy room." One experience that I did have, there was a veteran that I was in a group with who just wasn't able to be in that moment. He didn't fit the plan, how they were teaching this lesson. And his interjections, while they weren't bad, they were just disruptive and prevented the provider from continuing. He was asked to leave and not come back and what I did not like is they didn't recognize that maybe he needed something different. They did not

> provide him with an alternative before sending him away and I thought they could be a little more caring in that regard.

To address this incident, Participant #8 continued,

> As far as providers go, some sort of cultural training could go a long way in respecting, while maybe you don't have those same experiences, or you're not a veteran, or just because you are a veteran that you can't assume that you know what's best for another. Having some sort of cultural awareness or sensitivity training to learn the mindset that service members and veteran have and being able to tactfully relate to them. Or maybe understanding that you can't relate but being sensitive or empathetic to that situation would go a long way for providers.

When dealing with a unique population, a provider may benefit from enhancing his or her skill sets. This theme offered various counseling techniques that can assist veterans with PTSD. The research respondents provided examples of provider characteristics and practices that promoted their counseling process, while also disclosing what did not work. A provider's comprehension of the military culture and understanding how to acknowledge veterans are skill sets that may bolster a veteran's desire to retain treatment and move toward issue resolution.

Theme 6: Ways to Retain Counseling

The goal is to keep veterans in the behavioral health system so they can receive the assistance needed to reduce the effects of posttraumatic stress and other illnesses. The respondents' accounts aided in understanding why they did or did not stay. Participant #6 remembered,

> It's kind of strange because when I went to get help for PTSD, there was no follow-up and it's kind of dumb. You go to the VA and they say you have PTSD. They give you an extra 10 percent (service-connected compensation) but that money should not be the total focus. I believe the total focus should be the follow-up. But what I got to do is to also take responsibility. Here's what's weird, I should have taken responsibility when I didn't get that appointment and I didn't. So, I'm complaining and that's sort of hypocritical because I should have been the one to say, hey, when's my next appointment?

In giving feedback on the VA Participant # 3 explained:

> A lot of veterans don't want to go to the VA, they want to see someone on the outside. Is there someone on the outside that we can refer veterans to? I say this because they don't want to go to the VA, and I know the VA can't refer. We need a way for them to go to private practice.

Participant #5 relayed how veterans would benefit from knowing more about the counseling process:

> I didn't know how the mental health process worked. I was just going to these appointments, showing up, doing what they wanted me to do so on and so forth. Not realizing that I would probably require more help and I was afraid. A little bit after that I felt okay, but I felt weird because I needed more, I felt I needed more. I thought that once you were done with therapy you were fixed. I didn't realize it was a continuous process. No one told me it was a continuous process.

Participant #4 moved away and was no longer connected to their previous counselor, as a result, they did not retain counseling:

> For retaining (counseling), I think moving to another state and having to trust someone again (is hard) and going through everything again. How do I start services again? Maybe there could be a connection between the previous assignment and the next assignment. I was seeing a therapist for a couple of years and then I moved, and I haven't had time for myself. The time I do have for myself, I go to the gym. And kind of just let go on the equipment.

Participant #8, discussing trust, explained,

> I thought anything I say this guy's not having my best interest in mind, he's just going to report it back and it might lead to trouble. But it turned out that wasn't the case. The one on one turned out for me to be a check-in, about how things are going in life, how I can better manage situations and being accountable.

He continued with this theme by discussing group experiences,

> Group turned out to be a pow-wow of members of a tribe. We would get together in this controlled setting where our counselor kind of facilitated and I enjoyed that each person would go around and share like, what's going on with us this week. Something might have set us off and we're not proud about. And we could be accountable with that group or we could share new concepts to cope. I thought it was beneficial because sometimes people won't speak up and at least if they're present, they can hear something that may speak to them.

Participant #6 would have retained treatment with a similar provider:

> When I was in Iraq, I went over with people who were medical doctors and things like that. I say it would have been nice when I come back to the states to see somebody who's already been over there and might have experienced it. I would have been able to talk to them and stay in treatment.

Participant #7, through this exchange, emphasized how listening to veterans would help keep them in counseling:

> I struggle with our inability or our slowness to embrace ways to engage veterans seeking behavioral health assistance. One thing that frustrates me is the barriers that exist relating to our willingness to integrate technology in this exchange. I understand the benefit of you and I sitting here in this shared space. However, the change of the veteran we're serving, providing services to. They're engaging in this workforce and the ability to peel away from the job can waiver or vary. Let's say an application like VA video connect or any web-based opportunities exist to facilitate an exchange. We need to be ready and willing to embrace this thing because I like having the ability to call into my therapist. They have an opportunity to be our new tradition, where we're addressing the needs of veterans, no matter where they are. We should not allow geography to be the thing that gets in the way of providing treatment to those who need it.

This theme covered ways to retain counseling because it is important for veterans to continue treatment following their initial session. A key factor involves the veteran's perception of behavioral health providers and behavioral health care. The research respondents disclosed reasons why their counseling attendance was inconsistent and what

helped them retain their counseling regiment. Some of the respondents emphasized the importance of having someone close to them, who could assist with the retention journey.

Theme 7: Female Veterans Should Only See Female Providers

Four of the five female participants expressed the need for a female-to-female engagement, meaning female veterans should only receive counseling from female providers. They believed this would be the best way to encourage female veterans to come forward for counseling. Participant #2 remembered a negative interaction:

> Well, I think that honestly, for all woman veterans, like if you come to mental health you should automatically have a woman doctor (counselor). And the first doctor I had was a man and I (explicit) fought with that guy.

Participant #3 recalled a counselor engagement: "But I felt comfortable with her and she sees a lot of, you know, combat veterans. So, I felt comfortable that she could relate to me as a female combat veteran as well."

Participant #4 shared a strong viewpoint:

> So, what I would say is, if you're a female veteran, a female counselor is ideal especially if it's MST (military sexual trauma). I've seen people where they go see a counselor and it's a male and the counselor is like, "why did you put yourself in that situation?"

Participant #5 responding to a counselor connection question remembered: (Responding to a counselor connection question)

> She was a female, strong to me, I could just trust her. And it was like an immediate openness I had with her. I attributed my openness to her gender and

> military background. I had a guy counselor and I felt judged, I didn't feel like I had that connection.

Male Participant #7 added,

> A female veteran that's experienced military sexual trauma, I know I can help her. I have the empathy and compassion to help her. But let's face it, I'm a male and if she was assaulted by a male, no matter what, how deep my willingness is to help her, it'll always be in the way of her receiving the words and that has to be my reality.

The theme of female veterans should only see female providers included unique perspectives from the research respondents. Female service members and veterans are a notable part of the veteran behavioral health journey, and it is important to meet their needs. All five female respondents and one male respondent expressed their beliefs that female veterans should engage with female providers. They described the commonality, comfort of disclosing information, and the woman-to-woman relationship. Additional research supported the positive results that may occur when female veterans are paired with female providers or other female veterans.

Evidence of Trustworthiness

The validity of qualitative research refers to the trustworthiness of the data interpretation, ensuring that the findings deliver constructive evidence secured from the accurate employment of the research (Yuksel & Yildirim, 2015). Trustworthiness refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Connelly, 2017). Qualitative researchers address trustworthiness by posing the

question, “Can the findings be trusted?” (Korstjens & Moser, 2018). To be accepted as trustworthy, researchers must establish that data analysis has been achieved in a precise, consistent, and exhaustive manner by disclosing methods of analysis, with enough detail, to enable the reader to determine the research’s credibility (Nowell et al., 2017).

Credibility

Credibility was initiated by conducting this qualitative study according to Walden University and IRB's ethical principles. The credibility of a study is determined when the reader is confronted with the experience; in other words, they can recognize the experience (Nowell et al., 2017). Korstjens and Moser (2018) explained that credibility establishes whether the research findings represent plausible information extracted from the participants’ original data and is an accurate interpretation of the participants’ original views. I thoroughly reviewed the participants’ recordings and evaluated the transcription notes to produce credible information.

Transferability

Transferability permits credible findings to be applied to similar situations (Peterson, 2019). The researcher’s task is to provide a sound description of the participants and the research process to enable the reader to assess whether their findings are transferable to their setting (Korstjens & Moser, 2018). It is the responsibility of the researcher to provide enough information about context, participants, data gathering, and data analysis to guide other scholars in generally replicating the study. My focus was to accurately record the participants’ experiences so that it can be used in future studies.

Dependability

Dependability involves the participants' evaluation of the findings, interpretation, and recommendations of the study such that all are supported by the data as received from participants of the study (Korstjens & Moser, 2018). To achieve dependability, researchers must ensure the research process is logical, traceable, and clearly documented (Newell et al., 2017). Procedures for dependability include maintenance of an audit trail of process logs, which are the researcher's notes of all activities that happen during the study (Connelly, 2016). My study objective was to clearly define my research process and properly support it to ensure dependability.

Confirmability

Confirmability is the point to which the findings are consistent and could be repeated (Connelly, 2016). This is to the degree to which the findings of the research study could be substantiated by other researchers (Korstjens & Moser, 2018). Nowell et al. (2017) added that confirmability is involved with establishing that the researcher's interpretations and findings are undoubtedly derived from the data, requiring the researcher to demonstrate how conclusions and interpretations have been reached. My notes have been secured and will confirm that data were derived from participants with definitive conclusions.

Summary

In this chapter, I presented a summation of a hermeneutic phenomenological inquiry focused on understanding the lived experiences and insights of OEF/OIF veterans' perceptions of behavioral health services for posttraumatic stress. A single

research question was presented to comprehend the research problem. The participants voiced personal accounts of engaging in behavioral health services and the connection with their posttraumatic stress.

The respondents considered behavioral health services as a means for addressing posttraumatic stress. Some participants expressed difficulty in securing and/or retaining behavioral health services throughout their journey. Most participants, who had external relationships, mentioned how family members, and not friends, were more apt to encourage services and provide support. Two respondents admitted that they are not currently receiving behavioral health services, one because leaving their counselor following a move to Delaware and the other because they have not followed up for treatment. Many participants provided reasons why providers were not prepared or recommendations for providers to become better aware of veterans' characteristics both for enhancing the counseling process. The female participants were adamant that female veterans should only receive services from female providers because of the connection and commonality. Reminders of PTSD are ever-present in OEF/OIF veterans lived experiences; counseling is necessary but finding and maintaining services with a well-matched provider is difficult. In Chapter 5, the findings will be interpreted to provide a connection with the theoretical frameworks. The chapter will also expose the limitations of the study, recommendations for additional research, and ideas for social change.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

The purpose of this hermeneutic phenomenological study was to understand the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services. In this study, I used a hermeneutic phenomenological research design to collect and analyze data from eight participants. To further analyze, I applied Colaizzi's (1978) data analysis for phenomenological research. Extant literature illuminated the barriers toward behavioral health services among OEF/OIF veterans (Garcia et al., 2014) and illustrated this population's need for continuity of care (Graziano & Elbogen, 2017). In this study, I identified a gap in the literature in understanding the lived experiences of OEF/OIF veterans' lack of engagement and enrollment in behavioral health services programs. In this chapter, I provide an interpretation of the findings and the limitations of the study. I also offer recommendations for future research, implications for social change, and a conclusion of the research project.

Interpretation of the Findings

The findings from this study afforded me a deeper understanding of how veterans with PTSD interfaced with behavioral health services and the emotional impact this interaction had on their lives. In this study, I found that OEF/OIF veterans' personal world views and beliefs about behavioral health services and the providers' cultural sensitivities, affected their decisions to seek and retain behavioral health services. Vogt et al. (2014) discussed the importance of veterans seeking and obtaining behavioral health

services. Other researchers have conducted studies on barriers to behavioral health treatment and the need for intervention as it applies to veterans (Beks & Cairns, 2018; Fox et al., 2015; Garcia et al., 2014; Litz, 2014). However, I discovered a gap in the literature on OEF/OIF veterans, between posttraumatic stress and their experiences with behavioral health services. I explored the participants' responses to the research question: What are the lived experiences of OEF/OIF veterans regarding their decisions to seek and retain behavioral health services? By way of the responses, I derived seven themes from the data analysis: dealings with posttraumatic stress, getting veterans to counseling, relations with providers, family and/or friend involvement, enhancing the provider's skill sets, ways to retain counseling, and female veterans should only see female providers.

Theme 1: Dealings with Posttraumatic Stress

A significant theme that emerged from my research was the veterans' dealings with or attending to their posttraumatic stress. For OEF/OIF veterans, PTSD is one of the most disabling disorders, and it can have long-term and far-reaching impacts on health and social functioning (Armenta et al., 2018). All participants in this study described their struggles with PTSD and how it altered or continues to impact their day-to-day existence.

The respondents in my study expressed having a generalized sense of feeling unsafe, which in turn, led them to feel hypervigilant most of the time. This finding is consistent with Haun et al. (2016) who found that veterans became extremely sensitive to their surroundings following deployments. Similar to Castro et al.'s (2015) study, one participant in my study described how, at night, he memorized neighborhood sounds so that he could determine that it was not enemy forces coming at him, which enabled him

to go to sleep. Castro et al. (2015) explained that this psychological response is likely due to the individual having heightened arousal and that many veterans with PTSD are easily startled by loud or sudden noises that disrupt social and occupational functioning. Certain noises such as the sounds of planes or popping sound also have been found to trigger fear associated with traumatic experiences, ultimately affecting altered veterans' ability to function in their routine lives (Haun et al., 2016).

This theme also entails how daily occurrences in life present reminders and triggers of past threats and dangers. For instance, a participant in my research explained a feeling of continuously running from things and how no matter where he went, the feeling was still there. Another participant expressed the reaction to going under highway overpasses in America and how it was frightening because of the memory and similar sound of bombs being dropped from overpasses in Iraq. This type of response could be explained through what Sippel et al. (2018) described as *anxious arousal* where the affected persons struggle to calm themselves and they have a physiological response as well.

OEF/OIF veterans with PTSD can encounter serious physical health problems, legal difficulties, marital and family problems, and job instability (Hayes et al., 2017). Veterans with PTSD have significant underemployment and job loss, lower production rates, and often work below their skill and/or educational level (Hayes et al., 2017). Several participants in my study expressed marital and employment difficulties that were a direct result of their dealings with PTSD. One respondent in my study mentioned how his spouse, to this day, continues to remind him how his PTSD is affecting him and that

he needs to get help (he is not seeing a behavioral health provider). None of the participants in my study reported alcohol or drug concerns. However, Janke-Stedronsky et al. (2016) reported how substance abuse is a common occurrence in trying to manage PTSD and tends to align with recent PTSD research.

I included in my research a report on PTSD and female veterans as their symptoms sometimes differ from males. This finding was consistent with other research regarding veterans with PTSD. As such, they have found to have significantly higher cases of reexperiencing, avoidance, emotional numbness, and hyperarousal during routine actions (Hourani, Williams, Bray, & Kandel, 2015). In the current study, one participant remembered being in a male-dominated military career field and how PTSD caused her to avoid people leaving her disconnected from others. Another respondent recalled how PTSD left her angry and frustrated, which prevented her from maintaining steady civilian employment. Still another female participant mentioned how internalized emotions led to difficulty sleeping, fighting in the workplace, and an overall aggressive personality. This coincides with Hourani, Bray, and Kandel (2015) who reported that female veterans may be more likely to internalize psychopathology after trauma exposure related to PTSD, whereas males may be more apt to externalize expressions of suffering. It is important to note, the development of PTSD in females can be strongly tied to sexual assault because it occurs 13 times more frequently among females than males (Jacobson et al., 2015). Aligning with this finding, two of the five female respondents had experienced military sexual trauma.

Veterans regularly believe that their PTSD symptoms will dissipate over time, but that is unlikely, especially if they have suffered the symptoms for over 1 year (The National Center for PTSD, 2018). The National Center for PTSD continued that, even if veterans believe they can handle the symptoms, they may get worse over time. All participants freely expressed their struggles with PTSD, believing that they could handle the condition only to find out that behavioral health interventions were needed to attend to their conditions.

Theme 2: Getting Veterans to Counseling

There are various behavioral health services available for veterans, but respondents in my study confirmed that a major issue is finding ways to connect veterans with these counseling resources. These findings are aligned with much of contemporary research. The VA (as cited in Mohler & Sankey-Deemer 2017) mentioned that individuals who were active-duty military and did not receive a dishonorable discharge can apply for enrollment to see if they are eligible for free behavioral health care. All respondents were familiar with the VA health system, and some discussed personal experiences with VA care. According to the VA, almost 40% of the OEF/OIF veterans who were eligible for VA benefits via disability compensation did not use the VA for behavioral health care as it is likely that these veterans are seeking counseling outside of the VA system (as cited in Janke-Stedronsky et al., 2016). Mohler and Sankey-Deemer (2017) added that many veterans do not seek this VA benefit because they have private health care coverage through their employer or spouse or because there are no VA facilities close to their homes. Many of the respondents in my study expressed reasons for

not preferring VA care, and they ranged from provider knowledge of veterans, distance from the facility, and preference for a private practitioner.

Veterans need to get counseling because veterans reported a diverse range of emotional issues, related to PTSD, such as numbness, anger, hypervigilance, and depression (Haun et al., 2016). The accompanying emotional issues were confirmed by my participants responses during the interviews. They further reported that once they found positive behavioral health services, they were satisfied with the treatment and recognized that they had a psychological problem. Hayes et al. (2017) highlighted how PTSD can occur without combat-related events, one event being MST (military sexual trauma) as women who incurred MST were approximately 3 times more likely to develop PTSD than male MST victims. Not being directly in combat, yet providing a support role for combat, is a stressful function of military duty that may lead to psychological challenges. Several respondents, who had support roles, recalled the stressors that they internalized while performing supportive military roles. While in the armed services, military culture works against the identification and treatment of PTSD (Hayes et al., 2017). Various participants described why they did not seek treatment because they internalized how the Army taught them to resolve their problems, especially behavioral health, before seeking help. Their comments are aligned with Hayes et al.'s (2017) study that indicated that it is a military mantra and subculture not to disclose information about emotional distress related to service; this makes them avoid seeking treatment. In the military where masculine culture dominates, the culture emphasizes being strong and dealing with issues, which reduces treatment-seeking (Fox et al., 2015). Several

participants in my study recalled that when their concealment failed, their negative behaviors resulted in military leadership mandating them to attend counseling. It should be noted that the majority were appreciative of the intervention as they would not have gone to counseling on their own. Since veterans have transitioned to the civilian sector, they cannot be mandated to obtain treatment so decisive ideas must be sought to encourage their enrollment.

In today's world of social media posts, TED talks, and various discussion platform, veterans have access to get services by hearing from others about the positive results of their behavioral health engagements. For many veterans, behavioral health interventions can reduce psychological symptoms, while others find they have diminished symptoms or less severe symptoms, all leading to a better quality of life (The National Center for PTSD, 2018). Some respondents in my study remembered investigating the effects and benefits of counseling to better understand what they were seeking. Then following counseling, they had a better grasp of their conditions, felt more connected with their social groups, and noted improved functionality. Additionally, various participants shared stories of telling other veterans using word-of-mouth rather than social media as a platform to impart the benefits of obtaining counseling and how this recruiting role has positively shaped their lives. Discovering intervention can help keep PTSD from causing problems in veterans' relationships, careers, and education so that they can achieve personal goals (The National Center for PTSD, 2018). Based on these experiences, it would appear that educating veterans on understanding how their views of the world may change after military service, which Castro et al. (2015)

considered important interventions that are crucial after a veteran returns home from deployment or following his or her transition from the military. While my participants did not discuss outreach, their views conveyed that they might benefit from what Graziano and Elbogen (2017) suggested of policymakers, which entailed creating advertisement campaigns focusing on veterans' belief processes and incorporating veterans' support groups in a way that fosters veteran help-seeking. Multiple respondents in my study mentioned stigma and how it initially prevented the seeking of counseling. This is highlighted by Whealin et al. (2014) who reported that stigma-related viewpoints can be modified through education. Some respondents explained that after learning about behavioral health from educational resources, they were able to make better decisions on seeking help. This finding is consistent with Vogt et al. (2014) who noted a need to strengthen education especially when symptoms warrant counseling, as many OEF/OIF veterans reported that they would only seek counseling if problems were troublesome. Stecker et al. (2013) also indicated that to improve counseling seeking among veterans with PTSD symptoms, providers must first explain to veterans what they can expect from counseling and the counseling options available. If done precisely, marketing and education from behavioral health agencies and providers can have a positive impact on convincing veterans to seek counseling.

Theme 3: Relations with Providers

Participants in this study inferred that veterans' relationship with a counselor has a significant influence on helping them find their self-identity and resolving their behavioral health issues. This idea was supported by Graziano and Elbogen (2017) who

noted that behavioral health providers may benefit from learning about veterans' characteristics and military histories to improve their relations during the counseling process. The provider's comprehension of veteran clients can help minimize misunderstandings and eliminate negative counseling engagements. This statement about misunderstandings is consistent with Litz (2014) who reported that providers often use the generic use of the term *soldier,* which is bothersome for members from other branches of the military (not in the Army); the generic terms service member or veteran are more accurate and preferred choices. Respondents in the current study proudly served in the military and expected providers to associate them with their specific branch of service, which shows a minimum understanding of their service's mission (Navy – sea, Army – ground, Air Force – air). The focus on the branch of service was shown when a participant acknowledged being in the minority as a *female* aircraft mechanic in a male-dominated Air Force career field. Other participants proudly boasted on the branch of service and their retired rank associated with that branch of service. To better facilitate treatment, a provider would benefit from understanding these nuances and establishing a bond for resolving PTSD symptoms.

My respondents shared stories of negative engagements with providers that strained the counseling relationship. This negativity is confirmed with Hundt et al. (2018) who reported that veterans have mentioned how counselors were impatient, inattentive, doubting the veteran's story, or pushing medications on them. Koblinsky, Schroeder, and Leslie (2017) added that some veterans accused providers of overusing prescription drugs to address psychological conditions as they described receiving various medications for

depression, anxiety, and sleeping that resulted in negative side effects. A participant remembered being prescribed the drug Celexa (for depression) and recounted how it felt forced on him. He shared information on how the drug made him feel and his dislike of the sensation, eventually questioning how long he could remain like that. Stecker et al. (2013) highlighted that veterans who did not desire medications or who believed since behavioral health is not medical health, drugs are not be needed. Another respondent, in the current study, who did not want medications had to forcefully protest, during an initial intake, to find another therapist willing to provide non-prescription talk therapy. He was adamant about no medications because while previously being on medications for PTSD he recalled feeling suicidal and that feeling felt *really, really, fantastic*.

As counselors increase their awareness of veterans' experiences and characteristics, it promotes information exchange, comfort levels, and personal knowledge throughout the counseling process. Koblinsky et al. (2017) discovered that providers realized how developing a positive relationship with veterans is a significant step in building empathy, respect, and trust. My respondents mentioned how provider trust and understanding helped establish their counseling relationship and their ability to express their feelings concerning PTSD. This finding is consistent with DiLeone et al. (2013) who found that providers benefit from having veteran knowledge because understanding military experiences and perceptions of treatment methods may influence where a veteran decides to seek counseling. One respondent in my study recalled that, because of the positive relationship established during their sessions, being able to call or text his counselor even when he moved across the country. He remembered the optimistic

feeling of knowing even though his counselor was across the country, he (counselor) was there for him. Another participant remembered their positive counselor relationship and how they were also able to call after moving to Delaware. My respondent's comments coincided with Garcia (2018) who stated that providers need positive, lasting relationships with recent serving veterans because OEF/OIF veterans are more likely than earlier era veterans to report having previously been to therapy that did not help or did not establish a functional relationship.

Theme 4: Family and/or Friend Involvement

Participants in my study relayed how family and friend support systems were affected during their return from deployment or their transition into civilian life. This is consistent with Freytes et al. (2017) who found that post-deployment and the postmilitary transition is a time of instability for veterans and their families as they move toward understanding each other again. Multiple respondents in this study shared stories of how their deployments and subsequent PTSD negatively impacted their family dynamics. These findings are confirmed through Haun et al. (2017) who discovered how veterans described various PTSD-related issues influenced their relationships with family, including pretending that they were happy, feigning that everything was okay, and concealing the severity of their PTSD. This sense of *covering up* was relayed by multiple participants during my study as they sought to protect those closest to them. Family involvement in the care of disabled veterans is associated with better outcomes, clearer functioning, and improved treatment adherence (Freytes et al., 2017). Several respondents in my research remembered the positive influence that family members had

on directing them toward behavioral health services. This correlated with Freytes et al. (2017) who explained that awareness and comprehension of the perspectives of family members may result in positive gains in treatment strategies and support programs. Multiple participants during my research expounded on the influence that their spouses had in recognizing that treatment was needed and encouraged them toward behavioral health services. This matched information from McGinn et al. (2017) who shared how, among partnered veterans, significant others are generally a primary foundation of social support. Veteran families affected by PTSD may experience improved functioning and unity when partners participate in mental health treatments (Beks & Cairns, 2018). One of my participants recommended that spouses be by the veteran's side during counseling because it may encourage more disclosure by the veteran. This expression is confirmed through Beks and Cairns (2018) who proposed that high relationship satisfaction may lead to supportive conversations about entering care, but additional factors, such as partner education about PTSD and involvement in veteran care encouraged service retention.

It is important how just initiating counseling is not sufficient enough to address a mental condition: The veteran, through social support must maintain counseling to work toward a resolution. Janke-Stedronsky et al. (2016) reported how veterans with children in the home may be more likely to seek treatment for PTSD symptoms and may be more likely to receive a PTSD diagnosis because they do not want their symptoms to negatively affect their children. Some of the participants in the study did not report to having social support and pursued behavioral health services on their own. Two of those

respondents expressed not having any family or friend support through their PTSD journeys, which added to the challenge of pursuing behavioral health service. Still another participant shared how she hid her mental illness from her family due to embarrassment and stigma even though she knew she needed help. This coincided with Herbert et al. (2018) who noted that social support, especially via family and friends, protects against symptoms of PTSD, depression, and suicidal ideation in OEF/OIF veterans.

Theme 5: Enhancing the Provider's Skill Sets

Behavioral health providers and agencies are conduits for veteran encounters so their skill sets should encourage the seeking and retention of services to enrich a veteran's behavioral health. Given the abundant need for behavioral health services among OEF/OIF veterans, researchers are strengthening attention paid to likely barriers and facilitating the use of behavioral health services (Fox et al., 2015). Respondents throughout my study described engagements with the Department of VA, private practice, and community providers, furnishing an intrinsic view of the provider's capabilities. The respondents' engagements correlated with Signoracci et al. (2014) who shared that providers expressed a sense of urgency to connect with the growing OEF/OIF veterans for treatment and a desire to make counseling accessible. Unfortunately, most counselors do not understand the lived experiences or post-deployment challenges of OEF/OIF veterans with PTSD (Hayes et al., 2017). I believe this is because many counselors did not serve in the military, and they did not engage in veteran-based cultural competency learning. Some participants in my study requested that providers learn an

evidence-based therapy and adhere to it so that veterans could receive help for their PTSD. This corresponded with Hundt et al. (2018) who identified various trauma-focused therapies as the most efficient for PTSD: prolonged exposure, cognitive processing therapy, and eye movement desensitization reprocessing therapy. To increase productivity, counselors should become aware of various therapies and peer support programs that help veterans address their issues (Koblinsky et al., 2017). Some participants in my research acknowledged trying various therapies and providers, continuing until they found the right fit. Their experiences coincided with Koblinsky et al. (2017) who found that veterans recommended attempting different therapies and they discussed the benefits of art therapies, whose advantages are exploring behavioral health-related issues that individuals cannot truly verbalize. Providers mentioned the need to incorporate existing technology such as telehealth, email, and smartphone applications to expand counseling for OEF/OIF veterans (Signoracci et al., 2014). One participant in my study described mindfulness as labeling what the veteran is currently experiencing as okay and managing the emotions that surround it without a need to react. This response is consistent with Barr, Davis, Diguiseppi, Keeling, and Castro (2019) who mentioned mindfulness therapy that focuses on breathing, meditation, and transitioning negative thoughts to a positive place.

Various respondents in my study mentioned another way to enhance the providers' skill set is to teach them about veterans' nuances. This information corresponds with Mohler and Sankey-Deemer (2017) who explained that veterans securing care in the private sector are less likely to be screened for PTSD and other

military service conditions. According to Rishel and Hartnett (2015), some veterans expressed a lack of confidence in private practitioners citing their need for increased training on veteran issues. One respondent in my study expressed the frustration of meeting a private sector counselor who did not understand military culture and could not correlate his PTSD symptoms with the things he experienced while deployed in Iraq. This finding is consistent with Koblinsky et al. (2017) who found that private sector providers have described inadequate expertise in counseling skills for combat-related behavioral health conditions and partial confidence in administering veteran-centric care. Another respondent from my research believed that her counselors were better trained for marital and individual issues, versus veteran-centric items. On a positive note, another respondent in my study recalled that his private-sector counselor took the time to learn about military culture and was prepared to give effective treatment. This respondent's disclosure coincides with Koblinsky et al. who noted that establishing a positive counseling bond includes a thorough screening of the client's military background, transition challenges, and behavioral health issues. The American Academy of Nursing initiated a program called *Have You Ever Served in the Military?* intending on improving awareness among private sector providers on the importance of screening for military service (Mohler & Sankey-Deemer, 2017). Multiple participants in my study were proponents of military cultural training for providers, believing that the training would improve provider/veteran engagement. This belief coincides with Koblinsky et al. who emphasized how veterans advocated that providers should accomplish military cultural

competency training to gain a better understanding of combat, trauma, and counseling for military-related issues.

The provider's understanding of military culture may improve the initial meeting process and help guide future counseling toward PTSD resolution. One participant acknowledged how two of her providers had military experience and understood the military culture, which eased their counseling interaction. Providers should understand how their questioning and inquisitiveness of their client's military service provides a learning opportunity and a method for improving counseling. Various respondents agreed that counselors should know about the veteran's military service but that they were sometimes reluctant to share their full military story. This outcome is consistent with Castro et al. (2015) who formulated a modesty paradox that conveys that veterans desire to be recognized and valued for their service to our nation; yet, they may be embarrassed or anxious when being acknowledged for this service. As counselors increase their skillset and understanding of veterans, their efforts may strengthen the veteran's desire to retain treatment, working toward issue resolution.

Theme 6: Ways to Retain Counseling

From a counselor's perspective, a frustrating aspect of counseling involves enrolling a veteran into services only to have them fail to follow-up or drop out of treatment. The failure to retain veterans may be attributed to various factors as my research uncovered differing reasons contributing to these actions. These discoveries coincide with Doran et al. (2017) who noted that addressing PTSD remains a major challenge for veterans as behavioral health engagement and retention rates remain low.

Some of the respondents in my study admitted that they have not continued counseling after attending a few initial sessions. This behavior is consistent with Goetter et al. (2015) who emphasized that OEF/OIF veterans drop out of treatment at higher rates than veterans of other service eras (Korean War, Vietnam Conflict, Gulf War). Doran et al. (2017) contributed that although use levels were higher than expected, OEF/OIF veterans were 24% less likely to receive an adequate level of care in a specified timeframe, suggesting a problem with treatment retention.

According to Williston, Roemer, and Vogt (2019), veterans with behavioral health conditions expressed views of mental health treatments do not work, mental health counselors cannot be trusted, and mental health treatment should be a last resort. Some participants in my study recalled instances of negative behavioral health service engagement that made it difficult for them to remain with that provider. Still, other participants pinpointed negative aspects of the provider's methodology that caused them to leave treatment. One of my respondents recalled feeling like being the provider's paycheck because the provider was being paid for not delivering knowledgeable treatment methods. Another participant in my study reminisced about completing an initial intake session, but since there was no follow-up, that individual fell out of treatment (and remains out of treatment).

Another retention deterrent involved inconsistency while interacting with a provider. Sometimes respondents met with multiple providers, during initial visits, to clarify the treatment options. This action is consistent with Hundt et al. (2018) who reported that some veterans reported expecting to receive counseling from their initial

provider and did not understand that a separate counselor consult was required, which led to discontinuing treatment with behavioral health services. Participants in my study noted how provider inconsistencies led to an inability to connect and heightened the desire not to return. Another of my study's participants mentioned seeing various providers to *get the right fit* while another participant is not currently in treatment because after moving to Delaware, she did not want to retell her story to another provider. This correlates with Hundt et al. (2018) who found a lack of continuity of care, exacerbated by the assessment process, also made it difficult for some veterans to engage because they felt exposed or frustrated by telling their story to multiple, different providers.

Other challenges to the retention of behavioral health services centered around employment, college, and transportation/distance, specifically for work: difficulty getting time off, long workdays, frequent work travel, and unsupportive supervisors (Hundt et al., 2018). One participant in my research spoke to how her job, especially as a new civilian, interfered with her ability to maintain her counseling appointments. She recollected how her counselor would scold her for not making a follow-up appointment as she felt too busy with life to reschedule. Another respondent from my research provided examples of veterans having employment and school commitments, minimizing their ability to maintain counseling appointments. Providers need to consider the veterans' obligations concerning retaining counseling engagements, especially as they are trying to advance in postmilitary life.

Several participants in my study emphasized the importance of having someone close to them, to help assist them in their behavioral health journey. This is consistent

with Graziano and Elbogen (2017) who reported that providers should explore veterans' belief systems about perceived treatment needs as well as investigate the role of social support to improve behavioral health treatment use. Multiple respondents in my study acknowledged that they could not remain in counseling without additional support, with one respondent explaining how his mother and wife encouraged him following each appointment and confirming the rescheduling of appointments. These disclosures correlate with Elnitsky et al. (2017) who found that providers should endorse family and friendships as important resources and build on these supports to facilitate counseling, through veteran peer-based outreach and therapy.

To encourage veterans to return to counseling, providers must identify the client's belief systems, preferably in the first session, to encourage retention of treatment because the veteran may not believe they need help (Graziano & Elbogen, 2017). All participants in my study mentioned the significance of their initial counseling session and how it led to or discouraged follow-up appointments. Counselors would benefit from learning about the characteristics of veterans while blending that knowledge with methods to maintain counseling. Various respondents in my study believed that providers would benefit from completing military cultural competency training and from asking questions during counseling sessions to bolster their skill set. According to Elnitsky et al. (2017), community-based providers could encourage veterans to remain in counseling, via collaborations with VA and DoD (Department of Defense) services focusing on veteran reintegration programs. This promotes a connection between federal and community

providers, increasing counseling options for veterans, and expanding retention opportunities.

It was noteworthy that female respondents expressed the role of gender and how it influenced their retention of counseling. Their comments are consistent with Gallegos et al. (2014) who mentioned that mental health clinics should provide a *gender-sensitive* environment, defined as a setting where *women can feel safe and secure*. Many female veterans perceived VA facilities as male-oriented given a large number of men from multiple war eras being treated there (Koblinsky et al., 2017). In speaking with a female veteran colleague, she expressed displeasure with entering a VA facility because of the catcalls and request for a date from males, when she just wanted to attend her appointment. Although female veterans have counseling options with both VA and community agencies, overall, it is important for them to feel comfortable with the providers (regardless of gender) in an atmosphere that promotes positive engagement and retention of counseling.

Theme 7: Female Veterans Should Only See Female Providers

Females are an intricate part of the veteran structure and while serving the nation have been placed closer to combat than ever before during recent conflicts (Rishel & Hartnett, 2015). Various respondents in my research discussed their struggles with blending into the military environment and believed that their struggles contributed to their PTSD. This finding is consistent with Jacobson et al. (2015) who found that women have been working towards occupational equality in the military for many years and earned the right to have their views heard during research. Although this theme deals

with female veterans and female providers, I want to incorporate information about female veterans' military encounters.

According to Haun et al. (2016) as the number of female veterans increases, the VA behavioral health care system has moved to meet their unique needs through female-only focus groups that explored their particular concerns. When discussing support, women expressed a strong preference for attending female-only groups and connecting with female practitioners (Koblinsky et al., 2017). Participants in my study acknowledged how changes are needed within the VA behavioral health system to create a comfortable environment for women. These views align with Haun et al. (2016) who described female veterans as feeling vulnerable and uneasy with receiving VA services because of their perception of the VA as a male-dominant health care culture. This negative perception has led the VA, as compared to previous years, to formulate more female-centric initiatives within their care for PTSD. One respondent in my study was adamant that the VA was her preferred treatment source, but only with a female provider, although other female respondents preferred community or private practice care. This information coincided with Gallegos et al. (2014) who reported that although female veterans are more likely than male veterans, to seek behavioral health services, they preferred services from non-VA facilities.

During my research, female participants disclosed a unique set of concerns related to their PTSD. This coincides with Haun et al. (2016) who found that females are at risk for PTSD and military sexual trauma (MST) and comprise an increasingly large and underserved portion of the veteran population. Female veteran unique stressors include

MST, family separation, and role negotiation (Elnitsky et al., 2017). Two respondents in the study mentioned MST as a source of their trauma and expressed the need for a counselor who had trauma-informed care experience and who was female. This correlated with Gallegos et al. (2014) who mentioned that gender disparities or being matched with male providers, in counseling, may prevent female veterans from beginning the care they need. Female veterans recalled appointments where male providers appeared disinterested, avoided eye contact, or seemed hurried (Koblinsky et al., 2017). A female respondent in my study screamed about constantly disagreeing and conflicting with a male provider while contrasting the comfort she felt interacting with a female counselor. Gallegos et al. (2014) reported that female veterans believed that respectful treatment necessitated being familiar and up to date about women's circumstances, being familiar with the veteran's health record before she arrives, and not forcing her to repeat everything from day one up until the appointment date. Gender-sensitive engagement allows females to develop a continuous caring relationship with one behavioral health provider, often a female provider (Koblinsky et al., 2017). Each female respondent cited the importance of counselors knowing gender-related needs and concerns. This importance knowledge coincided with Koblinsky et al. (2017) who shared how gender-related relationships were vital to building hope, relating to common experiences, and expediting self-disclosure which may lead to the resolution of behavioral health symptoms.

Extended Knowledge

According to Dempsey, Butler, and Gaither (2016), Blacks trust in their church leaders and their spirituality more than pursuing assistance from behavioral health professionals. One respondent in my study, a Black male, shared his insights on the role of prayer and Black clergy linking it to veterans not seeking behavioral health services. He was responding to the question about friends or family involvement in seeking help. The participant mentioned how religion plays a major role and has significant influence within the Black community. This coincided with Dempsey et al. (2016) who mentioned how the Black church's lengthy history of support for Black worshippers is the main reason this population identifies the church as a comfort source. He spoke to having some challenging conversations with individuals who were convinced that his problem was he was not praying enough. His comments mirrored Hays and Lincoln (2017) who shared how Blacks are most likely to use prayer and will seek God's intervention when facing challenging issues. The conversation exposed his belief that Black clergy and religious family members were not prepared to offer advice to Black veterans about seeking behavioral health services. The respondent remembered seeking this population's advice on pursuing care because his PTSD symptoms were overwhelming; yet, instead of receiving encouragement to visit a professional, he was constantly asked if he had *prayed hard enough* about the issue. This matched Hays and Lincoln (2017) who confirmed that Black's religious beliefs are affiliated with negative attitudes regarding behavioral health providers and behavioral health services and also the higher one's religious beliefs, the lower their behavioral health help-seeking. The participant responded emotionally when

exclaiming how Black clergy were not equipped to assist those with behavioral health issues because they did not understand how to refer to this population for assistance. This is correlated by Dempsey et al. (2016) who posited that many of the Black clergies have no formal counseling training as compared with the education of professional counselors He believed that Black clergy and families need more information on behavioral health resources available to veterans. The conversation ended with how the Black clergy and community's reliance on prayer may be a way of avoiding veteran behavioral health issues because of this population because of a lack of understanding. Support from this came from Hays (2015) who pronounced that Blacks have a higher level of religiosity, are less likely to pursue behavioral health assistance, and have been steered to lean solely on God. I believe this is a valid topic and would benefit from additional research. If Black clergy and Black social networks are not aware of behavioral health service outlets, then veterans who seek their assistance may not receive adequate information for addressing their behavioral health needs. Improving these outlets is important because Hays (2015) stated that the Black church is a sounding board within the Black community and will continue to be asked about behavioral health concerns whether they can respond properly or not.

Connection to the Theoretical Framework

Participants in this study shared lived experiences regarding their decision to seek and retain behavioral health services relating to their posttraumatic stress. The study coincided with the hermeneutic (interpretive) phenomenological theory (Heidegger (1971), the attribution theory (Heider, 1958), and the cognitive behavioral theory (Beck,

1993). Each theory provided the structure for my data analysis and maintained the study's focus on the research question. The hermeneutic phenomenological theory stated that people are already and always connected to the world, interpreting and caring about matters surrounding them (Wilson, 2014). The common concept, for the attribution theory, is that people interpret behaviors in terms of its causes and that these interpretations play an important role in determining reactions to the behavior (Kelley & Michela, 1980). Through the cognitive behavioral theory, people learn to examine the validity of their thoughts, which generally constitutes either misinterpretations or exaggerations of a situation (Beck, 2019). Each theory served as a parameter for exploring the veterans' experiences of seeking and retaining behavioral health services.

Hermeneutic (Interpretive) Phenomenological Theory

According to Quinney et al. (2016), Heidegger emphasized that the significance of understanding individuals' origins lies in being the primary to developing an understanding of others. This means that people are a part of greater scope and cannot solely focus on functions; people must include the functions in the world surrounding them. Various respondents spoke about their engagement with society and how they strove to understand their place within this group. This finding is consistent with Crowther et al. (2017) who conveyed that hermeneutic research requires a bridging of the participants' actions and the researcher so that a connection between diverse groups can occur. Various participants expressed comfort in disclosing their behavioral health and PTSD experiences because of the bond that was developed during the interview process and included how it was influencing their place in the world. Heidegger believed that

data analysis was a constantly moving process where the researcher assessed parts, then the whole, and back to the parts again. I adhered to this belief by analyzing the various codes, themes, and then comparing them to the full transcript. I also focused on the respondent's nuances to add a fuller texture to the data analysis. Peoples (2020) noted how the hermeneutic theory can be paired with additional frameworks to expand and further the research. As a result, I also incorporated the attribution theory and cognitive behavioral theory.

Attribution Theory

Heider (1958) initiated the attribution theory, explaining that people are attentive observers, formulating assumptions on why others do what they do. This corresponded with the participants in my study and their observations of behavioral health providers and how they interpreted the providers' actions that influenced their acceptance of counseling. One participant in my study observed how she was angry daily and wondered if this was a result of a psychological imbalance, which eventually encouraged her to seek behavioral health intervention. This finding is consistent with Heider who founded the attribution theory to understand an individual's observations of everyday life and his or her questions as to why things happen. Heider emphasized how individuals seek answers for why events happen instead of just accepting the actions. This was demonstrated by participants in my study who questioned why their lives were disrupted by PTSD symptoms and wanted answers on how they could feel better. One respondent in my study continued to question multiple providers on why they prescribed medications for his psychosis and eventually persuaded the last one to deliver *only* talk therapy.

Attribution theory is connected through social perception and self-perception (Kelley, 1973), which was evident by the participants in my study and the observations of their world and the world that surrounded them. One participant in my study recalled being in group therapy and assessing the other veterans' psychoses while also looking inside himself to determine his mental status. Many participants in my research relied on family and friend observations, not only theirs, to help initiate and maintain behavioral health treatment. These participants also expressed concern about providers not knowing the veterans' social characteristics, believing better knowledge promoted treatment compatibility. This coincided with Weiner (2008) who noted that individuals seek causes from any event, action, or occurrence. Participants in my research discussed multiple factors that encouraged or discouraged their bond with behavioral health services. For the female veterans, many felt comfortable with female providers, relaying how their counseling was enhanced because their provider was a woman. One respondent in my study adamantly expressed that having a female provider was the only way she could feel comfortable and could disclose information during the counseling process. Overall providers can incorporate the attribution theory by using the theory's straightforward, common-sense approach during the counseling process (Kelley, 1973).

Cognitive Behavioral Theory (Therapy)

The CBT was devised to understand clients' interpretations and harmful thinking following the disclosure of negative cognitions (Beck, 2019). All participants in my study expressed how negative thoughts affected their ability or desire to pursue behavioral health services for PTSD. This correlated with Beck (2019) who specified how negative

cognitions were misinterpretations of prior situations, so the goal was to reframe the client's thought processes. Some participants in my study exalted the benefits of CBT reframing, highlighting how it minimized their negative thoughts and helped develop resilience. This coincided with Beck (2010) who noted that when individuals handle their thoughts more sensibly and adaptively, they gain poignant, behavioral successes. Many participants during my research realized that counseling is a continuous thing and needs to be done continuously to provide the counseling tools needed to deal with everyday life. This fact is consistent with Beck (1993) who found that CBTs are meant to transform inaccurate beliefs and reverse negative thinking so it is important to gather veteran buy-in so they can face their concerns.

CBT has a strong theoretical infrastructure that is backed by established support and research touting its effectiveness with psychological issues (Beck & Dozois, 2011). CBT is a preferred approach for PTSD, and therapists who treat PTSD should be familiar with its application (Levi et al., 2016). Participants in my study, especially those who received VA treatment, recalled the characteristics of CBT treatments. The therapy, provided one-on-one, is a first-line PTSD treatment meant to facilitate client disclosure (Falkenstein et al., 2017). Another participant in my study remembered that CBT was not the same session every time as some sessions were uplifting but most were not because they were thought-provoking and took the veteran to uncomfortable places. Not all CBT interactions were positive as some respondence during the study recalled troublesome counseling experiences. One respondent in my study remembered successful CBT involved bringing up negative deployment situations and being able to discuss them,

which cause her to stop counseling. Another study participant remembered CBT as recalling the most traumatic event during every session, believing that it would never end. Both views correlate with Hofman, Asmundson, and Beck (2013) who found that because CBT presumes that dysfunctional thinking of past trauma coincides with current emotions related to the trauma, therapy explores the memory of the trauma, which can be difficult for clients. Many of the respondents in my study reported seeking relief due to altered thinking related to their PTSD. This is consistent with Hofman et al. who noted that the objective of CBT is to increase the client's capacity to gain sensible and thorough images of their present circumstances.

Limitations of the Study

The purpose of this hermeneutic phenomenological study was to understand the lived experiences of OEF/OIF veterans regarding their decision to seek and retain behavioral health services for addressing posttraumatic stress. According to Wilson (2014), hermeneutic phenomenology allows me, as a researcher, to interpret a particular lifeworld by concentrating on versions and observations of participants' lived experiences. Various limitations were identified in the study. The study only focused on OEF/OIF veterans in a combat or support role in Afghanistan or Iraq eliminating data collection from other conflict groups (Korean War, Vietnam War, Gulf War). Another limitation was this study used a small sample size (eight participants), which was purposefully selected to make sure the participants fit the criteria for the study. A further limitation of this hermeneutic phenomenological study was the geographic location, as all participants were from the State of Delaware, and candidates from other areas were

excluded from the study. The final limitation of this study was that participants self-disclosed to having posttraumatic stress, and I did not verify the participant's diagnoses through formal channels.

Recommendations for Future Research

OEF/OIF veterans face numerous challenges during and following their military service, among them is an elevated risk for PTSD and the mental limitations that accompany the condition (Doran et al., 2017). I discovered that the veterans' avoidance of or sporadic use of behavioral health services can have a detrimental impact on their quality of life and mental stability. This is reinforced by Armenta et al. (2018) who stated that the high percentage of veterans with chronic PTSD reinforces the need for additional widespread and accessible treatment following separation from the military. Participants in my research expressed the positive influence of behavioral health services and providers who helped them encounter their PTSD symptoms. All participants in my study disclosed accounts of PTSD struggles and described their attempts to access and retain counseling. The participants in my study highlighted their relationship with behavioral health providers and how the relationship encouraged their follow-up treatment. Some respondents in my study mentioned their provider's skill set helped sustain counseling effectiveness and helped maintain attendance for treatment. This finding is consistent with Fox et al. (2015) who noted a significant need is to research aspects related to sustained engagement in counseling because many veterans who seek behavioral health care initially do not receive a minimally useful number of sessions. Future research may help examine how veterans can better learn about the value of behavioral health services

and its positive influence on addressing PTSD. Additional research could study how to motivate behavioral health providers to use cultural competency training for improving their veteran knowledge. Further research might enhance information, for behavioral health services, to expand the marketing and retention of veteran clients.

Implications for Social Change

The goal of this study was to understand the importance of veterans in seeking and retaining behavioral health services for addressing their posttraumatic stress symptoms. This coincided with Doran et al. (2017) who posited that veterans face various challenges during and following their military service, including an elevated risk for PTSD. This study provided opportunities for veterans to share lived experiences associated with behavioral health services. My research may be used to provide insight into how it is possible for OEF/OIF veterans, with PTSD, to seek and retain behavioral health services. My findings are in line with Litz (2014) who expounded that research must highlight the problems and concerns associated with veterans' PTSD and offer strategies to remedy their effects. Findings from this study may educate various professional disciplines about the challenges that veterans face when it comes to requesting and maintaining behavioral health services. Future researchers may be able to discover which cultural competency training work to help providers become accustomed to veteran clients. This study may supplement behavioral health providers in improving understanding of veterans' characteristics so that they can better deliver counseling services. This study could be employed to establish a foundation for additional research and to increase the understanding of this topic.

Conclusion

The purpose of this hermeneutic phenomenological study was to understand veterans' perceptions of behavioral health services and share their lived experiences as it relates to PTSD. This purpose coincided with Crowther et al. (2017) who revealed that the aim of hermeneutic phenomenological research is for the study to encourage thinking and provoke reinterpretations of lived experiences. Each participant, with confessed PTSD, disclosed personal encounters of dealing with behavioral health services. The outcomes corresponded with Armenta et al. (2018) who mentioned the path of PTSD varies, but the symptoms can become persistent and last years or even a lifetime. Respondents in this study professed how they were influenced by behavioral health providers, family/friends, and themselves as they sought to overcome counseling barriers. This study allowed me to deliver information encompassing a population that may be misunderstood, by behavioral health providers, because of limited military cultural knowledge. It should be noted that veterans can range in ages from 92 (World War II) through age 22 (Afghanistan conflict) embracing innumerable characteristics of race, gender, sexual identity, social-economic status, and more. I formulated mutual themes shared by the participants that were entitled: dealings with posttraumatic stress, getting veterans to counseling, relations with providers, family and/or friend involvement, enhancing the provider's skill sets, ways to retain counseling, and female veterans should only see female providers. Behavioral health provider's lack of knowledge of veterans' characteristics can adversely affect veterans seeking and retention of behavioral health services. Further research studies are proposed to augment the results of this study and to

better understand the lasting effects of how veterans' perceptions of behavioral health services can influence their care. Reminders of PTSD are ever-present in OEF/OIF veterans lived experiences; counseling is necessary but finding and maintaining services with a well-matched provider remains difficult.

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Appendix A: Interview Questions and Debrief Script

Open-ended Interview Questions

1. Could you share one of the most rewarding experiences that you had being a veteran? [designed to help the participant feel at ease and build researcher rapport]
2. How much time did you serve in the military? What branch did you serve in?
3. Please share your experiences in dealing with post-traumatic stress. If it isn't too uncomfortable, could you give some examples?
4. What were your experiences like, seeking behavioral health services for post-traumatic stress?
5. Please describe, if applicable, any engagement you had with family or friends who recommended behavioral health services. How did their involvement make you feel?
6. After finding behavioral health services, if applicable, what were your experiences like using their services? Are you still using their services?
7. Please describe one positive or negative experience that highlighted your view of behavioral health services? Do you still think that way?
8. What would have initially helped behavioral health services attract and retain you as a veteran?
9. Is there anything else you would like to share that I did not cover?

Debriefing Steps:

- This concludes our interview and I appreciate your openness. Should you feel any discomfort, please refer to the list of behavioral health resources.
- The next steps involve transcribing and assessing the data by this researcher. If I have additional questions, I would appreciate your permission to do a follow-up session(s).
- When I complete the study, you can request a summary of the research study.
- Please note, your confidentiality is very important to me. As a result, I will not use any identifying information in the interview transcript, the final summary, or the research document.

Appendix B: Demographic Screening Questionnaire

The purpose of this study is to understand the lived experiences of veterans regarding their decision to seek and retain behavioral (mental) health services.

Please respond to the following inclusion criteria questions:

- Are you an English speaking OEF/OIF veteran, who is at least 18 years of age or older? Yes/No

  Please enter the four-digit year in which you were born: _____ [for Age Compliance]

- Do you self-identify as having post-traumatic stress symptoms? Yes/No
- Have you ever been referred for behavioral (mental) health services? Yes/No
- Are you a resident of Delaware or a resident of Pennsylvania, New Jersey, or Maryland living within 30 miles of Delaware? Yes/No

  Please enter the initials of the state in which you live: _____